(b) explicit imposition of the "prudent man" rule for all employee benefit fund administrators and the imposition of an obligation on co-fiduciaries with joint responsibility to prevent and redress breaches of such responsibility by each other;

(c) the prohibition of a wider range of conflict of interest transactions between the fund and "parties in interest"; and

(d) the prohibition for 5 years of persons convicted of certain crimes serving in fiduciary positions on employee benefit funds.

S. 3—INTRODUCTION OF A BILL TO CREATE A NATIONAL SYSTEM OF HEALTH SECURITY

Mr. KENNEDY. Mr. President, on behalf of Senator COOPER, Senator SAXBE, and myself, together with Senators BAYH, CASE, CRANSTON, GRAVEL, HARRIS, HART, HUGHES, HUMPHREY, INOUYE, JAVITS, MAGNUSON, McGEE, McGOVERN, METCALF, MONDALE, MOSS, MUSKIE, PASTORE, PELL, RANDOLPH, STEVENSON, and TUNNEY, I introduce for appropriate reference S. 3, The Health Security Act of 1971.

The bill is a legislative proposal to establish a Health Security program for all Americans. Through the mechanism of comprehensive national health insurance, it will bring health security to our people and end our current health crisis by improving each of the three basic aspects of our health care system—the organization, delivery, and financing of personal health services. We commend this legislation to our colleagues in the Senate for their favorable consideration and early action.

I believe that in America today, health care is a right for all, not just a privilege for the few. The basic goal of the Health Security program is to make that right a continuing reality, not just the empty promise it is today. Just as the Social Security program of the decade of the 1930's brought hope and new faith to a nation mired in the social crisis of the great depression, so I believe the Health Security program in the decade of the 1970's can guarantee high quality health care to our people and lead us out of the current crisis of confidence in our health system.

We know from recent experience that changes in the organization and delivery of health care in the United States will come only by an excruciating national effort. Throughout our society today, there is perhaps no institution more resistant to change than the organized medical profession. Indeed, because the crisis is so serious in the organization and delivery of health care, there are many who argue that we must make improvements in the organization and delivery system first, before we can safely embark on changing the financing system through national health insurance.

I believe the opposite is true. We must use the financing mechanism to create strong new incentives for the reorganization and delivery of health care. Thomas Paine declared at the founding of our American Republic, echoing the words of the ancient Greeks, "Give us a lever and we shall move the world." I say, give us the lever of national health insurance, and together we shall move the medical world and achieve the reforms that are so desperately needed.

The fact that the time has come for national health insurance makes it all the more urgent to pour new resources into remaking our present system. The existing organization and delivery of health care are so obviously inadequate to meet our current health crisis that only the catalyst of national health insurance will be able to produce the sort of basic changes that are needed if we are to escape the twin evils of a national health disaster or the total federalization of health care in the 1970's.

The use of the phrase "national health disaster" is not too strong. That the danger is great and imminent is a point on which both President Nixon and I agree. In July of 1969, President Nixon told a news conference that the Nation faced a massive crisis in health care, and that unless action was taken both administratively and legislatively to meet the crisis within the next 2 or 3 years, we would have a breakdown of our medical care system.

Our view of the problem is the same, but—on the basis of the information available about the administration's health program—we differ profoundly on the solution to be proposed. The central issue is how we can begin to move the health care system from where we are today to where we want to be tomorrow and in the years ahead. Neither the Health Security program nor the administration's program seeks revolutionary change in health care. The change that comes must be evolutionary change, but it must also be change that is capable of reaching the goals we share.

In essence, our difference is over the question whether the existing health care system needs a major overhaul or simply a minor tuneup. The question is whether a coordinated and comprehensive new approach is needed, or simply the sort of patchwork approach we have been using for too long. To be sure, we do need health insurance for the poor, catastrophic illness insurance for middle America, more assistance for medical schools, a moonshot against cancer and a manhattan project against sickle-cell anemia, incentives for health maintenance, and all the other items likely to be unveiled in the administration's arsenal. But we cannot afford to take these steps alone. Such divided and categorical approaches have been tried under Government or private sponsorship in the past, and they have met with uniform frustration and defeat.

We propose that the Nation cannot afford to repeat the mistakes of the past. We must begin now to develop a more coherent health care system which provides for the efficient use of existing health services and resources, which encourages better services and resources for the future, and which offers a comprehensive, balanced and proportioned approach to the health care system as a whole. This is the goal of the Health Security program.

The experience of medicare and medicaid has demonstrated that money alone and health insurance alone are no longer adequate to deal with the health needs of the Nation. So long as the resources are insufficient and the organizational arrangements are inadequate, money alone will only make the problem worse. National health insurance is necessary, but it must now and for the years ahead be part of a broader program of Health Security.

To those who say that the Health Security program will not work unless we first have an enormous increase in health manpower, health facilities and our ability to deliver health care, I reply that until we begin moving toward such a Health Security program, neither Congress nor the medical profession will ever take the basic steps that are essential to improve the system. Without something like the Health Security program to galvanize us into action, I fear that we will simply continue to patch the present system beyond any reasonable hope of survival.

If we are to reach our goal of bringing adequate health care to all our citizens, we must have full and generous cooperation between Congress, the administration, and all the health professions. I believe that we shall have this cooperation. We know the dedication of the health professions, the heroic efforts of hospitals and other institutions, the conscientious efforts of Federal, State, and local government agencies and their health personnel. We know their strong desire to end the limitations under which they struggle today to meet the growing national need for better health care. We share a common goal, and I am confident that we shall prevail.

It is highly appropriate that we in the Senate launch this new debate over health care on this, our first day of legislative business in the 92d Congress. At last, the debate over health care has shifted from the halls of the universities to the hearing rooms of Congress. The anguished pleas of millions of our people are being heard.

In the weeks and months to come, a great national debate will take place. As the new chairman of the Senate Health Subcommittee, I intend to take this issue to the people in all parts of the country, and to make every effort to insure that the promise of good health care becomes a reality for every citizen.

Although the debate will be nationwide, the primary focus will be on Congress and the response we make to the challenge that so clearly exists. More and more, in recent years, Congress has shown itself capable of meeting great challenges with great responses, and I am confident that the 92d Congress will do no less. Indeed, there could be no finer tribute to the 92d Congress than to be recorded as the Congress that at last ended the crisis of health care in America and brought health security to all our people.

THE CURRENT CRISIS

If one thing is clear in the United States of 1971, it is that health care is the fastest-growing failing business in the Nation—a $70 billion industry that fails to meet the urgent needs of our people. Today, more than ever before, we are spending more on health care and enjoying it less.

In spite of our vaunted research and technology, unequaled by any other nation in the history of the world,

America is an also-ran in the delivery of health care to our people.

Almost every family knows the cruel burden of worry, frustration, and disappointment that mark our search for better health care. The average American lives in dread of illness and disability. He lives with the uncertainty of not knowing whether to seek medical care, or when to seek it, or where to find it, or how to pay for it.

For millions of our citizens, health care of any sort is simply not available at any price. For millions more, the quality of care available is so poor that it may be fairly said that the citizen will be worse off because of his contact with the system.

There is not a person in the Nation who has not felt the heavy burden of the soaring cost of medical care. There is not a family in the Nation that does not live in fear of sickness and ill health, and the very real prospect of financial ruin and worse because of accident or serious illness.

Our current health crisis cuts across all political, social, economic and geographic lines. It affects rich and poor, black and white, old and young, urban and rural alike. Of all the pressing domestic problems we face, none is more pervasive or more difficult to resolve than the deterioration of our once proud system of health care. Never have so many different elements in our population been so united in their demand for action.

COMPARISONS WITH OTHER NATIONS

We know very well the dismal health record of the United States compared to the other major industrial nations of the world. Our rates of sickness and mortality lag far behind the potential of modern health care in America, or the reality of such care in many foreign nations. Year after year, the statistics tell us how little progress we have been making in health care in recent decades compared to other nations. Our record is getting no better. Unless we stop the slide, the crisis will get worse, and the result will be disaster.

The comparisons are shocking:

In infant mortality, among the major industrial nations of the world, the United States today trails behind 12 other countries, including all the Scandinavian nations, most of the British Commonwealth, Japan, and East Germany. Half of these nations were behind us in the early 1950's.

We trail six other nations in the percentage of mothers who die in childbirth. In the early 1950's, we had the lowest rate of any industrial nation.

Tragically, the infant mortality rate for nonwhites in the United States is nearly twice the rate for whites. And nearly five times as many nonwhite mothers die in childbirth as whites—shameful evidence of the ineffective prenatal and postnatal care our minority groups receive.

The story told by other health indicators is equally dismal. The United States trails 17 other nations in life expectancy for males, 10 other nations in life expectancy for females, and 15 other nations in the death rate for middle-aged males.

THE ROLE OF PRIVATE HEALTH INSURANCE

The comparison with other nations, reveals one other very important point. The United States today is the only major industrial nation in the world without a system of national health insurance or a national health service. Instead, we have placed our prime reliance on private enterprise and private health insurance to meet the need.

I believe that the private health insurance industry has failed us. It fails to control costs. It fails to control quality. It provides partial benefits, not comprehensive benefits; acute care, not preventive care. It ignores the poor and the medically indigent.

Despite the fact that private health insurance is a giant $12 billion industry, despite more than three decades of enormous growth, despite massive sales of health insurance by thousands of private companies competing with each other for the health dollar of millions of citizens, health insurance benefits today pay only one-third of the total cost of private health care, leaving two-thirds to be paid out of pocket by the patient at the time of illness or as a debt thereafter, at the very time when he can least afford it.

Nearly all private health insurance is partial and limited. For most citizens, their health insurance coverage is more loophole than protection. In 1968, of the 180 million Americans under 65:

Twenty percent, or 36 million, had no hospital insurance;

Twenty-two percent, or 39 million, had no surgical insurance;

Thirty-four percent, or 61 million, had no in-patient medical insurance;

Fifty percent, or 89 million, had no outpatient X-ray and laboratory insurance;

Fifty-seven percent, or 102 million, had no insurance for doctors' office visits or home visits;

Sixty-one percent, or 108 million, had no insurance for prescription drugs;

Ninety-seven percent, or 173 million, had no dental insurance.

As a result, it is fair to say that private health insurance today is a major part of our current crisis in health care. Commercial carriers syphon off the young and healthy, leaving the old and ill to Blue Cross, vulnerable to escalating rates they cannot possibly afford.

Too often, private carriers pay only the cost of hospital care. They force doctors and patients alike to resort to wasteful and inefficient use of hospital facilities, thereby giving further impetus to the already soaring cost of hospital care and unnecessary strains on health manpower.

Valuable hospital beds are used for routine tests and examinations which, under any rational health care system, would be conducted on an out-patient basis.

Unnecessary hospitalization and unnecessarily extended hospital care are encouraged for patients for whom any rational system would provide treatment in other, less elaborate facilities.

Unnecessary surgery is encouraged. We know that far more surgery takes place in the United States than in other nations with far better health records. We know that under the Federal Employees Health Benefits program, more than twice as much surgery takes place on Federal employees enrolled in the indemnity reimbursement plan as on those enrolled in prepaid group practice plans in the Federal program. The figures are especially striking for female surgery and for surgical procedures like appendectomy and tonsillectomy.

This, then, is where we stand today. Private health insurance has done no more than this to provide health security for American families.

THE SOURCE OF OUR HEALTH CRISIS

Our system of health care is in crisis today largely because our knowledge of health care has evolved at a much greater rate than our ability to deliver health care. We are the richest nation in the world in Nobel Prizes for medicine, yet we are among the poorest nations of the world in our ability to translate the triumphs of medical research into the reality of better health care. Our success in the laboratory is hollow indeed, in light of the cruel truth that good health care is simply not available to millions of our people.

In large part, our health care system has been buried under our magnificent advances of medical research. We have allowed ourselves to become so preoccupied with developing techniques to treat disease that we have ignored the delivery of health care. To be sure, the delivery system has evolved, but it has evolved more by neglect than design, to the point where it can no longer be called a system in a meaningful sense. We have severe shortages of family doctors and dentists, and a surfeit of surgeons. Rural practitioners retire, and hundreds of counties and thousands of small communities in America find themselves without access to a physician. Patients everywhere face a bewildering array of health personnel who know more and more about one disease or organ, but less and less about the whole patient.

It is important to understand how our present health crisis came about. At the turn of the present century, medical care in the United States began to take firm root in the emerging modern science. Soon after 1910, medical education itself became a university undertaking with a solid foundation in science.

The explosion of scientific knowledge made vast new resources available to medicine. The science and art of medical care developed at an unprecedented rate. As a result, specialization in medicine became necessary, and a number of specialties began to develop in medical schools and in the practice of medicine. The family physician began to disappear, replaced by an increasing variety of specialists, according to ages of life, categories of disease, organs of the body, and medical techniques.

Medical care became increasingly fractionated. No adequate resources were developed to take the place of the disappearing family physician, to provide primary medical care, or to coordinate services of the emerging specialties. The quality and effectiveness of medical care became increasingly uneven.

The specialization of physicians was accompanied by an increasing variety and number of allied practitioners. And, inevitably, along with the increasing complexity in the function of physicians, a similar complexity developed in the services provided by hospitals—the essential workshops of most of the new specialists.

As a consequence of these developments, the cost of medical care began to rise, progressively pricing more and more medical care beyond the reach of more and more people.

At the same time, the system of medical practice in the Nation—which had developed over the centuries when medical care was simple and uncomplicated—became increasingly rigid and unchanging, and began to impede the availability of medical care for more and more people. It began to interfere with the development of the personnel, facilities, and organizations needed to make medical care actually available to the people.

In turn, the stagnation of the health care system had two further unfortunate developments—an increasing unavailability of medical care despite increasing public expectation and demand for better medical care; and steeply increasing costs. The system resisted the development of needed resources for the delivery of medical care, and it resisted organizational improvements to moderate the steep rise in costs.

These developments and progressions were not peculiar to the United States. They were also taking place in all developed countries of the world. As one nation after another faced the problem, it acted to deal with the situation. Some countries developed national health insurance programs. Others developed national health services. They met their problems as best they could, according to their own needs and resources.

The United States alone stood apart from these worldwide developments. We preserved our faith in the private sector. Although government did become involved in the effort to upgrade health care, the effort was always limited, categorical, and inadequate. We chose to leave basic planning and development of health care to professional leadership and to the play of the marketplace.

The crisis today reflects the fact that professional leadership alone was not capable of meeting the national needs, and that the demands and needs of medical care do not lend themselves to satisfaction solely through the forces and the dynamics of the marketplace.

THE DEVELOPMENT OF THE HEALTH SECURITY PROGRAM

Recently, an important new chapter began in the long history of American health needs and social policy. Walter Reuther, the late president of the United Auto Workers, was among the first to see that financing programs like medicare and medicaid or extensions of private health insurance could not resolve the crisis of disorganization and the spiraling cost of health care. Walter Reuther understood that the Nation needed to take a bold step forward. In November 1968, he announced the formation of the Committee of One Hundred for National Health Insurance. As he said, in establishing the mandate of the committee:

> I do not propose that we borrow a national health insurance system from any other nation. No nation has a system that will meet the peculiar needs of America. I am confident that we have in America the ingenuity and the social inventiveness needed to create a system of national health insurance that will be uniquely American—one that will harmonize and make compatible the best features of the present system, with maximum freedom of choice, within the economic framework and social structure of a national health insurance system.

Joining Walter Reuther on that committee were Dr. Michael E. deBakey, president of Baylor College of Medicine; Mrs. Mary Lasker, president of the Albert and Mary Lasker Foundation; Mr. Whitney M. Young, Jr., executive director of the National Urban League; and other outstanding citizens from the fields of medicine, public health, industry, agriculture, labor, education, the social services, youth, civil rights, religious organizations, and consumer groups. I have had the honor of serving on that committee, along with my Senate colleagues, JOHN SHERMAN COOPER and WILLIAM SAXBE, and my former colleague, Ralph Yarborough.

In its efforts over the past 2 years, the committee has worked to develop a sound program for improving the organization, financing and delivery of health services to the American people. The committee's deliberations were based upon the premise that progress toward a more rational health system should be orderly and evolutionary. The members of the committee felt that a better system of health care for America should rest upon the positive motivations and interests of both consumers and providers of health services. They believed that no system could succeed if it were imposed by fiat through rigid legislation and administrative regulations.

Throughout its deliberations, the committee has been guided by the work of its distinguished technical subcommittee, chaired by Dr. I. S. Falk, professor emeritus of public health of Yale University and the most eminent authority in the field of health economics in the Nation. The committee consulted extensively with representatives of professional associations, consumer organizations, labor unions, business groups, and many other interested organizations. The Health Security program is the result of these efforts, and it gives careful consideration to the recommendations of all of these groups.

Last August, Senators COOPER, SAXBE, YARBOROUGH, and I, together with 11 other Senators, introduced the original version of the Health Security program as S. 4297 in the 91st Congress. In September, the Senate Committee on Labor and Public Welfare held 2 days of hearings on the legislation, the first hearings to be held in Congress on comprehensive national health insurance since the critical problems of health care in America first became paramount 20 years ago. With the exception of the administration, testimony from a broad spectrum of witnesses was immensely favorable to the bill, and generated increased momentum for introduction of the bill in the 92d Congress.

At the time the bill was originally introduced last year, Congresswoman MARTHA GRIFFITHS of Michigan had already introduced legislation in the House of Representatives to create a national health insurance program similar in overall concept to the Health Security program, and her bill had received the strong endorsement of the AFL-CIO, under the leadership of President George Meany.

Before the 91st Congress adjourned last year, we had decided to pool our efforts and introduce a common bill in the 92d Congress. Hundreds of detailed differences between the two previous bills have been resolved, and the debate over the preparation of the new bill has led to the stronger Health Security program we introduce today.

As these and other developments make clear, we are now seeing the uniting of major American institutions to support the goal of Health Security. It is an issue destined to grow and remain before the American public until the goal of adequate health care for all is finally achieved.

MAJOR PROVISIONS OF THE HEALTH SECURITY PROGRAM

The Health Security program is intended to be comprehensive and extensive. At the conclusion of my remarks in the CONGRESSIONAL RECORD, I will include a section-by-section analysis of the bill and the text of the bill itself, so that the details of its provisions may be widely available to all. At this time, however, I would like to call attention to its main provisions:

Basic principle—The basic principle of the Health Security program is twofold: to establish a system of comprehensive national health insurance for the United States, capable of bringing the same high quality health care to every resident; and, to use the program to bring about major improvements in the organization and delivery of health care in the Nation.

The Health Security program does not envisage a national health service, in which Government owns the facilities, employs the personnel, and manages all the finances of the health care system. On the contrary, the program proposes a working partnership between the public and private sectors. There will be Government financing and administrative management, accompanied by private provision of personal health services through private practitioners, institutions, and other providers of health care.

Persons eligible for benefits—Every individual residing in the United States will be eligible to receive benefits. There will be no requirement of past individual contributions, as in Social Security, or a means test, as in Medicaid.

Starting date for benefits—July 1, 1973. The 2-year tooling-up period prior to that date will be used to prepare the health care system for the program.

Covered benefits—With certain modest limitations, the program will provide comprehensive health benefits for

every eligible person. The benefits available under the program will cover the entire range of personal health care services, including the prevention and early detection of disease, the care and treatment of illness, and medical rehabilitation. There are no cutoff dates, no coinsurance, no deductibles, and no waiting periods.

For example, the program provides full coverage for physicians' services, inpatient and outpatient hospital services, and home health services. It also provides full coverage for other professional and supporting services, such as optometry services, podiatry services, devices, and appliances, and certain other services under specified conditions.

The four limitations in the otherwise unlimited scope of benefits are dictated by inadequacies in existing health resources or in management potentials. They deal with nursing home care, psychiatric care, dental care, and prescription drugs, as follows:

Skilled nursing home care is limited to 120 days per benefit period. The period may be extended, however, if the nursing home is owned or managed by a hospital, and payment for care is made through the hospital's budget.

Psychiatric hospitalization is limited to 45 consecutive days of active treatment during a benefit period, and psychiatric consultations are limited to 20 visits during a benefit period. These limits do not apply, however, when benefits are provided through comprehensive health care organizations or comprehensive mental health care organizations.

Dental care is restricted to children through age 15 at the outset, with the covered age group increasing annually until persons through age 25 are covered. Persons eligible for coverage through age 25 will remain eligible for coverage throughout their lives.

Prescribed drugs are limited to those provided through hospital in-patient or out-patient departments, or through organized patient care programs. For other patients, coverage extends only to drugs required for the treatment of chronic or long-term illness.

Inevitably, simply stating these four limitations gives them a prominence they do not deserve. In all other respects, covered health services will be available without limit, in accordance with medical need.

Administration—The administration of the Health Security program will be carried out by a five-member full-time Health Security Board, appointed by the President with the advice and consent of the Senate. Members of the Board will serve 5-year terms, and will be under the authority of the Secretary of Health, Education, and Welfare.

A statutory National Advisory Council will assist the Board in the development of general policy, the formulation of regulations, and the allocation of funds. Members of the Council will include representatives of both providers and consumers of health care.

Field administration of the program will be carried out through the 10 existing HEW regions, as well as through the approximately 100 health subareas that now exist as natural medical marketplaces in the Nation. Advisory councils on matters of administration will be established at each of these levels. However, the Board will guide the overall performance of the program. It will coordinate its functions with State and regional planning agencies, and it will account for its activities to Congress.

Financing the program—The program will be financed through a Health Security Trust Fund, similar to the Social Security Trust Fund. Income to the Fund will derive from four sources:

Fifty percent from general Federal tax revenues;

Thirty-six percent from a tax of 3.5 percent on employers' payrolls;

Twelve percent from a tax of 1 percent on employees' wages and unearned income up to $15,000 a year;

Two percent from a tax of 2.5 percent on self-employment income up to $15,000 a year.

Employers may pay all or part of their employees' health security taxes, in accord with arrangements established under collective-bargaining agreements.

Payment mechanism—The essence of the payment mechanism and the central cost control feature of the program is that the health care system as a whole will be anchored to a budget established in advance. A given amount of money will be made available for the program each year, based on the available estimates of the needs to be met and the services to be provided, with due regard for the resources of the system. As in every area of our economic life, the health care system will be obliged to live within its budget. In this way we can end the unacceptable escalation of costs within our present system. In this way we can end the long financial binge in which health care has had a signed blank check on the whole economy of the Nation.

Each year, the Health Security Board will make an advance estimate of the total amount needed for expenditure from the Trust Fund to pay for health care services in the program. The Board will allocate funds to the several regions, and these allocations will be subdivided among categories of services in the health subareas. Advance estimates, constituting the program budgets, will be subject to adjustments in accordance with guidelines in the act. The allocations to regions and to subareas will be guided initially by the available data on current levels of expenditure. Thereafter, they will be guided by the program's own experience in making expenditures and in assessing the need for equitable health care throughout the Nation.

Compensation of doctors, hospitals, and other providers—Providers of health services will be compensated directly by the Health Security program. Individuals will not be charged for covered services.

Hospitals and other institutional providers will be paid on the basis of approved prospective budgets. Independent practitioners, including physicians, dentists, podiatrists, and optometrists, may be paid by various methods which they may elect: by fee-for-service, by capitation payments, or in some cases by retainers, stipends, or a combination of such methods. Comprehensive health service organizations may be paid by capitation, or by a combination of capitation and methods applicable to payments to hospitals and other institutional providers. Other independent providers, such as pathology laboratories, radiology services, pharmacies, and providers of appliances, will be paid by methods adapted to their special characteristics.

Foundations, sponsored by medical or dental societies or other specified nonprofit organizations, are specifically recognized as a class of providers with which the Board may contract for services. Foundations would be required to have an enrolled population and to permit participation by all qualified physicians in the area. Foundations would be reimbursed by the same formula used for prepaid group practice plans.

In addition, drug addiction and alcoholic treatment centers are specifically included as eligible providers of services under the program.

Resources Development Fund—An essential feature of the program is the Resources Development Fund, which will come into operation 2 years before benefits begin. In the first year of this "tooling up" period, $200 million will be appropriated for the fund; in the second year, $400 million will be made available. Once the program benefits begin, up to 5 percent of the Trust Fund—about $2 billion a year—will be set aside for resources development. These funds will be used to support innovative health programs, particularly in areas like manpower, education, training, group practice development, and other means to improve the delivery of health care. The principal attribute of the Fund is that it can be used to channel far more money into areas like education and training than is possible under the existing system of congressional authorization and appropriation for ongoing programs.

Quality Control—The Health Security program includes various provisions designed to safeguard the quality of health care. The program will establish national standards more exacting than medicare for participating individual and institutional providers. Independent practitioners will be eligible to participate if they meet licensure and continuing education requirements. Specialty services will be covered if, upon referral, they are performed by qualified persons. Hospitals and other institutions will be eligible for participation if they meet national standards, and if they establish utilization review and affiliation arrangements.

In addition, the Health Security Board is authorized to require prior consultation with an appropriately qualified specialist before the performance of designated nonemergency surgery, in order to allow administrative monitoring of surgical procedures that are frequently abused.

Incentives—Financial, professional and other incentives are built into the program to move the health care delivery system toward organized arrangements for patient care, and to encourage preventive care and the early diagnosis of disease.

In the area of health manpower, the program will supplement existing Federal programs. It will provide incentives for comprehensive group practice organizations, encourage the efficient use of personnel in short supply, and stimulate the progressive broadening of health services. It will provide funds for education and training programs, especially for members of minority groups and those disadvantaged by poverty. Finally, it will provide special support for the location of increased health personnel in urban and rural poverty areas.

Relation to existing programs—Various Federal health programs will be superseded, in whole or in part, by the Health Security program. Since persons of age 65 or over will be covered by the program, medicare under the social security system will be terminated. Federal aid to the States for medicaid and other Federal programs will also be terminated, except to the extent that benefits under such programs are broader than under the Health Security program. However, the bill does not affect the current provisions for personal health services under the Veterans Administration, temporary disability, or workmen's compensation programs.

Cost of the program and Federal revenue sharing—On the basis of data available for the fiscal year 1970, a total of $41 billion was expended for health care benefits that would have been covered by the Health Security program had the program been in effect for that year. In other words, if the Health Security program had been in effect in 1970, the cost of the program would have been $41 billion.

The $41 billion figure represents approximately 70 percent of the total actual expenditures for personal health care in the United States for that year. These expenditures consist of $30 billion in private health insurance payments and private out-of-pocket payments, $8 billion in payments by the Federal Government, and $3 billion in payments by State and local governments.

The cost of the health security program has been the source of enormous confusion and misunderstanding since the original version of the Health Security Act was introduced last year in the 91st Congress. The crucial point is that in no sense does the hypothetical $41 billion price tag for the Health Security program in 1970 represent new money. Rather, this is what Americans are already paying for personal health care under the existing system.

Thus, the Health Security program is not a new layer of Federal expenditures on top of existing public and private spending for health care. Instead, the Health Security program simply redistributes the health expenditures that are already being made. Although, of course, *Federal* expenditures in 1970 would have risen from $8 billion under the existing system to $41 billion if the Health Security program had been in effect, individuals and organizations throughout the Nation would have been relieved of $30 billion of *private* health insurance expenses and out-of-pocket payments for health care, and State and local governments would have been relieved of $3 billion, representing costs incurred largely in medicaid and other public assistance programs, and in city and county medical programs.

