The original documents are located in Box 37, folder "12/31/75 HR10284 Medicare Amendments" of the White House Records Office: Legislation Case Files at the Gerald R. Ford Presidential Library.

APPROVED
DEC 31 1975

signed 12/31/75
(11:15)

THE WHITE HOUSE

WASHINGTON

ACTION

Last Day: January 2, 1976

December 30, 1975

Posted 12/31

To Archives 12/31

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Enrolled Bill H.R. 10284 - Medicare Amendments

This is to present for your action H.R. 10284, Medicare Amendments.

BACKGROUND

H.R. 10284 would make numerous amendments to the Medicare and Professional Standards Review Organization (PSRO) programs, would authorize states to modify procedures for issuing food stamps to welfare families, and includes a tax rider relating to certain irrigation dams.

Most of the fourteen amendments contained in H.R. 10284 were added to the bill in "Christmas tree" fashion during the final days of the 1st session, 94th Congress. The two major amendments, supported by HEW, are:

-- Coordination between Medicare and the Federal Employee Health Benefits (FEHB) programs. Would repeal section 1862(c) of the Social Security Act which provides that, effective January 1, 1976, Medicare will not pay first for any medical service if the service is also covered under an FEHB plan and if the beneficiary has dual coverage.

-- Medicare Supplementary Medical Insurance (SMI) Premiums. Would correct a technical error in P.L. 92-233 which froze the premium for SMI, the voluntary medical insurance part of Medicare covering physicians' and other health services.

Several of these amendments affect deadlines occurring on December 31, 1975 and, accordingly, require prompt action. HEW must promulgate the new SMI premium by December 31, 1975,

in order to take advantage of the authority in H.R. 10284 to increase SMI premiums for the twelve-month period beginning July 1, 1976. The increase would reduce Federal payments from general revenues by $184 million in fiscal year 1977 and $725 million by 1981.

RECOMMENDATIONS AND COMMENTS

HEW:	Approval. HEW views enactment of the SMI premium provision and repeal of the Medicare/FEHB coordination provision to be of overriding importance and does not believe that any of the other provisions warrant recommending disapproval.
OMB:	Approval. OMB objects to a number of the enrolled bill's provisions for programmatic and budgetary reasons but concurs with HEW that the advantages of obtaining enactment of the SMI premium provision and the section 1862(c) repeal provision outweigh their objections to the bill. "In the long run, we believe that the provisions we support will result in a favorable net budgetary impact."
Civil Service Commission:	Approval
Agriculture:	No objection
Treasury:	No objection (Informally)
Justice:	Defers to other agencies
Seidman:	Approval
Friedersdorf:	Approval
Buchen (Lazarus)	No objection

Jim Lynn's memorandum which includes the recommendations from the departments is at Tab A. The enrolled bill is attached at Tab B.

RECOMMENDATION

I recommend that you approve H.R. 10284 and that you do so by Wednesday, December 31, 1975, to take advantage of the savings in Federal expenditures.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DEC 26 1975

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill H.R. 10284 - Medicare Amendments
Sponsor - Rep. Rostenkowski (D) Illinois and 12 others

Last Day for Action

January 2, 1976 - Friday (Action is urged no later than Wednesday, December 31, 1975 because of timing involved in several amendments, as explained below)

Purpose

Amends the Medicare and Professional Standards Review Organization (PSRO) programs; authorizes States to modify procedures for issuing food stamps to welfare families; includes a tax rider relating to certain irrigation dams.

Agency Recommendations

Office of Management and Budget	Approval
Department of Health, Education, and Welfare	Approval
Civil Service Commission	Approval
Department of Agriculture	No objection
Department of the Treasury	No objection (Informally)
Department of Justice	Defers to other agencies

Discussion

H.R. 10284 would make numerous amendments to the Medicare and PSRO programs. It also contains two amendments unrelated to health--one deals with the issuance of food stamps to families receiving welfare benefits and the other is a tax amendment relating to the exemption of interest on certain irrigation dam bonds. Most of the fourteen amendments contained in H.R. 10284 were added to the bill in "Christmas tree" fashion during the final days of the 1st session, 94th Congress. The

amendments and the Administration's position on them are discussed below. Several of these amendments affect deadlines occurring on December 31, 1975 and, accordingly, require prompt action.

Major Amendments

Physician reimbursement under Medicare. In an effort to control the escalating costs of the Medicare program, P.L. 92-603, the "Social Security Amendments of 1972," limited increases in the ceilings on rates paid for physicians' services by tying them to an economic index.

HEW regulations to implement these provisions were not issued until this year, in part because of the complexity of developing an appropriate index. The index allows the "prevailing charge" maximums in fiscal year 1976 to be no more than 18% above the fiscal year 1973 level. As a result, some physicians would receive less in 1976 than in 1975, because the 1976 fee allowances under the index would be lower than the amount they were paid during 1975.

H.R. 10284 would require physicians to receive Medicare reimbursements in fiscal year 1976 at a level not less than they received in 1975. HEW estimates that this "savings clause" would cost $35 million in 1976. HEW believes this provision is desirable and that, without it, beneficiaries might face increased out-of-pocket costs. OMB has opposed the provision on the grounds that it would unnecessarily raise payment rates to doctors.

Coordination between Medicare and the Federal Employee Health Benefits (FEHB) programs. H.R. 10284 would repeal section 1862(c) of the Social Security Act which provides that, effective January 1, 1976, Medicare will not pay first for any medical service if the service is also covered under an FEHB plan and if the beneficiary has dual coverage.

Section 1862(c) was enacted to force new legislation for coordination of these health insurance plans. If allowed to take effect, it would reduce net Federal costs by $137 million in calendar 1976, but raise premiums of Federal employees and annuitants by $75 million. H.R. 10284 would thus allow more time for consideration of a coordination option which has been proposed by the Administration.

Currently, Medicare makes payment first for the covered services; FEHB plans make payment only to the extent that Medicare has not already paid. Medicare thus bears a major share of the health care costs of those with dual coverage.

In a joint report submitted to Congress earlier this year, HEW and the Civil Service Commission (CSC) pointed out numerous problems involved in achieving the coordination specified by section 1862(c), and suggested an alternative approach which would require amendment of both the Medicare law and the FEHB Act, along with repeal of section 1862(c). The Administration's proposal to effect such coordination, submitted to the Congress on July 31, 1975, was not acted on. Accordingly, since it is impossible to implement the HEW-CSC proposal by January 1, 1976, both HEW and CSC favor repeal of the provision which imposes the deadline. CSC views enactment of the repeal provision as one of "critical importance" and urges that the bill be signed promptly. We believe that repeal of section 1862(c) will not prejudice further efforts to provide improved coordination between FEHB and Medicare.

Medicare Supplementary Medical Insurance (SMI) Premiums. H.R. 10284 would correct a drafting error in P.L. 92-233 which unintentionally froze the premium for SMI, the voluntary medical insurance part of the Medicare program covering physicians' and certain other health services. SMI is financed by monthly premiums paid by enrollees matched by payments from the Federal Government. The current monthly SMI premium is permanently set at $6.70 because of the technical error. Since enrollee premiums cannot be increased, Federal general revenues are financing the entire increase in SMI costs, currently about $1 billion annually.

HEW submitted legislation to the Congress on February 4, 1975 to correct this situation. The H.R. 10284 provision is similar to the HEW proposal and would permit a premium increase corresponding to increases in program costs, but no greater than the percentage by which monthly social security benefits have increased during the year.

HEW must promulgate the new SMI premium--estimated to be $7.20 per month--by December 31, 1975, in order to take advantage of the authority in H.R. 10284 to increase SMI premiums for the twelve-month period beginning July 1, 1976. The increase would reduce Federal payments from general revenues by $184 million in fiscal year 1977 and $725 million by 1981.

Reimbursement for PSRO Utilization Review Activities. PSROs currently may discharge their responsibilities for the review of health care in two ways: they can delegate their review responsibilities to hospital review committees or they can carry out that review directly. Where the hospital committee conducts the review, the costs are reimbursed through the Medicare and Medicaid programs. Where the review is conducted by a PSRO, the PSRO program bears the cost. H.R. 10284 would require the Medicare trust fund to pay for both the review conducted by hospitals and those reviews conducted by PSROs directly.

This provision is, in effect, a new "tap" on the Medicare hospital insurance trust fund to increase the funds available to PSROs. It is designed to overcome the deliberate PSRO implementation strategy of the Administration and the Appropriations Committees that holds off on full-scale establishment and funding of PSROs until concrete evidence of their cost-effectiveness is established. The estimated added costs under present law could range from $15 to $69 million in fiscal year 1977. HEW does retain the authority, however, to exert some controls on costs by limiting the number of PSROs--through agreements and regulations specifying PSRO activity--and through definition of reasonable costs for purposes of PSRO payments from the hospitals.

HEW states that the probable net cost of this provision is not sufficient to outweigh the desirability of unfreezing the SMI premium or repealing the Medicare/FEHB coordination provision.

Other Provisions

Waiver of 24-hour nursing service requirement for certain rural hospitals. H.R. 10284 would extend for three years--from January 1, 1976 to January 1, 1979--the current authority of the HEW Secretary to waive, for certain rural hospitals, Medicare's requirement that participating hospitals provide 24-hour service by a registered professional nurse. The current waiver authority recognizes the shortage of hospital services in some areas and the desire not to reduce services where nurses are in short supply. Daytime nurse supervision would still be required.

The Administration submitted legislation to extend the waiver provision for one year rather than three years. HEW believes a three-year extension is preferable to no extension at all and would accept this provision.

PSRO areas. Under present law, the HEW Secretary is required and has, in fact, designated 203 geographic areas as "Professional Standards Review Areas." There are six States in which multiple PSRO areas have been designated, but for which no HEW funding and approval has been provided. The Senate Finance Committee report claims that in those States there appears to be substantial physician preference to establish a single statewide PSRO rather than the presently required multiple PSROs.

H.R. 10284 would require HEW to designate a single statewide PSRO area where multiple local areas now exist, upon the approval of a majority of physicians in each presently designated local area. HEW believes this provision is undesirable because it could reduce the probability of widespread physician participation in the utilization review process, but does not believe its objections are sufficiently serious to warrant an adverse recommendation on the bill as a whole.

PSRO startup deadline. Under current law, the HEW Secretary may designate only physician organizations as PSROs until January 1, 1976. After that date, any organization may be designated. A Senate floor amendment to H.R. 10284 would extend the January 1, 1976 deadline for two years to January 1, 1978. HEW has announced that it does not intend to move to designate non-physician PSROs for the next 12 to 18 months in view of the difficulty in getting the physician-sponsored entities underway. The Department does not object to the two-year extension.

Life Safety Code Requirements. Under present law, skilled nursing facilities participating in the Medicare and Medicaid programs must meet the conditions of the 1967 Life Safety Code of the National Fire Protection Association. A provision of H.R. 10284 would update this requirement so that such facilities must meet the conditions of the 1973 Life Safety Code. The amendment also would assure that facilities currently qualified under the 1967 Code would not lose their eligibility for participation in the programs.

Sacramento Medical Care Foundation Grant. One provision of H.R. 10284 would have the effect of permitting HEW to give the Foundation $930,000 to make up past and future losses on a contract with the State of California. Unless it receives this $930,000, the Foundation will not be able to participate in an

HEW research project related to this contract. Although we have strong reservations about this provision, HEW desires the Foundation to participate in the project and favors this grant to make the Foundation solvent.

Study of Medicare coverage for certain optometric services. H.R. 10284 would direct the HEW Secretary to conduct a four-month study of the appropriateness of reimbursement of optometrists under Medicare for provision of prosthetic lenses for patients without natural lenses of the eye.

Utilization Review under Medicaid. Current law requires utilization review committees to conduct a review of each case before Federal Medicaid payments are authorized. H.R. 10284 would remove the mandatory 100% individual case review requirement and would permit a review on an appropriately designed sample basis.

Judicial review under Medicaid. The enrolled bill would require States to consent to suit in the Federal courts on actions brought against them by providers of Medicaid services. This provision would permit hospitals to take legal action against a State where such action may become necessary due to disputes arising between the State and hospital over payments under the Medicaid program.

Food stamp purchases by welfare recipients. Under the Food Stamp Act, beginning January 1, 1976, State and local welfare agencies are required to withhold, at the option of welfare recipients, the food stamp purchase price from their welfare payments and to distribute the food stamp coupon allotment directly to the household along with the reduced welfare payment (usually by mail).

Some States have found this mandatory provision extremely difficult to implement, and H.R. 10284 would delay its implementation until October 1, 1976. This is consistent with the Administration's food stamp reform legislative proposal (S. 2537) which would allow States the option of offering such withholding.

Tax-exempt bond status for American Falls Dam. Title III of H.R. 10284 contains language identical to that contained in the Revenue Adjustment Act of 1975, which you signed on December 23, 1975 (P.L. 94-164), and is therefore moot. The effect of the language is to permit the American Falls Reservoir District in Idaho to issue tax-exempt bonds for the construction of a dam to replace the original American Falls Dam constructed in 1927 by the Bureau of Reclamation.

Recommendations

HEW recommends that H.R. 10284 be approved. As indicated in the attached letter, HEW views enactment of the SMI premium provision and repeal of the Medicare/FEHB coordination provision to be of overriding importance. Accordingly, HEW does not believe that any of the other provisions of H.R. 10284 warrant a disapproval recommendation. The Department points out that in order to reduce Federal payments to the SMI trust fund (under the SMI premium increase provision) amounting to $184 million in fiscal year 1977, the enrolled bill must be signed by December 31, 1975.

* * * * *

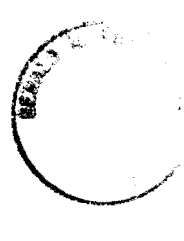
We object to a number of the enrolled bill's provisions for programmatic and budgetary reasons, particularly the "bail out" of the Sacramento Foundation, "saving" the 1975 prevailing charge limitation for physicians, and the PSRO tap on the Medicaid hospital insurance trust fund. Nevertheless, we concur with the views expressed by HEW that the advantages of obtaining enactment of the SMI premium provision and the section 1862(c) repeal provision outweigh our objections to the bill. In the long run, we believe that the provisions we support will result in a favorable net budgetary impact.

Accordingly, we recommend approval of H.R. 10284.

James M. Frey

Assistant Director for
Legislative Reference

Enclosures



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

DEC 24 1975

The Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D. C. 20503

Dear Mr. Lynn:

This is in response to your request for a report on H.R. 10284, an enrolled bill "To amend title XVIII of the Social Security Act, and for other purposes."

We recommend that the enrolled bill be approved. If our recommendation is accepted, the President will wish to sign the bill before January 1 in order to take advantage of the authority it contains to increase the Medicare part B premium for the twelve-month period beginning July 1, 1976. The increase will permit a $184 million reduction in the appropriation from general revenues for part B for fiscal year 1977.

