QUORUM CALL

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The second assistant legislative clerk proceeded to call the roll.

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ABOUREZK). Without objection, it is so ordered.

SENATOR FROM NEW HAMPSHIRE—CREDENTIALS

Mr. MANSFIELD. Mr. President, it is my intention, at an appropriate time after the Senate convenes tomorrow, to put in a live quorum call as soon as possible.

Following the message of the President of the United States on the State of the Union, the Senate will return to the Chamber. I ask unanimous consent that at that time there be a limitation of 40 minutes, 20 minutes to the distinguished assistant Republican leader and 20 minutes to the distinguished assistant majority leader, for the purpose of making the opening remarks on the Wyman-Durkin matter.

The PRESIDING OFFICER (Mr. ABOUREZK). Is there objection?

Mr. GRIFFIN. Mr. President, reserving the right to object, and I shall not object, when the majority leader says there will be a time limit, he is saying that the Senator from Michigan would be recognized for 20 minutes?

Mr. MANSFIELD. Exactly; that the Senator from Michigan be recognized first, to be followed by the Senator from West Virginia, this to apply only to that particular instance.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that at any time that the New Hampshire contested election matter is the pending business before the Senate, the following staff people be given the privilege of the floor: Mr. James Shoener, Mr. James Duffy, Mr. Bill Cochran, Mr. Joe O'Leary, Mr. Tom Hart.

It may be that the distinguished chairman of the Subcommittee on Privileges and Elections would like to add someone, the distinguished chairman of the Committee on Rules may wish to add someone, and the distinguished Republican whip may wish to add someone.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. PELL. Mr. President, I should like to add the names of Mr. Stephen Wexler and Mr. Thomas Hughes.

The PRESIDING OFFICER. Without objection, it is so ordered.

STANDING ORDER FOR RECOGNITION OF THE MAJORITY AND MINORITY LEADERS EACH DAY

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that, in each daily session throughout the 94th Congress, immediately after the prayer by the Chaplain, the two leaders or their designees may be recognized, each for not to exceed 10 minutes, as was the practice last year.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER FOR RECOGNITION OF MR. STEVENSON, MR. GRIFFIN, AND MR. ROBERT C. BYRD ON FRIDAY, JANUARY 17, 1975

Mr. ROBERT C. BYRD. Mr. President, I ask unanimous consent that on Friday, after the recognition of the two leaders or their designees, Mr. STEVENSON be recognized for not to exceed 15 minutes; that Mr. GRIFFIN then be recognized for not to exceed 15 minutes; and that the junior Senator from West Virginia be recognized for not to exceed 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROBERT C. BYRD. All Senators will have an opportunity prior to that date to indicate to the respective whips whether or not they want orders for recognition on Friday—that being the first day for speeches.

PROGRAM

Mr. ROBERT C. BYRD. Mr. President, the Senate shortly will adjourn until the hour of 12 o'clock noon tomorrow. For the information of Senators, no bills will be introduced on tomorrow.

Speeches on matters other than the pending motion and/or substitute motion will not be in order. Introduction of bills and speeches will be in order on Friday.

It is possible that a rollcall vote or votes could occur tomorrow on the New Hampshire matter. It is possible that that matter will go over until Thursday, at which time, a rollcall vote or votes could occur and would likely occur. All Senators should adjust their schedules accordingly, to take into consideration the possibility of rollcall votes tomorrow and the possibility of rollcall votes on Thursday and, additionally, the possibility of rollcall votes on Friday.

The discussion with respect to rule XXII will begin on Friday if, by that time, the Senate has made a disposition of the motion by Mr. GRIFFIN and the motion by Mr. MANSFIELD on the contested New Hampshire election.

