NATIONAL HEALTH INSURANCE

HEARINGS

BEFORE THE

COMMITTEE ON
BOR AND PUBLIC WELFARE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 4323

TO CREATE A HEALTH SECURITY PROGRAM

S. 3830

TO AMEND THE PUBLIC HEALTH SERVICE ACT BY ESTABLISHING A NEW TITLE X TO SUCH ACT TO PROVIDE FEDERAL ASSISTANCE TO DEVELOP LOCAL COMPREHENSIVE HEALTH SERVICE SYSTEMS, AND FOR OTHER PURPOSES

SEPTEMBER 23, 1970

PART 1

Printed for the use of the
Committee on Labor and Public Welfare

NATIONAL HEALTH INSURANCE

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 4323

TO CREATE A HEALTH SECURITY PROGRAM

S. 3830

TO AMEND THE PUBLIC HEALTH SERVICE ACT BY ESTABLISHING A NEW TITLE X TO SUCH ACT TO PROVIDE FEDERAL ASSISTANCE TO DEVELOP LOCAL COMPREHENSIVE HEALTH SERVICE SYSTEMS, AND FOR OTHER PURPOSES

SEPTEMBER 23, 1970

PART 1

Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE

51-658 O WASHINGTON : 1970

COMMITTEE ON LABOR AND PUBLIC WELFARE

RALPH YARBOROUGH, Texas, *Chairman*

JENNINGS RANDOLPH, West Virginia
HARRISON A. WILLIAMS, JR., New Jersey
CLAIBORNE PELL, Rhode Island
EDWARD M. KENNEDY, Massachusetts
GAYLORD NELSON, Wisconsin
WALTER F. MONDALE, Minnesota
THOMAS F. EAGLETON, Missouri
ALAN CRANSTON, California
HAROLD E. HUGHES, Iowa

JACOB K. JAVITS, New York
WINSTON L. PROUTY, Vermont
PETER H. DOMINICK, Colorado
GEORGE MURPHY, California
RICHARD S. SCHWEIKER, Pennsylvania
WILLIAM B. SAXBE, Ohio
RALPH TYLER SMITH, Illinois

ROBERT O. HARRIS, *Staff Director*
GENE E. GODLEY, *General Counsel*
ROY H. MILLENSON, *Minority Staff Director*
EUGENE MITTELMAN, *Minority Counsel*

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

WEDNESDAY, SEPTEMBER 23, 1970

STATEMENTS

ADDITIONAL INFORMATION

NATIONAL HEALTH INSURANCE

WEDNESDAY, SEPTEMBER 23, 1970

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in room 1202, New Senate Office Building, Hon. Ralph W. Yarborough (chairman of the full committee), presiding.

Present: Senators Yarborough, Kennedy, Eagleton, Cranston, Hughes, and Saxbe.

Committee staff present: Gene E. Godley, general counsel; Robert O. Harris, staff director; Leroy Goldman, professional staff member; and Jay B. Cutler, minority counsel.

The CHAIRMAN. The Committee on Labor and Public Welfare will come to order. Hearings begin today on the most important and, I might add, the most imperative piece of health legislation in the history of this country, S. 4323, the Health Security Act of 1970, bipartisan bill introduced by me on behalf of myself, Senator John Sherman Cooper of Kentucky, Senator Edward Kennedy of Massachusetts and Senator William Saxbe of Ohio.

Our Nation, despite the accomplishments that we have achieved in the past decade, is currently facing a health crisis of major proportions. The health of most Americans, as compared with the citizens of the other industrial countries is worse today than it was 15 or 20 years ago.

With regard to infant mortality during the first year of life, in the list of industrial nations, we rank 13th; we rank a poor 21st in the life expectancy for males and 12th for females; we stand too close to the bottom of the list for mortality in the middle years; and we are no better than 7th in the percentage of mothers who die in childbirth. In each instance, the United States ranked better 15 or 20 years ago. Although we have expanded our medical facilities and technology and enlarged on life expectancy in terms of total years, we have disseminated health services so poorly that we have slipped behind the pace of the other industrial countries.

These figures, sadly enough, only begin to reflect a small part of our dismal and severe failure to provide and to deliver essential health services to all our people. Yet, these frightening statistics are so monumental—they affect us with such devasting force—that we are compelled to understand and to sense the awesome crisis with which we are faced.

It is because of the immensity and the urgency of this crisis that the legislative proposal calling for a national health insurance program, bill S. 4323, receives so much focus and so much of our concern.

The dream that all Americans might be offered adequate health care at a reasonable cost seems, at this time, to be tremendously far away from realization. But it is because of this distant dream, also, that we, as men who are simply trying to better our peoples' lives and the lives of Americans yet unborn, commence these hearings on the Health Security Act of 1970. It is my idea this is not a belief that will take 25 years to enact. I think it will come about in a much shorter period of time.

The health care system in our Nation now is in shambles. We have allowed our marketplace view of economics to govern our handling of our people's health needs. Health manpower, like the merchant class, has been encouraged by institutional arrangements, as well as financial incentives of all sorts, to sell their goods where the price is right. The patient, like a buyer, has had to take his wants to the market, trying to find a healer at the smallest possible prices.

This chemistry has just not worked. Manpower, already small in number, has isolated itself, by and large, to a small segment of buyers, the richer ones, and has by one means or another employed a series of inefficient methods of delivery, thus making the cost of its product exorbitantly high. The buyer, meanwhile, in many places, has been excluded from purchasing altogether.

Adam Smith's economic liberalism might have been appropriate for single-owned shops and English marketplaces in the 18th and 19th centuries. But it simply will not do for our people's health needs and our 20th century health care system.

The visual symptoms of our health system's failing are evidenced most notably by the large amount of waste that exists. Of the $63 billion total that Americans paid out for health in 1969, $14 billion, experts maintain, is sheer waste. The $63 billion was paid out.

The waste begins early in, and often even before, the health treatment process. Hundreds of insurance providers, offering a vast array of benefits, all for the same services, received over $13.5 billion of our citizens' money and yet covered only about one-third of all personal health care expenditures.

Private insurers took over $1.7 billion as their costs of doing business. Not only does this figure represent an enormously unnecessary bureaucratic or administrative expense and not only does it provide skimpy coverage for most Americans, but it also encourages hospital overuse, another sore spot in the waste picture of our health system.

But the major fact with regard to insurance is that a substantial percentage of our citizens have little or no coverage at all. Of the 177 million noninstitutional civilians in the United States in 1968, under 65, 36.3 million, or 20.5 percent, had no hospital insurance; 38.8 million had no surgical insurance; 61 million had no in-the-hospial insurance; 102 million had no insurance for visits to doctors' offices or doctor visits to their homes; 108 million had no insurance against the cost of prescribed drugs—now terribly high here in the United States; and 173 million had no insurance against dental expenses.

In the current system where insured medical payments are only insured and paid off if you are in a hospital, we hospitalize far too many people who would be treated as well, or even better, on an outpatient basis. We could save some $575 million annually in construc-

tion costs alone by building ambulatory care facilities, extended care facilities and services in the place of acute need is hospitals.

If hospitals were in full operation 7 days a week instead of 5, as is now the practice, we could reduce the average stay by half a day, a $700 million annual savings.

A coordinated and consolidated use of maternity and pediatrics services could save as much as $250 million a year.

Ambulatory testing for surgical patients prior to hospital admission could save 118 hospital days per 100 patients, around $300 million a year.

And back to insurance, $1.8 billion wasted dollars could be saved annually if the inappropriate design of insurance programs were to no longer push patients into overly long hospital stays.

The waste in unnecessary surgery today is also immense. Surgery, according to Dr. John Bunker in the January 15, 1970, New England Journal of Medicine, could be reduced by 25 percent—nearly 4 million operations a year—lowering our national hospital bed requirements by 26 million days, or another $1.6 billion.

Yet, the waste continues. And the American public continues to feed that waste. From 1965 to 1969, hospital charges rose at an annual rate of nearly 13 percent compared with a 6-percent rise for all medical care prices and approximately 3 percent for all items in the Consumer Price Index.

In the total picture, each American is spending twice as much for health care as he was spending 10 years ago. The $63 billion spent on health in 1969 exceeds the 1950 figure by over 500 percent. Since 1950, when health spending amounted to $12 billion, the total health expenditures have risen at an average of 8.8 percent per year—an average of 12.2 percent in the past 3 years.

A good part of this upswing in costs is, as I have mentioned in some detail, due to mammoth waste in the current system. But I have to this point deleted one of the major difficulties with regard to waste—and, that is the scattered, disorganized way in which this society has applied its doctor-nurse manpower to the people's health problems.

We could save $3.6 billion of the nearly $12 billion that we spend for the services of private physicians if successful group practice programs could be developed. The logic is simple. We have used it elsewhere to make more comprehensive and better use of manpower. Instead of a doctor buying his own equipment and instead of a doctor spending his time on matters that could be performed as capably by less highly trained people, doctors in group practice would be able through professional controls, to offer a more efficient coordination of services, to serve a greater population more efficiently and effectively.

For example, if we could initiate 2,000 group practice programs in the next 5 years and staff them each with 20 physicians, along with other members of the health team, they could serve 60 million people. That would require 40,000 physicians out of a total of a quarter of a quarter of a million. The same number of solo physicians, however, could only meet the needs of 30 million people. This modification and improvement in the organization and methods of delivery of health services, along with increased training of manpower, might provide us with the essential manpower requirements that will be demanded of us in the coming decades.

This bill will not eliminate doctors or individual practitioners, but it will encourage group practice and result in more efficient cooperative endeavors where doctors will use their vast training and ability to aid the whole society and the individual patients.

Our failures to organize patient care properly have, furthermore, caused a waste of between 7 and 10 percent of our personal care expenditures for medicine and appliances, or between $550 million and $750 million.

And, finally, by being able to eliminate the complex and confusing matrix of overlapping programs in the status quo, we could save another $1 billion.

All told, if in full operation, the health security program would have cost under $40 billion in 1969. That is, once we have made our health delivery system responsive and efficient by enacting the reforms called for in the Health Security Act, we will have also made, through the elimination of waste, that care available at a lower cost.

The Health Security Act, in order to accomplish this goal of providing adequate health care at a reasonable cost, must solve not only the waste problems posed by our health delivery "nonsystem," but also the other spinoff defects. Two of these other, yet related, defects are the inaccessibility of health care and doctors to certain segments of the population and the resultant bad health for those segments.

Doctors and health facilities are just not present in certain parts of the country. Although the nationwide norm is one doctor per 950 citizens, there is only one doctor per 1,600 inhabitants within a single city, Chicago, in certain neighborhoods.

Furthermore, in some poorer sections of Appalachia there is only one doctor per 7,000 inhabitants. There are thousands of small towns and countless urban slum areas where our citizens go years without seeing a doctor. There are 134 counties in the United States without a single doctor in the entire county. All of this is because there is more incentive for doctors to practice in New Trier than West Chicago, all because it is more economically attractive to work in Austin rather than Three Rivers, Tex.

And, the results? Among the poor in this country, infant mortality rates are often five times greater than among the nonpoor. There are five times as many disabling heart conditions, twice as many cases of cancer of the cervix, six times as many mental and nervous conditions, vastly more cases of tuberculosis, more orthopedic impairments, rheumatism, and visual impairments. In this subcommittee's investigation last year on the condition of migrant laborers in the southern part of my State, we found 17 times the incidence of tuberculosis that you have in the nonmigrant labor population, and up to 30-odd more times as many cases of those diseases as you find among the nonmigrant workers. The cases of chronic illness, the days of disability per person per year, and shorter life expectancy—they all go up and down as the income scale does the reverse. The 40 million poor in this country, then, not only have no access to medical facilities, which they could not afford anyway, but their health is also remarkably poorer than that of the rest of the population.

The problem, however, is not isolated to lower income people. The middle class is beginning to feel the pinch, too. Dissatisfaction with the archaic, ineffective, and costly system spreads throughout all

classes, all races, and all types of people in this country. As I indicated earlier in my discussion of waste and exorbitant costs, only the wealthiest of us will be able to receive health treatment in the coming years, unless significant change can be measured through such proposals as the Health Security Act of 1970.

The most far-reaching advantage of the Health Security Act is that is would provide, through a system of national health insurance, decent health care to all residents of the United States. The maintenance of health for everyone, the improvement of general health standards would be emphasized as strongly as the treatment of illness. Thus, with the modification and improvement of the organization and means of delivery of health services through professional and financial controls and incentives, we will be able to motivate proper medical care. And, then, by the end of this decade, when this act will have been in effect for 10 years, we could expect quality health for all our people.

The benefits of the national health security will be manifold. Physicians, hospital and institutional, psychiatric, dental and miscellaneous services, plus the use of various medicines and certain types of therapeutic devices and equipment—all will be covered by this program.

We will be able to replace medicare, medicaid, the civilian health and medical program of the uniformed services, specific maternal and child health programs, and certain aspects of the temporary disability program. We will be able to eliminate the vast quantity of programs that today overlap, underlap, or form serious gaps and, thus, provide with this act comprehensive health benefits to all citizens in systematic and advantageous programs.

The final result will be that the average American, instead of spending close to $300 a year for health as he does now, would spend less than $200, and the coverage in terms of insurance would be remarkably better.

Now, then in the light of the powerful evidence that has been presented so far and that which will be offered today and tomorrow, some people will argue that we can patch up the present system. They will maintain that possible innovations as group practice will mend the deteriorating health care system of today.

Their logic, however, falls desperately short in three fundamental ways. First, it lacks all semblance of policy; second, it has no motivating force to transform alterably our crumbling health care system; and, third, it is a slow and passive philosophy that shows little sympathy toward the immediate and enormous needs of large segments of our population.

Plugging fingers into gaping holes in the dike will not suffice. Talk of increasing physician manpower by raising the number of medical students by one-quarter to one-half by 1975 is just that—talk. First, unless there is a major reorganization of the health system by 1975, we would have to double the number of graduating medical students to bring any substantial improvements in the doctor-patient ratio. And, if that isn't farfetched already, current Government budget slashing in health care programs makes it so. It is rather easy to talk about and promise 50,000 more physicians in the next 10 years; it is another story altogether to bring that about.

Further, isolated talk of such reforms smacks of the partial solution approach which we have employed in the past with regard to health matters. We now need a policy; we need scope. We need a total program of national health insurance to improve the health care system and to provide good health at a low cost to our citizens. And that goal will be achieved not by blind attempts at reform, but rather by an overall, comprehensive program of system analysis and change.

Second, the partial solutions perspective will have too small an effect on the health industry to allow for major revamping in the next decade. Without a full commitment backed by massive action, health costs will continue to rise, and the quality of health care will continue to go down. Through financial incentives, through an equalized and justly met demand, and through systematic reforms as encompassed in the national health insurance program, we will be able to reorient the medical suppliers to the needs of our people. Otherwise, with token measures or mere talk, the present drift toward medical irresponsibility and away from adequate coverage for all citizens will continue.

Third, and related, token reform measures, by failing to move the health care system quickly, will force substantial numbers of our people into miserably poor health. The millions of poor citizens, to whom I referred earlier, cannot wait for the present system to overcome its shortcomings. With five times the infant mortality rate of nonpoor, the poor cannot wait another decade for the promisers and slow movers amongst us to act. With a life expectancy of 7 years less than that of whites, nonwhites cannot and should not be expected to wait for a disintegrating health system to glue itself together. We must provide decent health to these people, as well as the vast number of middle class citizens who are losing their grip on adequate health provisions, and the best means to that end, I believe, is the national health insurance program which has been introduced before this committee today.

Before closing, I want to draw the attention of the committee to the outstanding set of recommendations, or big ideas that were submitted to the Department of Health, Education, and Welfare on June 29, 1970, by the Task Force on Medicaid and Related Programs:

(1) The first big idea is that all consumers should have access to health care without hardship or humiliation and, as far as possible, with some voice in how it is planned and some choice of how it is furnished.

(2) The second big idea is that the health-care delivery system cannot function effectively in response to consumer demand and provider self-interest but must be planned and managed so that the terms and conditions of payment shall have a powerful impact on the way the services are organized and delivered.

(3) The third big idea is that the whole has to be more than the sum of the parts. The health service system must be more than the aggregate of all the personal transactions among consumers and providers. If capacities are to be increased in keeping with the demand and effectiveness improved in keeping with responsible practice, the system must have a guiding intelligence not laid on from outside but designed and ingrained into the way the system operates.

I intend, as long as I am a Member of the Senate, and as long as I remain on this good earth, to fight for the day when good health care

for all Americans will be a reality. I cannot do it alone, nor can the Congress do it alone. But with the support of the people of this great land, we can take a major step toward that goal with the enactment of this Health Security Act.

When the framers of our Constitution had the insight to realize that their actions had implications for themselves as well as their posterity, they demonstrated admirable foresight and wisdom. We, today, must look far into the future and understand that our action, or inaction, will have a distinctive impact on our posterity. The life and health of tomorrow's America depends on our substantial action today.

Let us as a nation, and as men, win this race for life.

(A copy of the bill, S. 4323, with Senator Yarborough's introductory remarks in the Congressional Record, follows:)

91ST CONGRESS
2D SESSION

S. 4323

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 8, 1970

Mr. YARBOROUGH (for himself, Mr. COOPER, Mr. KENNEDY, and Mr. SAXBE) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To create a health security program.

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

DECLARATION OF PURPOSE

SEC. 2. The purpose of this Act is—

To create a national health security program which, through a system of national health insurance, will make health services available to all residents of the United States, and

Through the operation of the program, to effect modifications in the organization and methods of delivery of

health services which will increase the availability and continuity of care, 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 benefits will become effective on July 1, of 1973. 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 security benefits become available.

TABLE OF CONTENTS

TABLE OF CONTENTS—*Continued*

TITLE I—HEALTH SECURITY BENEFITS—*Continued*

TITLE I—HEALTH SECURITY BENEFITS

PART A—ELIGIBILITY FOR BENEFITS

BASIC ELIGIBILITY

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

AGREEMENTS FOR ELIGIBILITY OF OTHER PERSONS

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

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

SEC. 13. The Secretary of Health, Education, and Welfare in consultation with the Secretary of State and the Secretary of the Treasury, shall study (a) the practicability and the means of making prepaid health services (or prepaid indemnification for the cost of health services) available, more widely than can be done under section 12, to citizens of the United States who are resident in other countries or are temporarily visiting such countries, and (b) means of equitably financing such services (or indemnification); and not

later than June 30, 1975, shall report to the Congress his findings and recommendations.

PART B—NATURE AND SCOPE OF BENEFITS: COVERED SERVICES

ENTITLEMENT TO HAVE PAYMENT MADE FOR SERVICES

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

PHYSICIAN SERVICES

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

(b) Covered physicians' services consist of (1) primary medical services, which are the services (as defined in regulations, but including preventive services) ordinarily fur-

51-658 O - 70 - 2

nished by physicians (whether general practitioners or specialists) engaged in general or family practice for adults or for children or for both, and (2) specialized services. Major surgery and other specialized services designated in regulations are covered services only if they are furnished by an appropriately qualified specialist and, to the extent specified in regulations, on referral by a physician engaged in general or family practice, or if they are emergency services.

(c) Psychiatric (mental health) service to an ambulatory patient is a covered service (1) only if it constitutes an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders, and (2) only to the extent of twenty consultations during a spell of illness (as defined in regulations); but the limitation in clause (2) is not applicable if the service (A) is furnished by a comprehensive health service organization, by a hospital to an outpatient, or by a community mental health center or other mental health clinic which furnishes comprehensive services, or (B) is furnished to a patient of a day care service approved by the Board for this purpose.

DENTAL SERVICES

SEC. 23. (a) Professional services (described in subsection (b)) of a dentist, furnished in his office or elsewhere, are (subject to the provisions of section 28) covered services if they are furnished to a person born after June 30, 1958;

or if they are furnished after June 30, 1974, to a person born after June 30, 1957; after June 30, 1975, to a person born after June 30, 1956; after June 30, 1976, to a person born after June 30, 1955; after June 30, 1977, to a person born after June 30, 1954; or after June 30, 1978, to a person born after June 30, 1953. Covered services include services, materials, and supplies which are commonly furnished in a dentist's office, without separate charge, as an incident to his professional services.

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

(c) It is the intention of the Congress that the coverage of dental services under this title be extended to persons born before July 1, 1958, as rapidly as the availability of funds and of facilities and personnel makes possible, and the Board, in its annual reports to the Congress on the administration of this Act, shall review the operation of this section and recommend extension of the entitlement specified in this section as rapidly as the Board deems feasible. Not later than January 1, 1980, the Board shall submit its recommendation with respect to the scope and conditions of

availability of covered dental services to all persons not already entitled thereto.

INSTITUTIONAL SERVICES

SEC. 24. (a) Inpatient and outpatient hospital services, skilled nursing home services, the services of home health service agencies, and other institutional health services approved by the Board, which are ordinarily furnished by the institution to patients for the purposes stated in section 21, are covered services except to the extent otherwise provided in this section and section 28. Covered services include services furnished generally to the patients served by an institution, including pathology and radiology services and all other necessary services, whether they are furnished by the institution or by others under arrangements with the institution. To the extent provided in regulations, inpatient services of a Christian Science sanatorium are covered services.

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

(c) Covered services do not include care in a skilled nursing home for more than one hundred and twenty days in

a spell of illness (as defined in regulations), except that the Board is authorized to liberalize or eliminate this limitation whenever it finds that adequate funds and resources are available therefor and that such action will not lead to excessive utilization of skilled nursing home services.

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

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

(f) Covered services do not include the services of a

general or psychiatric hospital or a skilled nursing home, during a spell of illness (as defined in regulations), after the third day following receipt by the institution and the patient of notice of a finding by a utilization review committee pursuant to section 50(e) that further stay in the hospital or further stay in the nursing home, as the case may be, is not medically necessary.

DRUGS

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

(b) The list of drugs referred to in subsection (a) (1) shall be designed to provide physicians and dentists with an

armamentarium necessary and sufficient for rational drug therapy incident to comprehensive medical services or incident to covered dental services. The furnishing of a drug on this list is a covered service if it is furnished to a person who is enrolled in a participating comprehensive health service organization, or is administered within a participating hospital to an inpatient or an outpatient, or is administered to an inpatient of a participating skilled nursing home having in effect an affiliation agreement in accordance with section 51(b).

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

disease or condition is one appearing on the Board's list, (2) the physician or dentist meets specialist qualifications, if any, required by the Board, and (3) the drug is specified on the Board's list as one available for treatment of the disease or condition identified by the physician or dentist.

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

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

from the lists as the Board finds best calculated to effectuate the purposes of this section.

DEVICES, APPLIANCES, AND EQUIPMENT

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

(b) The furnishing of a device, appliance, or equipment prescribed by a participating physician or dentist, or by a physician or dentist on behalf of a participating institutional or other provider, is (subject to the provisions of section 28) a covered service if the item appears on a current list of essential items and the prescription falls within any conditions attached to the prescribing of that item on

the list. The furnishing of any other device, appliance, or equipment so prescribed is also a covered service if, in accordance with regulations, the furnishing of it has been approved in advance by the Board. Regulations under this section may list items or classes of items which, because of lack of efficacy or reliability or because of cost, the Board has determined may not be furnished as covered services.

MISCELLANEOUS AND SUPPORTING SERVICES

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

(1) the professional service of optometrists in refractive measurement of the eye and in prescribing eyeglasses;

(2) the professional services of podiatrists;

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

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

mental health center which furnishes comprehensive services; and

(5) ambulance and other emergency transportation services.

(b) Supporting services (such as psychological, physiotherapy, nutrition, social work, or health education services) are covered services when they are a part of institutional services or when, with the approval of the Board, they are furnished by a comprehensive health service organization meeting the requirements of section 47, or by an organization, agency, or center with which the Board has entered into an agreement pursuant to section 48(a), (b), or (c).

EXCLUSIONS FROM COVERED SERVICES

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

(b) Health services furnished in a primary or secondary school are not covered services.

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

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

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

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

(g) The services of a professional practitioner are not covered services if they are furnished in a hospital which is not a participating provider.

PART C—PARTICIPATING PROVIDERS OF SERVICES IN GENERAL; AGREEMENTS WITH THE BOARD

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

PROFESSIONAL PRACTITIONERS

SEC. 42. (a) A physician, dentist, optometrist, or podiatrist, legally authorized on June 30, 1973, to practice

his profession in a State, is a qualified provider of covered services within the State; subject, however, to the provisions of subsections (c) and (d). A practitioner first so authorized by a State after June 30, 1973, is a qualified provider if, in addition, he meets national standards established by the Board (taking into consideration the criteria applied to any recognized national testing organization) for the practitioner's profession. A practitioner who is a qualified provider in one State, if he meets the national standards, is also in any other State (in accordance with section 56(a)(1)) a qualified provider of services which (1) are covered services to persons entitled thereto under this title, and (2) are of a kind which such other State authorizes to be furnished by practitioners of his profession.

(b) For the purposes of this title—

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

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

(c) Not later than July 1, 1975, the Board shall establish for professional practitioners such requirements of continuing education (taking into consideration standards ap-

proved by appropriate professional organizations) as it finds reasonable and necessary to maintain and enhance the quality of professional services to eligible persons. A professional practitioner who fails to meet a requirement established under this subsection shall, if the deficiency persists after notice and a reasonable opportunity to correct it, cease to be a qualified provider.

(d) A physician qualified in accordance with subsection (a) is not qualified to perform major surgery as a covered service, or to furnish as covered services other specialized services designated in regulations, unless he holds a certificate from the appropriate national speciality board or possesses the qualifications requisite to such certification; except that a physician may be found qualified to furnish any specialized services as covered services if (1) prior to July 1, 1973, he has engaged in furnishing such services as a specialist or as a substantial part of his medical practice, (2) he meets standards established by the Board, and (3) where appropriate, a finding that he is so qualified is recommended by a participating hospital in which he has engaged substantially in furnishing such services.

GENERAL HOSPITALS

SEC. 43. Subject to the provisions of section 52, a general hospital is a qualified provider if it is an institution which—

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

(b) maintains adequate clinical records on all patients;

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

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

(e) provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

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

(g) has in effect a hospital utilization review plan which meets the requirements of section 50;

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

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

PSYCHIATRIC HOSPITALS

SEC. 44. Subject to the provisions of section 52, a hospital which is primarily engaged in furnishing psychiatric services to inpatients who are mentally ill is a qualified provider if it (or a distinct part of it) is an institution—

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

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

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

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

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

51-658 O - 70 - 3

SKILLED NURSING HOMES

SEC. 45. Subject to the provisions of sections 51 and 52 a skilled nursing home is a qualified provider if it (or a distinct part of it) is an institution which—

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

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

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

(d) operates under the supervision of an administrator licensed by the State in which such institution is situated;

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

(f) maintains adequate clinical records on all patients;

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

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

(i) has in effect a utilization review plan which meets the requirements of section 50;

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

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

HOME HEALTH SERVICE AGENCIES

SEC. 46. Subject to the provisions of section 51, 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 case of physicians;

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

(c) maintains adequate clinical records on all patients;

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

(e) meets such other requirements as the Board may find necessary in the interest of the quality of care and the safety of patients of the agency or organization.

COMPREHENSIVE HEALTH SERVICE ORGANIZATION

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

(a) the organization furnishes health services to an identified population (enrolled in the organization) in or near a specified service area, through arrangements

which embody prepaid group practice (as defined in regulations) or other definitive arrangements which the Board finds will so far as practicable provide to enrollees the benefits of prepaid group practice;

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

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

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

(e) all eligible persons, living in or near a specified service area, are eligible to enroll in the organization, except that (1) the number of enrollees may be limited to avoid overtaxing the resources of the organization, and (2) such restrictions upon enrollment may be imposed as are approved by the Board as necessary to prevent undue adverse selection;

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

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

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

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

(j) the organization undertakes, to the extent required by regulations, to arrange for reciprocal out-of-area services by other comprehensive health service organizations, or to pay for health services furnished to its enrollees by other participating providers, in emergencies, within or outside the specified services area of the organization.

OTHER HEALTH SERVICE ORGANIZATIONS

SEC. 48. Pursuant to an agreement with the Board containing such terms and conditions with respect to the qualifications of personnel and other matters as the Board may deem appropriate, any of the following is a qualified provider of such services as are specified in the agreement—

(a) a public or other nonprofit agency or organization which furnishes health services as comprehensive as those specified in section 47(c), but does not meet all other requirements of section 47;

(b) a public or other nonprofit center which (1) furnishes, as a minimum, the services of two or more physicians engaged in general or family practice, the services of nurses and supporting personnel, and basic laboratory services, which the Board finds sufficient for the primary medical care of a substantial population living in the vicinity of the center, and (2) has arrangements with other providers of services which

the Board finds assure to the population served by the center, on a coordinated basis, all components of health services as compresensive as those specified in section 47 (c) ;

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

(d) a State or local public health agency furnishing preventive or diagnostic services, a medical or dental group practice or clinic, a diagnostic and treatment center, or another organization or agency furnishing health services to ambulatory patients.

MISCELLANEOUS PROVIDERS

SEC. 49. (a) An independent pathology laboratory is a qualified provider of diagnostic pathology services if (whether or not it is engaged in transactions in interstate commerce) it meets the requirements established by or pursuant to section 353 of the Public Health Service Act. An independent radiology service is a qualified provider of diagnostic and therapeutic radiology if it 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.

(b) A provider of drugs, devices, appliances, or equipment is a qualified provider if he meets all applicable re-

quirements of the Federal Food, Drug, and Cosmetic Act and of the law of the State in which the provider is situated, and such other requirements as the Board finds necessary in the interest of the quality of care and the safety of eligible persons.

(c) A provider of ambulance 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 Sanitorium is a qualified provider of services specified in regulations prescribed under section 24 (a) if it is operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

UTILIZATION REVIEW

SEC. 40. A utilization review plan of a general or psychiatric hospital or a skilled nursing home shall be considered sufficient if it provides—

(a) for the periodic review on a sample or other basis (and the maintenance of adequate records of such review) of admissions to the institutions, the duration of stays, and the professional services (including drugs) furnished, (1) with respect to the medical necessity of the services, and (2) for the purpose of promoting the most efficient use of available health facilities and

services; and provides for periodic reports, to the institution and the medical staff (and, when requested, to the Board), of statistical summaries of the review;

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

(c) in the case of a skilled nursing home, for such review to be made by a committee, composed as provided in subsection (b), established by the State or local public health agency pursuant to a contract with the Board, or by such a committee established by the Board;

(d) for such review, in each case of inpatient hospital services or skilled nursing home services furnished to a patient during a continuous period of extended dura-

tion, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible after each day so specified, and in no event later than one week following such day; and

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

TRANSFER AND AFFILIATION AGREEMENTS

SEC. 51. (a) A skilled nursing home is a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensing with) a transfer agreement with at least one participating hospital, providing for the transfer of patients and of medical and other information between the institutions as medically appropriate.

(b) After June 30, 1975, a skilled nursing home or a home health service agency will be a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispening with) an affiliation agreement with a participating hospital or a participating comprehensive health service organization, under which the medical

staff of the hospital or organization (or a committee thereof) will furnish, or will assume responsibility for, the professional services in the skilled nursing home, or the professional services furnished by the home health agency, as the case may be.

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

NEWLY CONSTRUCTED FACILITIES

SEC. 52. A general or psychiatric hospital or a skilled nursing home the construction or substantial enlargement of which (whether or not in replacement of another institution) was undertaken (as defined in regulations) after December 31, 1970, is not a participating provider under the construction or enlargement has been found, by a State agency designated by the Governor of the State for this purpose, or has been found by the Board, to be needed for the

furnishing of adequate services to persons residing in the area to be served by the institution.

CONSIDERATION OF PROFESSIONAL ASSOCIATION STANDARDS

SEC. 53. In establishing requirements necessary in the interest of the quality of care and the safety of eligible persons, pursuant to section 43(i), 45(k), 46(e), 49(a), 49(b), or 49(c), the Board shall take into consideration standards or criteria established or recommended by any appropriate professional or other association or organization.

COMPLIANCE WITH DIRECTIONS FOR BETTER ORGANIZATION AND COORDINATION OF SERVICES

SEC. 54. If the Board finds that any participating provider of services (other than an individual professional provider) has, without reasonable cause, failed to comply with a direction issued pursuant to section 131, the provider shall, at such time as may be specified by the Board, cease to be a participating provider.

EXCLUSION: FEDERAL PROVIDERS OF SERVICES

SEC. 55. No institution of the Department of Defense, no institution of the Veterans' Administration, no institution of the Department of Health, Education, and Welfare engaged in the provision of services to merchant seamen or to Indians or Alaskan natives, and no employee of any of the foregoing acting as employee, is a participating provider.

The Board shall, however, reimburse the proper appropriation for any services furnished by any such institution or employee to an eligible person who is not, under any Act other than this Act, eligible to receive the service from the institution or employee.

RESTRICTIVE STATE LAWS INOPERATIVE

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

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

(2) A professional nurse, or a practitioner of another health profession or occupation designated in regulations, who meets national standards established by the Board for his profession or occupation is hereby authorized to furnish in any State, on behalf of participating providers of services, the services which that State authorizes or permits to be furnished by practitioners of his profession or occupation. National standards applicable to professional nursing, or to any

other profession or occupation the practice of which is subject in all States to licensure or similar authorization, shall contain a requirement of licensure or authorization by at least one State.

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

(4) A participating public or other nonprofit hospital or a participating comprehensive health service organization is hereby authorized (whether or not the arrangement may be deemed to constitute corporate practice of a profession) to employ physicians, dentists, or other professional practitioners, or to obtain and compensate their services in any other manner, and the practitioners are authorized to serve such a hospital or organization as employees or in any

manner; but only if the employment or other arrangement is not of a kind which the Board finds is likely to cause lay interference with professional acts or professional judgments.

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

PART D—PAYMENT TO PROVIDERS OF SERVICES

IN GENERAL

SEC. 81. Payment shall be made to participating providers, in accordance with this part, for covered services furnished to eligible persons (or, in the case of dental services, furnished to persons entitled thereto under section 23).

METHODS AND AMOUNT OF PAYMENT TO PROFESSIONAL PRACTITIONERS

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

(b) Every physician engaged as an independent practitioner in the general or family practice of medicine, and every dentist engaged as an independent practitioner in the furnishing of covered dental services, shall be entitled, at his election, to be paid by the capitation method if he has filed with the Board an agreement (1) to furnish all necessary and appropriate primary medical services (as defined in regulations) or covered dental services, as the case may be, to persons on a list of persons who have chosen to receive all such services from the practitioner, (2) to maintain arrangements for referral of patients to specialists, institutions, and other providers of covered services, and (3) to maintain such records and make such reports of services furnished

51-658 O - 70 - 4

as may be required by regulations for purposes of medical audit. A practitioner electing the capitation method is entitled to be paid by the fee-for-service method for services furnished to persons who are not on his list.

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

(d) The capitation method of payment for a specified kind and scope of covered services consists of the payment, to a provider of such services, of an annual capitation amount for each person who has chosen to receive all such services from the provider.

(e) The amounts allotted for a fiscal year pursuant to part D for each health service area for physician services, for dental services, for optometrist services, and for podiatrist

services, respectively, shall each be used (1) to provide for payments for professional services (made either directly to practitioners or as reimbursement to hospitals or other providers for the compensation of practitioners) to be made by the Board on a budget or stipend basis or any basis other than capitation, fee-for-service, or per case, and (2) from the remainder, to make available (for each kind of professional services) an equal per capita amount for each person resident in the area who is entitled to such services. In any area in which the Board finds that a substantial volume of services is furnished to nonresidents, it may reduce the per capita amount to such extent as it finds necessary to effect an equitable distribution of funds. The per capita amount shall constitute the annual capitation amount for purposes of payment to an organization or other provider furnishing all covered services (described in part B) of the kind for which the allotment is available. Lesser capitation amounts shall be fixed (on the basis of the relative cost of the services) for primary medical services and, as may be required, for any scope of services (less than comprehensive) which is furnished by an institutional or other provider. The remainder referred to in clause (2) of this subsection shall, after providing for capitation payments, be available for making fee-for-service and per case payments.

