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PREPARED BY THE STAFF

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

PART 7

MEDICARE-MEDICAID (CONTINUED)

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CONTENTS

Page

I. Committee staff recommendations for statutory changes ... 1
- Appointment and confirmation of Administrator of Social and Rehabilitation Services ... 1
- Exempt Christian Scientists from certain requirements ... 1
- Fiscal emergency ... 2

II. HEW and committee staff recommendations for statutory changes ... 3
- Provide a penalty, in the Social Security Act, for defrauding the various health care programs ... 3
- Provide a penalty for false reporting concerning a health care facility ... 3
- Provide for public access to records concerning an institution's qualifications ... 4
- Provide for reasonable approval of rural hospitals ... 4
- Cover part B services furnished in conjunction with covered hospital care for border residents ... 5
- Provide liens to permit recovery of overpayments ... 6
- Modifications in extended care and home health benefits ... 7
- Inclusion of the Trust Territory of the Pacific Islands under title V ... 8
- Relationship between medicaid and comprehensive health care programs ... 9

III. HEW and committee staff recommendations for report language ... 11
- Simplify medicare reimbursement ... 11
- Clarify intent concerning large capital expenditure provision ... 11
- Provide for reasonable limitations on medicare allowances for routine follow-up visits, injections, and laboratory services ... 12
- Provide for inclusion of Blue Shield payments in calculating reasonable charges ... 13

IV. Printed amendments ... 15

I. COMMITTEE STAFF RECOMMENDATIONS FOR STATUTORY CHANGES

Appointment and Confirmation of Administrator of Social and Rehabilitation Services

Present Law

The Social and Rehabilitation Services was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its Administrator is appointed by the Secretary.

Problem

The responsibilities of the Social and Rehabilitation Services include administration of the welfare titles of the Social Security Act, medicaid, the Vocational Rehabilitation Act, the Older Americans Act, the Juvenile Delinquency and Youth Offenses Control Act, and parts of other pieces of legislation. The sums involved are huge; estimated at $8.6 billion in 1970, and the rate of growth has been very high—44 percent from 1968 to 1970.

Heads of other agencies in the Department of Health, Education, and Welfare, with comparable responsibility—the Surgeon General, the Commissioner of Education, and the Commissioner of Social Security—are appointed by the President by and with the advice and consent of the Senate.

Proposal

That the statute provide that appointments to the office of Administrator of the Social and Rehabilitation Services after the date of enactment of this act be made by the President by and with the advice and consent of the Senate.

The Senate passed a bill, S. 1022, early last year that included this provision, among others. The Department of Health, Education, and Welfare made no objection to the provision. The House of Representatives has not yet acted on this bill.

Exempt Christian Scientists From Certain Requirements

Present Law

At present, Christian Science sanatoriums are exempted from certain provisions of the Medicare law which are not applicable to institutions operated by the First Church of Christ Scientist.

Problem

Section 238 of the House-passed bill authorizes the use of State health agencies to perform certain functions under medicaid relating to health services standards, standards for facilities other than those related to services and utilization review of services in health institutions.

Proposal

The staff recommends that section 238 of the House bill be modified to exempt Christian Science sanatoriums from those provisions in this section which do not properly apply to facilities operated by Christian Scientists. These institutions would be subject to standards other than those relating to the provision of health services (such as fire, safety or environmental standards). It is also recommended that sanatoriums be exempted from section 1902(a)(29) of the present law relating to the licensing of administrators of nursing homes.

Fiscal Emergency

In executive session on Friday, October 2 the committee directed the staff to prepare a recommendation for the committee's consideration under which States could be relieved for a temporary period from complying with the maintenance of effort provision of the medicaid statute when a fiscal emergency in the State is involved. The staff has prepared such a recommendation. Under it the Governor of the State would certify to the Secretary that because of a fiscal emergency—which would have to be determined on a State-by-State basis in light of conditions existing in the State—the State is unable to meet the maintenance of effort requirement. The Secretary would have to be satisfied that the total amount of State funds expended for medicaid would bear the same ratio to total controllable State expenditures for the period of the fiscal emergency as they bore for the period immediately preceding the fiscal emergency. Thus, if there is a general retrenchment of controllable State expenditures, the State would be relieved of the maintenance of effort requirement for a period not in excess of 4 calendar quarters the cutback in medicaid does not exceed the cutback in controllable State expenditures generally.

