Mr. KENNEDY. Mr. President, on behalf of Senator Cooper, Senator S axee, and myself, together with Senators Bayh, Case, Cranston, Gravel, Hart, Hughes, Humphrey, Inouye, Javits, Magnuson, McGee, McGovern, Medcalf, Mondale, Morse, 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 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 idea 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 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 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 continue, no matter who is in power. The crisis of national health insurance is not going to be resolved by the organization of staff or by redressing breaches of such responsibility by each other; the prohibition of a wider range of conflicts of interest; or the prohibition for 7 years of persons convicted of certain crimes serving in auxiliary positions on employee benefit funds.

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

The fact that the time has come for national health insurance makes it all the more necessary for new resources into remaking our present system. The existing organization and delivery of health care are so obviously inadequate to meet our present 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 5 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 and when to 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. But the changes that come 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 adjustment. That 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 unfolded in the administration's arsenal. But we cannot afford to take these steps alone. We need a comprehensive and coordinated approach that has 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 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, which enforces a more balanced and proportioned approach to the health 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 meet the health needs of the Nation. So long as the resources are insufficient and the organizational arrangements are inadequate, money alone will not make the problem worse. National health insurance is needed not only to take over the functions of medicare and medicaid, but to make necessary basic changes in health care delivery. The urges that we begin moving toward such a Health Security program, neither Congress nor the medical profession will make the basic changes 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 medical professions, the heroic efforts of hospitals and other institutions, the conscientious efforts of Federal, State, and local public health agencies, and the loyalty of our health personnel. We know their strong desire to end the limitations under which they live today that work to the nation's 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 session 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 anguish 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 national-wide, 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.
January 25, 1971

CONGRESSIONAL RECORD — SENATE

America is an also-ran in the delivery of health care to our people. Almost everyone knows the cruel burden of worry, frustration, and disappointment that mark our search for better health care. The average American lives in fear of illness and disability. He lives with the uncertainty of not knowing whether to seek medical care, 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 accidental 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. 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 unified 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.

In life expectancy among 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.

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 behind 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 comprehensive health service. Instead, we have placed our prime reliance on private enterprise and private health insurance.

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 there-after, at the very time when he can least afford it.

Nearly all private health insurance is partial and limited. For most citizens, their health coverage is more of a 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 Employee 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 coverage in the Federal program. The figures are especially striking for female surgery and 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 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 the advances of medical research. We have allowed ourselves to become 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 shortchanges 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 firmer 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 costs of medical care began to rise, progressively pricing 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 basic planning and development of national health services. They met their country's needs, and number of allied practitioners. And,

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, 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 Saxen, 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 met extensively with representatives of professional associations, consumer organizations, labor unions, 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, Saxe, 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 for a national health insurance program similar in overall concept to the Health Security program, and her bill has 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 unifying of major American organizations 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.

**Funding**—The new, 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 full cost 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, hospital and outpatient hospital services, and home health services. It also provides full coverage for的眼科服务, 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 necessity, 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 cost-based reimbursement system.

- **Psychiatric hospitalization** is limited to 45 consecutive days of active treatment during the 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.

- **Prescription 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.

The 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.

Financial 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 with state and regional planning agencies, and it will account for its activities to Congress.

**Financing**—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 employers' 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 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 to 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 Board 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**—Doctors of medicine in the United States, nurses, dentists, podiatrists, and optometrists, may be paid by various methods which they may elect: by fee-for-service, by capita-
In the area of health manpower, the program will supplement existing Federal programs. It will provide incentives for the private sector and other organizations, encourage the efficient use of personnel in short supply, and stimulate the provision of needed health services. It will provide funds for education and training programs, especially for members of minority groups and those engaged in work associated with poverty. Finally, it will provide special support for the location of increased health personnel in urban and rural poverty areas.

Relating 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.

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 States and local governments.

The cost of the health security program has been the source of enormous confusion and misunderstanding since the hypothesis of the hypothetical $41 billion price tag for the Health Security program in 1970 represent new money. Rather, this is what Americans are already spending 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 $6 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 county and city medical programs.

In a very real sense, therefore, the Health Security program is a direct form of Federal assistance. It offers an estimated $41 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 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 10 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 which we submit to the Senate and to the people of the United States differs from all previous proposals for national health care or national health insurance. It is not just another financing mechanism. It is not just another proposal to generate more 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.

Our is a plan that will 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 a 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 seen and understood by 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.

This 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:

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

Sec. 21. Basic eligibility.

Sec. 22. (a) Professional services of physicians, surgeons, and dentists.

(b) Covered physicians' services consist of (1) primary medical services, which are the services of physicians, surgeons, or dentists (other than preventive, diagnostic, or rehabilitative services) ordinarily furnished by physicians, whether general practitioners, specialists, or other entities designated in regulations.

(c) Psychiatric (mental health) service to an outpatient is a covered service only if it constitutes an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders.

(b) The service is furnished to a patient of the Board for this purpose, or (C) to the extent of twenty consultations during a benefit period (as defined in regulations).

Any community in which the available psychiatric services furnished otherwise than in accordance with clause (A) or (B) are furnished to patients by the Board may limit the coverage of such services by precluding referral or other similar conditions in order to give priority of access to the services to those persons most in need of them.

(b) Dental services.

Sec. 25. (a) Professional services (described in section 24(c)) of a dentist in his office or elsewhere, are covered services except to the extent otherwise provided in this Act.

(b) Covered services include services and supplies of kinds which are commonly furnished in a physician's separate charge, as an incident to his professional services.

(c) Dental services.

Sec. 26. (a) Professional services (described in section 24(c)) of a dentist in his office or elsewhere, are covered services except to the extent otherwise provided in this Act.

(b) Covered services include services and supplies of kinds which are commonly furnished in a physician's separate charge, as an incident to his professional services.

(c) Dental services.

Sec. 27. (a) Professional services (described in section 24(c)) of a dentist in his office or elsewhere, are covered services except to the extent otherwise provided in this Act.

(b) Covered services include services and supplies of kinds which are commonly furnished in a physician's separate charge, as an incident to his professional services.

(c) Dental services.

Sec. 28. (a) Professional services (described in section 24(c)) of a dentist in his office or elsewhere, are covered services except to the extent otherwise provided in this Act.

(b) Covered services include services and supplies of kinds which are commonly furnished in a physician's separate charge, as an incident to his professional services.

(c) Dental services.

Sec. 29. (a) Professional services (described in section 24(c)) of a dentist in his office or elsewhere, are covered services except to the extent otherwise provided in this Act.

(b) Covered services include services and supplies of kinds which are commonly furnished in a physician's separate charge, as an incident to his professional services.

(c) Dental services.
sary services, whether they are furnished by
stitution 21, are covered services except to the
are ordinarily furnished by the institution
skilled nursing home services, and the serv-
dation with respect to the scope and condi-
tion be extended to persons more than 15
lowing injury, disability, or disease.
ceeding year, persons who are then less
more than 25 years of age.
are included in (c) of subsection (b) of this sec-
covered services do not include insti-
sychiatric or another hospital during a bene-
der; and do not include care of
adequate funds and resources are available
is furnished to a person who
ment of drugs for
of subsections (b) and (c) and
treatment of which drugs may be furnished
ecessary and effective. To assure proper
ction in excess of
price, the Board has determined
ment with respect to the circumstances under
deems appropriate, by trade names.
ra, hearing aids, and prosthetic ap-
to the continued medical necessity of such
esses, the Board may require that the
same conditions for
the Board finds es-
organization or by a community mental
institutions or organizations, which or the frequency with which the
be, in accordance, with regulations, the furnishing of
Continental Health Service
use outside such institutions and orga-
ter, or under circumstances described in
served, or incident to covered dental services.
are covered services except to the
exceeding 25 years of age.
are provided in regulations, inpatient services of
has established and dissemi-

domly furnished or custodial care, or institu-
tion of a person who is not re-
ive active medical treatment.
are covered services do not include per-
clinical or custodial care, or institu-
tion of a person while he is not re-

who furnishes or prescribes. In
their established names (as defined in section
satisfied with respect to the determination
clusion of the list of items which,
the results of re-
ent the provisions of section 28) the following are covered ser-
are covered services. (a) Inpatient and outpatient
els, and the services of home health service agencies, which are
the institution or by others under arrange-
ment with the institution. To the extent
the Board, in the presence of a

one hundred and twenty days during a benefit
by the Board in the following cases:
are covered services, for either a stated number of
days in a benefit period or indefinitely—

in participating skilled nursing
homes having in effect affiliation agreements un-

in subsection 31 (d), or

in all participating skilled nursing
homes for which consolidated budgets with hospitals have been

is a covered service if (1) the
physician or dentist furnishing or prescr-
ing a drug is 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 prescr-
ing a drug 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 specific
requirements set forth in regulations, if any,
required by the Board, and (3) the drug is
specified on the Board's list as one available
for treatment of a condition or disease
identified by the physician or dentist.
ners on the Board's list, (2) the
physician or dentist meets specific
requirements set forth in regulations, if any,
required by the Board, and (3) the drug is
specified on the Board's list as one available
for treatment of a condition or disease
identified by the physician or dentist.