(f) The amounts of fees payable to independent pro-

fessional practitioners shall be determined by fee schedules or relative value scales prescribed by the Board after consultation with representatives of the respective professions in the region or the area, and the amounts of payments per case shall be prescribed by the Board after such consultation as it finds appropriate. If at any time during the fiscal year it appears that the aggregate of fees and per case payments for the year will exceed the amount available therefor in the health service area, all fees and payments for services furnished thereafter shall be reduced, proportionately, to such extent as the Board finds necessary to avoid a deficit for the year. The Board may, on such terms as it deems appropriate, delegate to a professional society or to an agency designated by representatives of a profession in the region or the area the payment of fees and per session amounts.

(g) The Board may, on an experimental or demonstration basis, enter into an agreement with a statewide or local professional society or other organization representative of independent professional practitioners to substitute another method of compensation for those set forth in this section (either for all such practitioners, or for all who have elected the fee-for-service, the per case, or the per session method of payment), if the Board is satisfied that the substitute method will not increase the cost of services and will not

encourage overutilization or underutilization of covered services. The Board shall review from time to time the operation of such an agreement, and shall, after reasonable notice, terminate it if the Board finds it to have led to increased cost or to overutilization or underutilization of covered services.

PAYMENT TO GENERAL HOSPITALS

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

(b) The costs recognized in each hospital budget shall be those, determined in accordance with subsection (a), of furnishing the covered services ordinarily furnished by the hospital to inpatients or outpatients, and of performing any other function ordinarily performed by the hospital, except as the scope of services or of other functions may be modified by agreement of the Board and the hospital or by direction of the Board pursuant to section 131. The budget shall recognize any increase or decrease of cost resulting from a

modification of the scope of services or of other functions, or resulting from compliance with any other direction issued pursuant to section 131.

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

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

(e) A hospital budget approved under this section for a fiscal year may, in such manner as provided in regulations, be amended before, during, or after the fiscal year if

there is a substantial change in any of the factors relevant to budget approval.

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 a general hospital. Any other participating psychiatric hospital shall be paid an amount determined in accordance with regulations for each patient day of covered services to an eligible person. Such regulations shall take into account, with respect to any distinct part of the hospital which meets the requirements of section 44, the factors to be considered in the approval of the budgets of general hospitals, but with such adjustments as are necessary to provide equitable compensation to the hospital.

PAYMENT TO SKILLED NURSING HOMES AND TO HOME HEALTH SERVICE AGENCIES

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

(b) Regulations under this section shall, for skilled nursing homes and for home health service agencies, re-

spectively, specify the method or methods to be used, and the items to be included, in determining costs; may, to the extent the Board deems desirable, specify nationally uniform systems of cost accounting; and, taking into account the prevailing practices of such homes or such agencies, may specify services which will be recognized in budgets and services which will not be so recognized.

PAYMENT FOR DRUGS

SEC. 86. (a) For each drug appearing on either of the lists established pursuant to section 25, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of the drug to a provider thereof. All 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 costs to the pharmacy (not in excess of the applicable product price) plus a dispensing fee. The Board, after consultation with representatives of the pharmaceutical profession, shall establish (and from time to time review and revise) schedules of dispensing fees, designed to afford reasonable compensation to independent

pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of drugs dispensed, differences in services provided, and other factors which the Board finds relevant.

PAYMENT TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS

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

(b) The basic capitation payment shall consist of a basic capitation rate multiplied by the number of eligible persons enrolled in the organization. The basic capitation rate shall be the sum of the appropriate capitation rate or rates for professional services (determined under section 82(e)) and a capitation rate fixed by the Board, on the basis of the average reasonable and necessary cost per enrollee, for each other service or class of services (exclusive of hospital and skilled nursing home services) to be furnished by the organization in accordance with section 47(c).

(c) If the organization furnishes hospital or skilled nursing home services through one or more institutions operated by it, payment for these services shall (subject to the provisions of subsection (e)) be made in accordance with sec-

tion 83 or section 85. If with the approval of the Board the organization furnishes such services through arrangements with other providers to which the organization undertakes to make payment for the services, the Board may reimburse the organization for such payments on the basis of patient-days of service utilized by persons enrolled in the organization.

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

(e) In lieu of payments under subsections (c) and (d), the Board may pay the comprehensive health service organization on a capitation basis for hospital services, or for hos-

pital and skilled nursing home services. The capitation amount for such services shall be determined by the Board on the basis of the average cost of such services under comparable circumstances to comparable population groups not enrolled in comprehensive health service organizations, reduced by such amount as the Board finds (on the basis of past experience of the organization) is calculated to yield 25 per centum of any saving resulting from average utilization of hospital and skilled nursing home services by persons enrolled in the organization which is less than the average utilization of such services by such comparable population groups.

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

PAYMENTS TO OTHER PROVIDERS

SEC. 88. (a) An agency, organization, or other entity with which the Board has entered into an agreement under section 48 shall be paid by such method (other than the fee-for-service method) as, in accordance with regulations, may be set forth in the agreement.

(b) An independent pathology laboratory or an independent radiology service shall, at its election, be paid by the fee-for-service method in accordance with a fee schedule approved by the Board, or on the basis of a budget so approved, or on such other basis as may be specified in regulations.

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

METHODS AND TIME OF PAYMENT

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

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

PURPOSE OF PART E; AVAILABILITY OF FUNDS

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

(1) prior to July 1, 1973, to inaugurate a program of strengthening the Nation's resources of health personnel and facilities and its system of delivery of health services, in order to enable the providers of health services better to meet the demands on them when health security benefits become available, and to that end (A) to expand and intensify the health planning process throughout the United States, with primary emphasis on preparation of the health delivery system to meet the demands of the health security program, and (B) to provide financial and other assistance in alleviating shortages and maldistributions of health personnel and facilities in order to increase the supply of services, and in improving the organization of health services to increase their accessibility and effective delivery; and

(2) after June 30, 1973, to reenforce the operation of the health security program as a mechanism for the continuing improvement of the supply and distribution of health personnel and facilities and the organization of health services, and to that end (A) to coordinate the

health planning process throughout the United States with a view to the continuing development of plans for maximizing capabilities for the effective delivery of covered services, and (B) to assist in meeting those costs of improvement of personnel, facilities, and organization that are not met either through the normal operation of the health security program or from other sources of public or private assistance.

(b) For the purposes of subsection (a), there are hereby authorized to be appropriated $200,000,000 for the fiscal year ending June 30, 1971, $400,000,000 for the fiscal year ending June 30, 1972, and $600,000,000 for the fiscal year ending June 30, 1973. Funds appropriated under this subsection shall remain available until expended.

PLANNING

SEC. 102. (a) In collaboration with State comprehensive health planning agencies approved under section 314 (a) of the Public Health Service Act, the Secretary shall promote and support, and as necessary shall conduct within the Department of Health, Education, and Welfare, a continuous process of health service planning for the purpose of improving the supply and distribution of health personnel and facilities and the organization of health services. Except for planning with respect to the national supply of professional health personnel, the planning shall proceed primarily on a

State-by-State basis but without excluding more particularized planning for portions of States, for metropolitan or interstate areas, or with respect to health facilities, health manpower development, or other particular aspects of health care. If a State comprehensive health planning agency does not undertake and carry out the responsibility for utilizing and coordinating all health planning activities within the State (including coordination with planning for interstate areas), and for coordinating health planning with planning in related fields, the Secretary shall assume the responsibility for correlating the product of such planning activities within the State.

(b) Prior to July 1, 1973, the planning process shall give first consideration to identification of the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the organization for delivery of covered services, and to means for the speedy alleviation of these shortcomings. Thereafter, it shall be directed to the continuing development of plans for maximizing capabilities for the effective delivery of covered services.

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

(A) by striking out "and" before the phrase "$15,000,000 for the fiscal year ending June 30, 1970" in

subsection (a) (1), and inserting immediately after that phrase, "$30,000,000 for the fiscal year ending June 30, 1971, and for each of the succeeding four fiscal years, so much as may be necessary"; and

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

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

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

(A) by inserting immediately after the second sentence, "In approving grants under this subsection the Secretary shall take into consideration the extent to which the agency or organization will supplement or otherwise contribute to the effectiveness of the planning

conducted by the State agency pursuant to paragraph (D) of subsection (a) (2);" and

(B) by striking out "and" before the phrase "$15,000,000 for the fiscal year ending June 30, 1970" in the last sentence, and inserting immediately after that phrase, "$30,000,000 for the fiscal year ending June 30, 1971, and for each of the succeeding four fiscal years, so much as may be necessary."

GENERAL POLICIES AND PRIORITIES

SEC. 103. (a) In providing assistance under this part, the Board shall give priority to improving and expanding the available resources for, and assuring the accessibility of, services to ambulatory patients which are furnished as part of coordinated systems of comprehensive care. To this end the Board shall encourage and assist (1) the development or expansion of comprehensive health service systems meeting the requirements of section 47, (2) the development or expansion of agencies, organizations, and centers described in section 48 (a) or (b) (including centers established by public and other nonprofit hospitals) to furnish services to persons in urban or rural areas who lack ready access to such services, (3) the recruitment and training of professional personnel to staff such organizations, agencies, and centers, (4) the recruitment and training of subprofessional and nonprofessional personnel (including the development and

51-658 O - 70 - 5

testing of new kinds of health personnel) to assist in the furnishing of such services, to engage in education for personal health maintenance, and to furnish liaison between such organizations, agencies, or centers and the people they serve, and (5) the strengthening of coordination and linkages among institutional services, among noninstitutional services, and between services of the two kinds, in order to improve the continuity of care and the assurance that patients will be referred to such services and at such times as may be medically appropriate.

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

(c) Funds available to carry out this part shall not be used to replace other Federal financial assistance, or to supplement the appropriations for such other assistance except to meet specific needs of the health security system such as the training of physicians or medical students for the general or family practice of medicine). In administering other programs of Federal financial assistance the Secretary and other officers of the executive branch, on recommendation of the Board, shall to the extent possible utilize those programs to further the objectives of this part. To this end the Board, on such terms as it finds appropriate, may

lend to an applicant or grantee not more than 90 per centum of the non-Federal funds required as a condition of assistance under any such program, and may pay all or part of the interest in excess of 3 per centum per annum on any loan made, guaranteed, or insured under any such program.

ORGANIZATIONS FOR THE CARE OF AMBULATORY PATIENTS

SEC. 104. (a) The Board is authorized to assist, in accordance with this section, the establishment, expansion, and operation of (1) comprehensive health service organizations which meet or will meet the requirements of section 47, and (2) public or other nonprofit agencies and organizations, described in section 48 (a) and (b), which furnish or will furnish care to ambulatory patients.

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

grants, the Board is authorized to provide technical assistance for the foregoing purposes.

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

(d) The Board is authorized to contract with an organization or agency which is described in subsection (a) 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 June 30, 1973, in the case of an agency or organization described in subsection (a) (2). Any such contract shall condition payments upon the contractors making all reasonable effort to avoid or minimize operating deficits and (if such deficits exist) making reasonable progress toward becoming self-supporting.

RECRUITMENT, EDUCATION, AND TRAINING OF PERSONNEL

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

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

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

(d) The training of personnel authorized by this section includes the development of new kinds of health personnel to assist in the furnishing of comprehensive health services, and also includes the training of persons to provide education for personal health maintenance, to provide liaison between the residents of an area and health organizations and personnel serving them, and to act as consumer representatives and as members of advisory bodies in relation to the operation of this title in the areas in which they reside. The Board may make grants to public or other nonprofit health agencies, institutions, or organizations (1) to pay a part or all of the cost of testing the utility of new kinds of health personnel, and (2) until June 30, 1973, to pay a part of the cost of employing persons trained under this subsection who cannot otherwise readily find employment utilizing the skills imparted by such training.

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

(f) The Board shall undertake to recruit and train professional practitioners who will agree to practice, in urban

or rural areas of acute shortage, in comprehensive health service organizations referred to in section 47 or in agencies or organizations referred to in section 48 (a) or (b). A practitioner who agrees to engage in such practice for at least five years and who enters upon practice in the area before July 1, 1973, may until that date be paid a stipend to supplement his professional earnings, and in an appropriate case the Board may make a commitment to compensate the practitioner after that date in accordance with section 82 (c).

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

SPECIAL IMPROVEMENT GRANTS

SEC. 106. (a) The Board is authorized to make grants to public or other nonprofit health agencies, institutions, and

organizations to pay part or all of the cost of establishing improved coordination and linkages among institutional services, among noninstitutional services, and between services of the two kinds.

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

LOANS UNDER PART E

SEC. 107. Loans authorized under this part shall be repayable in not more than twenty years, shall bear interest at the rate of 3 per centum per annum, and 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 be covered into the Treasury as miscellaneous receipts.

RELATIONS OF PARTS D AND E

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 D.

PART F—ADMINISTRATION

ESTABLISHMENT OF THE HEALTH SECURITY BOARD

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

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

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

(d) (1) Section 5315 of title 5, United States Code

(relating to executive pay rates for positions at level IV), is amended by adding at the end thereof the following new clause:

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

(2) Section 5316 of title 5, United States Code (relating to executive pay rates for positions at level V), is amended by adding at the end thereof the following new clause:

"(130) Members of the Health Security Board, Department of Health, Education, and Welfare."

DUTIES OF THE SECRETARY AND THE BOARD

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

(b) The Board shall have the duty of continuous study of the operation of this Act and of the most effective methods of providing comprehensive personal health services to all persons within the United States and to United States

citizens elsewhere, and of making, with the approval of the Secretary, recommendations on legislation and matters of administrative policy with respect thereto. The Board shall make, through the Secretary, an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to July 1, 1973, an evaluation by the Board of progress in preparing for the initiation of benefits under this title, and for periods thereafter, an evaluation of the operation of the title, of the adequacy and quality of services furnished under it, and of the costs of the services and the effectiveness of measures to restrain the costs.

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

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

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 (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service) and shall receive a salary at the rate fixed for level V of the executive pay schedule. The Executive Director shall serve as secretary to the Board, and shall perform such duties in the administration of this title as the Board may assign to him.

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

REGIONS AND HEALTH SERVICE AREAS

SEC. 124. This title shall be administered by the Board through the regions of the Department and, within each region, through such health service areas as the Board may establish. Each health service area shall consist of a State or a part of a State, except as the Board finds that patterns of

the organization of health services and of the flow of patients make an interstate area a more practical unit of administration.

NATIONAL HEALTH SECURITY ADVISORY COUNCIL

SEC. 125. (a) There is hereby established a National Health Security Advisory Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and twenty members, not otherwise in the employ of the United States, appointed by the Secretary on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall include persons who are representative of providers of health services, and of persons (who shall constitute a majority of the Council) who are representative of consumers of such services. Each appointed member shall hold office for a term of four years, except that (1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and (2) the terms of the members first taking office shall expire, as designated by the Secretary at the time of appointment, five at the end of the first year, five at the end of the second year, five at the end of the third year, and five at the end of the fourth year after the date of enactment of this Act. Members of the Council

who are representative of providers of health care shall be persons who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professinal health personnel; members who are representative of consumers of such care shall be persons, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the furnishing of such services.

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

(c) It shall be the function of the Advisory Council (1) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations,

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

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

REGIONAL AND LOCAL ADVISORY COUNCILS

SEC. 126. (a) The Board shall appoint for each of the regions of the Department and for each health service area a regional or local advisory council, consisting of the regional

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

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

PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEES

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

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

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

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

DISSEMINATION OF INFORMATION; STUDIES AND EVALUATIONS; SYSTEMS DEVELOPMENT

SEC. 128. (a) The Board shall disseminate, to providers of services and to the public, information concerning the provisions of this title, the persons eligible to receive the benefits of the title, and the nature, scope, and availability of covered services; and to providers of services, information concerning the conditions of participation, methods, and amounts of compensation to providers, and other matters relating to their participation. With the approval of the Secretary, the Board may furnish to all professional practitioners information concerning the safety and efficacy of

51-658 O - 70 - 6

drugs appearing on either of the lists established under section 25, the indications for their use, and contraindications.

(b) The Board shall make, on a continuing basis after June 30, 1973, a study and evaluation of the operation of this title in all its aspects, including study and evaluation of the adequacy and quality of services furnished under the title, analysis of the cost of each kind of services, and evaluation of the effectiveness of measures to restrain the costs.

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

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

(2) to develop and test methods of providing, through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy and quality; methods of peer review of the utilization of drugs, and of services not subject to utilization review under section 50; and methods of peer review of the quality of services;

(3) to develop and test, for use by the Board,

records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

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

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

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

EXPERIMENTS AND DEMONSTRATIONS

SEC. 129. The Board is authorized, pursuant to agreement with providers of services, to undertake experiments for the purpose of developing and testing alternative methods of compensating providers (in lieu of the methods otherwise prescribed by this title) which offer promise, through financial incentives or otherwise, of improving the coordination of services, improving their quality or their accessibility, or

decreasing their cost; and to undertake demonstrations of the results of such experiments. Any such experiment or demonstration with respect to independent professional practitioners shall be undertaken only in the manner specified in section 82 (g).

DETERMINATIONS; HEARINGS AND JUDICIAL REVIEW

SEC. 130. (a) Determinations of entitlement to benefits under this title, determinations of who are participating providers of services, determinations whether services are covered services, and determinations of amounts to be paid by the Board to participating providers, shall be made by the Board in accordance with regulations. If the Board finds that a participating provider of services no longer meets the qualifications established by or pursuant to part C for services of the kinds furnished by him (or for some classes of such services), or that he has intentionally violated the provision of this title or of regulations, or that he has failed substantially to carry out the agreement filed by him pursuant to section 41 (c), the Board may issue an order terminating the participation of the provider (or terminating it with respect to particular classes of services); but unless the Board finds that eligible persons are endangered, no such order shall be effective until after the provider has been afforded a hearing, or an opportunity therefor, under subsection (b).

(b) A person who is dissatisfied with a determination that he is not an eligible person or that a service furnished him is not a covered service, or a provider of services who is dissatisfied with a determination that he is not a participating provider or with an order terminating his participation (in whole or in part), or a participating provider who alleges that the amount of a payment to him by the Board is less than the amount required by this title and regulations prescribed under it, shall be entitled to a hearing. A person or provider who is dissatisfied with the decision after such a hearing shall be entitled to judicial review.

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

SEC. 131. (a) The Board is authorized, in accordance with this section, to issue to any participating provider of services (other than an individual professional provider) a direction, as a condition to the provider's continuing after a specified future date to be a participating provider, that the provider shall—

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

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

(3) initiate the furnishing of one or more covered

services at a place where the provider is not currently furnishing the services; or

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

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

(c) No direction shall be issued under this section except on the recommendation of, or after consultation with, the State health planning agency (referred to in section 102(a)) of the State in which the direction will be operative. No direction shall be issued under subsection (a) unless

the Board finds that it can practicably be carried out by the provider to whom it is addressed.

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

(2) If objection to the proposal is made by any interested provider of services (other than an individual professional provider) or by an interested health planning agency or by a substantial number of interested professional providers or of residents of the area, the Board shall call a public hearing at which it shall present evidence in support of the proposal, and any interested provider of services or health planning agency or any other interested person shall be entitled to participate in the hearing and to present evidence or argument or both. On the basis of evidence presented at the hearing the Board shall make findings of fact, and shall make a final determination either to issue the proposed direction, to modify and issue it, or to withdraw the proposal.

(e) Within thirty days after the issuance of the Board's

final determination, any interested provider, planning agency, or person who participated in the hearing may file, with the United States court of appeals for the circuit within which is situated any provider of services affected by the determination, a petition for review of the determination.

PART G—MISCELLANEOUS PROVISIONS

DEFINITIONS

SEC. 141. When used in this title—

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

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

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

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

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

EFFECTIVE DATES OF TITLE I

SEC. 142. Entitlement to health security benefits under this title shall commence on July 1, 1973, and no service

or thing furnished prior to that date shall constitute a covered service. Part D shall be effective with respect to fiscal years beginning after June 30, 1973. In all other respects this title is effective upon enactment.

TITLE II—FINANCING

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. For the purpose of carrying out any of the programs, functions, or activities authorized by this Act (other than any such programs, functions, or activities with respect to which funds are specifically authorized to be appropriated under any of the foregoing provisions of this Act), there are authorized to be appropriated for each fiscal year such sums as may be necessary.

[Excerpt from the Congressional Record, Sept. 8, 1970]

S. 4323—Introduction of the Health Security Act

Mr. Yarborough. Mr. President, today I introduce a bill along with Senator Edward Kennedy of Massachusetts, Senator John Sherman Cooper of Kentucky, and Senator William Saxbe of Ohio, to create a national health security program, to be funded out of general revenue appropriations. While I jointly introduced S. 4297 along with Senator Kennedy and 14 other Senators on Thursday, August 27, 1970, that bill was to be financed through the establishment of a Health Security Trust Fund and therefore was referred to the Senate Finance Committee. The bill I introduce today is financed out of general appropriations and therefore is to be referred to the Senate Labor and Public Welfare Committee.

I give notice that I intend to hold hearings on the national health security program on Wednesday, September 23, 1970, and Thursday, September 24, 1970. While this bill would normally be heard by the Health Subcommittee, of which I am chairman, I have had requests from members of the full committee to be able to participate in this hearing. Because of these requests and because of the significance of this bill and its relation to our national health problems, I will hold there hearings as chairman of the full Labor and Public Welfare Committee, rather than as chairman of the Health Subcommittee. In this manner, all the members of the full committee will be afforded an opportunity to participate. It is hoped that further hearings in addition to the 2 days in September will be held this year by me.

The need for improved health care is obvious and grows more persistent every day. The figures that used to shock us have now become common place: The United States ranks 13th in death of infants during the first year of life; seventh in the percentage of mothers who die in childbirth; no better than 18th in the life expectancy of males and 11th for females; and 16th in the death rate of males in their middle years.

This is the comparison of the United States with other industrial countries of the world, which are the countries that surpass us in their health programs. In all instances, the United States ranked better than 15 or 20 years ago. The fact is that the health of Americans is lagging behind our other national improvements and the national response to this fact is inadequate.

Not only are the facts becoming commonplace, but the rhetoric is also. At a press conference last year, President Richard Nixon said:

"We face a massive crisis in this area [health care] and unless action is taken both administratively and legislatively to meet that crisis within the next two or three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout the country."

Yet, the President's response to the crisis was to veto this year the two major bills that Congress put before him to improve health care.

It should be pointed out that Americans have not just sat idly by, but we have attempted within the framework of the present health system to secure adequate health care. In 1969, Americans spent $63 billion for health care—seven percent of the gross national product. This expenditure exceeded 1950 figures by over 500 percent. Since 1950 when health spending amounted to $12 billion the total health expenditures have risen at an average of 8.8 percent per year—an average of 12.2 percent in the past 3 years.

Furthermore, we have tried to cover the costs of health care through insurance, but the coverage has been inadequate. In 1968, health insurance was a giant $12 billion industry but benefit payments met only about one-third of the private costs of health care, leaving two-thirds to be paid from elsewhere by the recipients of the services. Twenty-four to 34 million Americans under age 65 have no private health insurance benefits at all.

That is a wide spread, Mr. President, but exact figures are impossible to obtain. We have searched this out, and we know that somewhere between those brackets is the accurate figure. The fact is that despite huge expenditures for health care and for medical insurance in this country, we still have not developed a system of adequate financing of health care for the people.

Even if we were to develop a better system of financing health care, however, there would still be an intense need to revamp the system to provide efficient care for all our citizens. That is, it is not simply a matter of more money to be spent on the present system, since experts maintain that $14 billion of the $63 billion we spend on health care is wasted and hospital overuse runs over 25 per-

cent of the beds. With this great shortage in hospital beds, the medical people who have worked on the problem say there is 25 percent overuse, use of beds which is not needed.

The lessons of medicare and medicaid should teach us that the system needs to be changed so as to provide the motivation for better care at a more reasonable cost, not the motivation to provide more health care whether needed or not. Unfair advantage has been taken of the public health care programs of the past and the bill that I introduce today is designed to prevent that abuse.

Let me repeat, Mr. President, that health experts in this country think that, of this $63 billion, $14 billion is wasted, and that we could, with better planning, get health care to all the people for much less money.

Under the national health security program bill which I offer today, costs of necessary health care would be paid for in full. This includes physician services, psychiatric services, hospital and other institutional care, dental services, medicines, therapeutic devices, appliances, and equipment, as well as needed supporting services.

Furthermore, money will be provided to develop a more adequate supply and appropriate distribution of health professionals and supporting personnel. The program will actively encourage more efficient organization of existing health manpower, provide funds for special training of physicians, dentists, and other health workers needed for this program, and apply financial incentives to stimulate the movement of health manpower to medically deprived areas.

We have heard talk all during this Congress that there were "new" proposals forthcoming from the administration, that we should wait and see.

Mr. President, I have been urged for months to wait and see, that the administration will have a bill. And I have been waiting. But it is late in the session. The time for waiting is now past. We can no longer wait for a band-aid approach for our disintegrating health system that needs major surgery. While the bill I introduce today is not the complete answer, it is the best answer we have yet come up with.

Mr. President, I have been on the Health Subcommittee on the Senate for nearly 13 years, up until last year under the great Lister Hill as chairman. I have listened to the evidence for 13 years. We have talked to the experts, and we have studied this question for years. Last January, when I became chairman of the subcommittee, I expressed a desire to introduce such a comprehensive health care bill. This, I repeat, is the best we have been able to come up with after hearing testimony from the people who have worked in this field over in the private structure of the economy, made a study of the problem, and come in with their recommendations.

Health Security Act—Section-By-Section Analysis

TITLE I

Part A—Eligibility for benefits

(Sections 11–12–13)

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. Further provision for U.S. residents in other countries will be studied.

Part B—Nature and scope of benefits: Covered services

(Section 21)

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

(Section 22)

All necessary professional services of physicians, wherever furnished are covered, including preventive care, with two important restrictions:

(1) specialist services are covered only when performed by a qualified specialist—except in emergency situations—and generally only on referral from a primary physician. This is intended to protect the public from inadequately trained

practitioners and to restore the primary or family practitioner to the role of the manager of health services.

(2) Psychiatric services to an ambulatory patient are covered only for active preventive, diagnostic, therapeutic or rehabilitative service with respect to mental illness. If the patient seeks care in an organized setting (such as a comprehensive health service organization, a hospital out-patient clinic, a community mental health center or other mental health clinic) there is no limit on the number of consultations. In these kinds of organized settings, peer review and budgetary controls can be expected to curtail unnecessary utilization. If the patient is consulting a solo practitioner, there is a limit of 20 consultations per spell of illness.

(Section 23)

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

(Section 24)

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

(1) Payments for skilled nursing home care is limited to 120 days per spell of illness. It is not practical to assume that the majority of nursing homes and extended care facilities in the country will be able to implement effective utilization review and control plans in the first years of Health Security. The demand for essentially domiciliary or custodial care in nursing homes is so overwhelming, that an initial arbitrary limit on days of coverage is necessary. Extension of the benefit is authorized when this becomes feasible.

(2) Many state hospitals do not provide optimal active treatment to their psychiatric patients but rather maintain them in a maintenance or custodial setting. If Health Security provided unlimited coverage for patients in these hospitals, it might tend to freeze the current 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 spell of illness.

(Section 25)

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

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

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

(Section 26)

The appliances benefit is similar in concept and operation to the drug benefit, subject to a limitation on aggregate cost. The Board shall prepare lists of approved devices, appliances or equipment which it finds are important for the maintenance or restoration of health, employability or self-management (taking

into consideration the reliability and cost of each item). The Board will also specify the circumstances or the frequency with which the item may be prescribed at the cost of the Health Security program.

(Section 27)

The professional services of optometrists and podiatrists are covered, subject to regulations, as are diagnostic or therapeutic services furnished by independent pathology laboratories and radiology services. The care of a psychiatric patient in a mental health day care service is covered for up to 60 days per spell of illness (day care benefits are unlimited if furnished by a comprehensive health service organization or by a community mental health center). Ambulance and other emergency transportation services are covered.

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

(Section 28)

Health services furnished or paid for under a workmen's compensation law are not covered. Reimbursement for loss of earnings is so closely interlocked with the health services aspects of workmen's compensation that absorption of the health services portion of workmen's compensation by Health Security could have the effect of delaying findings of eligibility for income payments. Also, health services furnished in a primary or secondary school are excluded, being generally organized, administered and financed through the education systems.

The Board may exclude from coverage medical or surgical procedures which are essentially experimental in nature. Individuals who enroll in a comprehensive health service organization or enroll themselves with a primary practitioner accepting capitation payments are not entitled to seek covered services from other providers of services (except as specified in regulations). Surgery primarily for cosmetic purposes is excluded from coverage.

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

Part C—Participating providers of services

(Section 41)

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

(Section 42(a))

Professional practitioners licensed when the program begins are eligible to practice in the State where they are licensed. All newly licensed applicants for participation must meet national standards established by the Board in addition to those required by his State. While stopping short of creating a Federal licensure system for health professionals, this will guarantee minimum national standards. Any state-licensed practitioner who meets national standards will be qualified to provide Health Security covered services in any other state. (See also Section 56(a)(1)).

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

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

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

(Section 43)

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

(Section 44)

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

(Sections 45 and 46)

Section 45 establishes conditions of participation for skilled nursing homes similar to those established for extended care facilities under Medicare. Important differences, however, are the requirement for affiliation by 1975 with a participating hospital or comprehensive health service organization (see Section 51(b)) and changes in the requirements for utilization review (see Section 50). Under section 46 participation by home health agencies will be limited to public agencies and non-profit private organizations—proprietary home health agencies are specifically excluded.

(Section 47)

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

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

Other requirements are spelled out in this section: The organization must furnish services through the prepaid group practice of medicine, or as near an approximation to prepaid group practice as is feasible. It must be a nonprofit

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

(Section 48)

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

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

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

Subsection (d) deals with a miscellany of other health care organizations, public, nonprofit, or proprietary. If a State or local public health agency is providing preventive or diagnostic services, such as immunizations or laboratory tests, the Board may contract with it for the continuance of these services. In the field of private practice, physicians or dentists or other practitioners may group themselves in a clinic, nonprofit or proprietary, or in any number of other ways, and it may be more convenient both to them and to the Board to regard them as an entity than to deal with each practitioner separately. The Board will have wide discretion in contracting with such entities subject only to the limitation that, like other organizations described in section 48, the entity may not (under section 88(a)) be paid on a fee-for-service basis. Practitioners who elect that method of payment may of course pool their bills for submission to the Board, but there is no reason to contract with a unit for the payment of fees to it.

(Section 49)

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

(Section 50)

The requirements of utilization review in hospitals and skilled nursing homes are in the main similar to those which Medicare has, since 1966, imposed with respect to services to aged patients. In Health Security the requirements will of course apply to the entire patient population. As in Medicare, the review is

designed to serve a dual purpose: identification of certain specific misuses of the institutional services with a view to their termination, and a focusing of continuing attention and concern of the medical staff on the necessity for efficient utilization of institutional resources. Section 50(a) strengthens the educational aspect of the process by requiring specifically that records of reviews be maintained and statistical summaries of them be reported periodically to the institution and its medical staff (and, on request, to the Board). As under Medicare, the review committee will consist of two or more physicians, with or without other professional participation; and in the case of hospitals, will normally be drawn from the medical staff unless for some reason an outside group is required. For skilled nursing homes, on the other hand, section 50(c) departs from Medicare by requiring that the Committee be established by the State or local public health agency under contract with the Board, or failing that, by the Board. Like Medicare, section 50(d) calls for review of specific long-stay cases as required by regulations, and section 50(e) for notice to the institution, the attending physician, and the patient when a decision adverse to further institutional services is made.

(Section 51)

Subsection (a) of Section 51 is also like Medicare in requiring a participating skilled nursing home to have in effect an agreement with at least one participating hospital for the transfer of patients and medical and other information as medically appropriate. Subsection (b) introduces a requirement, applicable by 1975 to both skilled nursing homes and home health service agencies, of affiliation with a participating hospital or comprehensive health service organization. Unless the medical staff of the hospital or organization undertakes to furnish the professional services in the nursing home or the professional services of the home health service agency, that medical staff or a committee of it must assume responsibility for these services. Subsection (c) allows the Board to waive the application of either of these requirements to a skilled nursing home or a home health agency which the Board finds essential to the provision of adequate services, if (but only for as long as) lack of a suitable hospital or organization within a reasonable distance makes a transfer or an affiliation agreement impractable.

(Section 52)

If the construction or substantial enlargement of a hospital or skilled nursing home has been undertaken after December 31, 1970, without prior approval by a planning agency designated by the governor of the state or the Board, section 52 precludes the institution from participating in the Health Security program. This should greatly strengthen state and local planning authorities.

(Section 53)

This section requires the Board in fixing, for institutional and other providers, standards beyond those specified in the statute, to take into consideration criteria established or recommended by appropriate professional organizations.

(Section 54)

If the Board issues a direction, as it is authorized by section 131 to do after opportunity for a hearing, that any provider of services (other than an individual practitioner) should expand, curtail, or otherwise modify the covered services which it furnishes, this section stipulates that failure of the provider to comply with the direction will terminate its entitlement to participate in the program.

(Section 55)

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

(Section 56)

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

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

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

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

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

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

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

Part D—Payment to providers of services

(Section 81)

Payments for covered services provided to eligible persons by participating providers will be made.

(Section 82)

This section delineates methods of paying professional practitioners. Every independent practitioner (physician, dentist, podiatrist, or optometrist) shall be entitled to be paid by the fee-for-service method (subsection (a)), the amounts

paid being in accordance with fee schedules or relative value scales prescribed after consultation with the professions (subsection (f)). Each physician engaged in general or family practice of medicine in dependent practice may elect to be paid by the capitation method if he agrees to furnish individuals enrolled on his list with all necessary and appropriate primary services, make arrangements for referral of patients to specialists or institutions when necessary, and maintain records required for medical audit; and independent dentist practitioners may elect the capitation method of payment similarly (subsection (b)).

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

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

Subsection (e) of this section describes the method to be used in applying as between practitioners electing the various methods of payment the monies available in each health service area for payment to each category of professional providers. From the amount allocated to each service area, the Board will earmark funds sufficient to pay practitioners receiving stipends and for the professional services component of institutional budgets, such as hospitals. The remainder of the money will be divided to compute the amount available per capita in the eligible population of the area for each category of service (i.e., physicians, dentists, podiatrists, optometrists). This per capita amount in each category will fix the capitation payments to organizations that underake to provide the full range of services in that category to enrolled individuals. Lesser amounts will be fixed for more limited services. For example, if the per capita amounts available for physician, dental and optometric services are $65, $25, and $5 respectively, primary physicians accepting capitation payments will receive the percentage of that $65 which is allocated for primary services, and a comprehensive health service organization which undertakes to provide all physician, dental and optometric services to enrolled individuals will receive $95 for each enrolled individual. After per capita allocations have been made to physicians and dentists who have elected to be paid on a capitation basis and to comprehensive health service organizations, the remainder of the money will be available in each category for pay fee-for-service and per case bills, subject to proration if the aggregate bills exceed the amounts available. This assures that comprehensive health service organizations and individual practitioners accepting capitation payments or a stipend, and professional practitioners on salary in an institutional setting, will not be in jeopardy of having their income diminished by the exhaustion of their service fund by reason of fee-for-service or per case payments.

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

(Section 83)

Hospitals will be paid on the basis of a predetermined annual budget covering their approved costs. To facilitate review of these budgets, the Board will institute a national uniform accounting system. Subsection (b) stipulates that the costs recognized for purposes of the budget will be those incurred in furnishing the normal services of the institution except as changed by agreement, or by order of the Board under section 131. This will enable the Board, on the basis of State and local planning, to eliminate gradually any wasteful or duplicative services, and also to provide for an orderly expansion of hospital services where needed.

Physicians and other professional practitioners whose services are held out as available to patients generally (such as pathologists and radiologists) will be compensated through the institutional budget, whatever the method of compensation of such practitioners and whether or not they are employees of the hospital.

This departs from the practice in Medicare which allowed independent billing by such physicians. Hospital budgets will be reviewed by the regional administrative agency of the Board, which may permit participation by representatives of the hospitals in each region. Budgets may be modified before, during, or after the fiscal year if changes occur which make modification necessary.