II. HEW AND COMMITTEE STAFF RECOMMENDATIONS FOR STATUTORY CHANGES

Provide a Penalty, in the Social Security Act, for Defrauding the Various Health Care Programs

Present Law

There is a criminal penalty provision in the cash benefit part of the Social Security Act with respect to fraudulent billings or claims that by cross reference has been made applicable to the Medicare title of the law. This provision provides for a penalty of up to one year of imprisonment, a fine of $1,000, or both. However, there is no specific criminal penalty provision with respect to fraud under Medicaid.

Problem

The present penalty provision applicable to Medicare has not been particularly effective in deterring the submission of fraudulent claims; moreover, this provision does not include as fraud such practices as kickbacks and bribes. In addition, the absence of a criminal penalty provision applicable to Medicaid may serve to encourage fraud under this program.

Proposal

The staff and the Department suggest that the Committee amend the provisions of the Social Security Act to include as fraudulent acts the soliciting, offering or accepting of kickbacks or bribes (including the rebating of a portion of a fee or charge for a patient referral) and to provide that the penalty for such acts, as well as the acts currently subject to penalty under Medicare, be increased to $10,000, one year of imprisonment, or both. The existence of a similar penalty provision should also be made a requirement for a State plan under the Medicaid program.

Provide a Penalty for False Reporting Concerning a Health Care Facility

Present Law

No specific provision.

Problem

State and local health department inspectors and officials are understood to have been requested to and occasionally have made false statements with respect to health and safety conditions and operating conditions in local institutions in order to secure their approval for Medicare participation.

Proposal

The staff and the Department recommend that in order to deter false reporting, a statutory provision would be incorporated providing a penalty of up to 6 months' imprisonment and/or a fine not to exceed

$5,000 for anyone who knowingly and willfully makes or induces or seeks to induce the making of a false statement of material fact with respect to the conditions and operation of a health care facility or home health agency in order to secure Medicare certification of the facility or agency.

Provide for Public Access to Records Concerning an Institution's Qualifications

Present Medicare Policy

At present, copies of a determination that a hospital or an extended care facility has a deficiency or fully meets statutory and regulatory requirements are generally available only to the facility involved, appropriate State agencies, and the administration.

Problem

Physicians and the public are currently unaware as to which hospitals and extended care facilities have deficiencies and which fully meet the statutory and regulatory requirements. This works to discourage the direction of physician and patient concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Proposal

To remedy the lack of knowledge among physicians and the public as to which facilities are certified to participate in the program and are still deficient, the staff and the Department suggest the Committee consider an amendment under which the Secretary would determine deficiencies and inform the institutions concerned. If, after a reasonable lapse of time during which the deficiencies could be corrected, not to exceed 90 days, they still exist the Secretary would make certification information and reports of deficiencies a matter of public record available at district offices and centrally at SSA headquarters.

Provide for Reasonable Approval of Rural Hospitals

Present Medicare Policy

Presently a hospital or extended care facility is certified for participation in medicare if it is in full compliance (meets all the requirements of the act and is in accordance with all regulatory requirements for participation) or if it is in substantial compliance (meets all the statutory requirements and the most important regulatory conditions for participation). However, certification is not granted where the institution has deficiences which are of a type that would endanger the health or safety of patients. Thus, while an institution may be deficient with respect to one or more standards of participation, it may still be found to be in substantial compliance, if the dificiencies do not represent a hazard to patient health or safety, and efforts are being made to correct the dificienies.

Problem

It has been recognized that there is a need to assure continuing availability of medicare-covered institutional care in rural areas, many of which may have only one hospital, without jeopardizing the health and safety of patients. To achieve this objective, the

approach has been adopted of certifying "access" hospitals while fully documenting their deficiencies and requiring upgrading of plant and staff. State agencies have also been required to provide consultation and assistance to these facilities in an effort to help them achieve compliance with the standards. Certain "access" hospitals have attempted to overcome deficiencies; however, many hospitals have not demonstrated sufficient willingness to take the steps necessary to correct deficiencies and have instead been willing to continue as "access" hospitals with all the limitations in quality care that this status entails. In other areas, rural hospitals despite proper efforts have been unable to secure required personnel or otherwise comply.