developed by a participating hospital to an

drug therapy incident to comprehensive medical
services or incident to covered dental services.

are covered services. (c) Covered
services do not include personal
comfort items or, unless required for medical
reasons, the additional cost of ac-
commodations more expensive than semi-
private accommodations; and do not include
omittary or custodial care, or institu-
tional care of a person while he is not re-
ceiving active medical treatment.

are covered services. (d) 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 the duration of covered services, for either a stated number of
days in a benefit period or indefinitely—

is a covered service if (1) the
physician or dentist furnishing or prescr-
ing a drug is 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 prescr-
ing a drug 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 specific
requirements set forth in regulations, if any,
required by the Board, and (3) the drug is
specified on the Board's list as one available
for treatment of a condition or disease
identified by the physician or dentist.

is a covered service if (1) the
physician or dentist furnishing or prescr-
ing a drug is 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 prescr-
ing a drug 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 specific
requirements set forth in regulations, if any,
required by the Board, and (3) the drug is
specified on the Board's list as one available
for treatment of a condition or disease
identified by the physician or dentist.
(b) Supporting services (such as psychological, physio-therapy, nutrition, social work, and similar services) are covered only when they are a part of institutional services under this subpart and when the participating provider is engaged in a participating hospital, and when the Board finds it necessary to determine the degree of qualification and the standard of quality of professional services required in each case. When the Board deems pertinent, the Board may require a written statement as to the reasons for the suspension or revocation of a provider's authorization.

(c) Special cases.—(1) The Board may, by regulation, exempt any provider from the requirements of section 47(a), (b), or (c) of this title, if it finds that the provider is engaged in a participating hospital, and if the Board finds necessary to determine the degree of qualification and the standard of quality of professional services required in each case. When the Board deems pertinent, the Board may require a written statement as to the reasons for the suspension or revocation of a provider's authorization.

(d) The furnishing of a drug otherwise than in accordance with section 23(a) shall be permitted only when the Board finds it necessary to determine the degree of qualification and the standard of quality of professional services required in each case. When the Board deems pertinent, the Board may require a written statement as to the reasons for the suspension or revocation of a provider's authorization.

(e) The provisions of subsection (c) shall be subject to the provisions of section 45(a) (1) a qualified provider of covered services which (1) is also in any other State (in accordance with the provisions of section 56(a) (1)) a qualified provider of services which (1) is also in any other State (in accordance with section 22(a) or section 23(a), as an Incident to professional services.

Section 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 diagnoses, 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 appointments it shall not discriminate on any ground unrelated to professional qualifications;

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

(e) satisfies the requirements of subsection (b) through (1) of section 42.

(f) Subject to the provisions of section 53 and subsection (a) of section 42, 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.

Section 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 is an institution which:

(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 (1) of section 42;

(c) which, on the basis of staffing and other factors it deems pertinent, finds it necessary to determine the degree of qualification and the standard of quality of professional services required in each case, if it finds that the provider is engaged in a participating hospital, and when the Board finds necessary to determine the degree of qualification and the standard of quality of professional services required in each case. When the Board deems pertinent, the Board may require a written statement as to the reasons for the suspension or revocation of a provider's authorization.

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

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

Section 45. Subject to the provisions of section 53, a hospital is a qualified provider if 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) satisfies the requirements of section 53 and subsection (a) of section 42, 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.

Section 46. Subject to the provisions of section 53, a 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 diagnoses, treatment, care, and rehabilitation of injured, disabled, or sick persons;

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

(c) satisfies the requirements of subsections (b) through (1) of section 42, 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.

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

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

Section 47. Subject to the provisions of section 53, a 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 diagnoses, 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 appointments it shall not discriminate on any ground unrelated to professional qualifications;

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

(e) satisfies the requirements of subsection (b) through (1) of section 42.

(f) Subject to the provisions of section 53 and subsection (a) of section 42, 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.
Sec. 46. Subject to the provisions of section 62, 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 personnel and regulatory agencies 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;

(c) maintains adequate clinical records on all patients;

(d) meets all applicable requirements of the State of 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 ensure the appropriate utilization of services; and

(f) meets any applicable requirements of such other qualification standards as the Board may find necessary in the interest of the quality of care and the safety of the agency or 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, or both, meet the objectives of prepaid group practice;

(2) the organization, or 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 21(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 at such times as may be medically appropriate, and to the maximum extent feasible makes all services readily accessible to the enrollees of 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 and fosters the development and use of preventive health services, and provides that a committee or committees of physicians and laypersons of the organization promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutic committees, and monitor and report to the organization on the utilization of all health services (including drugs);

(8) the organization, to the extent practicable, and within the scope and medical practice, employs allied health personnel and lay persons in the furnishing of services;

(9) premiums or other charges by the organization for 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 of 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 determines to be necessary or appropriate in the interest of the quality of care and the safety of eligible persons, or for other reasons.

Sec. 48. A professional foundation which is sponsored by a city, county, or State medical society, and 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 it furnishes health services to patients of the agency or organization, to pay for health services furnished by the agency or organization, or by its governing board.

Sec. 49. (a) Pursuant to an agreement with the Board, the foundation or any participating provider, or any of the following is a qualified provider of services as are specified in the agreement:

(1) a public or other nonprofit agency of the foundation (including a hospital) which...
furnishes health services not less comprehensively than those required by section 47(a)(3); but does not meet all other requirements of section 47(a).

(3) A nonprofit center (including a satellite center established by a hospital) which (A) furnishes as a minimum, all of the services of the center established by the Board, having the same qualifications and limitations as the center established by the Board, is not within its scope. Unless the agreement provides that, in the event of the transfer of a patient to the center established by the Board, the hospital shall be compensated for the services furnished, (1) with respect to the medical necessity of the services, and (2) by the Board.

(d) An agreement under this section shall be made on such terms and conditions 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 as the Board deems proper, and shall include any of the requirements of section 48 other than the requirement of sponsorship by a medical or dental society; or of a medical or dental group practice or clinic, a center for the treatment and rehabilitation of alcoholic or drug addicts, or a mental health service organization, under which the medical staff (and, when requested, to the Board), of such center, clinic, or organization shall be reviewed by a committee of the Board, for the purpose of promoting the most efficient use of available health facilities and services; and provides for such review, to the institution and the medical staff (and, when requested, to the Board), of statistical summaries of the services furnished to eligible persons residing in the area to be served by the institution.

OTHER PROVISIONS

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 (d) provided that (whether or not it is engaged in activities in interstate commerce) the requirements established by or pursuant to section 333 of the Public Health Service Act are met. 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 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 section 333 of the Federal Food, Drug, and Cosmetic Act, all 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.

(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 and licensed by the First Church of Christ, Scientist, Boston, Massachusetts.

TRANSFER AND AFFILIATION AGREEMENTS

Sec. 52. (a) A skilled nursing home is a qualified provider only if it has in effect an agreement with at least one participating hospital, providing for the transfer of patients and medical and other information between the institutions medically appropriate.

(b) In no event following the effective date of this section, a skilled nursing home or a home health service agency will be a qualified provider only if has been found by the Board to be providing services in the skilled nursing home or the home health service agency, for the home or a home health service agency, for the home or an organization, (or a committee thereof) will furnish, or will assume responsibility for, the professional or other services to persons residing in the area to be served by the home health agency, as the case may be.