In a very real sense, therefore, the Health Security program is a direct form of Federal revenue sharing. It offers $3 billion in substantial and immediate Federal financial relief to State and local governments, thereby freeing scarce State and local funds for other urgently needed purposes.

Over the long run, by revitalizing the existing health care system and ending the excessive inflation in the cost of health care, the Health Security program will be far less expensive than the amount we will spend if we simply allow the present system to continue.

Even at the beginning, moreover, the Health Security program will provide more and better services without increasing the cost, since the initial savings achieved by the program will be sufficient to offset the cost of the increased services. In other words, from the day the Health Security program begins, we will guarantee our citizens better value for their health dollar, and achieve a substantial moderation of the current exorbitant inflation in health costs. Even in the first year of the Health Security program, the comprehensive health services provided will be available for the same cost we would have paid for the partial and inefficient services of the existing system.

In 1970, for example, spending for health exceeded $70 billion. For the first time in our history, expenditures for health rose above 7 percent of our gross national product. If we continue to do nothing, the annual cost will exceed $100 billion in only 3 years.

CONCLUSION

In sum, the Health Security Act we submit to the Senate and to the people of the United States differs from all previous proposals for health care or national health insurance. It is not just another financing mechanism. It is not just another design for pouring more purchasing power into our already overstrained and overburdened nonsystem for the delivery of health care. It is not just another proposal to generate more professional personnel or more hospitals and clinics, without the means to guarantee their effective use.

Ours is a proposal to give us a national system of health security. Under this program, the funds we make available will finance and budget the essential costs of good health care for generations ahead. At the same time, these funds will be building new capacity to bring adequate, efficient and reliable health care to all families and individuals in the Nation.

I invite all Members of the Senate to study this proposed legislation and to join with us in seeking early enactment of the Health Security program.

Mr. President, in order that the details of this legislation may be widely available to all, I ask unanimous consent that the bill may be printed at this point in the RECORD, together with a section-by-section analysis of the bill.

The PRESIDENT pro tempore. The bill will be received and appropriately referred; and, without objection, the bill and section-by-section analysis will be printed in the RECORD.

The bill (S. 3) to create a national system of health security, introduced by Mr. KENNEDY, for himself and other Senators, was received, read twice by its title, referred to the Committee on Finance, and ordered to be printed in the RECORD, as follows:

S. 3

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

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds that—

(1) the health of the Nation's people is the foundation of their wellbeing and of our Nation's strength, productivity, and wealth;

(2) adequate health care for all of our people must now be recognized as a right; and

(3) a national system of Health Security is the means to implement that right.

(b) The purpose of this Act is—

(1) to create a national system of health security benefits which, through national health insurance, will make comprehensive health services available to all residents of the United States, and

(2) through the operation of the system, to effect modifications in the organization and methods of delivery of health services which will increase the availability and continuity of care, will enhance its quality, will emphasize the maintenance of health as well as the treatment of illness and, by improving the efficiency and the utilization of services and by strengthening professional and financial controls, will restrain the mounting cost of care while providing fair and reasonable compensation to those who furnish it.

INITIATION OF HEALTH SECURITY PROGRAM

SEC. 3. Health Security taxes will become effective on January 1, and health services will become available on July 1, of the second calendar year after the year in which this Act is enacted. Except for the benefit and related fiscal provisions, title I of this Act is effective upon enactment. Certain federally financed or supported health programs will be terminated or curtailed when health benefits under this Act become available. Effective dates of the several provisions of this Act are set forth in sections 142, 204, 214, 301, 302, and 303.

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TITLE I—HEALTH SECURITY BENEFITS

PART A—ELIGIBILITY FOR BENEFITS

BASIC ELIGIBILITY

SEC. 11. Every resident of the United States and every nonresident citizen thereof is eligible, while within the United States, to receive health services under this Act; except that an alien employee (as defined in regulations) of a foreign government, of an instrumentality of a foreign government exempt from the tax imposed by section 3111(b) of the Internal Revenue Code of 1954, or of an international organization (as defined in the International Organizations Immunity Act) is eligible only in accordance with an agreement under section 12. An alien admitted as a permanent resident and living within the United States, or an alien admitted for employment and employed within the United States, is for the purposes of this title a resident of the United States.

AGREEMENTS FOR ELIGIBILITY OF OTHER PERSONS

SEC. 12. The Health Security Board (hereafter referred to as the "Board"), with the approval of the Secretary of Health, Education, and Welfare and the Secretary of State, is authorized to enter into agreements with foreign governments, international organizations, or other entities to extend the benefits of this title to persons within the United States not otherwise eligible therefor, in consideration of payment to the United States of the estimated cost of furnishing the benefits to such persons, or of an undertaking to furnish in a foreign country similar benefits to citizens of the United States, or of a combination of payment and such an undertaking.

PART B—NATURE AND SCOPE OF BENEFITS; COVERED SERVICES

ENTITLEMENT TO HAVE PAYMENT MADE FOR SERVICES

SEC. 21. Every eligible person is entitled to have payment made by the Board for any covered service furnished within the United States by a participating provider if the service is necessary or appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following, injury, disability, or disease. Covered services are the services described in this part (subject to the exclusions stated in section 28); participating providers are providers described in part C.

PHYSICIAN SERVICES

SEC. 22. (a) Professional services of physicians, furnished in their offices or elsewhere, are covered services except to the extent otherwise provided in this section and section 28. Covered physicians' services include services and supplies of kinds which are commonly furnished in a physician's office, without separate charge, as an incident to his professional services.

(b) Covered physicians' services consist of (1) primary medical services, which are the services (as defined in regulations, but including preventive services) ordinarily furnished by physicians, whether general practitioners or specialists, engaged (as determined in accordance with standards for such practice prescribed in regulations) in general or family practice for adults or for children or for both, and (2) specialized services. Major surgery and other specialized services designated in regulations are covered services only if they are furnished by an appropriately qualified specialist and, to the extent specified in regulations, on referral by a physician engaged in general or family practice, or if they are emergency services.

(c) Psychiatric (mental health) service to an outpatient is a covered service (1) only if it constitutes an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders, and (2) only (A) if the service is furnished by a comprehensive health service organization, by a hospital, or by a community mental health center or other mental health clinic which furnishes comprehensive mental health services, or (B) if the service is furnished to a patient of a day care service approved by the Board for this purpose, or (C) to the extent of twenty consultations during a benefit period (as defined in regulations), if the service is furnished otherwise than in accordance with clause (A) or (B). In any community in which the available psychiatric services furnished otherwise than in accordance with clause (A) or (B) are found by the Board to be insufficient to meet the needs of the community, the Board may limit the coverage of such services by prescribing referral or other nonfinancial conditions in order to give priority of access to the services to those persons most in need of them.

DENTAL SERVICES

SEC. 23(a) Professional services (described in subsection (c)) of a dentist, furnished in his office or elsewhere, are (subject to the provisions of section 28) covered services if they are furnished to a person who, at the time when the services are furnished, is entitled to such services in accordance with subsection (b). Covered services include services, materials, and supplies which are commonly furnished in a dentist's office, without separate charge, as an incident to his professional services.

(b) Persons who on the effective date of health benefits are less than 15 years of age are entitled to covered dental services, and will remain so entitled throughout their lives. On July 1 of each of the five years immediately succeeding the year in which the effective date occurs, the following persons will become (and thereafter remain) entitled to such services: on July 1 of the first succeeding year, persons who are then less than 17 years of age; on July 1 of the second succeeding year, persons who are then less than 19 years of age; on July 1 of the third

succeeding year, persons who are then less than 21 years of age; on July 1 of the fourth succeeding year, persons who are then less than 23 years of age; and on July 1 of the fifth succeeding year, persons who are then less than 25 years of age.

(c) Covered dental services are preventive services (including personal dental health education), diagnostic services, therapeutic services (exclusive of orthodontic services other than for handicapping malocclusion), and services required for rehabilitation following injury, disability, or disease.

(d) It is the intention of the Congress that the coverage of dental services under this title be extended to persons more than 15 years of age on the effective date, as rapidly as the availability of funds and of facilities and personnel makes possible, and the Board, in its annual reports to the Congress on the administration of this title, shall review the operation of this section and recommend extension of the entitlement specified in this section as rapidly as the Board deems feasible. Not later than seven years after the effective date, the Board shall submit its recommendation with respect to the scope and conditions of availability of covered dental services to all persons not already entitled thereto.

INSTITUTIONAL SERVICES

SEC. 24. (a) Inpatient and outpatient services of a psychiatric or other hospital, skilled nursing home services, and the services of home health service agencies, which are ordinarily furnished by the institution to patients for the purposes stated in section 21, are covered services except to the extent otherwise provided in this section and section 26. Covered services include services furnished generally to the patients served by an institution, including pathology and radiology services and all other necessary services, whether they are furnished by the institution or by others under arrangement with the institution. To the extent provided in regulations, inpatient services of a Christian Science Sanatorium are covered services.

(b) Covered services do not include personal comfort items or, unless required for medical reasons, the additional cost of accommodations more expensive than semiprivate accommodations; and do not include domiciliary or custodial care, or institutional care of a person while he is not receiving active medical treatment.

(c) Covered services do not include care in a skilled nursing home for more than one hundred and twenty days during a benefit period (as defined in regulations); except that the Board may, on such conditions as it finds appropriate to assure effective control of utilization, extend the duration of covered services, either for a stated number of days in a benefit period or indefinitely—

(1) in all skilled nursing homes for which consolidated budgets with hospitals have been approved under section 83(f), or

(2) in all participating skilled nursing homes having in effect affiliation agreements under section 52(b), if the Board finds that adequate funds and resources are available therefor and that such action will not lead to excessive utilization of nursing home services.

(d) Covered services do not include institutional care of a person as a psychiatric patient while the patient is not receiving active treatment for an emotional or mental disorder; and do not include care of a person as a psychiatric patient for more than forty-five consecutive inpatient days in either a psychiatric or another hospital during a benefit period (as defined in regulations).

(e) Covered services do not include institutional care of an inpatient unless a physician has certified to the medical necessity of the patient's admission to the institution, and do not include such care (during a continuous stay in the institution) after such period (if any) as may be specified in regulations unless a physician has certified to the continued medical necessity of such care. Regulations may specify the classes of cases in which certification of continued necessity is required, may specify different periods for different classes of cases, and may permit retroactive certification under such circumstances and to such extent as the Board deems appropriate.

(f) Covered services do not include the services of a psychiatric or other hospital or a skilled nursing home, during a benefit period (as defined in regulations), after the third day following receipt by the institution and the patient of notice of a finding by a utilization review committee pursuant to section 51(e) that further stay in the hospital or further stay in the nursing home, as the case may be, is not medically necessary.

DRUGS

SEC. 25. (a) The Board, with the approval of the Secretary, shall establish and disseminate (and review, and if necessary revise, at least annually) (1) a list of drugs for use in participating institutions and comprehensive health service organizations, and (2) a list (for use outside such institutions and organizations) of diseases and conditions for the treatment of which drugs may be furnished as a covered service, and a specification of the drugs that may be so furnished for each disease or condition listed. Subject to the provisions of subsections (b) and (c) and of section 28, the furnishing of a drug to an eligible person is a covered service if it is furnished by or on prescription of a participating physician or dentist, or by or on prescription of a physician or dentist acting on behalf of a participating institutional or other provider.

(b) The list of drugs referred to in subsection (a)(1) shall be designed to provide physicians and dentists with an armamentarium necessary and sufficient for rational drug therapy incident to comprehensive medical services or incident to covered dental services. The furnishing of a drug on this list is a covered service if it is furnished to a person who is enrolled in a participating comprehensive health service organization, or is administered within a participating hospital to an inpatient or an outpatient, or is administered to an inpatient of a participating skilled nursing home operated by a participating hospital or having in effect an affiliation agreement in accordance with section 52(b).

(c) The list of diseases and conditions referred to in subsection (a)(2) shall include those chronic diseases and conditions for which drug therapy, because of its duration and cost, commonly imposes substantial financial hardship; and may include other diseases and conditions for which the Board finds costly drug therapy so be commonly required and effective. To assure proper utilization of drugs for specific diseases or conditions, the Board may require that the physician or dentist furnishing or prescribing a listed drug be a specialist qualified to diagnose and treat that disease or condition. The furnishing of a drug (although not to a person or under circumstances described in subsection (b)) is a covered service if (1) the physician or dentist furnishing or prescribing it identifies the disease or condition for which it is furnished or prescribed, and the disease or condition is one appearing on the Board's list, (2) the physician or dentist meets specialist qualifications, if any, required by the Board, and (3) the drug is specified on the Board's list as one available for treatment of the disease or condition identified by the physician or dentist.

(d) The Board shall not list a drug under this section unless (1) the Secretary has found that it is safe and efficacious for the purposes for which it is recommended and (on the list established under subsection (c)) for the treatment of each disease or condition for which it is specified on the list, and (2) the Board finds that it is available at a reasonable cost (considering, among other factors, the existence or absence of competition in the production, distribution, and sale of the drug). Drugs shall be listed by their established names (as defined in section 502(e) of the Federal Food, Drug, and Cosmetic Act) and also, to the extent the Board deems appropriate, by trade names.

(e) In reviewing and revising lists established under this section the Board shall take into consideration (1) current information about the safety and efficacy of listed drugs, and about their cost, (2) the results of review of drug utilization under this title, (3) experience bearing on the determination of what diseases and conditions meet the criteria stated in subsection (c), and (4) such other factors as the Board deems pertinent. Drugs shall be added to or eliminated from the lists as the Board finds best calculated to effectuate the purposes of this section.

DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 26. (a) The Board, with the approval of the Secretary, shall establish and disseminate (and review, and if necessary revise, at least annually) lists of the therapeutic devices, appliances, and equipment (including eyeglasses, hearing aids, and prosthetic appliances), or classes thereof, which it finds are important for the maintenance or restoration of health or of employability or self-management. The Board shall take into consideration the efficacy, reliability, and cost of each item listed, and shall attach to any item such conditions as it deems appropriate with respect to the circumstances under which or the frequency with which the item may be prescribed. In establishing and revising lists under this section the Board shall seek to avoid a rate of expenditure for the furnishing of devices, appliances, and equipment in excess of 2 per centum of the rate of expenditure for all covered services.

(b) The furnishing of a device, appliance, or equipment prescribed by a participating physician or dentist, or by a physician or dentist on behalf of a participating institutional or other provider, is (subject to the provisions of section 28) a covered service if the item appears on a current list of essential items and the prescription falls within any conditions attached to the prescribing of that item on the list. The furnishing of any other device, appliance, or equipment so prescribed is also a covered service if, in accordance with regulations, the furnishing of it has been approved in advance by the Board. Regulations under this section may list items or classes of items which, because of lack of efficacy or reliability or because of cost, the Board has determined may not be furnished as covered services.

OTHER PROFESSIONAL AND SUPPORTING SERVICES

SEC. 27. (a) To the extent provided in regulations (but subject to the provisions of section 28) the following are covered services:

(1) the professional service of optometrists;

(2) the professional services of podiatrists;

(3) the diagnostic services of independent pathology laboratories, and diagnostic and therapeutic radiology furnished by independent radiology services;

(4) the care of a patient in a mental health day care service (A) for not more than sixty full days (or its equivalent) during or following a benefit period (as defined in regulations), when furnished by a hospital or a service affiliated with a hospital, or (B) if furnished by a comprehensive health service organization or by a community mental health center or other mental health center which furnishes comprehensive mental health services; and

(5) ambulance and other emergency transportation services, and such nonemergency transportation services as the Board finds essential to overcome special difficulty of access to covered services.

(b) Supporting services (such as psychological, physio-therapy, nutrition, social work, or health education services) are covered services when they are a part of institutional services or when, with the approval of the board, they are furnished by a comprehensive health service organization meeting the requirements of section 47(a), or by an organization, agency, or center with which the Board has entered into an agreement pursuant to section 49(a) (1), (2), or (3).

EXCLUSIONS FROM COVERED SERVICES

SEC. 28. (a) Health services furnished or paid for under a workmen's compensation law of the United States or a State, or legally required to be so furnished or paid for, are not covered services. Such services, if furnished by a participating provider, shall nevertheless be treated as covered services in accordance with this part unless and until a determination has been made pursuant to the workmen's compensation law that the services are covered by that law, and any resulting overpayment under this title shall, when payment is made under the workmen's compensation law, be recouped in the same manner as other overpayments.

(b) Health services furnished in a primary or secondary school are covered services only to such extent and on such conditions as may be specified in regulations.

(c) Surgery performed solely for cosmetic purposes (as defined in regulations), and hospital or other services incident thereto, are not covered services.

(d) The furnishing of a drug otherwise than in accordance with section 25 is not a covered service. The furnishing of a device, appliance, or equipment otherwise than in accordance with section 26 is not a covered service unless it is furnished, in accordance with section 22(a) or section 23(a), as an incident to professional services.

(e) The Board may by regulation exclude from covered services medical or surgical procedures (and services incident thereto) which it finds are essentially experimental in character and which, because of cost or because of shortage of qualified personnel or facilities, it finds cannot practicably be furnished on a nationwide basis.

(f) Except as provided in regulations, services are not covered services if (1) they are furnished by another provider to a person enrolled in a participating comprehensive health service organization, a participating professional foundation, or an organization described in section 49(a)(5), and are within the range of services which the organization or foundation has undertaken to furnish, or (2) they are primary physicians' services or covered dental services and are furnished by another provider to a person on the list of a physician or a dentist who has elected to be paid by the capitation method.

(g) The services of a professional practitioner are not covered services if they are furnished in a hospital which is not a participating provider, or are furnished to a psychiatric inpatient of an institution at a time when the institutional services to the patient are, by reason of section 24(d), not covered services.

(h) The Board may by regulation exclude from covered services specified surgical procedures, when not required by life-threatening or other acute emergencies, which have not been preceded by consultation with, and recommendation of surgery by, such appropriately qualified specialists as may be required by the regulations. Hospital and other services incident to surgery excluded by regulations under this subsection are not covered services.

PART C—PARTICIPATING PROVIDERS OF SERVICES

IN GENERAL: AGREEMENTS WITH THE BOARD

SEC. 41. (a) A person, corporation, or other entity furnishing any covered service is a participating provider if he or it (1) meets such qualifications and conditions as are established by or pursuant to this part for providers of that service, (2) furnishes the service as an independent provider and not (as employee or otherwise) on behalf of another provider entitled under part E to payment for the service, and (3) has filed with the Board an agreement (A) that services to eligible persons will be furnished without discrimination on the ground of race, color, or national origin, (B) that no charge will be made for any covered service other than for payment authorized by this title, and (C) that the provider will furnish such information as may be reasonably required by the Board for utilization review by professional peers, for the making of payments under this title, and for statistical or other studies of the operation of the title, and will permit such examination of records as may be necessary for verification of information on which payments are based. Participation of a provider may, however, be suspended or terminated pursuant to section 132 or section 134.

(b) With respect to the performance of a surgical procedure specified in regulations under section 28(h) (including an emergency case) the Board may, for the purposes of subsection (a)(3)(C) of this section, require the furnishing of a pathology report on tissue removed and a clinical abstract or discharge report of the case.

PROFESSIONAL PRACTITIONERS

SEC. 42. (a) Subject to the provisions of subsections (c) and (d), a physician, dentist, optometrist, or podiatrist, legally authorized on the effective date of health security benefits to practice his profession in a State, is a qualified provider of covered services within the State. A practitioner first so authorized by a State after the effective date is a qualified provider if, in addition, he meets national standards established by the Board (taking into consideration the criteria applied by any recognized national testing organization) for the practitioner's profession. A practitioner who is a qualified provider in one State, if he meets the national standards, is also in any other State (in accordance with the provisions of section 56(a)(1)) a qualified provider of services which (1) are covered services to persons entitled thereto under this title, and (2) are of a kind which such other State authorizes to be furnished by practitioners of his profession.

(b) For the purposes of this title—

(1) A doctor of osteopathy legally authorized to practice medicine and surgery in a State is a physician.

(2) A dentist qualified in accordance with subsection (a) is a physician when performing oral surgery or other procedures which, in accordance with generally accepted professional standards, may be performed by either a physician or a dentist.

(c) Not later than two years after the effective date, the Board shall establish for physicians, dentists, optometrists, and podiatrists such requirements of continuing education (taking into consideration standards approved by appropriate professional organizations) as it finds reasonable and necessary to maintain and enhance the quality of professional services to eligible persons. A professional practitioner who fails to meet a requirement established under this subsection shall, if the deficiency persists after notice and a reasonable opportunity to correct it, cease to be a qualified provider. A hospital or other provider on whose behalf a physician, dentist, optometrist, or podiatrist furnishes covered services shall (after like notice and opportunity for correction) cease to be a qualified provider if the practitioner fails to meet such a requirement.

(d) A physician qualified in accordance with subsection (a) is not qualified to perform major surgery as a covered service, or to furnish as covered services other specialized services designated in regulations, unless he holds a certificate from the appropriate national specialty board or possesses the qualifications requisite to such certification; except that a physician may be found qualified to furnish any specialized services as covered services if (1) prior to the effective date he has engaged in furnishing such services as a specialist or as a substantial part of his medical practice, (2) he meets standards established by the Board, and (3) where appropriate, a finding that he is so qualified is recommended by a participating hospital in which he has engaged substantially in furnishing such services.

HOSPITALS (OTHER THAN PSYCHIATRIC HOSPITALS)

SEC. 43. Subject to the provisions of section 53, a hospital (other than a psychiatric hospital) is a qualified provider if it is an institution which—

(a) is primarily engaged in providing to inpatients (other than mentally ill persons) diagnostic, therapeutic, and rehabilitation services, furnished by or under the supervision of physicians, for medical diagnosis, treatment, care, and rehabilitation of injured, disabled, or sick persons;

(b) maintains adequate clinical records on all patients;

(c) has bylaws in effect with respect to its staff of physicians, and has filed with the Board an agreement that in granting or maintaining medical staff privileges it will not discriminate on any ground unrelated to professional qualification;

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

(e) provides twenty-four-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;

(f) has a pharmacy and drug therapeutics committee which establishes policies for the selection, acquisition, and utilization of drugs;

(g) has in effect a hospital utilization review plan which meets the requirements of section 51;

(h) meets all applicable requirements of the law of the State in which it is situated; and

(i) meets the requirements of section 42 (c) and such other requirements as the Board finds necessary in the interest of the quality of the care and the safety of patients in the institution.

PSYCHIATRIC HOSPITALS

SEC. 44. Subject to the provisions of section 53, a hospital which is primarily engaged in furnishing psychiatric services to inpatients who are mentally ill is a qualified provider if it (or a distinct part of it) is an institution—

(a) in which diagnostic, therapeutic, and rehabilitative services with respect to mental illness are furnished by or under the supervision of physicians;

(b) which satisfies the requirements of subsections (b) through (i) of section 43;

(c) which, on the basis of staffing and other factors it deems pertinent, the Board finds is qualified to furnish active treatment;

(d) which maintains such records as the Board finds necessary to determine the degree and intensity of the treatment furnished; and

(e) which is accredited by the Joint Commission on the Accreditation of Hospitals.

SKILLED NURSING HOMES

SEC. 45. Subject to the provisions of sections 52 and 53, a skilled nursing home is a qualified provider if it (or a distinct part of it) is an institution which—

(a) is primarily engaged in providing to inpatients (other than mentally ill persons) skilled nursing care and related services for patients who require medical and nursing services;

(b) has written policies, which are developed (and reviewed from time to time) with the advice of a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the services it provides;

(c) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(d) unless it is operated by a participating hospital, operates under the supervision of an administrator licensed by the State in which the institution is situated;

(e) has a requirement that the health care of every patient be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;

(f) maintains adequate clinical records on all patients;

(g) provides twenty-four-hour nursing service sufficient to meet nursing needs in accordance with the policies developed as provided in subsection (b), and has at least one registered professional nurse employed full time;

(h) provides appropriate methods and procedures for the dispensing and administering of drugs;

(i) has in effect a utilization review plan which meets the requirements of section 51;

(j) meets all applicable requirements of the law of the State in which it is situated and, unless the Board finds that such law provides equivalent protection, meets the provisions of the Life Safety Code of the National Fire Protection Association (other than any provision of the Code authorizing waiver of its requirements) applicable to nursing homes; and

(k) meets any applicable requirements of section 42(c) and such other requirements, including requirements relating to the physical facilities, as the Board may find necessary in the interest of the quality of care and the safety of patients in the institution.

HOME HEALTH SERVICE AGENCIES

SEC. 46. Subject to the provisions of section 52, a home health service agency is a qualified provider if it is a public agency or a nonprofit private organization, or a subdivision of such an agency or organization, which—

(a) is primarily engaged in furnishing, on an intermittent and visiting basis in patients' homes, skilled nursing and other therapeutic services to patients (other than mentally ill persons) who are under the care of physicians;

(b) has written policies developed (and reviewed from time to time) by a group of professional personnel associated with the agency or organization, including one or more physicians and one or more registered professional nurses, to govern the services which it furnishes, and provides for supervision of such services by a physician or registered professional nurse;

(c) maintains adequate clinical records on all patients;

(d) meets all applicable requirements of the law of the State in which it furnishes services;

(e) has written policies and procedures, which provide for a systematic evaluation of its total program at appropriate intervals in order to assure the appropriate utilization of services; and

(f) meets any applicable requirements of section 42(c) and such other requirements as the Board may find necessary in the interest of the quality of care and the safety of patients of the agency or organization.

COMPREHENSIVE HEALTH SERVICE ORGANIZATION

SEC. 47(a). A comprehensive health service organization is a qualified provider of covered services if—

(1) the organization furnishes health services to an identified population, living in or near a specified service area and enrolled in the organization, through arrangements which embody prepaid group practice (as defined in regulations) or other definitive arrangements which the Board finds will so far as practicable provide to enrollees the benefits of prepaid group practice;

(2) the furnishing of services is assured through a contract between the Board and a nonprofit provider of all the services to be furnished by the organization, or through a contract between the Board and a nonprofit provider of some of the services and subcontracts or other arrangements between such provider and providers (profitmaking or nonprofit) of the other services;

(3) the organization furnishes, as a minimum, all covered services described in part B (including such supporting services as the Board may have approved under section 27(b), other than institutional services, mental health services, or dental services: and with the approval of the Board it may furnish covered services which it is not required by this subsection to furnish, and may furnish health services not covered by this title;

(4) the organization furnishes services in such manner as to provide continuity of care and (when services are furnished by different providers) ready referral of patients to such services and at such times as may be medically appropriate, and to the maximum extent feasible makes all services readily accessible to enrollees who live in the specified service area;

(5) all eligible persons living in or near the specified service area are eligible to enroll in the organization, except that (A) the number of enrollees may be limited to avoid overtaxing the resources of the organization, and (B) such restrictions upon enrollment may be imposed as are approved by the Board as necessary to prevent undue adverse selection;

(6) the organization provides for periodic consultation with representatives of its enrollees regarding the policies and operation of the organization;

(7) the organization encourages health education of its enrollees and the development and use of preventive health services, and provides that a committee or committees of physicians associated with the organization promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the utilization and quality of all health services (including drugs);

(8) the organization, to the extent practicable and consistent with good medical practice, employs allied health personnel and subprofessional and lay persons in the furnishing of services;

(9) premiums or other charges by the organization for any services not paid for under this title are reasonable;

(10) the organization undertakes, to the extent required by regulations with respect to services of the kinds which it has undertaken to furnish, to arrange for reciprocal out-of-area services by other comprehensive health service organizations, or to pay for health services furnished to its enrollees by other participating providers, in emergencies, within or outside the specified service area of the organization; and

(11) the organization meets the requirements of section 42(c) and such other requirements as the Board finds necessary or appropriate in the interest of the quality of care and the safety of eligible persons, or for other reasons.