(Section 84)

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

(Section 85)

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

(Section 86)

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

(Section 87)

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

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

(Section 88)

Subsection (a) provides that organizations or agencies with which the Board has entered into an agreement under section 48 (such as a neighborhood health center, a nonprofit mental health center, or a state or local health agency furnishing preventive or diagnostic services) may be paid by any method agreed upon other than fee-for-service. Subsection (b) provides that independent pathology or radiology services may elect reimbursement by fee-for-service (with a fee schedule approved by the Board), an approved budget or other basis. Subsection (c) leaves the method of payment for other types of miscellaneous providers of service to be specified in regulations.

(Section 89)

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

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

(Section 101)

This section sets forth the general purposes of Part E and authorizes appropriations, for these purposes. The part envisages a substantial strengthening of the health planning process throughout the country with an eye, first to the special needs for personnel, facilities, and organization which inauguration of the Health Security program will entail, and thereafter, to continuing improvement of the capabilities for effective delivery of health services. Beyond this, this part enables the Board, through selective financial assistance, to stimulate and assist in the development of comprehensive health services, the education and training of health personnel who are in especially short supply, and the betterment of the organization and efficiency of the health delivery system. For the three-year "tooling-up" period, appropriations of $200, $400, and $600 million are authorized for financial assistance. From 1973 on, the leverage of these expanding funds will supplement and reinforce the incentives, which are built into the normal operation of the Health Security program, for improvement of the organization and methods of delivery of health services.

(Section 102)

This section directs the Secretary, in collaboration with State comprehensive health planning agencies, to institute a continuous process of health service planning. Prior to July 1, 1973, the planning process must give first consideration to the most acute shortages and needs for delivery of covered services under this Act. Thereafter, planning shall be focused on maximizing continuing capability for delivery of these services.

This section places primarily on the State agencies the responsibility for coordinating the work of the many health planning agencies within the States, and for coordination with interstate agencies and with agencies planning in other fields related to health, but charges the Secretary with this function in any State that fails to meet the responsibilty. The section amends the Public Health Service Act to increase the authorized appropriations for State and for local health planning ($30 million in each case for fiscal 1971, as against $15 million authorized for fiscal 1970), and to condition grants upon collaboration for these national purposes. Thus the section, strengthening State planning agencies, focuses in them a responsibility, visualized in the "partnership-for-health" legislation but in many States not yet an operating reality, for pulling together all health planning efforts within their territories. The task will not be easy, but it is one that is lent new urgency by the Health Security program. It belongs more properly to the States than to the national Government, but if any State proves unequal to the task it must and will be assumed by the Secretary.

(Section 103)

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

(Section 104)

Help of several kinds will be available under this section for the creation or the enlargement of organizations and agencies providing comprehensive care to ambulatory patients—either organizations to serve an enrolled population on a capitation basis, or agencies such as neighborhood health centers which need not require enrollment in advance. Grants may be made to any public or other nonprofit organization (which need not be a health organization) to help meet the cost, other than construction cost, of establishing such a health service organization, and to existing health service organizations to help meet the cost of expansion; the maximum grants being, in the former case 90 percent of the cost, in the latter 80 percent. The Board may also provide technical assistance for these purposes. Loans may be made for the cost of necessary construction, subject to the same 90 and 80 percent limitations on amount. Finally, start-up costs of operation of these organizations may be underwritten, for five years in the case of organizations which must build up an enrollment to assure operating income, and in other cases until the Health Security program begins payment for services in 1973. The effect of these several provisions is to reduce sharply, if not eliminate, the financial obstacles which have heretofore impeded the growth of comprehensive group practice organizations.

(Section 105)

This section contains a series of provisions to assist in the recruitment, education, and training of health presonnel. The Board will establish priorities to meet 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 Federal assistance for health education and training will be availed of, but the Board may supplement the other assistance if the Board believes it inadequate to the needs, until Congress has had opportunity to review its adequacy. The training authorized includes the development of new kinds of health personnel to assist in furnishing comprehensive services, and the training of area residents to participate in personal health education and to serve liaison functions and serve as representatives of the community in dealing with health organizations. Grants may be made to test the utility of such personnel, and to assist in their employment before 1973. Education and training are to be carried out through contracts with appropriate institutions and agencies, and suitable stipends to students and trainees are authorized. Finally, special assistance may be given, both to institutions and to students, to meet the additional costs of training persons disadvantaged by poverty, membership in minority groups, or other cause.

(Section 106)

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

(Section 107)

This section provides that loans under part E are to bear 3 percent interest and to be repayable in not more than 20 years. Other terms and conditions are discretionary with the Board. Repayment of loans made before 1973 from general appropriations will go to the general fund of the Treasury.

(Section 108)

This section specifies that payments under part E shall be in addition to, and not in lieu of, payments to providers under part D.

Part F—Administration

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

(Section 121)

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

(Section 122)

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

(Section 123)

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

(Section 124)

This section provides that the program will be administered through the regional offices of the Department of Health, Education, and Welfare. It also requires the establishment of sub-regional (service area) offices. These will in most instances be a state or a part of a state except where patterns in the organization of health services and the flow of patients indicate that an interstate area would provide a more practical administrative unit.

(Section 125)

Subsection (a) establishes a National Health Security Advisory Council, with the Chairman of the Board serving as the Council's Chairman and 20 additional members not in the employ of the Federal Government. A majority of the appointed members will be consumers who are not engaged in providing and have no financial interest in the provision of health services. Members of the Council representing providers of care will be persons who are outstanding in

the fields related to medical, hospital or other health activities or who are representatives of organizations or professional associations. Members will be appointed to four-year over-lapping terms by the Secretary upon recommendation by the Board.

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

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

(Section 126)

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

(Section 127)

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

(Section 128)

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

Subsection (b) requires the Board to make continuing study and evaluation of the program, including adequacy, quality and costs of services, Subsection (c) authorizes the Board directly or by contract to make detailed statistical and other studies on a national, regional, or local basis of any aspect of the title, to develop and test incentive systems for improving quality of care, methods of peer review of drug utilization and of other service performances, systems of information retrieval, budget programs, instrumentation for multiphasic screening or patient services, reimbursement systems for drugs, and other studies which it considers would improve the quality of services of administration of the program.

(Section 129)

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

(Section 130)

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

(Section 131)

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

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

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

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

Part G—Miscellaneous provisions

(Section 141)

This section contains definitions of certain terms used in the title.

(Section 142)

This section stipulates that the effective date for entitlement for benefits will be July 1, 1973.

TITLE II

Section 201. Authorizes appropriation of such funds as shall be necessary to carry out the act.

The CHAIRMAN. This legislation was not just thrown together on the spur of the moment. It has been carefully studied and drafted by outstanding experts in the health field. The senior Senator from Massachusetts has been most active in this measure and introduced S. 4297 for national health insurance. He is also a cosponsor of this bill S. 4543. I will call next on the distinguished Senator who has put in a great amount work on national health insurance, Senator Edward Kennedy of Massachusetts.

Senator KENNEDY. Thank you, Mr. Chariman.

I want to commend you for having these hearings. These are the first hearings on comprehensive national health insurance in 20 years. We are embarking on the consideration of major social legislation that

I believe is long overdue in America. I commend you for convening these hearings today.

I also commend the initiative provided in this area by the committee of 100 for national health insurance, which was created by Mr. Walter Reuther and is now chaired by Mr. Leonard Woodcock. The bill I have introduced—S. 4297—is based on the recommendations of the committee. Mr. Chairman, I know that you serve on that committee with Senator Saxbe, Senator Cooper, and myself, and many distinguished health experts and medical economists. The AFL–CIO is strongly supporting the parallel proposal introduced in the House by Congresswoman Martha Griffiths.

I look forward to these hearings, and I commend you for arranging them. With your permission, and in the interest of expediting the hearings, I will file my complete statement for the record at this point.

(The statement of Senator Kennedy follows:)

STATEMENT BY HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Mr. Chairman, With these hearings today in the Senate, we begin in earnest the journey toward fulfillment of another basic right for our people—the right to good health care.

A great national debate is being launched, comparable to the debate that gave rise to social security in the thirties and to medicare in the sixties. The call today is to build on the start we have made in social security and in medicare. The call is to create a health security program, a program of comprehensive national health insurance in the United States, capable of bringing the same high quality health care to every man, woman, and child in the Nation.

These are the first hearings to be held in Congress on comprehensive national health insurance since the critical contemporary problems of health care in America first began to emerge and multiply nearly two decades ago. Now the debate has been transferred from the halls of the universities to the hearing rooms of Congress, the issue can be effectively taken to the people by their representatives. In the great tradition of our democracy, it is the people who will decide.

If one thing is clear in the United States of 1970, it is that our health system is in crisis. Indeed, it is fair to say that health care is the fastest growing failing business in the Nation—a $63 billion industry that fails to meet the urgent demands of our people.

There is not a person in the Nation who has not felt the 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 the very real prospect of financial ruin because of serious illness.

Our health crisis cuts across all political, social, economic, and geographic lines. It affects all alike—rich and poor, black and white, old and young, urban and rural.

In large part, these hearings will document the widening health gap in our society:

The manpower gap, which leaves us 50,000 physicians, 20,000 dentists, and 150,000 nurses short of our current need, and which forces

us to import thousands of physicians each year from underdeveloped foreign nations that cannot afford to lose them.

The specialization gap, which allows us to train far too many surgeons, while leaving serious shortages in areas like pediatrics and internal medicine.

The vital statistics gap, which finds America, with its vaunted research and technology, trailing most of the developed nations of the Western World in statistics like infant and maternal mortality, life expectancy, and middle-aged death rate.

The inflation gap, which finds all of us, including the Federal Government, paying more and more money for our health care, but getting less and less value of our health dollar.

The insurance gap, which find thousands of private carriers engaged in cut throat competition to provide coverage that is more often loophole than protection.

The Federal program gap, which finds the Government without a coherent health policy for the Nation, or even for its own departments and agencies, but only a bewildering maze of overlapping and conflicting programs.

For more than a generation, we have allowed these gaps to widen under us, until today we face the ominous prospect of chaos and disintegration in our health care system. The problem goes even deeper, however. Not only have we allowed the gaps to widen—we have actually encouraged them to widen by backward-looking programs whose principal effect has been to preserve the status quo and forestall change. For too long, the world of medicine has clung to the traditions of the past, while the rest of the world has moved on to meet the future.

To me, the only reasonable way out of the paradox of poor health care in our rich land is through a program of comprehensive national health insurance. Last month, together with fifteen other Senate cosponsors—Senators Yarborough, Cooper, Saxbe, Bayh, Cranston, Hart, Hughes, McCarthy, McGovern, Metcalf, Mondale, Muskie, Pastore, Pell, and Senator Young of Ohio—I introduced S. 4297, the Health Security Act, to establish such a program.

The essence of the program is a simultaneous approach to upgrading each of the three basic aspects of our health care system—organization, delivery, and financing. As the mistakes of medicare and medicaid make clear, we know that national health insurance cannot simply be a financing mechanism. We know that the insurance program must also contain the catalyst to change the system.

The lessons of the past are clear. To those who say that national health insurance won't work unless we first have an enormous increase in health manpower and a revolution in the delivery of health care, I reply that until we begin moving toward national health insurance, neither Congress nor the medical profession will ever take the basic steps that are needed if we are to improve the system. Without national health insurance to galvanize us into action, we will go on subsidizing the present waste, patching the present system beyond any reasonable hope of survival.

Thoms Paine, echoing the words of the ancient Greeks, declared at the founding of the American republic, "Give me a lever and we shall move the world." I say, give us the lever of national health insurance,

and together we shall move the medical world and achieve the reforms that are so desperately needed.

The CHAIRMAN. Thank you, Senator Kennedy.

Next we call on the distinguished Senator from Ohio, Senator Saxbe who is one of the cosponsors of this bill. He is respected for his independent thinking, is an able and distinguished Senator, and we are happy to have him with us.

Senator SAXBE. I am always humbled by your introductions. Thank you.

In joining as a sponsor on this, it is not with enthusiasm that I might have but rather with the recognition that something must be done to change our present system of distribution of medicine in this country. I wish that it could be done at the local level. I wish it could be done at the State level, but I do not believe it is going to be. I think it is something that is only going to be done by some type of comprehensive health insurance through financial means of a bill such as this and a national organization.

At the present time, in most of our States, adequate coverage to all of the people is just not there, and added to that is the burden that inflation has put on our older people. Inflation has created a situation where people just do not have the savings for severe illness anymore, where they do not have the means, and medicare does not fill the gap altogether. People are proud. They like to feel that this is something to which they were entitled. They do not even have the $50 to go into that doctor's office, to go on to the hospital for treatment, They go once, they don't like the treatment they received so they do not go back even though they should.

One of the discouraging things that we see is the general practitioner's office filled with people sitting there with crying children all afternoon because the doctor is so busy or he is out on an emergency, and he cannot handle this number of people.

We can put more money into medical programs as they are; that is, medicare, medicaid. We can make more money for the doctor, but we cannot increase the number of doctors or their method of treatment by that manner.

We have about 175,000 practicing physicians in this country. We have a total of 200,000 doctors, but 25,000 of these are not available because of research, because of involvement in other areas, and 175,000 physicians will just not do the job under our present set-up of private practice.

There are a number of suggestions that will emerge from this bill and other suggestions, from the doctors themselves, how to spread them in a more equitable manner.

We hear about paramedical help and some say it will work and some say it will not, but we must be able to spread these doctors more efficiently over a greater number of people.

We must be sure that people will have the assistance of specialists and that there will be the money to pay for these specialists.

One of the things I like about this bill that we are introducing is that it does recognize the existence of the referral system to specialists and the fact that they are the ones who will have to do the serious work and the more highly trained work.

One of the areas that I do not like in the bill, but recognize it has to be there, is the question of the cost. At the present time, it is esti-

mated it will cost $37 billion. There are others who say it will cost more. It is true a great deal of this money is presently going into some type of health plan—Blue Cross, Blue Shield, individual plans. Everybody in this room, I dare say, is covered by some type of a program now. It is not as though we are breaking new ground as to coverage because all of us have some type of coverage to some degree at the present time. It only means it extends it to those who do not now belong, which is not a great many, and it expands the coverage. You are not limited to a certain dollar amount either at the bottom or at the top. It extends it to eyeglasses and various other devices that are part of our medical treatment. This cost would mean that the Federal Government itself would have to pay $5 or $6 additional billions a year. When you think that the war cost us last year $18 billion, I don't believe that this is too much to ask that we pay this for health coverage for all the people in the country.

I do not want to mislead anybody. It does not mean there is going to be a doctor on every street corner; that we are going to have almost overnight adequate numbers of physicians. We need at least 40,000 more. There is no question about that.

Some of my friends who are physicians—and I have a great many and my son is a physician—say this in itself would cure all the ills, and I am sure we are going to hear this type of testimony, and we should hear it. Simply 40,000 more physicians are going to cure all these ills? I don't believe it will. I want 40,000 more physicians and I join with the chairman today in bills to advance the cause of general practitioners and others and to help the medical schools because we do need 40,000 more physicians, but I think just supplying 40,000 more is not going to, by economic pressures, drive physicians to the outposts where they are needed. It has to be done by other means, and I believe this bill is one of those means.

Neither do I expect that this bill overnight is going to become popular and is going to be voted on and is going to be passed. It has a rough road ahead. I think the chairman, Senator Kennedy and Senator Cooper recognized it has a rough road ahead because it is revolutionary. But at least we are going to start talking about this program. We are not going to be adverse to changing in this system as the evidence discloses that we can do it in a different way.

I have half a dozen changes that have been presented to me already that sound good. So what comes out is probably going to be different from this bill that we introduced. I only hope that we and the other sponsors and people interested will be openminded enough to recognize in a revolutionary type of program such as this, we are going to welcome any corrections or any improvements to this bill.

I am happy to be a part of it and I look forward to working with the doctors, with the health system of our Government and with the health system of our States in trying to work out a better program for general health for all our people.

The CHAIRMAN. Thank you, Senator Saxbe, for your contribution to this opening session. I know from my conversations with the Senator, that his 2 years in the Senate is preceeded by a wide breadth of experience as attorney general for the State of Ohio, and that he has traveled in every county in his State and knows the health need of his State.

I will place in the record at this time a statement by Senator Javits to be printed at this point in the record. I also order printed in the

record Senator Javits' bills S. 3830 and S. 3711, with his statements and explanations of the bills. I also place in the record at this point the statement of Senator Claiborne Pell who is chairman of the Education Subcommittee who is very much interested in this subject. He could not be here today.

(The statement of Senator Javits, a copy of S. 3830 and S. 3711, and explanation of the bills follow:)

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. I congratulate the chairman for initiating these hearings on national health insurance. I have long urged that we begin an extensive examination of mandatory prepaid health care for all our citizens—an idea whose time has been too long in coming—and transfer the national health insurance debate from university lecture halls to congressional hearing rooms.

It is a tragic fact that although the United States leads the world in many branches of medical service, there is a national disparity in health services between the rich and the poor, between black and white. The poor suffer six times as many death from pregnancy complications, three and one-half times more deaths from diseases in early infancy, four times more deaths from TB, five times more deaths from syphilis, one and one-half times more deaths from cervical cancer, three times as much heart disease, seven times as many eye defects, and five times as much mental retardation. The life expectancy of a nonwhite American is 7 years less than his white counterpart, infant mortality rates are twice as great for nonwhites as for whites, and nonwhite maternal mortality is four times as great as the rate for whites. There is one doctor in private practice per 740 persons in New York State. Yet in Harlem, with a population of 185,000 persons, there are but 30 physicians in private practice relating to the local population.

We are dealing here with the lives and welfare of all Americans. The issue of adequate and accessible health care, therefore, has become an imperative of social justice. Now it is for us to take that imperative and see that it becomes an idea whose time has come.

To assure all Americans—whatever their economic status—accessible, quality health care and to provide form and direction to change the dangerously haphazard organization of health care in America, I introduced the National Health Insurance and Health Services Improvement Act of 1970, S. 3711.

Since the health insurance would be financed by a tax on employers, employees and the self-employed rather than general revenues—although the health benefit costs for public assistance recipients and the unemployed would be underwritten by the Government—this measure was referred to the finance committee.

To implement a national health insurance system, it is vital to proceed immediately with the rationalization of medical care services and facilities. To accomplish that end and put into motion initiatives that ultimately will reshape the inequities and hardships of our presently anachronistic national health-care system—a system aggravated by duplication, waste, overlap and poor coordination, I also introduced the Local Comprehensive Health Services Systems Act of 1970, S. 3830. This measure has been referred to this committee for consid-

eration and is, I am pleased to note, part of the subject of these hearings.

I ask unanimous consent, Mr. chairman, that a copy of the bills, S. 3711 and S. 3830, together with a section-by-section analysis prepared by the Legislative Reference Service of the Library of Congress may be made part of my remarks.

My own relationship to national health insurance goes back a very long time; 21 years ago, in 1949, I introduced H.R. 4919 in the 81st Congress, a bill for a system of national health insurance. One of its cosponsors, was then Congressman, now President Richard M. Nixon, and others included the late very distinguished Secretary of State, Christian Herter, and former National Republican Chairman Thruston Morton, who served with such distinction in this body.

Since then, along with many Members of the Senate, I have been actively engaged in the long struggle to provide health insurance to the aged. The landmark medicare legislation, finally enacted in 1965, was the culmination of an effort in which I had been engaged from the time I entered Congress. However, neither title XVIII—medicare program—nor the then little noticed title XIX enacted at the same time—medicaid—has proven adequate to meet an exploding demand for quality health care or—and this is critically important—to control a rapid and inflationary escalation of health care costs.

The national health insurance bills I have introduced Mr. Chairman—and the other bills that have been and will be introduced—are symbolic of the recognition by our country of the great social needs of our people, which have developed over the decades.

Almost 40 years ago President Herbert Hoover equated the right to public health with public education. In his inaugural address he said:

> Public health service should be as fully organized and as universally incorporated into our governmental system as is public education. The returns are a thousand-fold in economic benefits, and infinitely more in reduction of suffering and promotion of human happiness.

I quote President Herbert Hoover, Mr. Chairman, because he was no wild-eyed radical.

I believe our committee's study through these hearings of national health insurance legislative proposals will help arouse the conscience of the Nation to the urgent need for the development of a better system of health care—more readily accessible, more economical and more equitably distributed. I sincerely believe these hearings will stir the Congress to action in the enactment of legislation that takes a comprehensive and rational approach to the problems of health care. Not only must we increase purchasing power and therefore equalize access, but we must use those funds and the power of reimbursement to improve the delivery and availability of health care.

In view of the acute stage the health care crisis has already reached, the ensuing premium on time, the need to implement a national health insurance system and garner all the concurrent advantages of emphasizing health care rather than disease care, it is essential to proceed immediately with the rationalization of medical care services and facilities, including the provision for health surveillance.

I urge this committee to enact S. 3830 or similar legislation. We must begin a process of revolutionary change in medical care systems and stimulate the delivery of comprehensive health care to every American in need.

91ST CONGRESS
2D SESSION

S. 3830

IN THE SENATE OF THE UNITED STATES

MAY 13, 1970

Mr. JAVITS introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act by establishing a new title X to such Act to provide Federal assistance to develop local comprehensive health service systems, and for other purposes.

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

SHORT TITLE

SECTION 1. This Act may be cited as the "Local Comprehensive Health Services Systems Act of 1970".

AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 2. (a) The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE X—FEDERAL AID TO ESTABLISH LOCAL COMPREHENSIVE HEATH SERVICE SYSTEMS

"FINDINGS AND DECLARATION OF PURPOSE

"SEC. 1001. (a) (1) The Congress hereby finds and declares that improving the provision and the delivery of health care is of critical importance and of the highest national priority and that present programs of health services do not provide for continuing, efficient and comprehensive health care, and lead to an unnecessary duplication of facilities, equipment, and personnel.

"(2) The Congress further finds and declares that the establishment of a system of health insurance for every American must not only increase purchasing power and equalize access to quality health care but must also bring about significant change in the health care system.

"(b) It is the purpose of this title to provide financial and technical assistance through loans, grants, supplementary financing and otherwise to health service institutions and organizations which will stimulate and enable such institutions and organizations to plan, develop and implement comprehensive systems for the delivery and provision of health care.

"BASIC AUTHORITY

"SEC. 1002. The Secretary of Health, Education, and Welfare (hereinafter in this title referred to as the "Secre-

tary") is authorized to make loans and grants and to provide technical assistance, as provided by this title, to enable comprehensive health service systems (as defined in section 1007) to plan and develop comprehensive health care programs in accordance with the purpose of this title, and to assist them to become self-supporting.

"ELIGIBILITY FOR ASSISTANCE

"SEC. 1003. (a) A comprehensive health service system (as defined in section 1007 of this title) is eligible for assistance under section 1005 of this title if—

"(1) such system assures the provision of health services to all its members by a contract or contracts with the Secretary, or by such a contract and subcontracts, entered into by one or more providers of services (as defined in section 1861(u) of the Social Security Act) and other persons furnishing health services, or by a health insurance carrier or nonprofit prepayment plan, or by a combination of the foregoing;

"(2) such system is designed, to the maximum extent feasible, to make all health services readily accessible to persons residing in the specified primary service area and will pay for transportation where reasonable accessibility to persons in that area cannot otherwise be assured;

"(3) all persons, whether or not residing within

the primary service area, are eligible to become members of such system, except that (A) the number of members may be limited, with or without giving preference to persons living within the primary service area, to avoid overtaxing the resources of the system, and (B) such restrictions upon enrollment may be imposed as are approved by the Secretary as necessary to prevent undue adverse selection; and the system is so designed and operated as to encourage enrollment from as broad as practicable a range of income and social groups;

"(4) all health services are provided by providers or other persons who meet the standards imposed by or pursuant to title XVIII of the Social Security Act for the respective services;

"(5) such system encourages increased health education of its members and the development and use of preventive health services, and provides for a group of physicians (such as a committee of medical school faculty, of a hospital medical staff, or of a group practice organization), approved by the Secretary for this purpose, consulting periodically with representatives of the membership, to fix the professional policies of the system, to oversee the professional aspects of the delivery of services, and to review the utilization of all health services, drugs and supplies;

"(6) such system shall, to the extent practicable and consistent with good medical practice, train and employ allied health personnel and subprofessional and lay persons in the rendering of services;

"(7) any participating extended care facility is affiliated with a hospital or with a group practice or similar organization and the medical staff of the hospital or the group practice organization assumes responsibility for rendering or supervising professional services in the facility;

"(8) premiums charged by such system for services not paid for under title XVIII of the Social Security Act are reasonable; and

"(9) the establishment of such system shall be consistent with any comprehensive State health plan developed pursuant to section 314 (a) of the Public Health Service Act, as amended, and shall be approved by the State planning agency designated or established pursuant to that section, and, where appropriate, shall be in accord with areawide health planning carried out pursuant to section 314 (b) of that Act;

"(b) In administering this title, the Secretary shall emphasize local initiative and consumer and community involvement of the planning, development and operation of such

comprehensive health service systems, and shall seek to insure prompt response to local initiative, and maximum flexibility in the planning, development and operation of such systems. Appropriate Federal departments and agencies shall provide maximum coordination of other Federal assistance with the operation of this title.

"FINANCIAL AND TECHNICAL ASSISTANCE FOR PLANNING COMPREHENSIVE HEALTH SERVICE SYSTEMS

"SEC. 1004. (a) The Secretary is authorized to make grants to, and to contract with, any public or nonprofit hospital, or any medical school or other institution of higher education, or any insurance carrier or nonprofit prepayment plan providing health coverage, or any nonprofit community organization, or any community group organized for this purpose in a geographically defined primary service area and representing a broad range of income and social groups, or any combination of two or more such entities, to pay 80 percent of the cost of planning and developing a plan for a comprehensive health service system (as defined in section 1007) which will meet the requirements of section 1003. The Secretary is also authorized to undertake such activities as he determines to be desirable to provide, either directly or by contracts or other arrangements, technical assistance to such entities for the development of plans for such comprehensive health service systems.

"(b) Financial and technical assistance for planning such a system will be provided under this section only if the application for such assistance has been approved by the State health planning agency designated or established pursuant to section 314(a) of the Public Health Service Act, as amended.

"FINANCIAL AND TECHNICAL ASSISTANCE FOR THE OPERATION OF APPROVED COMPREHENSIVE HEALTH SERVICE SYSTEMS

"SEC. 1005. (a) The Secretary is authorized to approve a plan for a comprehensive health service system (as defined in section 407) if, after review of the plan, he determines that such plan satisfies the criteria set forth in section 1003.

"(b) The Secretary is authorized to contract, in accordance with section 1003(a)(1), with a comprehensive health service system, if he has approved the plan for such system, to pay so much of the administrative, operating, and maintenance costs of such system as exceed its income for the first five years of operation after approval under this section. Any such contract shall require the system to make all reasonable efforts to enroll members, to control costs and the utilization of services, facilities, and supplies, and otherwise to maximize its income and minimize its costs. If at any time the Secretary finds that the system is not making reasonable progress toward becoming self-supporting, he may,

after hearing, terminate the contract on not less than six months' notice.

"(c) To assist a comprehensive health service system to carry out programs of capital development which the Secretary finds necessary for the purposes of this title, the Secretary is authorized to make a grant to such system of not to exceed 80 per centum of the amount of non-Federal contribution otherwise required for the construction or modernization of hospitals and other medical facilities assisted under title VI of the Public Health Service Act, as amended: *Provided,* That such project has been approved by the State agency under that title and is consistent with the approved State plan, other than the provisions thereof respecting priorities.

"(d) In connection with any project of an approved comprehensive health service system for the modernization, rehabilitation, or construction of ambulatory care facilities which the Secretary finds necessary for the purposes of this title, the Secretary is authorized, in lieu of assistance under any other Federal program or under subsection (c) of this section, to make a grant for up to 50 per centum of the cost of such project and to make a loan, on such terms as he shall prescribe, except that the rate shall not exceed 3 per centum per anum, for the remaining cost of the project.

"(e) The Secretary is authorized to contract to make

periodic interest reduction payments on behalf of any group practice or other ambulatory care facility, nonprofit hospital or nursing home which is operated or to be operated as part of an approved comprehensive health service system, such interest reduction to be accomplished through payments to the holder of a mortgage insured under title XI, or section 232, or section 242, of the National Housing Act. Interest reduction payments with respect to a facility shall be made during such time as the facility is operated as part of the approved comprehensive health service system. The interest reduction payments shall be in an amount not exceeding the difference between the monthly payment for principal, interest, and mortgage insurance premium which the owner of the facility is obliged to pay under the mortgage, and the monthly payment for such purposes which the owner would be obliged to pay if the mortgage bore interest at the rate of 1 per centum per annum.

"(f) Of the sums appropriated pursuant to section 406 for any fiscal year, 2 per centum shall be available for grants by the Secretary to pay 100 per centum of the costs (but in no case to exceed $100,000) of projects, in areas designated by the Secretary as urban or rural poverty areas, for assessing local needs for comprehensive health service systems, obtaining local financial and professional assistance and support for local comprehensive health service systems, or for

comprehensive health service system projects which, in his judgment, are of national significance because they will assist in meeting the needs of the disadvantaged for comprehensive health services systems or demonstrate new or particularly effective or efficient methods of delivery of health care through comprehensive health service systems.

"APPROPRIATIONS

"SEC. 1006. There are authorized to be appropriated for the fiscal year ending June 30, 1970, and for each of the four fiscal years thereafter, such sums as may be necessary to carry out the purposes of this title.

"DEFINITIONS

"SEC. 1007. As used in this title, the term 'comprehensive service system' means a system providing health care to an identified population group in a primary service area and its environs enrolled as members, on the basis of contractual arrangements (which embody group practice, are established by a medical school, a hospital medical staff or a medical center, or similar arrangements) among participating providers of service and other persons organized so as to—

"(1) assure continuity of care and the ready referral and transfer of patients where medically appropriate;

"(2) provide comprehensive health services, which shall include dental services for children under eight years

of age, annual physical checkups, maintenance prescription drugs, and at least all services specified in title XVIII of the Social Security Act (such services to be provided except as authorized by the Secretary, without deductibles, coinsurance, or copayment), drugs prescribed for ambulatory patients, one hundred days of extended care services (which are not post-hospital extended care services) in any spell of illness, and necessary immunization, and may include other health services which are approved by the Secretary as appropriate to the particular comprehensive health service system."

(b) Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to X, inclusive, of this Act may be cited as the 'Public Health Service Act'."

(c) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title X (as in effect prior to the enactment of this Act) as title XI, and by renumbering sections 1001 through 1014 (as in effect prior to the enactment of this Act), and references thereto, as sections 1101 through 1114, respectively.

[From the Congressional Record, May 13, 1970]

S. 3830—Introduction of Local Comprehensive Health Services Systems Act of 1970

Mr. Javits. Mr. President, I send to the desk a bill called the Local Comprehensive Health Systems Act of 1970, dealing with the reform of local health care delivery systems. This bill is essential if we are to head toward a national health insurance scheme. I have introduced a bill with that purpose. Other bills have been introduced in the other body implementing the ideas of the AFL–CIO and the distinguished work done in this field by the late, lamented Walter Reuther, heading a major citizens committee for the same purpose.

In order to have prepaid health care for all our citizens, we have to transfer the debate from the university lecture hall to the congressional hearing rooms. There, the first question should be, If we want to rationalize medical care and service and facilities, do we have the systems, the means, with which to do it? Obviously the answer is "No."

Question: What can we do to begin to establish those systems even as we prepare for some plan, even if it is the plan of the American Medical Association—which has a plan being considered—which will give a higher level of care, with greater equity and without discrimination because of economic status or physical location, to our people?

Mr. President, to assure all Americans—whatever their economic status—accessible, quality health care and to provide form and direction to change the dangerously haphazard organization of health care in America, I recently introduced the National Health Insurance and Health Services Improvement Act of 1970, S. 3711.

This legislation, I believe, will mark the beginning of an extensive examination of mandatory prepaid health care for all our citizens—an idea whose time has been too long in coming—and will transfer the national health insurance debate from university lecture halls to congressional hearing rooms.

To implement a national health insurance system, it is vital to proceed immediately with the rationalization of medical-care services and facilities.

The bill I introduce today, the Local Comprehensive Health Service Systems Act of 1970, is designed to accomplish that end by putting into motion initiatives that ultimately will reshape the inequities and hardships of our presently anachronistic national health-care system—a system aggravated by duplication, waste, overlap and poor coordination. Health manpower and resources are now in short supply, often resulting in priority care to patients on the basis of ability to pay rather than the most pressing need for services.

We must begin a process of revolutionary change in medical care systems and stimulate the delivery of comprehensive quality health care to every American in need. Although we spend more money than any other country in the world on health care, the quality of care remains uneven—and for many—particularly the poor—it is abysmally low, if not nonexistent.

Although the United States leads the world in many branches of medical service, there is a national disparity in health services between the rich and the poor, between black and white.

In the disadvantaged areas we find the following tragic statistics and unchallenged facts:

First. The poor suffer six times as many deaths from pregnancy complications, 3½ time more deaths from diseases in early infancy, four times more deaths from TB, five times more deaths from syphilis, 1½ times more deaths from cervical cancer, three times as much heart disease, seven times as many eye defects, and five times as much mental retardation.

Second. The life expectancy of a non-white American is 7 years less than his white counterpart, infant mortality rates are twice as great for nonwhites as for whites, and nonwhite maternal mortality is four times as great as the rate for whites.

Third. According to an estimate made by the department of health, there is one doctor in private practice per 740 persons in New York State. Yet, in Harlem, with a population, of 185,000 persons there are a mere 30 physicians in private practice relating to the local population.

I believe the enactment of this legislation would be most important in developing comprehensive health care centers in disadvantaged areas and an excellent mechanism for meeting the ghetto's needs and combating the tragic statistics I have just cited. Also I would emphasize that my bill provides for com-

munity involvement and participation—significant factors in developing programs for satellite health centers.

What is needed is an innovative medical care delivery system, and toward this end, my bill would:

First, authorize the Secretary of Health, Education, and Welfare to make loans and grants and provide technical assistance to enable comprehensive health service systems to plan and develop comprehensive health care programs and assist them to become self-supporting.

Second, establish the criteria for systems seeking financial and technical assistance from the Government for the purposes of developing comprehensive health-service systems. Such systems would be required, among other things, to enter into an agreement with the Secretary to provide or arrange to provide services authorized by medicare. In addition to certain requirements concerning enrollment of beneficiaries in such systems, comprehensive health-service systems would have to develop preventive health-care programs, train and employ allied health personnel, be organized in a manner consistent with the State's overall comprehensive health-care plan, and emphasize local consumer and community involvement in its planning, development, and operation.

Third, authorize the Secretary of Health, Education, and Welfare to make grants to public or nonprofit hospitals, medical schools, any insurance carriers or nonprofit prepayment plans or nonprofit community group to pay 80 percent of the cost of planning and development of comprehensive health-service systems. Applications for assistance under this title would have to be approved by a State health planning agency.

Fourth, authorize the Secretary to contract with an approved comprehensive health-service system to pay as much of administrative, operating, and maintenance costs of such system as exceed its income for the first 5 years after approval. The contract would require the system to make efforts to enroll members, control costs and utilization of services, and otherwise maximize income and minimize costs. The Secretary may see fit to terminate a contract after giving 6 months' notice. The Secretary would be authorized to make grants to a system for programs of capital development in an amount not to exceed 80 percent of non-Federal contributions otherwise required for construction and modernization of hospital, and so forth, under title 6 of the Public Health Service Act. The awarding of such a grant would depend upon approval of the proposed project by the responsible State health planning agency.

Fifth, identify a comprehensive health service system as one providing health care to an identified population group in a primary service area on the basis of contractual arrangements which embody group practice, established by a medical school, hospital medical staff, or medical center or other entity among the participating providers of services.

Sixth, define comprehensive health service systems as those which provide at least all services specified in title 18, Social Security Act—hospital and physician benefits—and include annual physical checkups, provision of maintenance prescription drugs, and dental services for children under 8 years of age. Other appropriate preventive and comprehensive health care would be required by the Secretary.

Seventh, authorize "such sums as may be necessary" to carry out the purposes of this act.