(c) The requirement of a transfer agreement under subsection (b), shall not be applicable in any case if there is in effect an agreement, as defined in regulations, under which the board of directors of a hospital or a home health service agency have been found, to be providing services in the skilled nursing home or the home health service agency, for the home or a home health service agency, for the home or an organization, (or a committee thereof) will furnish, or will assume responsibility for, the professional or other 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—

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

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

EXCLUSION: FEDERAL PROGRAMS OF SERVICES

Sec. 55. No institution of the Department of Defense, no institution of the Veterans' Administration, no institution of the Department of Education, Health, and Welfare, or any other entity engaged in the provision of services to merchant seamen or to Indians of Alaska, and no employee of any of the foregoing acting as employee, is a participating provider. The Board shall reimburse the proper appropriation for any covered services furnished by any such institution to an eligible person who is not, under any Act other than this Act, eligible to receive the service from the institution to which the person is entitled. The Board shall reimburse the proper appropriation for any covered services furnished to eligible veterans pursuant to section 339 of the Public Health Service Act (added by Public Law...
of payments required by section 329(b).

(1) A physician, dentist, optometrist, or podiatrist who, legally authorized by the State or political subdivision to the contrary notwithstanding, is 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 he or she is customarily authorized 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 who is a podiatrist, is hereby authorized to furnish in any State, on behalf of himself or herself or on behalf of any law of a State or political subdivision to the contrary notwithstanding, the services which that State authorizes or permits to be furnished by practitioners of his profession.

(3) In a participating public or other nonprofit hospital or participating comprehensive health service organization, a practitioner of any health profession other than medicine or dentistry, such of the acts which that State authorizes or permits to be served such a hospital or organization, or makes other arrangements not of a kind which the Board may find that the Board estimates that the amount in the fiscal year current at the time when the determination is made, and (B) the Board finds that the amount fixed under subsection (a) shall be less than the maximum stated in paragraph (1) of that subsection.

(4) A participating public or other nonprofit hospital, or a participating comprehensive health service organization is hereby authorized (whether or not the arrangement made pursuant to subsection (a) or (b) exists) 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, or in any other manner, but only if the employment or other arrangements for their compen-
sation is likely to cause lay interference with professional acts or professional judgment.

(b) If the Board finds that a proposed corporate agreement will meet the requirements of section 201(g) of the Social Security Act (creating the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) and that the Board may issue a certificate of incorporation of such an organization, or that physicians constitute all or a majority of its governing board, or 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 to be necessary for the purpose of (A) the tax-free status of the trust funds, of the cost of administering (including the IRS, the Internal Revenue Code of 1954, and

(2) for any fiscal year except the fiscal year beginning on the effective date of the Board's regulations, shall not exceed the amount fixed pursuant to subsection (a) of section 201(g) of the Social Security Act, by an amount equal to 1 percent or more, or if an epidemic, disaster, or other occurrence increase the need for hospital or other care or services in any other manner, and the Board 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. 62. (a) There shall be established in the 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 at the end of each fiscal year, (2) if the Board finds that the amount fixed under subsection (a) is less than the maximum stated in paragraph (1) of that subsection.

(b) Notwithstanding the provisions of any other Act, the amount fixed under subsection (a) to be available for obligation will not exceed 200 percent of the expected net receipts during the fiscal year for the payment of sums appropriated under subsection (a) of section 201(g) of the Social Security Act, for the fiscal year beginning on the effective date of the Board's regulations, shall not exceed the amount fixed pursuant to subsection (a) of section 201(g) of the Social Security Act, by an amount equal to 1 percent or more, or if an epidemic, disaster, or other occurrence increase the need for hospital or other care or services in any other manner, and the Board shall promptly report its action to the Congress with a statement of the reasons therefor.
(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 determined pursuant to subsection (a) shall be increased proportionately.

(d) The Board shall be entitled, at its election, to pay the costs of specialized services furnished by independent practitioners, in accordance with this section for the services of the class for which the fund is to be available, to a provider of such services, of an annual capitation payment for each eligible person for which he is responsible under section 67 for a class of services. If an interregional equalization is required by events occurring after the division of funds by classes of services pursuant to section 65, or the allotment of funds from the General Account to the Board pursuant to section 64(c), the contingent reserve shall be available for interregional equalization.
area who has chosen to receive all such services from the provider.

(3) The Board may, on an experimental or demonstration basis, enter into an agreement with a state, a local professional society or other organization representative of independent practitioners to substitute another method of compensation for those set forth in this section (either for all such practitioners or 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 this 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 appropriate operating cost 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 provide that each hospital's proportion of the budget shall be determined in accordance with the relative size of the hospital's population served by the Board, the number of its residents in the health service area, the kind of services or other costs incident to the hospital it operates or has an agreement with. (b) The costs recognized in each hospital's budget shall be in accordance with subsection (a), of furnishing the covered services ordinarly furnished by the hospital to its patients, and of performing any other function ordinarily performed by a hospital and ordinarily financed from payments by or on behalf of patients, except as the scope of services or other costs incident to the hospital its operated or has an agreement with the Board or the hospital or by direction of the Board pursuant to section 194. The budget shall recognize any increase or decrease of cost resulting from the modification of the scope of services or other functions, or resulting from compliance with any other direction issued pursuant to section 194.

PAYMENT TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS AND PROFESSIONAL FOUNDATIONS

SEC. 87. (a) Payment to a comprehensive health service organization or a professional foundation for covered services to its eligible enrollees, other than for hospital services, shall consist of basic capitation payments plus additional payments (if any) determined in accordance with subsection (d) and regulations designed to reflect the cost of the services or other costs incident to the hospital or services which will not be so recognized.

PAYMENT TO SKILLED NURSING HOMES AND TO HOME HEALTH SERVICE AGENCIES

SEC. 88. (a) Payment to a skilled nursing home or to home health service agencies 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, which shall be as follows:

(b) In regulations under this section, the Board shall, for skilled nursing homes and for home health service agencies, respectively, specify the costs which or methods to be included in determining the cost of services furnished to eligible persons of skilled nursing home services. The Board may, at its discretion, modify the cost of services furnished to eligible persons of skilled nursing home services which will be recognized in budgets and services which will not be so recognized.

PAYMENT FOR DRUGS

SEC. 89. (a) For each drug appearing on either of the lists established pursuant to section 25, the Board shall be allowed to 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 pharmaceuticals and consumer organizations, 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 the cost of drugs, dispensing services, differences in the volume of drugs dispensed, differences in services provided, and other factors which the Board finds relevant.

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 its appropriate operating cost 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.

PAYMENT TO PSYCHIATRIC HOSPITALS

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, which shall be as follows:

(b) In regulations under this section, the Board shall, for skilled nursing homes and for home health service agencies, respectively, specify the costs which or methods to be included in determining the cost of services furnished to eligible persons of skilled nursing home services. The Board may, at its discretion, modify the cost of services furnished to eligible persons of skilled nursing home services which will be recognized in budgets and services which will not be so recognized.

PAYMENT TO PSYCHIATRIC HOSPITALS

SEC. 86. (a) For each drug appearing on either of the lists established pursuant to section 25, the Board shall be allowed to 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 pharmaceuticals and consumer organizations, 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 the cost of drugs, dispensing services, 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 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) and regulations designed to reflect the cost of the services or other costs incident to the hospital or services which will not be so recognized.

(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 capitation amount fixed under section 82 (f) and amounts fixed by the Board, on the basis of the average reasonable and necessary cost per enrollee for hospital and 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 (b).

(c) If the organization or foundation furnishes hospital or 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 or by other providers) has, during a fiscal year, been less than the average utilization of such services utilized by comparable circumstances to comparable population groups not enrolled eligible persons enrolled in comprehensive health service organizations or foundations, the Board finds (on the basis of past experience and to that end (A) to coordinate the health delivery system, (B) to provide financial and other assistance 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.

P. 16 — PLANNING AND ALLOCATION OF FUNDS

PART F—PLANNING—FUNDS TO IMPROVE SERVICES AND REDUCE 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 service programs under this title or from other sources of public or private assistance.
(b) Prior to the effective date of health service programs under this title or from other sources of public or private assistance.