Proposal

The staff and the Department suggest that a statutory change is needed to deal with the dilemma created by the need to assure the availability of hospital services of adequate quality in rural areas and the fact that existing shortages of nursing personnel generally make it difficult for some rural hospitals to meet the nursing staff requirements of present law. Under the proposed statutory change, which is similar to amendment No. 943, the Secretary would be authorized to waive the requirement that an access hospital have registered professional nurses on duty around the clock, but only if he finds that the hospital:

(a) has made, and is continuing to make, a bona fide effort to comply with the nursing staff requirement but is unable to employ the qualified personnel necessary because of nursing personnel shortages in the area;

(b) is located in a geographical area in which hospital facilities are in short supply, the closest other facilities are not readily accessible to inhabitants of the area, and

(c) nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to beneficiaries residing in the area. The Secretary would examine the situation each year, and the waiver would be granted on an annual basis for a one-year period. Moreover, the waiver authority would be applicable only with respect to the nursing staff requirement; no waiver authority would be provided with respect to any other conditions of participation or any standards relating to health and safety.

The proposed waiver authority would not be applicable with respect to those hospitals which undertake or contract for construction after 1970.

The Department further recommends that provision be made for expiration of the proposed waiver authority by January 1, 1975.

Cover Part B Services Furnished in Conjunction With Covered Hospital Care for Border Residents

Present Law

Services furnished outside the United States are excluded from coverage with the exception that hospital insurance benefits are payable for emergency inpatient services provided in foreign hospitals if the beneficiary was physically present within the United States when the emergency arose and the foreign hospital to which he is admitted

is more accessible to the place where the emergency arose than the nearest U.S. hospital.

Problem

There has been concern that under present law border residents who find that the nearest hospital suited to their inpatient needs located outside the United States may not receive protection against the health costs they incur in using these nearest hospitals except in emergency situations. Under the House bill, Medicare benefits would be payable for foreign inpatient hospital services if the beneficiary is a resident of the United States and the foreign hospital was more accessible from his residence than the nearest hospital within the United States. Inpatient hospital benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. However, the House bill does not provide for coverage of the physician's services furnished to the individual while he is an inpatient in the foreign hospital.

Proposal

The staff and the Department recommend coverage for physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services. To discourage unnecessary utilization of physicians' services outside the United States, payment for physicians' services should be restricted to the period during which the beneficiary is eligible to have payment made for the foreign inpatient hospital services he receives. The Secretary would be authorized to establish reasonable limitations upon the amount of a physician's charge accepted as reimbursable.

Provide Liens to Permit Recovery of Overpayments

Present Law

Determination of the amount of an overpayment is based on an actual review of the medical records. When the amount has been determined, the Department is authorized to withhold future payments for services in order to recover the amount overpaid. Where no future payments materialize, recovery action other than demand letters can be instituted only after referral to the Department of Justice.

Problem

In some cases determination of the amount of overpayment requires extensive review of many medical records. In other cases, all the information needed for such determination is not readily available. Where the amount of overpayment has been determined but the provider has not made a refund in response to the demand letters, no effective administrative action can be taken to prevent the provider from disposing of his assets during the time elapsing until the case gets to court. Furthermore, the provider has had Government funds at his disposal on which he does not have to pay interest.

Proposal

The staff and the Department suggest facilitating the recoupment of overpayments to providers of services by authorizing the Secretary to determine the amount of overpayment and by authorizing the establishment of a lien in favor of the United States in the amount of

any overpayment. Providers would have the right to contest the amount of the overpayment and to seek release of the lien to clear title.

Modifications in Extended Care and Home Health Benefits

Present Law

Medicare's extended care benefit is payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The home health benefit is payable on behalf of patients who need essentially the same type of nursing care on an intermittent basis, or physical or speech therapy. Social security has generally restricted its definition of skilled nursing care to the provision of identifiable skilled nursing procedures. The usual administrative process for determining eligibility for payment under this provision involves retrospective review of the services actually furnished to the patient.

Problem

In practice, the administration of extended care and home-health benefits has proved difficult and has led to considerable dissatisfaction. The complexity of the extended-care-coverage determination, and the fact that it must often be made retroactively, tends to create confusion regarding the type of care which is reimbursable and may encourage physicians to either delay discharge from the hospital, where coverage is less likely to be questioned, or to recommend a less economical, though financially more predictable, course of treatment. The aggregate effect is to reduce the value of the extended care benefit as a continuation of hospital care in a less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be discharged from the hospital. Patients receiving care at home or who might be ready for discharge if sufficient assistace were available at home face a somewhat similar situation with respect to home health benefits. The uncertainty of coverage of services may impede effective discharge planning or the formulation of a comprehensive health-care plan for a home-bound patient.