The materials included at tabs A and B describe the bill and its budget impact, respectively. Our views on each of the bill's provisions are as follows:

Prevailing charge level for fiscal year 1976: Application of the economic index provision added to Medicare by the Social Security Amendments of 1972 has reduced about 15 percent of fiscal year 1976 prevailing charge levels below the prevailing charge levels for the same service in the same area in fiscal year 1975. It was not the original intent of the index provision to cause a rollback of this kind, but merely to supply a means of limiting prevailing charge increases. The rollback came about because of the longer-than-estimated time needed to perfect our implementing regulations. If left uncorrected, we would expect the lower reimbursement levels caused by the rollback to reduce physician acceptance of assignment. Beneficiaries whose physicians do not accept assignment may then face increased out-of-pocket costs. Accordingly, we think the

provision desirable despite its $35 million reduction in the $100 million savings expected in FY 1976 from use of the index.

Extension of authority to waive 24-hour nursing service requirement for certain rural hospitals: On September 29 we submitted to the Congress proposed legislation for a one-year extension of our authority to waive the 24-hour nursing service requirement for rural hospitals, subject to the hospitals' extending services by registered professional nurses to an additional shift (beyond the regular daytime shift now required). Although the enrolled bill would enact a three-year extension without imposing the additional nursing service requirement, we think this to be far preferable than no extension at all. We therefore would accept the provision.

Coordination between Medicare and Federal Employees' Health Benefits program: On July 31, 1975, we sent to the Congress a proposal to coordinate Medicare and the Federal Employees Health Benefits program. The existing prohibition against Medicare contribution after 1975 to FEHB coverage was intended to stimulate the Executive Branch to submit such a proposal, and the prohibition's repeal at this time is therefore appropriate. Should the repeal fail, FEHB enrollees would be subjected to substantial additional enrollment costs for the coming year and thereafter.

Technical amendment relating to part B premium determination: As we pointed out above, in order to obtain the advantage of the correction of the technical error that has frozen the SMI premium, the President must act on the enrolled bill before the close of 1975. Although the enrolled bill takes a somewhat different approach than we proposed in our letter of January 31, 1975, to the Congress (i.e., it continues to require that the part B premium be determined in December, rather than, as we had proposed, forty-five days after the close of the first calendar quarter), the end result is substantially similar, and we endorse it.

Professional standards review areas: We do not favor the provision to allow physicians in certain PSRO areas to vote to establish the entire State as a single PSRO area. The establishment of a statewide PSRO in a State with many physicians could result in such a large grouping of physicians for so broad a geographic area as to reduce the probability of widespread physician participation in the utilization review process. Moreover, the provision may vitiate the PSRO planning efforts of existing organizations to which we have made planning grants in four of the affected States. Nevertheless, because this provision would affect, at most, only six States, our objections are not sufficiently serious to warrant our adverse recommendation on the bill as a whole.

Updating of the Life Safety requirements applicable to nursing homes: We think it appropriate to update the Life Safety requirement because the 1967 edition of the Life Safety Code has been superseded by the 1973 edition.

Grants for certain experiments and demonstration projects: The $930,000 cost of a retroactive grant to the Sacramento Foundation for Medical Care will preserve the solvency of the Foundation, and therefore make its cost data available in a forthcoming Department demonstration involving the Foundation and intended to establish satisfactory reimbursement formulas for HMO's in California and other States.

Professional standards review organization startup deadline: A delay in the physician-directed PSRO startup deadline will allow additional time for the Department to negotiate with conditionally designated PSRO's and is therefore acceptable.

Study regarding coverage under part B of Medicare for certain services provided by optometrists: Stated simply, the bill would have us consider whether Medicare should pay optometrists for prescribing eyeglasses for beneficiaries who have had their natural lens removed. We have no objection to exploring the question.

Utilization review under Medicaid: Utilization review by sample to determine patterns of care is consistent with the PSRO approach that looks to the establishment of norms of care. We see no objection, therefore, to permitting States to use appropriate patient samples to conduct Medicaid utilization reviews.

Consent by States to certain suits: The Federal courts are now open to test the Medicaid statute through suits for injunctive relief. Therefore, the provision that would require the States to make themselves amenable to suits in Federal court to enforce payment claims of hospital-providers is of limited significance to the Medicaid program at the Federal level. We see no objection to it.

Utilization Review Activities: The Department has preferred to fund direct PSRO utilization review, through the appropriations process. However, this past preference and the probable net cost of the new provision are not sufficient to outweigh the desirability of unfreezing the SMI premium or repealing the Medicare/FEHB coordination provision. Although that cost is projected at a maximum of $69 million for FY 1977 over the PSRO allowance, some of that cost will be offset by amounts in the Medicare and Medicaid programs that would otherwise have paid for utilization review now conducted by hospitals under current regulations.

We express no opinion on titles II and III of the bill, which are primarily of interest to other agencies.

We recommend that the President approve the enrolled bill, and we emphasize the importance of affecting that approval before the close of the year.

Sincerely,

Secretary

Enclosures

Tab A

TECHNICAL DESCRIPTION OF THE EFFECT OF ENROLLED BILL H.R. 10284

Prevailing charge level for fiscal year 1976

Section 101 of H.R. 10284 would alter the formula for computing the prevailing charge level applied to bills submitted in fiscal year 1976 for physicians' services reimbursed under the program of supplementary medical insurance benefits for the aged and disabled contained in part B of title XVIII of the Social Security Act.

The prevailing charge level is the charge that would cover 75 percent of the customary charges made for similar services in the same locality about 18 months previously, i.e., the customary charges made during the calendar year preceding the calendar year in which began the fiscal year in which the services were rendered.

The Social Security Amendments of 1972 (specifically, section 224 of Public Law 92-603) limited the rate of increase in the prevailing charge level for physicians' services for fiscal year 1974 and thereafter. By way of an amendment to section 1842(b) of the Social Security Act, it subjected any such increase to a ceiling to be set by a nationwide economic index promulgated by the Secretary's regulations.

The Secretary's regulations, published in final form in June of this year, established an economic index that in some cases has reduced the prevailing charge level for 1976 below the 1975 level. This has come about because the 1972 amendments, which are designed to accommodate post-FY 1973 increases in prevailing charges for physicians' services, use the customary charges for calendar year 1971 as the base to which the economic index is to be applied. These 1971 customary charges, as previously explained, determined the prevailing charge level for FY 1973. By the time the Secretary's regulations were promulgated in mid-1975, however, the FY 1975 prevailing charge level for some services in some areas had already increased beyond what the economic index, when applied to the 1971 customary charge base, would have allowed had it been in effect.

The enrolled bill provides that any such rollback in FY 1976 is to be avoided by using, where necessary, the FY 1975 prevailing charge level. The amendment would be retroactively applicable to all claims filed under the part B program for services rendered in fiscal year 1976, except that no payment would be made on claims processed prior to the enactment of the section where the difference between the amount paid and the amount due is less than one dollar.

Extension of authority to waive 24-hour nursing service requirement for certain rural hospitals

To participate in the Medicare program, a hospital must, inter alia, provide 24-hour nursing service rendered or supervised by a registered professional nurse, and have a licensed practical nurse or registered professional nurse on duty at all times. Until January 1, 1976, the Secretary is authorized to waive so much of this rule as would require a registered professional nurse to be on duty on the premises of certain rural hospitals beyond the regular daytime shift. The rural hospitals involved are those that provide necessary services in areas that suffer from a shortage of those services, and whose good faith effort to obtain registered professional nurses for other than the regular daytime shift is impeded by the lack of qualified nursing personnel in the area.

Section 102 of the enrolled bill would extend this waiver authority from January 1, 1976, to January 1, 1979.

Coordination between Medicare and Federal employees health benefits program

Section 103 of the enrolled bill would repeal section 1862(c) of the Social Security Act. Unless repealed, the section will bar Medicare payments for items or services furnished after December 31 of this year to an individual enrolled under a health benefits plan covered under chapter 89 of title 5, United States Code (i.e., a Federal employee health benefits plan). Absent its repeal, section 1862(c) would require that the Secretary certify before January 1, 1976, that the FEHB program has made available to Medicare (part A or part B) eligibles

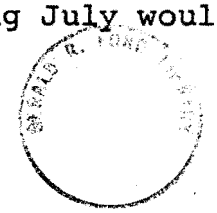
a supplement to the individual's Medicare protection, and entitle the individual to a contribution toward this supplementary protection (or the individual's part B premium) equal to that which the Government makes toward the health insurance of a high option enrollee under the FEHB plan.

Technical amendment relating to part B premium determinations

In December of each year the Secretary, following the mandate of section 1839(c) of the Social Security Act, determines the monthly actuarial rate for part B enrollees that will establish their premium payment for the 12 months beginning on July 1 of the next year. The monthly premium is limited by section 1839(c)(3)(B) of the Act, however, to the most recently promulgated premium rate plus a percentage of that premium equal to the percentage by which monthly OASDI benefits are scheduled to increase. The Secretary determines the OASDI benefit increase by looking back to the OASDI benefits in effect on June 1 of the year in which the determination is made, and comparing them to the benefits scheduled for June of the year for which the premium determination is made.

In 1972, when this limitation was first enacted, any automatic OASDI cost-of-living increase under section 215(i) of the Act was to occur in January of the year. Accordingly, the determination of that increase was required to be published on or before November 1. In December, 1973, Public Law 93-233 changed the effective month of an OASDI cost-of-living increase to June, and the publication date to on or before mid-May. However, the law failed to make a corresponding change in section 1839(c). In consequence, when the Secretary establishes the part B premium payment in December for the 12 months beginning with the following July, he finds that the OASDI benefits scheduled for the coming June are the same as the benefits in effect for the preceding June. The part B premium therefore remains the same: $6.70.

Section 104 of the enrolled bill would correct this error. It would amend section 1839(c) so that the part B premium established in December for a succeeding July would



be increased by the percentage by which the OASDI benefit then scheduled to be payable in the coming May exceeded that paid in the preceding May. Effective July, 1976, the increase in part B premiums will coincide with the OASDI cost-of-living increase.

Professional standards review areas

Section 1152 of the Social Security Act requires the Secretary to establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and to enter into an agreement with a qualified organization to serve as the PSRO for each such area. Section 105 of the enrolled bill would require the Secretary to establish an entire State as a single Professional Standards Review Organization area if (1) more than 50 percent of the physicians in each currently designated local or regional PSRO area within a State vote in favor of statewide designation in a poll to be conducted by the Secretary, and (2) the Secretary has not yet designated a PSRO for any such area in the State. The amendment would affect six States.

Updating the life safety requirements applicable to nursing homes

Effective six months from the date of H.R. 10284's enactment, section 106 would update section 1861(j)(13) of the Social Security Act, which now requires that a skilled nursing facility, to participate in the Medicare program, comply with the 1967 Life Safety Code of the National Fire Protection Association. (A similar requirement is imposed by section 1910 of the Social Security Act for SNF's in Medicaid.) Although the amendment would substitute the 1973 edition of the Code, a grandfather provision would deem a skilled nursing facility to be in compliance with the updated requirement (as applicable to Medicare and Medicaid) if it was in compliance with the 1967 Life Safety Code prior to the effective date of the bill's amendment to section 1861(j)(13) or if it meets the applicable provision of a Code imposed by State law and approved by the Secretary.

Grants for certain experiments and demonstration projects

Section 222(a) of the Social Security Amendments of 1972, P.L. 92-603, authorizes the Secretary to support experimental or demonstration activities to compare alternative methods of prospective reimbursement of Medicare and Medicaid providers. The section does not authorize the payment of any costs incurred by any such activity prior to the Secretary's agreement to assist it under the section.

Although cast in the language of general law, section 107 of the enrolled bill is specifically designed to permit the Secretary to make a grant to a California State agency to permit the agency to conduct a rate-setting experiment involving the Sacramento Foundation for Medical Care, the only large-scale operating independent practice association in the State. In order to maintain the solvency of the foundation so that it can serve as an element in the experiment, a portion of this payment is intended to reimburse it for health services provided to Medicaid enrollees from July 1 to December 31, 1975. The reimbursement would, prospectively and retroactively, supplement the fixed payment rate set by State law, which we understand to be below the foundation's costs of providing care for its 36,000 Medicaid enrollees.

Professional Standards Review Organization startup deadline

Section 108 of the enrolled bill would extend from January 1, 1976, to January 1, 1978, the period during which the Secretary is barred from entering into an agreement under which there is designated as a Professional Standards Review Organization an organization other than a nonprofit professional association whose membership is limited to physicians and consists of a substantial proportion of the physicians practicing in the area.

Study regarding coverage under part B of Medicare for certain services provided by optometrists

Section 109 of the enrolled bill would direct the Secretary to conduct a study of the appropriateness of part B reimbursement of optometrists for the provision of

prosthetic lenses for patients with aphakia. Aphakia is not a disease. The term means merely the absence of a natural lens. Under current law optometrists are compensated only for establishing the necessity for prosthetic lenses (section 1861(r)(4)). Although the cost of a prosthetic device (other than dental) is covered if it replaces all or part of an internal body organ, or if it is an artificial arm, leg, or eye (section 1861(s)(8) and (9)), eyeglasses are specifically excluded from coverage (section 1862(a)(7)).

The study, with recommendations, is to be submitted to the Congress not later than 4 months after the date of the enrolled bill's enactment.

Utilization review under Medicaid

Section 1903(g) of the Social Security Act reduces by one-third the Federal medical assistance percentage for the reimbursement of care beyond 60 days for an inpatient of a hospital, skilled nursing facility, or intermediate care facility, or care beyond 90 days for an inpatient of a mental institution, unless the State has in effect a continuous program to review utilization of services whereby the necessity for admission and the continued stay of each patient in such institution is periodically evaluated. Section 110 of the enrolled bill would amend this section to substitute for individual review, in the State's discretion, a program under which samples of admissions are reviewed in order to evaluate patterns of care. Only if the patterns of care warrant it would the State be obligated to undertake more extensive review.

The amendment would be effective beginning with the month that begins not less than 90 days after the enrolled bill's enactment.

Consent by States to certain suits

Section 111 of the enrolled bill would require a State to consent to suit by a Medicaid provider in Federal court for payment of the provider's claims against the State for payment for inpatient hospital services rendered by the

provider to Medicaid beneficiaries after June 30, 1975. In the case of a State that fails to consent, its Medicaid reimbursement with respect to quarters beginning with the first calendar quarter in 1976 would be reduced by 10 percent.

Providers may now sue for injunctive relief in Federal courts; money damages are barred, however, by the 11th Amendment to the Constitution, which provides that a State may not be sued in Federal court without its consent.

Because the Federal Government would often be a necessary party in such suits, but is not amenable to suit in State court, the provider has also been unable to sue the State for money claims in State court.

Utilization review activities

In the case of hospital-provided health services to patients entitled to have payment for those services made under part A Medicare, Medicaid, or the Maternal and Child Health and Crippled Children's Services program, section 112 of the enrolled bill would deem utilization review by a Professional Standards Review Organization to be undertaken under an arrangement with the hospital. The arrangement would obligate the hospital to pay the PSRO its reasonable cost for that review, as that cost is determined under regulations of the Secretary.

In any case in which such an arrangement is deemed to have occurred, no part A Medicare payments would be made to a hospital-provider unless the hospital has paid the PSRO the amount due for the conduct of the utilization review activities, or provided the Secretary with satisfactory assurance that the amount due will be promptly paid from the proceeds of the hospital's part A claim.

The costs of the review would be charged to the patients affected, rather than apportioned among all patients of the hospital.