(c) If it appears to the satisfaction of the Board (1) that the average utilization of hospital and skilled nursing home services eligible persons enrolled in 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 the Board finds (on the basis of past experience and to that end (A) to coordinate the health delivery system, (B) to provide financial and other assistance 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.

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fore the period at the end of the paragraph: “and for each of the succeeding five fiscal years, if necessary”. GENERAL POLICIES AND PRIORITIES

SEC. 105. (a) In providing assistance under this section, the Board shall give priority to improving and expanding the available resources for, and assuring the accessibility of, necessary health services to urban and rural areas who lack ready access to such services, (b) the recruitment and training of professional personnel to staff such organizations, agencies, or centers, (c) the development of comprehensive health service organizations meeting the requirements of section 47(a), (d) 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, or 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 educational activities for personal health maintenance and to furnish liaison between such organizations, agencies, or centers and the people they serve, and (b) the strengthening of coordination and linkage among institutions, agencies, or centers. (a) The Board is authorized to make loans to organizations described in subsection (a), for not more than 90 percent of the cost (excluding costs of construction) of planning and developing an enlargement of an existing health service or an expansion of its resources to enable it to serve more effectively or larger clientele. In addition to grants under this subsection, or in lieu of such grants, the Board is authorized to provide financial assistance for the foregoing purposes.

(c) The Board is authorized to make loans to organizations 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 effectiveness and efficiency of delivery of 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 of other Federal financial assistance in meeting such costs. (d) The Board is authorized to contract with an organization or agency which is described in subsection (a) (1) 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). Such contract shall condition payments upon the contractor’s making, an appropriate effort to avoid or minimize operating deficits and (if such deficits exist) making reasonable progress toward becoming financially self-supporting. (e) The Board is authorized to make loans to organizations described in subsection (a) (2), which furnish or will furnish care to ambulatory patients which are improving and expanding the available 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, of the non-Federal share of other Federal financial assistance in meeting such costs. (f) The Board shall undertake to recruit and train professional personnel 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 the objectives of this part. (g) The Board shall undertake to recruit physicians and medical students, training for them pending action by the Congress on legislation among other matters) In administering other programs of health planning, the Board deems it inadequate to meet the most urgent needs of the Health Security program. The Board may make grants to public or other nonprofit agencies, institutions, or other Federal financial assistance in meeting such costs. (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 a minority group. (i) To this end the Board may, through contracts in accordance with subsection (e), provide to such persons remedial or supplementary educational 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 all or part of the cost of establishing or improving comprehensive health service agencies, among institutional services, among noninstitutional services, and between services of the two kinds. (b) The Board is authorized to make grants to organizations, agencies, or centers described in section 47(a) for not more than 90 percent of the cost of installation of improved facilities, equipment, or information retrieval systems, including the acquisition of equipment thereof, or to pay all or part of the costs of the installation of diagnostic or therapeutic equipment.

LOANS UNDER PART F

SEC. 107. (a) Loans authorized under this section shall be repayable in not more than 20 years, and the Board may impose a rate of 3 per centum per annum, and (subject to the provisions of subsection (b) it 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 in 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. 1976; 40 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 members to be appointed by the President, by and with the advice and consent of the Senate. During his term of membership, no member of the Board shall be a member of the same political party as the President. No member of the Board shall hold office for a term of five years, except that

(1) a member appointed to fill a vacancy occurring prior to the expiration of the term of his predecessor shall be appointed for the remainder of that term, and

(2) the terms of 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.

(b) 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 on them, respectively, by this title. Regulations issued by the Board under 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 effective methods of providing comprehensive personal health security for all persons within the United States and to report to the United States citizens, where, and of making, with the approval of the Board, such recommendations on legislation and matters of administrative policy with respect thereto. The Board shall make, from time to time, such reports as it deems necessary, 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 this title, an evaluation of the operation of the Board in progress for the initial year of this title, and for periods thereafter, an evaluation of the operation of the title, of the adequacy and quality of the services provided 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 the 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 charge.

(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, upon 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 of programs of private health insurance and health prepayment plans, or experience in 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, to any other officer or employee of the Board, or, with the approval of the Secretary, 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 through local health service areas. Each region, through such health service areas as the Board may establish, shall have such health service area a regional or local health security service, and such regional health service area a regional or local health security service in each health service area.

(b) The Board shall establish in each local health service area a local health security service and an executive director for the local health security service shall be selected by the Board in accordance with the provisions of this title and of taking or recommending any changes in the administration or operation of private health service areas, or in the operation of the title, of the adequacy and quality of the services furnished under it, the flow of patients make an interstate area a more practical unit of administration.

(c) The Board shall receive from the executive director in each local health security service area a report each year. Upon request by seven or more members it shall be the duty of the Chairman to call a meeting of the Council on any matter appearing to him, from sources within the Department or from other sources, pertaining to the functions of the Board.

(d) Each member of the Board shall have the duty to report to the Congress on 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 find necessary, and the Board, through the Secretary, shall promptly transmit the report to the Congress along with a reply thereto, and the Board, through the Secretary, shall transmit to the Senate a report on his views with respect to any legislative recommendations made by the Council.

APPOINTMENT OF OFFICERS AND EMPLOYEES

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 (in such number as the President may determine) representatives of providers...
of health services and representatives (who shall constitute a majority of the members of such agencies) of other covered services. It shall be the function of such council to advise the regional or local representatives, as the case may be, on all matters directly relating to the administration, performance, cost, or accounting of such services and procedures followed in the handling of complaints.

(c) The Board shall appoint 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 on the professional and technical aspects of the furnishing and utilization of, the payment for, and the evaluation 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 138, to provide technical assistance to providers of such 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 43(b) and 46(b).

Sec. 130. (a) The Board shall disseminate, to providers of services and to the public, information concerning the qualifications established by or pursuant to this title; the persons eligible to receive the benefits of the title, and the nature, scope, and availability of the services; and to providers of services, information concerning the condition, methods, and amounts of compensation to providers, and other matters relating to their participation.

(b) The Board shall make, on a continuing basis, the following studies and other activities pursuant to an agreement under subsection (a), or to supplement the advice of standing committees.

(1) To make statistical and other studies, including studies of the effect of the results of such experiments. Any such determination under this subsection shall, in such cases and on such conditions as are specified in subsections, be entitled to an administrative appeal from it.

(c) The Board finds that a participating provider of services no longer meets the qualifications established by or pursuant to this title, or has intentionally violated the provisions of this title or of regulations, or that he has substantially to carry out the agreement filed by him under section 41(c), the Board may issue an order suspending or terminating (absolutely or on condition) the participation of the provider, or suspending or terminating it with respect to particular classes of services.

(2) To develop and test methods of providing, through or by which services or other services, which were not medically necessary but for which payment was claimed under this title:

(3) Furnished to eligible persons covered service which was furnished by a participating provider other than a professional practitioner furnishing covered services on behalf of an institutional or other participating provider, has in a substantial number of cases—

(furnished services, or

(4) Furnished to eligible persons covered services which was furnished by a participating professional practitioner or other services, which were not medically necessary but for which payment was claimed under this title;

(5) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care;

(6) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care; or

(7) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care.

(b) If the Board finds that a participating provider of services no longer meets the qualifications established by or pursuant to this title, or has intentionally violated the provisions of this title or of regulations, or that he has substantially to carry out the agreement filed by him under section 41(c), the Board may issue an order suspending or terminating (absolutely or on condition) 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 services, or

(2) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care; or

(3) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care.

(b) If the Board finds that a participating provider of services no longer meets the qualifications established by or pursuant to this title, or has intentionally violated the provisions of this title or of regulations, or that he has substantially to carry out the agreement filed by him under section 41(c), the Board may issue an order suspending or terminating (absolutely or on condition) 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 services, or

(2) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care; or

(3) Furnished to eligible persons covered services which was furnished by a participating professional recognized standards of care.
quest the organization or committee, with or without further investigation, to recommend to the Board what action, if any, should be taken by the Board. Taking into consideration any recommendations so made to it, the Board may issue an order suspending or terminating or recommending any activity of the practitioner or other provider or, in the case of a practitioner furnishing services on behalf of the provider, requiring the other provider, as a condition of continued participation, to suspend or discontinue such activity, at the reasonable cost incurred in so doing.