If we in the Congress are to soothe, not stir the angry feelings of frustration about health care in America, let us not depend upon an already overburdened health-care system to provide medical services. Let us begin now to make positive efforts to improve and preserve quality health care; develop the capacity in the health-care system to provide medical services; and reorganize health-care systems to benefit all Americans.

91ST CONGRESS
2D SESSION

S. 3711

IN THE SENATE OF THE UNITED STATES

APRIL 14, 1970

Mr. JAVITS introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide a national health insurance program by extending the benefits, enlarging the coverage, expanding the role of private carriers, and otherwise improving the health insurance program established by title XVIII of the Social Security Act, by establishing a new title XX to such Act to provide comparable health insurance benefits to individuals not covered therefor under the program established by such title XVIII, by providing Federal assistance to develop local comprehensive health service systems, and by authorizing the establishment of federally chartered national health insurance corporations.

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

SHORT TITLE

SECTION 1. This Act, with the following table of contents, may be cited as the "National Health Insurance and Health Services Improvement Act of 1970".

TABLE OF CONTENTS

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. The Congress hereby finds and declares that:

(1) the ability to deliver basic health protection is impaired as the result of the inadequate allocation of

health resources and less than optimum management and rapidly escalating health care costs. An anachronistic national health care system often operates to provide priority to patients on the basis of ability to pay rather than most pressing need for services. The inequities and hardships which result from such a system are further aggravated by duplication, waste, overlap, and poor coordination in the system at a time when health manpower and resources are in short supply.

(2) the right to quality health care has become a national objective and a right for all Americans. The removal of financial barriers to health care services, and improvement of the present system of delivery of health services, are matters of vital concern affecting the public health, safety, and welfare.

(3) every American regardless of economic status, should be enabled to obtain basic health benefits and a national system should be established which will allocate sufficient resources to bring about the needed changes in the system of health care.

(4) we should develop a system of health insurance benefits which will be financed by employer-employee contributions and from general revenues, and which will provide benefits to all Americans including the aged, the indigent, the disabled and the unemployed.

(5) we should encourage the development of a system of health care under Federal standard which utilizes a wide diversity of care and benefit mechanisms, including the valuable management skills of the commercial and nonprofit insurance industry, the nonprofit health care community and cooperative agencies and group practice units, and maximizes consumer choice between such competing mechanisms.

(6) we should encourage the development of systems of continuing and comprehensive health care which emphasize preventive, diagnostic, ambulatory, and rehabilitative services, as well as physicians' and hospital care, and which stimulate physicians and providers to enter into group practice and other arrangements and into relationships with other providers, under which the delivery of quality health care will be facilitated.

TITLE I—AMENDMENTS RELATING TO HEALTH INSURANCE PROVIDED BY TITLE XVIII OF THE SOCIAL SECURITY ACT

PART A—COVERAGE OF ALL AGED AND DISABLED; EXTENSION, WITHOUT PREMIUM, OF SUPPLEMENTARY BENEFITS TO ALL COVERED INDIVIDUALS

SEC. 101. (a) Section 226(a) of the Social Security Act is amended to read as follows:

"(a) (1) Every individual who—

"(A) has attained age 65, and

"(B) is—

"(i) (I) entitled to monthly insurance benefits under section 202, or (II) a qualified railroad retirement beneficiary, or

"(ii) a resident of the United States (as defined in section 210(i)) and—

"(I) a citizen of the United States (as so defined), or

"(II) an alien lawfully admitted for permanent residence who, after being so admitted, has resided in the United States (as so defined) continuously for a period of not less than 5 years,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the conditions specified in subparagraph (B), beginning with the first month after June 1971 for which he meets the conditions specified in subparagraphs (A) and (B).

"(2) Every individual who—

"(A) has not attained age 65, but

"(B) (i) is entitled to disability insurance benefits under section 223, or (ii) has attained the age of 18 and is entitled to child's insurance benefits under section 202(d) and is under a disability (as defined in section

223 (d)) which began before he attained age 18, or (iii) has not attained age 60 and is entitled to widow's insurance benefits, or (iv) has not attained age 62 and is entitled to widower's insurance benefits, or (v) is a qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1971 or (II) the first month he satisfies the applicable conditions of subparagraph (B), and ending with the second month after the first month in which he ceases to meet the applicable conditions of subparagraph (B) or, if earlier, with the month before the month in which he attains age 65.

"(3) Notwithstanding clauses (iii) and (iv) of subparagraph (B) of paragraph (2)—

"(A) a widow or surviving divorced wife who has attained age 60 shall be deemed to have satisfied the applicable conditions of such subparagraph (B) in any month in which (i) she is entitled to benefits under section 202 (e) (or would be entitled to benefits under section 202 (e) but for paragraph (1) (E) thereof, and (ii) she would be entitled to such benefits without regard to such paragraph (1) (E) and section 202 (e) (1) (B) (i)) had the period specified in section 202 (e) (5) ended in the month in which she attains age

65 instead of in the month in which she attains age 60, and had the reference to age 60 in section 202 (e) (1) (B) (ii) been a reference to age 65; and the first month in which she shall be deemed not to have satisfied such applicable conditions shall be the second month following the first month in which such benefits would have been terminated on the basis of the occurrence of an event specified in section 202 (e) (1); and

"(B) a widower who has attained age 62 shall be deemed to have satisfied the applicable conditions of such subparagraph (B) in any month in which (i) he is entitled to benefits under section 202 (f) (or would be entitled to benefits under section 202 (f) but for paragraph (1) (E) thereof, and (ii) he would be entitled to such benefits without regard to such paragraph (1) (E) and section 202 (f) (1) (B) (i)) had the period specified in section 202 (f) (6) ended in the month in which he attains age 62, and had the reference to age 62 in section 202 (f) (1) (B) (ii) been a reference to age 65; and the first month in which he shall be deemed not to have satisfied such applicable conditions shall be the second month following the first month in which such benefit would have been terminated on the basis of the occurrence of an event specified in section 202 (f) (1)."

(b) (1) Section 226 (b) (1) of such Act is amended to read as follows:

"(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to the benefits provided under part A of title XVIII (subject to the limitations, conditions, and procedures provided in such title for the provision of such services) furnished to him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814 (f)) during such month; and".

(2) Section 226 (b) (2) of such Act is amended by striking out "under section 202" and inserting in lieu thereof "under section 202 or 223".

(c) Section 226 (d) of such Act is hereby repealed.

(d) Section 103 of the Social Security Amendments of 1965 is hereby repealed.

SEC. 102. (a) The heading of title XVIII of the Social Security Act is amended by striking out "FOR THE AGED".

(b) The heading of part A of title XVIII of such Act is amended by striking out "FOR THE AGED".

(c) Section 1811 of such Act is amended by inserting immediately before the period at the end thereof the following: ", and for individuals who are disabled and are

entitled to benefits based on disability under title II of this Act or under such system".

SEC. 103. (a) The heading of part B of title XVIII of the Social Security Act is amended by striking out "FOR THE AGED".

(b) (1) Section 1831 of such Act is amended to read as follows:

"SEC. 1831. There is hereby established an insurance program to provide medical insurance benefits in accordance with the provisions of this part for individuals who are entitled to the hospital insurance benefits provided by part A."

(2) The heading for section 1831 of such Act is amended to read as follows: "ESTABLISHMENT OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM".

(c) (1) Section 1836 of such Act is amended to read as follows:

"SEC. 1836. Every individual who is entitled to hospital insurance benefits under part A shall be entitled to the benefits provided by the insurance program established by this part."

(2) The heading to section 1836 of such Act is amended to read as follows: "ENTITLEMENT TO BENEFITS".

(d) Sections 1837, 1838, 1839, 1840, 1841, 1843, and 1844 of such Act are repealed.

(e) Section 1815 of such Act is amended by striking out "Hospital" and inserting in lieu thereof "Health".

(f) (1) The heading to section 1817 of such Act is amended by striking out "HOSPITAL" and inserting in lieu thereof "HEALTH".

(2) Section 1817 (a) of such Act is amended by striking out, in the second sentence thereof, "part" and inserting in lieu thereof "title".

(3) Section 1817 (h) of such Act is amended by inserting "and part B" immediately after "this part".

(4) Section 1817 of such Act is further amended by adding at the end thereof the following new subsection:

"(i) On July 1, 1971, there shall be transferred to the Trust Fund all of the assets and liabilities of the Federal Supplementary Medical Insurance Trust Fund."

(g) The last sentence of section 1861 (v) (1) of such Act is amended by striking out "Hospital" and inserting in lieu thereof "Health".

(h) Section 1864 (b) of such Act is amended by striking out "Hospital" and inserting in lieu thereof "Health".

(i) Section 201 (g) (1) (A) of such Act is amended—

(1) by striking out "Hospital" and inserting in lieu thereof "Health", and

(2) by striking out "and the Federal Supplementary Medical Insurance Trust Fund".

(j) Section 1875 (a) of such Act is amended by striking out "health care of the aged" and inserting in lieu thereof "health care of the aged and disabled".

(k) Section 1902 (a) (10) of such Act is amended by striking out "the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or".

(l) Section 1902 (a) (15) of such Act is amended by striking out "either or both of".

(m) Section 1903 (b) (2) of such Act is repealed.

SEC. 104. (a) (1) Section 21 (a) of the Railroad Retirement Act of 1937 is amended by striking out "consisting of inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services (all hereinafter referred to as 'services')" and inserting in lieu thereof "and other benefits and services (such benefits and services hereinafter being referred to as 'services')".

(b) (1) Section 21 (d) of the Railroad Retirement Act of 1937 is amended by striking out "and sections 1840, 1843, and 1870" and inserting in lieu thereof "and section 1870".

(2) Section 21(e) of such Act is amended by striking out "Hospital" and inserting in lieu thereof "Health".

(c) The Railroad Retirement Act of 1937 is amended by adding after section 21 the following new section:

"HEALTH INSURANCE BENEFITS FOR THE DISABLED

"SEC. 22. Individuals under age sixty-five who are entitled to annuities under paragraph 4 or 5 of section 2(a) or are entitled to annuities under section 5(c) (or who have been or would be considered in applying the provisions of section 3(e)) and have attained the age of eighteen and have a disability (within the meaning of section (5)(1)(ii)) and who are in a 'period of disability' (as this term is described in section 3(e)) and, with respect to individuals entitled to annuities under paragraph 4 or 5 of section 2(a) are not in a 'waiting period' (as defined in section 223(c)(2) of the Social Security Act) shall be certified by the Board under section 21 in the same manner, for the same purposes, and subject to the same conditions, restrictions, and other provisions as individuals specifically described in such section 21, and also subject to the same conditions, restrictions, and other provisions as are disability beneficiaries under title II of the Social Security Act in connection with their eligibility for hospital insurance benefits and medical insurance benefits under title XVIII of such Act; and for the purposes of this Act and title XVIII of the Social Security Act,

individuals certified as provided in this section shall be considered individuals described in and certified under such section 21."

SEC. 105. The amendments made by this part shall take effect July 1, 1971.

PART B—COVERAGE OF DRUGS

SEC. 110. (a) (1) Section 1861 of the Social Security Act is amended by adding after subsection (y) the following new subsection:

"(z) (1) The term 'maintenance drugs' means those drugs appearing on the list specified in paragraph (2) of this subsection.

"(2) (A) Subject to the provisions of subparagraph (C), the Secretary shall establish and publish a list of those legend and nonlegend drugs for which payment may be made subject to the conditions of section 1812 (a) (4) under part A of this title. The Secretary shall distribute such list on a current basis to practitioners licensed by law to prescribe and administer drugs or to dispense drugs and shall make such other distribution as in his judgment will promote the purposes of this title. He shall from time to time (but at least once a year) review such list, and shall revise it or issue supplements thereto, as he may find necessary, so as to maintain insofar as practicable currency in the contents thereof

and shall publish and distribute such revisions in accordance with the preceding sentence.

"(B) Each drug appearing on the list established under subparagraph (A) shall be designated by its established name and with respect to each such drug, the Secretary may include such other information (including trade names of such drug) as he finds necessary or appropriate in the administration of this title.

"(C) A drug shall not appear on the list established under subparagraph (A) unless—

"(i) such drug is lawfully available in interstate commerce for dispensing or administration to humans;

"(ii) it is determined by the Secretary that such drug is appropriate for the treatment of diabetes or of chronic cardiovascular diseases, kidney conditions or respiratory conditions;

"(iii) such drug is usually used for treatment extending over a period of 90 days or more (but not necessarily consecutive); and

"(iv) (in the case of a nonlegend drug) it is a life-saving drug, or a drug the withdrawal of which would be seriously harmful to the health of the individual, or a drug which the Secretary determines (under such standards and criteria as he may prescribe) is a satisfactory substitute for a legend drug appearing on the list.

"(D) For purposes of this subsection—

"(i) the term 'drug' means a drug as defined in section 201 of the Federal Food, Drug, and Cosmetic Act (including those specified in section 351 of the Public Health Service Act);

"(ii) the term 'legend drug' refers to a drug specified in section 503(b) of the Federal Food, Drug, and Cosmetic Act; and

"(iii) the term 'established name' shall have the meaning assigned to such term by section 502(e)(2) of the Federal Food, Drug, and Cosmetic Act."

(2) Section 1861(t) of such Act is amended by inserting after "subsection (m)(5)" the following: "or subsection (z)".

(b) Section 1812(a) of such Act is amended by—

(1) striking out "and" at the end of paragraph (2);

(2) striking out the period at the end and inserting in lieu thereof: "; and"; and

(3) adding at the end the following new paragraph:

"(4) maintenance drugs furnished to such individual while he is not an inpatient in a hospital."

(c) Section 1813 of such Act is amended by adding at the end the following subsection:

"(c) (1) The amount payable for a maintenance drug furnished an individual shall be reduced by an amount equal to the copayment determined under paragraph (2) or, if less, the charges imposed with respect to such individual for such maintenance drug.

"(2) The copayment specified in paragraph (1) shall be $1 during the period ending December 31, 1973, and such amount as may be determined pursuant to paragraph (3) of this subsection during any period thereafter.

"(3) The Secretary shall, between July 1 and October 1 of 1973, and of each year thereafter, determine and promulgate the co-payment for purposes of the preceding paragraphs of this subsection and such co-payment shall be in effect for purposes of such paragraphs for the calendar year succeeding the year in which such co-payment is promulgated. Such co-payment shall be equal to $1 multiplied by the ratio of (A) the average per capita costs for maintenance drugs for the calendar year preceding the year in which the determination is made to (B) the average per capita costs for such maintenance drugs for the calendar year 1970. Any amount so determined, which is not a multiple of $0.10, shall be rounded to the nearest multiple of $0.10 (or, if it is midway between two multiples of $0.10, to the next higher multiple of $0.10)."

(d) Title XVIII of the Social Security Act is amended

by adding after section 1817 of such Act the following new sections:

"PAYMENT FOR MAINTENANCE DRUGS; CONDITIONS AND LIMITATIONS ON SUCH PAYMENT

"SEC. 1818. (a) (1) The amount paid to any provider of drugs with respect to maintenance drugs for which payment may be made under this part shall, subject to the provisions of this section and section 1813 (c), be the reasonable drug charge with respect to such drugs.

"(2) (A) The 'reasonable drug charge' for a maintenance drug shall be the acquisition allowance plus a dispensing allowance.

"(B) The Secretary shall by regulations establish the method or methods for determining the acquisition allowance of a maintenance drug, giving consideration to the cost to providers of drugs of acquiring the drug by its established name. If the source from which any maintenance drug is available charges different prices therefor to different classes or types of providers, or if a class of providers may reasonably obtain such drug from only certain types of sources, the Secretary may, in establishing the acquisition allowance, take into account these differences.

"(C) The Secretary shall by regulations establish the methods for determining a dispensing allowance for a main-

tenance drug, giving consideration to such factors as cost of overhead, professional services, and a fair profit. He may provide different dispensing allowances for different classes of providers.

"(b) Payment for maintenance drugs furnished to an individual may be made only to a dispenser of drugs eligible therefor under subsection (c) and only if—

"(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe; and

"(2) (in the case of a legend drug) a written prescription, signed by a physician, was filed with such provider of drugs, or (in the case of a nonlegend drug) a physician has certified that the covered drug furnished the individual was medically required by such individual;

except that (pursuant to such regulations as the Secretary may prescribe) no payment may be made for a maintenance drug—

"(3) to the extent that the quantity of such drug furnished an individual exceeds the quantity of such drug needed for the treatment of such individual for 90 days; or

"(4) if it fails to meet such requirements as to quality and standards of manufacture as the Secretary may prescribe; or

"(5) it fails to meet such specifications as to dosage form as the Secretary may require.

"(c) For purposes of subsection (a), a provider of drugs shall be eligible for payment if—

"(1) he is licensed or authorized to compound and dispense drugs to humans pursuant to State law;

"(2) he agrees to comply with such rules and regulations as the Secretary may issue with respect to—

"(A) submission of bills at such frequency and on such forms as may be prescribed in such rules and regulations;

"(B) availability for audit of his records relating to drugs and prescriptions;

"(C) the maintenance and retention of such records relating to the cost of drugs as may be specified in such rules and regulations;

"(3) he meets such other conditions relating to health and safety as the Secretary may find necessary;

"(4) he agrees not to charge any individual for a drug for which such individual is entitled to have payment made under this section and section 1861(z) an amount in excess of the amount which, when added

to the amount of payment made under this section and section 1813 (c) for such drug, exceeds the customary charge at which such dispenser of drugs sells or offers such drug to the public at the time such drug is furnished to such individual.

"USE OF ORGANIZATIONS IN ADMINISTRATION OF PROGRAM FOR FURNISHING MAINTENANCE DRUGS TO ELIGIBLE INDIVIDUALS

"SEC. 1819. (a) The Secretary is authorized to enter into contracts with organizations to perform such functions as he may find appropriate in administering a maintenance drug benefit if he finds that the utilization of one or more of such organizations will promote the effective and efficient administration of the program provided under this part for the furnishing of maintenance drugs to eligible individuals.

"(b) Contracts with organizations under subsection (a) may be entered into without regard to section 3709 of the revised statutes or any other provision of law requiring competitive bidding.

"(c) For purposes of this section, the term 'organization' means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, prescription drugs under group insurance policies or contracts, medical or hospital service agreements, membership,

or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the organization, including a health benefits plan duly sponsored or underwritten by an employee organization.

"STUDY OF DRUG UTILIZATION

"SEC. 1820. The Secretary is authorized to conduct and publish studies relating to the utilization, efficiency, and costs of maintenance drugs for which payment may be made under this part in order to encourage the proper use of such drugs."

(e) Title XVIII of the Social Security Act is further amended by adding after section 1867 of such Act the following new section:

"EXPERT COMMITTEE ON DRUG COVERAGE

"SEC. 1868. (a) There is hereby created an Expert Committee on Drug Coverage which shall consist of five persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in the fields of pharmacology, geriatrics, and other branches of medicine. Members of the Expert Committee, while attending meetings or conferences thereof or otherwise serving on

business of the Expert Committee shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Expert Committee shall meet as frequently as the Secretary deems necessary.

"(b) It shall be the function of the Expert Committee to advise the Secretary on matters of general policy in the administration of the program provided under this title for furnishing maintenance drugs to eligible individuals. The Expert Committee shall also make recommendations to the Secretary as to what drugs should be included in the list established under section 1861(z)(2) and what drugs should be deleted from such list. In making any such recommendation the Expert Committee shall submit in such detail as the Secretary may request the information and data the Expert Committee considered in making such recommendation. In carrying out its work, the Expert Committee shall consult with organizations representing the aged, pharmacists, the pharmaceutical industry, and with such other organizations or individuals as the Expert Committee finds appropriate. The Expert Committee shall make an annual

51-658 O - 70 - 10

report to the Secretary on the performance of its function, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.

"(c) The Expert Committee is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Expert Committee such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Expert Committee may require to carry out its functions."

(f) The heading of part A of title XVIII of such Act (as amended by section 102(b) of this Act) is further amended by striking out "INSURANCE" and inserting in lieu thereof "INSURANCE AND DRUG".

(g) Section 1811 of such Act (as amended by section 102(c)(3) of this Act) is further amended by inserting after "services" the following: "and the cost of maintenance drugs".

(h) Section 1814(c) of such Act is amended by—

(1) adding at the end of the heading the following "or Federal Provider of Drugs";

(2) inserting "(1)" after "(c)"; and

(3) adding at the end the following new paragraph:

"(2) No payment may be made under this part to any Federal provider of drugs (as provided for in section 1818), except a provider of drugs which the Secretary determines is dispensing drugs to the public generally as a community institution or agency; and no such payment may be made to any provider of drugs for any drug which such provider is obligated by a law of, or a contract with, the United States to render at public expense."

(i) Section 1815 of such Act is amended by—

(1) adding at the end of the heading the following "and Provider of Drugs";

(2) adding after "provider of services with respect to the services furnished by it": ", and each provider of drugs with respect to drugs,";

(3) inserting after "provider of services" the second time it appears "and the provider of drugs, as the case may be,".

(j) Section 1861(r)(3) of such Act is amended by adding at the end before the period the following: "and, for purposes of section 1818, only with respect to drugs he is legally authorized to prescribe by the State in which he prescribes such drugs".

(k) Section 1869(c) of such Act is amended by in-

serting after "provider of services" the following: "or any person dissatisfied with any determination by the Secretary that he is not a provider of drugs eligible for payment under this title,".

(l) (1) Section 1870 (a) of such Act is amended by—

(A) inserting ", provider of drugs," after "provider of services"; and

(B) inserting "or drugs" after "items or services".

(2) Section 1870 (b) of such Act is amended by—

(A) inserting ", or provider of drugs," after "provider of services" each time it appears;

(B) inserting "or drugs" after "items or services; and

(C) adding at the end of paragraph (2) the following: "or any payment has been made under section 1818 to a provider of drugs for drugs furnished an individual,".

(3) Section 1870 (d) of such Act is amended by inserting ", or provider of drugs," after "provider of services".

(m) (1) The heading of section 226 of such Act is amended by striking out "INSURANCE" and inserting in lieu thereof "INSURANCE AND DRUG".

(2) Section 226 (a) of such Act (as amended by section 101 (a) of this Act) is further amended by inserting,

in paragraphs (1) and (2), "and drug" immediately after "hospital insurance".

(3) Section 226(b)(1) of such Act (as amended by section 101(b)(1) of this Act) is further amended by inserting "and drug" immediately after "hospital insurance".

SEC. 111. Section 21(e) of the Railroad Retirement Act of 1937 (as amended by section 104(b)(2) of this Act) is further amended by inserting "(other than maintenance drugs)" immediately after "services" the first place it appears therein.

SEC. 112. The amendments made by this part shall be effective with respect to drugs dispensed after June 30, 1973.

PART C—ANNUAL PHYSICAL CHECKUPS

SEC. 120. (a) Section 1861 of the Social Security Act is amended by adding after subsection (z) (added by section 110(a) of this Act) the following new subsection:

"Physical Checkup

"(z-1) The term 'physical checkup' means eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, examinations of the ears for the purpose of determining the need for hearing aids, and such diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, as the Secretary may by regulations specify as being the type and

kind of tests which are the most likely to reveal defects, diseases, or conditions which are susceptible to effective treatment or control. Such regulations may specify different tests, as may be appropriate, for individuals on the basis of their age or sex. Such term shall also include such physicians' services as may be appropriate for the interpretation, evaluation, and analysis of such tests."

(b) Section 1861 (s) (3) of such Act is amended (1) by inserting "(A)" immediately after "(3)", and (2) by inserting before the semicolon at the end thereof the following: ", and (B) physicians' services and diagnostic tests included within a physical checkup (as defined in subsection (z–1))".

(c) Section 1862 (a) (1) of such Act is amended by inserting immediately before the semicolon the following: "(except physical checkups (as defined in section 1861 (z–1))".

(d) Section 1862 (a) (7) of such Act is amended by striking out all after "checkups" and inserting in lieu thereof the following: "(other than physical checkups as defined in section 1861 (z–1))".

(e) Section 1833 of such Act is amended by adding at the end thereof the following new subsection:

"(g) Notwithstanding any other provisions of this part,

with respect to expenses incurred by an individual in any calendar year for a physical checkup (as defined in section 1861 (z-1))—

"(1) the provisions of subsection (a) shall be applied without regard to the provisions of subsection (b);

"(2) such expenses shall be regarded as incurred expenses for purposes of subsection (a) only if such individual has not, previously during such year, incurred expenses for a physical checkup (as so defined);

"(3) such expenses shall not be taken into account for purposes of subsection (b);

"(4) there shall be considered as incurred expenses for purposes of subsection (a) only whichever of the following amounts is the smaller—

"(A) $75, or

"(B) the amount determined by the Secretary to be equal to the charge which would be imposed for such physical checkup if it had been provided by the most efficient provider of high quality physical checkups in the area wherein such physical checkup was conducted."

(f) The amendments made by the preceding provisions of this section shall apply only in the case of physical checkups performed after June 30, 1974.

PART D—DENTAL SERVICES

SEC. 130. (a) Section 1861 (r) (2) of the Social Security Act is amended (1) by striking out "or" at the end of clause (A), and by inserting at the end thereof the following: "(C) dental services for children (as defined in subsection (z–2))".

(b) Section 1861 of such Act is amended by adding after subsection (z–1) (added by section 120 (a) of this Act) the following new subsection:

"Dental Services for Children

"(z–2) The term 'dental services for children' means professional services rendered to children under 8 years of age by or under the direction of a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function; such term shall include oral examinations and diagnosis, oral prophylaxis, filling, and removal of teeth, but shall not include the provision of braces or prosthetic devices."

(c) Section 1862 (a) (12) of such Act is amended by inserting "(unless such services consist of dental services for children, as defined in section 1861 (z–2))" immediately after "supporting teeth".

(d) Section 1833 of such Act is amended by adding

after subsection (g) (added by section 120(e) of this Act) the following new subsection:

"(h) With respect to expenses incurred by an individual for dental services for children as defined in section 1861 (z–2)), the provisions of subsection (a) shall be applied without application of the provisions of subsection (b)."

(e) The amendments made by the preceding provisions of this section shall apply only in the case of dental services for children performed after June 30, 1974.

PART E—LIMITATIONS ON CERTAIN CHARGES FOR SERVICES; PHYSICIANS' QUALIFICATIONS

SEC. 140. Section 1833(a)(1) of the Social Security Act is amended, effective January 1, 1971, by striking out "reasonable charges" each place it appears therein and inserting in lieu thereof "appropriate and reasonable charges".

SEC. 141. Section 1861(r) of the Social Security Act is amended—

(1) by striking out "The" and inserting in lieu thereof "Subject to subsection (r–1), the"; and

(2) by adding immediately thereafter the following new subsection:

"(r–1)(1) Taking into consideration standards approved by appropriate professional organizations, and upon recommendation of the Health Insurance Benefits Advisory Council, the Secretary may, after public hearings, prescribe

for physicians (as defined in subsection (r)) providing services under this title—

"(A) standards of continuing professional education,

"(B) national minimum standards of licensure, applicable to any individual first licensed as a physician after the effective date of such standards, or

"(C) standards of qualification for the performance of major surgery or of other specialty services designated by the Secretary.

"(2) After the effective date of standards issued under clause (A) or (B) of paragraph (1), an individual who fails to meet such standards shall not be deemed to be a physician for purposes of this title; except that a failure to meet standards issued under clause (A) of paragraph (1) shall not be found until the Secretary has notified the individual involved of the deficiency and afforded him a reasonable opportunity to correct it. After the effective date of standards issued under clause (C) of paragraph (1), an individual who fails to meet such standards shall not be deemed, for purposes of this title, to be a physician in connection with any services to which such standards are applicable.

"(3) The provisions of section 553 of title 5, United

States Code, shall be applicable to the promulgation of standards under this subsection.

PART F—AGREEMENTS WITH STATES FOR ADMINISTRATION

SEC. 150. Section 1874 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(c) The Secretary may enter into an agreement with any State under which such State will administer, on behalf of the Secretary, the health insurance programs established by this title (or such part thereof as may be specified in the agreement) with respect to individuals in such State. The costs of carrying out any such agreement shall be paid to the State by the Secretary in advance or by way of reimbursement and in such installments as may be agreed upon."

PART G—IMPROVEMENT IN ORGANIZATION OF HEALTH CARE

SEC. 160. Title XVIII of the Social Security Act is amended by adding after part C thereof the following new parts:

"PART D—IMPROVEMENT IN ORGANIZATION OF HEALTH CARE

"PURPOSE

"SEC. 1881. The purpose of this part is (a) to encourage the rational organization of health care services and

facilities so as to provide greater continuity and comprehensiveness of care of the individual, to provide greater consumer education and participation, and to emphasize preventive, diagnostic, and early therapeutic services, (b) to control the costs of services paid for under this title, and (c) to stimulate diversity and innovation in the provision of health insurance protection.

"USE OF CARRIERS AND OTHER AGENCIES AND ORGANIZATIONS

"SEC. 1882. No agreement or contract shall be entered into under section 1816 or section 1842, or continued in force after the effective date of this section, unless the agency, organization, or carrier agrees to use its best effort to carry out the purposes of section 1881 (a), and agrees—

"(a) to make (alone or in conjunction with other appropriate public or private agencies) a continuing study of the organization and methods of delivery of health services in the geographic area in which it operates, and of potential improvement of such organization and methods with a view to the effectuation of those purposes;

"(b) to review periodically patterns of utilization of the services paid for under this title and the effectiveness of existing procedures for the control of unnec-

essary utilization, to develop programs for the strengthening of such procedures, and to perform the functions specified in section 1816(b) (1) (B) or section 1842 (a) (2), as the case may be; and

"(c) to take such action within its own authority, and to recommend such action by the Secretary authorized by part E (or by section 402 of the Social Security Act Amendments of 1967), as it finds calculated to further the objectives of section 1881 (a) and to strengthen the control of unnecessary utilization.

"CONTRACTS WITH COMPREHENSIVE HEALTH SERVICE SYSTEMS

"SEC. 1883. (a) The Secretary is authorized to contract with a comprehensive health service system which meets the conditions set forth in subsection (b), for the provision, to the members of the system, of all services for which payment may be made under this title. In lieu of payment otherwise prescribed by this title, he shall pay to such system, at its election, either (1) the reasonable cost of all such services, or (2) a periodically predetermined capitation amount for each member, equal to the estimated average reasonable cost of such services per member; and if he finds (A) that the average cost of such services in any fiscal year is less than the average cost of services (for which payment is made under this title) to comparable population

groups under comparable circumstances, and (B) that services provided by the system have been of high quality and adequate to the needs of its members, he may in addition make an incentive payment to the system equal to not more than two-thirds of such difference of cost per member. The amount of an incentive payment may be used by the system for any of its purposes, including application to the cost of services for which payment is not made under this title, whether or not such services are otherwise provided by the system. Expenditure of funds received as an incentive payment, for whatever purpose, shall not be deemed a cost of services under the contract.

"(b) No contract shall be made under this section with a comprehensive health service system unless—

"(1) such system assures the provision of health services to all its members by a contract or contracts with the Secretary, or by such a contract and subcontracts, entered into by one or more providers of services and other persons furnishing health services, or by a health insurance carrier or nonprofit prepayment plan, or by a combination of the foregoing;

"(2) such system is designed, to the maximum extent feasible, to make all health services readily accessible to persons residing in a specified primary service area and will pay for transportation where reasonable

accessibility to persons in that area cannot otherwise be assured;

"(3) all persons, whether or not residing within the primary service area, are eligible to become members of such system, except that (A) the number of members may be limited, with or without giving preference to persons living within the primary service area, to avoid overtaxing the resources of the system, and (B) such restrictions upon enrollment may be imposed as are approved by the Secretary as necessary to prevent undue adverse selection; and the system is so designed and operated as to encourage enrollment from as broad as practicable a range of income and social groups;

"(4) all health services are provided by providers or other persons who meet the standards imposed by or pursuant to this title for the respective services;

"(5) such system encourages increased health education of its members and the development and use of preventive health services, and provides for a group of physicians (such as a committee of a medical school faculty, of a hospital medical staff, or of a group practice organization), approved by the Secretary for this purpose, which group shall consult periodically with representatives of the membership, fix the professional policies of the system, oversee the professional aspects of

the delivery of services, and review the utilization of all health services, drugs and supplies;

"(6) such system, to the extent practicable and consistent with good medical practice, trains and employs allied health personnel and subprofessional and lay persons in the rendering of services;

"(7) any participating extended care facility under such system is affiliated with a hospital or with a group practice or similar organization, and the medical staff of the hospital or the group practice organization assumes responsibility for rendering or supervising professional services in the facility;

"(8) premiums charged by such system for services not paid for under this title are reasonable; and

"(9) the establishment of such system is consistent with any comprehensive State health plan developed pursuant to section 314 (a) of the Public Health Service Act, as amended, and has been approved by the State planning agency designated or established pursuant to that section, and, where appropriate, is in accord with area-wide health planning carried out pursuant to section 314 (b) of that Act.

"(c) In administering this section the Secretary shall emphasize consumer and community involvement in the

operation of comprehensive health service systems, and shall seek to insure prompt response to local initiative and maximum flexibility in such operation.

"(d) For the purposes of this section, 'comprehensive health service system' means a system of providing health care to an identified population in a primary service area and its environs, enrolled as members, on the basis of contractual arrangements (which embody group practice, or similar arrangements established by a medical school, a hospital medical staff or a medical center) among participating providers of services and other persons so as (1) to assure continuity of care and ready referral and transfer of patients where medically appropriate, and (2) to provide comprehensive health services, which shall include at least all services for which payment may be made under this title (such services to be provided, except as authorized by the Secretary without deductibles, coinsurance, or copayment), drugs prescribed for ambulatory patients, one hundred days of extended care services (which are not post-hospital extended care services) in any spell of illness, and necessary immunizations, and may include other health services approved by the Secretary as appropriate to the particular comprehensive health service system.

516-58 O - 70 - 11

"CONTRACTS FOR EQUIVALENT HEALTH INSURANCE PROTECTION

"SEC. 1884. The Secretary is authorized to contract with any carrier (as defined in section 1842 (f) (1)) to provide, to individuals electing insurance by such carrier in lieu of other rights under this title, health benefits equivalent to those for which payment would be made under this title. No such contract shall be made unless the Secretary is satisfied (a) that the carrier will make such insurance available to all individuals (or to all individuals who reside in a specified area), subject to such restrictions on enrollment as he has approved as necessary to avoid undue adverse selection, (b) that the benefits to be provided by the carrier under the contract will furnish health protection which the Secretary determines (under national standards prescribed by him) to be equivalent to, and at no greater cost than, the protection furnished by the benefits for which payment is made under this title, and (c) that premiums for any health insurance to be sold by the carrier to supplement the benefits provided under the contract will be reasonable. A contract under this section shall require the carrier to perform such of the functions specified in section 1882 as the Secretary finds appropriate.

"PROVISIONS RELATING TO CONTRACTS FOR ALTERNATIVE HEALTH SERVICE PLANS

"SEC. 1885. (a) The Secretary shall by regulation prescribe the manner of making an election (including the manner in which an election may be made on behalf of a legally incompetent individual) to become a member of a comprehensive health service system with which the Secretary has contracted under section 1883, or an election to be insured by a carrier with which the Secretary has contracted under section 1884; the manner in which the election may be revoked; and the frequency with which election and revocation may be made.

"(b) Notwithstanding other provisions of this title, an individual with respect to whom an election made in accordance with subsection (a) is in effect shall not, except in such cases and to such extent as may be provided in regulations, be entitled to have payment made to him or on his behalf for services other than those provided, or to be paid for, in accordance with such election.

"(c) Contracts under section 1883 or section 1884 may be entered into by the Secretary without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

"(d) Each such contract shall provide that the comprehensive health service system or the carrier, as the case may be, shall—

"(1) establish and maintain procedures pursuant to which an individual, with respect to whom an election in accordance with subsection (a) is in effect, will be granted an opportunity for a fair hearing by the system or carrier when any claim by or on account of such individual is denied (in whole or in part) or not acted upon with reasonable promptness;

"(2) will furnish the Secretary such timely information and reports as he may find necessary in performing his functions under this title; and

"(3) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such information and reports and otherwise to carry out the purposes of this title;

and shall contain such other terms and conditions (including, in the case of contracts entered into pursuant to section 1884 or this section, provisions relating to the methods of payment to be used in paying for health services provided under any such contract) not inconsistent with this section as the Secretary may find necessary, appropriate, and practicable.