The provision is apparently intended to overcome a departmental policy. Section 1168 of the Social Security Act

now provides that expenses incurred in the administration of part B of title XI, Professional Standards Review, "shall be payable" from the Federal Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund, and funds appropriated to carry out the health care provisions of the several titles of the Act. No special appropriation authority is required. The Department has nevertheless budgeted for PSRO expenses under section 201(g)(1) of the Act and limited its support of PSRO's to these budgeted, congressionally approved amounts. The amounts are insufficient to pay for direct PSRO utilization review. The effect of section 112 will be to neutralize this policy by assuring PSRO reimbursement for its direct review costs by the hospital, and hospital reimbursement through charges to patients reimbursable under Medicare, Medicaid, or title V.

The section would bar a hospital from apportioning the costs of a PSRO-conducted review to patients not affected by it, but would amend section 1168 to require the Secretary to make appropriate adjustments among the trust funds and appropriated funds so as to effect a proper apportionment of these PSRO costs.

Section 112 would be effective with respect to utilization reviews conducted on and after the first day of the first month which begins more than 30 days after the date of enactment of this Act.

Titles II and III of the bill are not described because they are not administered by this Department and would not directly affect its programmatic interests.

Provisions with Costs or Savings in H.R. 10284

The following sets forth the costs or savings associated with provisions of H.R. 10284:

Section 101 Prevailing Charge Level for FY 1976.

The Department is budgeting $100 million in savings from the regulations. This provision would reduce the savings by $35 million. There would virtually be no impact in FY 1977.

Section 104 Technical Amendment Relating to Part B Premium Determinations.

Enactment of H.R. 10284 before January 1, 1976, would provide the following income from premiums, and would result in comparable reductions for appropriations from general revenues for Supplementary Medical Insurance:

	Fiscal Years				
TQ	1977	1978	1979	1980	1981
$36 m	$184 m	$329 m	$456 m	$588 m	$725 m

Section 107 Grants for Certain Experiments and Demonstration Projects

The funding for this 28-month long project which we have been planning with the State of California has been anticipated and a differential premium was anticipated as of July 1, 1975. The bill enables the Department to meet costs from July 1 to the expected formal approval date of February 1, 1976, despite the delay in approval of the project. These costs are $930,000 or 7/12ths of the full first year costs of $1.6 million. There would be no added costs from this bill in FY 1977.

Section 112 Utilization Review Activities

This provision is not expected to have any added cost impact in FY 1976 because of the time required to publish regulations and establish administrative mechanisms.

The Department estimates full P.S.R.O. implementation to cost $156 million in FY 1977, or $69 million more than the 1977 allowance. The bill, by providing P.S.R.O. funding for non-delegated review through providers could result in a $156 million program.

However, part of this increase over the budget would be offset by already budgeted Medicare and Medicaid expenditures for institutional utilization review costs. We are unable to make an accurate estimate of the new costs to the Medicare and Medicaid programs but they would be relatively small in terms of the total benefit payments. When fully implemented we expect P.S.R.O.'s to cost about $200 million in current dollars (assuming a cost of $12 per review). Given the current rate of development we expect this bill to result in overall PSRO-related costs of $156 million in FY 1977.

UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON, D.C. 20415

CHAIRMAN

December 24, 1975

Honorable James T. Lynn
Director, Office of Management and Budget
Executive Office of the President
Washington, D. C. 20503

Attention: Assistant Director for
Legislative Reference

Dear Mr. Lynn:

This is in reply to your request for the Commission's views on enrolled bill, H.R. 10284, "To amend title XVIII of the Social Security Act, and for other purposes."

Enactment of one section of the enrolled bill -- section 103 -- is of critical importance to the continued economic and orderly operation of the Federal Employees Health Benefits Program (5 U.S.C., ch. 89). Section 103 repeals section 1862(c) of the Social Security Act. This section of the Social Security Act mandates that the method of coordinating Federal Employees Health Benefits coverage with Medicare coverage be changed in a manner requiring legislation, which has not been enacted, as a condition of Medicare's continuing to pay benefits for expenses incurred on or after January 1, 1976, for any item or service that is covered under the Federal Employees Health Benefits program. (Currently, Medicare pays hospital and medical claims first, and FEHB plans provide additional benefits up to 100% of covered expenses.)

The mandated coordination has not been effected, and cannot be before January 1, 1976. As a result, if the mandate is not removed by enactment of the enrolled bill, all persons who have Medicare and low option Federal employee plans (which together now generally provide full protection) will need to change to substantially more costly high options to assure themselves maximum health insurance protection. In addition, higher premium rates entailing higher government contributions will generally be required for Federal employee plans.

The Commission has no official concern with the other provisions in the enrolled bill. Because of our concern with section 103 and its critical importance we recommend that the President promptly sign the enrolled enactment.

By direction of the Commission:

Sincerely yours,

Robert Hampton

Chairman

DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D. C. 20250

December 4, 1975

Honorable James T. Lynn, Director
Office of Management and Budget
Washington, D. C. 20503

Dear Mr. Lynn:

This is in reply to your request for a report on the enrolled enactment H. R. 10284, a bill which includes an amendment to the Food Stamp Act of 1964.

The Department has no objection to the President's approval of the provision of the bill concerning the Food Stamp Program. The Department defers to the Department of Health, Education, and Welfare on the other provisions of the bill since they concern programs under that Department's jurisdiction.

Section 201 of H. R. 10284 would delay until October 1, 1976, implementation of the provision in the Food Stamp Act mandating States to establish Public Assistance Withholding (PAW) systems. PAW is a system whereby public assistance recipients may have the purchase price for food stamps automatically withheld from their welfare checks. The food coupons are then distributed directly to the household.

The delay authorized by H. R. 10284 will greatly assist the States which have not yet fully implemented PAW and, at the same time, will give Congress the necessary time to decide whether PAW systems should be mandatory or optional.

There will be little or no change in current program cost as a result of the food stamp provision in H. R. 10284 since the effect of the provision is to maintain the status quo for another nine months.

In summary, as a interim measure, we do not object to the enactment of the food stamp provision in H. R. 10284.

Sincerely,

John A. Knebel

Under Secretary

ASSISTANT ATTORNEY GENERAL
LEGISLATIVE AFFAIRS

Department of Justice
Washington, D.C. 20530

December 24, 1975

Honorable James T. Lynn
Director, Office of Management
and Budget
Washington, D. C. 20503

Dear Mr. Lynn:

In compliance with your request, I have examined a facsimile of the enrolled bill, H.R. 10284, "To amend Title XVIII of the Social Security Act, and for other purposes."

We have no comment on the substantive issue of the effect of these amendments on existing federal statutes, and take no position with respect to the advisability of the legislation. As we view this legislation, it would not appear to have any substantive impact on the activities of the Justice Department.

The Department of Justice defers to those agencies more directly concerned with the subject matter of the bill as to whether it should receive Executive approval.

Sincerely,

Michael M. Uhlmann

MICHAEL M. UHLMANN
Assistant Attorney General

To- J. Cavanaugh 12-29-75 10 a.m.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DEC 2 0 1975

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill H.R. 10284 - Medicare Amendments
Sponsor - Rep. Rostenkowski (D) Illinois and 12 others

Last Day for Action

January 2, 1976 - Friday (Action is urged no later than Wednesday, December 31, 1975 because of timing involved in several amendments, as explained below)

Purpose

Amends the Medicare and Professional Standards Review Organization (PSRO) programs; authorizes States to modify procedures for issuing food stamps to welfare families; includes a tax rider relating to certain irrigation dams.

Agency Recommendations

Office of Management and Budget	Approval
Department of Health, Education, and Welfare	Approval
Civil Service Commission	Approval
Department of Agriculture	No objection
Department of the Treasury	No objection (informally)
Department of Justice	Defers to other agencies

Discussion

H.R. 10284 would make numerous amendments to the Medicare and PSRO programs. It also contains two amendments unrelated to health--one deals with the issuance of food stamps to families receiving welfare benefits and the other is a tax amendment relating to the exemption of interest on certain irrigation dam bonds. Most of the fourteen amendments contained in H.R. 10284 were added to the bill in "Christmas tree" fashion during the final days of the 1st session, 94th Congress. The

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.: 1550

Date: December 29 Time: 1000am

FOR ACTION: Sarah Massengale
Max Friedersdorf
Ken Lazarus
Bill Seidman

cc (for information): Jack Marsh
Jim Cavanaugh

FROM THE STAFF SECRETARY

DUE: Date: December 29 Time: 6:00pm

SUBJECT:

H.R. 10284 - Medicare Amendments

ACTION REQUESTED:

____ For Necessary Action
____ For Your Recommendations
____ Prepare Agenda and Brief
____ Draft Reply
__x__ For Your Comments
____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

K. R. COLE, JR.
For the President

DEC 29 RECD

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.: 1550

Date: December 29 Time: 1000am

FOR ACTION: Sarah Massengale
Max Friedersdorf
Ken Lazarus
Bill Seidman

cc (for information): Jack Marsh
Jim Cavanaugh
Warren Hendriks

FROM THE STAFF SECRETARY

DUE: Date: December 29 Time: 6:00pm

SUBJECT:

H.R. 10284 - Medicare Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

x
____ For Your Comments ____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

Concur with O and B

JWS

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

THE WHITE HOUSE

WASHINGTON

December 30, 1975

MEMORANDUM FOR: JIM CAVANAUGH

FROM: MAX L. FRIEDERSDORF M. L.

SUBJECT: H.R. 10284 - Medicare Amendments

The Office of Legislative Affairs concurs with the agencies that the subject bill be signed.

Attachments

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.: 1550

Date: December 29 Time: 1000am

FOR ACTION: Sarah Massengale
Max Friedersdorf
Ken Lazarus
Bill Seidman

cc (for information): Jack Marsh
Jim Cavanaugh
Warren Hendriks

FROM THE STAFF SECRETARY

DUE: Date: December ~~29~~ 30 Time: 6:00pm

SUBJECT:

H.R. 10284 - Medicare Amendments

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

x
____ For Your Comments ____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

No objection. -- Ken Lazarus 12/30/75

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

Calendar No. 528

94TH CONGRESS
1st Session

SENATE

REPORT
No. 94-549

AMENDING TITLE XVIII OF THE SOCIAL SECURITY ACT

DECEMBER 12, 1975.—Ordered to be printed

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

REPORT

[To accompany H.R. 10284]

The Committee on Finance, to which was referred the bill (H.R. 10284) to amend title XVIII of the Social Security Act to assure that the prevailing fees recognized by medicare for fiscal year 1976 are not less than those for fiscal year 1975, to extend for 3 years the existing authority of the Secretary of Health, Education, and Welfare to grant temporary waivers of nursing staff requirements for small hospitals in rural areas, to maintain the present system of coordination of the medicare and Federal employees' health benefit programs, and to correct a technical error in the law that prevents increases in the medicare part B premiums, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

I. SUMMARY OF THE BILL

H.R. 10284 as passed by the House contained provisions relating to prevailing charges, nursing requirements in rural hospitals, the relationship between medicare and the Federal employee health program, and the medicare part B premium. The committee amendment incorporates these provisions, with some modifications, and adds a number of new provisions.

PREVAILING CHARGE DETERMINATIONS UNDER MEDICARE

Due to the late issuance of regulations implementing the provision in law intended to limit increases in physicians' prevailing fees from year-to-year, some physicians' fees have unintentionally been rolled back to a point below their previous level. The first provision of the House bill would assure that no prevailing charge in fiscal year 1976 is less than it was in fiscal year 1975. The committee amendment modi-

fies the House provision to indicate that, in calculating the index by which physicians' prevailing fees can increase, the Department should include, to the extent feasible, factors related to any increases in costs of malpractice insurance and that index calculations should be prepared on a regional rather than a national basis.

WAIVER OF 24-HOUR NURSING REQUIREMENTS FOR CERTAIN RURAL HOSPITALS

The second provision of the House bill extends for 3 years (until December 31, 1978) the Secretary's authority to grant temporary waivers of nursing staff requirements in hospitals located in areas where nurses are in short supply and other hospitals are not readily accessible. The committee amendment provides instead for a 1-year extension of the waiver authority.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM

The House bill would repeal a provision of Public Law 92–603 which provides that, unless the Federal employees' health program were rewritten to provide supplementary benefits to those older or retired Federal employees who also have medicare eligibility, the medicare program would no longer serve as the primary payer of benefits. The committee amendment incorporates this change, so that the medicare program would continue as the primary payer of benefits without requiring any change in the Federal employees' program.

MEDICARE PART B PREMIUM

The fourth provision of the House bill, included in the committee amendment, would correct a drafting error in Public Law 93–233 which, in modifying the social security cash benefit provision, had unintentionally failed to make corresponding changes allowing for annual changes in the part B medicare premium. The provision would correct this drafting error and permit adjustments in part B premiums on July 1, 1976 and in future years at rates no greater than the percentage rate of increase in cash social security benefits.

In addition, the committee amendment includes the new provisions described below.

PROFESSIONAL STANDING REVIEW ORGANIZATIONS (PSRO) AREA DESIGNATIONS

The committee amendment provides that in those States (1) which have been divided into more than one PSRO area, and (2) in which no conditional PSRO's have been designated, the Secretary would poll the physicians in each designated area as to their preference for a local or statewide PSRO. If a majority of physicians in each currently designated PSRO area in that State approved a statewide PSRO, the Secretary would redesignate that State as a single area.

PSRO DIRECT UTILIZATION REVIEW ACTIVITIES

The committee amendment also contains a provision aimed at equalizing the reimbursement for utilization review activities where they

are carried out by a hospital under delegation from a PSRO or by the PSRO itself. Under current law, utilization review expenditures are reimbursable by medicare for delegated review. Under this provision, utilization review expenses of the PSRO in carrying out nondelegated review would also be reimbursable through medicare benefit payments.

MEDICARE PAYMENTS TO VETERANS' ADMINISTRATION HOSPITALS IN CASE OF "GOOD FAITH" ERROR

Under this committee provision, the medicare program would be authorized to pay for care rendered to a medicare-eligible patient in a Veterans' Administration hospital if the patient had entered the hospital and the hospital had accepted the patient under the belief that he was eligible for veterans' benefits, and it was later determined that he was not eligible.

UPDATING OF THE LIFE SAFETY CODE REQUIREMENTS APPLICABLE TO SKILLED NURSING FACILITIES

The next committee provision would update the current requirements for skilled nursing facilities under the medicare and medicaid programs by replacing the current requirement that such facilities meet the provisions of the 1967 Life Safety Code with a requirement that they meet the conditions of the 1973 edition of the code. The provision would also assure that facilities currently qualified under the 1967 code, or State codes which are approved by the Secretary, would not lose their eligibility for participation in the programs.

GRANTS TO DEMONSTRATE APPROPRIATE MECHANISMS FOR CAPITATION PAYMENTS

Another committee provision would remove a technical barrier to the Secretary's approval of a grant to the Sacramento Medical Care Foundation which is aimed at obtaining data to assist the Department in developing appropriate reimbursement mechanisms for health maintenance organizations.

OCCUPATIONAL THERAPY UNDER MEDICARE

The committee amendment includes a provision to expand coverage of occupational therapy services under the medicare program to cover such services when they are provided through clinics, rehabilitation agencies and other organized settings. The provision also allows patients to qualify for home health services on the basis of a need for occupational therapy services alone.

