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SENATE

REPORT
No. 473

MEDICAL CARE VENDOR PAYMENTS

JUNE 20, 1957.—Ordered to be printed

Mr. BYRD, from the Committee on Finance, submitted the following

REPORT

together with

MINORITY AND SUPPLEMENTARY VIEWS

[To accompany H. R. 7238]

The Committee on Finance, to whom was referred the bill (H. R. 7238) to amend the public assistance provisions of the Social Security Act so as to provide for a more effective distribution of Federal funds for medical and other remedial care, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

PURPOSE OF THE BILL

H. R. 7238, as amended by your committee, is intended to assure that no State need lose Federal funds under the provisions of the Social Security Amendments of 1956 (Public Law 880, 84th Cong.) that are effective July 1, 1957, relating to Federal financial participation in expenditures made in the form of payments to suppliers of medical care for public assistance recipients (commonly called "vendor payments"). H. R. 7238, as passed by the House, proposed to accomplish this result by allowing States to use either the method of claiming Federal participation in the cost of vendor medical care payments that is in effect until June 30, 1957, the new method provided by Public Law 880 effective July 1, 1957, or a combination of both of these methods.

The bill as amended by your committee proposes to accomplish this result at less expense by allowing States to choose either the method now in effect or the method provided by Public Law 880. With this choice any State that would lose Federal funds under the provisions of Public Law 880 may continue under its present system for any of its public assistance programs, while those States that would receive additional funds under the provisions of Public Law 880 would be free

to choose that method. The choice would be made on a program-by-program basis.

REASONS FOR AND EXPLANATION OF THE LEGISLATION

Since the 1950 amendments to the Social Security Act, Federal financial participation in State expenditures for old-age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled has been available with respect to unrestricted money payments made to needy recipients of assistance and with respect to payments made directly to suppliers of medical or remedial care (vendor payments) on behalf of such recipients. The Federal Government has not participated, however, in that part of the total assistance, including both the money payment to the individual and any medical care vendor payments made on his behalf for any month to the extent that the total of such payments exceeded a specified maximum. Since October 1, 1956, under the provisions of Public Law 880, this maximum has been $60 in all of the programs except aid to dependent children (to which different amounts apply).

Public Law 880 also included provisions for the separate matching of vendor payments for medical care. Under these provisions the total amount of vendor payments for medical care in which the Federal Government will participate is $6 times the number of adult recipients and $3 times the number of child recipients. The Federal Government's share within these limits is one-half. Thus, under these provisions, no State could receive in Federal funds more than an average of $3 per adult recipient and $1.50 per child recipient. While approximately 14 States are making direct payments of medical care in excess of the $6 and $3 limits with respect to which Federal sharing will be available under the provisions of Public Law 880 becoming effective July 1, only 1 State would receive substantially less, for all of its public assistance programs combined, under these provisions than it is now receiving with respect to vendor medical care payments and only 2 other States would suffer a small loss. Three additional States, while suffering losses in one or another of the public assistance programs in which the Federal Government participates financially, would receive more in Federal funds than now with respect to their vendor medical care payments in all of their Federal-State assistance programs taken as a whole.

H. R. 7238 as passed by the House would permit any State to receive matching as at present within the individual maximums on the amount of the cash payment to the individual and the vendor medical-care payments on his behalf, and, in addition, to receive matching of the vendor payments under the provisions of Public Law 880 if the amount of the expenditures in this form is sufficient to warrant Federal matching under both formulas. This would result in gains for all of the 14 States that are currently expending more than an average of $6 per adult and $3 per child for medical-care payments to suppliers and would, in effect, assure to each such State up to an additional $3 in Federal funds for adult recipients and $1.50 in Federal funds for child recipients.