(3) where a claim has been denied by the Board, or a decision is rendered which is adverse to a person who was a party to the hearing before the Board, because of failure of the claimant or other provider or other person to submit proof in conformity with any regulation prescribed by the Board, the courts shall within thirty days after the date of the decision or the decision is made, in the case of a hearing under section 133 or an opportunity therefor.

SEC. 134. (a) The Board is authorized, in each case of any provider of services (other than an individual professional provider) a direction, to one or more covered services as the Board finds will best serve the purposes of this title.

(b) The court shall, after the mailing of the findings and decisions complained of are final, shall order a full or summary judgment in accordance with the provisions of section 135, judgment may be order of the Board or by a special panel designated by the court, and shall be subject to review in accordance with section 135 (c).
"(d) Members (other than the Chair-
man), Health Security Board, Department of
Health, Education, and Welfare.

(4) Section 3316, Title 5, U.S. Code (re-
lating to executive pay for persons pro-
nominally provided for in the title of this
Act) is hereby abolished.

(5) The President may authorize the pe-
son who immediately prior to the date of
enactment of this Act occupied the office
of Under Secretary of Health, Education,
and Welfare to act as Deputy Secretary of
Health, Education, and Welfare.

PART IV—MISCELLANEOUS PROVISIONS

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 Amer-
ican Samoa.

(b) The term "United States" when used
in a geographical sense means the States,
and the District of Columbia, the Virgin
Islands, and American Samoa.

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

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

(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 ben-
efits provided by this Act 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 section
pursuant to section 201(g) and section
(b) 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
inapplicable.

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 obliga-
tion, to provide hospital and health services
to his present and former employees
and their dependents (including their
offsprings, or the amount of any obligation for
payment (including any amount payable by
an employer for insurance premiums or in
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
hospitals and health services (including his
obligation 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
services to persons referred to in subsection
(a), it is the sense of the Congress

TYTLE II—HEALTH SECURITY TAXES

RATES AND COVERAGE

Sec. 201. (a) Section 3101(b) of the Inter-
nal Revenue Code of 1954 (imposing a hospi-
tal insurance tax on employers) is amended to
read as follows:

"(b) Hospital Insurance Tax.—In addi-
tion to the tax imposed by the preceding sub-
section, there is hereby imposed on the in-
come of every individual a tax equal to 1 per-
cent of the wages (as defined in section
3121(r)) received by him on or after the
effective date of health security taxes (as de-
fined in section 3121(u)) with respect to em-
ployees (as defined in section 3121(e))."

(b) Section 3111(b) of such Code (impos-
ing 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 a
health security tax, in respect of services
rendered by or on behalf of an individual, ex-
cept when there is a hospital insurance tax
imposed with respect to such services, in ex-
cise tax, with respect to having individuals in
his employ, equal to 3.5 percent of the
wages (as defined in subsection (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(e))."

(c) Section 3121 of such Code (containing
definitions applicable to social security pay-
roll taxes) is amended to read as follows:

"(f) Wage Base for Purposes of Health
Security Taxes.—For the purposes 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" means $7,800, except as
otherwise provided for in paragraphs (2) and
(3) for the purposes of section 3101(b), the
term "wages" shall have the meaning set forth
in subsection (a) of this section except that
paragraph (1) of that subsection shall not be
applied.

"(g) 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 subsec-
tion (h) of this section except that in appli-
cing paragraph (1) thereof "employment by
States and their political subdivisions" shall
not be applied, and

"(h) Effective Dates of Title I

Sec. 202. (a) Section 3121(1) of the In-
ternal Revenue Code of 1954 (relating to cov-
zerage of services performed in the employ
of foreign subsidiaries of domestic corpora-
tions) is amended by striking out "sections
3101 and 3111" in paragraph (1)(A) and
inserting in lieu thereof "sections 3101(a) and
3111(a)". (b) Sections 3122 and 3125 of such Code
are amended by striking out "section 3111"
whenever it appears in lieu thereof and inserting in lieu thereof "section 3111(a)".

(b) Section 3120 (relating to tax on
railroad employers) is amended by striking out
"plus the rate imposed by section 3101(b)"

(3) Health security contribution base

Sec. 203. (a) For each calendar year the
term "health security contribution base" means
$5,000, unless for that year the Secretary
has determined and published a contribution
base pursuant to this subsection.

(b) Effective Date of Title I

Sec. 204. (a) If, on or before November 6
of the sec-
ond year after the calendar year in which
occurs the effective date of health security
axes (as defined in subsection (a)), and health
security taxes means January 1 of the sec-
ond calendar year for the year in which
the Health Security Act is enacted.

CONFORMING AND TECHNICAL AMENDMENTS

Sec. 205. (a) Section 3121(1) of the In-
ternal Revenue Code of 1954 is amended by
inserting "plus the rate imposed by section
3101(b)"

(b) Effective Date of Title I

Sec. 206. (a) The term "calendar year"

(c) Members (other than the Chair-
man), Health Security Board, Department of
Health, Education, and Welfare.
the period at the end thereof: " and (ii) during any calendar year beginning on or after the effective date of the health security taxes (as defined in section 3121(u)) the wages taxable unearned income of every individual, a tax equal to 2.5 percent of the health security contribution base for such year." 

(2) Section 6015(c)(2) 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 January 1 of the taxable year begins, minus (B) 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." 

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

(a) by striking out "except that such term shall not be included" and inserting in lieu thereof "except that"; and (b) 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 $400; and

(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:

(3) for the purposes of section 1401(b) such term shall include the part of the net earnings from self-employment which is in excess of $400 of the health security contribution base (as defined in section 3121(a) 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

(4) by changing the comma following the term "wages" (A) includes and inserting in lieu thereof: "For purposes of clause (1), the term "wages" includes and in-"; and

(c) by striking out the remainder of the sentence in which such term appears, and inserting immediately after that sentence the following: "In the case of services performed by an alien in the employ of a foreign government, an instrumentality of a foreign government, or an international organization, or by an individual referred to in subsection (b) of section 3111(b) and section 3112(b) from wages taxable under section 3101(b)."

EXCLUSION FROM GROSS INCOME

Sec. 205. (a) Section 106 of the Internal Revenue Code of 1954 (as redesignated by section 212 of this Act) is amended, by inserting immediately after the period at the end thereof: "and (ii) during any calendar year after 1967," the following:

"(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 of Congress, 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 by an individual referred to in subsection (b) of section 3111(b) and section 3112(b) from wages taxable under section 3101(b)."

CONFORMING AND TECHNICAL AMENDMENTS

Sec. 210. (a) The heading and table of contents of chapter 3 of subtitle A of the Internal Revenue Code of 1954 are amended to read as follows:

"Chapter 3—TAXES ON SELF-EMPLOYMENT INCOME AND HEALTH SECURITY UNERUNNED 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) Sec. 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.

(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) (d) "the amount of the self-employment income 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 insertion made by paragraph (1) of that 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 such health security unearned income tax imposed by chapter 2;" and

(f) by striking out "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 remainder of that sentence, ", or on the separate health security unearned income of each spouse, as the case may be."

EFFECTIVE DATES OF PART A

Sec. 214. The amendments made by section 211, 212, and section 213 (and (e) (other than subsection (e) (2))) shall be effective
with respect to taxable years beginning on or after the effective date of health security services (or prepaid indemnification for the costs of health services), available, more widely than could be accomplished by section 12 of this Act, to citizens of the United States who are residents in other countries and are temporarily visiting such countries, by supplementing the authority for reciprocal arrangements under section 304 of this Act, for payments from the Health Security Trust Fund, and (b) means of equitably financing such services (or insurance) 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. 403. (a) The Congress finds that—

(1) there exists a serious shortage of appropriate services and facilities for the long-term care of persons with, 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, operating costs of facilities providing such care, and to the inability of such persons to pay the costs of the services they need;

(3) public programs for assistance to such persons and need additional facilities 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 such services among 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 to determine and pay fair compensation to persons entitled thereto.