FOOD STAMP PURCHASES BY WELFARE RECIPIENTS

Another provision of the committee amendment to H.R. 10284 relates to food stamps. Agriculture Department regulations scheduled to go into effect in January 1976 will require welfare agencies in all States to allow recipients of Aid to Families with Dependent Children (AFDC) to purchase food stamps through a withholding procedure. The price of the stamps would be deducted from the AFDC check and the stamps themselves would be mailed with the check. Current law requires the Department to impose this procedure on the States on a mandatory basis even though a significant number of States

believe that the adoption of this procedure will create severe problems of administration. The committee amendment will allow each State to decide whether or not to use this method of distributing food stamps to welfare recipients.

II. General Explanation of the Bill

Prevailing charge determinations under medicare

(Section 1 of the Bill)

The committee concurs in the House provision to avoid any rollback in allowable medicare fees which have occurred in fiscal year 1976. In addition, the committee is concerned that the administrative policies that HEW has adopted to carry out the economic index provisions do not conform to the legislative intent and result in reasonable charge ceilings which may unfairly benefit individuals in some areas while disadvantaging others. The legislative history of the 1972 amendments clearly intended that indexes be calculated separately for "areas of a size and nature permitting proper calculation and determination of the types required to adjust prevailing change levels." The objective of requiring at least regional indices was to assure that changes in office practice costs (including malpractice premiums) and general earnings levels that take place in varying areas, be reflected in the ceilings placed by the index or increases in physicians' allowable fees.

Nevertheless, HEW regulations provide for the establishment of a single, national index applicable to all physicians. Therefore, the committee has included in the bill a provision requiring the Secretary of HEW to submit a report to the Finance Committee and to the House Committee on Ways and Means explaining why it has not complied with the legislative intent by establishing separate indices on other than a national basis (certainly in at least 10 regions) and the steps that the Department is presently taking to conform to the legislative intent. If necessary, the committee would expect the Department to include in its report any recommendations as to remedial legislation which might be necessary to further implement congressional intent with respect to this provision. The report would be due 90 days after the date of enactment.

The committee has also noted that HEW has based the earnings component of the index on changes in the earnings of production and nonsupervisory workers. The committee expects that social security data be used to measure changes in general earnings levels because social security covers substantially all wage earners and self-employed people. The choice of the more limited data by HEW makes the index nonrepresentative of the earnings level of the general population. The report from the Secretary of HEW will also explain its choice of data on earnings and the steps it is taking to make the data base more representative.

Extension of authority to waive 24-hour nursing service requirements for certain rural hospitals

(Section 2 of the Bill)

In order to participate in the medicare program, providers and suppliers of health services must comply with specific requirements

set forth in the statute and with other conditions pertaining to the health and safety of medicare beneficiaries which the Secretary of Health, Education, and Welfare is authorized, by statute, to prescribe.

According to policy established by the Social Security Administration, a hospital is certified for participation in medicare if it meets all of the statutory requirements and is in "substantial" compliance with all regulatory requirements. Thus, while an institution may be deficient with respect to one or more regulatory requirements, it still may be found to be in substantial compliance, if the deficiencies do not represent a hazard to patient health and safety, and efforts are being made to correct the deficiencies.

In recognition of the fact that there is a need to assure continuing availability of medicare-covered institutional care in rural areas (many of which have only one hospital) without jeopardizing the health and safety of patients, the Social Security Administration follows the approach of certifying "access" hospitals which, to the extent they are capable have succeeded in overcoming deficiencies. Access hospitals are those located in isolated areas or in areas with insufficient facilities, the failure of which to approve for medicare reimbursement would seriously limit the access of beneficiaries to needed inpatient care.

However, during the 91st Congress, it became apparent that several hundred rural hospitals, despite proper efforts were unable to secure required nursing personnel and were thus unable to meet the statutory requirement for 24-hour registered nurse coverage.

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 qualified nursing personnel were making it difficult for several hundred rural hospitals to meet the nursing staff requirements and come into compliance with the law, legislation (H.R. 19470, Public Law 91–690) was enacted to authorize the Secretary of HEW, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock.

Under this amendment, the Secretary is given the authority, until December 31, 1975, to waive the nursing requirement if he finds that:

(*a*) the hospital is located in a rural area and the supply of hospital services in the area is not sufficient to meet the needs of medicare beneficiaries residing therein;

(*b*) the failure of the institution to qualify as a hospital would seriously reduce the availability of services to beneficiaries; and

(*c*) the hospital has made and continues to make a good faith effort to comply with the nurse staffing requirement, but compliance is impeded by the lack of qualified nursing personnel in the area.

While the House report notes that there has been considerable progress in reducing the number of "waivered" hospitals (presently 90), there are approximately 40 additional rural hospitals, while able to meet the statutory nurse staffing requirement, have major regulatory deficiencies. Such hospitals are also certified as "access" hospitals.

Based upon a 1974 study funded by the Department of Health, Education, and Welfare, besides those formally identified access hospitals, there are approximately another 400 rural hospitals with essentially

the same attributes, which have managed to meet certification requirements either through extraordinary efforts by the hospital or through lenient application of standards by the medicare surveyors.

Further, with respect to the specific problem of nurse staffing, there are indications in some States of licensure requirements which may tend to restrict the flow of nurses into shortage areas. For example, in one State, where approximately 50 percent of the "waivered" hospitals are located, the requirements for nurse licensure include, among other things, graduation from an accredited program in professional nursing of at least 2 *calendar* years in length. It is important to note that, of the 574 accredited associate degree programs in the United States, 486 are programs of 2 *academic* years. Accordingly, the State is able to draw from less than 20 percent of the schools which offer associate degrees in nursing. It appears inconsistent to the committee for a State with an identified nurse shortage to have, at the same time, what may be questionable licensure barriers against increasing the supply of nurses.

In the opinion of the committee, the inability to attract qualified nursing personnel is only one of several problems facing rural hospitals in providing health care services. Accordingly, the committee feels that there should be a review of all the conditions of participation imposed upon rural hospitals, as well as barriers to the flow of nurses into shortage areas.

Inasmuch as the Department of HEW completed an in-depth study of access hospitals in June, 1974, the committee feels that a further study as requested in the House report is unnecessary at this time, and that a 3-year extension of the waiver authority as provided for in the bill would serve to delay a more permanent solution to the access hospital problem. The committee has therefore approved a 1-year extension of the waiver authority and has asked committee staff to work with other committees and appropriate health organizations toward developing recommendations for legislative changes designed to establish specific rural hospital certification requirements commensurate with staff and facilities in rural areas.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Section 3 of the Bill)

The statute (section 1862(c) of the Social Security Act) calls for medicare to stop making payment, as of January 1, 1976, for services furnished to a beneficiary for which he also has coverage under the Federal Employees' Health Benefits (FEHB) program. The January 1, 1976, deadline is the result of a provision, originated by the Committee on Ways and Means, that was included in the 1972 Social Security Amendments (Public Law 92-603.). It was designed to focus attention on the need to consider improved coordination of medicare and the FEHB program.

Many Federal employees and retirees over 65 have worked long enough in employment covered by social security to become insured for benefits under part A of medicare. (Part B is available to everyone over age 65 except recent immigrants.) The Civil Service Commission estimates that by June 1976 about 258,000 FEHB enrollees, or 50

percent of the enrollees age 65 and over, and 150,000 dependents will be covered by medicare part A.

At present, when a person who has such dual entitlement receives health care, medicare acts as the primary insurer and makes payment first for the covered services; thereafter, the FEHB plan in which the person is enrolled makes payment, but only to the extent that medicare has not already paid for the services covered by the FEHB plan. Although medicare thus bears a major share of the dually entitled person's health care costs, the person pays the same FEHB premium as people not entitled under medicare.

Because of overlapping benefits, many Federal employees and retirees age 65 and over have not found it advantageous to enroll in medicare part B. As a result, they do not benefit from the general revenue contribution (equalling more than half of the program's cost) which is available to all who enroll in part B.

Section 210 of Public Law 92-603 (October 30, 1972) amended title XVIII of the Social Security Act by adding a new subsection 1862(c) prohibiting payment by medicare, on or after January 1, 1975, for any item or service covered by an FEHB plan in which the medicare beneficiary was enrolled, unless prior to that date the Secretary of HEW was able to certify that the individual FEHB plan in question or the entire FEHB program had been modified in specified ways. The intent of this provision was described in the report of the Committee on Ways and Means as "to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB."

To comply with this provision, the modifications in FEHB would have had to assure the following:

1. That one or more FEHB plans supplementing medicare protection are available to each Federal employee or retiree who is entitled to medicare parts A or B, or both A and B, and

2. That the Government or the FEHB plan will make available to each such individual a contribution at least equal to the contribution the Government makes toward the high-option coverage of any enrollee in the Government-wide FEHB plans. This contribution could be in the form of (a) a contribution toward the individual's FEHB protection supplementing medicare, or (b) a payment to offset the premium cost of part B of medicare, or (c) a combination of the two.

In the fall of 1974, when it became apparent that not enough progress toward coordination had been made to permit the requirements of subsection 1862(c) to be complied with by January 1, 1975, the effective date was extended for 1 year, to January 1, 1976, by Public Law 93-480 (October 26, 1974). The extension was conditional upon submission, no later than March 1, 1975, by the Department of HEW and the Civil Service Commission of a progress report (in the absence of which the effective date would have been July 1, 1975).

The report jointly submitted by the DHEW and the CSC pursuant to Public Law 93-480 pointed out a number of problems that it said would result from efforts to comply with all the requirements of section 1862(c), and proposed instead an alternative plan for coordination of the medicare and FEHB programs that would require amendment of both the medicare law and the FEHB Act.

Under the proposal, an FEHB medicare supplement option would be made available where the FEHB enrollee or a member of his family is covered by both parts A and B of medicare. The Government would pay 100 percent of the premium for this medicare supplement so long as this did not exceed the maximum dollar amount the Government pays with respect to other FEHB enrollees. For at least the first year, the enrollee would not have to pay any premium. The supplement, together with medicare, would cover up to 100 percent of expenses for a medicare beneficiary; for other family members, the regular high-option benefits of the FEHB plan would be provided.

The increased cost of this proposal to the Government is estimated for calendar year 1976 as $48 million ($39 million in increased FEHB contributions, and $9 million in increased general revenue contributions for medicare part B which would result from increased enrollment in part B by FEHB enrollees). Also, an additional $13 million in increased premiums would be paid by nonmedicare FEHB enrollees (their premiums would no longer reflect the reduction in FEHB program costs that results because medicare makes payment first for FEHB enrollees who have medicare coverage).

The committee has carefully considered this proposal by the administration as well as an alternative suggested in a report by the Comptroller General on the coordination issue—that the Government simply pay medicare part B premiums for all eligible FEHB enrollees. (The Comptroller General's report also suggested consideration of continuing without change the existing system for coordinating the benefits of the two programs.) The substantial costs of these proposals need to be weighed against the increased benefit protection or improved equity they would provide for people covered under both FEHB and medicare.

In general, the medicare supplements provided under FEHB today are richer than those offered to medicare beneficiaries under group health insurance plans in private industry. The coordination methods used by the various FEHB plans differ, but in general, after medicare makes payment, the FEHB plan pays for the services it covers in an amount that ordinarily will result in full coverage of most of the charges. Usually, enrollment in the low option of an FEHB plan (rather than the more costly high option) will achieve this result. The CSC has been advising medicare beneficiaries, during FEHB open enrollment periods, that low-option plans will in most cases adequately supplement both parts of medicare at lower cost than the high option.

Since section 1862(c) was enacted, the standard Government contribution toward FEHB premiums has increased from 40 to 60 percent of the total premium, and proposals have been made to increase the Government contribution again in future years. Medicare beneficiaries, as well as other FEHB enrollees, have benefited from this increased contribution.

Although it can be argued that more generous provisions than now exist for coordination of FEHB and medicare are merited, the committee is not convinced that equity requires the Government to substantially increase its expenditures under the two programs in an effort to accomplish this. It should be noted that Federal employees who have acquired medicare insured status have generally done so by

splitting their careers between Federal and private employment or by moonlighting, rather than through a lifetime of work covered under social security. Some offsetting of the benefits of one program against the other, such as now exists, seems justified in view of the major contributions the Government makes toward the financing of both programs.

The committee has therefore concluded that the existing relationship between the medicare and FEHB programs should be maintained. Accordingly, the bill would repeal section 1862(c) of the Social Security Act.

MEDICARE PART B PREMIUM

(Section 4 of the Bill)

The current monthly premium charged for part B of medicare is permanently frozen at $6.70 (the same amount as for last year) because of a technical error in the law that prevents the premium from being increased even though the Congress clearly intended to permit increases on July 1 of each year. The intention was to permit premium increases corresponding with increases in program costs, but limited to a maximum percentage increase no greater than the percentage by which monthly social security benefits have increased during the year.

Part B of medicare—the voluntary medical insurance part of the medicare program covering physicians' and certain other health services—has since its inception been financed through a combination of monthly premiums paid by beneficiaries who choose to enroll and matching payments from Federal general revenues. For the great majority of beneficiaries, the medicare premium is deducted each month from the social security benefit check.

The amount of the premium is determined through a calculation that begins with the cost of providing part B protection to beneficiaries age 65 and over. The premium was originally designed to equal one-half of this cost, but subsequent legislation enacted in 1972 limited the maximum premium increase each year to the percentage by which monthly social security benefits increased. (Beneficiaries under age 65 who are covered by part B by virtue of their status as social security disability beneficiaries or as end-stage renal disease patients pay the same premium as the aged, even though the cost of providing benefits to them is far greater.)

The technical error, freezing the premium, occurred when Public Law 93-233, enacted December 31, 1973, modified the schedule for automatic increases in social security cash benefits, but unintentionally failed to make corresponding changes in the provisions that relate percentage increases in the medicare part B premium to increases in cash benefits. Federal general revenues are used to finance whatever part of the cost of part B is not met through premiums paid by beneficiaries. So long as the premium amount remains frozen, the proportion of part B costs financed by general revenues will continue to rise.

The committee recognizes that many people would prefer not to allow the part B premium to increase at a time when the elderly, as well as others, are feeling the effects of inflation in health care costs. Failure to increase the premium, however, results in millions of dollars

of increased general revenue expenditures in future years. If such amounts were to be expended, the money might better be used to provide some improvement in benefit protection.

The committee's bill would correct the technical error in the law by changing from June 1 to May 1 the date used in determining the percentage increase from one year to the next in social security benefit levels, to arrive at the maximum percentage by which the medicare premium may be increased. The premium increase would be determined and promulgated in December of each year as under present law and the increased premium would be deducted from the same benefit check that reflects a cash benefit increase under the provisions for automatic increases in social security benefits. Thus, as intended by the Congress in enacting Public Law 93–233, premium increases would not result in reducing the amount of the monthly checks received by beneficiaries (because both a benefit increase and a very much smaller premium increase would be reflected in the same check).

Because of the technical error, the monthly premium has remained at $6.70 for the 12-month period beginning July 1, 1975, instead of increasing. The committee bill would not attempt to "catch up" by permitting 2 years' worth of benefit increases to be reflected in the single increase for the year beginning July 1, 1976. Instead, that premium increase would reflect only 1 year's increase in social security cash benefits.