The Department of Health, Education, and Welfare estimates that on the basis of the present vendor medical care payment expenditures by the States the additional cost of H. R. 7238 as passed by the House

would be $26.4 million annually in Federal funds. It was agreed by all concerned that this additional cost was a maximum and that it was likely to be reduced (in comparison with the cost of the Public Law 880 provisions becoming effective July 1, 1957) to some extent by the States changing a part of their payments now being made directly to suppliers of medical care into additional payments to the recipients on an unrestricted cash basis within the individual maximums on money payments—thereby increasing the matching funds received under the provisions of Public Law 880. There was some disagreement, however, on the extent to which such reduction would be made. Representatives of some of the States indicated that substantially all of the additional cost would be thus eliminated. Representatives of the Department, on the other hand, did not acknowledge that a major part of the cost could be eliminated in this way and they did not believe that as a practical matter the States would, to any substantial degree, make such changes—changes which all agree are undesirable from the standpoint of administration and public relations and may possibly increase administrative costs.

The provisions of Public Law 880 affecting the method of Federal sharing in the cost of vendor medical care payments will not become effective until July 1, 1957. The effect these amendments will have in particular States among those which now provide vendor payments for medical care (approximately half of the States have not, up to this time, made such payments with Federal participation) cannot, thus, be assessed on the basis of experience.

The bill reported out by your committee will assure that no State need receive less in Federal funds under any of its Federal-State public-assistance programs with respect to its vendor payments for medical care than it is now receiving. It would do this by giving to each State the option of continuing to receive its Federal matching of such vendor payments either as at present (within the individual maximums on the cash payments to or vendor medical care payments on behalf of the individual) or receiving the Federal funds with respect to these vendor payments under the new provisions of Public Law 880 which become effective on July 1, 1957. This choice could be made once a year, or less frequently, as the State desired, and with respect to each of its Federal-State public-assistance programs.

Since all States that stand to lose funds for vendor medical care payments under the provisions of Public Law 880 with respect to all of their Federal-State public-assistance programs combined expect to receive more Federal funds for payments in at least one of their programs, the committee bill would result in some additional funds for them under this choice. At the same time, it would preserve in large measure the advantages of separate matching of vendor payments which the Congress sought to achieve through the enactment last year of the provisions in Public Law 880 relating to Federal sharing in the cost of such payments.

The Department of Health, Education, and Welfare estimates the cost of the committee bill at $8.6 million per year in comparison with an annual cost of $26.4 million for H. R. 7238 as passed by the House of Representatives, assuming continuation by the States of their present expenditures in the form of vendor medical-care payments.

Your committee believes that the assurance to each State that it need not lose funds under any program and the indication that all

of the States which anticipate a loss under Public Law 880 will actually receive some increase in Federal funds for vendor medical care payments affords sufficient protection to all States. It has, therefore, amended H. R. 7238 to incorporate this assurance and at the same time to reduce the larger costs which it is advised would be entailed if the House bill were passed.

CHANGES IN EXISTING LAW

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets; new matter is printed in italics; existing law in which no change is proposed is shown in roman):

PUBLIC LAW 880—84TH CONGRESS

CHAPTER 836—2D SESSION

H. R. 7225

AN ACT To amend title II of the Social Security Act to provide disability insurance benefits for certain disabled individuals who have attained age fifty, to reduce to age sixty-two the age on the basis of which benefits are payable to certain women, to provide for child's insurance benefits for children who are disabled before attaining age eighteen, to extend coverage, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Amendments of 1956".

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TITLE III—PUBLIC ASSISTANCE AMENDMENTS

DECLARATION OF PURPOSE

SEC. 300. It is the purpose of this title (a) to promote the health of the Nation by assisting States to extend and broaden their provisions for meeting the costs of medical care for persons eligible for public assistance by providing for separate matching of assistance expenditures for medical care, (b) to promote the well-being of the Nation by encouraging the States to place greater emphasis on helping to strengthen family life and helping needy families and individuals attain the maximum economic and personal independence of which they are capable, (c) to assist in improving the administration of public assistance programs (1) through making grants and contracts, and entering into jointly financed cooperative arrangements, for research or demonstration projects and (2) through Federal-State programs of grants to institutions and traineeships and fellowships so as to provide training of public welfare personnel, thereby securing more adequately trained personnel and (d) to improve aid to dependent children.