STUDY OF MALPRACTICE LIABILITY

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

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

(2) the costs 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 potential 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;

(3) the risk of harm arising out of medical treatment can be reduced but cannot be completely eliminated from the delivery of health services, and it is essential to develop more precise, efficient, and equitable methods of determining and paying fair compensation for harm 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 connection with 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 the methods, (B) concerning the cost, availability, and adequacy of liability insurance as a means of providing funds for such harm, and (C) concerning the cost, availability, and adequacy of liability insurance as a means of providing funds for such harm;

(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 claims through the judicial process; (B) of substituting other tests of entitlement to such compensation, in lieu of the test based on negligence or fault on the part of providers of services; and (C) of establishing statutory criteria to govern the determination of the amounts of such compensation;

(3) an examination of the relationship of malpractice claims to the costs of health care, including an examination of the manner in which delivery of health services, including an analysis of the professional and economic impact of actual or threatened malpractice claims on health care diagnostic and therapeutic practices, the use of health manpower, and the use of health care facilities.
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(4) an examination of existing methods and potential alternative methods of meeting the mental health needs of the population, while seeking reasonable protection to the providers of mental health services.

(c) The Secretary shall make to the Congress an interim report of his studies under this section no 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, or (2) except for such appointments (and fix their compensation at not more than $100 a day), and to create such advisory committees, as they may find useful; (3) 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 scope of the Act.

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.

Sections 22-23. All necessary professional services of physicians, wherever furnished, are covered, including preventive care, with two exceptions:

1. Major surgery, and other specialist services designated in regulations, are covered only when performed by a physician specifically prepared to do so.

2. The appliances benefit is covered only for a nonsurgical diagnosis, except as provided in regulations.

Parts provided for ambulatory patients are covered only for active preventive, diagnostic, therapeutic or rehabilitative services. There is no limitation on the number of consultations. In these kinds of organized settings, peer review and budgetary controls can be expected to control costs and maintain quality. In general, the patient is consulting a solo practitioner, there is a limit of 25 consultations per patient per year. In those cases where psychiatric services are in 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.

Comprehensive dental services (exclusion of most orthodontics) are covered for children under age 15, with the covered age group increasing by two years each year until age 25 and then age 55 are covered. This benefit is limited initially because, even though most adults with evidence of dental caries, there is insufficient manpower to provide dental benefits for the entire population. Periodontal care and non-emergency surgical services remain covered throughout their lives, and it is the declared intention to extend this benefit to emergencies as rapidly as this becomes feasible.

Inpatient and outpatient hospital services and services of a home health agency are covered without arbitrary limitations. 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 essential or custodial care in nursing homes is so overwhelming that an initial arbitrary limit on days of coverage is necessary. As the benefits are authorized when this becomes feasible.

2. Many state hospitals do not provide optimal active treatment for their psychiatric patients but rather maintain them in a maintenance 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.

Part C—Specific benefits

(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 pharmacy 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 lists of drugs and their uses which can be used to provide a broad basis for use outside such organized settings. The restricted list shall stipulate which drugs on it shall be available for use outside of the specifications 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 in 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, differing only in the aggregate cost. The Board shall prepare lists of approved devices or equipment which fit are found to be important for the maintenance or restoration of health, employability or social activity. Each item will be considered 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 limitations that they be licensed by the Board and be part of their respective state associations, and that the professional fees do not exceed $100 a day. The professional services of the care of a psychotic patient in a mental health care service is covered for up to 90 days in the initial period, but may be excluded, as rapidly as this becomes feasible.

(Section 28.) The restricted provision for acupuncture and other non-emergency transportation services are covered, as well as non-emergency services where (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 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.

(Section 29.) Health services furnished or paid for under a workmen's compensation law are not covered. Regional variations in levels of earnings is so closely interlocked with the health services aspects of workmen's compensation that absorption of these services portion of workmen's compensation by Health Security could have the effect of delaying findings of eligibility for 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 D—Participating providers of services (Section 41.) Participating providers are required by subsections (a) and (b) of this title to be licensed under any laws established in this title or by the Board. In addition, they must sign contracts with the Board without discrimination, to make no charge to the patient for any covered services, and to submit to review and supervision by professional peers, statistical studies by the Board, and verification of information for payment.
standards and the maintenance of health and the care of sick, or disabled persons to demonstrate that the Institution is providing medical, dental, or related services to mentally ill patients. The standards will exclude costs incurred by state mental institutions to the extent they serve demented, Alzheimer's disease, or dementia patients. The standards will exclude costs incurred by state mental institutions to the extent they serve demented, Alzheimer's disease, or dementia patients. The standards will exclude costs incurred by state mental institutions to the extent they serve demented, Alzheimer's disease, or dementia patients. The standards will exclude costs incurred by state mental institutions to the extent they serve demented, Alzheimer's disease, or dementia patients.

(Section 47.) This section permits the Board to contract with other organizations to provide mental health or dental services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 48.) This section permits the Board to contract with other organizations for the provision of mental health or dental services. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 49.) This section permits the Board to contract with other organizations for the provision of mental health or dental services. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 50.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 51.) The requirements of utilization review in billing for services rendered to members of the Board must be in keeping with the standards established by the Board. The Board must maintain a system of utilization review for all services provided to members of the Board. The Board must maintain a system of utilization review for all services provided to members of the Board.

(Section 52.) This section establishes the Board's authority to establish contracts with other organizations for the provision of mental health or dental services. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 53.) This section permits the Board to contract with other organizations for the provision of mental health or dental services. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

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(Section 56.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 57.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 58.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 59.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 60.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.

(Section 61.) This section specifies the broad and general conditions under which independent pathology laboratories, independent medical laboratories, independent medical laboratories, and independent medical laboratories may provide services for the Board. The Board may not enter into contracts with any organization that is not able to meet the Board's standards for mental health or dental services.
respect to services to aged patients. In Health Security the requirements will of course apply to the entire patient population. As in January and the beginning of the process by requiring specifically that records of reviews be maintained and that 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(e) requires that by mutual agreement as an alternative that the Committee be established by the State or local public health agency. A similar arrangement holds when a hospital, the review will be made by the hospital committee. Like Medicare, the Board shall have the power to require that one or more states shall adopt or modify its application for participation in the program under the Act.

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 health personnel and the effective use of ancillary personnel in the furnishing of health care. The dispensations contained in these provisions are applicable to persons who meet national standards established by the Board.

Paragraph (2) permits a physician, dentist, optometrist, or podiatrist, licensed in one State, to practice under 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 attempting to practice in a State in which he has not been licensed.

Paragraph (3) grants a similar authority to other health professional and nonprofessional personnel. For occupations such as pharmacy and professional nursing, which are subject to State or local professional standards of State governments, such 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 medical judgment is threatened. No conflict of interest results from such arrangements, in the nonprofit setting loyalty to employer and loyalty to patient run parallel.

Board and to 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 60(b) empowers the Secretary to designate an alternative that the Committee be established by the State or local public health agency. A similar arrangement holds when a hospital, the review will be made by the hospital committee. Like Medicare, the Board shall have the power to require that one or more states shall adopt or modify its application for participation in the program under the Act.

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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 medical judgment is threatened. No conflict of interest results from such arrangements, in the nonprofit setting loyalty to employer and loyalty to patient run parallel.
for obligation in the next fiscal year (in accordance with subsection (a)) if the Board estimates the amount in the Health Security Trust Fund at the beginning of the next fiscal year will be less than the amount needed to fund the obligations to be incurred for the current year and that such restriction will not impair the Board's ability to meet its obligations for the year. The amount may be modified before or during the fiscal year if the Secretary of the Treasury finds that the estimated Health Security Trust Fund will differ by 1 percent or more from the estimate used under subsection (a); or if the Board finds that either an unexpected change or the cost of administration is expected to differ from the amount 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 amount has to be increased (rather than being decreased), the Board (through the Treasury Department) shall promptly report its action to the Congress with its reasons.

Subsection (c) provides against various other contingencies which may result in an 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 Trust Fund will differ by 1 percent or more from the estimate used under subsection (a); or if the Board finds that either an unexpected change or the cost of administration is expected to differ from the amount 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 Treasury Department) shall promptly report its action to the Congress with its reasons.