Thus, the present $6.70 premium would go up only 50 cents on July 1, 1976, the same date that the social security benefit checks will be increased by reason of the automatic cost-of-living provisions in title II of the Social Security Act. Current estimates are that cash social security benefits will be increased by about 7 percent for the checks that are mailed early in July. The minimum dollar increase would be several times the 50-cent increase in the premium which is deducted from the same check in which the general benefit increase appears.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION AREA DESIGNATIONS

(Section 5 of the Bill)

Under present law, the Secretary of Health, Education, and Welfare is required to and has, in fact, designated geographic areas in the several States as "Professional Standards Review Areas." There are 203 such areas in the country. In more than one-half of these areas, physician-sponsored organizations have formally contracted with the Secretary as either designated PSRO's with operating responsibility (64 organizations as of this date) or planning PSRO's (56 as of this date).

There are, however, a number of States in each of which multiple PSRO areas have been designated, and in which no formal PSRO relationships have been established. It is the committee's understanding that the development of PSRO's in those States has, in large part, been inhibited by widespread physician concern over their inability to establish a single statewide PSRO rather than the presently required multiple PSRO's.

The committee amendment would, under certain circumstances, eliminate the barrier to designating a single statewide PSRO area in a

number of States where multiple areas now obtain. The amendment requires the Secretary to conduct, as soon as possible, separate polls in each of the presently designated areas of a State with multiple areas if in no area of that State, as of the effective date of this act, has the Secretary designated and entered into an agreement with an organization as the Professional Standards Review Organization. As has been noted, the Secretary has so designated and entered into such agreements with more than 60 organizations thus far.

The physicians in each presently designated local area meeting the conditions described would be polled, on a confidential basis, as to whether they were willing to forego the local designation in favor of a statewide area. If in each presently designated local area a majority of the physicians responding opt for the statewide designation, then the Secretary would be required to redesignate and consolidate the multiple areas into a statewide area. Thus, if a majority of the physicians elect a change in every presently designated local area in a State, the Secretary would follow up with statewide designation. If, however, a majority of physicians in an area elect to retain the local designation then the present multiple area designations in that State would continue.

PSRO DIRECT UTILIZATION REVIEW ACTIVITIES

(Section 6 of the Bill)

Public Law 92–603 established Professional Standards Review Organizations (PSRO's) throughout the country. These organizations, consisting of practicing physicians in an area, are charged with reviewing the quality and necessity of health services provided under the medicare and medicaid programs.

The PSRO's may discharge their review responsibilities with respect to hospitals in two ways: first, they can delegate their review responsibilities to hospital review committees where the PSRO is satisfied as to the capacity of the hospital to conduct proper review (in which case the PSRO is charged with the responsibility to continuously monitor the effectiveness of the hospital review committee); alternatively, the PSRO's can carry out the review activities on their own in those cases and, to the extent that a hospital either cannot conduct satisfactory review or chooses that the PSRO perform the review for it.

Under present law, where the PSRO delegates review responsibility to a hospital committee, the costs of that review are reimbursed through Medicare and Medicaid benefit payments to the hospital since these costs are considered a part of the hospital benefit cost. However, where the PSRO does not delegate review to a hospital, the PSRO must bear the cost of the review out of its own administrative budget.

Since PSRO administrative budgets are often quite limited, the PSRO's in effect have an incentive to delegate review so that they will not have to bear the cost—conversely, they have a disincentive to perform review directly. The result of this may be inappropriate or premature delegations of review authority to hospitals which are not really competent or willing to carry out the review.

The committee amendment would allow the medicare benefit trust fund to pay not only for delegated review to the hospitals, but to also pay the PSRO through the hospital for nondelegated hospital review.

This would equalize reimbursement treatment of review activities. The payment in the case of nondelegated review would flow from the hospital to the PSRO following billing by the PSRO on a prospective or retroactive basis with the hospital then fully reimbursed for the total amount of the charge (without any requirement of allocation) by the intermediary for such payments under guidelines established by the Bureaus of Health Insurance and Quality Assurance defining the amount and circumstances of such charges. The Federal agencies, and not the hospitals or intermediaries, would be responsible for assuring the appropriateness and reasonableness of PSRO charges for direct utilization review.

Further the committee anticipates that in order to completely eliminate any financial incentive either for or against the delegation of review responsibility and authority by a PSRO to a hospital, existing medicare policies of the Bureau of Health Insurance will be modified to provide that a separate cost center be established by a hospital to clearly identify the reasonable costs of required review activities. It is expected that for medicare and medicaid reimbursement purposes (whether such review be conducted under a delegation by a PSRO to a hospital review committee, or directly by the PSRO), 100 percent of the reasonable costs incurred in the reasonable review of medicare, medicaid, and material and child health patients admitted to the hospitals concerned shall be recognized as a direct cost of such programs without requirement of any apportionment of the review costs among patients of the institution for whom such costs had not been incurred.

Of course, in the case of the costs of any review and related activities which have customarily been undertaken as a routine aspect of medical staff privileges in a hospital any costs for such work (such as that of hospital tissue and formulary committees, etc.) are not intended to be compensated on other than an apportionment basis.

This amendment also provides for the transfer of funds for medicaid appropriations to the medicare trust fund to reimburse the trust fund for funds expended for PSRO nondelegated review of medicaid patients.

MEDICARE PAYMENTS TO VETERANS' ADMINISTRATION HOSPITALS IN CASE OF "GOOD FAITH" ERROR

(Section 7 of the Bill)

Under present law, payments may not be made under part A of medicare to any Federal provider of services, such as a Veterans' Administration hospital, where such institution is otherwise obligated by law to render care at public expense.

The committee has had its attention called to circumstances in which an individual, entitled to part A benefits, was admitted to a veterans' hospital with both the hospital and the beneficiary believing the patient was eligible for such care and was subsequently found to be ineligible for care as a veteran. Following such a determination, the Veterans' Administration is required, by law, to recover the costs of such care from the patient (or his estate, if the patient is deceased).

The committee amendment would permit payment by the medicare program to VA hospitals for care rendered to a part A beneficiary in certain circumstances. Payment may be made only when (1) the beneficiary is admitted to the VA facility in the reasonable belief that he

is entitled to have service furnished to him by the VA free of charge; (2) the authorities of such hospital and the beneficiary acted in good faith in making such admission; (3) that the beneficiary is, in fact, not entitled to care in the facility free of charge; and (4) the care was provided while those operating the facility remained unaware of the fact that the individual was not eligible for VA benefit or before it was medically feasible to arrange a transfer or discharge.

Payment for services would be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) reasonable costs for such services (as estimated by the Secretary following consultation with the Chief Medical Director of the Veterans' Administration).

UPDATING OF THE LIFE SAFETY CODE REQUIREMENTS APPLICABLE TO SKILLED NURSING FACILITIES

(Section 8 of the Bill)

Under present law, skilled nursing facilities participating in the medicaid and medicare programs must meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes. The committee amendment would update medicare and medicaid requirements by deleting the reference to the 1967 edition of the Code and adding the 1973 edition. The amendment would also assure that facilities currently qualified under the 1967 Code or State codes which are approved by the Secretary, would not lose their certification status due to any changes in requirements imposed by the 1973 edition of the Code.

GRANTS TO DEMONSTRATE APPROPRIATE MECHANISMS FOR CAPITATION PAYMENTS

(Section 9 of the Bill)

Under present law the various State medicaid programs can make capitation payments to Health Maintenance Organizations (HMO's) which contract in advance to provide services to enrolled medicaid recipients. The use of this type of arrangement has occurred most prevalently in the State of California.

Over recent years, audits by the General Accounting Office and extensive investigative activities by the Senate's Government Operations Committee have shown that the basis on which payments have been made to these organizations is not necessarily reasonable. Officials of the State of California have agreed with this judgment and have applied to the Department of Health, Education, and Welfare for a grant in order to support a program to develop appropriate mechanisms to measure the true cost of providing health care services through HMO's and to measure the quality of services so provided. The results of this HEW-grant-supported project would be used to structure a reasonable payment mechanism for HMO's in California and other States.

One key aspect of the project for which HEW grant support has been sought would include measuring the costs of providing care in an individual practice association—a type of HMO which, while receiving prepaid capitation payment from the State, would continue to pay its member physicians on a fee-for-service basis.

State officials maintain that cost data from this type of HMO is essential to any valid study.

There is one large-scale operating independent practice association in the State, the Sacramento Foundation for Medical Care. This foundation involves over 800 physicians and 20 hospitals and is providing prepaid health services to more than 36,000 medicaid enrollees. Because of an unalterable fixed payment rate set by State law, the State has been unable to pay the foundation an amount fully equal to the costs of providing care for the medicaid enrollees. However, State officials want to pay the foundation a rate sufficient to cover its costs so that it can continue to operate and so that its unique costs data can be used as a part of the overall study.

A problem has arisen in that the General Counsel of HEW has ruled that the section of the social security law which authorizes cost and quality evaluation studies does not allow for any funding of costs already incurred for providing patient care.

This provision would clarify existing law and congressional intent so as to specifically allow in this case for the payment of such retroactive costs where these payments are necessary to assure that the individual practice association can continue in a study, carried out by a State agency aimed at developing a rate setting methodology for HMO's.

The total grant from HEW to the State of California would call for payments of approximately $5.2 million. Of this amount, approximately $1.6 million will be used for conducting the rate setting experiment with the foundation and approximately $700,000 of this $1.6 million will be used to reimburse the foundation for health services provided from July 1 to December 31, 1975.

OCCUPATIONAL THERAPY UNDER MEDICARE

(Section 10 of the Bill)

Under present law, occupational therapy services are covered under part A when provided to medicare beneficiaries who are inpatients in medicare-approved hospitals or skilled nursing facilities. Patients receiving home health services under part A or part B are entitled to occupational therapy services only if they are receiving either intermittent skilled nursing care or physical or speech therapy. In addition to coverage as part of home health services, occupational therapy services are covered under part B only when provided to outpatients in medicare-approved hospitals. Occupational therapy services provided to outpatients in a clinic, rehabilitation agency or other organized setting are not now covered.

The committee is concerned that present law treats occupational therapy differently from physical or speech therapy on two grounds. First, occupational therapy services are not covered when outpatient services are provided through clinics and organized health settings, although physical and speech therapy services are covered in such settings. Second, patients cannot receive occupational therapy through a home health agency unless they also require skilled nursing services, physical therapy or speech therapy.

The committee bill, therefore, eliminates these distinctions between occupational therapy and the other therapy groups. It expands the

outpatient physical therapy and speech pathology benefit as provided through clinics, rehabilitation agencies, and other organized settings to include occupational therapy. Additionally, it amends the requirements for patients to qualify for home health services to provide that a need for occupational therapy alone can qualify the homebound patient for this benefit. However, the need for occupational therapy alone would not qualify a person for the service of a home health aide.

In administering the occupational therapy benefit, the committee intent is to have the Department of HEW apply the definition, guidelines, and criteria as to covered and noncovered occupational therapy services included in the "Skilled Nursing Facility Manual" Revision No. 109, issued by the Social Security Administration in November, 1975.

FOOD STAMP PURCHASES BY WELFARE RECIPIENTS

(Section 201 of Title II of the Bill)

Under a provision of Public Law 93–86, State agencies were mandated to withhold, at the option of the recipient, the amount of the AFDC grant needed to purchase the recipient's food stamp allotment and to distribute the food stamp coupon allotment along with the reduced cash grant (usually by mail).

Although many States do use Public Assistance Withholding (PAW) issuance successfully, some States have found the mandatory provisions in present law extremely difficult to implement. There is a serious problem in the mail issuance of food stamp coupons in urban areas where the probability of mail loss is high. Major design problems are met in attempting to coordinate State-run AFDC systems with locally run or contracted-out food stamp issuance systems. Many States even though they utilize computers encounter the costly problem of computer incompatibility between the AFDC and food stamp systems. The heavy additional cost of establishing computer capability to implement withholding or computer compatibility is a financial burden with which a number of States cannot cope. There is, in addition, strong opposition in some States to requiring that the public assistance withholding (PAW) issuance program operate in all areas of the State.

The committee believes the problems posed by State agencies are valid. To date, only 21 States and one jurisdiction have fully implemented PAW and mail issuance program of food stamp coupons. Eight other States have implemented the program in some of the counties in the State. However, 21 States and 3 jurisdictions have not implemented the PAW and mail issuance program. The following shows the breakdown by State.

States with full implementation

Alaska, Arizona, Arkansas, Delaware, Guam, Hawaii, Idaho, Iowa, Kansas, Kentucky, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Utah, Vermont, Virginia, Washington, and West Virginia.

States with partial implementation

California, Colorado, Indiana, Maryland, Minnesota, New York, Texas, and Wisconsin.

States without implementation

Alabama, Connecticut, District of Columbia, Florida, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Virgin Islands, and Wyoming.

Under current law, Agriculture Department regulations mandate that all States offer, statewide, PAW food stamp issuance procedures to AFDC recipients beginning January 1, 1976.

In response to the problems encountered by some States, title II of the committee bill will give States the option of offering PAW issuance procedures. States could choose not to offer PAW procedures, offer them statewide, or offer them only in selected areas of the State. For those States choosing to offer PAW issuance procedures to AFDC recipients, the administrative cost of the procedures would continue to be governed by the Federal-State cost-sharing provisions of the Food Stamp Act.

III. Costs of Carrying Out the Bill

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, the following statement is made relative to the costs to be incurred in carrying out this bill.

The provision allowing the Part B premium to increase would result in reduced general revenue outlays of $184 million in fiscal 1977, with increased reduction each year to a reduction of $725 million in fiscal 1981.

The provision preventing rollbacks in physicians' fees would cost $37 million in fiscal 1976.

The provision broadening coverage of occupational therapy services would have a cost of $1 million in fiscal year 1976 and $2 million per year thereafter.

The provision relating to food stamps will save an estimated $3 million in Federal funds in fiscal year 1976.

The committee believes that the other provisions have either no cost or have only a nominal cost.

IV. Vote of Committee in Reporting the Bill

In compliance with section 133 of the Legislative Reorganization Act, as amended, the following statement is made relative to the vote of the committee on reporting the bill. This bill was ordered favorably reported by the committee without a rollcall vote and without objection.

V. Changes in Existing Law

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, as reported).

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94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 94-626

MEDICARE DEADLINE AMENDMENTS

NOVEMBER 6, 1975.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 10284]

The Committee on Ways and Means, to whom was referred the bill (H.R. 10284) to amend title XVIII of the Social Security Act to assure that the prevailing fees recognized by medicare for fiscal year 1976 are not less than those for fiscal year 1975, to extend for three years the existing authority of the Secretary of Health, Education, and Welfare to grant temporary waivers of nursing staff requirements for small hospitals in rural areas, to maintain the present system of coordination of the medicare and Federal Employees' Health Benefits programs, and to correct a technical error in the law that prevents increases in the medicare part B premiums, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PURPOSE AND BACKGROUND OF THE BILL

Your committee's Subcommittee on Health held 2 days of public hearings on possible legislative changes in medicare during September of this year. The hearings brought to light many problems in the present operation of the medicare program that warrant legislative action. Of particular and immediate importance, however, was the recognition of the need for your committee to act promptly on several issues with critical time limitations; that is, issues on which it is imperative that the Congress take quick action if it is going to act at all. The action taken by the committee on the four issues are contained in your committee's bill, H.R. 10284.