The House sought to alleviate the problem by including a provision authorizing the Secretary to establish presumptive periods of coverage according to diagnosis and other medical factors for patients admitted to an extended care facility or started on a home-health plan. While this approach alleviates much of the administrative complexity by focusing determinations on the totality of needs of certain categories of patients, rather than evaluation of specific nursing procedures, it introduces certain new administrative problems. The wide range of illnesses common to the aged, as well as the frequent occurrence of "combination diagnoses" makes specific categorization difficult.

Proposal

The staff and the Department suggest that Medicare's post-hospital extended care benefit and home health benefit be modified to (1) better respond to needs of beneficiaries including those for whom a short period of institutional care under skilled supervision is needed to restore self-sufficiency and (2) substantially eliminate retroactive determinations. To achieve these goals, the focus of the benefit would be placed on the patient's need for a type of institutional or home care

which requires the availability of skilled nursing and related skilled services. In all cases, the attending physician would be expected to certify the need for such care and provide a plan of treatment to the extended care facility or home health agency in advance of admission or start of care.

The proposed changes involve modification of several features of the House-passed bill. To the extent feasible, preadmission evaluation of a request and approval of need for extended care would be made by a PSRO, hospital utilization review committee or other appropriate group. Unless disapproved in advance, coverage upon admission would continue for the lesser of: (a) the initially certified period (b) until notice of disapproval, or (c) 10 days. The physician and facility would be expected to forward supporting documentation for continued coverage of patients usually at least 3 days prior to expiration of the initially approved period or upon request of the review group. Where certifications and evidence are provided on a timely basis, any subsequent determination (for purposes only of determining medicare payment liability) that the patient no longer requires covered care would be effective 2 days after notification to the facility, thus giving the patient and his physician an opportunity to make other arrangements to meet the patient's needs.

Administration of the home health benefit would follow essentially the same approach. Review of the proposed plan of treatment, prior to its implementation, would be made wherever possible and could be performed by a PSRO, the utilization review committee of the institution from which the patient is being discharged (for part A home health benefits) or other qualified group. In the absence of a negative finding or a specific limitation payment would ordinarily be made for up to 10 visits before additional review of the patient's needs was required. (The 10 visit limitation would apply on a calendar year basis for part B home health benefits.) Where evidence and certifications were submitted promptly, determinations that the patient no longer need the type of home care is covered by medicare would be made prospectively.

Cost: $200 million.

Inclusion of the Trust Territory of the Pacific Islands Under Title V

Present Law

The Trust Territory of the Pacific Islands are currently excluded from receiving Federal funds under the provisions of the Crippled Children and Maternal and Child Health Programs (title V).

Problem

All other territories and possessions of the United States are presently eligible for the benefits of these programs. The provision of public health services to mothers and children with crippling diseases is one of the areas of greatest weakness in Public Health programs in Micronesia, and this is reflected in a high infant mortality rate.

Proposal

The staff and the Department suggest that the Committee include the Trust Territory of the Pacific as eligible to receive an allotment of funds under title V of the Social Security Act.

Cost

No new cost, $22,000 estimated expense, would come from reallocation of existing title V appropriation.

Relationship Between Medicaid and Comprehensive Health Care Programs

Present Law

Present law provides that under Title 19 all eligible recipients should receive the same scope of services; that those services should be available throughout the State and that recipients should have freedom of choice with regard to where they receive their care.

Section 1902(a)(23) also provides that recipients be allowed to obtain medical care through organizations which provide such services (or arrange for their availability) on a prepayment basis, if the recipient so chose.

Problem

State agencies often cannot make pre-payment arrangements which might result in more efficient and economical delivery of health services, because the prospective arrangements might violate Title 19 because some recipients might receive a broader scope of benefits than others inasmuch as the possibility for making such arrangements may only exist in certain areas of a State.

Proposal

The staff and the Department suggest that the Committee amend Section 1902(a)(23) to permit a State to make arrangements for the delivery of health services on a pre-paid basis in an area, where such services are available and to the extent they are provided, without a requirement that such arrangement necessarily be provided all Medicaid eligibles in the State with the approval of the Secretary.

III. HEW AND COMMITTEE STAFF RECOMMENDATIONS FOR REPORT LANGUAGE

Simplify Medicare Reimbursement

Present law

At present, providers have the option (up to the end of the fourth month of the period for which the change is to be applied) of using either the departmental method or the combination method of cost apportionment for medicare reimbursement purposes.