"(e) Each such contract shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of

intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the system or carrier involved as he may provide in regulations) if he finds that the system or carrier has failed substantially to carry out the contract.

"EMPLOYER-EMPLOYEE HEALTH PLAN OPTION

"SEC. 1886. (a) The Secretary may authorize under appropriate regulations promulgated by him agreements or arrangements with any employer who, in agreement with his employees or their representatives, provides for his employees health care benefits under a qualified plan (as specified in subsection (b)) in lieu of the benefits provided under other provisions of this title.

"(b) For purposes of subsection (a), a qualified plan is a health benefits plan—

"(1) which is provided through or in conjunction with an insurance carrier or similar organization or a union-management health or health and welfare plan;

"(2) not less than 75 per centum of the cost of which is paid by the employer offering such plan;

"(3) covers the employees of the employer offering such plan, and the dependents of such employees;

"(4) provides benefits of a type and level which, in terms of actuarial and health care considerations, is supe-

rior to the health benefits provided under other provisions of this title;

"(5) which contains provision for a fair hearing to any individual covered thereunder who is dissatisfied with the disposition of any claim he may have for benefits provided thereunder; and

"(6) which employs methods of payment determined by the Secretary to carry out the objectives of part E.

"(c) Any agreement entered into under this section with an employer shall provide that the employer shall supply to the Secretary such information and data as may be necessary to keep the Secretary currently advised as to the identification of the particular employees covered by such plan as well as such other information and data as the Secretary may reasonably require in carrying out the purposes of this title.

"(d) Any agreement entered into pursuant to this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such agreement at any time (after such reasonable notice and opportunity for hearing to the employer involved as he may provide in regulations), if he

finds that the employer has substantially failed to carry out the agreement, or that the agreement is not carrying out the purposes of this title.

"(e) The Secretary shall provide to the Secretary of the Treasury such information regarding employees covered by qualified plans covered under agreements under this section as may be necessary or appropriate to enable the Secretary properly to administer the provisions of chapter 21 of the Internal Revenue Code of 1954.

"PART E—METHODS OF COMPENSATION FOR HEALTH SERVICES

"MODIFICATION OF METHODS OF COMPENSATION FOR HEALTH SERVICES

"SEC. 1891. (a) The Secretary, with the approval of the President, is authorized in accordance with this section to modify, effective July 1, 1973, the methods prescribed in this title for determining the amounts of payments to providers of services and other persons furnishing services to individuals entitled to benefits under this title. If any such action requires modification of the provisions of section 1813 or section 1833 relating to deductibles, coinsurance, and copayment, it shall contain provisions imposing equivalent requirements as nearly as may be.

"(b) The Secretary shall forthwith undertake a comprehensive study of methods of determining and paying com-

pensation to providers of services and other persons furnishing health services, with a view to ascertaining what methods are, for the purposes of this title, best calculated to further the following objectives:

"(1) to control the cost of services paid for under this title, to reduce costs wherever possible, and to assure that costs will not in any event increase more rapidly than average wage levels;

"(2) to control the utilization of services paid for under this title, so that to the greatest extent possible unnecessary utilization will be eliminated;

"(3) to improve the organization of health services and the manner of their delivery, in order (A) to increase their accessibility to all individuals wherever resident in the United States, (B) to provide continuous and comprehensive care, and (C) to emphasize the maintenance of health as well as the treatment of illness; and

"(4) to assure, through improved organization and methods of delivery, that control of the aggregate cost of health services will not deprive providers of services and other persons furnishing health services of fair and reasonable compensation therefor.

"(c) Such study shall include (1) alternative methods of compensating hospitals and other providers of services

(such as negotiated charges, capitation payments, or annual budgets), (2) alternative methods of compensating professional practitioners (such as fee schedules or unit value scales with or without proration, capitation payments, or salaries or per session allowances), (3) alternative methods of paying for drug and other supplies, (4) the use of specific financial incentives and disincentives as means to further the objectives set forth in subsection (b), and (5) methods of compensation designed to encourage assumption of responsibility, by local or State medical societies or other professional organizations or organizations or providers of services, for maintaining and improving (through peer review and otherwise) the quality and efficiency of care provided by their members, for the avoidance of unnecessary utilization and for the continuing education of professional and paramedical personnel.

"(d) In making such study the Secretary shall solicit the widest possible expression of views from interested organizations and their members and from the public. To this end he shall appoint such advisory committees, hold such conferences and hearings, and publish such proposals, as he finds appropriate to obtain the views of providers of services and other persons furnishing health services, of health insurance carriers of qualified students of the health care system, and of users of health services.

"(e) Not later than December 1, 1972, the Secretary, with the approval of the President, shall publish in the Federal Register a proposed regulation prescribing the methods of payment for services for which payment may be made under this title. Such proposed regulation shall be subject to the provisions of title 5, section 553, United States Code.

"(f) Not later than March 1, 1973, the Secretary, with the approval of the President, shall issue and publish in the Federal Register his final regulation. Such regulation shall be effective on and after July 1, 1973, and shall supersede all inconsistent provisions of this title.

"(g) The regulations of the Secretary under this part with respect to the methods of payment for services for which payment may be made under this title may be amended or modified by the Secretary, with the approval of the President, from time to time, in accordance with the provisions of section 553 of title 5, United States Code.

"STATE AND LOCAL ADVISORY COMMITTEES

"SEC. 1892. (a) The Secretary, in carrying out the provisions of this part, shall consult with and seek the advice of the State committees representative of consumers and professional health personnel, and such local committees of like character as he may deem appropriate.

"(b) If in any State, or in any local area in which he

decides to utilize such a committee, there is not in existence an appropriate State or local consumer-physician committee, the Secretary is authorized to encourage and assist in the establishment of such a committee, or appoint such a committee."

PROCEDURES REQUIRED OF SECRETARY IN ESTABLISHING STANDARDS

SEC. 161. Standards promulgated by the Secretary with respect to qualifications of institutional providers of service under section 1861 (e) (8), section 1861 (f) (3) and (4), section 1861 (g) (3) and (4), section 1861 (j) (10), section 1861 (p) (4) (A) (v) and (B) shall be promulgated in accordance with the provisions of section 553 of title 5, United States Code.

EFFECTIVE DATE

SEC. 162. That part of the amendments made by section 160 which added new sections 1881 through 1885 to title XVIII of the Social Security Act shall take effect July 1, 1971.

TITLE II—HEALTH BENEFITS FOR THE GENERAL PUBLIC

SEC. 201. (a) The Social Security Act, as amended by the preceding provisions of this Act, is further amended by adding after title XIX the following new title:

"TITLE XX—HEALTH BENEFITS FOR THE GENERAL PUBLIC

"PURPOSE

"SEC. 2001. It is the purpose of this title to secure to every individual who—

(1) is a resident of the United States, and

(2) is a citizen of the United States or an alien lawfully admitted for permanent residence in the United States,

coverage for all the benefits provided under parts A and B of title XVIII of this Act.

"ENTITLEMENT TO BENEFITS

"SEC. 2002. (a) Every individual who—

"(1) is not entitled or deemed to be entitled (and upon the filing of appropriate application or applications could not become entitled or deemed to be entitled) under section 226 to hospital insurance benefits under part A of title XVIII;

"(2) is a resident of the United States (as defined in section 210(i));

"(3) is (i) a citizen of the United States, or (ii) an alien lawfully admitted for permanent residence; and

"(4) has filed application under this section in such

manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary, shall be entitled to hospital insurance benefits under part A of title XVIII (and consequently to the benefits provided by part B thereof) for each month that he meets the conditions specified in paragraphs (1) through (3), beginning with the first month after June 1973 for which he has filed application for such benefits and meets the conditions specified in paragraphs (1) through (3). An individual who met the conditions specified in paragraphs (1) through (3) for any month shall be deemed to be entitled to such benefits for such month if he files application in accordance with the requirements imposed pursuant to paragraph (4) prior to the end of the twelfth month following such month.

"(b) Except as otherwise provided in this title or by regulations of the Secretary, individuals entitled to hospital insurance benefits under part A of title XVIII by reason of the provisions of this title shall receive such benefits in like manner and under the same conditions as obtained in the case of individuals who are entitled to such benefits by reason of the provisions of section 226.

"TRUST FUND ACCOUNT FOR PERSONS COVERED UNDER TITLE XX

"SEC. 2003. (a) There is hereby established in the Federal Health Insurance Trust Fund a special account to be known as the 'Special Account for Persons Covered Under

Title XX' (hereinafter in this section referred to as the 'Special Account').

"(b) Notwithstanding any provision of title XVIII, all benefits to which individuals are entitled under such title by reason of the provisions of this title, and all administrative expenses attributable to the providing of such benefits, shall be paid from and only from the Special Account.

"(c) Moneys in the Federal Health Insurance Trust Fund which are not transferred to the Special Account shall be regarded as being held in the General Account of such Fund and moneys in such General Account shall be available for the purposes for which moneys in such Fund were available prior to the establishment of the Special Account.

"(d) (1) The Secretary shall prior to each fiscal year, estimate the total amounts which will be necessary—

"(A) to pay the total of the benefits payable from the General Account for such fiscal year, together with the administrative expenses attributable to the payment of such benefits, and

"(B) to pay the total of the benefits payable from the Special Account for such fiscal year, together with the administrative expenses attributable to the payment of such benefits.

"(2) The Board of Trustees of the Federal Health Insurance Trust Fund, shall, on the basis of estimates of the

Secretary with respect to any fiscal year, apportion moneys which will be appropriated to the Trust Fund for such year between the General Account and the Special Account; except that, if, on the basis of estimates of the Secretary of the Treasury as to the total amounts which will be so appropriated, such total amounts will be less than the aggregate of the estimates of the Secretary for the General Account and for the Special Account, there shall be apportioned to the General Account the full amount estimated under paragraph (1) for the General Account and the balance shall be apportioned to the Special Account.

TITLE III—FINANCING OF HEALTH INSURANCE

SEC. 301. (a) (1) Section 3121 of the Internal Revenue Code of 1954 (relating to definitions for purposes of the Federal Insurance Contributions Act) is amended by adding at the end thereof the following new subsection:

"(r) WAGE BASE FOR PURPOSES OF HEALTH INSURANCE.—For purposes of the tax imposed by section 3101 (b) only, the term 'wages' (as defined in subsection (a)) shall have the same meaning as that set forth in such subsection, except that the amount '$7,800', wherever it appears therein, shall be deemed to be '$15,000'; and, for purposes of the tax imposed by section 3111 (b) only, the term 'wages' (as defined in subsection (a)) shall have the same meaning as that set forth in such subsection, except that the provisions of

paragraph (1) of such subsection shall be deemed to be inapplicable."

(2) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "section 3111" wherever it appears therein and inserting in lieu thereof "section 3111 (a)".

(3) Section 3125 of such Code (relating to returns in case of Governmental employees in Guam, American Samoa, and the District of Columbia) is amended—

(A) by striking out (in the second sentence of subsection (a) thereof) "section 3111" and inserting in lieu thereof "section 3111 (a)";

(B) by striking out (in the second sentence of subsection (b) thereof) "section 3111" and inserting in lieu thereof "section 3111 (a)"; and

(C) by striking out (in the second sentence of subsection (c) thereof) "section 3111" and inserting in lieu thereof "section 3111 (a)".

(4) Section 6413 (c) (1) (D) of such Code (relating to special refunds) is amended—

(A) by inserting "(ii)" immediately after "(D)";

(B) by striking out "section 3101" and inserting in lieu thereof "section 3101 (a)"; and

(C) by inserting immediately before the period at the end thereof the following: "; and (ii) during any

calendar year after the calendar year 1970, the wages received by him during such year exceed $15,000, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101(b) and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to the first $15,000 of such wages received in such calendar year".

(5) The amendment made by paragraph (1) shall be effective only with respect to remuneration paid after December 1970; the amendments made by paragraphs (2) and (3) shall be effective only with respect to taxes imposed by chapter 21 of the Internal Revenue Code of 1954 with respect to service performed after December 1970; and the amendments made by paragraph (4) shall be effective only in the case of wages received during calendar years after the calendar year 1970.

(b) (1) Section 1402 of the Internal Revenue Code of 1954 (relating to definition for purposes of the Self-Employment Contributions Act of 1954) is amended by adding at the end thereof the following new subsection:

"(i) SELF-EMPLOYMENT INCOME BASE FOR PURPOSES OF HEALTH INSURANCE.—For purposes of the tax imposed by section 1401(b) only, the term 'self-employ-

ment income' (as defined in subsection (b)) shall have the same meaning as that set forth in such subsection, except that the amount '$7,800' contained in paragraph (1) (E) thereof shall be deemed to be "$15,000'.".

(2) The amendment made by paragraph (1) shall be effective only with respect to taxable years ending after December 1970.

SEC. 302. (a) Section 3121 of the Internal Revenue Code of 1954 (relating to definitions for purposes of the Federal Insurance Contributions Act), as amended by section 301 (a) (1) of this Act, is further amended by adding after subsection (r) thereof (as added by such section 301 (a) (1)) the following new subsection:

"(s) EMPLOYMENT FOR PURPOSES OF HEALTH INSURANCE.—For purposes of the tax imposed by section 3101 (b) only, the term 'employment' (as defined in subsection (b)) shall have the same meaning as that set forth in such subsection, except that the provisions of paragraphs (3), (5), (6), (7), (8), (9), (10), and (17) of such subsection shall be deemed to be inapplicable; and, for purposes of the tax imposed by section 3111 (b) only, the term 'employment' (as defined in subsection (b)) shall have the same meaning as that set forth in such section, except that the provisions of paragraphs (3), (5), (6), (9), (10), and (17) of such subsection shall be deemed to be inapplicable."

(b) (1) (A) Section 218 (e) (1) (A) of the Social Security Act is amended by striking out "sections 3101 and 3111 of the Internal Revenue Code of 1954" and inserting in lieu thereof "sections 3101 (a) and 3111 (a) of the Internal Revenue Code of 1954".

(B) Section 218 (e) of such Act is further amended by adding at the end thereof the following new paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section prior to January 1, 1971, no State shall be required to pay or be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed after December 31, 1970, amounts equivalent to the taxes which would have been imposed by sections 3101 (b) and 3111 (b) of the Internal Revenue Code of 1954 if such service constituted employment as defined in section 3121 of such Code."

(2) Section 218 (h) (1) of such Act is amended—

(A) by striking out "and the Federal Hospital Insurance Trust Fund", and

(B) by striking out "subsection (a) (3) of section 201, subsection (b) (1) of such section, and subsection (a) (1) of section 1817, respectively" and inserting in lieu thereof "subsection (a) (3) and (b) (1) of section 201".

(c) The amendment made by subsections (a) and (b) (2) of this section shall be applicable only with respect to service performed after December 31, 1970; and the amendment made by subsection (b) (1) (A) shall apply with respect to agreements under section 218 of the Social Security Act which are entered into after December 31, 1970, or which are entered into prior to such date but which first become effective on or after January 1, 1971.

SEC. 303. Section 3121 of the Internal Revenue Code of 1954 (relating to definitions for purposes of the Federal Insurance Contributions Act), as amended by sections 301 (a) (1) and 302 (a) of this Act, is further amended by adding after subsection (s) thereof (as added by such section 302 (a)) the following new subsection:

"(t) EXCLUSION FROM EMPLOYMENT OF CERTAIN SERVICES FOR PURPOSES OF HEALTH INSURANCE.—For purposes of the taxes imposed by sections 3101 (b) and 3111 (b) only, the term 'employment' shall not include performance of service by an employee of an employer who has in effect an agreement entered into between such employer and the Secretary of Health, Education, and Welfare pursuant to section 1886 of the Social Security Act for the provision of health care benefits for the employees of such employer, if such employee is, at the time such service is

performed, entitled to the health care benefits provided pursuant to such contract."

SEC. 304. (a) (1) Section 3101 (b) of the Internal Revenue Code of 1954 (relating to rate of tax on employees) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar year 1971, the rate shall be 0.7 percent;

"(2) with respect to wages paid during the calendar year 1972, the rate shall be 0.9 percent;

"(3) with respect to wages paid during the calendar year 1973, the rate shall be 2.0 percent;

"(4) with respect to wages paid during the calendar year 1974, the rate shall be 3.1 percent; and

"(5) with respect to wages paid during the calendar year 1975, or any calendar year thereafter, the rate shall be 3.3 percent."

(2) The amendment made by paragraph (1) shall be effective only with respect to remuneration paid after December 31, 1970.

(b) (1) Section 3111 (b) of such Code (relating to tax on employers) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar year 1971, the rate shall be 0.7 percent;

"(2) with respect to wages paid during the calendar year 1972, the rate shall be 0.9 percent;

"(3) with respect to wages paid during the calendar year 1973, the rate shall be 2.0 percent;

"(4) with respect to wages paid during the calendar year 1974, the rate shall be 3.1 percent; and

"(5) with respect to wages paid during the calendar year 1975, or any calendar year thereafter, the rate shall be 3.3 percent."

(2) The amendment made by paragraph (1) shall be effective only with respect to remuneration paid after December 31, 1970.

(c) (1) Section 1401 (b) of such Code (relating to rate of tax on self-employment income) is amended by striking out paragraphs (1) through (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1970 and before January 1, 1972, the tax shall be equal to 0.7 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1971 and before January 1, 1973, the tax shall be equal to 0.9 percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning

after December 31, 1972 and before January 1, 1974, the tax shall be equal to 2.0 percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1973 and before January 1, 1975, the tax shall be equal to 3.1 percent of the amount of the self-employment income for such taxable year; and

"(5) in the case of any taxable year beginning after December 31, 1974, the tax shall be equal to 3.3 percent of the self-employment income for such taxable year."

(2) The amendment made by paragraph (1) shall apply only with respect to taxable years beginning after December 31, 1970.

SEC. 305. Section 1817 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) In addition to the funds appropriated for each fiscal year to the Federal Health Insurance Fund pursuant to subsection (a), there is authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1972, an amount which is equal to 50 per centum of the amount appropriated to such Fund for such year pursuant to such subsection, and such additional amount as the Secre-

tary estimates would have been so appropriated if he had not entered into any agreements pursuant to section 1886."

TITLE IV--FEDERAL AID TO ESTABLISH LOCAL COMPREHENSIVE HEALTH SERVICE SYSTEMS

FINDINGS AND DECLARATION OF PURPOSE

SEC. 401. (a) (1) The Congress hereby finds and declares that improving the provision and the delivery of health care is of critical importance and of the highest national priority and that present programs of health services do not provide for continuing, efficient and comprehensive health care, and lead to an unnecessary duplication of facilities, equipment, and personnel.

(2) The Congress further finds and declares that the establishment of a system of health insurance for every American must not only increase purchasing power and equalize access to quality health care but must also bring about significant change in the health care system.

(b) It is the purpose of this title to provide financial and technical assistance through loans, grants, supplementary financing and otherwise to health service institutions and organizations which will stimulate and enable such institutions and organizations to plan, develop and implement comprehensive systems for the delivery and provision of health care.

BASIC AUTHORITY

SEC. 402. The Secretary of Health, Education, and Welfare (hereinafter in this title referred to as the "Secretary") is authorized to make loans and grants and to provide technical assistance, as provided by this title, to enable comprehensive health service systems (as defined in section 407) to plan and develop comprehensive health care programs in accordance with the purpose of this title, and to assist them to become self-supporting.

ELIGIBILITY FOR ASSISTANCE

SEC. 403. (a) A comprehensive health service system (as defined in section 407 of this title) is eligible for assistance under section 405 of this title if—

(1) such system assures the provision of health services to all its members by a contract or contracts with the Secretary, or by such a contract and subcontracts, entered into by one or more providers of services (as defined in section 1861 (u) of the Social Security Act) and other persons furnishing health services, or by a health insurance carrier or nonprofit prepayment plan, or by a combination of the foregoing;

(2) such system is designed, to the maximum extent feasible, to make all health services readily accessible to persons residing in the specified primary service area and will pay for transportation where reasonable

accessibility to persons in that area cannot otherwise be assured;

(3) all persons, whether or not residing within the primary service area, are eligible to become members of such system, except that (A) the number of members may be limited, with or without giving preference to persons living within the primary service area, to avoid overtaxing the resources of the system, and (B) such restrictions upon enrollment may be imposed as are approved by the Secretary as necessary to prevent undue adverse selection; and the system is so designed and operated as to encourage enrollment from as broad as practicable a range of income and social groups;

(4) all health services are provided by providers or other persons who meet the standards imposed by or pursuant to title XVIII of the Social Security Act for the respective services;

(5) such system encourages increased health education of its members and the development and use of preventive health services, and provides for a group of physicians (such as a committee of medical school faculty, of a hospital medical staff, or of a group practice organization), approved by the Secretary for this purpose, consulting periodically with representatives of the membership, to fix the professional policies of the sys-

tem, to oversee the professional aspects of the delivery of services, and to review the utilization of all health services, drugs and supplies;

(6) such system shall, to the extent practicable and consistent with good medical practice, train and employ allied health personnel and subprofessional and lay persons in the rendering of services;

(7) any participating extended care facility is affiliated with a hospital or with a group practice or similar organization and the medical staff of the hospital or the group practice organization assumes responsibility for rendering or supervising professional services in the facility;

(8) premiums charged by such system for services not paid for under title XVIII of the Social Security Act are reasonable; and

(9) the establishment of such system shall be consistent with any comprehensive State health plan developed pursuant to section 314 (a) of the Public Health Service Act, as amended, and shall be approved by the State planning agency designated or established pursuant to that section, and, where appropriate, shall be in accord with areawide health planning carried out pursuant to section 314 (b) of that Act;

(b) In administering this title, the Secretary shall em-

phasize local initiative and consumer and community involvement of the planning, development and operation of such comprehensive health service systems, and shall seek to insure prompt response to local initiative, and maximum flexibility in the planning, development and operation of such systems. Appropriate Federal departments and agencies shall provide maximum coordination of other Federal assistance with the operation of this title.

FINANCIAL AND TECHNICAL ASSISTANCE FOR PLANNING COMPREHENSIVE HEALTH SERVICE SYSTEMS

SEC. 404. (a) The Secretary is authorized to make grants to, and to contract with, any public or nonprofit hospital, or any medical school or other institution of higher education, or any insurance carrier or nonprofit prepayment plan providing health coverage, or any nonprofit community organization, or any community group organized for this purpose in a geographically defined primary service area and representing a broad range of income and social groups, or any combination of two or more such entities, to pay 80 percent of the cost of planning and developing a plan for a comprehensive health service system (as defined in section 407) which will meet the requirements of section 403. The Secretary is also authorized to undertake such activities as he determines to be desirable to provide, either directly or by contracts or other arrangements, technical assistance to

such entities for the development of plans for such comprehensive health service systems.

(b) Financial and technical assistance for planning such a system will be provided under this section only if the application for such assistance has been approved by the State health planning agency designated or established pursuant to section 314(a) of the Public Health Service Act, as amended.

FINANCIAL AND TECHNICAL ASSISTANCE FOR THE OPERATION OF APPROVED COMPREHENSIVE HEALTH SERVICE SYSTEMS

SEC. 405. (a) The Secretary is authorized to approve a plan for a comprehensive health service system (as defined in section 407) if, after review of the plan, he determines that such plan satisfies the criteria set forth in section 403.

(b) The Secretary is authorized to contract, in accordance with section 403(a)(1), with a comprehensive health service system, if he has approved the plan for such system, to pay so much of the administrative, operating, and maintenance costs of such system as exceed its income for the first five years of operation after approval under this section. Any such contract shall require the system to make all reasonable efforts to enroll members, to control costs and the utilization of services, facilities, and supplies, and otherwise to maximize its income and minimize its costs. If at any

time the Secretary finds that the system in not making reasonable progress toward becoming self-supporting, he may, after hearing, terminate the contract on not less than six months' notice.

(c) To assist a comprehensive health service system to carry out programs of capital development which the Secretary finds necessary for the purposes of this title, the Secretary is authorized to make a grant to such system of not to exceed 80 percent of the amount of non-Federal contribution otherwise required for the construction or modernization of hospitals and other medical facilities assisted under title VI of the Public Health Service Act, as amended: *Provided*, That such project has been approved by the State agency under that title and is consistent with the approved State plan, other than the provisions thereof respecting priorities.

(d) In connection with any project of an approved comprehensive health service system for the modernization, rehabilitation, or construction of ambulatory care facilities which the Secretary finds necessary for the purposes of this title, the Secretary is authorized, in lieu of assistance under any other Federal program or under subsection (c) of this section, to make a grant for up to 50 percent of the cost of such project and to make a loan, on such terms as he shall prescribe, except that the rate shall not exceed 3 percent per annum, for the remaining cost of the project.

(e) The Secretary is authorized to contract to make periodic interest reduction payments on behalf of any group practice or other ambulatory care facility, nonprofit hospital or nursing home which is operated or to be operated as part of an approved comprehensive health service system, such interest reduction to be accomplished through payments to the holder of a mortgage insured under Title XI, or Section 232, or Section 242, of the National Housing Act. Interest reduction payments with respect to a facility shall be made during such time as the facility is operated as part of the approved comprehensive health service system. The interest reduction payments shall be in an amount not exceeding the difference between the monthly payment for principal, interest, and mortgage insurance premium which the owner of the facility is obliged to pay under the mortgage, and the monthly payment for such purposes which the owner would be obliged to pay if the mortgage bore interest at the rate of 1 percent per annum.

(f) Of the sums appropriated pursuant to section 406 for any fiscal year, 2 per centum shall be available for grants by the Secretary to pay 100 per centum of the costs (but in no case to exceed $100,000) of projects, in areas designated by the Secretary as urban or rural poverty areas, for assessing local needs for comprehensive health service systems, obtaining local financial and professional assistance and sup-

port for local comprehensive health service systems, or for comprehensive health service system projects which, in his judgment, are of national significance because they will assist in meeting the needs of the disadvantaged for comprehensive health services systems or demonstrate new or particularly effective or efficient methods of delivery of health care through comprehensive health service systems.

APPROPRIATIONS

SEC. 406. There are authorized to be appropriated for the purposes of this title $———— for the fiscal year ending June 30, 1970, $———— for the fiscal years ending June 30, 1971 and June 30, 1972, $———— for each of the three fiscal years thereafter, and for succeeding fiscal years sums sufficient to carry out contracts entered into pursuant to this title.

DEFINITIONS

SEC. 407. As used in this title, the term "comprehensive service system" means a system providing health care to an identified population group in a primary service area and its environs enrolled as members, on the basis of contractual arrangements (which embody group practice, are established by a medical school, a hospital medical staff or a medical center, or similar arrangements) among participating providers of service and other persons organized so as to—

(1) assure continuity of care and the ready referral and transfer of patients where medically appropriate;

(2) provide comprehensive health services, which shall include at least all services specified in title XVIII of the Social Security Act, as amended by this Act (such services to be provided except as authorized by the Secretary, without deductibles, coinsurance, or copayment), drugs prescribed for ambulatory patients, one hundred days of extended care services (which are not post-hospital extended care services) in any spell of illness, and necessary immunization, and may include other health services which are approved by the Secretary as appropriate to the particular comprehensive health service system.

TITLE V—FEDERALLY CHARTERED HEALTH INSURANCE CORPORATIONS

SEC. 501. Title VII of the Social Security Act is amended by adding at the end thereof the following new sections:

"SEC. 708. In order to assure maximum availability of a variety of techniques for the administration of benefits and services under title XVIII, the Secretary of Health, Education, and Welfare is hereby authorized to organize and establish one or more national health insurance corporations, each of which shall be an agency of the United States under the

51-658 O - 70 - 13

policy guidance of the Secretary, and shall have such organization and such powers as the Secretary finds necessary for the effectuation of title XVIII.

"SEC. 709. The Secretary shall be authorized to contract with, or enter into arrangements with, the corporation or corporations organized and established under section 708 to the same extent as he is authorized to contract with carriers and other agencies and organizations under part G of title XVIII and to enter into agreements with States under part F of such title."

[Excerpt from the Congressional Record, Apr. 14, 1970]

THE LIBRARY OF CONGRESS,
Washington, D.C., April 13, 1970.

To: Hon. JACOB JAVITS.
From: Education and Public Welfare Division.
Subject: Review of the major provisions of your proposed National health insurance plan.

This is in reply to your recent request asking for a review and description of the major provisions of your proposed program of National health insurance for the United States. The description of the provisions of the bill, which is outlined below, is intended only to summarize the principal features of the legislation and in no way is intended to constitute a comprehensive analysis of any single provision in the legislation. Because of the time requirements imposed on us by this request, we are unable to touch upon every aspect of the proposal. We have, therefore, confined this discussion to capsule statements summarizing the principal features of each part of the proposal. In the event you would like us to examine the bill in greater detail, please let us know.

PURPOSE AND ORGANIZATION OF THE LEGISLATION

The proposed "National Health Insurance and Health Services Improvement Act of 1970" would create a National health insurance program for the United States by extending the benefits, enlarging the scope of coverage, and by otherwise revising the existing program of health insurance for the aged, commonly know as medicare (title 18 of the Social Security Act), and provide Federal assistance for the development of local comprehensive health care.

According to the findings outlined in the draft bill, Congress finds that the existing health care system in the Nation cannot guarantee the right to quality health care for every citizen regardless of economic status. The legislation states that the Government has, therefore, an obligation to encourage the development of systems of care which would eliminate economic and organizational barriers to health care for every American, including the aged, the indigent, the disabled and the unemployed.

Specifically, the draft legislation would seek to meet these objectives by means of five titles.

First, the existing Title 18 program would be revised, both as to its coverage of certain insured individuals and to the benefits provided by the program. Basic hospital insurance benefits (Part A of the existing Title 18 program) would be available under the bill not only to all older people but to the disabled, widows, and widowers as well. The supplementary benefits program (Part B of the existing Title 18 program) would be provided to such covered individuals without separate premium costs. Title I of the bill would also add, among the services covered by the newly expanded Title 18 program, the costs of certain maintenance drugs, annual physical checkups and certain dental health services for children under 8 years of age. Other provisions provide for limitations on certain charges for services, for administration of the program and for means of stimulating improvements in the organization of health care in the United States.

Title II of the proposed legislation establishes a health benefits program for all persons not otherwise protected under the revised title 18 program. The benefit package provided for under this new title (a proposed title 20 of the Social Security Act) is identical with those benefits provided to the aged and disabled under the revised title 18 program.

Title III of the proposal provides for the financing of the National health insurance program by expanding upon the current payroll tax mechanism used to finance retirement, survivors, disability and hospital insurance benefits in the present Social Security Act. Changes in the tax rates and earnings base, to which such rates are applied, are provided for in the legislation. In addition to the wage-related financing provisions authorized by the bill, however, a separate source of income for the program is authorized by requiring the Government to meet one-third of the total costs of National health insurance out of general revenue funds.

Title IV of the proposal provides for financial and technical assisstance through programs of loans, grants, and supplementary financing to institutions and to other organizations for the purposes of stimulating and developing improved comprehensive systems delivering and providing health care to the public.

Title V of the proposed Act calls for the establishment of national health insurance corporations which would be federally chartered and operate as agencies of the U.S. under the guidance of the Secretary of Health, Education and Welfare. Such federal health insurance corporations would operate under contract with the Secretary in a manner similar to contract agreements entered into between the Secretary and various private health insurance carriers, non-profit organizations, etc.

SELECTIONS OF THE DRAFT PROPOSAL

Title I—Amendments relating to the present title 18 of health insurance program

Title I of the proposed legislation contains seven parts designed to revise the scope of coverage of the title 18 program to groups of persons in addition to those now covered by law, to expand the scope of benefit coverage provided by the existing program, and to provide for improved health care administration in connection with a National health insurance program.

Part A

Sec. 101.—*Changes in Entitlement to Health Insurance:* revises Sec. 226 of the present Social Security Act, relating to who is entitled to hospital insurance benefits under medicare (title 18, Part A), by including all persons aged 65 and older (including those not presently insured) and all others receiving benefits based upon their disability (including those 18 and over with childhood disabilities). In addition, entitlement is established for widows aged 60 and over and for widowers aged 62 and over. The existing provisions relating to entitlement for certain uninsured persons are repealed by the bill.

Sec. 102—*Changes in the Name of the Title 18 Program:* the present Health insurance Program for the Aged is renamed the "Health Insurance Program," and the program description is changed to refer to the disabled as well as to the aged. The phrase "for the Aged" is dropped from the names of the present Hospital and Supplemental Medical Insurance Programs.

Sec. 103—*New Supplementary Medical Insurance Program:* deletes reference of this program solely for the aged and makes entitlement to supplemental benefits solely a matter of entitlement to the Part A, or hospital insurance program. Repeals certain provisions of the present supplementary program and transfers to a Federal Health Insurance Fund the assets and liabilities of the Supplementary Medical Insurance Trust Fund now used to finance current Part B benefits. Eliminates reference in the present medicaid law (title 19) to the present Part B, or supplementary program.

Sec. 104—*Coordination with the Railroad Retirement Act:* Coordinates provisions of the Railroad Retirement Act with the expanded title 18 program and includes the disabled railroad retirement employees among those entitled to health insurance benefits, in a manner similar to those disabled covered under the Social Security Act.

Sec. 105—*Effective Date:* The effective date of the Part A provisions would be July 1, 1971.

Part B

Sec. 110—*Coverage of Drugs under the New Health Insurance Program:* expands the benefit coverage under the new title 18 program to include protection against the costs of certain maintenance drugs appropriate to the treatment of certain long-term conditions. Provides for the cost-sharing by beneficiaries for such maintenance drugs available on an outpatient basis. Establishes the conditions for which drugs are to be included, now drug costs are to be paid, and other standards for administering and supervising a drug benefit under the program. The inclusion of a maintenance drug benefit would be effective with respect to drugs dispensed after June 30, 1973.

Part C

Sec. 120—*Coverage of Physical Examination:* adds a new benefit to the revised title 18 program by covering the costs of physical checkups to include eye examinations, ear examinations, and such other diagnostic tests or examinations which would be likely to reveal defects, diseases or conditions susceptible to effective treatment and control. Checkup services would also include the costs of physicians' service appropriate for the interpretation, evaluation or analysis of these tests.

The deductible provision, now applicable to the Part B program, would not apply in the case of expenses incurred for checkups, except that limits are placed upon the maximum charges which would constitute incurred charges for checkups. These additional benefits, would become available after June 30, 1974.

Part D

Sec. 130—*Dental Services for Children:* amends the new health insurance program to provide for routine dental care for children under 8 years of age. As in the case of physical checkups, the deductible provisions of the present Part B program would not apply. These benefits would become available after June 30, 1974.

Part E

Sec. 140—*Limitations on Certain Charges for Services:* amends effective January 1, 1971 the current "reasonable charges" section of the present Part B program and substitutes the phrase "appropriate and reasonable charges."

Sec. 141—*Physicians' Qualifications:* Revises under Title 18 of the Social Security Act the definition of the term "physician" by imposing certain qualifications for physicians providing services under the health insurance program. Such qualifications would be related to standards for 1) continuous professional education 2) national minimum licensure requirements 3) performance of various specialty services. Any physician or specialist failing to meet such standards would not be recognized as a "physician" for purposes of the program, although the Secretary of HEW would be required to notify the physician of any deficiency and allow for a "reasonable opportunity" to correct it.

Part F

Sec. 150—*Agreements with States for Administration:* amends Title 18 of the Social Security Act to allow the Secretary of HEW to arrange for State administration of the health insurance programs established pursuant to Title 18 of the Act. Reimbursement to the States for costs of carrying out such agreements would be made by the Secretary of HEW.

Part G

Sec. 160—*Improvement in the Organization of Health Care:* Amends Title 18 of the Social Security Act (the revised medicare program) by adding a new "Part D" to the program. The purpose of this part is to encourage the rational organization of health care services and facilities so as to provide greater continuity and comprehensiveness of care of the individual, to provide greater consumer education and participation, and to emphasize preventive, diagnostic, and early therapeutic services, to control the costs of services paid for under the title and to stimulate diversity and innovation in the provision of health insurance protection.