(b) A comprehensive health service organization, or with its approval a professional practitioner who furnishes services on its behalf, may furnish services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made by one of the methods provided in part E for payment to independent practitioners, and shall be made to the organization unless the organization requests that it be made to the practitioner who furnishes the services.

PROFESSIONAL FOUNDATIONS

SEC. 48. A professional foundation which is sponsored by a city, county, or State medical or dental society, and is approved by the Board for this purpose, is a qualified provider of such services as may be specified in an agreement with the Board, if the foundation—

(a) is a nonprofit organization, the general policies of which are developed (and reviewed from time to time) by the sponsoring society, or by a group of physicians or dentists (as the case may be) selected by the society or by its governing board;

(b) subject to any limitations which may be approved by the Board, undertakes, if sponsored by a medical society, to furnish all covered physician services (described in section 22), or if sponsored by a dental society, to furnish all covered dental services (described in section 23); at the option of the foundation but subject to approval by the Board, undertakes to furnish other covered services or services not covered by this title or both; and undertakes that the quality and utilization of all services will be reviewed regularly by a professional group composed in a manner approved by the Board;

(c) undertakes to furnish services to all eligible persons who (1) are residents of the area (city, county, or State) of the sponsoring society, (2) in the case of dental services, are entitled to such services under section 23, and (3) have, by enrolling in the foundation, chosen to receive from it all covered services of the kinds which it has undertaken to furnish; except that (A) the number of enrollees may be limited to avoid overtaxing the resources of the foundation, and (B) such restrictions upon enrollment may be imposed as are approved by the Board as necessary to prevent undue adverse selection;

(d) undertakes, without discrimination on any ground unrelated to professional qualifications, (1) to permit any physician or dentist (as the case may be) practicing in the area (city, county, or State), whether or not a member of the sponsoring society, to participate in furnishing, on behalf of the foundation, covered services of a kind which he is qualified to furnish and which the foundation has undertaken to furnish, and (2) to compensate, directly or through a fiscal agent, professional practitioners and other providers furnishing services on its behalf;

(e) undertakes, to the extent required by regulations with respect to services of the kind which the foundation has undertaken to furnish, to pay for health services furnished to its enrollees by other participating providers, in emergencies, within or without the area (city, county, or State) of the sponsoring society;

(f) undertakes that premiums or other charges by the foundation for any services not paid for under this title will be reasonable; and

(g) meets the requirements of section 42 (c) and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons, or necessary to improve the efficiency with which covered services are delivered, or necessary to assure the continuing education of nurses, medical technicians, and other paramedical personnel in the health sciences.

OTHER HEALTH SERVICE ORGANIZATIONS

SEC. 49. (a) Pursuant to an agreement with the Board in accordance with subsection (b), any of the following is a qualified provider of such services as are specified in the agreement—

(1) a public or other nonprofit agency or organization (including a hospital) which

furnishes health services not less comprehensive than those required by section 47(a)(3), but does not meet all other requirements of section 47(a);

(2) a public or other nonprofit center (including a satellite center established by a hospital) which (A) furnishes as a minimum, the services of two or more physicians engaged in general or family practice, the services of nurses and supporting personnel, and basic laboratory services, which the Board finds sufficient for the primary medical care of a substantial population living in the vicinity of the center, and (B) has arrangements with other providers of services which the Board finds assure to the population served by the center, on a coordinated basis, all components of health services not less comprehensive than those required by section 47(a)(3);

(3) a public or other nonprofit mental health center or mental health day care service;

(4) a State or local public health agency furnishing preventive or diagnostic services, or a public agency furnishing covered health services in a primary or secondary school in accordance with section 28(b);

(5) a nonprofit health prepayment or insurance organization which (A) furnishes health services, not less comprehensive than those required by section 47(a)(3), to an identified population living in or near a specified service area and enrolled in the organization, and (B) meets requirements established by the Board as nearly equivalent as practicable to those set forth in section 48, other than the requirement of sponsorship by a medical or dental society; or

(6) a medical or dental group practice or clinic, a center for the treatment and rehabilitation of alcoholic or drug addicts, or another organization or agency furnishing health services to ambulatory patients.

(b) an agreement under this section shall be made on such terms and conditions as the Board deems proper, and shall include any applicable requirements of section 42(c) and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons, and in such cases as the Board finds appropriate may include other requirements referred to in section 48(g).

(c) An agreement under section 48 or this section shall not, except to the extent that it specifically so provides, preclude a professional practitioner who furnishes services on behalf of the provider from furnishing also, either on behalf of the provider or as an independent practitioner, services which are of a kind not within the scope of the agreement or are furnished to persons not within its scope. Unless the agreement provides that payment for covered services furnished to eligible persons shall be made to the provider who has entered into the agreement, payment shall be made to the practitioner by one of the methods provided in part E for payment to independent practitioners.

OTHER PROVIDERS

SEC. 50. (a) an independent pathology laboratory (as defined in regulations) is a qualified provider of diagnostic pathology services if it meets the requirements of section 42(c) and (whether or not it is engaged in transactions in interstate commerce) the requirements established by or pursuant to section 353 of the Public Health Service Act. An independent radiology service (as defined in regulations) is a qualified provider of diagnostic and therapeutic radiology services if it meets the requirements of section 42(c) and all applicable requirements of the law of the State in which the services are furnished, and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons.

(b) A provider of drugs, devices, appliances or equipment is a qualified provider if he meets all applicable requirements established by or pursuant to the Federal Food, Drug, and Cosmetic Act, all requirements of the law of the State in which the provider is situated, and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons.

(c) A provider of ambulance or other covered transportation services is a qualified provider if he meets all applicable requirements of the law of the State in which the services are furnished, and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons.

(d) A Christian Science Sanatorium is a qualified provider of services specified in regulations prescribed under Section 24(a) if it is operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

UTILIZATION REVIEW

SEC. 51. A utilization review plan of a psychiatric or other hospital or a skilled nursing home shall be considered sufficient if it provides—

(a) for the periodic review on a sample or other basis (and the maintenance of adequate records of such review) of admissions to the institution, the duration of stays, and the professional services (including drugs) furnished, (1) with respect to the medical necessity of the services, and (2) for the purpose of promoting the most efficient use of available health facilities and services; and provides for periodic reports, to the institution and the medical staff (and, when requested, to the Board), of statistical summaries of the review;

(b) in the case of a psychiatric or other hospital, for such review to be made either (1) by a staff committee of the hospital composed of two or more physicians (consulting, with respect to drug utilization, with the pharmacy and drug therapeutics committee), with or without participation of other professional personnel, or (2) by a group outside the hospital which is similarly composed and which, if practicable, is established by the local medical society and hospitals in the locality, or is established in such other manner as may be approved by the Board; but clause (1) of this subsection shall be inapplicable to any hospital where, because of its small size or for such other reason as may be specified in regulations, it is impracticable for the hospital to have a properly functioning staff committee for the purposes of this section;

(c) in the case of a skilled nursing home, for such review to be made by a committee, composed and established as provided in subsection (b), or by a committee so composed which is established by the State or local public health agency pursuant to a contract with the Board, or by the Board; except that if a consolidated budget has been approved for the nursing home and a hospital, under section 83(f), the review shall be made by the utilization review committee of the hospital;

(d) for such review, in each case of inpatient hospital services or skilled nursing home services furnished to a patient during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible after each day so specified, and in no event later than one week following such day; and

(e) for prompt notification to the institution, the patient, and his attending physician of any finding (made after opportunity for consultation afforded to such attending physician) by the physician members of such committee or group that any admission, further stay, or furnishing of particular services in the institution is not medically necessary.

TRANSFER AND AFFILIATION AGREEMENTS

SEC. 52. (a) A skilled nursing home is a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensing with) a transfer agreement with at least one participating hospital, providing for the transfer of patients and of medical and other information between the institutions as medically appropriate.

(b) After two years following the effective date of health benefits, a skilled nursing home or a home health service agency will be a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensing with) an affiliation agreement with a participating hospital or a participating comprehensive health service organization, under which the medical staff of the hospital or organization (or a committee thereof) will furnish, or will assume responsibility for, the professional services in the skilled nursing home, or the professional services furnished by the home health agency, as the case may be.

(c) The requirement of a transfer agreement under subsection (a), or of an affiliation agreement under subsection (b), shall not be applicable in any case if there is in effect a finding by the Board that the lack of a suitable hospital or organization within a reasonable distance makes such an agreement impracticable, and that the services of the skilled nursing home or the home health agency are essential to the furnishing of adequate services to eligible persons. Such a finding shall be reviewed periodically, and shall be revoked whenever the Board finds it practicable to do so.

NEWLY CONSTRUCTED FACILITIES

SEC. 53. A psychiatric or other hospital or a skilled nursing home the construction or substantial enlargement of which (whether or not in replacement of another institution) was undertaken (as defined in regulations) after December 31 of the year in which this title is enacted is not a participating provider unless the construction or enlargement has been found by a State Agency designated by the Governor of the State for this purpose, or has been found by the Board, to be needed for the furnishing of adequate services to persons residing in the area to be served by the institution.

CONSIDERATION OF PROFESSIONAL ASSOCIATION STANDARDS

SEC. 54. In establishing requirements under this part to assure the quality of care and the safety of eligible persons, the Board—

(a) shall take into consideration standards or criteria established or recommended by any appropriate professional or other association or organization; and

(b) may require the revision of a provider's staffing patterns, or its standards for the selection or retention of professional or other personnel, which fail to meet standards or criteria established or recommended by such an association or organization.

EXCLUSION: FEDERAL PROVIDERS OF SERVICES

SEC. 55. No institution of the Department of Defense, no institution of the Veterans' Administration, no institution of the Department of Health, Education, and Welfare engaged in the provision of services to merchant seamen or to Indians or Alaskan natives, and no employee of any of the foregoing acting as employee, is a participating provider. The Board shall, however, reimburse the proper appropriation for any covered services furnished by any such institution or employee to an eligible person who is not, under any Act other than this Act, eligible to receive the service from the institution or employee. The Board shall also reimburse the proper appropriation for any covered services furnished to eligible persons pursuant to section 329 of the Public Health Service Act (added by Public Law

91-623), such reimbursement to be in lieu of payments required by section 329(b).

SEC. 56. (a) In the furnishing of covered services to eligible persons (any law of a State or political subdivision to the contrary notwithstanding)—

(1) A physician, dentist, optometrist, or podiatrist who is legally authorized by a State to practice his profession and who meets national standards established by the Board pursuant to section 42(a) is hereby authorized to furnish in any other State, either as an independent participating provider or on behalf of an institutional or other participating provider, the services which such other State authorizes to be furnished by practitioners of his profession.

(2) A professional nurse, or a practitioner of another health profession or occupation designated in regulations, who meets national standards established by the Board for his profession or occupation is hereby authorized to furnish in any State, on behalf of participating providers of services, the services which that State authorizes or permits to be furnished by practitioners of his profession or occupation. National standards applicable to professional nursing, or to any other profession or occupation the practice of which is subject in all States to licensure or similar authorization, shall contain a requirement of licensure or authorization by at least one State.

(3) In a participating public or other nonprofit hospital or a participating comprehensive health service organization, a practitioner of any health profession other than medicine or dentistry or of any nonprofessional health occupation who meets national standards established by the Board for his profession or occupation, and meets any additional qualifications established by the Board for the performance of particular acts or procedures, is hereby authorized to perform, under the supervision and responsibility of a physician or dentist, such of the acts which might lawfully be performed by the physician or dentist as are specified in regulations.

(4) A participating public or other nonprofit hospital or a participating comprehensive health service organization is hereby authorized (whether or not the arrangement may be deemed to constitute corporate practice of a profession) to employ physicians, dentists, or other professional practitioners, or to obtain and compensate their services in any other manner, and the practitioners are authorized to serve such a hospital or organization as employees or in any other manner; but only if the employment or other arrangement is not of a kind which the Board finds is likely to cause lay interference with professional acts or professional judgments.

(b) If the Board finds that a proposed corporation will meet the requirements of section 47 for participation as a comprehensive health service organization (or as the principal contractor for such an organization), but that it cannot be incorporated in the State in which it proposes to furnish services because the State law requires that a medical society approve the incorporation of such an organization, or requires that physicians constitute all or a majority of its governing board, or requires that all physicians in the locality be permitted to participate in the services of the organization, or makes any other requirement which the Board finds incompatible with the purposes of this title, the Board may issue a certificate of incorporation to the organization, and it shall thereupon become a body corporate. The powers of the corporation shall be limited to the furnishing of services under this title, and the doing of things reasonably necessary or incident thereto. So far as the Board finds to be compatible with the purposes of this title, the certificate of incorporation shall accord with, and the corporation shall be subject to, provisions of the State law which are applicable to nonprofit corporations generally.

PART D—TRUST FUND; ALLOCATION OF FUNDS FOR SERVICES

HEALTH SECURITY TRUST FUND

SEC. 61. (a) Section 1817 of the Social Security Act (creating the Federal Hospital Insurance Trust Fund and appropriating to the fund the proceeds of the hospital insurance payroll taxes and the hospital insurance self-employment tax) is amended—

(1) by striking out the section heading, and the name of the trust fund appearing in subsection (a), and in each case inserting in lieu thereof: "Health Security Trust Fund";

(2) by striking out paragraph (2) of subsection (a) (appropriating to the trust fund the proceeds of the self-employment tax for hospital insurance) and inserting in lieu thereof:

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income, and by section 1403 of the Code with respect to unearned income, reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code."

(3) by striking out subsections (g), (h), and (i) and inserting in lieu thereof:

"(g) On the effective date of benefits under title I of the Health Security Act, there shall be transferred to the Trust Fund all of the assets and liabilities of the Federal Supplementary Medical Insurance Trust Fund. The Health Security Trust Fund shall remain subject to the liabilities of the Federal Hospital Insurance Trust Fund existing immediately prior to such effective date.

"(h) In addition to the sums appropriated by subsection (a), there are authorized to be appropriated to the Trust Fund from time to time, out of any moneys in the Treasury not otherwise appropriated, a Government contribution equal to 100 percent of the sums appropriated by subsection (a). There shall be deposited in the Trust Fund all recoveries of overpayments, and all receipts under loans or other agreements entered into, under title I of the Health Security Act.

"(i) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Health Security Board certifies are necessary to make payments provided for by title I of the Health Security Act, and the payments with respect to administrative expenses in accordance with section 201(g)."

(b) Section 201(g) of the Social Security Act (providing for annual authorization by the Congress of payment, from the respective trust funds, of the cost of administering the several national systems of social insurance) is amended—

(1) by striking out in paragraph (1)(A) "the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund" and inserting in lieu thereof: "the Health Security Trust Fund";

(2) by striking out the words "title XVIII" wherever they appear in the subsection and inserting in lieu thereof: "title I of the Health Security Act".

ANNUAL DETERMINATION OF FUND AVAILABILITY

SEC. 62. (a) For each fiscal year the Board shall, not later than March 1 next preceding the beginning of the fiscal year, fix the maximum amount which may (except as provided in subsection (c)) be obligated during the fiscal year for expenditure from the Trust Fund. The amount so fixed—

(1) shall not exceed 200 percent of the expected net receipts during the fiscal year (as estimated by the Secretary of the Treasury) from the taxes imposed by sections 1401(b), 1403, 3101(b) and 3111(b) of the Internal Revenue Code of 1954, and

(2) for any fiscal year except the fiscal year beginning on the effective date of health benefits, shall not exceed the aggregate obligations, as estimated by the Board, incurred and to be incurred by the Trust Fund during the fiscal year current at the time when the determination is made, adjusted to reflect (A) any estimated change expected in the prices of goods and services which enter into the cost of living, (B) the expected change in the number of eligible persons, (C) any expected change (to the extent that the Board finds it not otherwise adequately reflected) in the number of participating professional providers, or in the number or capacity for the provision of services of institutional or other participating providers, and (D) any change in the cost of administration of this Act indicated in the President's budget estimates pursuant to section 201(g) of the Social Security Act.

(b) In fixing the amount to be available for obligation during a fiscal year, pursuant to subsection (a)—

(1) if and to the extent that (A) the Board estimates that the amount in the Trust Fund at the beginning of the fiscal year will be less than one-quarter of the obligations incurred and to be incurred during the fiscal year current at the time when the determination is made, and (B) the Board finds that restriction of the amount to be available for obligation will not materially impair the adequacy or quality of services to eligible persons, the amount fixed under subsection (a) shall be less than the maximum stated in paragraph (1) of that subsection; and

(2) if and to the extent that the Board finds that improvement in the organization and delivery of services or in the control of their utilization has lessened their aggregate cost (or has lessened an increase in their aggregate cost), the amount fixed under subsection (a) shall be less than the maximum stated in paragraph (2) of that subsection.

(c) The amount to be available for obligation during a fiscal year, fixed pursuant to subsection (a), may be modified before or during the fiscal year if the Secretary of the Treasury finds that the tax receipts referred to in subsection (a)(1) will differ from the estimate by 1 percent or more, or if the Board finds that any of the factors of expected change referred to in subsection (a)(2), or action on the budget estimate for the cost of administration, will differ from the estimate by 5 percent or more; or if an epidemic, disaster, or other occurrence increases the need for health services to an extent which the Board finds requires the expenditure of additional funds. If the amount fixed pursuant to subsection (a) is increased, the Board, through the Secretary, shall promptly report its action to the Congress with a statement of the reasons therefor.

HEALTH SERVICES ACCOUNT, HEALTH RESOURCES DEVELOPMENT ACCOUNT, ADMINISTRATION ACCOUNT, AND GENERAL ACCOUNT

SEC. 63. (a) There shall be established in the Trust Fund a Health Services Account, a Health Resources Development Account, an Administration Account, and a General Account (consisting of all moneys in the Trust Fund which have not been transferred to another account).

(b) For each fiscal year there shall from time to time be transferred from the General Account to the Health Resources Development Account the following percentage of the amount to be available for obligation during that year (as determined pursuant to section 62(a) and (b)): for the fiscal year beginning on the effective date of health benefits, and for the next succeeding fiscal year, 2 percent; for each of the next two succeeding fiscal years, 3 percent; for each of the next two succeeding fiscal years, 4

percent; and for each fiscal year thereafter, 5 percent. Funds in the Health Resources Development Account shall be used exclusively for the purposes of part F, and shall remain available for such uses until expended.

(c) The remainder of the amount to be available for obligation during a fiscal year, after deducting the amount of the President's budget estimates for the cost of administering this Act, shall from time to time be transferred from the General Account to the Health Services Account. Funds in the Health Services Account shall be used exclusively for making payments for covered services in accordance with part E, and shall remain available for such payments until expended.

(d) As amounts available for a fiscal year (or for portions of the year) for the administration of this Act are determined by the Congress, the amount available for the administration of this title shall be transferred from the General Account to the Administration Account. From time to time any necessary adjustments shall be made in the amount transferred to the Health Services Account and in allocations previously made from that account.

REGIONAL ALLOCATIONS FROM HEALTH SERVICES ACCOUNT

SEC. 64. (a) For each fiscal year the Board shall, not later than March 1 next preceding the beginning of the fiscal year, make allocations to the regions of the Department from the funds to be available for the fiscal year in the Health Services Account. The allocation to each region shall be equal to the estimated aggregate expenditures in the region for services, described in part B as covered services, in the most recent twelve-month period for which reliable data are available, adjusted to reflect the factors of change referred to in clauses (A), (B), and (C), of section 62(a)(2), and further adjusted in accordance with subsections (b) and (c) of this section.

(b) It shall be the objective of the Board to reduce gradually, and ultimately to eliminate substantially, existing differences among the regions of the Department in the average per capita cost of health services, except as such differences reflect estimates of differences in the prices of goods and services which enter into the cost of living for people in the several regions. To this end the Board shall modify the allocations for each fiscal year determined under subsection (a) in order (1) to reduce, or to lessen any increase in, the cost of covered services in regions in which the average per capita cost is higher (to an extent greater than the difference in the estimated weighted average cost of goods and services) than the national average per capita cost, to such extent as the Board finds practicable without impairing materially the adequacy or quality of services to eligible persons, and (2) to stimulate, to such extent as the Board finds practicable and desirable, increases in the availability and utilization of covered services in regions in which the average per capita cost is lower (to an extent greater than the difference in the estimated weighted average cost of goods and services) than the national average per capita cost. In modifying allocations to the regions, the Board shall take account of regional differences in the composition of population, in the prevalence and incidence of morbidity indicating need for covered services, in the available and needed resources in personnel or facilities for provision of covered services, in the costs of providing covered services, and in such other factors as the Board may deem pertinent, to the extent that such regional differences are not reflected in allocations under subsection (a) and have not already been taken into account, under this subsection, in modifying those allocations.

(c) The Board shall withhold from allocation to the regions a reserve for contingencies, in an amount not more than 5 percent of the funds to be available for the fiscal year in the Health Services Account. If the remaining amount to be available for the fiscal year in the account is less than the sum of the regional allocations determined pursuant to subsections (a) and (b), the allocations shall be reduced proportionately.

(d) Allocations under this section may be modified before or during a fiscal year if the amount to be available for obligation is modified pursuant to section 62(c). The contingency reserve shall be available to increase one or more regional allocations, as the Board may find necessary. From the contingency reserve, or from additional funds in the General Account made available for obligation, one or more allocations may also be increased if an epidemic, disaster, or other occurrence increases the need for health services to an extent which the Board finds requires the expenditure of additional funds.

DIVISION OF REGIONAL FUNDS BY CLASSES OF SERVICES

SEC. 65. (a) For each fiscal year the Board shall, not later than April 1 next preceding the beginning of the fiscal year, divide the allocation to each region into funds to be available, respectively, to pay the cost within the region of the following classes of services: (1) institutional services, (2) physician services, (3) dental services, (4) the furnishing of drugs, (5) the furnishing of devices, appliances, and equipment, and (6) other professional and miscellaneous services.

(b) The content, for purposes of the division of funds, of each class of services shall be defined in regulations. Within the funds to be available for miscellaneous services, the regulations shall establish subfunds, respectively, for the making of incentive payments not otherwise provided for, for supporting services described in section 27(b), for payments to optometrists, for payments to podiatrists, for payments to independent pathology laboratories, for payments to independent radiology services, and for such other purposes as the Board may determine.

(c) The amounts assigned to the several funds and subfunds in each region shall be determined in accordance with regulations, which shall take into account, in addition to the factors considered in making the regional allocations, trends in utilization of the several services and, to the extent the Board finds it practicable, the creation of incentives for the improved utilization thereof.

FUNDS FOR HEALTH SERVICE AREAS

SEC. 66. (a) For each fiscal year the Board shall, not later than April 1 next preceding the beginning of the fiscal year, allot among the health service areas established in each region under section 124(a), each of the funds established for the region pursuant to section 65 for a class of services. If an interstate health service area lies partly in each of two or more regions, appropriate allotments of funds from each region shall be made to it.

(b) The amount allotted to each health service area from each regional fund shall be equal to the aggregate expenditures in the area for services of the class for which the fund is to be available, as determined (or, if necessary, estimated) by the Board for such twelve-month period as may be specified in regulations; modified to take account of the factors considered in making regional allocations and in dividing such allocations by classes of services (including modifications designed to further the objective of equalization within each region, in the manner set forth in section 64(b) with respect to interregional equalization).

(c) Payment for services, in accordance with part E, shall be made to participating providers in each health service area by such officer of the Board as it may designate for the purpose. There shall be established for each area such accounts as the Board may find convenient for making payment to providers of more than one class of services (such as an account for payment to hospitals, or an account for payment to comprehensive health service organizations), in which shall be deposited the appropriate portions of the funds for the several classes of services to be furnished by such providers.

MODIFICATION OF FUND ALLOTMENTS

SEC. 67. Before or during a fiscal year the division of funds by classes of services pursuant to section 65, or the allotment of funds to health service areas pursuant to section 66, may be modified if the regional allocations are modified, or if the Board finds that modification is required by events occurring or information acquired after the division and allotment were made.

PART E—PAYMENT TO PROVIDERS OF SERVICES IN GENERAL

SEC. 81. Payment shall be made to participating providers, in accordance with this part, for covered services furnished to eligible persons (or, in the case of dental services, furnished to persons entitled thereto under section 23). Payments shall be made from the amounts allocated from the Health Services Account in the Trust Fund, in accordance with part D, for the respective areas and purposes.

METHODS AND AMOUNT OF PAYMENT TO PROFESSIONAL PRACTITIONERS

SEC. 82. (a) Every independent professional practitioner shall be entitled, at his election, to be paid by the fee-for-service method, consisting of the payment of a fee for each separate covered service.

(b) Every physician engaged as an independent practitioner in the general or family practice of medicine (as determined in accordance with regulations under sec. 22(b)(1)), and every dentist engaged as an independent practitioner in the furnishing of covered dental services, shall be entitled, at his election, to be paid by the capitation method if he had filed with the Board an agreement (1) to furnish all necessary and appropriate primary medical services (as defined in such regulations) or covered dental services, as the case may be, to persons on a list of persons who have chosen to receive all such services from the practitioner, (2) to maintain arrangements for referral of patients to specialists, institutions, and other providers of covered services, and (3) to maintain such records and make such reports of services furnished as may be required by regulations for purposes of medical audit. A practitioner electing the capitation method is entitled to be paid by the fee-for-service method for services furnished to eligible persons who are not on his list, but not (except as provided in regulations) for specialized services furnished to persons who are on his list.

(c) When the Board deems it necessary in order to assure the availability of services or for other reasons, the Board (1) may pay an independent practitioner a full-time or part-time stipend in lieu of or as a supplement to the foregoing methods of compensation, and it may reimburse a practitioner for special costs of continuing professional education and of maintaining linkages with other providers of services (such as costs of communication and of attendance at meetings or consultations), and (2) may pay for specialized medical services (including services referred to in section 42(b)(2)) a stated amount per session or per case or may utilize a combination of the methods authorized by this section.

(d) The capitation method of payment for a specified kind and scope of covered services consists of the payment, to a provider of such services, of an annual capitation amount (determined for a health service area) for each person resident in that

area who has chosen to receive all such services from the provider.

(e) The amounts allotted for a fiscal year pursuant to part D for each health service area for physician services, for dental services, for optometrist services, and for podiatrist services, respectively, shall each be used (1) to provide for payments for professional services (made either directly to practitioners or as reimbursement to hospitals or other providers for the compensation of practitioners) to be made by the Board on a budget or stipend basis or any basis other than capitation, fee-for-service, or per case, and (2) from the remainder, to make available (for each kind of professional services) an equal per capita amount for each person resident in the area who is entitled to such services. In any area in which the Board finds that a substantial volume of services is furnished to nonresidents, it may reduce the per capita amount to such extent as it finds necessary to effect an equitable distribution of funds.