Problem

Virtually all providers use the combination method of reimbursement. Many do so after performing analyses of which method is likely to be more favorable to them. The fact that certain pediatric and obstetrical costs are included in the cost ratios applied to the charges to the aged accounts at least in part for the advantage to hospitals in using the combination method. There are no rational grounds for preserving this unintended reimbursement for such costs. The statute requires that medicare pay only for costs associated with the elderly.

The combination method of apportionment is less accurate than is the departmental method of apportionment but has been retained to avoid imposing the greater complexity of the departmental method on institutions incapable of handling it.

Proposal

The staff and the Department concur that at this point in time regulations should be modified so that providers with 100 or more beds would be required to use the departmental method of cost apportionment while smaller hospitals would use the simpler computations involved in the combination method. At the time of enactment of medicare it was felt that even some relatively large hospitals would be unable to apportion costs by the departmental method because of poor recordkeeping practices and this seems reasonable for the past. However, now better cost-finding is practical for larger hospitals. The removal of a choice of methods would make the operation simpler and more uniform in application.

The GAO and the HEW audit agency have recommended that use of the combination method should be eliminated.

Clarify Intent Concerning Large Capital Expenditure Provision

Present Law

No provision.

House Bill

Where a State voluntarily elected, section 221 would prohibit reimbursement to providers under the medicare and medicaid programs for capital costs associated with expenditures of $100,000 or more which

are determined by a State planning agency designated by the Governor to be inconsistent with State or local health facility plans.

Problem

The language in the House bill could be interpreted to allow a Governor to set up an entirely new health planning agency, in spite of the fact that each State has existing health planning agencies established under the Partnership for Health Act.

Proposal

The staff and the Department suggest that the committee specify that the State and local planning agencies organized under the Partnership for Health Act should be utilized wherever they are capable of assuming necessary responsibility, and that new planning agencies should not be established for the purpose of performing the function described in this provision.

Provide for Reasonable Limitations on Medicare Allowances for Routine Follow-up Visits, Injections, and Laboratory Services

Present Law

At present neither the statute nor the regulations call for specific limitations in what are acceptable physicians' charges for routine follow-up visits, multiple visits, injections, and laboratory services.

Problem

The above are areas where extensive overcharging and overutilization have occurred in Part B of Medicare by virtue of "gang-visiting", "overvisiting" and excessive numbers of injections administered to patients.

Proposal

The staff recommends and the Department concurs that the report include language indicating that reimbursement for routine follow-up and multiple visits to institutionalized patients be limited in terms of a proportion of the charge made for the initial visit to the patient. Where more than routine care is required during the course of a follow-up visit and documented by the physician discretion should be permitted to increase the amount otherwise allowable for a follow-up visit.

Where a separate charge is made by a physician for an injection, Medicare's maximum allowance should be a scheduled amount based upon the approximate ingredient and supply cost plus a specified amount (such as one dollar) to cover the injection service.

Similarly, schedules of allowances should be established by geographic or medical service area, where appropriate, for routine laboratory work—including interpretation of results—for tests not ordinarily included in the charge for a physician visit. The scheduled allowance should not exceed the estimated cost of such tests (purchased prudently) to physicians plus a reasonable amount for non-routine handling and interpretation generally not encompassed in the cost of an office visit. Such schedules of allowances should include combination allowances for common groupings of tests.

In determining allowances to be paid for laboratory work the intent is to base the allowance upon how much a doctor would have had to pay for the work if he had used the most economical qualified facility for such work available to him. Therefore, the recommendation is that

the allowances should be based on the costs of tests when undertaken by qualified, efficient and economical sources—such as independent automated laboratories—to which physicians in an area have reasonable access.

Provide for Inclusion of Blue Shield Payments In Calculating Reasonable Charges

Present Law

Part B refers to "reasonable charges" in evaluating the basis for program payments to physicians. Such charges are considered in terms of the individual doctor's "customary" billings in relation to all billings by doctors for that same service in the same area.