Part D would authorize the Secretary to develop, by means of contracts and by other methods, the growth of comprehensive health service systems. Such systems would agree to provide the basic benefits provided for in the revised health insurance program and also agree to carry out appropriate utilization and cost control responsibilities in connection with the provision of benefits. Such systems would have to be consistent with comprehensive health plans developed by each State. The Secretary would be authorized to use various means of reimbursement (other than a reasonable cost system) to pay for benefits provided by comprehensive health service systems, and could develop special incentive provisions for these systems if their costs were generally less than costs otherwise experienced by the health insurance program. A special employer-employee health plan option is authorized where employers provide for their employees' health care benefits under a qualified plan in lieu of benefits otherwise provided by the new program. The effective date of the new Part G program would be July 1, 1971.

Title II—Amendments relating to health benefits for the general public

Title II of the proposed legislation would add a new title 20 to the Social Security Act to provide for the entitlement to benefits of the revised title 18 program for all persons not otherwise so entitled by reasons of other provisions in the law. The new title 20 is composed of two sections:

Sec. 2001—*Entitlement to Benefits for the Uninsured:* provides that any person, who is a resident and a citizen (or an alien lawfully admitted for permanent residence), not otherwise entitled to the revised title 18 program (by reason of Sec. 226 of the Act) would be entitled to the same benefits of that program on July 1, 1973. Special provisions would govern the manner and period during which such entitlement would be established.

Sec. 2002—*Trust Fund Account for the Uninsured:* creates within the new Federal Health Insurance Trust Fund a special account known as the "Special Account for the Uninsured." Benefits provided for the persons entitled under title 20 would be paid from, and only from, this Special Account. This section also specifies the manner in which funds are to be appropriated to the Special Account within the Health Insurance Trust Fund.

Title III—Financing of health insurance

Title III of the proposed legislation is divided into five parts which identify and explain the taxing mechanism devised to provide the financial resources with which the national health insurance program will operate. The new title includes amendments to the Internal Revenue Code relating to payroll deductions for the purposes of health insurance:

Sec. 301—*Wage and Income Bases for Purposes of Health Insurance:* amends those sections of the Internal Revenue Code of 1954 (relating to definitions for the purposes of Federal Insurance Contributions) by adding new subsections setting forth definitions of wage and self-employment income bases for purposes of health insurance. The wage and income bases on which taxes are imposed in connection with the financing of health insurance benefits provided under the proposed Act would be set at $15,000 rather than $7,800 per annum with respect to the tax paid by employees of the self-employed. No ceilings are placed on the wages with respect to taxes paid by the employer. The bill indicates that the effective date of the tax change and wage base would begin with taxable years ending after December, 1970.

Sec. 302—*Definition of the Term "Employment" for the* Purposes of Health Insurance: amends Internal Revenue Code so as to include only within the framework of the revised taxing mechanism, certain additional categories of employees and employers formerly excluded from taxing provisions used to finance benefits under Title 18 Social Security Act. Additional categories of employees to be included for taxing purposes are: individuals engaged in family employment; federal, state and local government employees; ministers; railroad employees, individuals in employ of tax-exempt organizations; individuals in employ of registered subversive organizations. Employers of these individuals in above-mentioned categories would also be included in the taxing mechanism for health insurance with the exception of employers falling into the categories of state and local governments and churches and religious orders. Elective date of this section will be 12/70.

Sec. 303—*Exception of Certain Employment for Health Insurance Taxing Purposes:* provides that employment which includes the performance of service by an employee for an employer, who has in effect a contract with the Government relating to a comprehensive health service system, is excluded for purposes of health insurance taxation.

Sec. 304—*Rate of Tax for Health Insurance Purposes on Employees, Employers, and Self-Employed Individuals:* amends Internal Revenue Code by establishing new tax rate schedules for health insurance purposes applicable equally to employers, employees, and self-employed individuals as follows:

[In percent]

Calendar years	Employers	Employees	Self-employed
1971	0.7	0.7	0.7
1972	.9	.9	.9
1973	2.0	2.0	2.0
1974	3.1	3.1	3.1
1975 and thereafter	3.3	3.3	3.3

Sec. 304—*Appropriations to Federal Health Insurance Fund:* provides that in addition to funds appropriated to Federal Health Insurance Fund through taxing mechanism described above, there shall also be appropriated from general revenues an amount equal to 50% of the amount deposited in the Health Insurance Fund collected by means of the payroll tax mechanism and any additional amounts that would have been appropriated if no agreements had been authorized for employer-employee health plan options (as provided for in Part C, Title I of this bill).

Title IV—Federal aid to establish local comprehensive health service systems

Title IV is composed of seven sections which emphasize the need for a reorganization of the present health care system and provisions of Federal financial and technical assistance to affect the desired changes:

Sec. 401—*Findings and Declaration of Purpose:* in keeping with its findings that present programs of health services fail to provide for continuous, efficient, and comprehensive health care, Congress declares that a system of national health insurance must be established in a way that will increase purchasing power, equalize access to quality care, and affect a change in the health care system. Declares that the purpose of this title is the provision of financial and technical assistance through the awarding of grants and loans to health service institutions and organizations in order to stimulate the planning, development, and implementation of comprehensive health service systems.

Sec. 402—*Basic Authority:* authorizes the Secretary of Health, Education, and Welfare to make such loans, grants, etc. as are provided for under this title.

Sec. 403—*Systems Eligible for Financial and Technical Assistance:* establishes the criteria for systems wishing to receive financial and technical assistance from the Government for the purposes of developing comprehensive health service systems. Such systems must, among other things, enter into an agreement with the Secretary to provide or arrange to provide services authorized by medicare. In addition to certain requirements concerning enrollment of beneficiaries in such systems, comprehensive health service systems must develop preventive health care programs, train and employ allied health personnel, and be organized in a manner consistent with the State's overall comprehensive health care plan.

Sec. 404—*Financial and Technical Assistance for Planning Comprehensive Health Service Systems:* authorizes Sec. of HEW to make grants to public or non-profit hospitals, medical schools, any insurance carriers or non-profit prepayment plans, etc. to pay 80% of the cost of planning and development of comprehensive health service systems. Applications for assistance under this title must be approved by a State health planning agency.

Sec. 405—*Financial and Technical Assistance for Operation of Approved Comprehensive Health Service Systems:* authorizes Secretary to contract with approved comprehensive health service system to pay so much of administrative, operating, and maintenance costs of such system as exceed its income for the first five years after approval. The contract shall require the system to make efforts to enroll members, control costs and utilization of services, and otherwise maximize income and minimize costs. Secretary may see fit to terminate contract after giving 6 months notice. Secretary is authorized to make grants to system for programs of capital development in an amount not to exceed 80% of non-Federal contributions otherwise required for construction and modernization of hospital, etc., under Title 6 of Public Health Service Act. The awarding of such a grant depends upon approval of the proposed project by the responsible State health planning agency.

Sec. 406—*Appropriations:* authorizes appropriations to carry out contracts pursuant to Title IV.

Sec. 407—*Definitions:* the term "comprehensive health service systems" is intended to identify a system providing health care to an identified population group in a primary service area on basis of contractual arrangements which embody group practice, are established by a medical school, a hospital medical staff or medical center or similar arrangements among the participating providers of services. Describes comprehensive health service systems as those which provide at least all services specified in Title 18 Social Security Act as amended by this Act.

Title V—Federally chartered health insurance corporations

Title V of the proposed Act is composed of one section which amends the Social Security Act by adding new sections authorizing the Secretary of HEW to establish various national health insurance corporations which will operate under the guidance of the Secretary.

Sec. 501—National Health Insurance Corporations: Authorizes the Secretary of Health, Education, and Welfare to establish and contract with one or more Federally chartered health insurance corporations for provision of health benefits under Title 18 of the Social Security Act. Health Insurance corporations so organized will act as agents of the U.S. Government under the guidance of the Secretary of HEW.

LEVEL OF BENEFITS—NATIONAL HEALTH INSURANCE AND HEALTH SERVICES IMPROVEMENT ACT OF 1970

The benefits provided to all citizens of the United States under my national health insurance bill—subject to existing coinsurance and deductibles—shall consist of no less than the following (effective for over 65 and disabled, July 1, 1971; for general public, effective July 1, 1973):

1. Up to 90 days—with a lifetime reserve of 60 additional hospital days—of bed patient care in any participating general care, tuberculosis or psychiatric hospital. When a bed patient in a hospital, some of the services paid for include:

Bed in semiprivate room (2–4 beds in a room) and all meals, including special diets;

Operating room charges;

Regular nursing services (including intensive care nursing);

Drugs furnished by the hospital;

Laboratory tests;

X-ray and other radiology services;

Medical supplies such as splints and casts;

Use of appliances and equipment furnished by the hospital such as wheelchairs, crutches, braces, etc.; and

Medical social services.

2. When the patient no longer needs the intensive care which hospitals provide, but still needs full-time skilled nursing care, he may be transferred—for up to 100 days—to an extended care facility—a specially qualified facility, staffed and equipped to furnish full-time skilled nursing care and related health services, which include:

Bed in a semiprivate room (2–4 beds in a room) and all meals, including special diets;

Regular nursing services;

Drugs furnished by the extended facility;

Physical, occupational, and speech therapy;

Medical supplies such as splints and casts;

Use of appliances and equipment furnished by the facility such as wheelchairs, crutches, braces, etc., and

Medical social services.

3. After a stay in a hospital (or in an extended care facility after a hospital stay) if the physician determines continued care can be best given at home through a home health agency, the individual will be covered for as many as 100 home health visits for further treatment of the condition for which he received services as a bedpatient in hospital or extended care facility. The home health services include:

Part time nursing care;

Physical, occupational, or speech therapy;

Part-time services of home health aides;

Medical social services;

Medical supplies furnished by the agency; and

Use of medical appliances.

4. Doctors' services no matter where he treats the patient—in a hospital, his office, an extended care facility, home, a group practice or other clinic—and included are:

Medical and surgical services by a doctor of medicine or osteopathy;

Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery;

Services by podiatrists which they are legally authorized to perform by the State in which they practice; and

Other services which are ordinarily furnished in the doctor's office and included in his bill, such as:

Diagnostic tests and procedures;

Medical supplies;

Services of his office nurse; and

Drugs and biologicals which cannot be self-administered.

5. Ambulance service to a hospital when

(a) ambulance services are medically necessary to protect the health of the patient,

(b) transportation by other means could endanger the patient's health, and

(c) the patient is taken to the nearest hospital that is equipped to take care of him (or to one in the same locality).

6. Outpatient hospital benefits which include:

Laboratory services such as blood tests and electrocardiograms;

X-ray and other radiology services;

Emergency room services; and

Medical supplies such as splints and casts.

7. In addition to "3" above, home health benefits—up to 100 home health visits each calendar year—even if the individual was not first hospitalized, if confined to home, a doctor determines home health care needed and periodically reviews the home health care plan. It would include:

Part-time nursing care;

Physical, occupational, or speech therapy;

Part-time services of home health aides;

Medical social services;

Medical supplies furnished by the agency; and

Use of medical appliances.

8. Other medical services and supplies for the treatment of illness or injury—furnished by a doctor as part of his treatment, or by the outpatient department of a hospital, or a medical clinic in connection with treatment, includes:

Diagnostic tests such as X-rays and laboratory tests;

Radiation therapy;

Portable diagnostic X-ray services furnished in your home under a doctor's supervision;

Surgical dressings, splints, casts, and similar devices;

Rental or purchase of durable medical equipment prescribed by a doctor to be used at home; for example, a wheelchair, hospital bed, or oxygen equipment, and

Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.

9. Payment for maintenance drugs, a drug used for treatment extending over a period of 90 days or more and the withdrawal of which would be seriously harmful to the individual's health. The copayment shall be $1 until January 1974 and thereafter, an amount to be determined by the Secretary pursuant to the formula set up in the bill, effective July 1, 1973.

10. Payment of up to $75 for annual physical checkups, which include eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; ear examinations for the purpose of determining the need for hearing aids; and such diagnostic X-ray, laboratory and other tests as are likely to reveal defects, diseases or conditions susceptible to effective treatment or control; including physician's services appropriate for interpretation, evaluation and analysis of such tests, for all over and under 65, effective July 1974.

11. Dental services for children under 8 years of age, including oral examinations and diagnosis, oral prophylaxis, fillings and removal of teeth, effective July 1, 1974.

STATEMENT OF HON. CLAIBORNE PELL, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator PELL. Mr. Chairman, today's hearings represent an historic occasion for our Nation's health care system. Today's hearings symbolize the momentum that is developing for a reform of our Nation's

health care system—an event which I believe is inevitable in the coming session.

In my mind there can be no greater tribute to the efforts of our chairman, Senator Yarborough, who has labored so hard for so many years to improve and protect our citizens' health, than that the first hearing on this historic movement toward universal health care coverage should occur under his chairmanship.

I have no doubts that the time has come to develop a health system in the United States capable of providing a floor of minimum health care coverage for each American. The question is no longer should we but how can we move toward this goal.

Spiraling health costs, continued and persistent high morbidity statistics among major elements of our population, and an unequal distribution of health care services among different groups of Americans are all factors which point unwaveringly toward the need for a major reform of our health care system.

Many different proposals have been suggested. I, myself, have cosponsored Senator Kennedy's proposal which, of course, is very much similar to the proposal we are considering today excepting for the insurance feature. The American Medical Association has suggested a tax credit proposal. Various European countries have national health care plans which may deserve emulation.

A proposal which I consider as meritorious is the proposal to require employers to provide a minimum level of health care services to their employees and their families through legislation similar to our minimum wage legislation. Under a proposal such as this, employers will have the option of providing minimum health care services, either directly by contract with an existing health insurance company or by contract with the Federally established health services corporation. Persons not employed would continue to receive health coverage under the various provisions of existing medicaid and medicare plans.

Under this proposal, the minimum health services required to be provided could be made primarily preventive in nature and complimentary to existing curative health plans for employees and their families.

There are many obvious advantages to the approach of securing universal health care coverage through the work place. First, a corporation is a much stronger consumer bargaining force in the health industry than, of course, the individual health services consumer. Since the industry is paying the cost of health care service, it has an extremely strong incentive to promote economical means of health care services. It would, thus, be assumed to encourage ideas such as group practice and preventive care in neighborhood health centers as alternatives to our present expensive hospital-oriented health care system.

Second, by authorizing the Department of Health, Education, and Welfare to incorporate health service corporations as alternative sources of health care services for employees, the Federal Government is provided with a tool for promoting economy and efficiency in our health industry through competition; and, of course, the employer is provided with an alternative to existing health insurance companies as a source of the health coverage he must provide to his employees.

A third advantage that a minimum health care law would have would be that it would allow for regional variations in the types of health care services provided, allow for the least disruption in the present health care industry, and it would not require a nationalized, centralized, health bureaucracy.

The fourth advantage of such a proposal is that this committee would, of course, have legislative jurisdiction over such a minimum health care proposal. I have described this alternative proposal not because I am convinced that it is the right solution to our health care problem, but I mention it because I believe it is necessary that we give detailed consideration to every option of health care reform.

We are discussing a radical restructuring of a $63 billion industry. I believe it is of utmost importance that we consider every option and that we move toward this reform in an orderly fashion. It is for this reason that I am delighted that the Senate approved as title II of the Health Improvement Act my bill, S. 3634, providing for a systems analysis of alternative national health care plans. This, I believe, represents the first orderly step that needed to be taken.

This provision would require the Department of Health, Education, and Welfare to present to the Congress in the coming session detailed information in cost-benefit terms of the alternative means by which our health care system can be reformed. This study would include a description of the legislative and administrative requirements needed for the implementation of each alternative plan.

A second step for the orderly reform of our health care system, which I think we should consider, is the method by which the Congress will legislate that reform.

With all due respect to our distinguished chairman of the Health Subcommittee, we must be aware that there are many more committees than the Senator Labor and Public Welfare Committee that have legislative jurisdiction over health care.

The Senate Finance Committee has jurisdiction over the medicaid and medicare programs. The Post Office and Civil Service Committee has jurisdiction over Federal employee health plans. The Judiciary Committee has examined the antitrust implications of rising hospital costs. The Government Operations Committee has held hearings on the organization of the Federal Government's 23 health programs.

It seems to me that a major reform for a national health care system cannot be done on a patchwork basis among competing congressional committees.

I think we should give serious consideration in the next session of Congress to the establishment of a Senate Select National Health Care Committee in order that we may have a comprehensive coordinated legislative approach in the development of a new national health care system.

In conclusion, I wish to say that I believe that there are few greater priorities than the matter before us today.

I congratulate the chairman on calling these hearings, and I hope they will provide us with the insight we need to move toward the establishment of a floor of minimum health care services for all Americans.

The CHAIRMAN. I next call on the distinguished Senator from Missouri who served as Governor of that great State. He sought service on this committee and he attained it. I believe the future for this bill rests with the young and dynamic Senators on this committee. Senators Kennedy, Saxbe, Hughes, Cranston, and Eagleton certainly sought this committee to render a service to the people in the form of better health care. It is a pleasure to see you here, Senator Eagleton.

Senator EAGLETON. I am so stunned by the warmth of your remarks that I will pass.

The CHAIRMAN. Next we have a Senator who has shown a great interest in health care, chairing a special subcommittee on narcotics and drugs and alcoholism. He has attended more hours in this health subcommittee since I have been here than any other Senator except me and maybe more than me, Senator Hughes, formerly one of the outstanding Governors of the State of Iowa.

Senator HUGHES. In the interest of time, Mr. Chairman, I will also pass.

The CHAIRMAN. Our first witness is Hon. John G. Veneman, Under Secretary of the Department of Health, Education, and Welfare.

STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY HON. LEWIS H. BUTLER, ASSISTANT SECRETARY, PLANNING AND EVALUATION, AND DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS

Mr. VENEMAN. Thank you, Mr. Chairman.

At the outset, let me introduce the gentlemen who are with me at the table. To my left is Assistant Secretary (Planning and Evaluation) Lewis H. Butler, and to my right, Dr. Roger O. Egeberg, Assistant Secretary (Health and Scientific Affairs). These gentlemen have been responsible for the formulation of the health policy in the Department and they are available for questions after my opening statement.

Mr. Chairman and members of the committee, my testimony today will be on Senate bill 4323. This bill would enact the program originally proposed by Senator Kennedy to federalize the health financing system in the United States at an annual cost in its first full year of operation of $77 billion.

We share the concerns of this committee for the health status of the American people, concern about the financial hardship that can accompany illness, concern about the apparently unending rise in health care costs, concern about inadequacies in the Nation's health care resources and our failure to organize and coordinate our existing resources in ways designed to improve the health of our citizens.

Before discussing this bill—which in our opinion is not a proper or workable approach to the solution of the health problems of this Nation—I would like to comment briefly about its costs. Actuarial estimates from the Social Security Administration indicate that the total expenditures under this bill in the year 1974, which would be first full year of its operation, would come to $77 billion.

Senator KENNEDY. I know we are pressed on time, Mr. Chairman, but I think we ought to pause on this cost figure. As I understand it the committee did not have this testimony prior to this morning——

The CHAIRMAN. When was the testimony of the Under Secretary received?

Mr. VENEMAN. It was delivered this morning.

The CHAIRMAN. It is a rule of this committee that testimony is delivered 72 hours before the hearing begins. This administration has consistently come up here on major bills and never let us see their testimony until the hour of the hearing. I think there has been a lack of cooperation and then they show up with some exaggerated claim.

Senator KENNEDY. Is that $77 billion projection based on the present rate of inflation in health costs that we have seen over the period of the last few years?

Mr. VENEMAN. Senator, initially it was estimated that in 1969 the measure would have cost $37 billion. Using this as a base, we have projected population increases, utilization increases, and price increases. Mr. Bill Hsiao, who is the Deputy Chief Actuary with the Social Security Administration is present. He independently developed this estimate and is available to explain the methods and the assumptions he used. I understand the committee itself has come up with an estimate of some $65 billion for 1974. By committee, I refer to the Committee on National Health Insurance.

Do you want Mr. Hsiao to justify the figure now?

Senator KENNEDY. I hope we will have an opportunity to examine his material.

We know that medical expenses have been rising rapidly, far in excess of the Consumer Price Index, which, itself, is also rising rapidly because of our current inflation. It seems to me that in reaching this figure of $77 billion, the administration is using a scare tacting to try to scare people away from the program because of its cost. It is worthwhile to find out right at the beginning just what the basis is for this figure.

The inference that the $77 billion figure is a scare tactic is strengthened by the press reports only last week that Dr. Vernon H. Wilson, the head of the Health Services and Mental Health Administration in HEW and the No. 3 health officer in the Administration, had praised the bill. Dr. Wilson called it an important approach to solving the Nation's health delivery problems. This initial praise from HEW demonstrates to me that at least the first professional response of the Administration to the bill is highly favorable, whatever the political response we are getting today.

Mr. Chairman, I would like to provide a copy of the statement prepared by Dr. Wilson, to be printed in the hearing record at this point.

(The statement of Dr. Wilson follows:)

STATEMENT OF VERNON H. WILSON, M.D., ADMINISTRATOR OF THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

On August 27, Senator Kennedy introduced S. 4297, the "Health Security Act" in the Senate. On September 8, Senator Yarborough introduced an identical legislative proposal, with the modification that financing would be totally from general revenues. Hearings on this proposal are scheduled for September 23–24 before the Senate Committee on Labor and Public Welfare.

The Health Security Program proposal outlines a comprehensive national health program which could potentially affect the availability of health services to all residents of the United States. Because health service is our primary mission, as Administrator of the Health Services and Mental Health Adminis-

tration, I would like to provide an initial professional assessment of the concepts and principles embodied in this proposal. If appropriate we would appreciate the opportunity to give this more detailed study in behalf of the DHEW.

In general, many of the principles contained in this proposal are ones which have had long standing support within HSMHA and its programs: The emphasis in the comprehensive benefit structure on preventive services, health maintenance, and ambulatory care; the provisions for establishment of at least minimum standards of quality for the participation of all providers of services, and the requirements for professional review of performance; the effective involvement of consumers of health services in all aspects of the program.

Three concepts of the Health Security Proposal are especially noteworthy: The establishment of a Resources Development Fund formed by taking a percentage (initially 2% and up to a maximum of 5%) of the annual income of the program's Trust Fund. This concept recognizes (1) that a national health insurance plan is not enough to assure availability of health services: there must be investment in the capacity of the health system to operate, and (2) the insurance schemes must accept responsibility to finance, in part, increases in the ability of the Nation's resources to deliver adequate health care. A front-end tax on the Trust Fund would help to overcome present difficulties in financing improvements in the health care delivery system under a fiscal policy which treates health investment as a controllable budget item, but subject to the dictates of uncontrollable programs such as Medicare and Medicaid. The mechanism of the front-end tax brings about an appropirate proportional relationship between the demand and supply.

The emphasis in the proposal on creation and support of organized health care delivery systems serving defined population groups on a prepayment basis. This is a concept which HSMHA programs have been promoting for several years as one means to bring about improved efficiency and effectiveness in the delivery of health care. However, the Health Security Proposal recognizes, as does HSMHA, that it is neither feasible nor desirable to promote and support only one method of delivering health care. All present health care delivery methods would continue under the plan, but through incentive payments and various cost control methods, linkages between providers would be encouraged, and the expensive cost reimbursement and fee for service methods of paying for care would be discouraged.

The recognition that the program is conceived and will be administered as a health program, establishing a Health Security Board and Health Security Council, and decentralizing management through regional HEW offices. The concept of the Health Security Board as a full-time administering body directly responsible to the Secretary of HEW would appear to be an effective way to resolve the present fragmented administration of health programs within HEW.

Just as these concepts in the Health Security Proposal are professionally acceptable, there are other concepts in the proposal which are questionable and may pose problems. These problems are of such a nature that until they are resolved, one may question the wisdom of proceeding too rapidly with program implementation. Among the problems we have identified are:

The timing of the availability of benefits in relation to activities designed to improve the capacity of the health care system. It is proposed that the program would begin to provide benefits in 1973, a short three years if the legislation were passed today. Even with added investment funding in the interim period. our experience with the inertia of the health care system suggests this is simply not enough time to effect the major changes and improvements which would be needed in order to meet the new demands in 1973.

The Yarborough proposal that funding be entirely from the general revenues. A mixed source of funds. heavily dependent upon contributory social insurance, should be the preferred financing methods since: (1) the public psychology has come to accept social insurance as an acceptable method of making access to service a right and not a concession; (2) it is a rich source of revenue and highly dependable; (3) supplements from the general revenue would be needed to cover individuals difficult to cover through the payroll tax system, to overcome the difficulty of raising all the funds needed through social insurance alone, and to accommodate the equity problems associated with the regressive nature of social insurance taxes.

The sub-regional "medical market areas" and their role in administration. This aspect of the administrative arrangements, calling for potentially 100 sub-regional administrative-management entities needs considerably more expli-

cation. Are the 100 areas envisioned as being based with medical schools? What is the nature of the management authority in the sub-region? Is it a fiscal and planning agency? Or is it concerned with the delivery or health care on a regionalized basis? Is it feasible or desirable to by-pass the State political boundaries and to allow permissive use of the State agencies in the program administration?

The issues related to Workmen's Compensation, the Indian Health Service, and the Medical program of the Veterans Administration. Problems related to integrating these programs into the Health Security Program must be faced squarely. If the goal is to create an operative national health program for all citizens, is it desirable to continue to countenance separate financing and delivery systems for special groups in the population?

In summary, the Health Security Program is a well-conceived, thoughtfully prepared, comprehensive and integrated approach to solving many of the Nation's health care delivery problems. Most of the principles embodied in the proposal are worthy of support. In fact, many of them parallel proposals which we have been engaged in formulating during the past several weeks as part of the DHEW effort to identify a range of Health Options. Similarly, one can view the Department's policies on Health Maintenance Organizations (Section 239 of H.R. 17550), its activities to devise a Family Health Insurance Program related to the Family Assistance Plan, as initial or partial steps by this Administration in the direction of the same goal of adequate health care for all Americans.

Senator KENNEDY. Mr. Veneman, I think we ought to have a clear understanding at the outset whether your cost figure includes a continuation of the current inflationary trend in health costs.

Mr. VENEMAN. It takes into consideration an increase in medical cost to the same extent that the medicare projections were made. We are using the same actuaries and the same basic assumptions we used for that.

I think you recognize that is one on which we based the needs for employer contributions and other deductible factors. I will let Mr. Hsiao explain specifically. I do not think it contains a 13-percent increase. There has been a degree of leveling off.

Last year physicians' fees and services increased approximately 6 percent, and we have to recognize that trend is not over. I would prefer to have Mr. Hsiao justify this figure at the conclusion of my testimony and present for the committee the assumptions upon which they were based. If you would like to do it now, I have no objection.

Senator SAXBE. Does this projection contemplate any change in the present delivery system?

Mr. VENEMAN. Mr. Chairman, with your consent, this point has raised some questions perhaps which I could have Mr. Hsiao answer. He is the actuary for the Social Security Administration and he can quickly summarize the basis upon which this figure was derived. I would prefer to do it later but I will do it now if you prefer.

The CHAIRMAN. I share the interest of the other members of this committee, and I have my doubts that that figure can be substantiated, too. We have so many out-of-town witnesses here: two entire panels, nearly all of them from out of the city. Although the members of the committee are very much interested and although I don't think the costs can be justified, I will have to ask that your estimates be examined later.

Mr. VENEMAN. I asked Mr. Hsiao in the car on the way over here if this was in accordance with the Social Security Administration in estimating the costs of health care which traditionally have been low.

The CHAIRMAN. You are going to make this more efficient system cost more than the present inadequate system, and we can blow you out of the water on that.

You may proceed.

Mr. VENEMAN. Going back to our $77 billion figure for 1974, I point out that section 201 of this bill provides that those expenditures would be financed from general revenues of the Federal Government and would be equivalent to a Federal health tax of over $1,000 per year for every household in the United States.

There are those who insist that the present system is sound and should be left alone. Others demand that we throw out the baby with the bath water and replace our pluralistic health enterprise with some monolithic scheme in which the Federal Government controls everything.

I think both points of view are wrong. The deep troubles of the health care enterprise have been nurtured by many factors, not the least of which is past failure to plan and prepare for the soaring demand that observant people knew was coming. But I do not believe that past neglect means that we now have to start over and pursue some course of action that would be entirely alien to our basic traditions.

I simply can not subscribe to the idea that we must now break—utterly and totally—with the past—which Senate bill 4323 proposed to do.

What is the claimed justification for this enormous expansion of Federal spending in the field of health? The assumptions appear to be these:

That the serious problems with health care delivery in this country can be cured by total Federal domination of the system.

That even though 80 percent of Americans under 65 have some form of private health insurance coverage, and the elderly are protected by medicare, the only way to fill the gaps in such coverage is to force everyone into a single system.

That doctors, hospitals, and other providers of care will work willingly in a system where all payments are made by the Federal Government and all fees fixed by it under a system of rationing health-care dollars by untested governmental boards in various regions.

The central issue, over and above the inconceivable commitment of general fund revenues for S. 4323, is whether such a drastic abandonment of existing meechanisms in our health care system is necessary to remedy the defects in the system and whether, in fact, it may not create more problems than it will solve.

Before examining these issues, we should look at what we all know are problems with health care in America. Among the most serious of these problems is the lack of adequate financial resources of low income families who cannot afford to pay high health costs or purchase voluntary insurance.

To meet this problem, the administration has proposed the family health insurance plan which would for the first time make available health insurance protection to all poor and near-poor families. This plan now being developed will be submitted to the Congress early next year, and we look forward to productive debate on that critical issue also. More than 20 million people will be eligible under the family health insurance plan, which would establish for the first time a basic national standard of health protection for needy families. This will be a dramatic advance toward the goal of assuring all persons financial access to health care.

Much of our progress toward this goal to date has been through the continuous growth of voluntary health insurance. Between 1940 and 1968, the number of persons of all ages with hospital coverage rose from 12 million to about 175 million. At the end of 1968, almost four-fifths of the population under age 65 had some form of private health insurance. Insurance for surgical costs was provided to 77 percent of this population, and insurance for in-hospital physician visits to 68 percent.

As with medicare and soon with the family health insurance plan, the role of the Federal Government in part is properly to do what the private sector cannot do—to provide protection to those who cannot otherwise acquire it, either because their medical risks are too great or their ability to pay too limited. The bill before us rejects the role of voluntary health insurance in serving the needs of the majority of Americans.

An increasingly serious problem for all Americans has been the inadequacy of the health system itself, as evidenced by rising costs, inefficiency and fragmentation in the delivery of services, and poor distribution of services. Only within the last 2 years has it become generally understood that the Federal Government as well as private insurance must use their existing programs to produce changes in the health system that will solve these problems. A basic stated purpose of the medicare-medicaid legislation was to buy into the existing health structure without compelling any changes.

Government is currently purchasing more than 36 percent of the total output of the health care system. This figure indicates that the use of its purchasing power is probably the Government's primary source of leverage to initiate changes in the organization and delivery of health care. As Government becomes more involved in financing it also has a greater responsibility to remedy the defects in the system.

To control costs, we have proposed to limit increases in the fees of doctors and other professionals under medicare and medicaid to an index that assures the fees will not exceed increases in the cost of doing business.

I might clarify that by pointing out in medicaid this was done and the provisions in medicare are now before the Senate Finance Committee.

We are proposing that reimbursement for hospital costs under medicare be made on a prospective basis to encourage institutions, through financial incentives, to operate efficiently and to require that they bear the risk of incurring higher costs than contemplated; asked for authority to terminate payments for services rendered by health care supplier found guilty of program abuses and to facilitate recovery of overpayments. Proposed improvements in existing hospital utilization review and for experiments with new and alternative kinds of medical and utilization review mechanisms, such as the application of computers and related technology in the utilization and medical audits.

To promote efficiency and competition in the system and to provide incentives to reduce unnecessary care, particularly high-cost hospitalization, we have proposed payment to health maintenance organizations prepared to provide comprehensive health services at a fixed annual rate per person for all covered services; requested authority to withhold amounts for depreciation and interest related to capital expenditures under medicare from those health care institutions that make

51-658 O - 70 - 14

major capital expenditures that are disapproved by local and State planning bodies, in order to avoid costly duplication.

To improve distribution of health care, we have proposed a strengthening and coordination of the health planning mechanisms under the regional medical program and the partnership for health; proposed reform of the Hill-Burton legislation to provide grants for lower cost ambulatory care units and loans to more expensive acute bed hospitals.

But these measures are directed only at improving the medical care system of the Nation. In the long run, a healthy nation depends more on the steps we take to prevent illness and accidents than it does on those to cure it. Perhaps the best investments we can make as a nation in improved health are those directed toward assuring sufficient food and an adequate income for those in need, and a healthy environment for all. Hence, the enormous significance for health of President Nixon's proposals for the family assistance plan, which would assure that almost half of the families in the United States now classified as poor will have income above the poverty line; assuring more adequate nutrition through major increases and expansion of Federal food assistance programs; and national air pollution standards for vehicles and stationary sources to combat respiratory disease.

The question now is whether we should divert revenues needed for income maintenance, nutrition, the environment, housing, and other health-related efforts, and concentrate them all on creating the Federal system of health financing proposed by S. 4323. To do so would assume the failure of the measures currently proposed to correct defects in the present mixed public-private health system.

In short, we have made substantive recommendations for improving the organization and delivery of services, increasing the efficiency of the health-care industry, and for stimulating necessary reorganization and redistribution through financing mechanisms. We are very much aware of the urgent need for solution of many problems in the financing and delivery of care, and we have committed ourselves to an insurance program to provide protection to low-income families with children.

However, we have serious reservations about the desirability of embarking on a program like S. 4323 that will protect not only the unprotected but those with substantial coverage, and that will radically restructure the health financing and health service industry without having tested the instruments of change.

Mr. Chairman, I also have additional resource people who are available to answer questions. If you would like to have Mr. Hsiao up to direct himself to the $77 billion estimate——

The CHAIRMAN. Since we have an opportunity to call you later, and we have out-of-town witnesses, we will forego oral questions now and ask everyone to submit written questions. There are two panels here from out of town and I feel in the interest of time in hearing them we should call the next witness. Thank you very much. There is much we don't agree with in there but we will develop that later on.

The next witnesses are the Health Security Action Council Panel: Leonard Woodcock, president of the council and also president of the United Automobile Workers; Dr. Michael DeBakey vice chairman of the council from Houston, Tex., and world-famous heart specialist; Mr. Whitney Young, Jr., vice chairman of the council and executive

director of the Urban Coalition; and Dr. I. S. Falk, member of the Council and professor emeritus of public health at Yale University. We welcome you here.

It is a pleasure to have Leonard Woodcock, a great labor leader, appear before us this morning. Mr. Woodcock was born in Providence, R.I., was schooled in British schools while his father installed machinery in Europe. When Mr. Woodcock returned to the United States in 1926, he studied at a city college in Detroit, but in 1933 he went to work at the Detroit Gear Co., in the machine shop. He quickly became involved in the union movement and became a ful-time union worker.

He took over the General Motors department of the union, the largest section, after the 1955 negotiations and has headed it since then. He is also on the board of governors of Wayne State University. It is an honor to welcome you here. As president of this health Security Action Council, Mr. Woodcock, we invite you to proceed with your statement. We thank you gentlemen for coming. We welcome all of you. We think you are making a great contribution to the better health of the American people.

STATEMENT OF LEONARD WOODCOCK, PRESIDENT; DR. MICHAEL DeBAKEY, VICE CHAIRMAN; WHITNEY YOUNG, JR., VICE CHAIRMAN; DR. I. S. FALK, MEMBER; ALLISON WILCOX, LEGAL ADVISER, HEALTH SECURITY ACTION COUNCIL

Mr. WOODCOCK. I, too, would like to congratulate this committee on holding these important hearings. There are few more pressing interests than the health care of all Americans. We are deeply dismayed at the continuing skyrocketing costs and the lack of availability of services, and we see need for prompt action.