(f) The per capita amount shall constitute the annual capitation amount for purposes of payment to any organization, professional foundation, or other provider furnishing all covered services (described in part B) of the kind for which the allotment is available. Lesser capitation amounts shall be fixed, on the basis of the relative cost of the services, for primary medical services, and, as may be required, for any scope of services (less than comprehensive) which is furnished by any institutional or other provider. If the Board finds that the population served by a provider requires on the average, because of age distribution or other factor, a volume of services significantly greater or smaller than the average requirement of the population of the local health service area, the Board may, after consultation with the provider, make an appropriate adjustment in the capitation amount payable to him. The aggregate of capitation payments under this subsection to any organization, professional foundation, or other provider may be used by it for the compensation of professional practitioners furnishing services on its behalf, by whatever method (including salary, capitation, fee-for-service, or any other method) may be agreed upon between the provider and the practitioners.

(g) For the compensation of professional practitioners who are to be paid by the Board (directly or through a delegation under this subsection) on a fee-for-service or per case basis, there shall be available—

(1) the per capita amount determined under subsection (e), multiplied by the number of residents of the health service area for whom no capitation payment (for services of the kind for which the allotment is available) is to be made under subsection (f),

(2) increased to reflect any excess resulting from a lowering of the per capita amount under subsection (e) on account of services furnished to nonresidents, or from the fixing of lesser capitation amounts under subsection (f) for services less than comprehensive, and

(3) increased or reduced to reflect adjustments under subsection (f), on the ground of age distribution or other factor, in capitation amounts payable to other providers.

The amount of payments under this subsection shall be determined in accordance with relative value scales prescribed by the Board after consultation with representatives of the respective professions in the region, State, or area, and in accordance with unit values prescribed by the Board from time to time. The Board may, on such terms as it deems appropriate, delegate to a professional society or to an agency designated by representatives of a profession in the region, State, or area the payment of fees and per session amounts under this subsection.

(h) The Board may, on an experimental or demonstration basis, enter into an agreement with a statewide or local professional society or other organization representative of independent professional practitioners to substitute another method of compensation for those set forth in this section (either for all such practitioners, for all who have elected the fee-for-service method of payment, or for all who have elected another method), if the Board is satisfied that the substitute method will not increase the cost of services and will not encourage overutilization or underutilization of covered services. The Board shall review from time to time the operation of such an agreement, and shall, after reasonable notice, terminate it if the Board finds it to have led to increased cost or to overutilization or underutilization of covered services.

PAYMENT TO HOSPITALS (OTHER THAN PSYCHIATRIC HOSPITALS)

SEC. 83. (a) A participating hospital (other than a psychiatric hospital) shall be paid its approved operating costs, determined in accordance with regulations, in the furnishing of covered services to eligible persons, as such approved costs for a fiscal year are set forth in a prospective budget approved by the Board. Regulations under this section shall specify the method or methods to be used, and the items to be included, in determining costs, and shall prescribe a nationally uniform system of cost accounting.

(b) The costs recognized in each hospital budget shall be those, determined in accordance with subsection (a), of furnishing the covered services ordinarily furnished by the hospital to inpatients or outpatients, and of performing any other function ordinarily performed by the hospital and ordinarily financed from payments by or on behalf of patients, except as the scope of services or of other functions may be modified by agreement of the Board and the hospital or by direction of the Board pursuant to section 134. The budget shall recognize any increase or decrease of cost resulting from a modification of the scope of services or of other functions, or resulting from compliance with any other direction issued pursuant to section 134.

(c) The costs recognized in the budget shall include the cost of reasonable compensation to (and other costs incident to the services of) pathologists, radiologists, and other physicians and other professional or nonprofessional personnel whose services are held out as generally available to patients of the hospital or to classes of its patients, whatever the method of compensation of such physicians and other personnel, and whether or not they are employees of the hospital.

(d) The Board shall review, through such of its officers or employees or through such boards, and in such manner, as may be provided in regulations, proposed budgets prepared and submitted to it by hospitals, and may provide for participation in such review by representatives of the hospitals in the region or health service area in which the hospital is situated. Each officer of the Board charged with final action on hospital budgets shall receive and consider written justifications of budget proposals, and may provide oral hearings thereon.

(e) A hospital budget approved under this section for a fiscal year may, in such manner as is provided in regulations, be amended before, during, or after the fiscal year if there is a substantial change in any of the factors relevant to budget approval.

(f) If a hospital (other than a psychiatric hospital) operates or has an affiliation agreement (described in section 52(b)) with a participating skilled nursing home, and also operates or has such an agreement with a participating home health service agency, the Board may, on request of the institution or institutions and in accordance with regulations designed to reflect the cost of a combined operation, approve a consolidated budget and make all payments thereunder to the hospital.

PAYMENT TO PSYCHIATRIC HOSPITALS

SEC. 84. A participating psychiatric hospital which is primarily engaged in furnishing covered services shall be paid in the same manner as other hospitals. Any other participating psychiatric hospital shall be paid an amount determined in accordance with regulations for each patient day of covered services to an eligible person. Such regulations shall take into account, with respect to any distinct part of the hospital which meets the requirements of section 44, the factors to be considered in the approval of the budgets of hospitals other than psychiatric hospitals, but with such adjustments as are neecssary to provide equitable compensation to the psychiatric hospital.

PAYMENT TO SKILLED NURSING HOMES AND TO HOME HEALTH SERVICE AGENCIES

SEC. 85 (a) A participating skilled nursing home or home health service agency shall be paid in the same manner as a hospital (other than a psychiatric hospital), except as provided in subsection (b) of this section, its approved operating costs in the furnishing to eligible persons of skilled nursing home services or home health services, as the case may be.

(b) Regulations under this section shall, for skilled nursing homes and for home health service agencies, respectively, specify the method or methods to be used, and the items to be inculded, in determining costs; may, to the extent the Board deems desirable, specify nationally uniform systems of cost accounting; and, taking into account the prevailing practices of such homes or such agencies, may specify services which will be recognized in budgets and services which will not be so recognized.

PAYMENT FOR DRUGS

SEC. 86. (a) For each drug appearing on either of the lists established pursuant to section 25, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of the drug to a provider thereof. Product prices shall be so fixed as to encourage the acquisition of drugs in substantial quantities, and differing product prices for a single drug may be established only to reflect regional differences in cost or other factors not related to the quantity purchased.

(b) Payment for a drug furnished by an independent pharmacy shall consist of its cost to the pharmacy (not in excess of the applicable product price) plus a dispensing fee. The Board, after consultation with representatives of the pharmaceutical profession, shall establish (and from time to time review and revise) schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of drugs dispensed, differences in services provided, and other factors which the Board finds relevant.

PAYMENT TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS AND PROFESSIONAL FOUNDATIONS

SEC. 87. (a) Payment to a comprehensive health service organization or to a professional foundation for covered services to its eligible enrollees, other than for hospital or skilled nursing home services, shall consist of basic capitation payments plus additional payments (if any) determined in accordance with subsection (d).

(b) The basic capitation payment shall consist of a basic capitation amount multiplied by the number of eligible persons en-

rolled in the organization or foundation. The basic capitation amount shall be the sum of the appropriate capitation amount or amounts for professional services (determined under section 82(f)) and a capitation amount fixed by the Board, on the basis of the average reasonable and necessary cost per enrollee, for each other service or class of services (exclusive of hospital and skilled nursing home services) to be furnished by the organization or foundation in accordance with section 47(a)(3) or 48(b).

(c) If the organization or foundation furnishes hospital or skilled nursing home services through one or more institutions operated by it, payment for these services shall (subject to the provisions of subsection (e)) be made in accordance with section 83, 84, or 85. If with the approval of the Board the organization or foundation furnishes such services to enrollees through arrangements with other providers to which the organization or foundation undertakes to make payment for the services, the Board may reimburse the organization or foundation for such payments on the basis of patient-days of service utilized by eligible persons enrolled in the organization or foundation.

(d) If it appears to the satisfaction of the Board (1) that the average utilization of hospital and skilled nursing home services by eligible persons enrolled in the organization or foundation (whether or not such services are furnished by the organization or foundation, either directly or through other providers) has, during a fiscal year, been less than the average utilization of such services under comparable circumstances by comparable population groups not enrolled either in comprehensive health service organizations or in professional foundations, and (2) that the services of the organization or foundation have been of high quality and adequate to the needs of its enrollees, the Board shall (subject to the provisions of subsection (e)) make an additional payment to the organization or foundation equal to 75 percent of the amount which the Board finds has been saved by such lesser utilization of hospital and skilled nursing home services.

(e) In lieu of payments under subsections (c) and (d), the Board may pay the comprehensive health service organization or the foundation on a capitation basis for hospital services, skilled nursing home services, or both. The capitation amount for such services shall be their average reasonable and necessary cost per enrollee; except that, if the conditions stated in subsection (d) are met, the capitation amount shall be determined by the Board on the basis of the average cost of such services under comparable circumstances to comparable population groups not enrolled in comprehensive health service organizations or in professional foundations, reduced by such amount as the Board finds (on the basis of past experience of the organization or foundation) is calculated to yield to the trust fund 25 per centum of the saving referred to in subsection (d).

(f) The amount of any additional payment under subsection (d), or the excess of aggregate payments under subsection (e) over the cost of furnishing hospital services, skilled nursing home services, or both, to eligible persons enrolled in the organization or foundation, may be used by the organization or foundation for any of its purposes, including the application of such amounts to the cost of services not covered by this title.

PAYMENT TO OTHER PROVIDERS

SEC. 88. (a) An agency, organization, or other entity with which the Board has entered into an agreement under section 49(a) shall be paid by such method (other than the fee-for-service method) as, in accordance with regulations, may be set forth in the agreement.

(b) An independent pathology laboratory or an independent radiology service shall be paid on the basis of a budget approved by the Board, or on such other basis as may be specified in regulations.

(c) Payment for devices, appliances, and equipment, payment for ambulance or other transportation services, and payment for the services of a Christian Science sanatorium shall be made on such basis as may be specified in regulations.

METHODS AND TIME OF PAYMENT

SEC. 89. The Board shall periodically determine the amount which should be paid under this part to each participating provider of services, and the provider shall be paid, from the Health Services Account in the Trust Fund, at such time or times as the Board finds appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, the amounts so determined, with adjustments on account of underpayments or overpayments previously made (including appropriate retrospective adjustments following amendment of approved institutional budgets). Payment may be made in advance in such cases and to such extent as the Board finds necessary to supply providers with working funds, on such terms as it finds sufficient to protect the interests of the United States.

PART F—PLANNING: FUNDS TO IMPROVE SERVICES AND ALLEVIATE SHORTAGES OF FACILITIES AND PERSONNEL

PURPOSE OF PART F—AVAILABILITY OF FUNDS

SEC. 101. (a) The purpose of this part is—

(1) prior to the effective date of health security benefits, to inaugurate a program of strengthening the Nation's resources of health personnel and facilities and its system of delivery of health services, in order to enable the providers of health services better to meet the demands on them when benefits under this title become available, and to that end (A) to expand and intensify the health planning process throughout the United States, with primary emphasis on preparation of the health delivery system to meet the demands of the Health Security program under this title, and (B) to provide financial and other assistance (i) in alleviating shortages and maldistributions of health personnel and facilities in order to increase the supply of services, and (ii) in improving the organization of health services in order to increase their accessibility and effective delivery; and

(2) after the effective date, to reinforce the operation of the Health Security program under this title as a mechanism for the continuing improvement of the supply and ties and the organization of health services, distribution of health personnel and facili- and to that end (A) to coordinate the health planning process throughout the United States with a view to the continuing development of plans for maximizing capabilities for the effective delivery of covered services, and (B) to assist in meeting those costs of improvement of personnel, facilities, and organization that are not met either through the normal operation of the Health Security program under this title or from other sources of public or private assistance.

(b) For the purposes of subsection (a)(1), there are hereby authorized to be appropriated $200,000,000 for the fiscal year beginning on July 1 of the calendar year in which this title is enacted, and $400,000,000 for the next succeeding fiscal year. Funds appropriated under this subsection shall remain available until expended.

(c) For the purposes of subsection (a)(2), the Board is authorized to make expenditures from the Health Resources Development Account in the Trust Fund, established pursuant to section 63.

PLANNING

SEC. 102. (a) In consultation with State comprehensive health planning agencies approved under section 314 (a) of the Public Health Service Act, and with regional medical programs and other health planning agencies, the Secretary shall promote and support, and as necessary shall conduct within the Department of Health, Education, and Welfare, a continuous process of health service planning for the purpose of improving the supply and distribution of health personnel and facilities and the organization of health services. Except for planning with respect to the national supply of professional health personnel, the planning shall proceed primarily on a State-by-State basis but without excluding more particularized planning for portions of States, for metropolitan or interstate areas, or with respect to health facilities, health manpower development, or other particular aspects of health care. If a State comprehensive health planning agency does not undertake and carry out the responsibility for utilizing and coordinating all health planning activities within the State (including coordination with planning for interstate areas), and for coordinating health planning with planning in related fields, the Secretary shall assume the responsibility for co-ordinating such planning activities within the States.

(b) Prior to the effective date of health benefits, the planning process shall give first consideration to identification of the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the organization for delivery of covered services, and to means for the speedy alleviation of these shortcomings. Thereafter, it shall be directed to the continuing development of plans for maximizing capabilities for the effective delivery of covered services.

(c)(1) Section 314(a) of the Public Health Service Act (authorizing grants for comprehensive State health planning) is amended—

(A) by striking out "June 30, 1973" in the first sentence of paragraph (1) and inserting "June 30, 1978" in lieu thereof, and by striking out "and" after "June 30, 1972," in the second sentence of the paragraph and inserting before the period at the end of the paragraph: "and for each of the five succeeding fiscal years, so much as may be necessary"; and

(B) by redesignating paragraphs (D) through (K) of subsection (a)(2) as paragraphs (E) through (L), respectively, and by inserting immediately after paragraph (C) a new paragraph:

"(D) provide that the State agency will place emphasis on the achievement, in consultation with the Secretary, of the purposes set forth in section 102 of the Health Security Act, and will utilize and coordinate all local or particularized health planning activities within the State (including coordination with planning for interstate areas), and coordinate health planning with planning in related fields;"

(2) Paragraph (1)(A) of section 314(b) of the Public Health Service Act (authorizing project grants for areawide health planning) is amended—

(A) by striking out "June 30, 1973" in the first sentence and inserting "June 30, 1978" in lieu thereof;

(B) by inserting immediately before the last sentence, "In approving grants under this subsection the Secretary shall take into consideration the extent to which the agency or organization will supplement or otherwise contribute to the effectiveness of the planning conducted by the State agency pursuant to paragraph (D) of subsection (a)(2);" and

(C) by striking out "and" after "June 30, 1972," in the last sentence, and inserting be-

fore the period at the end of the paragraph: "and for each of the succeeding five fiscal years, so much as may be necessary".

GENERAL POLICIES AND PRIORITIES

SEC. 103. (a) In providing assistance under this part, the Board shall give priority to improving and expanding the available resources for, and assuring the accessibility of, services to ambulatory patients which are furnished as part of coordinated systems of comprehensive care. To this end the Board shall encourage and assist (1) the development or expansion of comprehensive health service organizations meeting the requirements of section 47(a), (2) the development or expansion of agencies, organizations and centers described in section 49(a) (1) or (2) to furnish services to persons in urban or rural areas who lack ready access to such services, (3) the recruitment and training of professional personnel to staff such organizations, agencies, and centers, (4) the recruitment and training of subprofessional and nonprofessional personnel (including the development and testing of new kinds of health personnel) to assist in the furnishing of such services, to engage in education for personal health maintenance, and to furnish liaison between such organizations, agencies, or centers and the people they serve, and (5) the strengthening of coordination and linkages among institutional services, among noninstitutional services, and between services of the two kinds, in order to improve the continuity of care and the assurance that patients will be referred to such services and at such times as may be medically appropriate, and (6) the strengthening of coordination and cooperation between hospital medical staffs and hospital administrators.

(b) In administering financial assistance under this part the Board shall be guided so far as possible by findings and recommendations of appropriate health planning agencies.

(c) Funds available to carry out this part shall not be used to replace other Federal financial assistance, or to supplement the appropriations for such other assistance except to meet specific needs of the Health Security program under this title (such as the training of physicians or medical students for the general or family practice of medicine). In administering other programs of Federal financial assistance the Secretary and other officers of the Executive Branch, on recommendation of the Board, shall to the extent possible utilize those programs to further the objectives of this part. To this end the Board, on such terms as it finds appropriate, may lend to an applicant or grantee not more than 90 per centum of the non-Federal funds required as a condition of assistance under any such program, and may pay all or part of the interest in excess of 3 percent per annum on any loan made, guaranteed, or insured under any such program.

ORGANIZATIONS FOR THE CARE OF AMBULATORY PATIENTS

SEC. 104. (a) The Board is authorized to assist, in accordance with this section, the establishment, expansion, and operation of (1) comprehensive health service organizations which meet or will meet the requirements of section 47(a), and (2) public or other nonprofit agencies, organizations, and centers described in section 49(a)(1) and (2), which furnish or will furnish care to ambulatory patients.

(b) The Board is authorized to make grants (1) to any public or nonprofit agency or organization (whether or not it is a provider of health services), for not more than 90 percent of the cost (excluding costs of construction) of planning, developing, and establishing an organization or agency described in subsection (a) of this section; or (2) to an existing organization or agency described in subsection (a), for not more than 80 percent of the cost (excluding costs of construction) of planning and developing an enlargement of the scope of its services or an expansion of its resources to enable it to serve more enrollees or a larger clientele. In addition to grants under this subsection, or in lieu of such grants, the Board is authorized to provide technical assistance for the foregoing purposes.

(c) The Board is authorized to make loans to organizations and agencies described in subsection (a) of this section to assist in meeting the cost of construction (or otherwise acquiring, or improving or equipping) facilities which the Board finds will be essential to the effective and economical delivery, or to the ready accessibility, of covered services to eligible persons. No loan to a newly established agency or organization shall exceed 90 percent and no loan to any other agency or organization shall exceed 80 percent of such cost, or of the non-Federal share if other Federal financial assistance in meeting such cost is available.

(d) The Board is authorized to contract with an organization or agency which is described in subsection (a) of this section and which has been either newly established or substantially enlarged, to pay all or a part of any operating deficits, for not more than five years in the case of an organization described in subsection (a)(1), and until not later than the effective date of health security benefits in the case of an agency or organization described in subsection (a)(2). Any such contract shall condition payments upon the contractor's making all reasonable effort to avoid or minimize operating deficits and (if such deficits exist) making reasonable progress toward becoming self-supporting.

RECRUITMENT, EDUCATION, AND TRAINING OF PERSONNEL

SEC. 105. (a) In consultation with State comprehensive health planning agencies, and with Regional Medical Programs, the Board shall promptly establish (and from time to time review and, if necessary, revise) schedules of priority for the recruitment, education, and training of personnel to meet the most urgent needs of the Health Security program. The schedules may differ for different parts of the United States.

(b) The Board is authorized to provide, to physicians and medical students, training for the general or family practice of medicine and training in any other medical specialty in which the Board finds that there is, for the purposes of this title, a critical shortage of qualified practitioners.

(c) The Board shall provide education or training for those classes of health personnel (professional, subprofessional, or nonprofessional) for whom it finds the greatest need, if other Federal financial assistance is not available for such education or training; and if other assistance is available but the Board deems it inadequate to meet the increased need attributable to the Health Security program, it may, with the approval of the Secretary, provide such education or training pending action by the Congress on a recommendation promptly made by the Secretary to increase the authorization of appropriations (or, if the authorization is deemed adequate, to increase the appropriations) for such other assistance.

(d) The training of personnel authorized by this section includes the development of new kinds of health personnel to assist in the furnishing of comprehensive health services, and also includes the training of persons to provide education for personal health maintenance, to provide liaison between the residents of an area and health organizations and personnel serving them, and to act as consumer representatives and as members of advisory bodies in relation to the operation of this title in the areas in which they reside. The Board may make grants to public or other nonprofit health agencies, institutions, or organizations (1) to pay a part or all of the cost of testing the utility of new kinds of health personnel, and (2) until the effective date of health security benefits, to pay a part of the cost of employing persons trained under this subsection who cannot otherwise readily find employment utilizing the skills imparted by such training.

(e) Education and training under this section shall be provided by the Board through contracts with appropriate educational institutions or such other institutions, agencies, or organizations as it finds qualified for this purpose. The Board may provide directly, or through the contractor, for the payment of stipends to students or trainees in amounts not exceeding the stipends payable under comparable Federal education or training programs.

(f) The Board shall undertake to recruit and train professional practitioners who will agree to practice, in urban or rural areas of acute shortage, in comprehensive health service organizations referred to in section 47 (a) or in agencies, organizations, or centers referred to in section 48 (a)(1) or (2). A practitioner who agrees to engage in such practice for at least five years and who enters upon practice in the area before the effective date of health benefits, may until that date be paid a stipend to supplement his professional earnings, and in an appropriate case the Board may make a commitment to compensate the practitioner after that date in accordance with section 82(c).

(g) The Board shall undertake to recruit physicians to serve hospitals as their medical directors and to train such physicians (among other matters) in advising on and managing the development and implementation of medical policies and procedures and their coordination with planning and operational functions of the hospital, with its financing, and with its program of utilization review.

(h) In administering this section the Board shall seek to encourage the education and training, for the health professions and other health occupations, of persons disadvantaged by poverty, inadequate education, or membership in ethnic minorities. To this end the Board may, through contracts in accordance with subsection (e), provide to such persons remedial or supplementary education preparatory to or concurrent with education or training for the health professions or occupations, and may (directly or through such contracts) provide to such persons stipends adequate to enable them to avail themselves of such education or training.

SPECIAL IMPROVEMENT GRANTS

SEC. 106. (a) The Board is authorized to make grants to public or other nonprofit health agencies, institutions, and organizations to pay part or all of the cost of establishing improved coordination and linkages among institutional services, among noninstitutional services, and between services of the two kinds.

(b) The Board is authorized to make grants to organizations, agencies, and centers described in section 104(a) to pay part or all of the cost of installation of improved utilization review, budget, statistical, or records and information retrieval systems, including the acquisition of equipment therefor, or to pay part or all of the cost of acquisition and installation of diagnostic or therapeutic equipment.

LOANS UNDER PART F

SEC. 107. (a) Loans authorized under this part shall be repayable in not more than twenty years, shall bear interest at the rate of 3 per centum per annum, and (subject to the provisions of subsection (b)) shall be made on such other terms and conditions as the Board deems appropriate. Amounts paid as interest on any such loan or as repayment of principal shall, if the loan was made

from funds appropriated pursuant to section 101(b), be covered into the Treasury as miscellaneous receipts, and if the loan was made from funds in the Health Resources Development Account, be deposited in the Trust Fund to the credit of that account.

(b) No loan for the construction or improvement of a facility shall be made under this part unless the borrower undertakes that all laborers and mechanics employed by contractors or subcontractors in the performance of construction or improvement on the project will be paid wages not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act (40 U.S.C. 276a–276a-5). The Secretary of Labor shall have with respect to the labor standards specified in this subsection the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix 133z–15) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

RELATIONS OF PARTS E AND F

SEC. 108. Payments under this part pursuant to any grant or loan to, or any contract with, a participating provider of services shall be made in addition to, and not in substitution for, payments to which the provider is entitled under part E.

PART G—ADMINISTRATION

ESTABLISHMENT OF THE HEALTH SECURITY BOARD

SEC. 121. (a) There is hereby established in the Department of Health, Education, and Welfare a Health Security Board to be composed of five members to be appointed by the President, by and with the advice and consent of the Senate. During his term of membership on the Board, no member shall engage in any other business, vocation, or employment. Not more than three members of the Board shall be members of the same political party.

(b) Each member of the Board shall hold office for a term of five years, except that (1) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of one, two, three, four, and five years, respectively, after the date of enactment of this Act. A member who has served for two consecutive five-year terms shall not be eligible for reappointment until two years after he has ceased to serve.

(c) The President shall designate one of the members of the Board to serve, at the will of the President, as Chairman of the Board.

DUTIES OF THE SECRETARY AND THE BOARD

SEC. 122. (a) The Secretary of Health, Education, and Welfare, and the Board under the supervision and direction of the Secretary, shall perform the duties imposed upon them, respectively, by this title. Regulations authorized by this title shall be issued by the Board with the approval of the Secretary, in accordance with the provisions of section 553 of title 5, United States Code (relating to the publication of, and opportunity to comment on, proposed regulations).

(b) The Board shall have the duty of continuous study of the operation of this Act and of the most effective methods of providing comprehensive personal health services to all persons within the United States and to United States citizens elsewhere, and of making, with the approval of the Secretary, recommendations on legislation and matters of administrative policy with respect thereto. The Board shall make, through the Secretary, an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to the effective date of health benefits, an evaluation by the Board of progress in preparing for the initiation of benefits under this title, and for periods thereafter, an evaluation of the operation of the title, of the adequacy and quality of services furnished under it, and of the costs of the services and the effectiveness of measures to restrain the costs.

(c) In performing his functions with respect to health manpower, education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, as well as in supervising and directing the administration of this title by the Board, the Secretary shall direct all activities of the Department toward mutually complementary contributions to the health of the people. He shall include in his annual report to the Congress a report on his discharge of this responsibility.

(d) The Secretary shall make available to the Board all information available to him, from sources within the Department or from other sources, pertaining to the functions of the Board.

(e) The Civil Service Commission, in consultation with the Board, shall to the greatest extent practicable facilitate recruitment, for employment by the Board in the competitive service, of qualified persons experienced in the administration or operation of private health insurance and health prepayment plans, or experienced in other fields pertinent to the administration of this title.

EXECUTIVE DIRECTOR: DELEGATION OF AUTHORITY

SEC. 123. (a) There is hereby established the position of Executive Director of the Health Security Board. The Executive Director shall be appointed by the Board with the approval of the Secretary, and shall serve as secretary to the Board and perform such duties in the administration of this title as the Board may assign to him.

(b) The Board is authorized to delegate to the Executive Director or to any other officer or employee of the Board or, with the approval of the Secretary (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department, any of its functions or duties under this title other than (1) the issuance of regulations, or (2) the determination of the availability of funds and their allocation, under sections 62, 63, or 64.

REGIONS AND HEALTH SERVICE AREAS

SEC. 124. (a) This title shall be administered by the Board through the regions of the Department (as they may be established from time to time) and, within each region, through such health service areas as the Board may establish. Each health service area shall consist of a State or a part of a State, except as the Board finds that patterns of the organization of health services and of the flow of patients make an interstate area a more practical unit of administration.

(b) The Board shall establish in each local health service area a local health security office and such branch offices as the Board may find necessary. The local offices and branch offices, in addition to such informational and other administrative duties as the Board may assign them, shall have the function of receiving and investigating complaints by eligible persons and by providers of services concerning the administration of this title and of taking or recommending appropriate corrective action.

NATIONAL HEALTH SECURITY ADVISORY COUNCIL

SEC. 125. (a) There is hereby established a National Health Security Advisory Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and twenty members, not otherwise in the employ of the United States, appointed by the Secretary on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall include persons who are representative of providers of health services, and of persons (who shall constitute a majority of the Council) who are representative of consumers of such services. Each appointed member shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of the members first taking office shall expire, as designated by the Secretary at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and five at the end of the fourth year after the date of enactment of this Act. Members of the Council who are representative of providers of health care shall be persons who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health personnel; members who are representative of consumers of such care shall be persons, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the furnishing of such services.