The staff expressed the opinion in its report on "Medicare and Medicaid," that the statute calls for *consideration* of customary and prevailing physician charges whereas the Department was basing payments *solely* on customary and prevailing charges. In addition, the Staff felt the Department unfairly ignored that portion of the statute intended to limit payments to not more than the charge applicable under the carrier's private policies. (Sec. 1842(b)(3)(B). The staff noted further that Blue Shield carriers were not limiting Medicare payments to the "same agreed-upon fee schedules that are employed in their own programs"—language included in the Committee reports accompanying the Medicare legislation in 1965. The argument given for not applying this provision was that the limitation was applicable *only* where a carrier had a policy virtually *identical* with Medicare policy on customary and prevailing charges in establishing the reimbursible charges. The staff believed the Congressional intent was to limit reimbursement generally to not more than the levels in Blue Shield policies prevailing in an area. That intent became a meaningless nullity as interpreted by H.E.W. because virtually no carrier provided coverage on a basis identical with Medicare.

Problem

The millions of payments made under Blue Shield "service benefit" contracts which are accepted as full payment by physicians for persons within certain income limits are not taken into consideration when carriers determine "prevailing charge" levels in an area. This creates a situation where Medicare pays what a doctor would like to get rather than what he may usually be paid and accept for patients with larger incomes than the elderly Medicare beneficiaries.

Proposal

The staff recommends and the Department concurs that Medicare regulations and policy be modified to include in the determination of reasonable charges, prevailing payments made by other third parties (such as Blue Shield) for comparable services. In evaluating prevailing payment levels, wherever possible, payments made under Blue Shield service benefit contracts having income limits reasonably related to the income of the elderly, (and where such policies are widely-held in an area) should be included in such determinations. Of course, a Blue Shield service benefit contract (such as that in Alabama) with an obviously and exceptionally low payment level might be disregarded in determining prevailing payment levels. In using Blue Shield payments, the average should be determined weighting by the frequency of payments under various service benefits contracts.

IV. PRINTED AMENDMENTS

Amendment 822 (Byrd of West Virginia)

This amendment provides social security hospital and medical insurance benefits for disabled persons age 50 and over who are entitled to monthly disability insurance benefits. (Long-range cost: .62% of payroll assuming automatic wage base increases; first year cost about $1.9 billion.)

Amendment 823 (Byrd of West Virginia)

This amendment provides social security hospital and medical insurance benefits for disabled persons, regardless of age, who are entitled to monthly disability insurance benefits. (Long-range cost: .83% of payroll assuming automatic wage base increases; first year cost about $2.5 billion.)

Amendment 882 (Tydings)

This amendment authorizes such sums as may be necessary for grants to public agencies, institutions of higher learning and private nonprofit organizations to facilitate training of nursing home administrators.

Amendment 920 (Tower)

This amendment permits small capacity hospitals to substitute nursing care by licensed practical nurses for certain kinds of care by registered professional nurses for purposes of meeting the definition of hospital under the hospital insurance provisions of the Social Security Act. (Long-range cost less than .005% of payroll.)

Amendment 929 (Long)

This amendment establishes National Formulary and procedure by which medicare and medicaid would purchase drugs of proper quality, however named, at a reasonable price. (First year savings of $80 million to $100 million in medicare and medicaid).

Amendment 935 (Mondale)

This amendment eliminates from the medicare program the "blood deductible" provision which requires beneficiaries to pay for the first 3 pints of blood. (First-year cost of $16 million.)

Amendment 936 (Mondale)

This amendment provides a limit on the premium which may be required under part B of the medicare program (presently $5.30 monthly) to no more than $4 a month after 1970 and to no more than $3 a month after June 1971; Federal general funds to make up the

difference between premiums and the cost of the program. (First full year cost: $600 million.)

Amendment 937 (Mondale)

This amendment provides hospital and supplementary health insurance benefits to disabled persons entitled to social security benefits. (Long-range cost: .93% of payroll, assuming automatic increases in wage base; first year cost of about $2.8 billion.)

Amendment 943 (Yarborough)

This amendment permits the Secretary of HEW to waive the 24-hour professional nursing requirement for approval of hospitals under medicare when the failure to meet the requirement results from a manpower shortage, if the hospital continues to make a bona fide effort to try to meet the requirement. (Long-range cost of less than .005% of payroll.)

Amendment 964 (Mondale)

This amendment provides for paying under Part A of medicare for the reasonable charge of maintenance drugs. (Cost–.11% taxable payroll—$9,000 base, with automatic adjustment. First calendar year–1971–$650 million.)

Amendment 965 (Mondale)

This amendment provides hospital insurance for people age 72 and over who have not worked long enough to qualify under present law if they are U.S. citizens or aliens who have resided in the U.S. for at least 5 years. (Cost–calendar year 1971–$57 million.)