At approximately 12:43 p.m. tomorrow, Senators will depart in a body to the House of Representatives to attend the joint session of the two Houses for the President's state of the Union address. Immediately after the President's address, Senators will return to the Chamber, at which time Mr. GRIFFIN will be recognized for not to exceed 20 minutes to discuss the Mansfield motion and Mr. GRIFFIN's substitute motion on the New Hampshire contested election. The junior Senator from West Virginia, Mr. ROBERT C. BYRD, will then be recognized for not to exceed 20 minutes to speak on the two motions. All Senators are urged to be in attendance on the floor during this discussion.

ADJOURNMENT

Mr. ROBERT C. BYRD. Mr. President, there being no further business to come before the Senate, I move, in accordance with the previous order, that the Senate stand in adjournment until the hour of 12 o'clock noon tomorrow.

The motion was agreed to; and at 5:14 p.m., the Senate adjourned until tomorrow, Wednesday, January 15, 1975, at 12 o'clock noon.

HOUSE OF REPRESENTATIVES—*Tuesday, January 14, 1975*

This being the day fixed by the 20th amendment of the Constitution and Public Law 93–553 of the 93d Congress for the annual meeting of the Congress of the United States, the Members-elect of the House of Representatives of the 94th Congress met in their Hall, and at 12 o'clock noon were called to order by the Clerk of the House of Representatives, Hon. W. Pat Jennings.

The Chaplain, Rev. Edward G. Latch, D.D., prefaced his prayer with these words of Scripture:

Before the mountains were brought forth, or ever Thou hadst formed the Earth and the world, even from everlasting to everlasting, Thou art God—Psalms 90: 2.

O Thou who hast preserved us as a nation and by whose providence we have been brought to this hour, we humbly beseech Thee to make us ever mindful of Thy presence, eager to do Thy will and earnest in our desire to serve our country.

With the dawn of a new year, in a world anxious and troubled about many things, we turn to Thee seeking light and life for our day, faith and freedom for our world, and the triumph of truth for our age.

At this high altar of our national life we pray for our President, our Vice President, our Speaker, every Member of Congress, and all our leaders in government, business, and labor. May they be so strengthened by Thy spirit that they may meet depressing fears with daring faith and discouraging words with encouraging works. Together may they strive for the day when good will shall dwell in the hearts of our citizens, justice shall reign in the relationship of people, and peace shall regulate the affairs of nations.

We pray in the spirit of Him who said: "When you pray, say—*Our Father who art in heaven, hallowed be Thy name. Thy kingdom come. Thy will be done in earth, as it is in heaven. Give us this day our daily bread. And forgive us our trespasses as we forgive those who trespass against us. And lead us not into temptation, but deliver us from evil: For Thine is the kingdom, and the power, and the glory, forever.*" Amen.

The CLERK. Representatives-elect to the 94th Congress, this is the day fixed by law for the meeting of the 94th Congress.

This law directs the Clerk of the House to prepare the official roll of the Representatives-elect.

Credentials covering 435 seats in the 94th Congress have been received, and are now on file with the Clerk of the 93d Congress.

The names of those persons whose credentials show they were regularly elected in accordance with the laws of the several States and of the United States will be called; and as the roll is called, following the alphabetical order of the States, beginning with the State of Alabama, Representatives-elect will answer to their names to determine whether or not a quorum is present.

The reading clerk will call the roll.

The Clerk called the roll by States and the following Representatives-elect answered to their names:

[Roll No. 1]

ALABAMA

Edwards, Jack
Dickinson
Bevill
Jones, Robert E.
Buchanan
Flowers

ALASKA

Young, Don (at large)

ARIZONA

Rhodes
Udall
Steiger, Sam
Conlan

ARKANSAS

Alexander
Hammer-schmidt
Thornton

CALIFORNIA

Johnson, Harold T.
Clausen, Don H.
Moss
Leggett
Burton, John L.
Burton, Phillip
Miller, George
Dellums
Stark
Edwards, Don
Ryan
McCloskey
Mineta
McFall
Sisk
Talcott
Krebs
Ketchum
Lagomarsino
Goldwater
Corman
Moorhead, Carlos J.
Rees
Waxman
Roybal
Rousselot
Bell
Burke, Yvonne
Hawkins
Danielson
Wilson, Charles H.
Anderson, Glenn
Clawson, Del
Hannaford
Lloyd, Jim
Brown, George E.
Pettis
Patterson
Wiggins
Hinshaw
Wilson, Bob
Van Deerlin
Burgener