(b) The Advisory Council is authorized to appoint such professional or technical committees, from its own members or from other persons or both, as may be useful in carrying out its functions. The Council, its members, and its committees shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions. The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request by seven or more members it shall be the duty of the Chairman to call a meeting of the Council.

(c) It shall be the function of the Advisory Council (1) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations, and in the performance of the Board's functions under part D, and (2) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the title or in its provisions which may appear desirable. The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board, through the Secretary, shall promptly transmit the report to the Congress, together with a report by the Board on any administrative recommendations of the Council which have not been followed, and a report by the Secretary of his views with respect to any legislative recommendations of the Council.

(d) Appointed members of the Advisory Council and members of technical or professional committees, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Board, but not exceeding $100 per day; and shall be entitled to receive actual and necessary traveling expenses and per diem in lieu of subsistence while so serving away from their places of residence.

REGIONAL AND LOCAL ADVISORY COUNCILS

SEC. 126. (a) The Board shall appoint for each of the regions of the Department and for each health service area a regional or local advisory council, consisting of the regional or local representative of the Board as chairman and (in such numbers as the Board may determine) representatives of providers

of health services and representatives (who shall constitute a majority of the members of each council) of consumers of such services. It shall be the function of each such council to advise the regional or local representative of the Board, as the case may be, on all matters directly relating to the administration of this title in the region or area, including methods and procedures followed in the handling of complaints.

(b) The provisions of section 125(d) shall be applicable to the members of councils appointed under this section.

PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEES

SEC. 127. (a) The Board shall appoint such standing professional and technical committees as it deems necessary to advise it on the administration of this title with respect to the several classes of covered services described in part B. Each such committee shall consist of experts (in such number as the Board may determine) drawn from the health professions, from medical schools or other health educational institutions, from providers of services, or from other sources, whom the Board deems best qualified to advise it with respect to the professional and technical aspects of the furnishing and utilization of, the payment for, and the evaluation of, a class of covered services designated by the Board, and with respect to the relationship of that class of services to other covered services.

(b) The Board is authorized to appoint such temporary professional and technical committees as it deems necessary to advise it on special problems not encompassed in the assignments of standing committees appointed under subsection (a), or to supplement the advice of standing committees.

(c) Committees appointed under this section shall report from time to time to the Board, and copies of their reports shall be transmitted by the Board to the National Advisory Council.

(d) The provisions of section 125(d) shall be applicable to the members of committees appointed under this section.

PARTICIPATION BY STATE AGENCIES

SEC. 128. (a) The Board shall (in addition to the consultation with State planning agencies required by section 102) consult from time to time with State health agencies or other appropriate State agencies in preparing for and in administering health security benefits, with a view to coordinating the administration of this title with State and local activities in the fields of environmental health, licensure and inspection, education for the health professions and other health careers, and other fields relating to health. Insofar as practicable, the Board shall conduct such consultation through the regional offices of the Department.

(b) The Board shall make an agreement with any State which is able and willing to do so under which the State health agency or other appropriate State agency will be utilized by the Board in determining whether providers of services meet or continue to meet the qualifications and conditions established by or pursuant to part C. Such an agreement shall fix the frequency of inspection of the several classes of providers, other than professional practitioners, and shall establish the qualifications required of persons making the inspections. Determinations by State agencies based upon inspections made in accordance with such agreements, and determinations with respect to professional practitioners, may be given by the Board the same effect as determinations by the Board.

(c) An agreement under subsection (b) may provide that a State agency, either directly or through local public agencies, will undertake activities specified in the agreement, directed to the health education of the residents of the State, the maintenance and improvement of the quality of covered services furnished in the State, the maintenance of effective utilization review, or the better coordination of services of different kinds.

(d) The Board shall pay to a State, in advance or otherwise as specified in the agreement, the reasonable cost of services and activities pursuant to an agreement under subsection (b) or (c); and may pay a part or all of the cost of training (or may train) State personnel to enable them to meet the qualifications established by the Board for inspectors.

TECHNICAL ASSISTANCE TO SKILLED NURSING HOMES AND HOME HEALTH SERVICE AGENCIES

SEC. 129. The Board is authorized, either directly or through agreements with State agencies under Section 128, to provide technical assistance to skilled nursing homes and home health service agencies to supplement, in regard to social services, dietetics, and other matters, the skills of the groups referred to in section 45(b) and 46(b).

DISSEMINATION OF INFORMATION; STUDIES AND EVALUATIONS; SYSTEMS DEVELOPMENT

SEC. 130. (a) The Board shall disseminate, to providers of services and to the public, information concerning the provisions of this title, the persons eligible to receive the benefits of the title, and the nature, scope, and availability of covered services; and to providers of services, information concerning the conditions of participation, methods and amounts of compensation to providers, and other matters relating to their participation. With the approval of the Secretary, the Board may furnish to all professional practitioners information concerning the safety and efficacy of drugs appearing on either of the lists established under section 25, the indications for their use, and contraindications.

(b) The Board shall make, on a continuing basis after the effective date of health security benefits, a study and evaluation of the operations of this title in all its aspects, including study and evaluation of the adequacy and quality of services furnished under the title, analysis of the cost of each kind of services, and evaluation of the effectiveness of measures to restrain the costs.

(c) The Board is authorized, either directly or by contract—

(1) to make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this title, including studies of the effect of the title upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(2) to develop and test methods of providing, through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy and quality; methods of peer review and peer control of the utilization of drugs, of laboratory services, and of other services not subject to utilization review under section 51; and methods of peer review of the quality of services;

(3) to develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(4) to develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of health services, and equipment (such as equipment for the monitoring of patients' functions, or for multiphasic screening) useful in the furnishing of preventive or diagnostic services;

(5) to develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(6) to make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this title.

EXPERIMENTS AND DEMONSTRATIONS

SEC. 131. The Board is authorized, pursuant to agreement with providers of services, to undertake experiments for the purpose of developing and testing alternative methods of compensating providers (in lieu of the methods otherwise prescribed by this title) which offer promise, through financial incentives or otherwise, of improving the coordination of services, improving their quality or their accessibility, or decreasing their cost; and to undertake demonstrations of the results of such experiments. Any such experiment or demonstration with respect to independent professional practitioners shall be undertaken only in the manner specified in section 82(h).

DETERMINATIONS; SUSPENSION OR TERMINATION OF PARTICIPATION

SEC. 132. (a) Determinations of entitlement to benefits under this title, determinations of who are participating providers of services, determinations whether services are covered services, and determinations of amounts to be paid by the Board to participating providers, shall be made by the Board in accordance with regulations. A provider or other person aggrieved by a determination under this subsection shall, in such cases and on such conditions as are specified in regulations, be entitled to an administrative appeal from it.

(b) If the Board finds that a participating provider of services no longer meets the qualifications established by or pursuant to part C for services of the kinds furnished by him, or for some classes of such services, or that he has intentionally violated the provisions of this title or of regulations, or that he has failed substantially to carry out the agreement filed by him pursuant to section 41(c), the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the provider, or suspending or terminating it with respect to particular classes of services.

(c) If the Board has reason to believe that a participating professional practitioner, or a professional practitioner furnishing covered services on behalf of an institutional or other participating provider, has in a substantial number of cases—

(1) furnished professional services, or caused the furnishing of institutional or other services, which were not medically necessary but for which payment was claimed under this title;

(2) furnished to eligible persons covered services which were not of a quality meeting professionally recognized standards of care; or

(3) neglected to furnish necessary services to eligible persons who were his patients, under circumstances such that the neglect constituted a breach of his professional obligation;

or has reason to believe that a participating provider other than a professional practitioner has in a substantial number of cases—

(4) furnished services, for which payment was claimed under this title, known to the provider not to have been medically necessary; or

(5) furnished to eligible persons covered services which were not of a quality meeting professionally recognized standards of care; the Board shall submit the evidence in its possession either to an appropriate professional organization or to a committee constituted by the Board after consultation with such an organization (which committee may, when the Board deems it proper, include nonprofessional persons). The Board shall re-

quest the organization or committee, with or without further investigation, to recommend what action, if any, should be taken by the Board. Taking into consideration any recommendation so made to it, the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the practitioner or other provider or, in the case of a practitioner furnishing services on behalf of another provider, requiring the other provider, as a condition of continued participation, to suspend or discontinue (absolutely or on conditions) the furnishing of covered services by the practitioner.

(d) The Board shall, either in advance or by way of reimbursement, pay to an organization or committee making a recommendation under subsection (c) its reasonable cost incurred in so doing.

(e) No determination under subsection (a) that a person, previously determined to be eligible for benefits, is not eligible therefor, and (unless the Board finds that eligible persons are endangered) no order under subsection (b) or (c), shall be effective until after the person or provider has been afforded a hearing under section 133 or an opportunity therefor.

HEARINGS: JUDICIAL REVIEW

SEC. 133. (a) A provider of services or other person who is dissatisfied with a determination made or an order issued under section 132 shall, upon request therefor filed in accordance with regulations, be entitled to a hearing before a hearing officer or a hearing panel of the Board. The hearing shall be held as promptly as possible and at a place convenient to the provider or other person requesting the hearing. For the purpose of reviewing the determinations of hearing officers or panels, the Board shall establish a national appeals tribunal and may establish regional or other intermediate appeals tribunals, and shall by regulation prescribe the jurisdiction of such tribunal or tribunals. Decisions of hearing officers or hearing panels shall, subject to appeals under this subsection, constitute final decisions of the Board.

(b) In any case in which the Board finds (on the basis of the request for hearing and the records of the Board) that a substantial issue of professional practice or conduct, in a health profession specified for this purpose in regulations, will be involved in the hearing, the hearing shall be held either before a person who is qualified in an appropriate health profession or before a panel which includes a person or persons so qualified, and an appeal in such a case shall be heard before an appellate tribunal (or a panel thereof) which includes a person or persons so qualified. In any case in which a single person qualified as a health professional, or a panel composed entirely of persons so qualified, conducts a hearing or hears an appeal, the Board shall assign an attorney to assist in the conduct of the hearing or the appeal and to advise upon the decision of issues of law.

(c)(1) Any provider of services or other person, after any final decision of the Board made after a hearing to which he was a party irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Board may allow. Such action shall be brought in the district court of the United States, for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia. As part of its answer the Board shall file a certified copy of the transcript of the record, including the evidence upon which the findings and decisions complained of are based.

(2) The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Board, with or without remanding the cause for a rehearing. The findings of the Board as to any fact, if supported by substantial evidence, shall be conclusive.

(3) Where a claim has been denied by the Board, or a decision is rendered which is adverse to a provider or other person who was a party to the hearing before the Board, because of failure of the claimant or such provider or other person to submit proof in conformity with any regulation prescribed by the Board, the court shall review only the question of conformity with the regulation and the validity of the regulation. The court shall not review a finding by the Board under subsection (b), or a refusal to find, that a substantial issue of professional practice or conduct will be involved in a hearing.

(4) The court shall, on motion of the Board made before it files its answer, remand the case to the Board for further action by the Board, and may, at any time on good cause shown, order additional evidence to be taken before the Board. The Board shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm its findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision and a transcript of the additional record and testimony. Such additional or modified findings of fact and decision shall be reviewable only to the same extent as the original findings of fact and decision.

(5) The judgment of the court shall be final except that it shall be subject to review in the same manner as judgments in other civil actions.

DIRECTIONS BY THE BOARD FOR THE BETTER ORGANIZATION AND COORDINATION OF SERVICES

SEC. 134.(a) The Board is authorized, in accordance with this section, to issue to any participating provider of services (other than an individual professional provider) a direction that the provider shall—

(1) discontinue (for purposes of payment under part E) one or more services which the provider is currently furnishing;

(2) initiate one or more covered services which the provider is not currently furnishing;

(3) initiate the furnishing of one or more covered services at a place where the provider is not currently furnishing the services; or

(4) enter into arrangements with one or more other providers of services (A) for the transfer of patients and medical records as may be medically appropriate, (B) for making available to one provider the professional and technical skills of another, or (C) for such other coordination or linkage of covered services as the Board finds will best serve the purposes of this title.

A direction under this subsection shall specify a future date on which, if the direction has not been complied with, the provider to whom it is addressed shall cease to be a participating provider.

(b) If the Board finds (1) that the services furnished by a provider of services (other than an individual professional provider) are not necessary to the availability of adequate services under this title and that their continuance as covered services is unreasonably costly, or (2) that the services are furnished inefficiently and at unreasonable cost, that efforts at correction have proved unavailing, and that necessary services can be more efficiently furnished by other providers, the Board may issue a direction that on a specified future date the provider shall cease to be a participating provider.

(c) No direction shall be issued under this section except on the recommendation of, or after consultation with, the State health planning agency (referred to in section 102(a)) of the State in which the direction will be operative. No direction shall be issued under subsection (a) unless the Board finds that it can practicably be carried out by the provider to whom it is addressed.

(d) (1) No direction shall be issued under this section until the Board has published notice, in the service area of the provider or providers affected, describing in general terms the proposed action, giving a brief statement of the reasons therefor, and inviting written comment thereon. The notice shall be published in at least one newspaper circulating in the area, and the Board shall use such other means as it finds calculated to inform residents of the area of the proposed action.

(2) If objection to the proposal is made by any interested provider of services (other than an individual professional practitioner) or by an interested health planning agency or by a substantial number of interested professional practitioners or of residents of the area, the Board shall call a public hearing before a hearing officer or hearing panel meeting the requirements of section 133 (b). At the hearing the Board shall present evidence in support of the proposal, and any interested provider of services or health planning agency or any other interested person shall be entitled to participate in the hearing and to present evidence or argument or both. On the basis of evidence presented at the hearing the hearing officer or hearing panel shall make recommended findings of fact and a recommended determination either to issue the proposed direction, to modify and issue it, or to withdraw the proposal. The final determination shall be made by the Board or by a special panel designed by it for the purpose, and shall be subject to judicial review in accordance with section 133 (c).

DEPUTY SECRETARY OF HEALTH, EDUCATION, AND WELFARE; UNDER SECRETARY FOR HEALTH AND SCIENCE; SALARY LEVELS

SEC. 135. (a) There shall be in the Department of Health, Education, and Welfare in addition to the Assistant Secretaries now provided for by law, a Deputy Secretary of Health, Education, and Welfare and an Under Secretary for Health and Science each of whom shall be appointed by the President, by and with the advice and consent of the Senate, and shall perform such functions (related to health and science in the case of such Under Secretary) as the Secretary may prescribe. The provisions of the second sentence of section 2 of Reorganization Plan Numbered 1 of 1953 shall be applicable to such Deputy Secretary to the same extent as they are applicable to the Under Secretary of Health, Education, and Welfare and shall be applicable to the Under Secretary for Health and Science to the same extent as they are applicable to the Assistant Secretaries authorized by that section.

(b)(1) Section 5313, title 5, United States Code (relating to executive pay rates for positions at level II) is amended by inserting after clause (19) the following new clause:

"(20) Deputy Secretary of Health, Education, and Welfare."

(2) Section 5314, title 5, United States Code (relating to executive pay rates for positions at level III), is amended by striking out clause (7) and inserting in lieu thereof:

"(7) Under Secretary for Health and Science, Department of Health, Education, and Welfare,";

and by adding at the end thereof the following new clause:

"(54) Chairman, Health Security Board, Department of Health, Education, and Welfare."

(3) Section 5315, title 5, United States Code (relating to executive pay rates for positions at level IV), is amended by adding at the end thereof the following new clause:

"(94) Members (other than the Chairman), Health Security Board, Department of Health, Education, and Welfare."

(4) Section 5316, Title 5, U.S. Code (relating to executive pay rates for positions at level V) is amended by adding at the end thereof the following clause:

"(130) Executive Director, Health Security Board, Department of Health, Education, and Welfare."

(c)(1) The office of Under Secretary of Health, Education, and Welfare, created by section 2 of Reorganization Plan Numbered 1 of 1953 (67 Stat. 631), is hereby abolished.

(2) The President may authorize the person who immediately prior to the date of enactment of this Act occupies the office of Under Secretary of Health, Education, and Welfare to act as Deputy Secretary of Health, Education, and Welfare until that office is filled by appointment in the manner provided by subsection (a) of this section. While so acting, such person shall receive compensation at the rate now or hereafter provided by law for the Deputy Secretary of Health, Education, and Welfare.

PART H—MISCELLANEOUS PROVISIONS

DEFINITIONS

SEC. 141. When used in this title—

(a) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(b) The term "United States" when used in a geographical sense means the States, as defined in subsection (a).

(c) The term "Secretary", except when the context otherwise requires, means the Secretary of Health, Education, and Welfare.

(d) The term "Department", except when the context otherwise requires, means the Department of Health, Education, and Welfare.

(e) The term "Board" means the Health Security Board established by section 121.

EFFECTIVE DATES OF TITLE I

SEC. 142. The effective date of health benefits under this title shall be July 1 of the second calendar year after the year in which this title is enacted, and no service or item furnished prior to that date shall constitute a covered service. Part D shall be effective with respect to fiscal years beginning on or after the effective date, except that action pursuant to section 201(g) and section 1817 (h) of the Social Security Act, as amended by section 61 of this Act, to make funds available on and after the effective date, is authorized to be taken by the Congress prior to that date. In all other respects this title is effective upon enactment.

EXISTING EMPLOYER-EMPLOYEE HEALTH BENEFIT PLANS UNAFFECTED

SEC. 143. (a) No provision of this Act, and no amendment of the Internal Revenue Code of 1954 made by this Act, shall affect or alter any contractual or other nonstatutory obligation of an employer to provide health services to his present and former employees and their dependents, or to any of such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the cost of such services.

(b) If notwithstanding subsection (a) the availability, on or after the effective date, of benefits under this title shall result in a diminution in the cost to an employer of his aggregate obligations (including his liability for taxes imposed by section 3111(b) of the Internal Revenue Code of 1954, as well as any contractual or other undertaking to pay the taxes imposed on his employees by section 3101(b) of the Code) to provide or pay for health services to persons referred to in subsection (a), it is the sense of the Congress that, at least to the extent of such diminution in costs, and at least for the duration of any nonstatutory obligation to provide or pay for health services subsisting immediately prior to the effective date, equity and fair dealing require the employer to undertake an equivalent cost, either by paying without deduction from their remuneration part or all of the taxes imposed by section 3101(b) of the Code on his employees, or by increasing their remuneration, or by providing other benefits to them, or by a combination of these methods, as may be agreed between the employer and his employees or their representatives.

TITLE II—HEALTH SECURITY TAXES

PART A—PAYROLL TAXES

RATES AND COVERAGE

SEC. 201. (a) Section 3101(b) of the Internal Revenue Code of 1954 (imposing a hospital insurance tax on employees) is amended to read as follows:

"(b) HEALTH SECURITY TAX.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 1 percent of the wages (as defined in section 3121(r)) received by him on or after the effective date of health security taxes (as defined in section 3121(u)) with respect to employment (as defined in section 3121(s))."

(b) Section 3111(b) of such Code (imposing a hospital insurance tax on employers) is amended to read as follows:

"(b) HEALTH SECURITY TAX.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 3.5 percent of the wages (as defined in section 3121(r)) paid by him on or after the effective date of health security taxes (as defined in section 3121(u)) with respect to employment (as defined in section 3121(s))."

(c) Section 3121 of such Code (containing definitions applicable to social security payroll taxes) is amended by adding at the end thereof the following subsections:

(r) WAGE BASE FOR PURPOSES OF HEALTH SECURITY TAXES.—For the purpose of section 3101(b), the term "wages" shall have the meaning set forth in subsection (a) of this section except that in applying paragraph (1) of that subsection the term "health security contribution base (as defined in subsection (t))" shall be substituted for the figure "$7,800" each place it appears therein. For the purpose of section 31111(b), "wages" shall have the meaning set forth in subsection (a) of this section except that paragraph (1) of that subsection shall not be applied.

"(s) EMPLOYMENT FOR PURPOSES OF HEALTH SECURITY TAXES.—For the purposes of sections 3101(b) and 3111(b), the term 'employment' shall have the meaning set forth in subsection (b) of this section except that—

"(1) the exclusions contained in the following paragraphs of subsection (b) shall not be applied: paragraph (1) (relating to foreign agricultural workers), paragraphs (5) and (6) (relating to employment by the United States or its instrumentalities) other than paragraph (6)(C)(i) (relating to the President, the Vice President, and Members of Congress) and paragraph (6)(C)(iii) through (v) (relating to certain minor employments), paragraph (8) (relating to employment by charitable and similar organizations), paragraph (9) (relating to employment covered by the railroad retirement system), and paragraph (17) (relating to employment by subversive organizations),

"(2) subsection (m) of this section (including services by members of the uniformed services in the term 'employment') shall not be applied, and

"(3) for the purposes of section 3101(b), the exclusion contained in paragraph (7) of subsection (b) of this section (relating to employment by States and their political subdivisions and instrumentalities) shall not be applied, other than paragraph (7)(C)(i) through (iv) (relating to certain minor employments by the District of Columbia).

"(t) HEALTH SECURITY CONTRIBUTION BASE.—

"(1) For each calendar year the term 'health security contribution base' means $15,000, unless for that year the Secretary has determined and published a contribution base pursuant to this subsection.

"(2) On or before November 1 of the second year after the calendar year in which occurs the effective date of health security taxes (as defined in subsection (u)), and at two-year intervals thereafter, the Secretary shall determine and publish in the Federal Register the health security contribution base for the first two calendar years following the year in which the determination is made.

"(3) The health security contribution base for a particular calendar year shall be whichever of the following is the larger:

"(A) the product of $15,000 and the ratio of (i) the average of the wages, taxable under section 3101(b), of all persons for whom such wages were reported to the Secretary for the first quarter of the calendar year in which a determination under paragraph (2) is made, to (ii) the average of the wages, taxable under that section, of all persons for whom wages were reported to the Secretary for the calendar quarter commencing on the effective date of health security taxes, but with such product (if it is not a multiple of $600) being rounded to the nearest multiple of $600 (or, if it is a multiple of $300 but not of $600, to the next higher multiple of $600); or

"(B) the health security contribution base for the calendar year immediately preceding such particular calendar year."

"(u) EFFECTIVE DATE OF HEALTH SECURITY TAXES.—The term 'effective date of health security taxes' means January 1 of the second calendar year after the year in which the Health Security Act is enacted."

CONFORMING AND TECHNICAL AMENDMENTS

SEC. 202. (a) Section 3121(1) of the Internal Revenue Code of 1954 (relating to coverage of services performed in the employ of foreign subsidiaries of domestic corporations) is amended by striking out "sections 3101 and 3111" in paragraph (1)(A) and inserting in lieu thereof "sections 3101(a) and 3111(a)", and by inserting at the end of the subsection the following paragraph:

"(11) Notwithstanding the provision of any agreement entered into under this subsection, no domestic corporation shall be under any obligation to pay to the Secretary, with respect to services covered under the agreement and performed on or after the effective date of health security taxes (as defined in subsection (u) of this section) amounts equivalent to the taxes which would be imposed by sections 3101(b) and 3111(b) if such services constituted employment as defined in subsection (b)."

(b) Sections 3122 and 3125 of such Code are amended by striking out "section 3111" wherever it appears and inserting in lieu thereof "section 3111(a)".

(c)(1) Section 3201 (relating to tax on railroad employees) and section 3211 (relating to tax employee representatives) of such Code are each amended by striking out "plus the rate imposed by section 3101(b)".

(2) Section 3221(b) of such Code (relating to tax on railroad employers) is amended by striking out "plus the rate imposed by section 3111(b)".

(d)(1) Section 6413(c)(1)(D) of such Code is amended by inserting "(i)" immediately after "(D)", by striking out "section 3101" and inserting "section 3101(a)" in lieu thereof, and by inserting immediately before

the period at the end thereof: "; and (ii) during any calendar year beginning on or after the effective date of health security taxes (as defined in section 3121(u)) the wages received by him during such year exceed the health security contribution base (as defined in section 3121(t)) for that year, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101(b) and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to an amount of such wages received in such calendar year equal to the health security contribution base for such year."

(2) Section 6413(c)(2)(A) of such Code is amended by inserting immediately after "any calendar year after 1967," the following: "or (with respect to the tax imposed by section 3101(b)) the health security contribution base for any calendar year beginning on or after the effective date of health security taxes,".

(e) Section 218 of the Social Security Act (relating to agreements for the coverage of services performed in the employ of States and their political subdivisions and instrumentalities) is amended—

(1)(A) by striking out, in subsection (e)(1)(A), "sections 3101 and 3111" and "section 3121" and inserting in lieu thereof, "sections 3101(a) and 3111(a)" and "section 3121(b)", respectively;

(B) by striking out, in subsection (e)(2)(B), "section 3111" and inserting in lieu thereof, "section 3111 (a)"; and

(C) by adding at the end of subsection (e) the following paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section, no State shall be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed on or after the effective date of health security taxes (as defined in section 3121(u) of the Internal Revenue Code of 1954), amounts equivalent to the taxes which would be imposed by sections 3101(b) and 3111(b) of such code if such service constituted employment as defined in section 3121 of such code."; and

(2) by striking out in subsection (h)(1), "and the Federal Hospital Insurance Trust Fund", and striking out in such subsection "subsection (a)(3) of section 201, subsection (b)(1) of such section, and subsection (a)(1) of section 1817, respectively" and inserting in lieu thereof "subsections (a)(3) and (b)(1) of section 201".

EXCLUSION FROM GROSS INCOME

SEC. 203. (a) Section 106 of the Internal Revenue Code of 1954 (excluding from gross income employer contributions to accident and health plans for their employees) is amended by inserting immediately before the period at the end thereof: ", and payments by the employer (without deduction from the remuneration of the employees) of the tax imposed upon his employees by section 3101(b)".

(b) The heading of section 106, and the line referring to that section in the table of contents in subtitle A, chapter 1, subchapter B, part III of such code, are each amended by adding at the end: "and employer payment of health security taxes".

EFFECTIVE DATES OF PART A

SEC. 204. The amendments made by section 201 of this Act, and the amendments made by subsections (b) and (d) of section 202, shall be effective only with respect to remuneration received, and remuneration paid, on or after the effective date of health security taxes (as defined by section 3121(u) of the Internal Revenue Code of 1954, added by section 201(c) of this Act), and section 3121(s) of such Code shall be applicable only with respect to remuneration for services performed on or after that date. The amendments made by subsections (a), (c), and (e) of section 202 shall be effective only with respect to remuneration for services performed on or after such effective date. The amendments made by section 203 shall apply to taxable years beginning on or after such effective date.

PART B—TAXES ON SELF-EMPLOYMENT INCOME AND UNEARNED INCOME

TAX ON SELF-EMPLOYMENT INCOME

SEC. 211. (a) Section 1401(b) of the Internal Revenue Code of 1954 (imposing a hospital insurance tax on self-employed individuals) is amended to read as follows:

"(b) HEALTH SECURITY TAX.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.5 percent of the self-employment income for such taxable year."