I may say that the figure of $77 billion that was mentioned this morning by the administration shocks us. We have a highly competent technical committee which worked for many months on this area. In order to have a control on the estimates that were made, Mr. Walter Reuther met with then Secretary Finch to get the services of the Social Security Administration technical experts to doublecheck the estimates that the Committee for National Health Insurance has made, and their estimates were checked out by the experts in the Social Security Administration under then Secretary Finch.

I would like Dr. Falk at a subsequent time to comment further on this matter.

Senator KENNEDY. Would you please make that available for the record today the figures you have on the cost of the program, and your reaction to the administration's projected cost of $77 billion? I think it important to have that as part of today's opening record. I know you have some comments on this. We are pressed for time and the chairman has asked us to refrain from asking questions. But as Mr. Woodcock observed, the issue of costs is an extremely important one, and it is clear that many conflicting allegations will be made. So, I would hope any material you can provide may be made available for the record.

The CHAIRMAN. We can order it printed in the record immediately at the conclusion of Mr. Woodcock's statement.

Mr. WOODCOCK. I am informed we can furnish it.

(The information may be found on p. 262.)

The CHAIRMAN. The more realistic estimate is $37 billion and not this figure of $77 billion offered by the administration.

Mr. WOODCOCK. The trade union movement and most thoughtful Americans recognize health care cannot be improved on a piecemeal basis. The Committee for National Health Insurance which was largely brought into being by Walter Reuther was based on this recognition. Its membership represents a broad spectrum of U.S. leadership, with an excellent technical task force led by Dr. Falk which sought a realistic health-care system. It recognized the strength and the serious flaws of the present health-care system. We think it has devised a uniquely American plan.

The health security program reflected in the bill builds on existing health care structures but recognizes the need for real changes. It would do more than pay benefits. Simply adding money to the present nonsystem would raise costs and charges and subsidize inefficiency.

The health security program makes possible ready and continuing access to needed health care services. The bill proposes to use the leverage of money, the financial resources of universal health insurance, to effect fundamental health care changes.

Speaking on behalf of my own union, the UAW, I have taken time from the critical negotiations and the strike now underway with General Motors involving some 400,000 families to be here because the issue of obtaining vital health care is vital to labor.

While the UAW health care program provides far more coverage than is available to most Americans it is really mostly sickness insurance and not health insurance. We were the first industrial union to commit our organization to health care as a major bargaining issue and our members have always placed high priority on health care. We are now spending, with the three big automobile companies, 30 cents an hour of what could otherwise be wages for the purchase of our existing sickness insurance. We have made gains at the bargaining table but those gains are presently threatened by the company demanding a cutback on what is really only partial protection. This is among the reasons I am here. A major stumbling block to the settlement of the General Motors strike is this:

Back in 1961 we bargained over the question of wages and set aside certain wages and had the company agree to pay the full premiums on hospital, surgical-medical insurance. Because of the escalating costs the last 3 years, the price to General Motors went up 41 percent, and that is a great problem.

They proposed to solve that problem not by attacking the root causes but by saying that starting with the fall of 1971, any future increases will be paid entirely by the workers, thereby negating the the bargain we freely made back in 1961.

So this is directly related to the current General Motors strike—the escalating uncontrolled costs of the present health system.

We have proposed to them that the best way to meet this problem is to join us in getting a realistic national health insurance program, the health security program that is here before us.

I might also add, Senator Saxbe, that retired workers and their families, better than 200,000 of them, find medicare inadequate to

protect them. We have to bargain additional insurance because medicare covers an average of only 45 percent of their health care needs, and we have to supply additional coverage through the wage money of the active workers, because obviously, out of their meager resources they can't afford that health care supplementation.

Millions of Americans, both rich and poor, do not receive even moderate quality health care, and that certainly goes for middle America. And it certainly goes for the forgotten blue-collar worker whom I have the privilege of representing and have represented more than certain Washington figures who have suddenly discovered the blue-collar worker.

We spent $63 billion in 1969, and a higher percentage of our gross national product, 6.7 percent, on health care than any other nation, but without meeting the needs of the people. Our central problem is lack of organization; the pieces of health care are scattered and they are uncoordinated. Hospitals are often poorly staffed. They are generally crowded. But at the same time they are largely under utilized, because they operate for the most part on a 5-day-a-week basis, have duplicate facilities, and often lack the ability to employ even minimal techniques of modern management.

There is much misuse of scarce manpower, which is primarily related to outmoded solo practice, fee-for-service methods of practicing medicine. The present program is uncoordinated, wasteful, overspecialized, and it results in a maldistribution of personnel and facilities. The medical market mechanism today is absolutely incapable of meeting the real health needs of the public.

Despite 30 years of effort, private insurance has failed to provide a major mechanism for financing health care for all Americans. Only one-third of consumer health expenditures are paid by insurance; 30 million Americans have no coverage whatsoever. Many more have limited and partial protection; 36 million have no hospital insurance; 39 million have no surgical insurance; over 100 million have no coverage for basic physician's office or home care visits.

Insurance has frequently misdirected health care away from appropriate and uninsured methods. There is little emphasis on ambulatory or diagnostic care.

We estimate private health insurance wastes $1.1 billion annually in advertising, acquisition and duplicative administrative costs. Private insurance cannot be expected to organize and finance health care for the American people.

Most major industrial nations exceed the United States in indices reflecting good health care.

In almost every category, the rate of serious illness among the poor is two or three times higher than the population as a whole. The rate of chronic illness rises as family income falls. The ratio of nonwhite to white mothers dying in childbirth today is 3 to 1, whereas 40 years ago, in 1930, it was 2 to 1.

The question is not "whether" but when we shall have health security for this Nation. The primary concern of the committee should be to assure that the right kind of national health insurance is adopted. Spokesmen for the American Medical Association and for the administration have been advancing the proposition that we should delay passage of national health insurance until we develop additional health resources. This misses the point.

At present, many medical schools are in serious financial troubles. We cannot really assess resource need in a misguided, misallocated nonsystem. A shift to group practice would mean we need fewer additional physicians required—a ratio of 1 doctor to 1,250 people rather than 1 to 650.

We need the leverage of national health insurance to bring about needed reorganization of the nonsystem. If we did provide more hospital beds, more physicians, and more health personnel, without restructuring health care organization and financing, it would add further to health care costs and subsidize the present nonsystem.

Health Security would deal with the present manpower shortages, spiraling costs, unacceptable quality of care, and the root cause of all of these: lack of organization for the delivery of services.

This bill proposes a rationalized system of national health insurance within a comprehensive health insurance program. It does not propose socialized or nationalized medicine. It does emphasize the American approach of providing professional and financial incentives.

It provides built-in quality and cost controls. Benefits of the Health Security Program would be available, with minor exceptions, to all residents in the United States. Eligibility would require neither an individual contribution history nor any means test.

The benefits would embrace the entire range of personal health services, including prevention and early detection of disease, the treatment of illness, and physical rehabilitation.

With the exception of four limitations, there are no restrictions on needed services, no cutoff points, no coinsurance, no deductibles, and no waiting periods.

The four limitations are dictated by present inadequacies of resources or management potentials with respect to skilled nursing home care, psychiatric care, dental care—and here the coverage starts with those under age 15, and would extend to others gradually—and covered prescription medicines and appliances.

Very important—and Dr. DeBakey will speak to this—a fixed percentage of program funds is earmarked as a resources development fund. Money would be used to supplement the Nation's health care resources for development of personnel and facilities, to direct the medical care system to more effective programs for health services, and above all, would insure a stable flow to those resources.

As an 11-year member of the governing board of Wayne State University, I can tell you that we could never plan for our medical school except on a hit-and-miss basis, and frequently had to cut back on 5-year programs because the appropriations from the legislature did not meet target.

This bill provides transition to new patterns of organizing, financing, and delivery of services wholly within the context of the American value system.

Health security will reduce paperwork for consumers and doctors. So many times we hear from our UAW retired people that they have thrown up their hands because they get buried in the paperwork that stands between them and what their Government does provide them. Under health security providers of services will relate to one administering agency.

The public health programs, including all of medicare and most of medicaid, would be integrated under health security. The bill places

most administrative responsibility at regional and local levels. The Health Security Board would establish overall policies and standards and assure national financing.

Most importantly, consumer representatives would have important roles throughout the proposed system.

Health Security is not an instant cure-all, but it does provide an important beginning. It is an evolutionary framework in the American tradition. It would begin to build with what we have and build toward what we should have.

If implemented, it should eventually solve the problems of manpower shortages, uneven quality, escalating costs, and lack of organization. Prompt enactment will pay huge dividends in the saving of lives and in the saving of previously wasted health-care dollars.

Health security, we are convinced, will provide the basis for a new level of health security for all Americans.

It is my privilege now to ask, with your permission, Mr. Chairman, Dr. DeBakey to supplement this testimony.

The CHAIRMAN. Yes, President Woodcock; as one of the original Committee of One Hundred for National Health Insurance, created under the leadership of the late Walter Reuther, I want to congratulate you on this very, very fine statement. It is worthy of the Walter Reuther tradition, and we appreciate your putting one myth aside—socialized medicine.

I studied the system in England in June, and it is not characterized by the myths that are used to describe it.

Dr. DeBakey, we welcome you as a member of this panel and congratulate you on your leadership in health. You have been a leader for years in medical legislation aimed at getting the fine medical knowledge in America—the superior medical knowledge of all the world—getting it available to the people in this country.

Here again you are in the forefront of leadership in your own profession. We welcome you here. We know of the great demands on your time.

Welcome, Dr. DeBakey.

Dr. DEBAKEY. Mr. Chairman, and members of the committee, let me express my appreciation for your very kind comments. I want to thank the committee for the opportunity of being here and commend the committee on its serious interest and concern, and indeed, perspicacity, in dealing with this extremely important problem: the health of the American people.

I know that there is concern about the costs of a program of this kind and I have heard some statements made today about how much it would cost and implications that this program was beyond our financial ability.

Mr. Chairman, the aspect of this bill that I would emphasize most, is that I believe it is the most effective approach that has yet been developed toward achieving what every person in this country wants: good health for all.

I just refuse to accept the attitude that we can't afford to give our people good health. This is a Nation of great ability and great potential; it has the greatest wealth ever accumulated. I simply refuse to accept the inability on a financial basis to achieve good health for all our fellow Americans.

It is important to emphasize also that without good health we do not have the potentialities of fulfilling other goals we seek in life.

As a practitioner of medicine, I see people every day who have lost good health. No matter what your economic status may be, once you lose good health and cannot regain it, you lose everything.

We must recognize that good health is a right of life, and without good health we cannot have a good life. We should therefore approach this objective of achieving good health for all of our people.

Now, anyone who is realistic must accept the fact that there are large segments of our population that are not getting any kind of health care at all and still larger segments that are getting inadequate medical care.

So it becomes apparent that this is a problem of great magnitude, and we must find a way to solve it.

Anyone who has had any experience with the present health care delivery system knows that we will not be able to achieve our objective without revamping the system to bring the opportunity for good care to all Americans. The system is just too out-of-date. There is need to use a different approach, and one that primarily provides every citizen of this country with equal opportunity to receive good health care. Whether or not they get it is another matter, but at least provide them with an equal opportunity to do so.

The one great advantage of this program as set forth in the bill you are considering over any other method presented to Congress so far, is that it changes the dynamics affecting the present system.

This is well illustrated with medicare, I can recall very well when the late President Kennedy provided leadership in fighting for medicare, and I joined his activities in this regard very strongly. Medicare was finally enacted. There are inadequacies in medicare, but the one thing it does is provide hospital and medical care for people of that age group who previously did not have it.

Curiously enough, what it has done is shift some of the availability of medical care from other groups to medicare people for the simple reason that the medicare provisions, financially, are better than some of the other forms of medical care support.

A very important aspect of the current bill which I would like, very much to emphasize and discuss with you is the health resources development fund. Through this fund, built into the bill, a certain percentage of the total trust fund is available for support of means for improving the delivery of medical care, and for enlarging the opportunities for training, especially much needed personnel and additional and new types of allied health personnel.

Within recent years, particularly, this problem has grown to be very critical because despite the increasing need of medical personnel and institutional support for medical research and the need for training of allied health personnel, there has been a relative decline in the financial outlays, particularly in Federal funds, which constitute the major sources for this purpose. This is especially true in medical research.

I think it would be self-defeating to provide support for delivery of health care without continuing to support additional personnel and subsidizing medical education and research.

We take great pride in the present standards of our medical activities, and over the last two decades we have conquered many diseases.

We have virtually eliminated certain forms of diseases, and are able to control many others.

Many forms of congenital heart diseases are now curable and many forms of heart diseases and cancer are well controlled. They were uncontrolled and unsolvable one or two decades ago. This has occurred because of the emphasis we have put on medical research. Every single advance made in this country has been made through medical research, a major portion of which has been supported by Federal funds.

In the past few years there has been a relative curtailment of funds for these purposes, in medical education and research, largely because of the emphasis placed on delivery of health care and improvement of this delivery.

I think one of the advantages of this bill is that it fixes a certain amount of the program's trust fund for these purposes, permits a budgeting for these activities, and emphasizes their importance.

I speak from personal experience, because I am a practitioner of medicine and I see many patients from all over the country, and indeed all over the world. They are referred to me because of their special problems.

I see many pitiful cases that need highly specialized services. But they are financially unable to receive these services. Even if they have had some form of insurance in that past, it has run out.

These are not older people, these are people in the middle age group. They are often people who have families that have some member who is working, but who have exhausted their resources. In our own hospital, for example, many of these patients are carried to the extent that the hospital can afford to do so. But this is a limited resource, so many of the patients are not able to get into the hospital for the simple reason they are unable to afford the hospital services, even though physicians' services are provided free of charge to people in that category.

So I can speak from personal experience, and indicate the need to provide equal opportunity for all of the people in this country to meet their health needs.

Thank you, Mr. Chairman.

Mr. WOODCOCK. Mr. Whitney Young is our next speaker.

The CHAIRMAN. Thank you, Dr. DeBakey.

Dr. DEBAKEY. May I submit for the record that which I did not read?

The CHAIRMAN. We will order the full statement of Dr. DeBakey and Mr. Woodcock be included in the record.

The CHAIRMAN. Your statement will be printed in full in the hearing record.

(The prepared statements of Mr. Woodcock and Dr. DeBakey follow:)

Statement of Leonard Woodcock

President, International Union United Automobile,
Aerospace and Agricultural Implement Workers of America, UAW
and
Chairman, Health Security Action Council

Before the Senate Committee on Labor and Public Welfare Concerning the Health Security Bill (S.4323)

TABLE OF CONTENTS

SUMMARY

Statement of Leonard Woodcock, President, International Union United Automobile, Aerospace and Agricultural Implement Workers of America, UAW and Chairman, Health Security Action Council; Before the Senate Committee on Labor and Public Welfare, September 23, 1970.

THE HEALTH SECURITY BILL
(S. 4323)

Americans have a right to good health. To realize this right they need equal and actual opportunity of access to a comprehensive range of health services. The proposed Health Security Program would revitalize America's health care system to fit contemporary needs of the people and make more available than at present, to all segments of the population, the capabilities of modern medical science and technology.

S. 4323 is a constructive approach to meet America's health care crisis.

The labor movement has long recognized that health services cannot be significantly improved for the working men and women of this country, or for any other Americans, on a piecemeal basis. The Committee of 100 for National Health Insurance (CNHI), composed of outstanding citizens involved in health care and many other areas of social concern, with the aid of numerous technical experts, has developed a realistic yet imaginative Health Security Program to be implemented through a uniquely American plan for national health insurance. It envisages not a radical new system of

SUMMARY

health care, but an evolutionary movement toward more effective means to deliver and finance comprehensive, quality care.

The program would not seek merely to add more money to our current, inefficient "non-system" of health services, but would seek gradual organizational changes in present patterns of care and improve the supply, availability and productivity of our health resources -- all directed to assure all Americans easy and continuing access to needed personal health services.

The UAW has negotiated health insurance plans for more than 30 years, for its 1.7 million active members, retirees and their families. Yet these plans, in spite of frequent improvements and extensions of coverage, still do not cover more than 50% of our members' health care expenditures and continue to have serious deficiencies in the scope of services covered. While providing far more comprehensive protection than is available to millions of other Americans, the premium costs involved are now growing rapidly, fed by the uncontrolled inflationary forces in our medical care pricing system.

The reaction of the auto industry to rising premium costs is simply to attempt to limit their liabilities by passing on premium increases to the workers and reducing coverage for benefits. General Motors and the other auto companies completely miss the point. The consumer, without the vast influential powers of the auto companies, is being asked to bear the burden of the failure of the present health system to control future costs.

Rather, the auto companies and all business should accept our invitation to join in support of a comprehensive national approach

SUMMARY

to controlling and reallocating health care costs through a universal public program of Health Security. The employers will benefit directly from the savings under Health Security. Our members and the companies will share in the vastly improved health care that will be available to all Americans.

Today, America has the capacity and the technology to provide all citizens with high quality health care services. Yet even minimal care is not available to millions of people because we lack an organizational system more rationally to make available both health manpower and resources. Marketplace economic values and forces have distorted the distribution of resources, fostered duplication and waste and led to excessive specialization and under and over-utilization of services. Valuable resources of scarce personnel have been wasted and costs inflated through primary dependence on solo practice. In this uncoordinated system, the consumer, with heightened demands and expectations, is increasingly unable to find the care he needs or to meet the costs involved.

Private insurance, after a quarter century of effort, has failed to provide comprehensive coverage to meet the actual health needs of people. Thirty million have no insurance whatever. Of those under 65 years, 36 million have no private hospital insurance; 39 million have no surgical insurance and over 100 million have no coverage of basic physician office or home care visits. Only just over 1/3 of private consumer health expenditures are now insured. The insurance industry is wasteful (spending, we estimate, $1.1 billion annually on duplication of administrative systems, competitive practices and expensive advertising); has offered little incentive

SUMMARY

towards organization, economy and efficiency in the provision of health services; and has added to inflationary pressures by continuing to focus on high cost, institutional services.

The health care crisis cannot be solved by broadening the scope of private insurance. Voluntary or compulsory health insurance through private carriers cannot be considered as the vehicle for organizing, extending and financing health care for the American people.

While spending more money and health resources and services than any other country -- over 6.7% of GNP, the nation has experienced a frightening record of ill health. Our record of infant mortality, life expectancy and death rates places us behind most other industrialized nations. Rates of disease, disability and death are disgracefully high among the poor and nonwhite groups. Their plight can only be solved by abandoning our separate and inferior system of charity medicine.

Few objective observers argue today that the U.S. does not need a national health insurance program. Nor is it credible to argue that we must first increase the supply of personnel and facilities before devising a means to finance these services. Providing increased health resources, without improving financing and organization of the delivery system through a Health Security Program would only pour more money into an outmoded medical care system and further escalate costs.

Health Security would deal simultaneously with the manpower shortages, spiraling costs, unacceptable quality of care and the root cause of all of these: lack of organization for the delivery of services. The Bill proposes a rationalized system of national

SUMMARY

health insurance within a Health Security Program. It does not propose socialized or nationalized medicine. Rather, it emphasizes the American approach of providing financial and professional incentives to improve the services, with built-in quality and cost controls.

The benefits of the Health Security Program would be available, with minor exceptions, to all persons resident in the country. Eligibility would not require either an individual contribution history or any means test.

The benefits are intended to embrace the entire range of personal health services including care for the prevention and early detection of disease, the treatment of illness, and physical rehabilitation. With only four exceptions, there are no restrictions on needed services, no cut-off points, no coinsurance, no deductibles and no waiting periods. The four exceptions are dictated by inadequacies in existing resources or in management potentials with respect to skilled nursing home care, psychiatric care, dental care (this benefit starts with those who are under age 15, and extends to others gradually), and covered prescription medicines and appliances.

The Health Security Program recognizes the necessity of moving rapidly and concurrently with the proposed insurance mechanism to increase the nation's resources for the delivery of health services. Therefore, a fixed percentage of program funds will be earmarked as a Resources Development Fund. The money will be used to supplement the nation's resources for development of health personnel and facilities and to move the medical care system to more effective programs of health services.

SUMMARY

To repeat, the emphasis is on concurrent programs to develop health resources and their allocation and a system to give all people access to modern medical services. The Bill provides a transition to new patterns of organizing, financing and delivering services wholly within the context of our American value system.

The framework of the program permits health professionals to improve their performance, conditions of practice and professional opportunities. Compared to today's massive "paperwork" requirements of many public and private plans, providers of service under the Bill could look to simplified administrative relationships with one administering agency. A large number of unsatisfactory piecemeal public programs would be integrated, including all of Medicare and most of Medicaid.

The Bill places most administrative responsibility at the regional and local levels -- while a Health Security Board would establish overall policies and standards and would assure national financing, the important decisions affecting allocation of resources and delivery of service would be made at regional and local levels -- thus obviating the specter of the "Washington bureaucracy". To provide further flexibility, important roles have been assigned to consumer representatives throughout the proposed system.

A Health Security Program is not an instant cure-all but the Health Security Bill does provide an important beginning. If implemented, it should eventually solve the problems of manpower shortages, uneven quality,escalating costs and lack of organization. Its prompt enactment will pay great dividends in the saving of lives and wasted health care dollars. Equally important, it will provide the basis for a new level of health security for all Americans.

My name is Leonard Woodcock. I am President of the International Union United Automobile, Aerospace and Agricultural Implement Workers of America, UAW.

With me today are four associates who are actively supporting National Health Security: Dr. Michael E. DeBakey, President of Baylor University College of Medicine; Mr. Whitney M. Young Jr., Executive Director of the National Urban League; Dr. I. S. Falk, Professor Emeritus of Public Health at Yale University; and Mr. Melvin A. Glasser, Director, Social Security Department, UAW. We appear before this Committee as members of the Health Security Action Council. The Council has been formed to seek the enactment and implementation of a progressive Health Security Program.

I wish to congratulate this Committee for holding these important hearings. Few issues are more significant or more pressing than the issue of good health care for all Americans.

We are convinced that the program embodied in this legislation would revitalize America's health care system according to the contemporary needs of the people and the capabilities of modern medical science and technology. We are among the millions of people in this nation deeply concerned that America has failed to act on what President Richard Nixon and many other concerned Americans have recognized as a major crisis that confronts our health care services. I appear before you today in behalf of millions of our fellow citizens who are determined to bring about early and affirmative action to make access to good health services a right for each and all of us.

American medicine has promises to keep. We possess the greatest medical competence in the world. We are a nation bursting with wealth. But for all our competence and affluence, we have failed to bridge the chasm between the kind of health care that this country is capable of providing and what most Americans are actually receiving.

These hearings are a promising beginning because they offer an opportunity to do more than merely tinker with the financing of the present health care non-system. I am encouraged that you are prepared to examine the issues underlying our health care crisis and to consider proposals to create a better system.

We strongly endorse and support the concept of a national Health Security Program included in this Bill. It deals with diagnosis as well as prescription for America's health care ills. Its purposes are consistent with our Council's goals: to reform the health care delivery system to bring adequate care to all Americans. Health Security proposes a soundly financed, coherent structure for our personal health services and at the same time strengthens the government's support of medical research, health resources development and teaching activities. It will help relieve the pressures on medical research activities now in competition for scarce funds, and open new possibilities for the further development and application of our basic store of medical knowledge.

The CNHI Health Security Plan

The labor movement has long recognized that health services cannot be significantly improved for the working men and women of this country, or for any other Americans, on a piecemeal basis. The benefits gained under Medicare for our older citizens,

improved health insurance plans for union members, and Medicaid for the poor are being rapidly diminished by inflationary pressures and the weaknesses inherent in our present disorganized health delivery programs.

My predecessor, the late Walter P. Reuther, recognized that nothing short of a national health insurance program could bring quality health services, with dignity, to all of our citizens. In November of 1968, in announcing the formation of the Committee of One Hundred for National Health Insurance (CNHI), he said:

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

From its outset, the Committee for National Health Insurance has had the great fortune of having as its vice-chairmen Mrs. Albert D. Lasker, who has done so much to further improvements in medical research and delivery, and two of the distinguished gentlemen who are with me today: Dr. Michael E. DeBakey and Mr. Whitney M. Young, Jr. The Committee is composed of a broad spectrum of outstanding citizens from the fields of medicine, public health, industry, agriculture, labor, education, the social services, youth, civil rights, religious organizations, consumer groups and public affairs. Included among its distinguished members is the Chairman of this Committee and three other members of the U. S. Senate -- Senators Edward S. Kennedy, John Sherman Cooper and William B. Saxbe.

At its first meeting the Committee appointed a technical task force under the chairmanship of Dr. Falk. This group of technical experts, in consultation with numerous other specialists in the organization, financing and delivery of health services, have spent eighteen months drafting a realistic yet imaginative health care system, to be implemented through a uniquely American plan for national health insurance.

Its members recognized, however, that it was not feasible to start from scratch and propose a radically new system. Instead they began with a thorough and factual assessment of our present health care patterns -- recognizing their strengths and their serious flaws. From this they developed a plan for evolutionary movement from where we are now, toward an improved system for the efficient delivery and financing of quality, comprehensive health services.

The program reflected in the Health Security Bill does not propose to tear down the present structure, for it contains many elements that can be adapted to a national system. But the Bill recognizes that real changes are needed -- including open-mindedness by the providers of health services.

This is a 20th century health care program for 20th century America. The program is not designed merely to pay benefits. Simply adding more money, as some are proposing to do, and being prepared to pay more is not enough. The main effect would be to raise charges and costs and to subsidize the inefficiencies now in the non-system.

The Health Security Program proposes to make possible ready and continuing access to needed personal health care services. Incentives will be offered so as to increase the availability and

productivity of highly skilled physicians, dentists and other health personnel by the support of prepaid group practices and other organized patient care concepts. At the present time, we are barely utilizing our knowledge of medical care organization and administration.

Encouraging organized care will do much to permit the early detection of disease and prompt treatment which can often eliminate the need for costly hospitalization or surgery, and prevent unnecessary death.

With funds universally available to pay for their services, the rapid development of less costly extended care and nursing home facilities, home health programs and rehabilitation services will be possible. And Health Security will provide more effective protection than is now generally the case against the mounting costs of dental care, prescription drugs and appliances. Promoting efficient and effective methods of health care delivery will also help to slow down the price spiral that has resulted in health care costs rising at double the rate of the cost of living in the last decade.

In essence, the Bill before you proposes to use the leverage of money -- the financial resources of a universal health insurance program -- to effect fundamental changes in the ways in which health services are offered and delivered.

Speaking on Behalf of the UAW

The UAW, which has strongly supported CNHI, is vitally concerned with health and health care -- both for our members and the nation. In fact, the issue of obtaining and paying for reliable health care is so important for all working people that I have taken

time from overseeing the crucial negotiations with the major automobile companies, in which we are currently involved in Detroit, in order to appear before you today.

While we in the UAW continue to work to improve existing negotiated and public programs, we are convinced that a comprehensive Health Security Program is the best way, indeed the only way, to provide quality, comprehensive health care, at a price America can afford.

Our negotiated health insurance plans, which protect the 1.7 million active UAW members and retirees and their families in nearly every State of the U.S., are among the best available. Still we recognize that they would more accurately be described as "sickness insurance" rather than health insurance.

For example, UAW members, along with the vast majority of Americans, do not have insurance to cover the basic services of physicians in their offices or at home. A major obstacle that has prevented attainment of such coverage is the apparent inability of private insurance carriers to control the utilization and prices charged for such fundamental health services.

Our plans are still basically directed to covering episodes of illness by the use of high cost hospital and other institutional services. No emphasis is given to early or preventive care. Indeed, the cars our members make are often given better "health care" than our members.

We pay too much at the bargaining table and out-of-pocket for health care that is often inappropriate and made excessively costly by current modes of medical practice fostered by private insurance. Further, serious gaps in our insurance coverage, despite

our efforts to close them, frequently discourage obtaining needed care.

We estimate that our negotiated health insurance program presently covers no more than about 50% of our members' health costs. This is considerably more than for the population as a whole. Yet, we lack important coverages, and chronic illness, or recurring acute illnesses, can result in economic catastrophe for our members. Even a short run illness can be disastrous for the typical American working family with little or no insurance protection.

The threat of illness to family security involves the loss of family income as well. At the time when medical bills are greatest there are frequently too few resources available to keep the family financially solvent. Thus, health care and related matters have always had high priority in our collective bargaining efforts.

The UAW was among the first industrial unions explicitly to commit itself to health care as a bargaining issue. Though numerous problem areas remain, we have had some success in bargaining improved health insurance. These collective bargaining gains are now threatened by proposals of the General Motors Corporation and other auto manufacturers to cut back our present partial protection as a means of controlling their costs.

We have long recognized that we cannot achieve all of our goals through collective bargaining. Many can be realized only through public programs reflecting society's commitment to protect family security. We were, therefore, in the forefront of the fight for Medicare and have supported many other public health programs of benefit to the community as well as our members.

The UAW has had some 30 years of experience with insurance for health services. One of our pressing problems, now felt throughout the nation, is the inflation of costs not related to improvements in quality or effectiveness of care. For example, in 1970, the standard premium for Michigan Blue Shield increased by almost 50%. For many of our negotiated contracts, the premium increase has been even greater. The end is nowhere in sight. An additional 5% increase has already been requested for the first quarter of 1971.

At one large UAW bargaining unit in Michigan, we estimate that more than 50% of the Blue Cross-Blue Shield premium increase since 1967 was the result of pure inflation of charges. Less than 30% of the premium increase was paid for the introduction of new negotiated benefits. Less than 20% of the increased premium reflected increased benefit utilization. The chief factors in the inflationary 50% were increased hospital charges and inflation of physician costs largely attributable to solo practice fee-for-service methods of delivering and charging for services.

While we complain publicly about excessive rate increases, Michigan Blue Cross-Blue Shield responds by mounting a campaign to sell our members and the community at large on the idea of seeing the doctor and utilizing hospitals less often. This is a ludicrous remedy to the fundamental problem of the frightening inflation of medical service costs. It goes counter to sound notions of early diagnosis and treatment. It overlooks the fundamental fact that only physicians prescribe treatment and order hospitalization.

Even more disturbing is the reaction of the auto industry to rising premium costs. The companies' answer is simply to limit

51-658 O - 70 - 15

their liabilities by passing on premium increases to the workers by reintroducing contributory elements in our negotiated programs. General Motors and the other auto companies completely miss the point. The consumer, without the vast influential powers of the auto companies, is being asked to bear the burden of the failure of the present health care system to control future costs.

Rather, the auto companies and all business should accept our invitation to join us in support of an overall approach to controlling and reallocating health care costs through a public program of Health Security. The companies will benefit directly from the savings under the Health Security Program you are considering. Our members and the companies will share in the vastly improved health care that will be available to all Americans.

An Overview of Current Health Care

Today, America has the capability and the technology to provide all citizens with high quality health care. Yet:

- Many Americans, rich and poor, do not receive even moderate quality health care;
- Minimal medical services do not reach millions of people;
- The delivery system has been unplanned so that the distribution of resources -- both facilities and manpower -- is uneven and does not begin to provide the greatest good for the greatest number.

The central problem is lack of organization. The American people have indicated that they want the health professions and the institutions to organize themselves so that families and

individuals can obtain comprehensive health care -- coordinating primary physician and specialist services, acute and chronic facilities and preventive, diagnostic, curative and rehabilitative care -- and always preserving the dignity of the consumer as well as the provider.

But each year, it becomes more difficult for millions of Americans to find even the fragments of care that are acutely needed. We have excellent hospitals and outstanding practitioners, and a growing (and lucrative) industry of extended care facilities, intermediate care facilities, multiphasic screening operations and even health spas. But, at best, these are only pieces of comprehensive care. They are scattered and uncoordinated, motivated by marketplace economic values that have no relevance for the development, control and extension of what should be considered essential public services.

Most Americans can no longer find a family physician to guide them through the complexities and the money traps of the misguided medical marketplace. So the consumer gropes alone, often making unfortunate choices which cost him dearly. Our current health system is in fact based on the myth that consumers can recognize their true health needs and make the most appropriate judgments in seeking care.

Frequently no doctor is available to aid the consumer in his choice. One hundred and fifty American counties are without a single doctor. Another 150 have only one doctor. The trend to specialization among medical students and the aging of the general practitioner group means that the problem will get worse over time. The ratio of doctors to population in the urban ghettos all over America already resembles data on underdeveloped countries.

The millions who cannot find a private physician because of their maldistribution or overspecialization, increasingly turn to overburdened hospital emergency rooms for routine care. Today, it is estimated that only one-third of those seeking such care from the hospital are true emergencies.

The hospitals are often poorly staffed, crowded and in urgent need of modernization. They generally lack the ability to utilize even minimal techniques of modern management. Costly duplication of competitive facilities, and in many areas under-utilization of facilities and services, are commonplace rather than the exception.

Today, the most dilapidated and inadequate hospitals are located in heavily populated urban areas. In stark contrast, many shiny new federally funded facilities located in rural communities and small towns are forced to close entirely or in part because they cannot attract or hold the necessary professional manpower. Meanwhile, thousands of returning medical corpsmen who have proven their ability to provide routine and emergency care in Vietnam have returned to civilian life and found no place to practice their skills. We give lip service to the use of "doctors' assistants" but archaic licensure laws prevent most of these men from finding a niche in a community health care team.

These paradoxes abound because we have not shown a willingness to define and pursue a coherent national health policy. We cannot continue to waste talent, treasure and, most important, human life because we do not have a system to assure the availability and quality of health services.

In summary, the current health care system is uncoordinated, wasteful, overspecialized and has resulted in

maldistribution of personnel and facilities. The medical market mechanism is incapable of meeting the real health needs of the public.

Failure of Private Health Insurance

10 Private health insurance has provided some needed protection against health costs to certain segments of the population, including labor unions. But it has failed, after a quarter century of effort, to provide a major mechanism for financing health care for all Americans.

11 A survey made by the National Center for Health Statistics indicates that of the 177 million civilian non-institutionalized Americans under 65 in 1968, 36.5 million had no private hospital insurance whatsoever, and 38.8 million had no surgical insurance. Thirty million have no private health insurance whatsoever. And, for many of those with coverage, payments are restricted to limited covered services and often do not meet the full charges involved.

12 Frequently, as a result of insurance, the health services provided are chosen with reference to the scope of the individual's insurance coverage rather than the most appropriate means to meet actual health care needs. For example, distressingly little emphasis has been placed on ambulatory, diagnostic or preventive care. In fact, according to the National Center for Health Statistics, only about half of the civilian population under 65 had any coverage for x-ray and laboratory examinations outside the hospital; 58 percent had no coverage for physician office or home visits, and 61 percent had no coverage for prescription drugs outside the hospital.

Even if the coverage were universal, private health insurance offers little incentive toward organization, economy and efficiency in the provision of health services. Private insurance has had virtually no impact on overcoming "administered" health prices. If anything, it has accelerated the already too rapid health care price inflation and has failed to improve the performance of the delivery system.

And the Medicare program, providing urgently needed coverages to the elderly, has further stoked the fires of health price inflation, because its insurance design is an exact copy of the private health insurance model.

The marketing of inappropriate but saleable packages of private health insurance is today becoming even more difficult as costs rise and consumers demand more comprehensive levels of protection. Moreover, because of the vast duplication of insuring agencies in the field, the nation is asked to finance activities totally unrelated to their primary function -- the distribution of the costs of care over large numbers of people. For example, of the approximately $1.7 billion now spent on administration by private carriers, the Committee of One Hundred for National Health Insurance has estimated that $1.1 billion is attributable to duplication of administrative systems, competitive practices and expensive advertising.

Private health insurance is paying just over a third of the total private consumer health bill today -- only some eight percentage points more than it was ten years ago. At that rate, it will be almost the year 2000 before insurance covers even two-thirds of the U.S. private health care bill.

Some groups have asserted that the "health crisis" can be solved by broadening the scope of private health insurance. But private health insurance has not been a creative force. It has shown

little interest in quality or cost control or improved organization of services. Realistically assessing the self-interest, traditions and values and institutional limitations of the voluntary private health insurance sector, it is totally unrealistic to expect that it could be a force toward rationalization of the health care system.