Subsection (d) provides that separate accounts shall be established in the Health Services Account, a Health Resources Development Account, and an Administration Account, as well as a residual General Account. Subsection (e) 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% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

(c) (d) After deducting the amounts appropriated by the Board, the remaining of the amounts shall be allocated to the Health Services Account, and shall be used exclusively for making payments for services in accordance with part E.

(Section 6.) This section provides for allocation of the Health Services Account among the regions of the country. The allocation to each region shall be based on the per capita amount expended during the most recent 12-month period for covered services (with appropriate modification for estimated changes in the relative value of goods and services, the expected number of eligible beneficiaries, and the number of participants). The Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

Subsection (f) provides that the Health Services Account shall be allocated among the regions of the country. The allocation to each region shall be based on the per capita amount expended during the most recent 12-month period for covered services (with appropriate modification for estimated changes in the relative value of goods and services, the expected number of eligible beneficiaries, and the number of participants). The Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

Subsection (g) provides that the Health Services Account shall be allocated among the regions of the country. The allocation to each region shall be based on the per capita amount expended during the most recent 12-month period for covered services (with appropriate modification for estimated changes in the relative value of goods and services, the expected number of eligible beneficiaries, and the number of participants). The Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

Subsection (h) provides that the Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

Subsection (i) provides that the Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.

Subsection (j) provides that the Health Services Account shall be set aside for the Health Resources Development Fund; and the allocation shall be increased by 1% per year only when within the next 6 years. The money in the account shall be used exclusively for the planning and improvement purposes described in part E.
resentatives of the hospitals in each region.

Section 86. Reimbursement for drugs will be made to the dispensing agent on the basis of a "product price" for each drug on the approved list plus a dispensing fee for each drug. The product price will be set at a level which will enable the dispensing agent to purchase substantial quantities of the drug at a price resulting in minimal reductions in the unit cost of each drug. The official price may be modified regionally to reflect differences in the cost of drug acquisition and distribution.

The Board will establish dispensing fee schedules for reimbursing independent pharmacies. These schedules will account for regional differences in costs of operations, personnel, physical plant, volume of services provided and other factors.

Section 87. A comprehensive health service organization which undertakes to provide for hospital or skilled nursing home services for its enrollees may be paid on the basis of an annual budget. The Board may specify that uniform systems of accounting and reporting must be used to determine the items to be used in determining approved costs and the services which will be recognized in budgets.

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

Subsection (c) leaves the method of payment for the organization of efficient services to be specified in regulations.

Subsection (d) requires 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 (e) leaves the method of payment of the organization of efficient services to be specified in regulations.

Subsection (f) requires that amounts available for the payment of the organization of efficient services shall be paid in the same manner as a general hospital (on the basis of an approved annual budget basis). Otherwise the Board will negotiate a patient-day rate to be used for each day of covered service provided to an eligible beneficiary.

Section 90. This section provides that participating providers may be reimbursed on the basis of actual costs. The Board may specify that uniform systems of accounting and reporting must be used to determine the items to be used in determining approved costs and the services which will be recognized in budgets.

Section 91. This section sets forth the general purposes of Part F and authorizes appropriate expenditures from the Trust Fund, for these purposes. The part envisages a substantial strengthening of the health services throughout the country with an eye, first, to the special needs for personnel, facilities, and organization which are necessary to improve the Health Security program and, thereafter, to continuing improvement of the capabilities for effective delivery of health services.

Beyond this, the part enables the Board, through liberal grants and loans, 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 of efficient services of the health delivery system. For the two-year "tooling-up" period, appropriations of $200 million and $400 million will be available 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 92. This section directs the Secretary, in collaboration with State comprehensive health planning agencies, regional professional services, and other planning agencies, to institute a continuous process of health assessment and planning. The process must give first consideration to the most urgent needs of the Health Security system, but the priorities will be flexible both as between 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 provisions for health education and training will be made available, but the Board may supplement the services and assistance if the existing funds are inadequate to the needs, until Congress has had the opportunity to review the situation. Training service will be paid for in the case of services furnished to persons who are covered under the Health Security system, but the priorities will be flexible both as between different regions and from time to time.

Section 93. This section contains a series of provisions designed to establish the functions, education, and training of health personnel. The Board will establish priorities to meet the urgent need for health education and training. The Board will be given the authority to extend training services and to determine the conditions under which the grants for training authorized are to be obtained. The Board will also be given the authority to establish the policies for health education and training and to determine the conditions under which the grants for training authorized are to be obtained. The Board will also be given the authority to establish the policies for health education and training and to determine the conditions under which the grants for training authorized are to be obtained.
representatives of the community in dealing with health organizations. Grants may be made in the quality 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. Suitable students to students and trainees are authorized. Physicians will be recruited and trained to serve as coordinators, or REC in comprehensive ambulatory care, to improve their interest and to be repayable in not more than three years.

(Section 106.) This section authorizes the Secretary to establish improved coordination and linkages with other providers of services; and, second, to organizing programs with comprehensive ambulatory care, to improve their interest and to be repayable in not more than three years.

(Section 107.) This section provides that loans under Part F are to be repaid in not more than three years.

(Section 108.) This section specifies that all payments under Part F shall be made by the Board.

(Section 109.) This section authorizes the Board to establish offices and agencies, and suitable stipends for training programs in health care.

(Section 110.) This section requires the Board to make recommendations on legislative and administrative matters.

(Section 111.) This section authorizes the Board to act in an advisory capacity in regard to social services, dietetics, etc.

(Section 112.) This section provides for the conduct of studies and surveys under the Board's authority.

(Section 113.) This section requires the Board to enter into contracts with States to perform health-related programs under its jurisdiction.

(Section 114.) This section authorizes the Board to make recommendations on legislative and administrative matters.

(Section 115.) This section requires the Board to make recommendations on legislative and administrative matters.

(Section 116.) This section authorizes the Board to act in an advisory capacity in regard to social services, dietetics, etc.

(Section 117.) This section authorizes the Board to consult with appropriate State and local health agencies to assure the coordination of the Health Security program with State and local activities in the fields of environmental health, licensure and inspection, etc.

(Section 118.) This section requires the Board to develop and test incentives for improving quality of health care.

(Section 119.) This section requires the Board to develop and test incentives for improving quality of health care.

(Section 120.) This section requires the Board to develop and test incentives for improving quality of health care.

(Section 121.) This section establishes a National Health Security Advisory Council.

(Section 122.) This section requires the Board to act in an advisory capacity in regard to social services, dietetics, etc.

(Section 123.) This section authorizes the Board to make recommendations on legislative and administrative matters.

(Section 124.) This section provides for the conduct of studies and surveys under the Board's authority.

(Section 125.) This section requires the Board to enter into contracts with States to perform health-related programs under its jurisdiction.

(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 shall be composed of members representing the interests of the community, and such Councils shall be composed of members representing the interests of the community.

(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, 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.) The Board is required to consult with appropriate State and local health 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.

(Section 129.) The Board is authorized 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 130.) The Board is authorized to provide technical assistance either directly or through contracts with 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 131.) Subsection (a) requires the Board to establish an advisory council, with the assistance of the Secretary, to consult with the Secretary and to make recommendations on legislative and administrative matters.

(Section 132.) Subsection (b) requires the Board to make recommendations on legislative and administrative matters.

(Section 133.) Subsection (c) requires the Board to make recommendations on legislative and administrative matters.

(Section 134.) Subsection (d) requires the Board to make recommendations on legislative and administrative matters.

(Section 135.) Subsection (e) requires the Board to make recommendations on legislative and administrative matters.

(Section 136.) Subsection (f) requires the Board to make recommendations on legislative and administrative matters.

(Section 137.) Subsection (g) requires the Board to make recommendations on legislative and administrative matters.

(Section 138.) Subsection (h) requires the Board to make recommendations on legislative and administrative matters.

(Section 139.) Subsection (i) requires the Board to make recommendations on legislative and administrative matters.

(Section 140.) Subsection (j) requires the Board to make recommendations on legislative and administrative matters.

(Section 141.) Subsection (k) requires the Board to make recommendations on legislative and administrative matters.

(Section 142.) Subsection (l) requires the Board to make recommendations on legislative and administrative matters.

(Section 143.) Subsection (m) requires the Board to make recommendations on legislative and administrative matters.