(b) Section 1402(b) of such Code (defining self-employment income) is amended—

(1) by striking out "except that such term shall not include—" and inserting in lieu thereof "except that—", and by amending so much of clause (1) as precedes paragraph (A) to read as follows:

"(1) for the purposes of section 1401(a), such term shall not include that part of the net earnings from self-employment which is in excess of —";

(2) by striking out "or" at the end of clause (1) and inserting "and" in lieu thereof, and by striking out clause (2) and inserting in lieu thereof the following:

"(2) for the purposes of section 1401(b), such term shall not include that part of the net earnings from self-employment which is in excess of (A) the amount of the health security contribution base (as defined in section 3121(t)) for the calendar year in which the taxable year begins, minus (B) the amount of wages paid to such individual during the taxable year; and

"(3) for the purposes of both section 1401(a) and section 1401(b), such term shall not include any net earnings from self-employment if such net earnings for the taxable year are less than $400.";

(3) by striking out "For purposes of clause (1), the term 'wage' (A) includes" and inserting in lieu thereof: "For purposes of clause (1), the term 'wages' means wages as defined in section 3121(a), except that it includes"; and

(4) by changing the comma following the term "section 3121(b)" to a period and striking out the remainder of the sentence in which such term appears, and inserting immediately after that sentence the following sentence: "For purposes of clause (2), the term 'wages' means wages as defined in section 3121(r) with respect to section 3101(b)."

(c) Section 1402(d) of the Code is amended by striking out "and the term 'wages'" and inserting in lieu thereof, "and (except as otherwise provided in subsection (b) of this section) the term 'wages'".

TAX ON HEALTH SECURITY UNEARNED INCOME

SEC. 212. Section 1403 of the Internal Revenue Code of 1954 is redesignated as section 1404, and the following new section is inserted immediately after section 1402:

"SEC. 1403. TAX ON HEALTH SECURITY UNEARNED INCOME

"(a) IMPOSITION OF TAX.—In addition to other taxes, there shall be imposed for each taxable year beginning on or after the effective date of health security taxes (as defined in section 3121(u)), on the income of every individual residing in the United States whose health security unearned income (as defined in subsection (b) of this section) for the taxable year is $400 or more, a tax equal to 1 percent of the amount of such health security unearned income for such taxable year.

"(b) DEFINITION OF HEALTH SECURITY UNEARNED INCOME.—The term 'health security unearned income' means an amount determined by deducting from the adjusted gross income of an individual for the taxable year any part of such income (whether from wages or any other source) in excess of the amount of the health security contribution base (as defined in section 3121(t)) for the calendar year in which such taxable year begins, and deducting from the remainder any part of the adjusted gross income which—

"(1) consists of wages taxable under section 3101 (b), or

"(2) consists of self-employment income taxable under section 1404 (b), or

"(3) consists of remuneration for services performed in the employ of the United States as President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress, or as a member of a uniformed service on active duty, or

"(4) consists of remuneration (not taxable under section 3101 (b)) for service performed by an alien in the employ of a foreign government, an instrumentality of a foreign government, or an international organization, or

"(5) consists of payments excluded by section 3121 (a) (6) from wages taxable under section 3101 (b)."

CONFORMING AND TECHNICAL AMENDMENTS

SEC. 213. (a) The heading and table of contents of chapter 2 of subtitle A of the Internal Revenue Code of 1954 are amended to read as follows:

"Chapter 2—TAXES ON SELF-EMPLOYMENT INCOME AND HEALTH SECURITY UNEARNED INCOME

"Sec. 1401. Rates of tax on self-employment income.

"Sec. 1402. Definitions relating to self-employment income.

"Sec. 1403. Tax on health security unearned income.

"Sec. 1404. Miscellaneous provisions."

(b) Section 1401 of the Code, as amended by section 211 (a) of this Act, is further amended by striking out the heading of the section and inserting in lieu thereof,

"SEC. 1401. RATES OF TAX ON SELF-EMPLOYMENT INCOME."

(c) Section 1404 of the Code (as redesignated by section 212 of this Act) is amended by striking out "'Self-Employment Contributions Act of 1954'" and inserting in lieu thereof, "'Self-Employment and Health Security Contributions Act'".

(d) Section 6015 of the Code (relating to declarations of estimated income by individuals) is amended by striking out in subsection (c)(2) "the amount of the self-employment tax imposed by chapter 2" and inserting in lieu thereof "the amount of the taxes imposed by chapter 2".

(e) Section 6017 of the Code is amended—

(1) by striking out the heading of the section and inserting in lieu thereof,

"SEC. 6017. SELF-EMPLOYMENT AND HEALTH SECURITY TAX RETURNS.";

(2) by inserting, immediately after the first sentence of the section, the following sentence: "Every individual residing in the United States and having health security unearned income of $400 or more for the taxable year shall make a return with respect to the health security unearned income tax imposed by chapter 2."; and

(3) by striking out "the tax" in the sentence immediately following the insertion made by paragraph (2), and inserting in lieu thereof, "the taxes", and by inserting immediately before the period at the end of that sentence, ", or on the separate health security unearned income of each spouse, as the case may be".

EFFECTIVE DATES OF PART B

SEC. 214. The amendments made by section 211, 212, and section 213 (d) and (e) (other than section 213(e)(1)) shall be effective

with respect to taxable years beginning on or after the effective date of health security taxes (as defined by section 3121(u) of the Internal Revenue Code of 1954, added by section 201(c) of this Act.) The amendments made by section 213(a), (b), (c) and (e)(1) shall be effective on such effective date.

TITLE III—REPEAL OR AMENDMENT OF OTHER ACTS, REPEAL OF MEDICARE AND FEDERAL EMPLOYEE HEALTH BENEFIT STATUTES

SEC. 301. (a) Effective on the effective date of health security benefits (set forth in section 142)—

(1) Title XVIII of the Social Security Act, except section 1817 thereof, is repealed.

(2) The Act of September 28, 1959 (5 U.S.C., ch. 89) and Public Law 86-724 are repealed.

(b) Subsection (a) shall not affect any right or obligation arising out of any matter occurring before the effective date of health security benefits or any administrative or judicial proceeding (whether or not initiated before that date for the adjudication or enforcement of any such right or obligation.

MEDICAID STATUTE

SEC. 302. After the effective date of health security benefits no State (as defined in section 1101(a)(1) of the Social Security Act) shall be required, as a condition of approval of its State plan under title XIX of that Act, to furnish any service which constitutes a covered service under title I of this Act, and any amount expended for the furnishing of any such service to a person eligible for services under title I of this Act shall be disregarded in determining the amount of any payment to a State under such title XIX. The Secretary of Health, Education, and Welfare shall by regulation prescribe the minimum scope of services required (in lieu of the requirements of section 1902(a)(13) of the Social Security Act) as a condition of approval, after the effective date of health security benefits, of a State plan under such title XIX. Such minimum scope of services shall, to the extent the Secretary finds practicable, be designed to supplement the benefits available under title I of this Act, with respect to the duration of skilled nursing home services during a benefit period and with respect to the furnishing of dental services and of drugs (appearing on the list established under section 25(b) of this Act) to persons not entitled to such services, or not entitled to such drugs, under title I of this Act.

VOCATIONAL REHABILITATION ACT; MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SEC. 303. Funds made available under the Vocational Rehabilitation Act or under title V of the Social Security Act shall not be used, after the effective date of health security benefits, to pay for personal health services available under title I of this Act; but they may, in accordance with regulations of the Secretary of Health, Education, and Welfare, be used (a) to pay for institutional services which are either more extensive or more intensive than the services recognized in institutional budgets approved under title I of this Act, or (b) to pay for special medical or other procedures peculiar to vocational rehabilitation, or peculiar to the correction or amelioration of defects or chronic conditions of crippled children, as the case may be.

TITLE IV—STUDIES RELATED TO HEALTH SECURITY

STUDY OF THE PROVISION OF HEALTH SECURITY BENEFITS TO UNITED STATES CITIZENS IN OTHER COUNTRIES

SEC. 401. The Secretary of Health, Education, and Welfare in consultation with the Secretary of State and the Secretary of the Treasury, shall study (a) the practicability and the means of making prepaid health services (or prepaid indemnification for the cost of health services) available, more widely than can be done under section 12 of this Act, to citizens of the United States who are resident in other countries or are temporarily visiting such countries, by supplementing the authority for reciprocal arrangements under section 12 with authority for payments from the Health Security Trust Fund, and (b) means of equitably financing such services (or indemnification) through the extension of health security taxes; and not later than five years after the enactment of this Act shall report to the Congress his findings and recommendations.

STUDY OF NEED FOR LONG-TERM CARE

SEC. 402. (a) The Congress finds that—

(1) there exists a serious shortage of appropriate services and facilities for the long-term care of persons who, because of age or chronic illness or other cause, are unable to live in their own homes without assistance, but who do not need services as extensive as those of hospitals or skilled nursing homes;

(2) the shortage is due in substantial part to the inadequacy of assistance from public sources in meeting developmental costs, capital costs, or operating costs of facilities providing such care, and to the inability of such persons to pay the cost of the services they need;

(3) public programs for assistance to such persons are divided among medical facilities construction programs, housing programs, public assistance programs, programs specifically for the aged, and other programs, each addressed to a facet of the problem but without sufficient coordination with respect to the differing kinds and levels of care required by different persons or the relative need for services and facilities of the several kinds; and

(4) the shortage of appropriate services and facilities results both in severe hardship to many of the elderly and the disabled and their families, and in much improper and wasteful use of hospitals and skilled nursing homes.

(b) The Secretary of Health, Education, and Welfare shall conduct a study of (1) the need for additional social, homemaker and other services to enable persons referred to in subsection (a) to live in their own homes, (2) the most effective method of providing such services by public agencies and encouraging their provision by private agencies, and (3) the most equitable and appropriate means of financing such services.

(c) The Secretary of Health, Education, and Welfare and the Secretary of Housing and Urban Development shall conduct a joint study of the extent of the need for additional facilities of various kinds for the care of persons referred to in subsection (a), and of the most appropriate and equitable means of meeting both the capital cost and the operating cost of such additional facilities.

(d) Not later than two years after the enactment of this Act, the Secretaries shall transmit to the Congress reports of their studies under subsections (b) and (c), together with recommendations of legislation to meet the needs for services and facilities, including the coordination of existing programs and any expansion of such programs or the initiation of any new programs which may be deemed appropriate.

STUDY OF COORDINATION WITH OTHER FEDERAL HEALTH BENEFIT PROGRAMS

SEC. 403. (a) The Secretary of Health, Education, and Welfare shall conduct studies of the most satisfactory means of coordinating the program for the health care of merchant seamen, the program for the health care of Indians and Alaskan natives, or both, with the system of health security benefits created by this Act; the Administrator of Veterans' Affairs and the Secretary shall conduct a joint study of the most satisfactory means of coordinating with that system some or all of the programs for the health care of veterans. Reports of these studies, and legislative recommendations to achieve improved coordination, shall be submitted to the Congress not later than three years after the enactment of this Act.

(b) In conducting the studies required by this section, the Secretary and the Administrator, as appropriate, shall consult with representatives of the respective beneficiary groups, and shall include in their reports to the Congress summaries of the views of such representatives.

STUDY OF MALPRACTICE LIABILITY

SEC. 404. (a) The Congress finds that—

(1) with the increasing complexity and sophistication of diagnostic and therapeutic health care procedures, determination whether a patient has been injured by malpractice or other fault has become increasingly difficult and the existing method of making this determination through the judicial process has become increasingly costly, inefficient, and unsatisfactory;

(2) the cost of insurance against malpractice liability has become a substantial element in the cost of health services, and there is growing evidence that the risk of such liability, together with the limited availability of insurance, may be inhibiting the proper and desirable use of certain diagnostic or therapeutic procedures as well as the effective use of health manpower and health care facilities; and

(3) the risk of harm arising out of medical treatment can be reduced but cannot be eliminated from the delivery of health services, and it is essential to develop more precise, efficient, and equitable methods of determining whether harm to patients has been caused by negligence or other factors and of determining and paying fair compensation to persons entitled thereto.

(b) The Secretary of Health, Education, and Welfare shall conduct a comprehensive study of all relevant aspects of the malpractice problem with particular emphasis on the methods used for compensating patients for harm suffered as a result of malpractice or other causes arising out of or in the course of the provision of health services to them. The study shall include, but shall not be limited to—

(1) the collection of information (A) concerning the existing methods of determining liability and paying compensation for harm caused by malpractice or other fault, including information bearing on the costs and effectiveness of those methods, the reasonableness and timeliness of such payments, and the significance of the cost of liability insurance and the cost of processing malpractice claims to conclusion as an element in the cost of health care; and (B) concerning the cost, availability, and adequacy of liability insurance as a means of providing funds for such compensation and protecting providers of health services against undue financial risks;

(2) an examination of the feasibility, costs, and desirability (A) of substitute or alternative methods of determining entitlement to, and the amount of, compensation for harm suffered, in lieu of determination of these issues through the judicial process; (B) of substituting other tests of entitlement to such compensation, in lieu of tests based on negligence or fault on the part of providers of services; and (C) of establishing statutory criteria to govern the determination of the amount of such compensation;

(3) an examination of the relationship of malpractice claims and litigation to the delivery of health services, including an analysis of the professional and economic impact of actual or threatened claims on health care diagnostic and therapeutic practices, the use of health manpower, and the use of health care facilities; and

(4) an examination of existing methods and potential alternative methods of meeting the cost of such compensation, while affording reasonable protection to the providers of health services.

(c) The Secretary shall make to the Congress an interim report of his studies under this section not later than one year after the enactment of this Act, and a final report, and such recommendations of legislation as he deems appropriate, not later than two years after such enactment.

GENERAL PROVISIONS

SEC. 405. (a) There are hereby authorized to be appropriated such sums as may be necessary for the conduct of the studies authorized by this title.

(b) In conducting such studies the Secretary of Health, Education, and Welfare, the Secretary of Housing and Urban Development, and the Administrator of Veterans' Affairs are each authorized (1) without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, to appoint such consultants (and fix their compensation at not more than $100 a day), and to create such advisory committees, as they may find useful; and (2) to enter into contracts with public or private agencies or organizations for the collection of information, the conduct of research, or other purposes relating to the respective studies.

The material furnished by Mr. KENNEDY is as follows:

SECTION-BY-SECTION ANALYSIS OF THE HEALTH SECURITY ACT

TITLE I

Part A—Eligibility for benefits

(Sections 11–12.) Every resident of the U.S. (and every non-resident citizen when in the U.S.) will be eligible for covered services. Reciprocal and "buy-in" agreements will permit the coverage of groups of non-resident aliens, and in some cases benefits to U.S. residents when visiting in other countries.

Part B—Nature and scope of benefits: Covered services

(Section 21.) Every eligible person is entitled to have payments made by the Board for covered services provided within the United States by a participating provider.

(Section 22.) All necessary professional services of physicians, wherever furnished, are covered, including preventive care, with two important restrictions:

(1) Major surgery, and other specialist services designated in regulations, are covered only when performed by a qualified specialist—except in emergency situations—and generally only on referral from a primary physician. This is intended to protect the public from inadequately trained practitioners and to restore the primary or family practitioner to the role of the manager of health services.

(2) Psychiatric services to an ambulatory patient are covered only for active preventive, diagnostic, therapeutic or rehabilitative service with respect to mental illness. If the patient seeks care in the organized setting of a comprehensive health service organization, or a hospital out-patient clinic, or other comprehensive mental health clinic, there is no limit on the number of consultations. In these kinds of organized settings, peer review and budgetary controls can be expected to curtail unnecessary utilization. If the patient is consulting a solo practitioner, there is a limit of 20 consultations per benefit period. In communities where psychiatric services are in especially short supply the Board may prescribe referral or other non-financial conditions to give persons most in need of services a priority of access to solo practitioners.

(Section 23.) Comprehensive dental services (exclusive of most orthodontia) are covered for children under age 15, with the covered age group increasing by two years each year until all those under age 25 are covered. This benefit is limited initially because, even with full use of dental auxiliaries, there is insufficient manpower to provide dental benefits for the entire population. Persons once covered for dental services remain covered throughout their lives, and it is the declared intention to extend dental benefits to persons initially excluded, as rapidly as this becomes feasible.

(Section 24.) Inpatient and outpatient hospital services and services of a home health agency are covered without arbitrary limitation. Pathology and radiology services are specifically included as parts of institutional services, thus reversing the practice of Medicare. Domiciliary or custodial care is specifically excluded in any institution, thus necessitating the two important restrictions on payments for institutional care:

(1) Payment for skilled nursing home care is limited to 120 days per benefit period except that this limit may be increased when the nursing home is owned or managed by a hospital and payment for care is made through the hospital's budget. It is not practical to assume that the majority of nursing homes and extended care facilities in the country will be able to implement effective utilization review and control plans in the first years of Health Security. The demand for essentially domiciliary or custodial care in nursing homes is so overwhelming that an initial arbitrary limit on days of coverage is necessary. Extension of the benefit is authorized when this becomes feasible.

(2) Many state hospitals do not provide optimal active treatment to their psychiatric patients but rather maintain them in a maintenance or custodial setting. If Health Security provided unlimited coverage for patients in these hospitals, it might tend to freeze the level of care instead of stimulating these institutions to upgrade their medical-care performance. Therefore the psychiatric hospital benefit is limited to 45 consecutive days of *active treatment* during a benefit period.

(Section 25.) The bill provides coverage for two categories of drug use: prescribed medicines administered to inpatients or outpatients within participating hospitals, or to enrollees of comprehensive health service organizations, and drugs necessary for the treatment of specified chronic illnesses or conditions requiring long or expensive drug therapy. This will provide coverage of most drug costs for individuals who require costly drug therapy.

The bill requires the Board and the Secretary of HEW to establish two lists of approved drugs, taking into account the safety, efficacy and cost of each drug. There will be a broad list of approved medicines available for use in institutions and by comprehensive health service organizations and a more restricted list which is available for use outside such organized settings. The restricted list shall stipulate which drugs on it shall be available for treatment of each of the specified chronic diseases. No such restrictions shall be placed upon drug therapy within an institutional setting.

Use of the restricted list will meet the most costly needs for drug therapy while restraining unnecessary utilization. The benefit is more liberal where adequate control mechanisms exist.

(Section 26.) The appliances benefit is similar in concept and operation to the drug benefit, subject to a limitation on aggregate cost. The Board shall prepare lists of approved devices, appliances or equipment which it finds are important for the maintenance or restoration of health, employability or self-management (taking into consideration the reliability and cost of each item). The Board will also specify the circumstances or the frequency with which the item may be prescribed at the cost of the Health Security program.

(Section 27.) The professional services of optometrists and podiatrists are covered, subject to regulations, as are diagnostic or therapeutic services. The care of a psychiatric patient in a mental health day care service is covered for up to 60 days (day care benefits are unlimited if furnished by a comprehensive health service organization or by a community mental health center). Ambulance and other emergency transportation services are covered, as well as non-emergency services where (as in some sparsely settled areas) transportation is essential to overcome special difficulty of access to covered services.

Supporting services such as psychological, physiotherapy, nutrition, social work and health education are covered if they are part of institutional services or are furnished by a comprehensive health service organization. This establishes the important principle that these and other supporting services should be provided as part of a coordinated program of health maintenance and care. Psychologists, physical therapists, social workers, etc. will not be permitted to establish independent practices and bill the program on a fee-for-service basis. This is intended to assure that whenever services of this nature are provided they are under appropriate medical supervision and are germane to the over-all care of the patient.

(Section 28.) Health services furnished or paid for under a workmen's compensation law are not covered. Reimbursement for loss of earnings is so closely interlocked with the health services aspects of workmen's compensation that absorption of the health services portion of workmen's compensation by Health Security could have the effect of delaying findings of eligibility for income payments.

School health services are covered only to the extent provided in regulations.

The Board may exclude from coverage medical or surgical procedures which are essentially experimental in nature. The Board may exclude coverage of specified non-emergency surgical procedures unless an appropriately qualified specialist has been consulted and has recommended surgery. Individuals who enroll in a comprehensive health service organization or enroll themselves with a primary practitioner accepting capitation payments are not entitled to seek covered services from other providers of services (except as specified in regulations). Surgery primarily for cosmetic purposes is excluded from coverage.

The services of a professional practitioner are not covered if they are furnished in a hospital which is not a participating provider. This is intended to discourage physicians from admitting patients to hospitals which cannot or will not meet standards for participation in the program.

Part C—Participating providers of services

(Section 41.) Participating providers are required by subsection (a) to meet standards established in this title or by the Board. In addition, they must agree to provide services without discrimination, to make no charge to the patient for any covered service, and to furnish data necessary for utilization review by professional peers, statistical studies by the Board, and verification of information for payments.

Under subsection (b) the Board may, for those surgical procedures for which advance consultation is required under section 28, require pathology reports on tissue removed and clinical abstracts or discharge reports of the cases.

(Section 42(a).) Professional practitioners licensed when the program begins are eligible to practice in the State where they are licensed. All newly licensed applicants for participation must meet national standards es-

tablished by the Board in addition to those required by their State. While stopping short of creating a Federal licensure system for health professionals, this will guarantee minimum national standards. A state-licensed practitioner who meets national standards will be qualified to provide Health Security covered services in any other state. (See also Section 56(a)(1)).

(b) For purposes of this title a doctor of osteopathy is a physician, as is a dentist when performing procedures which, in generally accepted medical practice, may be performed by either a physician or a dentist.

(c) Participating professional providers shall be required to meet continuing education requirements established by the Board (in consultation with appropriate professional organizations).

(d) Major surgery and certain other specialty services shall be covered only when provided by a board certified or board eligible physician (except in emergency circumstances). Physicians who do not meet these standards but who are providing such services as a substantial part of their practice when the program begins may be found qualified if they meet standards established by the Board and, where appropriate, if recommended by a participating hospital.

(Section 43.) This section establishes conditions of participation for general hospitals similar to those required by Medicare. Two requirements not found in the Medicare program are: (1) that the hospital must not discriminate in granting staff privileges on any grounds unrelated to professional qualifications; (2) that the hospital establish a pharmacy and drug therapeutics committee for supervision of hospital drug therapy. Medicare allows any hospital accredited by the Joint Commission on the Accreditation of Hospitals (if it provides utilization review) to participate in the program, thus in effect delegating to the Commission the determination whether the standards are met. This title requires all participating hospitals to meet standards established by the Board.

(Section 44.) Psychiatric hospitals will be eligible to participate only if the Board finds that the hospital (or a distinct part of the hospital) is engaged in furnishing *active* diagnostic, therapeutic and rehabilitative services to mentally ill patients. Psychiatric hospitals are required to meet the same standards as those prescribed for general hospitals in Section 43, and such other conditions as the Board finds necessary to demonstrate that the institution is providing active treatment to its patients. These standards will exclude costs incurred by state mental institutions to the extent they serve domiciliary or custodial functions. In addition, psychiatric hospitals must be accredited by the Joint Commission on the Accreditation of Hospitals. (As in Medicare, accreditation is an *additional* requirement in the case of psychiatric hospitals, as further assurance that they meet the requirements of an active treatment program.)

(Sections 45 and 46.) Section 45 establishes conditions of participation for skilled nursing homes similar to those established for extended care facilities under Medicare. Important differences, however, are the requirement for affiliation with a participating hospital or comprehensive health service organization (see Section 52(b), and changes in the requirements for utilization review (see Section 51). Under section 46 participation by home health agencies will be limited to public agencies and non-profit private organizations—proprietary home health agencies are specifically excluded.

(Section 47.) Subsection (a) describes a comprehensive health service organization which undertakes to provide an enrolled population either with complete health care or, at the least, with complete Health Security services (other than institutional services, mental health or dental services) for the maintenance of health and the care of ambulatory patients. The bill, in its aim to improve the methods of delivery of health services, places much emphasis on the development of new organizations of this kind and the enlargement of old ones.

The section is designed to accommodate forms of organization typical of existing prepaid group practice plans, but also to be flexible enough to permit experimentation with somewhat different forms. In some urban or rural areas, for example, it may be impracticable to bring all of the various services together in one place, and the section has been designed to encompass what has been described as "comprehensive group practice without walls"; the basic essential is the assumption of responsibility for a reasonably comprehensive range of services (including health maintenance) on a continuing and coordinated basis to a group of persons who have chosen to receive all or nearly all their health care from the organization.

Other requirements are spelled out in this section: The organization must furnish services through the prepaid group practice of medicine, or as near an approximation to prepaid group practice as is feasible. It must be a nonprofit organization, or if several providers share in the furnishing of services the prime contractor with the Board must be nonprofit. All persons living in or near a specified service area will be eligible to enroll, subject to the capacity of the organization to furnish care and subject to minimal underwriting protections. Services must be reasonably accessible to persons living within the specified service area. Periodic consultation with representatives of enrollees is required. Professional policies and their effectuation, including monitoring the quality of services and their utilization, are to be the responsibility of a committee or committees of physicians. Health education and the use of preventive services must be stressed, and lay persons are to be employed so far as is consistent with good medical practice. Charges for any services not covered by Health Security must be reasonable. Finally, the organization must agree to pay for services furnished by other providers in emergencies, either within the service area of the organization or elsewhere, but may meet this requirement to the extent feasible through reciprocal service arrangements with other organizations of like kind.

Subsection (b) makes clear that the organization, or professionals furnishing services for it, may also serve non-enrollees, with payment to be made to the organization, or, at its request, to such professionals.

(Section 48.) This section permits a foundation sponsored by a city, county, or State medical or dental society, by agreement with the Board, to participate as a provider of services. The foundation's general policies must be developed, and reviewed periodically, by the society or a committee selected by it, and it must establish a professional group to review the quality and utilization of services. Generally, the foundation must furnish all covered medical or dental services, and may furnish other covered or non-covered services if the Board approves; it must accept for enrollment any resident of the area it serves, subject to the same limitations as appear in section 47(a). It must permit any practitioner who meets its professional qualifications to participate in furnishing services, whether or not he is a member of the sponsoring society. The foundation must agree to pay for emergency services to its enrollees in or outside its area, and must make no more than reasonable charges for any services not covered by Health Security. Finally, it must meet requirements for continuing education and other requirements which the Board may specify.

(Section 49.) This section deals with several classes of health organizations that vary widely, even within a single class, in their structure and in the scope of the services which they offer. Because statutory specifications cannot well be tailored to so many variables, the section sets forth only a general statement of the kinds of organizations to which it relates and leaves participation of each organization to a case-by-case decision of the Board.

Subsection 49(a)(1) permits the participation of community health centers or the like which, though furnishing services as comprehensive as are required by section 47(a), do not serve an enrolled or otherwise predetermined population and may not meet some other requirements of section 47(a). Subsection (a)(2) authorizes the Board to deal separately with the primary care portion of a system of comprehensive care where it is necessary to rely on arrangements with other providers, rather than on a unified structure, to round out the other elements of the system. Where organizations meeting the extensive requirements of section 47(a) are not available, these two subsections will give the Board flexibility in furthering one of the bill's prime objectives, the development and broad availability of comprehensive services furnished on a coordinated basis.

Because of the extent to which mental health services are separated from other health care, subsection (a)(3) permits the Board to contract directly with public or other nonprofit mental health centers and mental health day care services.

If a State or local public health agency is providing preventive or diagnostic services, such as immunization or laboratory tests, the Board may under subsection (a)(4) contract with it for the continuance of these services. Subsection (a)(5) permits the Board to contract with nonprofit health prepayment or insurance organizations which provide substantially comprehensive services to ambulatory patients, on terms similar to those specified in section 48 for professional foundations.