PART I—MATCHING OF ASSISTANCE EXPENDITURES FOR MEDICAL CARE

MEDICAL CARE FOR OLD-AGE ASSISTANCE RECIPIENTS

SEC 301. (a) Clauses (1) and (2) of section 3 (a) of the Social Security Act are each amended by striking out "during such quarter as old-age assistance under the State plan" and inserting in lieu thereof "during such quarter as old-age assistance in the form of money payments under the State plan".

(b) Section 3 (a) (1) (A) of such Act is amended by striking out "who received old-age assistance for such month" and inserting in lieu thereof "who received old-age assistance in the form of money payments for such month".

(c) Section 3 (a) of such Act is further amended by inserting the following new clause immediately before the period at the end thereof: ", and (4) in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan in the form of medical or any other type of remedial care (including expenditures for insurance premiums for such care or the cost thereof), not counting so much of such expenditure for any month as exceeds the product of $6 multiplied by the total number of individuals who received old-age assistance under the State plan for such month".

MEDICAL CARE FOR RECIPIENTS OF AID TO DEPENDENT CHILDREN

SEC. 302. (a) Clauses (1) and (2) of section 403 (a) of the Social Security Act are each amended by striking out "during such quarter as aid to dependent children under the State plan" and inserting in lieu thereof "during such quarter as aid to dependent children in the form of money payments under the State plan".

(b) Section 403 (a) (1) (A) of such Act is amended by striking out "with respect to whom aid to dependent children is paid for such month" and inserting in lieu thereof "with respect to whom aid to dependent children in the form of money payments is paid for such month".

(c) Section 403 (a) of such Act is further amended by inserting the following new clause immediately before the period at the end thereof: "; and (4) in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as aid to dependent children under the State plan in the form of medical or any other type of remedial care (including expenditures for insurance premiums for such care or the cost thereof), not counting so much of such expenditure for any month as exceeds (A) the product of $3 multiplied by the total number of dependent children who received aid to dependent children under the State plan for such month plus (B) the product of $6 multiplied by the total number of other individuals who received aid to dependent children under the State plan for such month".

MEDICAL CARE FOR RECIPIENTS OF AID TO THE BLIND

SEC. 303. (a) Clauses (1) and (2) of section 1003 (a) of the Social Security Act are each amended by striking out "during such quarter as aid to the blind under the State plan" and inserting in lieu thereof

"during such quarter as aid to the blind in the form of money payments under the State plan".

(b) Section 1003 (a) (1) (A) of such Act is amended by striking out "who received aid to the blind for such month" and inserting in lieu thereof "who received aid to the blind in the form of money payments for such month".

(c) Section 1003 (a) of such Act is further amended by inserting the following new clause immediately before the period at the end thereof: "; and (4) in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan in the form of medical or any other type of remedial care (including expenditures for insurance premiums for such care or the cost thereof), not counting so much of such expenditure for any month as exceeds the product of $6 multiplied by the total number of individuals who received aid to the blind under the State plan for such month".

MEDICAL CARE FOR RECIPIENTS OF AID TO PERMANENTLY AND TOTALLY DISABLED

SEC. 304. (a) Clauses (1) and (2) of section 1403 (a) of the Social Security Act are each amended by striking out "during such quarter as aid to the permanently and totally disabled under the State plan" and inserting in lieu thereof "during such quarter as aid to the permanently and totally disabled in the form of money payments under the State plan".

(b) Section 1403 (a) (1) (A) of such Act is amended by striking out "who received aid to the permanently and totally disabled for such month" and inserting in lieu thereof "who received aid to the permanently and totally disabled in the form of money payments for such month".

(c) Section 1403 (a) of such Act is further amended by inserting the following new clause immediately before the period at the end thereof: "; and (4) in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan in the form of medical or any other type of remedial care (including expenditures for insurance premiums for such care or the cost thereof), not counting so much of such expenditure for any month as exceeds the product of $6 multiplied by the total number of individuals who received aid to the permanently and totally disabled under the State plan for such month".