57-006—75——1

First, the bill would eliminate an unintended result of the application of section 224 of the Social Security Amendments of 1972 which requires the use of an economic index in determining how much the prevailing fee(s) for physicians' services can increase from year to year. Your committee's bill would assure that no prevailing charge in fiscal year 1976 would be less than it was in fiscal year 1975.

Second, the bill would extend for 3 years, from January 1, 1976, through December 31, 1978, the present authority of the Secretary of HEW to grant temporary waivers of nursing staff requirements for the purpose of enabling small hospitals in rural areas where nursing personnel are in short supply and alternative health facilities are not readily available to qualify under the medicare program.

Third, the bill would provide for the continuation of the present system of coordination of the medicare and Federal Employees' Health Benefits (FEHB) programs, which your committee now believes, on the basis of extensive analysis, is the most desirable of the alternative approaches to effectively coordinate these programs. The bill would repeal that section of the Social Security Act that would require medicare to stop making payment, as of January 1, 1976, for services furnished to a beneficiary who is also covered by the FEHB program.

Finally, the bill would permit increases in premiums for part B of medicare, on July 1, 1976, and in future years at rates no greater than the rate of increase in monthly social security benefits (from which the premiums are deducted). In doing so, the bill would correct a technical error in existing law.

II. GENERAL STATEMENT

A. Limits on Prevailing Charge Levels

Responding to concerns over the rapidly increasing expenditures under the medicare program, your committee included several cost-control provisions in the Social Security Amendments of 1972. One of these provisions set a limit on increases in the reimbursement for physicians' services.

The original 1965 medicare law provided for coverage of physicians' services under part B of title XVIII of the Social Security Act (the supplementary medical insurance program). After the beneficiary has incurred an initial deductible, medicare pays 80 percent of what is determined as the "reasonable charge" for the covered service.

Payment for the covered service is made directly to the beneficiary unless the beneficiary assigns the right to the benefits to the physician who furnished the service, in which case payment is sent directly to the physician. When the physician accepts assignment, the reasonable charge has to be accepted as the full payment—the physician agrees to bill the patient *only* for the 20 percent coinsurance which medicare does not pay.

The legislation requires that in determining the reasonable charge, the carrier take into consideration the customary charges for similar services generally made by the physician as well as the prevailing charges in the locality for similar services.

In 1966, very few health insurance plans routinely considered a physician's customary charges in their reimbursement policy. As the carriers began to develop reasonable charge determinations, it soon became evident that the policies were not consistent among the various carriers. This led the Social Security Administration (SSA) to bring about greater uniformity in reasonable charge determination through the issuance of regulations and guidelines.

The SSA interpreted it as congressional intent that the medicare "reasonable charge" be the lowest of: (1) the actual charge, (2) the customary charge of a physician for a similar service, and (3) the prevailing charge in a locality for a similar service.

There were no specifics in the law or legislative history as to how either the customary charge or the prevailing charge was to be established. Regulations in 1967 directed the carriers to consider a physician's customary charge for a particular service to be the median or midpoint of all the charges made for that service. Where evidence showed that a physician had changed his charge for a service, the new customary charge was to be recognized as the medicare customary charge.

Inherent in this procedure was a certain lag time; the regulations required that any new customary charge be based on accumulated evidence that the physician's customary charge pattern had changed. This lag time became one of the methods used to delay recognition of increases in physicians' fees. In 1968, SSA informally encouraged carriers to delay at least 12 months before changing the customary charge level.

In 1971, SSA issued a letter to intermediaries mandating a one and one-half year lag time. Carriers were to develop customary charge screens based on actual charge data for all of calendar year 1970 and use the screen for all claims received on or after July 1, 1971. This policy was consistent with the provisions of H.R. 1 as it passed the House in 1971.

These guidelines were the beginning of the present medicare reimbursement policy under which customary charge screens used during a fiscal year (beginning July 1 or as soon thereafter as they can be incorporated into the carriers' payment systems) are based on all the actual charges made during the preceding calendar year. This creates a lag of 18 months in updating customary charges.

The prevailing charge screen is, in essence, a ceiling on the customary charges of physicians in a locality for a particular service. As in the case of the customary charge, neither the law nor legislative history specified how the prevailing charge was to be determined.

Initially carriers used a variety of methods to determine the prevailing charge. In 1968, SSA directed all carriers to use a method which based the prevailing charge limit on the 83rd percentile of all the customary charges of all physicians for a particular service. Under the percentile approach, a carrier determined the amount which covered 83 percent of all the customary charges for a service; then, this amount became the maximum amount which could be paid—the prevailing charge limit—even though the customary charge of a particular physician for a particular service was higher.

In the 1971 intermediary letter, the SSA directed that this 83rd percentile be reduced to the 75th percentile of the customary charges. This was the same letter which directed carriers to update customary charges only every July 1 and base them on actual charges made during the preceding calendar year. Since the prevailing charge is based on customary charges there is, of course, the same 18-month lag created for the prevailing charge.

The Social Security Amendments of 1972 included several provisions designed to control the escalating costs of the medicare program. Among these were two provisions specifically related to the determination of the reasonable charge for physicians' services. Although separate provisions, these were both in section 224 of the law (Public Law 92–603).

One of the provisions embodied in the statute was the existing administrative policy for determining the reasonable charge, the customary charge and the prevailing charge. The law required that the reasonable charge for claims submitted after December 31, 1970, could not exceed the customary charge of the physician for similar services or the prevailing charge for similar services in the locality. The customary charges of physicians for particular services were to be determined at the beginning of each fiscal year based on actual charge data from the preceding calendar year (i.e., FY 1973 data was to be based on calendar year 1971 actual charge data). The prevailing charge (limit) for each service was to be based on the 75th percentile of all customary charges for that service in a locality.

The second provision limited how fast the prevailing charge can increase from year to year irrespective of what the 75th percentile amount might be. The House report expressed the rationale for tying increases in the reasonable charge to increases in an economic index:

> Your committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

Under the provision, the prevailing charges recognized in fiscal year 1973 for a locality could be increased in fiscal year 1974 and in later years only to the extent justified by indices reflecting changes in the operating expenses of physicians and in earnings levels. The statistical methods used to calculate the limit on increases allowed by this provision were to be established by the Secretary of HEW.

The base for the proposed economic index would be calendar year 1971. The increase in the index that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges that would be recognized in the fiscal year beginning after the end of that calendar year. For example, the change in the index for calendar year 1974 would form the basis for how much the prevailing charge could increase July 1, 1975, over that effective during the previous fiscal year.

The regulations to implement provisions of section 224, the economic index, were not issued until April 14, 1975, nearly 2½ years after the provisions were enacted. HEW allowed only 30 days for interested

parties to comment on the complex index. This short comment period and the initial evaluations of the index generated such criticism that the regulations were the subject of hearings held by your committee's Subcommittee on Health on June 12, 1975. Nevertheless, the regulations were issued in final form on June 16, 1975, with no major changes.

Aside from the question of whether the design of the index is equitable and reflects congressional intent, its application has had an unintended and unanticipated effect. More than limiting increases in prevailing charges, the index is, in some cases, causing fiscal year 1976 prevailing charges to be rolled back below fiscal year 1975 prevailing charge levels. This means a beneficiary or a physician who was reimbursed $20 for an office visit in fiscal year 1975 may get only $15 in fiscal year 1976.

Preliminary results from a study by the Social Security Administration suggest that the fiscal impact of the economic index is over $100 million. (Estimates on the savings of the index made in June were much lower—$25 million.) Of the $100 million, approximately $37 million is due to rollbacks.

It should be pointed out that if HEW had not delayed so long in implementing the regulations there would not have been any rollbacks in prevailing charges.

Over the years, the rate at which physicians accept assignment of medicare claims (and thus accept the medicare reasonable charge as payment in full) has been steadily declining. Assignment rates (the percentage of claims which are accepted) decreased from 61.5 percent in 1969 to 51.9 percent in 1974. Your committee is particularly concerned that the rollbacks are further discouraging physicians from accepting assignment.

When a physician refuses to accept assignment, the beneficiary must, of course, make up any difference between what medicare reimburses as the reasonable charge and the physician's actual charge. Both the number of claims and the amount of reduction has been increasing as can be seen from the tables below:

NUMBER OF CLAIMS REDUCED [1]

	Numbers (millions)		Percentage	
	1973	1974	1973	1974
Total claims reduced	32.2	43.6	60.6	68.3
Assigned	15.8	21.5	55.6	64.5
Not assigned	16.4	22.2	66.4	72.7

[1] Those claims for which medicare allowed a reasonable charge less than the actual charge of the physician.

AMOUNT OF REDUCTION OF CLAIMS

	Amounts (millions)		Percentage	
	1973	1974	1973	1974
Total amount of reduction	$446.5	$665.8	12.3	14.5
Assigned	208.0	313.6	11.9	14.3
Not assigned	238.5	352.2	12.6	14.7

Source: "Quarterly Reports on SMI Carrier Charge Determination," May 23, 1974, and Feb. 25, 1975.

Clearly, the rollback will result in an even further decrease in the assignment rate with the consequence that beneficiaries will pay an even larger proportion of their medical bills out-of-pocket.

In testimony before your committee's Subcommittee on Health during the September 19 hearing, the administration acknowledged that there is indeed a rollback but suggested that it "will not reoccur in the future updates of prevailing charge screens." They did not indicate that they favor any measure to correct the existing rollback situation.

In view of the fact, however, that it was never intended that implementation of the economic index should have such an adverse effect on beneficiaries, your committee believes that legislation is needed to eliminate the rollbacks. The bill would provide that during fiscal year 1976 (when the index went into effect) no prevailing fee level for a physician's service would be less than the prevailing fee for the same service in fiscal year 1975.

In a case where a beneficiary or physician has already been affected by the rollback (i.e., he has been reimbursed in fiscal year 1976 for a particular service at a prevailing fee level which is less than the prevailing fee for the same service in fiscal year 1975), the carrier would pay the individual the amount he is due. The payment would be made as soon as is administratively possible, but all payments would be made within 6 months after the date of enactment of this provision. To make the retroactive reimbursement administratively practical, no payment would be made on any claim where the difference between the amount paid and the correct amount due is less than $1.

Your committee believes that the problem of rollbacks in prevailing charge levels should be dealt with as quickly as possible to modify the current situation. Your committee wishes to make it clear, however, that it is holding for later consideration more substantive improvements in the present method for reimbursing physicians' services under medicare. Of major concern is the declining assignment rate (with the resulting increased burdens on medicare beneficiaries) and the inability of beneficiaries to determine which physicians will accept assignment and under what circumstances. Unreasonable geographical (both urban-rural and regional) and specialty differences in prevailing charge levels also indicate that the present system lacks rationality.

B. Extension of Authority To Waive 24-Hour Nursing Service Requirements for Certain Rural Hospitals

In order to participate in the medicare program, providers and suppliers of health services must comply with specific requirements set forth in the statute and with other requirements pertaining to the health and safety of medicare beneficiaries which the Secretary of Health, Education, and Welfare is authorized, by the statute, to prescribe. Among the "conditions of participation" for hospitals is a requirement that the hospital have an organized nursing department with a departmental plan delineating responsibilities and duties for nursing personnel, with a registered nurse on duty in the hospital on a 24-hour basis.

According to policy established by the Social Security Administration, a hospital is certified for participation in medicare if it is in full compliance (meets all the requirements of the Social Security 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). 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 deficiencies do not represent a hazard to patient health or safety, and efforts are being made to correct deficiencies.

In recognition of the fact that there is a need to assure continuing availability of medicare-covered institutional care in rural areas (many of which have only one hospital) without jeopardizing the health and safety of patients, the Social Security Administration follows the approach of certifying "access" hospitals which, to the extent they are capable, have succeeded in overcoming deficiencies. Access hospitals are those located in isolated areas or in areas with insufficient facilities, the failure of which to approve for medicare reimbursement would seriously limit the access of beneficiaries to needed inpatient care.

However, during the 91st Congress, it became apparent that some rural hospitals, despite proper efforts, were unable to secure required nursing personnel and were thus unable to meet the conditions of participation. Several hundred small rural hospitals at that time were not meeting the medicare requirement for these reasons and were unable to participate in the medicare program.

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 qualified nursing personnel were making it difficult for several hundred rural hospitals to meet the nursing staff requirements and come into compliance with the law, legislation (H.R. 19470, Public Law 91-690) was enacted to authorize the Secretary of HEW, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock.

Under this amendment, the Secretary is given the authority, until December 31, 1975, to waive the nursing requirement if he finds that a hospital:

(*a*) has at least one registered nurse on the day shift and has made, and is continuing to make, a bona fide effort to comply with the registered nursing staff requirement with respect to other shifts (which, in the absence of an R.N., are covered by licensed practical nurses) but is unable to employ the qualified personnel necessary at prevailing wage or salary levels, because of nursing personnel shortages in the area;

(*b*) is located in an isolated geographical area in which hospitals are in short supply and the closest other participating hospitals are not readily accessible to people of the area; and

(*c*) nonparticipation of the access hospital would seriously reduce the availability of hospital services to medicare beneficiaries residing in the area.

Under the provision, the Secretary regularly reviews the situation with respect to each hospital, and waivers are granted on an annual basis for not more than one year at a time.

The waiver authority is applicable only with respect to the nursing staff requirement; no waiver authority is provided with respect to any other conditions of participation or any standards relating to health and safety. The temporary waiver provision is scheduled to expire at the end of this calendar year.

Your committee has noted that although several hundred small hospitals were affected by the nursing staff requirement when the waiver provision was first enacted in 1971, all but 72 hospitals in the United States are in compliance with the statutory requirement at this time. Further, a survey conducted by the Department of Health, Education, and Welfare this year indicates that nearly 65 percent of the hospitals affected have R.N. coverage for at least two shifts daily; and the hospitals have an average of over three R.N.'s on their staffs.

While emphasizing the importance of having registered nursing personnel on duty in hospitals at all times to insure quality of care, your committee recognizes that the number of hospitals not meeting the nursing staff requirement has dramatically decreased during the operation of the existing waiver provision and that failure to continue the provision could severely disadvantage medicare beneficiaries in these areas who would have to travel long distances to receive needed inpatient hospital care should the access hospital in their community become ineligible to participate in the medicare program. Your committee's bill, therefore, would authorize the Secretary of HEW, under the conditions specified in existing law, to continue for an additional three years until December 31, 1978, to waive the requirement that an access hospital have a registered professional nurse on duty 24 hours a day.

Your committee believes that the favorable trend during the last five years whereby most access hospitals have come into compliance with the statutory requirement that a registered nurse be on duty at all times will continue and that there eventually will be no hospitals who must operate under the waiver provision. Your committee has requested the Department of HEW to arrange for the conduct of an independent study of the status of the hospitals still affected by the waiver and report their findings to the Committee on Ways and Means and the Senate Finance Committee by July 1, 1977 (18 months from the beginning of the extension of the waiver), setting forth the Department's recommendations with respect to future legislative action.