In the field of private practice, physicians or dentists or other practitioners may group themselves in a clinic, nonprofit or proprietary, or in any number of other ways, and it may be more convenient both to them and to the Board to regard them as an entity than to deal with each practitioner separately. Subsection (a)(6) permits this. The Board will have wide discretion in contracting with such entities subject only to the limitation that, like other organizations described in section 49(a), the entity may not (under section 88(a)) be paid on a fee-for-service basis. Practitioners who elect that method of payment may of course pool their bills for submission to the Board, but there is no reason to contract with a unit for the payment of fees to it.

Subsection (d) sets forth the Board's authority to specify terms and conditions or agreements under this section. Subsection (c) makes clear that agreements with the Board under section 48 or 49 shall not (unless expressly so stipulated) preclude practitioners furnishing services under the agreements from furnishing other services as independent providers.

(Section 50.) This section specifies the broad and general conditions under which independent pathology laboratories, independent radiological services, providers of drugs, devices, appliances, equipment, or ambulance services may qualify as providers under Health Security. As under Medicare, a Christian Science Sanatorium qualifies if operated, or listed and certified, by the First Church of Christ, Scientist, Boston.

(Section 51.) The requirements of utilization review in hospitals and skilled nursing homes are in the main similar to those which Medicare has, since 1966, imposed with

respect to services to aged patients. In Health Security the requirements will of course apply to the entire patient population. As in Medicare, the review is designed to serve a dual purpose: identification of certain specific misuses of the institutional services with a view to their termination, and a focusing of continuing attention and concern of the medical staff on the necessity for efficient utilization of institutional resources. Section 51(a) strengthens the educational aspect of the process by requiring specifically that records of reviews be maintained and statistical summaries of them be reported periodically to the institution and its medical staff (and, on request, to the Board). As under Medicare, the review committee will consist of two or more physicians, with or without other professional participation; and in the case of hospitals, will normally be drawn from the medical staff unless for some reason an outside group is required. For skilled nursing homes, on the other hand, section 51(c) departs from Medicare by permitting as an alternative that the Committee be established by the State or local public health agency under contract with the Board, or failing that, by the Board. If the nursing home operates under a consolidated budget with a hospital, the review will be made by the hospital committee. Like Medicare, section 51(d) calls for review of specific long-stay cases as required by regulations, and section 51(e) for notice to the institution, the attending physician, and the patient when a decision adverse to further institutional services is made.

(Section 52.) Subsection (a) of Section 52 is also like Medicare in requiring a participating skilled nursing home to have in effect an agreement with at least one participating hospital for the transfer of patients and medical and other information as medically appropriate. Subsection (b) introduces a requirement, applicable two years after the effective date of health benefits to both skilled nursing homes and home health service agencies, of affiliation with a participating hospital or comprehensive health service organization. Unless the medical staff of the hospital or organization undertakes to furnish the professional services in the nursing home or the professional services of the home health service agency, that medical staff or a committee of it must assume responsibility for these services. Subsection (c) allows the Board to waive the application of either of these requirements to a skilled nursing home or a home health agency which the Board finds essential to the provision of adequate services, if (but only for as long as) lack of a suitable hospital or organization within a reasonable distance makes a transfer or an affiliation agreement impracticable.

(Section 53.) If the construction or substantial enlargement of a hospital or skilled nursing home has been undertaken after December 31, of the year of enactment, without prior approval by a planning agency designated by the governor of the state or the Board, section 53 precludes the institution from participating in the Health Security program. This should greatly strengthen state and local planning authorities.

(Section 54.) Subsection (a) requires the Board in fixing, for institutional and other providers, standards beyond those specified in the statute, to take into consideration criteria established or recommended by appropriate professional organizations. The Board is given authority under subsection (b) to require upgrading in staffing patterns and personnel standards of participating institutional providers that fall below standards recommended by such organizations.

(Section 55.) Institutions of the Department of Defense and the Veterans Administration, and institutions of the Department of Health, Education, and Welfare serving merchant seamen or Indians or Alaskan natives, are excluded by section 55 from serving as participating providers, as is also any employee of these institutions when he is acting as an employee. The Board will, however, provide reimbursement for any services furnished (in emergencies, for example) by these institutions or agencies to eligible persons who are not a part of their normal clientele. It will also provide reimbursement for services furnished by the Public Health Service under the recently enacted Emergency Health Personnel Act of 1970.

(Section 56.) This section overrides, for purposes of the Health Security program, State laws of several kinds which inhibit the utilization or the mobility of health personnel, cloud the legality of so-called "corporate practice" of health professions, or restrict the creation of group practice organizations. The authority of Congress to do this, in conjunction with a program of Federal expenditure to provide for the general welfare, flows from the Supremacy Clause of the Constitution and seems now to be clearly established. (*Ivanhoe Irrigation District v. McCracken*, 357 U.S. 275 (1958); *King* v. *Smith*, 392 U.S. 309 (1968)).

The first three paragraphs of subsection (a), while stopping short of creating a system of Federal licensure for health personnel, will greatly facilitate both the interstate mobility of State licensees and the effective use of ancillary personnel in the furnishing of health care. The dispensations contained in these paragraphs will be available to persons who meet national standards established by the Board.

Paragraph (1) permits a physician, dentist, optometrist, or podiatrist, licensed in one State and meeting the national standards, to furnish Health Security benefits in any other state, the scope of his permissible practice being governed by the law of the State in which he is practicing. This paragraph obviates the difficulty and cost which a practitioner may encounter, especially where reciprocity of licensure is not available, in taking up practice in a State in which he has not been licensed.

Paragraph (2) grants a similar authority to other health professional and nonprofessional personnel. For occupations such as pharmacy and professional nursing, which are subject to licensure in all States, a person can avail himself of this paragraph only if he is licensed in one State and meets the national standards; in other cases, where licensure is not universally required, compliance with national standards is sufficient. Here again, impediments to mobility created by existing licensure laws will be removed.

The restrictions which many professional practice acts impose on the use of lay assistants, and the legal uncertainties which often deter such use, discourage practices that can increase greatly, without sacrifice of safety, the volume of services which professionals can render. Accordingly, paragraph (3) of subsection (a) enables the Board to permit physicians and dentists, participating in public or nonpublic hospitals and comprehensive health service organizations, to use ancillary health personnel, acting under professional supervision and responsibility, to assist in furnishing Health Security benefits. Such assistants may do only things which the Board has specified, and may be used only in the context of an organized medical staff or medical group. Persons employed as assistants must not only meet national standards for their respective occupations, but must also satisfy special qualifications that the Board may set for particular acts or procedures.

In the interest of encouraging salaried practice and the integration of professional practitioners into well-structured organizations for the delivery of health services, paragraph (4) of subsection (a) does away with the "corporate practice" rule insofar as concerns participating public or other nonprofit hospitals and comprehensive health service organizations. These institutions may employ physicians or make other arrangements for their services, unless in the unlikely event that lay interference with professional acts or judgments should be threatened. No conflict of interest results from such arrangements; in the nonprofit setting loyalty to employer and loyalty to patient run parallel.

Some state laws place restrictions of one kind or another on the incorporation of group practice organizations. When these restrictions prevent the State incorporation of an organization meeting the strict requirements of the Health Security Act, section 56 (b) empowers the Secretary to incorporate it for purposes of the Act. Except for the special restrictions, State law will govern the corporation.

Part D—Trust fund; allocation of funds for services

(Section 61.) This section establishes the Health Security Trust Fund, to receive the net assets of existing (Medicare) funds taken over by the Health Security program, the yield of the Health Security taxes, and the Government's contribution from general revenues amounting to 100% of the yield from these taxes.

Accordingly, this section amends the Social Security Act to convert the present Hospital Insurance Trust Fund (Medicare, Title XVIII, Part A) into the Health Security Trust Fund, and to provide that the appropriations that would have gone into the former (increased by the new tax provisions) shall go into the latter. In addition, on the effective date of benefits the assets and liabilities of the Federal Supplementary Medical Insurance Trust Fund (Medicare, Title XVIII, Part B) will be transferred to the Health Security Trust Fund. Also, a Government contribution to the new Trust Fund is authorized to be appropriated, equal to 100% of the aggregate yield from the payroll taxes on employees and employers and the taxes on self-employment and unearned income, imposed for Health Security under Title II of this Act. The Fund will also receive recoveries of overpayments, and receipts from loans and other agreements. To implement the role of the Trust Fund, the Managing Trustee (the Secretary of the Treasury) will make payments from the Trust Fund provided for under Title I, as the Board certifies, and with respect to administrative expenses as authorized annually by the Congress.

(Section 62.) The Health Security program is intended to operate on a budget basis overall. Accordingly, subsection (a) requires the Board to determine for each fiscal year the maximum amount which may be available for obligation from the Trust Fund. The amount so determined in advance (by March 1 preceding each fiscal year) shall not exceed the smaller of two stated limitations. The first limit is fixed at 200% of the expected net receipts from all the Health Security taxes (i.e., the tax receipts augmented by 100% thereof, to be appropriated into the Fund from general revenues of the Government). The second limit, applicable to each fiscal year after the first year of benefit operation, (i.e., after a year's availability of covered services), is an amount equal to the estimated obligations of the current year (within which the estimate is being made), subject to certain adjustments. Such adjustments will reflect changes expected in: (A) the price of goods and services; (B) the number of eligible persons; (C) the number of participating professional providers, or the number or capacity of institutional or other participating providers so far as such changes are not readily adequately reflected; and (D) the expected cost of program administration.

In the interest of prudent fiscal management, subsection (b) requires the Board to restrict its estimate of the amount available

for obligation in the next fiscal year (in accordance with subsection (a)) if the Board estimates that the amount in the Trust Fund at the beginning of the next fiscal year will be less than one-quarter of the total obligations to be incurred for the current year, and that such restriction will not impair the adequacy or quality of the services to be provided. Also, the Board is required to reduce its alternative estimate of the maximum amount to be available if it finds that the aggregate cost to be expected has been reduced (or an expected increase has been lessened) through improvement in organization and delivery of service or through utilization control.

Subsection (c) provides against various other contingencies which may result in increase or decrease in the estimate of the maximum amount to be available for obligation in the next fiscal year. The amount may be modified before or during the fiscal year: if the Secretary of the Treasury finds that the expected Health Security tax receipts will differ by 1 percent or more from the estimate used under subsection (a); or if the Board finds that either its factors of expected change or the cost of administration is expected to differ from the estimate by 5 percent or more; or if an epidemic, disaster or other occurrence compels higher expenditure than had been expected. If, as a result, the maximum estimate has to be increased (rather than being decreased), the Board (through the Secretary) shall promptly report its action to the Congress with its reasons.

(Section 63.) Subsection (a) provides that three separate accounts shall be established in the Health Security Trust Fund—a Health Services Account, a Health Resources Development Account, and an Administration Account, as well as a residual General Account. Subsection (b) provides that in each of the first two years of program operation, 2% of the Trust Fund shall be set aside for the Health Resources Development Fund; and the allocation shall increase by 1% at two-year intervals to 5% within the next 6 years. The money in this account will be used exclusively for the planning and system improvement purposes described in part F.

(c) (d) After deducting the amount appropriated by the Congress into the Administration Account, the remainder of the monies shall be allocated to the Health Services Account, and shall be used exclusively for making payment for services in accordance with part E.

(Section 64.) This section provides for allocation of the Health Services account among the regions of the country. (a) The allocation to each region shall be based on the aggregate sum expended during the most recent 12-month period for covered services (with appropriate modification for estimated changes in the price of goods and services, the expected number of eligible beneficiaries, and the number of participating providers). (b) In allocating funds to the regions the Board shall seek to reduce, and over the years gradually eliminate, existing differences among the regions in the average per capita amount expended upon covered health services (except when these reflect differences in the price of goods and services). To accomplish this, the Board will curtail increases in allocations to high expenditure regions and stimulate an increase in the availability and utilization of services in regions in which the per capita cost is lower than the national average. (c) A contingency reserve of up to 5% may be withheld from allocation. If the remaining funds available are inadequate, allocations will be reduced pro rata. (d) Allocations may be modified before or during a fiscal year if the Board finds this is necessary.

(Section 65.) The Board will divide the allocation to each region into funds available to pay for: institutional services; physican services; dental services; furnishing of drugs; furnishing of devices, appliances and equipment; and other professional and supporting services, including subfunds for optometrists, podiatrists, independent pathology laboratories, independent radiology services, and other items. The percent allocated to each category of service may vary from region to region. In determining the allocation to these funds, it will be guided by the previous year's expenditures for each category of service but also take into account trends in the utilization of services and the desirability of stimulating improved utilization of resources. It will encourage a shift from heavy reliance on institutional care to better utilization of preventive and ambulatory services.

(Section 66.) These regional funds will be subdivided among the health service areas in each region, primarily upon the basis of the previous year's expenditure for each kind of service. Again, the Board will gradually attempt to achieve the equalization of services within each region by restraining the increase of expenditures in high cost areas and channeling funds into health service areas with a low level of expenditures.

(Section 67.) Before or during a fiscal year, the division of regional funds by classes of service or the allotments to health service areas may be modified if necessary or if indicated by newly acquired information.

Part E—Payment to providers of services

(Section 81.) Payments for covered services provided to eligible persons by participating providers will be made from the Health Services Account in the Trust Fund.

(Section 82.) This section delineates methods of paying professional practitioners. Every independent practitioner (physician, dentist, podiatrist, or optometrist) shall be entitled to be paid by the fee-for-service method (subsection (a)), the amounts paid being in accordance with relative value scales prescribed after consultation with the professions (subsection (g)). Each physician engaged in general or family practice of medicine in independent practice may elect to be paid by the capitation method if he agrees to furnish individuals enrolled on his list with all necessary and appropriate primary services, make arrangements for referral of patients to specialists or institutions when necessary, and maintain records required for medical audit; and independent dentist practitioners may elect the capitation method of payment similarly (subsection (b)).

These requirements in connection with capitation payments are intended to assure that the physician (or dentist) provides to his patients all professional services within the range of his undertaking and secures other needed services by referral. Through regular medical audits, the Board will monitor the level and quality of care provided.

When necessary to assure the availability of services in a given area, subsection (c) permits paying an independent practitioner a full-time or part-time stipend in lieu of or as a supplement to other methods of compensation. This method of payment will be used selectively by the Board, mainly to encourage the location of practitioners in remote or deprived areas. Practitioners may also be reimbursed for the special costs of continuing education required by the Board and for maintaining linkages wth other providers—for example, communication costs. Incentives operative under this provision will encourage physicians to improve the quality and continuity of patient care, even if the physician does not participate in a group practice. The Board may pay for specialized medical services on a per session, or per case basis, or may use a combination of methods authorized by this section.

Subsection (d) defines the capitation method of payment.

Subsection (e) of this section describes the method to be used in applying, as between practitioners electing the various methods of payment the monies available in each health service area for payment to each category of professional providers. From the amount allocated to each service area, the Board will earmark funds sufficient to pay practitioners receiving stipends and for the professional services component of institutional budgets, such as hospitals. The remainder of the money will be divided to compute the amount available per capita in the eligible population of the area for each category of service (i.e. physicians, dentists, podiatrists, optometrists). This per capita amount in each category will fix the capitation payments to organizations that undertake to provide the full range of services in that category to enrolled individuals. Lesser amounts will be fixed for more limited services. For example, if the per capita amounts available for physician, dental and optometric services are $65, $25, and $5 respectively, primary physicians accepting capitation payments will receive the percentage of that $65 which is allocated for primary services, a medical society sponsored foundation would receive the entire $65 for physician services, a dental society foundation would receive the $25 allocated for dental services, and organizations which undertake to provide all physician, dental and optometric services to enrolled individuals will receive $95 for each enrolled individual.

The budgeted per capita amount for each type of covered service (physician, dental, etc.) will be divided between the categories of providers of service according to the number of individuals who elect to receive care from those providers. For example, in a city of 100,000 people, 25,000 may enroll in a comprehensive health service organization. Using the figures cited in the example above, the Board will pay the comprehensive health service organization $1,625,000 ($65 x 25,000) for physicians' services. The other 75,000 individuals elect to receive their physician services from solo, fee-for-service practitioners. The Board will create a fund of $4,875,000 ($65 x 75,000) to pay all fee-for-service bills submitted by physicians in that community, in accordance with relative value scales and unit values fixed by the Board. The fund for fee payments will be augmented to the extent that some capitation payments have been lowered because they cover only primary services, and may be augmented further where a substantial volume of services is furnished, on a fee basis, to nonresidents of the area.

Subsection (h) authorizes the Board to experiment with other methods of reimbursement so long as the experimental method does not increase the cost of service or lead to overutilization or underutilization of services.

(Section 83.) Hospitals will be paid on the basis of a predetermined annual budget covering their approved costs. To facilitate review of these budgets, the Board will institute a national uniform accounting system. Subsection (b) stipulates that the costs recognized for purposes of the budget will be those incurred in furnishing the normal services of the institution except as changed by agreement, or by order of the Board under section 134. This will enable the Board, on the basis of State and local planning, to eliminate gradually any wasteful or duplicative services, and also to provide for an orderly expansion of hospital services where needed.

Physicians and other professional practitioners whose services are held out as available to patients generally (such as pathologists and radiologists) will be compensated through the institutional budget, whatever the method of compensation of such practitioners and whether or not they are employees of the hospital. This departs from the practice in Medicare which allowed independent billing by such physicians. The institution's budget may also be increased to

reflect the cost of owning or operating an affiliated skilled nursing home, or home health service agency. Hospital budgets will be reviewed by the Board, locally or regionally, which may permit participation by representatives of the hospitals in each region. Budgets may be modified before, during, or after the fiscal year if changes occur which make modification necessary.

(Section 84.) If an entire psychiatric hospital is found by the Board to be providing active treatment to its patients, and the institution is therefore primarily engaged in providing covered services to eligible beneficiaries, it will be paid on the same basis as a general hospital (on the basis of an approved annual budget). Otherwise the Board will negotiate a patient-day rate to be paid for each day of covered service provided to an eligible beneficiary.

(Section 85.) This section provides that skilled nursing homes and home health agencies will be paid in the same manner as a general hospital (on an approved annual budget basis). The Board may specify use of nationally uniform systems of accounting and may prescribe by regulation the items to be used in determining approved costs and the services which will be recognized in budgets.

(Section 86.) Reimbursement for drugs will be made to the dispensing agent on the basis of an official "product price" for each drug on the approved list plus a dispensing fee. The official product price will be set at a level which will encourage the pharmacy to purchase substantial quantities of the drug (this should result in significant reductions in the unit cost of each drug). The official price may be modified regionally to reflect differences in costs of acquiring drugs. The Board will establish dispensing fee schedules for reimbursing independent pharmacies. These schedules will take into account regional differences in costs of operation, differences in volume, level of services provided and other factors.

(Section 87.) A comprehensive health service organization or professional foundation will be paid for other than hospital or skilled nursing home services, on the basis of a fixed capitation rate multiplied by the number of eligible enrollees. The amount of the capitation rate will be determined by the per capita amounts available for the several professional services in the area, and a rate fixed by the Board as the average reasonable and necessary cost per enrollee for such other covered services as the organization or foundation undertakes to provide (exclusive of hospital and skilled nursing home services) such as physical therapy, nutrition, etc.

A comprehensive health service organization or foundation which undertakes to provide for hospital or skilled nursing home services for its enrollees may be paid on an approved annual budget basis or on a capitation basis. An organization or foundation which arranges for such services through other providers may be reimbursed on the basis of patient days of service utilized by enrollees. The organization or foundation will also be entitled to share in up to 75% of any savings which are achieved by lesser utilization of such institutional services. Entitlement to such savings is conditional upon a finding by the Board that the services of the organization or foundation have been of high quality and adequate to the needs of its enrollees, and that the average utilization of hospital or skilled nursing services by enrollees of the comprehensive health service organization or foundation is less than use of such services by comparable population groups under comparable circumstances. This money may be used by the comprehensive health service organization or professional foundation for any of its purposes, including the provision of services which are not covered under the Health Security Program.

(Section 88.) Subsection (a) provides that organizations or agencies with which the Board has entered into an agreement under section 49 (such as a neighborhood health center, a nonprofit mental health center, a nonprofit prepayment insurance agency, or local health agency furnishing preventive or diagnostic services) may be paid by any method agreed upon other than fee-for-service.

Subsection (b) provides that independent pathology or radiology services may be paid on the basis of an approved budget or such other methods as may be specified in regulations.

Subsection (c) leaves the method of payment for other types of supporting services to be specified in regulations.

(Section 89.) All participating providers will be paid from the Health Services Account in the Trust Fund at such time or times as the Board finds appropriate (but not less often than monthly). The Board may make advance payment to supply providers with working funds when it deems advisable.

Part F—Planning; funds to improve services and to alleviate shortages of facilities and personnel

(Section 101.) This section sets forth the general purposes of Part F and authorizes appropriations, and subsequently expenditures from the Trust Fund, for these purposes. The part envisages a substantial strengthening of the health planning process throughout the country with an eye, first, to the special needs for personnel, facilities, and organization which inauguration of the Health Security program will entail, and thereafter, to continuing improvement of the capabilities for effective delivery of health services. Beyond this, the part enables the Board, through selective financial assistance, to stimulate and assist in the development of comprehensive health services, the education and training of health personnel who are in especially short supply, and the betterment of the organization and efficiency of the health delivery system. For the two-year "tooling-up" period, appropriations of $200 and $400 million are authorized for financial assistance. Beginning with the effective date of health benefits, percentages of the Trust Fund expenditures will be earmarked for such assistance (section 63). From that date on, the leverage of these expanding funds will supplement and reinforce the incentives, which are built into the normal operation of the Health Security program, for improvement of the organization and methods of delivery of health services.

(Section 102.) This section directs the Secretary, in collaboration with State comprehensive health planning agencies, regional medical programs, and other planning agencies, to institute a continuous process of health service planning. Prior to the effective date of health benefits, the planning process must give first consideration to the most acute shortages and needs for delivery of covered services under this Act. Thereafter, planning shall be focused on maximizing continuing capability for delivery of these services.

This section places primarily on the State agencies the responsibility for coordinating the work of the many health planning agencies within the States, and for coordination with interstate agencies and with agencies planning in other fields related to health, but charges the Secretary with this function in any State that fails to meet the responsibility. The section amends the Public Health Service Act to increase the authorized appropriations for State and for local health planning to extend them to 1978, and to condition grants upon collaboration for these national purposes. Thus the section, strengthening State planning agencies, focuses in them a responsibility, visualized in the "partnership-for-health" legislation but in many States not yet an operating reality, for pulling together all health planning efforts within their territories. The task will not be easy, but it is one that is lent new urgency by the Health Security program. It belongs more properly to the States than to the national Government, but if any State proves unequal to the task it must and will be assumed by the Secretary.

(Section 103.) In administering part F, this section stipulates, the Board will give priority to improving comprehensive health services for ambulatory patients through the development or expansion of organizations furnishing such services, the recruitment and training of personnel, and the strengthening of coordination among providers of services. Financial assistance will be dispensed, so far as possible, in accordance with recommendations of the appropriate health planning agencies. Funds will not be used to replace other Federal financial assistance, and may supplement other assistance only to meet specific needs of the Health Security program. Other Federal assistance programs are to be administered when possible to further the objectives of part F, and the Board may provide loans or interest subsidies to help the beneficiaries of other programs to meet the requirements for non-Federal funds.

(Section 104.) Help of several kinds will be available under this section for the creation or the enlargement of organizations and agencies providing comprehensive care to ambulatory patients—either organizations to serve an enrolled population on a capitation basis, or agencies such as neighborhood health centers which need not require enrollment in advance. Grants may be made to any public or other nonprofit organization (which need not be a health organization) to help meet the cost, other than construction cost, of establishing such a health service organization, and to existing health service organizations to help meet the cost of expansion; the maximum grants being, in the former case 90 percent of the cost, in the latter 80 percent. The Board may also provide technical assistance for these purposes. Loans may be made for the cost of necessary construction, subject to the same 90 and 80 percent limitations on amount. Finally, start-up costs of operation of these organizations may be underwritten, for five years in the case of organizations which must build up an enrollment to assure operating income, and in other cases until the Health Security program begins payment for services in the first year of entitlement to benefits. The effect of these several provisions is to reduce sharply, if not eliminate, the financial obstacles which have heretofore impeded the growth of comprehensive group practice organizations.

(Section 105.) This section contains a series of provisions to assist in the recruitment, education, and training of health personnel. The Board will establish priorities to meet the most urgent needs of the Health Security system, but the priorities will be flexible both as beween different regions and from time to time. Professional practitioners will be recruited for service in shortage areas, both urban and rural, and in comprehensive health service organizations, and such practitioners may be given income guarantees. Other Federal assistance for health education and training will be availed of, but the Board may supplement the other assistance if the Board believes it inadequate to the needs, until Congress has had opportunity to review its adequacy. The training authorized includes the development of new kinds of health personnel to assist in furnishing comprehensive services, and the training of area residents to participate in personal health education and to serve liaison functions and serve as rep-

resentatives of the community in dealing with health organizations. Grants may be made to test the utility of such personnel, and to assist in their employment before the effective date of health benefits. Education and training are to be carried out through contracts with appropriate institutions and agencies, and suitable stipends to students and trainees are authorized. Physicians will be recruited and trained to serve as hospital medical directors. Finally, special assistance may be given, both to institutions and to students, to meet the additional costs of training persons disadvantaged by poverty, membership in minority groups, or other cause.

(Section 106.) This section authorizes special improvment grants: first, to any public or other nonprofit health agency or institution to establish improved coordination and linkages with other providers of services; and, second, to organizations providing comprehensive ambulatory care, to improve their utilization review, budget, statistical, or records and information retrieval systems, to acquire equipment needed for those purposes, or to acquire equipment useful for mass screening or for other diagnostic or therapeutic purposes.

(Section 107.) This section provides that loans under Part F are to bear 3 percent interest and to be repayable in not more than 20 years. Other terms and conditions are discretionary with the Board, except for required compliance with the Davis-Bacon Act and related laws. Repayment of loans made from general appropriations will go to the general fund of the Treasury; repayment of later loans will revert to the Health Resources Development Account in the Trust Fund.

(Section 108.) This section specifies that payments under Part F shall be in addition to, and not in lieu of, payments to providers under Part F.

Part G—Administration

This part of the bill creates an administrative structure within the Department of Health, Education and Welfare with exclusive responsibility for administration of the Health Security program. Program policy will be made by a five-member Board serving under the Secretary of HEW. The Board will be assisted by a National Health Security Advisory Council which will recommend policy and evaluate operation of the program, and an Executive Director who will serve as Secretary to the Board and chief administrative officer for the program. Administration of the program will be greatly decentralized among the HEW Regional Offices. Regional and local health services advisory councils will advise on all aspects of the program in their regions and local areas. The Board may also appoint such professional or technical committees as it may deem necessary.

(Section 405.) This section authorizes appropriations for the conduct of studies under this title and confers authority to employ consultants and to contract for services in making the studies.

(Section 121.) This section establishes a five-member full-time Health Security Board serving under the Secretary of Health, Education and Welfare. Board members will be appointed by the President with the advice and consent of the Senate, for five-year overlapping terms. Not more than three of the five appointees may be members of the same political party. A member who has served two consecutive terms will not be eligible for reappointment until two years after the expiration of his second term. One member of the Board shall serve as chairman at the pleasure of the President.