16 Given the real interests of the voluntary private health insurance sector, this is not surprising. Blue Cross is exactly what its motto proclaims "the hospitals' plan" and its sister organization, Blue Shield, is as it proclaims, "the doctors' plan". Nowhere, unfortunately, is there a consumers' plan. The commercial companies are interested in making money in the medical marketplace and have succeeded admirably in this endeavor, although times are hard right now. Voluntary or compulsory health insurance through private carriers cannot be considered as the vehicle for organizing, extending and financing health care for the American people.

America's Record of Ill Health

Amid the existing jumble of frequently conflicting official health policies and programs and an unrelated, costly and unsatisfactory system of private health insurance, one consistent trend has emerged -- Americans ~~seem determined to~~ spend more on health services than any other nation in the world. The cost of health services in the 60's increased at a rate of more than twice the rise in the overall consumer price index. If cost could be equated with quality, then America would be the healthiest nation in recorded history. We spend more money on health and medical care than any other people in the world: $63 billion a year in 1969. That represents a little over 6.7% of our Gross National Product -- and the percentage continues to rise.

While the cost of health care in the U. S. has been escalating at a staggering pace, we have witnessed a relative decline in many well known indices affecting poor quality and the scope of care and services. Many other nations, far less wealthy than the U. S. , have lower rates of infant mortality and longer periods of life expectancy. Most of the major industrial nations of the world exceed the U. S. in the universally accepted indices of a people's health. The comparison is shameful:

- In infant mortality, among the major industrial nations of the world, the U. S. trails 12 other countries. If we omit nonwhites from the statistical computation -- and nonwhites suffer an infant mortality rate almost twice that of whites in the U. S. -- we still rank only 10th.
- We trail 17 other nations in life expectancy for males, 10 other nations in life expectancy for females.
- An American man of 40 has less chance of living to be 50 than his contemporary in 16 other nations.
- Death rates due to diabetes, heart disease and other controllable man-killers are higher in the U. S. than in at least 10 other industrial nations.

The picture is even more distressing as it portrays the conditions of the poor in America. Poverty increases the risk of disease, disability and death. In 1968, the Blue Cross Association published a survey of health care in this country, conducted by the Louis Harris organization, which described the poor as "the living sick". And indeed, "living sick" is the prevailing condition of the impoverished in America today.

The survey found that the poor place a high priority on trying to achieve a healthy status. For example, 59% of the poor blacks and 72% of the poor whites give health a higher priority than having a good job, compared with 51% of the American people as a whole. The poor recognize that good health is an essential precondition to achieving other valued goals. Illness and disease are unwelcome visitors to any home but to the poor they are a constant affliction. The poverty-poor health cycle means that the entire nation shares some of the burden of the inferior health of those afflicted by poverty.

The poor suffer four times as many heart conditions as those in the highest income group; six times as much mental and nervous trouble; six times as much arthritis and rheumatism; six times as many cases of high blood pressure; over three times as many orthopedic impairments and almost eight times as many visual impairments.

The incidence of disease by income group is shocking. In almost every category the rate of serious illness is reportedly two to three times higher for the poor than for the population as a whole. The rate of serious chronic illness seems to rise as one approaches poverty.

Other statistics confirm the deprivation of nonwhite, disadvantaged Americans.

In Detroit's "inner city", maternal deaths occur almost seven times as often as in Michigan, or the nation, as a whole. And on a national scale, the ratio of nonwhite to white mothers dying in childbirth was almost 3 to 1. The ratio of nonwhite to white babies dying in their first year was more than 2 to 1. The life expectancy of nonwhites is 7 years less than for the white American.

51-658 O - 70 - 16

The racial health gap has apparently widened: in 1930, for example, the ratio of nonwhite to white mothers who lost their lives in childbirth was 2 to 1.

These conditions will not improve until the poor are fully integrated into the mainstream of medical care. Indeed, as long as we perpetuate a system of charity medicine, the poor will remain isolated in a separate and inferior health system that diminishes health care for all Americans.

The Need for Health Security Is Urgent

Few objective observers would argue today that the U. S. does not need a national health insurance program. As Business Week magazine suggested earlier this year -- and I quote from an editorial --

> "The question no longer is whether the U. S. is to have a national health program. It is whether we shall have a good one or a bad one. The chances of getting a good one will be far better if everyone involved accepts that fact."

This past May, when asked whether national health insurance is in the offing, Dr. Raymond Waggoner, President of the American Psychiatric Association, replied:

> "I think it is inevitable and I don't favor approaching it, as some other associations do, by beating our brains out in opposition to it. It is going to come, so why don't we concentrate our efforts toward making certain that it includes coverage for mental illness as well as physical illness."

Some representatives of the American Medical Association and spokesmen for the federal administration assert that the nation is not yet prepared for national health insurance; that we must get ready for the increase in demand the program would bring; that we must

first increase the supply of personnel and facilities and rationalize the health care system to achieve greater productivity. I suggest to you that this is not a credible argument. It is just another symptom of the chicken-and-egg syndrome that has forestalled action for decades while all other major industrial nations have adopted public systems of health care for all.

We need to stop procrastinating and move to improve our health resources and overhaul the wasteful organizational and financial mechanisms now used to support health care services. Production of more health manpower or more hospitals or other institutions without improving financing and organization would at best be an exercise in futility in dealing with indeterminate needs; or at worst would invite disastrous problems of costs.

Trying to solve the problems of steeply rising costs by merely pouring more dollars into the outmoded medical care system will perpetuate the sellers' monopoly, the inefficiency, the lack of accountability -- all of the abuses and failures of the existing system -- and would only lead to further dissipation of resources. Attempts to deal with the organizational system in a vacuum have no hope of success as decades of well-meaning efforts have demonstrated.

Dr. Roger O. Egeberg, Assistant Secretary for Health Affairs at the U. S. Department of Health, Education and Welfare, has for example repeatedly asserted that the nation must have 50,000 additional doctors in the next ten years if we are adequately to meet medical care requirements. The assertion has little meaning, however, for there is no evidence since he first made the statement well over a year ago that plans have been inaugurated to produce any increase at all. As things now stand a number of medical schools may not be able to maintain even their present enrollments.

Furthermore, this approach begs the issue. As a result of wasteful and inappropriate use of the valuable time of physicians, the average American doctor in solo fee-for-service practice serves between 600 and 750 people on an annual basis. The physician in organized group practice programs, where the health care team is used, provides services to between 1,200 and 1,500 people. Even, therefore, if we were able to increase the net number of new physicians annually, we would require far fewer in a properly organized and structured health care system, such as this Bill proposes.

The United States can no longer ~~afford the luxury of~~ expensive but inadequate private health ~~insurance. It cannot any longer~~ tolerate the human tragedies that result from reliance on a health care "non-system" plagued by increasingly critical inadequacies of resources; by almost incredible fragmentations and complexities that impede the delivery of medical care and by nationally unacceptable escalation of costs.

The Health Security Bill

Health Security would deal simultaneously with the problems of manpower shortages, spiraling costs, unacceptable quality and the root cause of all of these: lack of organization for the delivery of services.

This Bill proposes a rationalized system of national health insurance. Surely a country with the world's most advanced management skills and administrative capacities can expect these to be applied to health care. The Bill envisages that the funds we as a nation can afford to provide will finance the essential costs of good medical care for the years ahead. At the same time, these funds will be building up our capacity for making the availability and delivery of medical care adequate, efficient and reliable.

The Bill would provide the framework for a living program, adaptable to emerging technology and delivery mechanisms. It does not propose nationalized or socialized medicine. (Those who would raise such a specter fail to understand the Bill). It does not propose that the federal government take over hospitals and put physicians and dentists on salaries; nor would it arbitrarily compel the health professionals in our country to reorganize and coordinate their fragmented services into a more efficient and less costly health care system.

It undertakes, rather, the thoroughly American approach of providing financial and professional incentives to improve the health care delivery systems, with built-in quality and cost controls. It would provide viable and acceptable alternative payment methods to the traditional and costly fee-for-service system.

The Health Security Bill would provide a sound foundation upon which this nation could build a modern health system. Its cornerstone is the recognition in official national policy that adequate health care is a fundamental right in a progressive society. Further, the program contains practical provisions to translate this promised right into reality.

The benefits of the Health Security Program would be available, with minor exceptions, to all persons resident in the country. Eligibility would not require either an individual contribution history or any means test.

The benefits are intended to embrace the entire range of personal health services including care for the prevention and early detection of disease, the treatment of illness, and physical rehabilitation. With only four exceptions, there are no restrictions

on needed services, no cut-off points, no co-insurance, no deductibles and no waiting periods. The four exceptions are dictated by inadequacies in existing resources or in management potentials with respect to skilled nursing home care, psychiatric care, dental care (this benefit starts with those who are under age 15, and extends to others gradually), and covered prescription medicines and appliances.

The Health Security Program recognizes the necessity of moving rapidly and concurrently with the proposed insurance mechanism to increase the nation's resources for the delivery of health services. A special feature of this Bill would provide a Resources Development Fund. A fixed percentage of overall program funds will be earmarked and used to strengthen the nation's resources of health personnel and facilities and its system for delivery of care.

This Development Fund would supplement rather than supplant present government programs. It would give incentive and innovative support to comprehensive group practice and other organizational means to achieve the efficient use of personnel in short supply and for the productive delivery of services. It would provide supplemental funds for education and training programs for new personnel -- especially for those disadvantaged by poverty or membership in minority groups. It would also private financial support for the location of needed health personnel in both urban and rural shortage areas.

All services covered under the Health Security Program will be financed on a budgeted basis. Advance budgeting will restrain the steeply rising costs and provide a method of allocating available funds among categories of covered services. Through this process, the Bill can support a range of basic and auxilliary services and modify the undue emphasis on high cost services and facilities.

By a system of regional allocation of funds, annual budgetary review and approval of institutional services expenditures, and financial reviews and controls on service costs, this Bill provides the means of effecting important health cost controls.

The financial and administrative arrangements of the entire program are designed to move the medical care system toward organized programs of health services, utilizing teams of professional, technical and supporting personnel. Earmarked funds would be available to support the most rapid practicable development toward this goal. State statutes which restrict or impede the development of group practice programs are superseded by provision of the Health Security Program.

A key principle of the Health Security Program is guaranteeing new options in the delivery of health services. We believe the doctor and the patient should both be free to choose an organized health services plan as an alternative to solo service. In either case, there should be freedom of choice to select a doctor or accept a patient.

The program includes significant provisions to safeguard quality of care. It would establish national standards for participating individual and institutional providers. Independent practitioners would be eligible to participate upon meeting licensure and continuing education requirements. Provision is made for professional review and competent peer judgments to assure a level of service delivery compatible with good medical standards.

Consumers will be assured a meaningful role at every administrative level. A National Health Security Advisory Council, with a majority of consumer members, would work closely with the proposed Health Security Board in establishing policy and operating

procedures. Consumer organizations will be given technical and financial assistance to establish their own comprehensive health care programs.

Health Security builds upon the strengths of American medicine today and establishes practical measures to eliminate the weaknesses. The Bill provides a transition to new patterns of organizing, financing and delivering health services wholly within the context of our American value system.

Health Security will increase the opportunities available to doctors, hospitals, and other providers to extend the range and effectiveness of their services. The program provides a framework in which health professionals can improve conditions of practice, quality of education, and professional opportunities. Physicians will have improved support from other members of the health team enabling them to reduce their heavy work schedules and enjoy additional leisure time.

Medical careers at all levels will attain a security and stability within the system, and the program will serve as an attraction for increased recruitment into the various health careers. This will be especially true when adequacy of resources for good practice and easy communication within the system are added to the guarantee of decent income.

When considering a program of the magnitude of Health Security, especially remembering the experience of such federally financed programs as Medicare, Medicaid and CHAMPUS, it is easy to conjure up the specter of hospitals and physicians inundated by unremitting paperwork.

Providers struggle today with the conflicting eligibility and reporting requirements of more than 1800 private health insurance carriers and a score of state and federal programs. Many physicians spend much of their valuable time each day filling out insurance forms, and a significant amount of money for billing and financial record keeping. The burden on hospitals is even worse. The cost of this inefficiency is now somehow passed on to the consumer in higher health care and health insurance costs.

Rather than increasing this mountain of paperwork, the program you are considering would reduce it. Under Health Security there will be one administering agency and one set of forms -- highly simplified. Both patients and physicians will welcome the change. Hospital billing would be vastly simplified.

The Bill would further simplify today's complex web of payment arrangements for many fragmented public programs for personal health services by incorporating into the Health Security Program all of Medicare, almost all of Medicaid, and a number of other public medical programs.

The equally fictitious prospect of an enormous uncontrolled increase of administrators at the central office of a national health program can be disposed of as well. Health Security places most administrative responsibility at the regional and local levels. It will establish national standards and assure national financing, but the important decisions affecting allocation of resources and delivery of care will be made in the field. State governments will be actively involved in survey and utilization review programs.

Conclusion

We feel there is a great deal to be said for a health care system which treats everyone equally, regardless of their race, religion or income. The Health Security Program proposes to use the lever of a national financial mechanism to reorganize services so that all Americans can share equally in its benefits, as a matter of right.

We believe that there is a great deal to be said for a program which will provide all families with the fundamental security of knowing they will not be ruined by the cost of a serious or prolonged illness. Health Security accomplishes this. And equally important, under Health Security all Americans would have ready and continuing access to appropriate levels of care.

We also believe there is much to commend a program that increases the choices available to both providers and consumers of health services. By promoting the development of new group practice programs, hospital based community programs and other organized patient care systems, Health Security does just that.

We believe further there is a great deal to be said for a program which recognizes its responsibility to support the necessary and intelligent development of manpower and facilities. The Health Security Program does that through its Resources Development Fund and its methods of payment for services.

We see considerable merit in a program which undertakes to protect the public against costly yet inferior and inappropriate services. Health Security contains strong measures to assure the quality of care. It involves the consumer at every level and offers consumer organizations opportunities and support for organizing and managing community health care services.

But we do not claim that Health Security is an instant cure-all. As I have said repeatedly, it provides a foundation upon which we can build a modern health system for this country. It will not transform our obsolete medical system overnight and make it workable. Our doctors are too badly distributed; their practices are too fragmented; and in many instances, not designed to meet real health needs on a community or personal level. The United States is the richest country in the history of the world, but the vested interests have made us doctor-poor and organizationally unsound.

The Health Security Bill does provide a beginning. If implemented we feel it will eventually solve the problems of manpower shortages, uneven quality, escalating costs and lack of organization. Its prompt implementation will pay great dividends in the saving of lives and presently wasted health care dollars. Equally important, it will provide the basis for a new level of security for all Americans.

STATEMENT OF

Michael E. DeBakey, M. D.
President and
Professor of Surgery and Chairman
Cora and Webb Mading Department of Surgery
Baylor College of Medicine
Houston, Texas

Presented September 23, 1970
before the
Senate Health Subcommittee
Senator Ralph Yarborough, Chairman

Mr. Chairman and Members of the Subcommittee:

I would like to discuss still another dimension of what has been termed "crisis" in health care in America; that is, the crisis in medical education and research caused by sharp curtailment of the Federal health budget. The American investment in medical research since World War II has resulted in the most productive enterprise in the world and has yielded undreamed of health benefits for our people. Now this enterprise is threatened by lowered priorities as a result of the runaway costs of medicaid. The difficulties of medicaid have threatened to obscure this nation's desperate need to maintain the highest priority for medical research. Research has led to the suppression of serious infectious diseases; to satisfactory control of such disabling conditions as hypertension, diabetes, and numerous mental and emotional disturbances; to effective surgical correction of most congenital and acquired heart diseases; to the development of such dramatic procedures as organ transplantations and such devices as mechanical heart assistors; and to numerous other startling medical advancements.

But now research is threatened because investigators must compete for the scant Federal funds. This unwise competition is not in the public interest.

Today, funds allocated by the National Institutes of Health for research and training represent only 1/10 of 1% of our gross national product. And yet even these relatively small expenditures, with their resulting dividends in better health, longer life, and lowered incidence and costs of disease, are perenially threatened.

Cancer research has produced encouraging results. Almost a million and a half Americans who have had a major form of cancer are today leading productive, happy lives. But without funds to continue research in this important field, we can never expect to find the cause of cancer and other diseases or ways of preventing them.

Impressive progress has been made in research to control cardiovascular diseases, and new and important discoveries may be just over the horizon. Already impressive reductions have occurred in the death rate for hypertension, rheumatic heart disease, and stroke. The artificial heart-lung machine, a product of the research laboratory, is now in daily use all over the country.

Advances in treatment of the mentally and emotionally ill have been revolutionary, with newly-discovered drugs which enable these patients to return to their communities where they are able to lead normal, productive lives. These and countless other benefits have been gained from a relatively small expenditure for medical research.

When the 89th Congress passed Medicare, Medicaid, the Heart Disease, Cancer, and Stroke Amendments, and a number of other major health programs, it was not the intent that those programs should detract from the nation's commitment to medical research and professional training. On the contrary, the nation acted toward the ideal of a combination of the new programs to finance and deliver services, along with continued and increased support of research and educational programs. Now we recognize that only

a national health insurance program provides the support and leverage to create delivering methods of health care that are more cost-effective than generally are to be found today. And by budgeting for health care services through national health insurance, as we must budget for research and education, we can reduce the danger of imbalances and the resulting crippling of activities.

I support the Health Security Program because, while establishing programs aimed directly at improving medical care and its delivery, it will relieve the pressure on research and teaching. We should consider appropriations for medical research in relation to the total need or opportunity, and to the nation's enormous resources, and not in competition with payment programs which devour a common budget.

I support Health Security because within the program there is explicit and implicit support for professional training.

We all know there is a serious health manpower shortage. This scarcity threatens to become much more acute unless we act to train more physicians and allied health personnel than we have in the past. It is an appalling fact that one-fourth of the physicians newly-licensed to practice in this country last year were graduates of foreign medical schools. We could not operate our hospitals without the interns and residents who have been trained abroad. Most of these physicians are from less-developed countries than ours. We could help them more by training our own physicians rather than seeking them in countries where they are in extremely short

supply. Meanwhile, more than 2,000 fully-qualified American medical students are being trained in foreign schools. There are no places for them in our schools.

Medical schools have proposed increasing their enrollments, but with spiraling costs of education and construction, they need major assistance from the Federal government. Most existing medical schools depend heavily on Federal grants for financing, and for some time they have been operating at serious deficits. Student grants and loans have not fared notably well in the HEW appropriations, in competition with other demands and needs. Health Security will help to relieve these pressures on the budget. In its Resources Development Fund, medical education, especially support for the training of economically-disadvantaged students, will find expression.

To concentrate health appropriations heavily on improvement of delivery of health care at the expense of medical research and the training of health manpower is self-defeating. Health Security will help this nation and its government to strike a proper balance.

The CHAIRMAN. Our next witness is Mr. Whitney Young, executive director of the National Urban League. Welcome Mr. Young.

Mr. YOUNG. I know we are pushed for time. My formal statement is available to you.

I do want to express my very strong support for what I regard as one of the most significant pieces of legislation before the Senate in many, many decades. I am wearing three hats. I am here on behalf of the Health Security Action Council and as the executive director of the National Urban League, and the president of the National Association of Social Workers.

Wearing all of these hats, I bring you my constituents' concerns. It is an unfortunate situation when a society like ours lacks the capability to provide for the health care of its citizens. But it is criminal when it has the capability to provide good services, as we clearly do, and fails to provide for necessary needs of the people of the country.

I would like to reemphasize the point that national health insurance is inevitable in this society, just as social security back in 1932 was inevitable, but it took us 3 years to get it. The issue is whether the Senate wants to be the reflector or the leader of this society, whether it wants to sit back and await massive demands and urgent and tragic confrontations before it does what it knows it should do.

The issue before the Senate is: Is it going to be the caboose or the engine in this whole effort to bring about what is inevitable and, I think, obvious: national health insurance.

I am dismayed by the allegations as to costs. I am dismayed by this kind of inconsistent appreciation of values. This is what has our young people most disturbed in our society. The amount of money we are talking about is minimal, if you consider what it costs for not doing what needs to be done.

I think we spend entirely too much time talking about what is an expenditure when, in fact, it is an investment. The costs of not providing adequate medical care in this country, in terms of human potential, in terms of human resources, is staggering.

So what we are talking about is investing in what I would regard as America's most prized possession. The notion that this helps poor people or black people or minorities is a fallacious idea. The middle class and lower middle class people of this country, the so-called political majority, in this country, are the greatest victims of inadequate medical care.

I think the sooner this majority is made aware of the fact that it is being given a snow-job, that overnight a catastrophic illness can completely deplete their whole family savings and resources, the better off we are going to be. Language, like "throwing out the baby with the wash," is more scare language—we are trying to get the baby to participate in the bath, not throw it out with the water.

I think the time has come when we have to speak honestly. We have to use the facts and the figures that will show the problems—take the case of black people, about which I am most concerned right now. We estimate that probably 30 percent or maybe more of black mothers, at the time of childbirth, have never seen a doctor until the actual birth itself. Loss of prenatal care means a great deal in the future development and health of the child. These figures are very much the same for other minority groups as well.

51-658 O - 70 - 17

Let me give you a few figures. Life expectancy is much lower for blacks than for whites. The average black baby, man or woman, will not live long enough to collect social security.

The black maternal death rate is almost four times the white rate; almost twice as many black as white families have no hospitalization or surgical insurance coverage.

The test of society, in the final analysis, is whether we have the basic things and meet the basic needs of our people—not how many SST's, or spaceships, or how many flights to the moon. If we don't meet our people's needs, we are basically an immoral society.

I commend the Senators who join in sponsoring this legislation. The legislation, and the problems it seeks to overcome must be dramatically projected to the people in this country, and I think the Senate is in the best position to do this. National health insurance is going to come. We can be the midwives or we can be the abortionists; we have to make the decision as to what we are going to do.

I cannot state too strongly my deep concern about what is happening in the delivery and the organization of medical care. We are not talking about money. We are talking about a system that does not work. To say that we must cling to the past because there is a past, although the past has not worked, is terribly regressive thinking.

The organizations that I represent, the National Urban League, the social workers of the country, as well as the Health Security Action Council, are behind this legislation.

The CHAIRMAN. Thank you for that statement. I want to assure you there will be adequate leadership in the Senate.

This Health Subcommittee, which I chair this year, is not a subcommittee where we have to pull somebody in and ask them to serve, as with many committees. These dynamic Senators you see here and more who could not be here are pushing for leadership on this Health Subcommittee.

When I came to the Senate over 12 years ago, few Senators made this committee their first choice on which to serve, but now they are pushing, the young, dynamic Senators are fighting for leadership. They know the needs of the country and I believe we are going to see this bill enacted faster than many people in this country think.

It is of great importance to have organizations like yours support us. We thank you for this statement.

I order Mr. Young's full statement printed in the record.

(The prepared statement of Mr. Young follows:)

Testimony of
WHITNEY M. YOUNG, JR.
National Urban League
before the
Senate Committee on Labor and Public Welfare
on
National Health Insurance
Room 1202, New Senate Office Building
September 23, 1970

Mr. Chairman and members of this Committee, my name is Whitney M. Young, Jr. I appear before this Committee on Health as part of a panel of representatives of the Health Security Action Council. On a day-to-day basis however, I serve as executive director of the National Urban League.

The National Urban League is a professional, non-profit, non-partisan community service organization founded in 1910 to secure equal opportunity for black Americans and other minorities. It is governed by an interracial Board of Trustees and is concerned with fostering good race relations and increased understanding among all people of these United States.

The League seeks solutions to problems of income, employment, education, housing, health, and civil rights for the masses of black and brown Americans who want a better way of life. It recognizes that any meaningful and significant changes in these problem areas rest with changing the network of systems which produce black-white disparities.

It works through local affiliates in some 97 cities located in 36 states and the District of Columbia, five regional offices, and a Washington Bureau. These units are staffed by some 1,600 persons, trained in the social sciences and related disciplines, who conduct the day-to-day activities of the organization throughout the country.

Strengthened by the efforts of upward of 10,000 volunteers who bring expert knowledge and experience to the resolution of minority problems, the National Urban League is unique as the only national educational and

community service agency which devotes its entire resources to the use of social work and research techniques for bettering the lives of the disadvantaged and for improving race relations.

This means, Mr. Chairman, that I appear here today as the wearer of two hats---one as executive director of a community service organization and the other as vice chairman of a group dedicated almost exclusively to improving health services to the Nation. These two hats, however, are not totally dissimilar because much of the League's effort is also devoted to improving health services.

While the details differ somewhat, both of these groups support the concept of a national health insurance program. Because I know, Mr. Chairman, of your broad knowledge of national health insurance programs as reflected in S. 4323 which you recently introduced and S. 4297 which you co-sponsored with Sen. Edward Kennedy and more than a dozen other members of this august body, I will not dwell too long on details. In the interest of time I would like to touch on some general components of the proposed health security legislation.

So much has been said and written about national health insurance in recent months that there is little new that can be added to the body of knowledge already available to this Committee. Few knowledgeable people argue about the need for expanded health services.

The program being proposed by the Committee for National Health Insurance would:

___provide comprehensive health care to all Americans;

___pay for such services with contributions from employers, employees, the self-employed and a general trust fund;

___cover all necessary health care wherever it is given;

___substantially expand preventive health care and improve early diagnosis of illness; and

___establish a Resources Development Fund to expand group medical practice and other approaches to easing the shortage of health manpower.

Such a program appeals to most Americans because it touches their daily lives. People want to be healthy; they want to protect their health with the best possible medical practices; and they want to maintain their health at a reasonable cost. These three facts motivate Americans to spend an estimated $63 billion annually for health services. The problem is that the cost of health services is so high that few people can afford to get sick.

Even with the private health insurance plans we now have, the average person could be financially ruined by a spell of sickness which hospitalized him for more than three weeks. The average uninsured person simply cannot afford to be hospitalized. Some experts are already predicting that the cost of hospitalization for a serious heart attack will approach $16,000 within the next three years. That amount of money could wipe out a substantial number of "family nest eggs" and rob many young people of the college educations Americans save their money for.

It is important to bear in mind that the problem is now more than the inadequacy of medical care available to the poor. As medical technology has advanced, it has also raised the cost of care beyond the reach of many poor people. Good medical care is rapidly becoming a privilege of the middle-class citizenry.

The National Center for Health Statistics, Public Health Service, estimates that between 1962-1963 some 34 per cent of all decedents were individuals or members of families with a total income of less than $2,000 during the last calendar year before death. This may indicate that rich people don't die as rapidly simply because they can afford the diagnostic, preventive, and therapeutic care denied poor people.

Mr. Chairman, I appeared before the Subcommittee on Economy in Government, Joint Economic Committee, three months ago to discuss the changing of our national priorities. At that time I said that while I have no medical credentials, I do have a wealth of experience in dealing with the poor who sorely need improved health services. In spite of the fact that we spend billions of dollars for health, we have failed to establish the national priorities necessary to provide every citizen full access to humane and comprehensive health care.

One obvious approach to the solution of this problem is a national health insurance program which includes a well-planned and carefully coordinated system of health care for all Americans. This Nation must make health services accessible---both physically as well as financially.

The National Urban League supports the principle of a national health insurance program which provides universal coverage without exception for all persons, so long as such coverage is based upon the development of a comprehensive delivery system available to all. The League's Board of Trustees has endorsed a national health program in which the following components are included:

___general tax revenue as the source of financing;

___emphasis on improving the geographic distribution of health services;

___no reimbursement formulae or use of private insurance carriers; and

___funding for the education of health manpower.

The United States ranks 17th among all nations in the life expectancy of men; 10th in life expectancy of women, and 13th in the rate of infant mortality. One-fourth of all children face the probability of untreated physical and mental disorder.

More importantly, as in other areas of our national life, health care for blacks presents an especially dismal picture. Consider, Mr. Chairman, the following facts:

___life expectancy is lower for blacks than for whites at all ages;

___the average black male baby cannot expect to live long enough to collect social security;

___the black maternal death rate is almost four times the white rate in spite of substantial reductions during the past three decades; and

___almost twice as many black as white families have no hospitalization or surgical insurance coverage.

We feel, therefore, that it is imperative that the Nation move rapidly toward a national system of health insurance and delivery of medical care and medical education on an equal basis for all. We do not argue here for a specific proposal. While most of the popular NHI proposals differ in some details, they all have the same general goals. Even the proposals supported by the two organizations I represent today differ in some ways. These differences, however, are not major obstacles and can be reconciled.

All of them call for tremendous budgets, but this country can afford the cost, whatever it may be. All we need is the will. When we wanted to expand the highway system, we found the method and the money. When we wanted to explore the moon, we developed the technology and we didn't let the budget bother us. Now we are pumping an estimated $290 million into the SST program.

Something is wrong with our national priorities, and I trust that this Committee will see fit to begin a reordering of those priorities---at least to a point where a national health insurance program will become the order of the day, replacing space exploration, highway construction, and super transports as the "fair headed" children of American progress.

The obvious need for a national health insurance program was summed up expertly by the Washington Post when it said:

> "A legislative proposal is put forward every now and then embodying an idea so natural, so reasonable and so right that one wonders how the country could have floundered along for nearly two hundred years without it. The proposal that the American People finance their inescapable and immense annual bill for medical care through a national system of insurance seems to us just such an idea."

The Post editorial concluded that "the time is ripe for national discussion and national resolution of the national health problem."

The Washington Evening Star, editorializing on NHI, concluded that "cradle-to-the-grave health insurance is coming, possibly in the first half of this decade." The Star continued:

> "It is coming not because, to use the well-worn phrase, it is an idea whose time has come. National health insurance will be adopted because it is a necessity that can no longer be avoided."

We agree with the conclusions of these two stalwarts of the Fourth Estate. The Nation cannot afford to delay enactment of a national health insurance program much longer if it is to continue in a position of world leadership. America's most precious resource is its citizens.

I thank you.

The CHAIRMAN. The next panelist is Dr. I. S. Falk, professor emeritus of public health, Yale University.

Dr. FALK. Mr. Chairman, I have no prepared statement, but I will be glad to assist the course of these hearings by making available information we have accumulated in the development of the proposals which are embodied in the bill which is before the committee.

I would first like to direct my remarks to the question raised earlier with respect to the estimate of $77 billion presented by Secretary Veneman in his testimony on this bill as the Department's estimate of the costs for the first fiscal year, or the first year in which the program proposed in this bill may become operational.

Not knowing the details about the data that were used for the development of the estimate or arithmetic processes to which the data were subjected, I cannot undertake to comment on the reasons why the figure presented by Secretary Veneman is in very substantial variance from the estimates we have developed in our studies.

I would like to explain our objections to that figure:

When our committee was at work on the development of specifications for a health security program, we undertook to act responsibly with respect to the prospective costs in the program, so we undertook as careful studies as we could, of what the costs might be.

The methodology in this field is to undertake first to analyze substantive proposals as to the existing situation and, thus, to say: What would the costs have been, had the program been operational in the latest year for which we have reliable data?

At that time, the last formal figures were for the fiscal year 1968–1969. We, therefore, undertook an analysis of what the benchmark costs might have been, had the program we were developing and designing been in operation in fiscal 1969.

In the course of our studies, we took the fullest advantage of the agreement which had been effected between the late Mr. Walter Reuther and former Secretary Finch, and which made it possible for us to work collaboratively with the experts in the Department of Health, Education, and Welfare who are knowledgeable about medical care costs and expenditures.

We developed the cost estimates for the benchmark fiscal year 1968–1969——

The CHAIRMAN. Doctor, I am forced to stop you. The morning hour has ended in the Senate, and there has been an official protest by the Republicans of the Senate concerning our committee's hearings. They have that right under the rules to stop our hearing if they wish after the morning hour, since it takes unanimous consent to continue hearings after the Senate begins conducting business.

They have stopped this hearing. I will announce publicly why it is stopped.

I want the record to show here, Mr. Melvin Glasser came with the panel. He has been working on this for years as director of the social security department at the UAW.

I invite all the Senators to file any written questions they have with the members of this panel.

I am concerned about the stoppage of our hearing here. I can not conceive how any procedure in the Senate was ended, retarded, or

slowed up by the hearings we are holding, and we would have stopped probably by 12:30 anyway, but the minority has protested.

It is their right, but I don't think it is proper to stop this matter of such importance.

Now we have another panel here of medical students. I invite them to come back tomorrow if they can possibly stay in town. I am going to recess this hearing until 9 o'clock in the morning to give us extra time to move ahead.

The CHAIRMAN. If any other witnesses have additional statements they can file them later on. We are grateful for the great support you witnesses have given in the months of working out this bill. With your help we have been able to bring this bill this far. Thank you.

(The following information was subsequently supplied for the record:)

COST ESTIMATES FOR THE HEALTH SECURITY PROGRAM SUBMITTED BY THE TECHNICAL COMMITTEE FOR NATIONAL HEALTH INSURANCE

The Technical Committee of the Committee for National Health Insurance has been asked to submit additional data to the Senate Committee on Labor and Public Welfare with respect to cost estimates for the Health Security Program.

The Technical Committee has estimated that Health Security would have cost $37.0 billion in FY 1969. Since the proposed Health Security program would not become operational until FY 1974, and since hospital, medical and other health costs would continue to rise in the interim (by an estimated 10 percent annually), the estimates for Health Security in FY 1974 would reflect the cost increases which would already have occurred. HEW experts estimated that the costs of personal health care services (within the scope of services covered by Health Security) would approximate $57 billion in FY 1974. The Technical Committee's own estimates are of the same general magnitude. It is a basic position of the Technical Committee and CNHI, that the $57 billion to be channeled through the system established by Health Security beginning with FY 1974 would produce more services, for more people, and would revitalize the archaic health care delivery system that currently produces double or triple inflation of health care costs.

These estimates take into account increases in population, utilization of services, and general increase in the cost of living.

To give a more detailed picture, our starting point in developing the estimates was an estimate of what the cost would have been if the proposed program had been operational in the last year for which detailed cost and expenditure data were available: fiscal year 1968–69.

At price and utilization rates of that year, our program would have cost $37.0 billion. This estimate was worked out more or less independently by us in the Committee and by the experts on this subject in the U.S. Social Security Administration.

Even if our program were enacted in 1970, we had to allow time for the "tooling up" for program operations. It would, therefore, be mid-1973 before the program could become operational. We had to ask: What would happen to medical care costs in the meantime, and what would the Health Security Program cost be in its first full operational year, fiscal year 1973–74?

It had already become evident that medical care costs in general had continued to go up steeply between fiscal year 1968–69 and the fiscal year which ended in July 1970. Also, the Social Security Administration's forecasts indicated that the costs may be expected to climb further. If medical care costs continue to rise by approximately 10 percent a year (the average rate of increase in 1960–1968, both before and after the enactment of Medicare and Medicaid), the benchmark cost for Health Security would have gone up from $37.0 billion (1968–69) to $54.2 billion (1972–73) before the program can become operational. In other words, the Health Security program will have to start with cost and expenditure levels that will prevail in the country before this new program goes

into effect in mid-1973. We have estimated that, after Health Security becomes operational, cost increase would be only 6 percent (for increase in population, utilization and general price rise, combined—as against 10 percent a year previously). The cost of Health Security in its first full operational year, July 1973–June 1974, is therefore expected to be $57.4 billion—reflecting what will have happened to medical care costs in the absence of the program.

Thereafter, the program's costs would increase only as population grows and as the benefits of the program are broadened further; and they would increase or decrease as cost of living in general changes upward or downward.

Under-Secretary Veneman told the Senate Committee on Labor and Public Welfare this morning he estimated that Health Security would cost $77 billion in its first full year of operation. That figure is nearly $20 billion higher than our estimate. Since we do not know on what basis his estimate was developed—what basic data were used and with what assumptions about cost increases for the fiscal years between 1968–69 and 1972–73 and in Health Security's first operational year 1973–74—we do not know the source of the difference or how to reconcile the two figures.

We are prepared to submit to the Committee our review of Under-Secretary Veneman's cost estimate when the basis of these figures is made available to the Senate Committee on Labor and Public Welfare.

The CHAIRMAN. We are recessed until 9 a.m. tomorrow.

(Whereupon, at 11:45 a.m. the committee was recessed, to reconvene at 9 a.m., Thursday, September 24, 1970.)

○