C. Relationship Between Medicare and Federal Employees Health Benefits Program

The statute (section 1862(c) of the Social Security Act) calls for medicare to stop making payment, as of January 1, 1976, for services furnished to a beneficiary for which he also has coverage under the Federal Employees' Health Benefits (FEHB) program. The January 1, 1976, deadline is the result of a provision, originated by the Committee on Ways and Means, that was included in the 1972 Social Security Amendments (Public Law 92–603). It was designed to focus attention on the need to consider improved coordination of medicare and the FEHB program.

Many Federal employees and retirees over 65 have worked long enough in employment covered by social security to become insured for benefits under part A of medicare. (Part B is available to everyone over age 65 except recent immigrants.) The Civil Service Commission estimates that by June 1976 about 258,000 FEHB enrollees, or 50 percent of the enrollees age 65 and over, and 150,000 dependents will be covered by medicare part A.

At present, when a person who has such dual entitlement receives health care, medicare acts as the primary insurer and makes payment first for the covered services; thereafter, the FEHB plan in which the person is enrolled makes payment, but only to the extent that medicare has not already paid for the services covered by the FEHB plan. Although medicare thus bears a major share of the dually entitled person's health care costs, the person pays the same FEHB premium as people not entitled under medicare.

Because of overlapping benefits, many Federal employees and retirees age 65 and over have not found it advantageous to enroll in medicare part B. As a result, they do not benefit from the general revenue contribution (equalling more than half of the program's cost) which is available to all who enroll in part B.

Section 210 of Public Law 92–603 (October 30, 1972) amended title XVIII of the Social Security Act by adding a new subsection 1862(c) prohibiting payment by medicare, on or after January 1, 1975, for any item or service covered by an FEHB plan in which the medicare beneficiary was enrolled, unless prior to that date the Secretary of HEW was able to certify that the individual FEHB plan in question or the entire FEHB program had been modified in specified ways. The intent of this provision was described in the report of the Committee on Ways and Means as "to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB."

To comply with this provision, the modifications in FEHB would have had to assure the following:

1. That one or more FEHB plans supplementing medicare protection are available to each Federal employee or retiree who is entitled to medicare parts A or B, or both A and B, and

2. That the Government or the FEHB plan will make available to each such individual a contribution at least equal to the contribution the Government makes toward the high-option coverage of any enrollee in the Government-wide FEHB plans. This contribution could be in the form of (a) a contribution toward the individual's FEHB protection supplementing medicare, or (b) a payment to offset the premium cost of part B of medicare, or (c) a combination of the two.

In the fall of 1974, when it became apparent that not enough progress toward coordination had been made to permit the requirements of subsection 1862(c) to be complied with by January 1, 1975, the effective date was extended for 1 year, to January 1, 1976, by Public Law 93–480 (October 26, 1974). The extension was conditional upon submission, no later than March 1, 1975, by the Department of HEW and the Civil Service Commission of a progress report

(in the absence of which the effective date would have been July 1, 1975).

The report jointly submitted by the DHEW and the CSC pursuant to Public Law 93–480 pointed out a number of problems that it said would result from efforts to comply with all the requirements of section 1862(c), and proposed instead an alternative plan for coordination of the medicare and FEHB programs that would require amendment of both the medicare law and the FEHB Act.

Under the proposal, an FEHB medicare supplement option would be made available where the FEHB enrollee or a member of his family is covered by both parts A and B of medicare. The Government would pay 100 percent of the premium for this medicare supplement so long as this did not exceed the maximum dollar amount the Government pays with respect to other FEHB enrollees. For at least the first year, the enrollee would not have to pay any premium. The supplement, together with medicare, would cover up to 100 percent of expenses for a medicare beneficiary; for other family members, the regular high-option benefits of the FEHB plan would be provided.

The increased cost of this proposal to the Government is estimated for calendar year 1976 as $48 million ($39 million in increased FEHB contributions, and $9 million in increased general revenue contributions for medicare part B which would result from increased enrollment in part B by FEHB enrollees). Also, an additional $13 million in increased premiums would be paid by nonmedicare FEHB enrollees (their premiums would no longer reflect the reduction in FEHB program costs that results because medicare makes payment first for FEHB enrollees who have medicare coverage).

Your committee has carefully considered this proposal by the administration as well as an alternative suggested in a report by the Comptroller General on the coordination issue—that the Government simply pay medicare part B premiums for all eligible FEHB enrollees. (The Comptroller General's report also suggested consideration of continuing without change the existing system for coordinating the benefits of the two programs.) The substantial costs of these proposals need to be weighed against the increased benefit protection or improved equity they would provide for people covered under both FEHB and medicare.

In general, the medicare supplements provided under FEHB today are richer than those offered to medicare beneficiaries under group health insurance plans in private industry. The coordination methods used by the various FEHB plans differ, but in general, after medicare makes payment, the FEHB plan pays for the services it covers in an amount that ordinarily will result in full coverage of most of the charges. Usually, enrollment in the low option of an FEHB plan (rather than the more costly high option) will achieve this result. The CSC has been advising medicare beneficiaries, during FEHB open enrollment periods, that low-option plans will in most cases adequately supplement both parts of medicare at lower cost than the high option.

Since section 1862(c) was enacted, the standard Government contribution toward FEHB premiums has increased from 40 to 60 percent of the total premium, and proposals have been made to increase the Government contribution again in future years. Medicare beneficiaries, as well as other FEHB enrollees, have benefited from this increased contribution.

Although it can be argued that more generous provisions than now exist for coordination of FEHB and medicare are merited, your committee is not convinced that equity requires the Government to substantially increase its expenditures under the two programs in an effort to accomplish this. It should be noted that Federal employees who have acquired medicare insured status have generally done so by splitting their careers between Federal and private employment or by moonlighting, rather than through a lifetime of work covered under social security. Some offsetting of the benefits of one program against the other, such as now exists, seems justified in view of the major contributions the Government makes toward the financing of both programs.

Your committee has therefore concluded that the existing relationship between the medicare and FEHB programs should be maintained. Accordingly, the bill would repeal section 1862(c) of the Social Security Act.

D. Medicare Part B Premium

The current monthly premium charged for part B of medicare is permanently frozen at $6.70 (the same amount as for last year) because of a technical error in the law that prevents the premium from being increased even though the Congress clearly intended to permit increases on July 1 of each year. The intention was to permit premium increases corresponding with increases in program costs, but limited to a maximum percentage increase no greater than the percentage by which monthly social security benefits have increased during the year.

Part B of medicare—the voluntary medical insurance part of the medicare program covering physicians' and certain other health services—has since its inception been financed through a combination of monthly premiums paid by beneficiaries who choose to enroll and matching payments from Federal general revenues. For the great majority of beneficiaries, the medicare premium is deducted each month from the social security benefit check.

The amount of the premium is determined through a calculation that begins with the cost of providing part B protection to beneficiaries age 65 and over. The premium was originally designed to equal one-half of this cost, but subsequent legislation enacted in 1972 limited the maximum premium increase each year to the percentage by which monthly social security benefits increased. (Beneficiaries under age 65 who are covered by part B by virtue of their status as social security disability beneficiaries or as end-stage renal disease patients pay the same premium as the aged, even though the cost of providing benefits to them is far greater.)

The technical error, freezing the premium, occurred when Public Law 93–233, enacted December 31, 1973, modified the schedule for automatic increases in social security cash benefits, but unintentionally failed to make corresponding changes in the provisions that relate percentage increases in the medicare part B premium to increases in cash benefits. Federal general revenues are used to finance whatever part of the cost of part B is not met through premiums paid by beneficiaries. So long as the premium amount remains frozen, the

proportion of part B costs financed by general revenues will continue to rise.

Your committee recognizes that many people would prefer not to allow the part B premium to increase at a time when the elderly, as well as others, are feeling the effects of inflation in health care costs. Failure to increase the premium, however, results in millions of dollars of increased general revenue expenditures in future years. If such amounts were to be expended, the money might better be used to provide some improvement in benefit protection.

The burden of the increased premiums would be spread evenly among all enrollees in part B, and spread throughout the year in even monthly installments. This seems preferable to alternative ways of controlling medicare outlays and general revenue costs, such as the increases in deductible and coinsurance amounts that the Administration has suggested. The burden of those increases would fall unevenly upon part B beneficiaries and tend to hit hardest the people who could least afford them.

Your committee's bill would correct the technical error in the law by changing from June 1 to May 1 the date used in determining the percentage increase from one year to the next in social security benefit levels, to arrive at the maximum percentage by which the medicare premium may be increased. The premium increase would be determined and promulgated in December of each year as under present law and the increased premium would be deducted from the same benefit check that reflects a cash benefit increase under the provisions for automatic increases in social security benefits. Thus, as intended by the Congress in enacting Public Law 93–233, premium increases would not result in reducing the amount of the monthly checks received by beneficiaries (because both a benefit increase and a very much smaller premium increase would be reflected in the same check).

Because of the technical error, the monthly premium has remained at $6.70 for the 12-month period beginning July 1, 1975, instead of increasing. The committee bill would not attempt to "catch up" by permitting 2 years' worth of benefit increases to be reflected in the single increase for the year beginning July 1, 1976. Instead, that premium increase would reflect only 1 year's increase in social security cash benefits.

Thus, the present $6.70 premium would go up only 50 cents on July 1, 1976, the same date that the social security benefit checks will be increased by reason of the automatic cost-of-living provisions in title II of the Social Security Act. Current estimates are that cash social security benefits will be increased by about 7 percent for the checks that are mailed early in July. The minimum dollar increase would be several times the 50-cent increase in the premium which is deducted from the same check in which the general benefit increase appears.

E. Committee Jurisdiction

In connection with any possible jurisdictional points which might be made about your committee's bill the following exchange of correspondence is included in this report.

Committee on Ways and Means,
U.S. House of Representatives,
Washington, D.C., October 28, 1975.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives.

Dear Mr. Chairman: On October 22, the Subcommittee on Health of the Committee on Ways and Means approved for consideration of the full Committee a bill, H.R. 10284, whose four provisions amending title XVIII of the Social Security Act are designed solely to respond to several deadline-type situations under the medicare program.

One of these provisions, for example, involves coordination between medicare and the Federal Employees' Health Benefits (FEHB) Program. Failure to enact it will require FEHB premiums to be increased substantially, and because the bill is pending, the annual November FEHB open enrollment period will be delayed or extended. Our Subcommittee on Health approved the bill unanimously, and I think it reasonable to expect that the full Committee on Ways and Means will do so also.

Although, with regard to some portions of the medicare law, questions have been raised concerning the jurisdiction of our respective committees, I hope those questions can be held in abeyance and not delay consideration of this particular bill which involves these deadline situations. Prompt passage by the House of Representatives is essential if the Senate is to have sufficient time for its action to meet the forthcoming deadlines.

If, upon your examination of H.R. 10284, you find no objection to its provisions, it would be most helpful if you could so advise me by letter. Such a letter, leaving any question of jurisdiction for later resolution, would facilitate the necessary prompt consideration of H.R. 10284 by the House. We hope to take up the bill before the full Committee early next week.

Sincerely,

Al Ullman. *Chairman.*

Congress of the United States,
House of Representatives,
Washington, D.C., October 29, 1975.

Hon. Al Ullman,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Chairman Ullman: Thank you for your letter of October 28 concerning H.R. 10284 whose four provisions amend title XVIII of the Social Security Act to allow continued use of the present system of coordination between Medicare and the Federal employees health benefits program, extend for three years the present waiver for rural hospitals of requirements for around-the-clock registered nursing services, correcting a technical error respecting Part B premiums, and amends the prevailing charge provisions to prevent cutbacks in prevailing fees in 1976.

Several of these amendments affect the supplemental medical insurance program (Part B of Medicare), which in my judgment is properly in the jurisdiction of this Committee for the reasons explained in the attached correspondence. However, I have reviewed the content of H.R. 10284 and agree with you that it is reasonable and noncontroversial legislation which needs rapid enactment because of deadlines in the Social Security Act to which it responds. I would, therefore, like you to know I will not object to its further consideration in the Committee on Ways and Means, the Committee on Rules, or the House of Representatives. You should understand that I do this without prejudice to further consideration of the question of jurisdiction over the various parts of the Medicare program, holding that question in abeyance for later resolution. In the event of Senate amendments to the bill, I will let you know what role I feel Members of this Committee should play in their consideration after I have had the opportunity to examine them. In order to forestall any possible confusion, I think it would be appropriate for this correspondence, with attachments, to appear in the report of your Committee on H.R. 10284.

I congratulate you on your efforts and hope that we may cooperate further in the future in improving the nation's health.

Sincerely yours,

HARLEY O. STAGGERS, *Chairman.*

III. COSTS OF CARRYING OUT THE BILL AND EFFECT ON THE REVENUES

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, the following statement is made:

Section 4 of your committee's bill makes a technical amendment relating to premium determinations under part B of the medicare program. The increased premiums permitted by section 4 generate additional revenue for the financing of part B and produce a corresponding reduction in expenditures that would otherwise, pursuant to law, be financed out of Federal general revenues. The estimated reductions in general revenue outlays are shown below:

Medicare part B premium—Reduction in general revenue outlays resulting from correction of technical error

[In millions of dollars]

Fiscal years:	
Transitional fiscal period (July 1, 1976 through Sept. 30, 1976)	$36
1977	184
1978	329
1979	456
1980	588
1981	725

Administration estimates of the anticipated savings in fiscal year 1976 from the application of the economic index were $25 million. Current data suggest the savings will exceed $100 million, of which $37 million is attributable to the rollback. Thus, the net cost for the remainder of fiscal year 1976 of section 1 of the bill, which would preclude the rollbacks of prevailing fees, will be $37 million, although savings from the application of the index will still be far in excess of original administration estimates.

IV. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER HOUSE RULES

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote by your committee on the motion to report the bill. The bill was *unanimously* ordered favorably reported by your committee.

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee. As a result of hearings conducted in March, June, and September of this year, by the Subcommittee on Health, your committee concluded that it would be desirable to enact legislation changing the present medicare law as is done in H.R. 10284.

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in present law by this bill involve no new budgetary authority or new or increased tax expenditures.

With respect to clause 2(l)(3)(C) and clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, your committee advises that no estimate or comparison has been submitted to your committee by the Director of the Congressional Budget Office relative to H.R. 10284, nor have any oversight findings or recommendations been submitted to your committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, your committee states that the four changes made in title XVIII of the Social Security Act under this bill would not have an inflationary impact on prices and costs in the operation of the national economy. Section 2 and section 3 would merely continue provisions of existing law. Section 4 would correct a technical error in the medicare law to again allow the Secretary of Health, Education, and Welfare to make necessary adjustments in the part B premium. Any adjustments made pursuant to this section would not increase the overall cost of the program and thus would not have an inflationary effect on the operation of the national economy. Section 1 would, for fiscal year 1976, assure that prevailing fees recognized by medicare are not reduced below the levels for fiscal year 1975. Since this provision will not affect how much is charged for specified services but only what portion will be recognized as reimbursable by medicare, it will not have an inflationary impact.

V. SECTION-BY-SECTION ANALYSIS AND JUSTIFICATION OF THE BILL

SEC. 1. PREVAILING CHARGE LEVEL FOR FISCAL YEAR 1976

Analysis.—Section 1(a) assures that no fiscal year 1976 prevailing charge for a physician service in a particular locality determined for the purposes of part B of medicare will be less than the same prevailing charge in the same locality in fiscal year 1975 because of application of economic index data.