EFFECTIVE DATE

SEC. 305. *(a) Except as provided in subsection (b), the* [The] amendments made by this part shall become effective July 1, 1957.

(b) The amendments made by any section of this part shall not apply to any State (as defined in section 1101 of the Social Security Act for purposes of title I thereof) for any fiscal year for which there is in effect an election by it not to have the amendments made by such section apply to it. Any such election shall be in effect for a fiscal year only if notice of the election has been filed with the Secretary of Health, Education, and Welfare at some time prior to May 16 of the preceding fiscal year, except that any such election shall be in effect for the fiscal year beginning July 1, 1957, if notice of the election is filed with the Secretary prior to August

1, 1957. An election by a State under this subsection shall continue in effect until the close of any fiscal year designated in a notice of termination of such election which is filed with the Secretary of Health, Education, and Welfare prior to May 16 of such year. Elections hereunder shall be made, and notices thereof and notices of termination shall be filed, on such form or forms and in such manner as the Secretary of Health, Education, and Welfare may prescribe.

MINORITY VIEWS

We, the undersigned, dissent from the action of the Senate Finance Committee and support, instead, the language of H. R. 7238 as passed by the House. The central issue is whether States will be allowed to continue the freedom of choice they now have as to how they shall make medical payments.

I. EXPLANATION

1. The present law

Under the present law States may claim up to the maximum Federal ceiling per person for the four traditional public assistance programs, i. e., aid to the blind, the old-age and survivors program, aid to the disabled, and aid to dependent children. This is known as the $60 program.

At the present time, medical payments under these programs may be paid directly to the recipient of the service in cash or directly to the vendor of the service, i. e., doctors, hospitals, druggists, nursing homes, etc. States have a choice and may make either "cash" or "vendor" payments.

2. The new law

On July 1 the full provisions of Public Law 880, passed by the Congress last year, go into effect. Under the new law, the traditional or $60 program is continued. In addition, a new program of "vendor" medical payments begins. This new program is called the "$6 and $3" program. The Federal Government will match one-half of $6 paid in "vendor" payments for adults and one-half of $3 paid in "vendor" payments for children.

Under the traditional $60 program, medical payments can continue, but they must be made in "cash." This means that any State with present vendor medical payments in excess of $6 must have 2 programs (1) "cash" payments under the $60 program and "vendor" payments under the $6–$3 program. There are some 15 such States and they include Connecticut, Illinois, Indiana, Kansas, Massachusetts, Minnesota, New Hampshire, New York, North Dakota, New Mexico, Ohio, Oregon, Rhode Island, Washington, and Wisconsin. A number of other States, such as Colorado and California, because their average cash payments exceed $60, will be forced to go to the vendor method.

A number of other States are planning expanded programs beginning July 1 on the assumption that they could take advantage of the new $6–$3 program as well as the traditional $60 program. These States, some of whose legislatures have already adjourned, include Pennsylvania, New Jersey, Louisiana, Iowa, Nevada, Vermont, Oklahoma, and Michigan.

3. The House-passed bill

The House-passed bill differs from Public Law 880 in only one major respect. It allows States the freedom of choice to make either

"cash" or "vendor" payments under the traditional $60 program—which is presently the law—and, in addition, to qualify for the new $6–$3 program. Under Public Law 880, States may qualify for the new $6–$3 program only if they make "cash" payments under the traditional $60 program.

4. The Senate amendment

Under the Senate amendments States may have the choice of either "cash" or "vendor" payments under the traditional $60 program only if they forego the new $6–$3 program.

As a practical matter, all but one to three States—because of the Federal matching funds involved—will make cash payments under the $60 program and thereby qualify for the new $6–$3 program, even though they might prefer to make vendor payments under the $60 program as they are now doing or as they might like to do in order to avoid two systems of payments.