COLORADO

Schroeder
Wirth
Evans, Frank E.
Johnson, James P.
Armstrong

CONNECTICUT

Cotter
Dodd
Giaimo
McKinney
Sarasin
Moffett

DELAWARE

du Pont (at large)

FLORIDA

Sikes
Fuqua
Bennett
Chappell
Kelly
Young, C. W. Bill
Gibbons
Haley
Frey
Bafalis
Rogers
Burke, J. Herbert
Lehman
Pepper
Fascell

GEORGIA

Ginn
Brinkley
Levitas
Young, Andrew
Flynt
McDonald, Larry
Stuckey
Landrum
Stephens

HAWAII

Matsunaga
Mink

IDAHO

Symms
Hansen

ILLINOIS

Metcalfe
Murphy, Morgan F.
Russo
Derwinski
Erlenborn
Hall
Anderson, John
O'Brien
Kluczynski
Hyde
Collins, Cardiss
Rostenkowski
Michel
Railsback
Findley
Madigan
Shipley
Yates
Mikva
Annunzio
Crane
McClory
Price
Simon

INDIANA

Madden
Fithian
Brademas
Roush
Hillis
Evans
Myers, John T.
Hayes, Philip H.
Hamilton
Sharp
Jacobs

IOWA

Mezvinsky
Blouin
Grassley
Smith, Neal
Bedell
Harkin

KANSAS

Sebelius
Keys
Winn
Shriver
Skubitz

KENTUCKY

Hubbard
Natcher
Mazzoli
Snyder
Carter
Breckinridge
Perkins

LOUISIANA

Hébert
Boggs
Treen
Waggonner
Passman
Moore
Breaux
Long, Gillis W.

MAINE

Emery
Cohen

MARYLAND

Bauman
Long, Clarence D.
Sarbanes
Holt
Spellman
Byron
Mitchell, Parren J.
Gude

MASSACHUSETTS

Conte
Boland
Early
Drinan
Tsongas
Harrington
Macdonald, Torbert H.
O'Neill
Moakley
Heckler, Margaret M.
Burke, James A.
Studds

MICHIGAN

Conyers
Esch
Brown, Garry
Hutchinson
Vander Veen
Carr
Riegle
Traxler
Vander Jagt
Cederberg
Ruppe
O'Hara
Diggs
Nedzi
Ford, William D.
Dingell
Brodhead
Blanchard
Broomfield

MINNESOTA

Quie
Hagedorn
Frenzel
Karth
Fraser
Nolan
Bergland
Oberstar

MISSISSIPPI

Whitten
Bowen
Montgomery
Cochran
Lott

MISSOURI

Clay
Symington
Sullivan
Randall
Bolling
Litton
Taylor, Gene
Ichord
Hungate
Burlison, Bill D.

MONTANA

Baucus
Melcher

NEBRASKA

Thone
McCollister
Smith, Virginia

NEVADA

Santini (at large)

NEW HAMPSHIRE

D'Amours
Cleveland

NEW JERSEY

Florio
Hughes
Howard
Thompson
Fenwick
Forsythe
Maguire
Roe
Helstoski
Rodino
Minish
Rinaldo
Meyner
Daniels, Dominick V.
Patten

NEW MEXICO

Lujan
Runnels

NEW YORK

Pike
Downey
Ambro
Lent
Wydler
Wolff
Addabbo
Rosenthal
Delaney
Biaggi
Scheuer
Chisholm
Solarz
Richmond
Zeferetti
Holtzman
Murphy, John M.
Koch
Rangel
Abzug
Badillo
Bingham
Peyser
Ottinger
Fish
Gilman
McHugh
Stratton
Pattison
McEwen
Mitchell, Donald J.
Hanley
Walsh
Horton
Conable
LaFalce
Nowak
Kemp
Hastings

NORTH CAROLINA

Jones, Walter B.
Fountain
Henderson
Andrews, Ike
Neal
Preyer
Rose
Hefner
Martin
Broyhill
Taylor, Roy A.