(Section 144.) Subsection (n) requires the Board to make recommendations on legislative and administrative matters.

(Section 145.) Subsection (o) requires the Board to make recommendations on legislative and administrative matters.

(Section 146.) Subsection (p) requires the Board to make recommendations on legislative and administrative matters.

(Section 147.) Subsection (q) requires the Board to make recommendations on legislative and administrative matters.

(Section 148.) Subsection (r) requires the Board to make recommendations on legislative and administrative matters.

(Section 149.) Subsection (s) requires the Board to make recommendations on legislative and administrative matters.

(Section 150.) Subsection (t) requires the Board to make recommendations on legislative and administrative matters.

(Section 151.) Subsection (u) requires the Board to make recommendations on legislative and administrative matters.

(Section 152.) Subsection (v) requires the Board to make recommendations on legislative and administrative matters.

(Section 153.) Subsection (w) requires the Board to make recommendations on legislative and administrative matters.

(Section 154.) Subsection (x) requires the Board to make recommendations on legislative and administrative matters.

(Section 155.) Subsection (y) requires the Board to make recommendations on legislative and administrative matters.

(Section 156.) Subsection (z) requires the Board to make recommendations on legislative and administrative matters.
care, methods of peer review of drug utilization and of other service performance, systems of information retrieval, budget provisions for adequate services, methods of peer review of drug utilization, and any other matters that are required by this part. Subsection (a) provides that an employer will not be relieved, by the enactment of the Health Security Act, of any existing non-statutory obligation to provide or pay for health services to his present or former employees and their families and dependent children. Subsection (b) expresses the sense of Congress that if, nevertheless, the 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 payroll taxes, and raise the rates to 1.5 percent on employees and 3.5 percent on employers. Subsection (c) raises the wage base for the employer tax from the present $7,800 to $15,000 with subsequent further increase if wage levels rise. The wage ceiling from the employer tax, and broadens the definitions of covered employment to include foreign agricultural employees of the U.S. and its instrumentalities (other than members of Congress, the President, Vice-President, and Members of Congress), employees of charitable and similar organizations employed by employees, and (for the employee tax only) employees of charitable and similar organizations instrumentalities. This subsection also provides for the mechanism for increasing the wage base, by an amount equal to the proportion to future increases in average wage levels.

(Section 202.) This section sets forth the level of contributions from the employers and employees, and the ability to provide for the contributions in a form other than an individual personal 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 to provide services to women and their families. The other hospital 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 may 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 unsatisfactory), the Board may terminate participation of the provider.

No direction shall be issued under this section to the Board on the recommendation of, or after consultation with, the appropriate state health planning agency. And no direction issued under this section unless the Board finds that it can be provided for the benefit of the patient to whom it is addressed. The Board is required to give due notice and to establish and obtain 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. The Board establishes programs for 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 Executive Director (level V).

**Part IV—Miscellaneous provisions**

(Section 141.) This section contains definitions of certain terms used in the 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 report 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 Fring, or even the consideration of such integration. Rather, the section recognizes that any national health security or health insurance program should 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 (e) sets forth Congress' view that a program of national health security and a better America. It notes that the cost of malpractice insurance is a significant element in the growing 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 the system of malpractice insurance, as it now exists, should be found to determine and award fair compensation in appropriate cases to patients who have been injured in the receipt of health services.

Subsection (b) directs the Secretary to make a comprehensive study of the problem including the most appropriate criterion of compensation, and means of financing the payment of compensation. The Secretary is required to make a report to the Committee 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.

Last spring, 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 is 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, along with several other of my colleagues in the United States Senate, I 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 April 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, the problem of the nature of the effort itself, it probably is wise that the actual legislation may be a time coming.

FURTHER TO PIECES

As the Washington Post pointed out in an editorial endorsing the idea on Sept. 27, "... the insurance bill ... will not and should not be subjected to piecemeal session. To place it in effect would be like installing a jumbo jet engine on a Ford Trt-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. Gripping 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 bill.

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 of doctors and the lack of preventive treatment, adequate coverage for all of our people. Just as never does not exist. And inflation has created a serious problem. Much of the burden rests on our older people, those who are hurt most by inflation. These people receive adequate care and they are not adequately covered. Medicare doesn't begin to cover all of their medical costs.

Columnist Sylvia Porter pointed out 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 expensive 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 by merely putting more and more money into our present health programs. This bill will not, at least, help substantially. We need at least 40,000 more doctors, but that alone won't cure the ills of the nation. Just putting more practitioners won't drive physicians to the outpatient offices where patients must spread doctors more efficiently and we must make sure that people who need specialized services get them. The system needs a specialist go without one because they can't afford it. This bill recognizes the importance of the role 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. I consider that the war in Vietnam has been costing us anywhere from $16 billion to $30 billion a year for the last six years and annual dollar 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. It would provide coverage for all major health services except custodial care for the aged and disabled, and psychiatric 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 $18,000 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 care or some kind of program of national health insurance. I believe that such a program, together with concomitant changes in 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 would be working with and planning to leverage the public and the private sectors. The Government would, of course, assist in 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 a step-by-step, evolutionary manner 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, with only minor exceptions, to all persons residing in the United States. Target date for this particular bill is the middle of 1973. Eligibility will require neither an annual contribution to Social Security nor a means test as in Medicare.

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

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, rather than by third party payers. This means covered services. Hospitals and other institutional providers will be paid on a fixed or a per diem basis.

5. Benefits of the program will be provided to all persons residing in the United States, with special emphasis on teams of professional, technical and supporting personnel. The resources development fund-
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amount in the trust fund—will be available to support the most rapid practicable development, in a far reaching movement of improving America's health resources.

While the Supreme Court has upheld the State statutes which restrict or impair the development of group practice plans, So the program will do its part to ease the 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 participation in national 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 manpower incentives for comprehensive group practice organizations. It will encourage the efficient use of personnel in short supply to unite the progressive broadening of health services. It will provide funds for education and training programs, especially for members of minority groups and those disadvantaged. Finally, it will provide spe-

ial support for the location of needed health personnel in urban and rural poverty areas. Because Medicare will be covered by the program, Medicare under the Social Security system will be ended. Federal aid to the Medicaid program and other Federal programs will also be ended except to the ex-
tent 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 Veteran's Administration, temporary disability, or workmen's compensation programs.

Mr. President, I am proud to report that:

(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 action 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 standards, the allocation of funds, and the statutory National Advisory Council will assist the board. Members of the Council will include representatives of both providers and consumers of health care.

The overall administration of the program will be carried out throughout 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. Ad-

visory 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 control activities with State and regional planning agencies, and it will ac-
count to the Congress.

(10) A health security trust fund, similar to the Social Security trust fund, will finance the health care system. The fund will derive its income from three sources: 40 per cent from Federal general revenues; 30 per cent from a tax on employers' and employees' Social Security premiums, and 25 per cent from a 2.1 per cent tax on individual income up to $15,000 a year.

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 ex-
penditures 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 broad categories of 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.

(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 $57 billion personal health services in the United States. Had the program been in existence in 1960, therefore, it would have paid ap-

proximately 70 per cent of the $83 billion in total personal health expenditures for that year, or about 10 per cent that existing forms of public and private health insurance now pay.

It is also important to stress that, overall, expenditures under the health security pro-

gram will not create a Federal program of health expenditures, layered on top of exist-
ing public and private programs 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 effi-
ciently.

In essence, health security expenditures will replace the large amount of wasteful and inefficient expenditures already being made by private employers, by volun-
tary private agencies and by Federal, State and local governments. Only in this way can we begin to preserve 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-stimulated and over-burdened system for delivery of medical care. It is not just an-
other proposal to generate more professional personnel or more hospitals and doctor's of medical care to all families and individ-
uals in the nation.

WORSE TODAY

In closing, I want to point out a few facts which I believe are not widely understood by others illus-

rate the need for this program.

For example, the health of most Americans is worse today than it was 15 or 20 years ago. The infant death rate has increased, maternal mortality, life expectancy 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 Finance 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 indus-
try 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 the textile-apparel workers 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 impor-
tant to large and small communities alike. In hundreds of small towns and villages throughout the Nation, textile-apparel plants are the only employers of