II. ARGUMENT

There are three principal arguments in favor of the language of the bill as passed by the House. These are (1) the right of States to freedom of choice and the avoidance of dual systems, (2) the superiority of the vendor payments system, and (3) the little or no additional cost to the Federal Government of the House passed bill as opposed to the Senate amendment.

1. Freedom of choice

For many years, prior to 1950, States were allowed to make only "cash" payments under the traditional programs. In 1950, they succeeded in gaining the right to select their own system of payment, either "cash" or "vendor" as they saw fit. In 1956 this choice was taken away. Some States prefer one method and some the other. They should be allowed to keep this choice. If this choice is not retained and in order for States to qualify for full Federal matching under the 1956 law, they will have to set up two separate systems—cash and vendor—with the additional administrative costs involved. In Illinois, for example, it is estimated that the administrative cost of a cash system would amount to an additional $870,000 on an annual basis, for which the Federal Government would pay 50 percent or $435,000 per year. Further, it would require 180 additional staff personnel in that State alone.

Those States with a "cash" system will have to set up a new "vendor" system to qualify for the $6–$3 program. Those States with a "vendor" system under which average payments exceed $6, must shift to a "cash" system if they are to qualify for Federal matching funds in excess of $6.

It would appear, then, that two separate issues are involved; i. e., freedom of choice and the avoidance of a dual system.

2. The superiority of the "vendor" system

The States with the most comprehensive medical programs have, in almost every case, selected the "vendor" payment method under the traditional $60 program. These are the States which must shift to "cash" payments under the new law or will shift to "cash" under the Senate amendment in order to retain the funds for which they can now

qualify. The "vendor" payment system has proven the better system for several reasons. Among them are:

(*a*) Administrative costs are lower and administrative procedures are simpler.

(*b*) It insures that the vendor receives payment.

(*c*) It avoids confusion among recipients of medical care and insures that they receive that care. This would not always be the case if the recipient were given cash to purchase the service for himself. This is particularly true of the very aged, the senile, or those who lack knowledge of the detailed purposes for which their total monthly public assistance funds are given.

(*d*) Services tend to be less expensive where the vendor is insured of payment. Doctors, for example, tend to charge less for office calls for those they know are on public assistance and for whom payment is assured through the State public aid commission than for those whom they do not know are on public assistance and from whom payment is not assured.

(*e*) If States shift to the "cash" system, they will have few records of the particular diseases and ailments for which payments are made. At the present time States with "vendor" payments know these facts from the bills which are presented directly to them. This allows proper coordination with rehabilitation agencies for the physically handicapped and contributes specific knowledge of the diseases of those on public assistance which is helpful in medical research in geriatrics, in the field of the physically handicapped, and in preventive medicine.

The Department of Health, Education, and Welfare, in commenting on S. 1209, a bill substantially the same as the House language of H. R. 7238, made this point very well in their letter to the chairman of the Finance Committee:

> The type of changes described (shifting to the "cash" system), however, are in many instances not desirable. Suppliers of medical care and services would much prefer to receive payment directly rather than to rely on receiving payment from the recipient out of the money given to him for his unrestricted use. Also the fact that medical costs are frequently large, nonrecurring costs make direct payment appropriate. Undue emphasis on attempting to provide certain medical needs through giving money directly to the recipient would undoubtedly lead to both confusion and dissatisfaction in the affected States where medical expenditures are already substantial.

We concur in that statement and for that reason, primarily, support the House language as opposed to the Senate amendments.

Cost

The Department of Health, Education, and Welfare assigned a "maximum" cost of $26 million to the House passed bill as opposd to $8.6 million to the Senate amendment. In other words, the cost of the House bill is placed at $18 million above the Senate amendment. We believe that these "maximum" cost figures are excessive.

In the first place, we have been informed by the Department that the additional administrative expenses for which the Federal Government would be obligated if the Senate amendment goes into effect on

July 1 have not been taken into account. This is a cost attributable to the Senate amendment and which is not attributable to the House language and, by itself, reduces the differential between the estimated costs of the two bills.