NORTH DAKOTA

Andrews, Mark (at large)

OHIO

Gradison
Clancy
Whalen
Guyer
Latta
Harsha
Brown, Clarence J.
Kindness
Ashley
Miller, Clarence E.
Stanton, J. William
Devine
Mosher
Seiberling
Wylie
Regula
Ashbrook
Hays, Wayne L.
Carney
Stanton, James V.
Stokes
Vanik
Mottl

OKLAHOMA

Jones, James R.
Risenhoover
Albert
Steed
Jarman
English

OREGON

AuCoin
Ullman
Duncan, Robert
Weaver

PENNSYLVANIA

Barrett
Nix
Green
Eilberg
Schulze
Yatron
Edgar
Biester
Shuster
McDade
Flood
Murtha
Coughlin
Moorhead, William S.
Rooney
Eshleman
Schneebeli
Heinz
Goodling
Gaydos
Dent
Morgan
Johnson, Albert W.
Vigorito
Myers, Gary A.

RHODE ISDAND

St Germain
Beard, Edward P.

SOUTH CAROLINA

Davis
Spence
Derrick
Mann
Holland
Jenrette

SOUTH DAKOTA

Pressler
Abdnor

TENNESSEE

Quillen
Duncan, John J.
Lloyd, Marilyn
Evins, Joe L.
Fulton
Beard, Robin L.
Jones, Ed
Ford, Harold E.

TEXAS

Patman
Wilson, Charles
Collins, James M.
Roberts
Steelman
Teague
Archer
Eckhardt
Brooks
Pickle
Poage
Wright
Hightower
Young, John
de la Garza
White
Burleson, Omar
Jordan
Mahon
Gonzalez
Krueger
Casey
Kazen
Milford

UTAH

McKay
Howe

VERMONT

Jeffords (at large)

VIRGINIA

Downing
Whitehurst
Satterfield
Daniel, Robert W., Jr.
Daniel, Dan
Butler
Robinson
Harris
Wampler
Fisher

WASHINGTON

Pritchard
Meeds
Bonker
McCormack
Foley
Hicks
Adams

WEST VIRGINIA

Mollohan
Staggers
Slack
Hechler, Ken

WISCONSIN

Aspin	Reuss	Cornell
Kastenmeier	Steiger,	Kasten
Baldus	William A.	
Zablocki	Obey	

WYOMING

Roncalio (at large)

The CLERK. The rollcall discloses that 432 Representatives-elect have answered to their names.

A quorum is present.

ANNOUNCEMENT BY THE CLERK

The CLERK. The Clerk wishes to state that credentials are on file showing the election of the Honorable JAIME BENITEZ as Resident Commissioner from the Commonwealth of Puerto Rico, the election of the Honorable WALTER E. FAUNTROY as Delegate from the District of Columbia, the election of the Honorable ANTONIO BORJA WON PAT as Delegate from Guam, and the election of the Honorable RON DE LUGO as Delegate from the Virgin Islands.

ELECTION OF SPEAKER

The CLERK. The next order of business is the election of a Speaker of the House of Representatives for the 94th Congress.

Nominations are now in order.

The Clerk recognizes the gentleman from California (Mr. PHILLIP BURTON).

Mr. PHILLIP BURTON. Mr. Clerk, as chairman of the Democratic Caucus, I am directed by the unanimous vote of that caucus to present for election to the office of the Speaker of the House of Representatives of the 94th Congress the name of the Honorable CARL ALBERT, a Representative-elect from the State of Oklahoma.

The CLERK. The Clerk now recognizes the gentleman from Illinois (Mr. ANDERSON).