(Section 122.) This section charges the Secretary of HEW and the Board with responsibility for performing the duties imposed by this title. The Board shall issue regulations with the approval of the Secretary. It is required to engage in the continuous study of operation of the Health Security program; and, with the approval of the Secretary, to make recommendations on legislation and matters of administrative policy, and to report to the Congress annually on administration and operations of the program. The report will include an evaluation of adequacy and quality of services, costs of services and the effectiveness of measures to restrain the costs. The Secretary of HEW is instructed to coordinate the administration of other health-related programs under his jurisdiction with the administration of Health Security, and to include in his annual report to the Congress a report on his discharge of this responsibility.

The Civil Service Commission is instructed to make every effort to facilitate recruitment and employment, to work in the Health Security Administration, of persons experienced in private health insurance administration and other pertinent fields.

(Section 123.) This section creates the position of an Executive Director, appointed by the Board with the approval of the Secretary. The Executive Director will serve as secretary to the Board and shall perform such duties in administration of the program as the Board assigns to him. The Board is authorized to delegate to the Executive Director or other employees of HEW any of its functions or duties except the issuance of regulations and the determination of the availability of funds and their allocations to the regions.

(Section 124.) This section provides that the program will be administered through the regional offices of the Department of HEW. It also requires the establishment of local health service area offices and local offices.

The health service areas will in most instances be a State or a part of a State except where patterns in the organization of health services and the flow of patients indicate that an interstate area would provide a more practical administrative unit. One of the responsibilities of local offices will be to investigate complaints about the administration of the program.

(Section 125.) Subsection (a) establishes a National Health Security Advisory Council, with the Chairman of the Board serving as the Council's Chairman and 20 additional members not in the employ of the Federal Government. A majority of the appointed members will be consumers who are not engaged in providing and have no financial interest in the provision of health services. Members of the Council representing providers of care will be persons who are outstanding in fields related to medical, hospital or other health activities or who are representatives of organizations or professional associations. Members will be appointed to four-year over-lapping terms by the Secretary upon recommendation by the Board.

Subsection (b) authorizes the Advisory Council to appoint professional or technical committees to assist in its functions. The Board will make available to the Council all necessary secretarial and clerical assistance. The Council will meet as frequently as the Board deems necessary, or whenever requested by seven or more members, but not less than four times each year.

Subsection (c) provides that the Advisory Council will advise the Board on matters of general policy in the administration of the program, the formulation of regulations and the allocation of funds for services. The Council is charged with responsibility for studying the operation of the program and utilization of services under it, with a view to recommending changes in administration or in statutory provisions. They are to report annually to the Board on the performance of their functions. The Board, through the Secretary, will transmit the Council's report to the Congress together with a report by the Board on any administrative recommendations of the Council which have not been followed, and a report by the Secretary of his views with respect to any legislative recommendations of the Council.

(Section 126.) To further provide for participation of the community, the Board will appoint an advisory council for each region and local area. Each such Council would have a composition parallel to that of the National Council; and each will have the function of advising the regional or local representative of the Board on all matters directly relating to the administration of the program.

(Section 127.) The Board is authorized to appoint standing committees to advise on the professional and technical aspects of administration with respect to services, payments, evaluations, etc. These committees will consist of experts drawn from the health professions, medical schools or other health educational institutions, providers of services, etc. The Board is also authorized to appoint temporary committees to advise on special problems. The committees will report to the Board, and copies of their reports are to be made available to the National Advisory Council.

(Section 128.) Subsection (a) requires the Board to consult with appropriate State health and planning agencies to assure the coordination of the Health Security program with State and local activities in the fields of environmental health, licensure and inspection, health education, etc.

Subsection (b) requires the Board, whenever possible, to contract with States to survey and certify providers (other than professional practitioners) for participation in the program. This is similar to Medicare except that the Board is given authority to establish the qualifications required of persons making the inspections.

Subsection (c) authorizes the Board to contract with State agencies to undertake health education activities, supervision of utilization review programs, and programs to improve the quality and coordination of available services in that State.

Subsection (d) requires the Board to reimburse States for the reasonable cost of performing such contract activities and authorizes the Board to pay all or part of the cost of training State inspectors to meet the qualifications established by the Board.

(Section 129.) The Board is authorized to provide technical assistance either directly or through contract with a State to skilled nursing homes and home health agencies to supplement the skills of their permanent staff in regard to social services, dietetics, etc.

(Section 130.) Subsection (a) charges the Board with responsibility for informing the public and providers about the administration and operation of the Health Security program. This will include informing the public about entitlement to eligibility, nature, scope, and availability of services. Providers would be informed of the conditions of participation, methods and amounts of compensation, and administrative policies. In support of the program's effort to improve drug therapy, the Board is authorized, with the approval of the Secretary, to furnish all professional practitioners with information concerning the safety and efficacy of drugs appearing on either of the approved lists (Section 25), indications for their use and contraindications. Information of this nature is not now always available to practitioners.

Subsection (b) requires the Board to make a continuing study and evaluation of the program, including adequacy, quality and costs of services. Subsection (c) authorizes the Board directly or by contract to make detailed statistical and other studies on a national, regional, or local basis of any aspect of the title, to develop and test incentive systems for improving quality of

care, methods of peer review of drug utilization and of other service performances, systems of information retrieval, budget programs, instrumentation for multiphasic screening or patient services, reimbursement systems for drugs, and other studies which it considers would improve the quality of services or administration of the program.

(Section 131.) This section authorizes the Board to enter into agreements with providers to experiment with alternative methods of reimbursement which offer promise of improving the coordination of services, their quality or accessibility.

(Section 132.) This section grants authority to the Board, in accordance with regulations, to make determinations of who are participating providers of service, determinations of eligibility, of whether services are covered, and the amount to be paid to providers. The Board is granted authority to terminate participation of a provider who is not in compliance with qualifying requirements, agreements or regulations. But unless the safety of eligible individuals is endangered, the provider shall be entitled to a hearing before the termination becomes effective.

(Section 133.) This section establishes procedures for appeals similar to those under the Social Security Act.

(Section 134.) This section has one of the bill's most important provisions with respect to achieving improvement in coordination, availability, and quality of services. It greatly strengthens state and local planning agencies and gives the Board authority to curtail inefficient administration of participating institutional providers.

The Board is authorized to issue a direction to any participating provider (other than an individual professional practitioner) that, as a condition of participation, the provider add or discontinue one or more covered services. For example, if two community hospitals are operating maternity wards at low occupancy rates, the Board may require that one hospital cease to provide such service. A provider may be required to provide services in a new location, enter into arrangements for the transfer of patients and medical records, or establish such other coordination or linkages of covered services as the Board finds appropriate.

In addition, if the Board finds that services furnished by a provider are not necessary to the availability of adequate services, under this title, that their continuance is unreasonably costly, or that the services are furnished inefficiently (and that efforts to correct such inefficiency have proved unavailing) the Board may terminate participation of the provider.

No direction shall be issued under this section except upon the recommendation of, or after consultation with, the appropriate state health planning agency. And no direction shall be issued under this section unless the Board finds that it can be practicably carried out by the provider to whom it is addressed. The Board is required to give due notice and to establish and observe appropriate procedures for hearings and appeals, and judicial review is provided.

(Section 135.) Subsection (a) creates the positions of Deputy Secretary of Health, Education, and Welfare and Under Secretary for Health and Science in the Dept. of Health, Education, and Welfare.

Subsection (b) fixes the levels of compensation in the Executive pay rates scale for the Deputy Secretary (level II), the Under Secretary for Health and Science (level III), the Health Security Board chairman (level III), Board Members (level IV), and the Exec. Director (level V).

Part H—Miscellaneous provisions

(Section 141.) This section contains definitions of certain terms used in the title.

(Section 142.) This section stipulates that the effective date for entitlement for benefits will be July 1, of the second calendar year following enactment.

(Section 143.) Subsection (a) provides that an employer will not be relieved, by the enactment of the Health Security Act, of any existing contractural or other non-statutory obligation to provide or pay for health services to his present or former employees and their families. Subsection (b) expresses the sense of Congress that if, nevertheless, inauguration of the Health Security Program lessens the cost of an employer's aggregate obligations for health services to such persons, the savings should, at least for the period of any contract subsisting on the effective date of benefits, be applied to the payment of the employees' health security taxes, to wage increases, or to other employee benefits.

TITLE II

Part A—Payroll taxes

(Section 201.) Effective on January 1 of the second year after enactment, subsections (a) and (b) convert the existing Medicare hospital insurance payroll taxes into Health Security taxes, and raise the rates to 1 percent on employees and 3.5 percent on employers. Subsection (c) raises the wage base for the employee tax from the present $7,800 to $15,000 with subsequent further increase if wage levels rise, eliminates the wage ceiling from the employer tax, and broadens the definitions of covered employment to include foreign agricultural workers, employees of the U.S. and its instrumentalities (other than members of the armed forces, and the President, Vice-President, and Members of Congress), employees of charitable and similar organizations, railroad employees, and (for the employee tax only) employees of States and their political subdivisions and instrumentalities. This subsection also provides the mechanism for increasing the wage base, by $600 intervals, in proportion to future increases in average wage levels.

(Section 202.) Section 202 makes a number of conforming and technical amendments. Chief among these are provisions for refund of excess taxes collected from an employee, who has held two or more jobs, on wages aggregating in a year more than the amount of the new wage base; exclusion of Health Security contributions from agreements with State governments for the social security coverage of State and municipal employees (since these employees will contribute to Health Security through payroll taxes); and exclusion of Health Security contributions from agreements for the coverage of United States citizens employed by foreign subsidiaries of United States corporations (since these employees will not benefit directly from Health Security in its present form).

(Section 203.) This section excludes from the gross income of employees, for income tax purposes, payment by their employers of part or all of the Health Security taxes on the employees.

(Section 204.) This section spells out the precise effective dates of the new payroll tax provisions.

Part B—Taxes on self-employment income and unearned income

(Section 211.) Effective at the beginning of the second calendar year after enactment, this section converts the existing Medicare self-employment tax into a Health Security self-employment tax, raises the rate to 2.5 percent, and raises the maximum taxable self-employment income from $7,800 to $15,000 (with the same upward adjustment as in the employee tax for subsequent rises in average wage levels).

(Section 212.) Effective on the same date, this section adds a new 1 percent Health Security tax on unearned income (unless such income is less than $400 a year), subject to the same maximum on taxable income as is applicable to the employee and self-employment taxes. Taxable unearned income is adjusted gross income up to the stated maximum, minus wages and self-employment income already taxed for Health Security purposes (excluding certain items of income specifically excluded from the other taxes).

(Section 213.) This section makes appropriate changes in nomenclature and in the requirements of tax returns, including reports of estimated tax liability under the new tax on unearned income.

(Section 214.) This section details the specific effective dates of the taxes imposed by this part.

TITLE III

(Section 301.) Subsection (a) repeals Medicare on the date benefits become effective but stipulates that this shall not affect any right or obligation incurred prior to that date.

(Section 302.) This section requires that after the effective date of benefits, no State shall be required to furnish any service covered under Healtn Security as a part of its State plan for participation under Medicaid, and that the Federal government will have no responsibility to reimburse any State for the cost of providing a service which is covered under Health Security. After the effective date of benefits, the Secretary of HEW shall prescribe by regulation the new minimum scope of services required as a condition of State participation under Title XIX. To the extent the Secretary finds practicable, the new minimum benefits will be designed to supplement Health Security—especially with respect to skilled nursing home services, dental services and the furnishing of drugs.

(Section 303.) This section provides that funds available under the Vocational Rehabilitation Act or the Maternal and Child Health title of the Social Security Act shall not be used to pay for personal health services after the effective date of benefits, except (to the extent prescribed in regulations by the Secretary of HEW) to pay for services which are more extensive than those covered under Health Security.

TITLE IV

(Section 401.) This section authorizes the Secretary of Health, Education, and Welfare in consultation with the Secretary of State and the Secretary of the Treasury to study the coverage of health services for U.S. residents in other countries.

(Section 402.) Subsection (a) sets forth Congressional findings concerning the shortage of appropriate services and facilities for the long-term care of the aged or chronically sick. It notes that the shortage is in large measure due to the inadequacy and fragmentation of public programs, and that the shortage of appropriate services results in a severe hardship to the elderly and disabled and causes much improper use of hospitals and skilled nursing homes. Subsection (b) directs the Secretary to make a comprehensive study of the need for additional social, homemaker and other services for persons described in subsection (a) and the most equitable and appropriate means of financing such services. The Secretary is required to report his findings together with recommendations of legislation to the Congress within two years of the enactment of this title.

(Section 403.) Subsection (a) directs the Secretary of HEW to study the feasibility and desirability of coordinating the federal health benefit programs for merchant seamen, and Indians and Alaskan natives with the health security benefit program. The Secretary and the Administrator of Veterans Affairs shall conduct a similar joint study of the desirability and feasibility of coordinating veterans health care programs with the health security benefits program. Reports to the Congress and any legislative recommendations arising from the studies are required within three years after the enactment of this title.

Subsection (b) requires the Secretary and Administrator to consult with representatives of the affected beneficiary groups and include a summary of their views in the reports to Congress.

With respect to the joint study to determine the most effective method of coordinating the Veterans Administration Health Program with the Health Security Program established under this bill, it is important to understand that there is no intention to require either the integration of the VA program into the Health Security Program, or even the consideration of such integration. Rather, the section recognizes that any national health security or health insurance program would be so pervasive as to require other federal health programs such as those of the Veterans Administration to be effectively coordinated with them. Through such coordination, needless duplication and expenditures should be avoided.

(Section 404.) Subsection (a) sets forth Congressional findings concerning medical malpractice, and the methods of determining liability and assessing damages, are unsatisfactory. It notes that the cost of malpractice insurance is a significant element in the mounting cost of health care, and points to increasing evidence that the cost, together with the limited availability of insurance, may tend to discourage desirable medical procedures and have a detrimental effect on the use of health services. It concludes that better mechanisms must be found to determine and award fair compensation in appropriate cases to patients who have been injured in the course of the receipt of health services.

Subsection (b) directs the Secretary to make a comprehensive study of the problem, including the most appropriate criterion of compensable injury, means of adjudication, and means of financing the payment of compensation. The Secretary is required to make to the Congress an interim report within one year, and a final report and recommendations for legislation within two years of enactment of this title.

Mr. SAXBE. Mr. President, I have long called for a massive overhaul of our national health machinery. That is primarily the reason I was pleased to cosponsor with several colleagues the Health Security Act of 1970. The bill has been reintroduced, again with my cosponsorship. I hope the proposal will be debated at length, not just in this body, but across the land.

Mr. President, a few months ago I prepared an article for the Bond Buyer magazine which details my views on health security and a better America. This as clearly as anything explains why I believe we must begin now to talk about the idea of health security for all Americans.

I ask unanimous consent to insert the article at this point in the RECORD.

There being no objection the article was ordered to be printed in the RECORD, as follows:

HEALTH SECURITY AND A BETTER AMERICA

(By Senator WILLIAM B. SAXBE)

With a bow to an over-used phrase, I submit that a program of national health insurance for all Americans is an idea whose time has come.

That is why I, along with several other of my colleagues in the United States Senate, am sponsoring a legislative proposal to establish a program of comprehensive national health insurance to provide better health care for all of our people.

Before I go further, let me add this proviso: The bill (S. 4297, introduced Aug. 27, 1970) is not going to pass this year. It is not going to pass next year. Maybe it will never pass. But it's something we've got to start talking about. Because of the complex nature of the effort itself, it probably is wise that the actual legislation may be a time coming.

PULL IT TO PIECES

As "The Washington Star" pointed out in an editorial endorsing the idea on Sept. 27, ". . . the insurance bill . . . will not and should not be passed in this session. To place it in effect would be like installing a jumbo jet engine on a Ford Tri-Motor plane; it would pull the whole fragile health works to pieces. It is the only logical long-run objective, but preparations must be made. Crippling deficiencies of manpower, money and planning must be dealt with . . ."

This said, let me go on to explain why I think the program is needed as soon as feasible. Let me also tell you a little about this particular proposal.

I wish that the needed corrections in our health care systems could be done on the local level, or the State level, but I don't see this happening. We have to meet this problem on the Federal level. At the present time, adequate coverage for all of our people just does not exist. And inflation has created a situation where there are no savings available in all too many cases for long-term, serious illness.

Much of the burden rests on our older people, those who are hurt most by inflation. These people don't receive adequate care and they are not adequately covered. Medicare doesn't begin to cover all of their medical costs.

Columnist Sylvia Porter pointed up the problem quite clearly in a recent piece, when she told about a friend who was admitted to a major New York hospital, suffering a coronary heart attack. The friend remained in an intensive care unit for six weeks before moving to a private room with round-the-clock private nurses. He was finally released three months after entering the hospital and his bill was a mind-boggling $22,000.

MORE DOCTORS

As Miss Porter wrote: "Fortunately, this man had extensive health insurance. But what if he had been among the tens of millions who have only a bare minimum or no coverage at all?"

We can't significantly increase the number of doctors or the methods of treatment by merely putting more and more money into our present health programs. This bill provides for increasing the numbers of doctors. We need at least 40,000 more doctors, but that alone won't cure the ills of the nation. Just supplying 40,000 more practitioners won't drive physicians to the outposts where they are needed. We must spread doctors more efficiently and we must make sure that people who need specialized services get them. Many people who need a specialist go without one because they can't afford it. This bill recognizes the importance of the referral system which makes efficient use of the general practitioner and the specialist.

My only objection to the bill is the cost, but sometimes you have to pay the price for a good system. Estimates range anywhere from $37 billion to $77 billion a year by fiscal 1974, when this particular bill would become effective. But when you consider that the war in Vietnam has been costing us anywhere from $18 billion to $30 billion a year for the last six years, a similar expenditure for health care for all doesn't seem too much or too awesome.

In its purest sense, this bill would be financed by an increase in Social Security payroll taxes. The plan would provide coverage for all major health services except custodial care for the aged and disabled, and psychiatric and dental care. It would be financed 35 per cent by an employer-paid payroll tax; 25 per cent by a tax on workers' income up to $15,000 a year and the remaining 40 per cent would come from general Federal revenues.

EASY TO FORGET

It is easy to forget—in fact, millions don't know at all—that the United States is the only major industrial nation in the world that does not have a national health service or some kind of program of national health insurance. I believe that such a program, together with concomitant changes in the organization and delivery of health care in the United States, is our single most important issue of health policy today.

When the health security bill was introduced in the Senate, Sen. Edward Kennedy, D-Mass., detailed some of its major provisions. I think it would be helpful if I summarized those provisions at this point.

Several basic principles have served as guidelines for the proposal:

(1) Health security doesn't envisage a national health service, in which the Government would own the facilities, employ the personnel and manage the finances of the health system. Rather, the program proposes a working partnership between the public and the private sectors. The Government will, of course, assist with financing and administrative management, joined with private provision of personal health services through private practitioners, institutions, and other providers. The program itself would be carried out gradually, moving in an orderly, evolutionary way from where we stand today toward the goals we have set for the future.

BUDGETED BASIS

Comprehensive service covered by the health security program will be financed on a budgeted basis. Funds will be provided from a pool of national resources, with reasonable limitations, governed by such demands as the national economy warrants. In other words, safeguards would be provided against runaway expenditures.

(2) Benefits of the health security program will be available, with only minor exceptions, to all persons residing in the country. Target date for this particular bill is the middle of 1973. Eligibility will require neither an individual contribution history as in Social Security nor a means test as in Medicaid.

(3) Benefits of the program will embrace the entire range of services required for personal health. These include services for the prevention and early detection of disease, for the care and treatment of illness, and for medical rehabilitation.

(4) Providers of health services will be compensated directly by the health security program. Individuals will not be charged for covered services. Hospitals and other institutional providers will be paid on the basis of approved prospective budgets. Independent practitioners, including physicians, dentists, podiatrists and optometrists, may be paid by various methods which they elect: by fee-for-service, by capitation payments, or in some cases by retainers, stipends, or a combination of methods. Comprehensive health service organizations may be paid by capitation or by a combination of capitation and methods applicable to payments to hospitals and other institutional services. Other independent providers, such as pathology, laboratories, radiology services, pharmacies, and providers of appliances, will be paid by methods adapted to their special characteristics.

STATE LAW SUPERSEDED

(5) Financial and administrative arrangements are designed to move the medical care system toward organized programs of health services, with special emphasis on teams of professional, technical and supporting personnel. The resources development fund—containing up to 5 per cent of the total

amount in the trust fund—will be available to support the most rapid practicable development toward this goal of strengthening and improving America's health resources. Federal law will supersede State statutes which restrict or impede the development of group practice plans. So, the program will do its best to assure increased availability of covered health services. It will not be content with merely contributing further strains on our already overburdened resources.

(6) The health security program includes various provisions to safeguard the quality of health care. The program will establish national standards more exacting than Medicare for participating individual and institutional providers. Independent practitioners will be eligible to participate if they meet licensure and continuing education requirements. Specialty services will be covered if, upon referral, they are performed by qualified persons. Hospitals and other institutions will be eligible if they meet national standards.

(7) On the subject of health manpower, the health security program will supplement existing Federal programs. It will provide incentives for comprehensive group practice organizations. It will encourage the efficient use of personnel in short supply. It will stimulate the progressive broadening of health services. It will provide funds for education and training programs, especially for members of minority groups and those disadvantaged by poverty. Finally, it will provide special support for the location of needed health personnel in urban and rural poverty areas.

(8) Health security will supersede in whole or part various Federal health programs. Because all persons over 65 will be covered by the program, Medicare under the Social Security system will be ended. Federal aid to the States for Medicaid and other Federal programs will also be ended except to the extent that benefits under such programs are broader than under health security. However, the bill does not revise the current provisions for personal health service under the Veterans' Administration, temporary disability, or workmen's compensation programs.

FIVE-MEMBER BOARD

(9) Administering the health security program will be concerned primarily with the availability of services, the observance of high quality standards, and the containment of costs within reasonable bounds. Policy and regulations will be established by a five-member, full-time Health Security Board, appointed by the President with the advice and consent of the Senate. Members of the board will serve five-year terms and will be under the authority of the Secretary of Health, Education and Welfare.

So far as general policy, the formulation of regulations and the allocation of funds, a statutory National Advisory Council will assist the board. Members of the Council will include representatives of both providers and consumers of health care.

Administration of the program will be carried out through the 10 existing HEW regions as well as through the approximately 100 health sub-areas that now exist as natural medical marketplaces in the nation. Advisory councils on matters of administration will be established at each of these levels. Through its regulation, the board will guide the overall performance of the program. It will coordinate its activities with State and regional planning agencies, and it will account for its activities to Congress.

(10) A health security trust fund, similar to the Social Security trust fund, will finance the program. The fund will derive its income from three sources: 40 per cent from Federal general revenues; 35 per cent from a tax of 3.5 per cent on employers' payrolls and 25 per cent from a 2.1 per cent tax on individual income up to $15,000 a year.

It is important to note that employers may pay all or part of their employees' health security tax, and they would be expected to preserve obligations under existing collective-bargaining agreements.

The board each year will make an advance estimate of the total amount needed for expenditure from the trust fund to pay for services, for program development, and for administration. The board will allocate funds to the several regions, and these allocations will be subdivided among categories of services in the health sub-areas. Advance estimates, constituting the program budgets, will be subject to adjustments in accordance with guidelines in the act. The allocations to regions and to sub-areas will be guided initially by the available data on current levels of expenditures. Thereafter, they will be guided by the program's own experience in making expenditures and in assessing the need for equitable health care throughout the nation.

TWICE PRESENT TOTAL

(11) On the basis of data from fiscal 1969, the most recent year for which complete statistics are available, the health security program that we are talking about here would have paid for a total of $37 billion in personal health care services in the United States. Had the program been in existence in 1969, therefore, it would have paid approximately 70 per cent of the $53 billion in total personal health expenditures for that year, or about twice the percentage that existing forms of public and private health insurance now pay.

It is also important to stress that, overall, expenditures under the health security program will not create a new round of Federal health expenditures, layered on top of existing public and private expenditures for health care. Instead, the health security program is designed to achieve a rechanneling of expenditures already being made, so that existing funds may be allocated more efficiently.

In essence, health security expenditures will replace the large amount of wasteful and inefficient expenditures already being made by private citizens, by employers, by voluntary private agencies and by Federal, State and local governments. Only in this way can we begin to guarantee our citizens better value for their health dollar.

THE DIFFERENCES

In the end, I think the Health Security Act differs from previous proposals for national health insurance. As I and others have noted, it is not just another proposal for insurance. It is not just another design for pouring more purchasing power into our already over-strained and over-burdened system for delivery of medical care. It is not just another proposal to generate more professional personnel or more hospitals and clinics, without the means to guarantee their effective utilization.

This is a proposal to give us a national system of health security. Under this program, the funds we make available will finance and budget the essential costs of good medical care for the years ahead. At the same time, these funds will be building new capacity to bring adequate, efficient and reliable medical care to all families and individuals in the nation.

WORSE TODAY

In closing, I want to point up a few facts which I believe as well as any others illustrate the need for this program.

For example, the health of most Americans is worse today than it was 15 or 20 years ago compared with other industrial countries. Despite the high percentage of our earnings we pay for health care, the high competence of our doctors and the highest level of income in the world, this is true.

The Committee for National Health Insurance recently compiled statistics on infant deaths, maternal mortality, life expectancy and the mortality of men in their middle years with those of other industrialized countries, and found that the United States ranks:

Thirteenth among industrial countries in death of infants during the first year of life.

Seventh among industrial countries in the percentage of mothers who die in childbirth.

No better than 18th in the life expectancy of males and 11th for females.

Sixteenth among other industrial countries in the death rate of males in their middle years.

In all instances, the U.S. ranked better 15 or 20 years ago.

In a nutshell, these statistics point up quite clearly that something is indeed wrong with the delivery on massive scales of health care in our country.

And that is why I say that a bold, new, innovative program of national health insurance for all Americans is an idea whose time is at hand.

S. 4—INTRODUCTION OF A BILL TO AMEND THE TRADE EXPANSION ACT OF 1962

Mr. THURMOND. Mr. President, I send to the desk a bill on behalf of myself and Senator COTTON to amend the Trade Expansion Act of 1962. This bill is identical to the trade bill that was reported out of the Senate Committee on Finance December 11, 1970, in the 91st Congress.

The flood of cheap foreign goods in unreasonable quantities into the United States is literally destroying the textile-apparel industry—an industry vital to the well-being of our economy and one which is rated second only to steel as far as national defense is concerned. The fate of America's textile-apparel industry and its employees is now in the hands of the Congress.

Mr. President, throughout the history of this country the textile-apparel industry has been a major source of American jobs, greatly assisting in providing this country with a very high rate of employment. Today it directly employs one out of every eight manufacturing workers for a total of 2.5 million people and indirectly employs another 3 million. Because of the tremendous increase in foreign imports during the last few years, these jobs of American workers have been placed in serious jeopardy. Since 1965 imports have doubled, resulting in over 300,000 workers being laid off. This situation becomes more critical each year as exemplified by the fact that one-third of these job losses occurred between January and September of last year alone. The Department of Commerce estimates that a total of 125,000 textile-apparel workers lost their jobs during the year 1970. I should like to point out that a laid-off textile worker not only ceases to pay taxes but may be reluctantly forced to go on relief. Passage of the trade bill is the only way we are going to be able to stop this number from increasing and make it possible for those who have already lost their jobs to get back on a payroll.

The textile-apparel industry has plants in all of our 50 States, and they are important to large and small communities alike. In hundreds of small towns and villages throughout the Nation, textile-apparel plants are the only employers of