In the second place, the States, by going on the "cash" system on July 1, if they are forced to do so, may actually qualify for the amounts they may qualify for under the House language of H. R. 7238. This is made clear from the Department of Health, Education, and Welfare's letter to the chairman of the Senate Finance Committee commenting on S. 1209. After giving maximum cost figures for the various proposals, that letter stated:

> It should be noted, however, that States are free to meet more of the medical needs of the recipients through money payments made directly to the recipients and to correspondingly reduce the payments for medical care made directly to doctors, hospitals, nursing homes, druggists, etc. Insofar as this occurs, and the States affected have indicated that such modifications will be utilized to the greatest possible degree, both the net additional cost attributable to S. 1209 and the cost of the suggested option (the Senate amendment) will be reduced.

In the Senate hearings, it was admitted by representatives of the Department that the costs of H. R. 7238 as passed by the House and the Senate amendment were "theoretically" the same. As State public-aid commissioners are obligated to secure the maximum Federal funds, the practical as well as the theoretical costs would be substantially the same.

In other words, the only substantive issue between the bill as passed by the House and the bill as reported by the Senate Finance Committee is whether the States may have a choice of the method of medical payments under the traditional $60 program or whether they shall be required by Federal statute to make those payments in "cash."

III. CONCLUSION

We believe that the House language is much to be preferred over the Senate amendment. We believe this because:

(1) States should continue to have freedom of choice as to how medical payments shall be made under the traditional $60 program.

(2) As a matter of public policy the promotion of vendor payments is much to be preferred over "cash" payments. The Senate amendment makes "cash" payments mandatory if States are to qualify for the new $6 and $3 program which they have every right to qualify for under the 1956 social-security amendments.

(3) By making a transition to the "cash" system, States can, in fact, qualify for Federal grants substantially equal to those for which they could qualify under the Senate amendment. Therefore, the cost of the House bill as opposed to the Senate amendment is insignificant. In fact, when it is understood that the Federal Government is obligated to match, on a 50-50 basis, the additional administrative costs occasioned by shifting to the cash system, it is entirely possible that the Senate substitute is actually more costly than the House language.

Finally, we should like to make an additional point. This is a very complex matter. In 1956, the Senate bill which eventually became Public Law 880 included an amendment substantially the same as the House language of H. R. 7238. Because of the complexity of this problem, the amendment was not fully understood by the House conferees and was therefore lost in conference.

This year, the House Ways and Means Committee passed H. R. 7238 substantially like the Senate amendment of last year which was lost in conference. Now it is the Senate committee which has failed to accept that bill and which has substituted a language which is far less acceptable than the language in its own bill of last year. Of course, the Senate committee has every right to change its mind, but the circumstances remain as they were 1 year ago and, in our opinion, the Senate amendment of last year and the language of the House passed bill this year, are preferable to the action which the committee has now taken.

PAUL H. DOUGLAS.
FRANK CARLSON.

SUPPLEMENTAL VIEWS

Substantially I agree with the position in the minority report. In my judgment, however, the cost to the Federal Government of the House bill would be somewhat higher than shown in the estimates in the minority report. However, the House version will make it possible for States to plan a more adequate program of medical services to be made available to the needy aged, the disabled, the blind, and dependent children. As the number of aged persons increases and the average age of persons on old-age-assistance rolls increases, the health aspect of the problem will become increasingly important.

Because of the admittedly superior administration of funds to be made possible, and the improved medical care which States will be able to plan for and to provide for their needy, the slight monetary saving involved in the Senate Finance Committee bill is too costly when compared with what it would deny to the needy in terms of better care and to the program itself in better administration.

The issue is very simple. The small amount of additional Federal funds under the House bill would help to pay for additional medical services and save money on administrative costs. Under the Senate Finance Committee version, less money would be spent on medical assistance and relatively more money spent on the administration of the smaller program.

RUSSELL B. LONG.

23002°—58 S. Rept., 85-1, vol. 2——79