Mr. ANDERSON of Illinois. Mr. Speaker, as chairman of the Republican conference and by authority, by direction, and by unanimous vote of the Republican conference, I nominate for Speaker of the House of Representatives the Honorable JOHN J. RHODES, a Representative-elect from the State of Arizona.

The CLERK. The Honorable CARL ALBERT, a Representative-elect from the State of Oklahoma, and the Honorable JOHN J. RHODES, a Representative-elect from the State of Arizona, have been placed in nomination.

Are there further nominations?

There being no further nominations, the Clerk will appoint tellers.

The Clerk appoints the gentleman from Ohio (Mr. HAYS), the gentleman from Alabama (Mr. DICKINSON), the gentlewoman from Missouri (Mrs. SULLIVAN), and the gentlewoman from Massachusetts (Mrs. HECKLER).

Tellers will come forward and take their seats at the desk in front of the Speaker's rostrum.

The roll will now be called, and those responding to their names will indicate by surname the nominee of their choice.

The reading clerk will call the roll.

The tellers having taken their places, the House proceeded to vote for the Speaker.

The following is the result of the vote:

[Roll No. 2]

ALBERT

Abzug	Ginn	Obey
Adams	Gonzalez	O'Hara
Addabbo	Green	O'Neill
Alexander	Haley	Ottinger
Ambro	Hall	Passman
Anderson, Calif.	Hamilton	Patman
Andrews, N.C.	Hanley	Patten
Annunzio	Hannaford	Patterson, Calif.
Ashley	Harkin	Pattison, N.Y.
Aspin	Harrington	Pepper
AuCoin	Harris	Perkins
Badillo	Hawkins	Pickle
Baldus	Hayes, Philip H.	Pike
Barrett	Hays, Wayne L.	Poage
Baucus	Hébert	Preyer
Beard, R.I.	Hechler, W. Va.	Price
Bedell	Hefner	Randall
Bennett	Helstoski	Rangel
Bergland	Henderson	Rees
Bevill	Hicks	Reuss
Biaggi	Hightower	Richmond
Bingham	Holland	Riegle
Blanchard	Holtzman	Risenhoover
Blouin	Howard	Roberts
Boggs	Howe	Rodino
Boland	Hubbard	Roe
Bolling	Hughes	Rogers
Bonker	Hungate	Roncalio
Bowen	Ichord	Rooney
Brademas	Jacobs	Rose
Breaux	Jarman	Rosenthal
Breckinridge	Jenrette	Rostenkowski
Brinkley	Johnson, Calif.	Roush
Brodhead	Jones, Ala.	Roybal
Brooks	Jones, N.C.	Runnels
Brown, Calif.	Jones, Okla.	Russo
Burke, Calif.	Jones, Tenn.	Ryan
Burke, Mass.	Jordan	St Germain
Burleson, Tex.	Karth	Santini
Burlison, Mo.	Kastenmeier	Sarbanes
Burton, John	Kazen	Satterfield
Burton, Phillip	Keys	Scheuer
Byron	Kluczynski	Schroeder
Carney	Koch	Seiberling
Carr	Krebs	Sharp
Casey	Krueger	Shipley
Chappell	LaFalce	Sikes
Chisholm	Landrum	Simon
Clay	Leggett	Sisk
Collins, Ill.	Lehman	Slack
Conyers	Levitas	Smith, Iowa
Corman	Litton	Solarz
Cornell	Lloyd, Calif.	Spellman
Cotter	Lloyd, Tenn.	Staggers
D'Amours	Long, La.	Stanton,
Daniel, Dan	Long, Md.	James V.
Daniels, Dominick V.	McCormack	Stark
Danielson	McDonald	Steed
Davis	McFall	Stephens
de la Garza	McHugh	Stokes
Delaney	McKay	Stratton
Dellums	Macdonald	Stuckey
Dent	Madden	Studds
Derrick	Maguire	Sullivan
Diggs	Mahon	Symington
Dingell	Mann	Taylor, N.C.
Dodd	Matsunaga	Teague
Downey	Mazzoli	Thompson
Downing	Meeds	Thornton
Drinan	Melcher	Traxler
Duncan, Oreg.	Metcalfe	Tsongas
Early	Meyner	Udall
Eckhardt	Mezvinsky	Ullman
Edgar	Mikva	Van Deerlin
Edwards, Calif.	Milford	Vander Veen
Eilberg	Miller, Calif.	Vanik
English	Mineta	Vigorito
Evans, Colo.	Minish	Waggonner
Evans, Ind.	Mink	Waxman
Evins, Tenn.	Mitchell, Md.	Weaver
Fascell	Moakley	White
Fisher	Moffett	Whitten
Fithian	Mollohan	Wilson, Charles H., Calif.
Flood	Montgomery	
Florio	Moorhead, Pa.	Wilson, Charles, Tex.
Flowers	Morgan	Wirth
Flynt	Moss	Wolff
Foley	Mottl	Wright
Ford, Mich.	Murphy, Ill.	Yates
Ford, Tenn.	Murphy, N.Y.	Yatron
Fountain	Murtha	Young, Ga.
Fraser	Natcher	Young, Tex.
Fulton	Neal	Zablocki
Fuqua	Nedzi	Zeferetti
Gaydos	Nix	
Giaimo	Nolan	
Gibbons	Nowak	
	Oberstar	