Section 1(b) provides that if a beneficiary or physician received less than the correct amount on claims processed prior to the enactment of this section due to application of economic index data, the carrier shall pay the additional amount due within such time (but not exceeding 6 months) as is administratively feasible. No payment shall be made on any claim where the difference between the amount paid and the correct amount due is less than $1.00.

Justification.—This section is necessary to protect beneficiaries and physicians against an unintended result of the use of an economic index to limit how much prevailing charges can increase from year to year. Those situations would be corrected where application of the index has resulted in the determination of a prevailing charge for a physician service in fiscal year 1976 which is less than the prevailing charge for the same service in fiscal year 1975.

As prompt a refund as possible on an administratively practical basis would be assured for those physicians and beneficiaries who, under the provisions of this section, did not receive the correct amount of reimbursement. The $1.00 minimum payment provision is necessary to avoid incurring heavy administrative costs in making payments for very insignificant amounts.

SEC. 2. EXTENSION OF AUTHORITY TO WAIVE 24-HOUR NURSING SERVICE REQUIREMENT FOR CERTAIN RURAL HOSPITALS

Analysis.—Section 2 of the bill amends section 1861(e)(5) of the Social Security Act to extend from January 1, 1976, to January 1, 1979, the period during which the Secretary of Health, Education, and Welfare is authorized to grant temporary waivers of nursing staff requirements to permit certain hospitals which have had difficulty in securing required nursing services to continue to participate in the medicare program under specified conditions.

Justification.—Seventy-two hospitals currently participate in the medicare program under a waiver of the statutory requirement that requires a hospital to have at least one registered nurse on duty on a 24-hour basis. The extension of the waiver for an additional three years will provide these small rural hospitals an additional period of time to come into full compliance with the nursing standards.

SEC. 3. COORDINATION BETWEEN MEDICARE AND FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

Analysis.—Section 3 of the bill repeals section 1862(c) of the Social Security Act. Under section 1862(c), unless the Secretary of Health, Education, and Welfare has certified that the Federal Employees' Health Benefits (FEHB) program has been modified in specified ways, medicare will cease making payment on January 1, 1976, for any otherwise covered item or service with respect to which the beneficiary also has coverage under an FEHB plan.

Justification.—Deletion of this prohibition against medicare payment reflects a decision (discussed in detail in section II of this report) that the existing system of coordinating medicare and FEHB benefits should be continued.

SEC. 4. TECHNICAL AMENDMENT RELATING TO PART B PREMIUM DETERMINATIONS

Analysis.—Effective for determinations made after the enactment of the bill, section 4 amends section 1839(c)(3) of the Social Security Act to change from June 1 to May 1 the date that is used in determining the percentage increase over the course of a year in social security cash benefits for the purpose of determining each year the maximum percentage increase that will be permitted in the monthly premium for part B of medicare—the voluntary medical insurance part of medicare covering physicians' and certain other health services.

Justification.—This section corrects a technical error in the law that prevents premiums under part B of medicare from being increased, even though the Congress clearly intended to permit increases on July 1 of each year, corresponding with increases in costs of the program, but limited to a maximum increase no greater than the percentage by which monthly social security benefits increase during the year.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, 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):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * * * *

(c) (1) * * *

* * * * * * *

(3) The Secretary shall, during December of 1972 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium shall be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that 12-month period, or

(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph or, in the case of the determination made in December 1971, such rate promulgated under subsection (b)(2) multiplied by the ratio of (i) the amount in column IV of the table which, by reason of the law in effect at the time the promulgation is made, will be in effect as of [June] *May* 1 next following such determination appears (or is deemed to appear) in section 215(a) on the line which includes the figure "750" in column III of such table to (ii) the amount in column IV of the table which appeared (or was deemed to appear) in section 215(a) on the line which included the figure "750" in column III as of [June] *May* 1 of the year in which such determination is made.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1) (A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2) (A) determine compliance with the requirements of section 1861(k) as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such deduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodolgy acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economics index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or

misrepresentation is eliminated or corrected. *Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.*

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PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

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Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, [1976] *1979*, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

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EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

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[(c) No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual or on after January 1, 1976, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that such plan or the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that—

[(1) there is available to each Federal employee or annuitant enrolled in such plan, upon becoming entitled to benefits under part A or B, or both parts A and B of this title, in addition to the health benefits plans available before he becomes so entitled, one or more health benefits plans which offer protection supplementing the protection he has under this title, and

[(2) the Government or such plan will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of his coverage under this title, or (C) a combination of such contribution and such payment.]

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H. R. 10284

Ninety-fourth Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the fourteenth day of January, one thousand nine hundred and seventy-five

An Act

To amend title XVIII of the Social Security Act, and for other purposes.

Be it enacted by the House of Representative and the Senate of the United States of America in Congress assembled,

TITLE I—PROVISIONS RELATING TO HEALTH SERVICES

PREVAILING CHARGE LEVEL FOR FISCAL YEAR 1976

SEC. 101. (a) Section 1842(b)(3) of the Social Security Act is amended by adding at the end thereof the following new sentence: "Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.".

(b) The amendment made by subsection (a) shall be applicable with respect to claims filed under part B of title XVIII of the Social Security Act with a carrier designated pursuant to section 1842 of such Act and processed by such carrier after the appropriate changes were made in the prevailing charge levels for the fiscal year beginning July 1, 1975, on the basis of economic index data under the third and fourth sentences of section 1842(b)(3) of such Act; except that (1) if less than the correct amount was paid (after the application of subsection (a) of this section) on any claim processed prior to the enactment of this section, the correct amount shall be paid by such carrier at such time (not exceeding 6 months after the date of the enactment of this section) as is administratively feasible, and (2) no such payment shall be made on any claim where the difference between the amount paid and the correct amount due is less than $1.

EXTENSION OF AUTHORITY TO WAIVE 24-HOUR NURSING SERVICE REQUIREMENT FOR CERTAIN RURAL HOSPITALS

SEC. 102. Section 1861(e)(5) of the Social Security Act is amended by striking out "January 1, 1976" and inserting in lieu thereof "January 1, 1979".

COORDINATION BETWEEN MEDICARE AND FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

SEC. 103. Section 1862(c) of the Social Security Act is repealed.

TECHNICAL AMENDMENT RELATING TO PART B PREMIUM DETERMINATIONS

SEC. 104. (a) Section 1839(c)(3) of the Social Security Act is amended by striking out "June 1" each place it appears and inserting in lieu thereof "May 1".

(b) The amendments made by subsection (a) shall apply with respect to determinations made under section 1839(c)(3) of the Social Security Act after the date of the enactment of this Act.

PROFESSIONAL STANDARDS REVIEW AREAS

SEC. 105. Section 1152 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(g)(1) In any case in which the Secretary has established, within a State, two or more appropriate areas with respect to which Professional Standards Review Organizations may be designated, he shall, prior to designating a Professional Standards Review Organization for any such area, conduct in each such area a poll in which the doctors of medicine and doctors of osteopathy engaged in active practice therein will be asked: 'Do you support a change from the present local and regional Professional Standards Review Organization area designations to a single statewide area designation?'. If, in each such area, more than 50 per centum of the doctors responding to such question respond in the affirmative, then the Secretary shall establish the entire State as a single Professional Standards Review Organization area.

"(2) The provisions of paragraph (1) shall not be applicable with respect to the designation of Professional Standards Review Organization areas in any State, if, prior to the date of enactment of this subsection, the Secretary has entered into an agreement (on a conditional basis or otherwise) with an organization designating it as the Professional Standards Review Organization for any area in the State.".

UPDATING OF THE LIFE SAFETY REQUIREMENTS APPLICABLE TO NURSING HOMES

SEC. 106. (a) Section 1861(j)(13) of the Social Security Act is amended by striking out "(21st edition, 1967)" and inserting in lieu thereof "(23d edition, 1973)".

(b) Subject to subsection (c), the amendment made by subsection (a) shall be effective on the first day of the sixth month which begins after the date of enactment of this Act.

(c) Any institution (or part of an institution) which complied with the requirements of section 1861(j)(13) of the Social Security Act on the day preceding the first day referred to in subsection (b) shall, so long as such compliance is maintained (either by meeting the applicable provisions of the Life Safety Code (21st edition, 1967), with or without waivers of specific provisions, or by meeting the applicable provisions of a fire and safety code imposed by State law as provided for in such section 1861(j)(13)), be considered (for purposes of titles XVIII and XIX of such Act) to be in compliance with the requirements of such section 1861(j)(13), as it is amended by subsection (a) of this section.

GRANTS FOR CERTAIN EXPERIMENTS AND DEMONSTRATION PROJECTS

SEC. 107. Nothing contained in section 222(a) of Public Law 92–603 shall be construed to preclude or prohibit the Secretary of Health, Education, and Welfare from including in any grant otherwise authorized to be made under such section moneys which are to be used for payments, to a participant in a demonstration or experiment with respect to which the grant is made, for or on account of costs incurred or services performed by such participant for a period prior to the date that the project of such participant is placed in operation, if—

(1) the applicant for such grant is a State or an agency thereof,

(2) such participant is an individual practice association which has been in existence for at least 3 years prior to the date of enactment of this section and which has in effect a contract with such State (or an agency thereof), entered into prior to the date on which the grant is approved by the Secretary, under which such association will, for a period which begins before and ends after the date such grant is so approved, provide health care services for individuals entitled to care and services under the State plan of such State which is approved under title XIX of the Social Security Act,

(3) the purpose of the inclusion of the project of such association is to test the utility of a particular rate-setting methodology, designed to be employed in prepaid health plans, in an individual practice association operation, and

(4) the applicant for such grant affirms that the use of moneys from such grant to make such payments to such individual practice association is necessary or useful in assuring that such association will be able to continue in operation and carry out the project described in clause (3).

PROFESSIONAL STANDARDS REVIEW ORGANIZATION STARTUP DEADLINE

SEC. 108. (a) Subsections (c)(1) and (f)(1) of section 1152 of the Social Security Act are each amended by striking out "January 1, 1976" and inserting in lieu thereof "January 1, 1978".

(b) The amendments made by subsection (a) shall not apply in any area designated in accordance with section 1152(a)(1) of the Social Security Act where—

(1) the membership association or organization representing the largest number of doctors of medicine in such area, or in the State in which such area is located if different, has adopted by resolution or other official procedure a formal policy position of opposition to or noncooperation with the established program of professional standards review; or

(2) the organization proposed to be designated by the Secretary under section 1152 of such Act has been negatively voted upon in accordance with the provisions of subsection (f)(2) thereof.

STUDY REGARDING COVERAGE UNDER PART B OF MEDICARE FOR CERTAIN SERVICES PROVIDED BY OPTOMETRISTS

SEC. 109. The Secretary of Health, Education, and Welfare shall conduct a study of, and submit to the Congress not later than 4 months after the date of enactment of this section a report containing his findings and recommendations with respect to, the appropriateness of reimbursement under the insurance program established by part B of

title XVIII of the Social Security Act for services performed by doctors of optometry but not presently recognized for purposes of reimbursement with respect to the provision of prosthetic lenses for patients with aphakia.

UTILIZATION REVIEW UNDER MEDICAID

SEC. 110. (a) Section 1903(g)(1)(C) of the Social Security Act is amended to read as follows:

"(C) such State has in effect a continuous program of review of utilization pursuant to section 1902(a)(30) whereby each admission is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved; and the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 per centum of all admissions and must be of sufficient size to serve the purpose of (i) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (ii) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted; and".

(b) The amendment made by subsection (a) shall take effect on the first day of the first calendar month which begins not less than 90 days after the date of enactment of this Act.

CONSENT BY STATES TO CERTAIN SUITS

SEC. 111. (a) Section 1902 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(g) Notwithstanding any other provision of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subsection (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(l) Notwithstanding any other provision of this section, the amount payable to any State under this section with respect to any quarter beginning after December 31, 1975, shall be reduced by 10 per centum of the amount determined with respect to such quarter under the preceding provisions of this section if such State is found by the Secretary not to be in compliance with section 1902(g)."

(c) The amendments made by this section shall (except as otherwise provided therein) become effective January 1, 1976.

UTILIZATION REVIEW ACTIVITIES

SEC. 112. (a)(1) Section 1861(w) of the Social Security Act is amended—

(A) by inserting "(1)" immediately after "(w)", and

(B) by adding at the end thereof the following new paragraph:

"(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under a State plan approved under title V or XIX, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.".

(2) Section 1815 of such Act is amended—

(A) by inserting "(a)" immediately after "SEC. 1815.", and

(B) by adding at the end thereof the following new subsection:

"(b) No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1861(w)(2), to have in effect an arrangement with a Professional Standards Review Organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this title for utilization review activities provided by a Professional Standards Review Organization pursuant to an arrangement or deemed arrangement with a hospital under section 1861(w)(2) shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.".

(c) Section 1168 of such Act is amended by adding at the end thereof the following new sentence: "The Secretary shall make such transfers of moneys between the funds, referred to in clauses (a), (b), and (c) of the preceding sentence, as may be appropriate to settle accounts between them in cases where expenses properly payable from the funds described in one such clause have been paid from funds described in another of such clauses.".

(d) The amendments made by this section shall be effective with respect to utilization review activities conducted on and after the first day of the first month which begins more than 30 days after the date of enactment of this Act.

TITLE II—PROVISIONS RELATING TO FOOD STAMPS PROVIDED TO AFDC FAMILIES

FOOD STAMP DISTRIBUTION TO AFDC FAMILIES

SEC. 201. Notwithstanding any other provision of law, the final date for compliance with regulations in implementation of section 10(e)(7) of the Food Stamp Act of 1964, as amended, may be extended until October 1, 1976.

TITLE III—INTERNAL REVENUE CODE AMENDMENT

CERTAIN IRRIGATION DAMS

SEC. 301. (a) Section 103 of the Internal Revenue Code of 1954 (relating to interest on certain governmental obligations) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(e) CERTAIN IRRIGATION DAMS.—A dam for the furnishing of water for irrigation purposes which has a subordinate use in connection with the generation of electric energy by water shall be treated as meeting the requirements of subsection (c)(4)(G) if—

"(1) substantially all of the stored water is contractually available for release from such dam for irrigation purposes, and

"(2) the water so released is available on reasonable demand to members of the general public.".

(b) The amendment made by subsection (a) shall apply to obligations issued after the date of the enactment of this Act.

Speaker of the House of Representatives.

Vice President of the United States and
President of the Senate.

December 22, 1975

Dear Mr. Director:

The following bills were received at the White House on December 22nd:

H.J. Res. 749	H.R. 8304	H.R. 11184
H.R. 4016	H.R. 9968	S.J. Res. 157
H.R. 4287	H.R. 10035	S. 95
H.R. 4573	H.R. 10284	S. 322
H.R. 5900	H.R. 10355	S. 1469
H.R. 6673	H.R. 10727	S. 2327

Please let the President have reports and recommendations as to the approval of these bills as soon as possible.

Sincerely,

Robert D. Linder
Chief Executive Clerk

The Honorable James T. Lynn
Director
Office of Management and Budget
Washington, D. C.