RHODES

Abdnor	Frenzel	Myers, Ind.
Anderson, Ill.	Frey	Myers, Pa.
Andrews, N. Dak.	Gilman	O'Brien
	Goldwater	Pettis
Archer	Goodling	Peyser
Armstrong	Gradison	Pressler
Ashbrook	Grassley	Pritchard
Bafalis	Gude	Quie
Bauman	Guyer	Quillen
Beard, Tenn.	Hagedorn	Railsback
Bell	Hammer-schmidt	Regula
Biester		Rinaldo
Broomfield	Hansen	Robinson
Brown, Mich.	Harsha	Rousselot
Brown, Ohio	Hastings	Ruppe
Broyhill	Heckler, Mass.	Sarasin
Buchanan	Heinz	Schneebeli
Burgener	Hillis	Schulze
Burke, Fla.	Hinshaw	Sebelius
Butler	Holt	Shriver
Carter	Horton	Shuster
Cederberg	Hutchinson	Skubitz
Clancy	Hyde	Smith, Nebr.
Clausen, Don H.	Jeffords	Snyder
	Johnson, Colo.	Spence
Clawson, Del	Johnson, Pa.	Stanton, J. William
Cleveland	Kasten	
Cochran	Kelly	Steelman
Cohen	Kemp	Steiger, Ariz.
Collins, Tex.	Ketchum	Steiger, Wis.
Conable	Kindness	Symms
Conlan	Lagomarsino	Talcott
Conte	Latta	Taylor, Mo.
Coughlin	Lent	Thone
Crane	Lott	Treen
Daniel, Robert W., Jr.	Lujan	Vander Jagt
	McClory	Walsh
Derwinski	McCloskey	Wampler
Devine	McCollister	Whalen
Dickinson	McDade	Whitehurst
Duncan, Tenn.	McEwen	Wiggins
du Pont	McKinney	Wilson, Bob
Edwards, Ala.	Madigan	Winn
Emery	Martin	Wydler
Erlenborn	Michel	Wylie
Esch	Miller, Ohio	Young, Alaska
Eshleman	Mitchell, N.Y.	Young, Fla.
Fenwick	Moore	
Findley	Moorhead, Calif.	
Fish		
Forsythe	Mosher	

ANSWERED "PRESENT"—2

Albert Rhodes

The CLERK. The tellers agree on their tallies. The total number of votes cast is 432, of which the Honorable CARL ALBERT, of Oklahoma, received 287, and the Honorable JOHN J. RHODES received 143, with two voting "present."

Therefore, the Honorable CARL ALBERT, of Oklahoma, is the duly elected Speaker of the House of Representatives for the 94th Congress, having received a majority of the votes cast.

The Clerk appoints the following committee to escort the Speaker-elect to the chair: the gentleman from Arizona (Mr. RHODES), the gentleman from Massachusetts (Mr. O'NEILL), the gentleman from Illinois (Mr. MICHEL), the gentleman from California (Mr. PHILLIP BURTON), and the gentleman from Oklahoma (Mr. STEED).

The Doorkeeper announced the Speaker-elect of the House of Representatives of the 94th Congress, who was escorted to the chair by the committee of escort.

Mr. RHODES. Mr. Speaker, my colleagues, it is a distinct honor for me to introduce our great Speaker.

As you know, nobody enjoys losing an election. I sort of thought I would lose this one, and I did. I thank those who supported me, and I assure those who did not support me that I understand their reasons. But if one has to lose I can think of no one I would rather lose to than my good friend, the Honorable CARL ALBERT.

Under the leadership of CARL ALBERT the House of Representatives has regained much of the prestige and influence which has been slowly eroded over a period of many years. CARL ALBERT has been not just the leader of the majority. As long as he has occupied the Speaker's chair he has been the leader for all Members of the House. This is the hallmark of a truly great Speaker.

As a result of efforts made in the 93d Congress, we begin our work today with a considerable chance to influence the direction of our troubled Nation. Our challenge will be to marshal that influence along responsible lines so that the truly formidable problems of the Nation can be solved, and solved properly and promptly. The American people have indicated they expect the Congress to take decisive action toward meeting the problems of both inflation and recession. The decisions which we will face in this historic Chamber are going to be tough decisions. Solving our economic problems will require that we make a realistic assessment of where our Government can and should act, and where our great free enterprise system should be left to regain its own momentum without either planning or interference by anyone. It is also going to require that we exercise, on both sides of the aisle, the type of courage that will enable us to resist the temptation to make political advantage in the interest of getting things done.

I would like to take this opportunity to welcome back the many distinguished colleagues with whom it has been my pleasure to serve over the years. I would also like to extend a greeting to all those who are now beginning their first term in the House. To them, I suggest that the job is not an easy one. It has been said that sitting in Congress is the privilege of the few—sitting on Congress is the prerogative of the many.

But I welcome all of you, and I can assure you that, as one who has served in this House for many years, there is no experience that is more rewarding and more wonderful to attain in one's life than this today, when for the first time you become a Member of what I consider to be the greatest deliberative body ever founded on this Earth.

In a Republic the majority rules while the minority tries to show the majority how things really should be done. I can assure you that as minority leader I will speak out as forcefully as I know how whenever I feel that the majority has adopted a direction or a decision that is not well advised. I can also assure you that my Republican colleagues will have many suggestions to make during the 94th Congress. That is how it should be, that is how it has always been, and I hope that it will always be that way.

But I am also determined to work toward the consensus approach to our Nation's problems which I feel is necessary in order for the 94th Congress to take the action that the Nation requires. The House of Representatives, being closest to the people, has an obligation, in my judgment, to be the most responsive body in Government. The people want us to act. They expect us to avoid the stalemate which many have predicted will occur. We can only fulfill their expectations and hopes if we work together, not as Democrats, not as Republicans, but as Americans elected by our peers to be Members of the House of Representatives.

Mr. Speaker, this is a time that calls for good judgment and great care in the kind of legislation we enact. It is a time that requires cooperation between the branches of Government. It is a time for the majority and the minority in this House to join together on the big issues in order to enhance the Nation's economic and political health.

It is my opinion that our chances for success in this endeavor have been substantially advanced as a result of the election this day of you, sir, to be Speaker of the House of Representatives. You have been a Speaker of great honesty and fairness, a champion of the rights and privileges of our membership, and all the Members, and the traditions of this great body. It is with profound honor that I introduce to you, my colleagues of the 94th Congress, a fine American, a dedicated lawmaker, and a distinguished son of the State of Oklahoma, and my friend—past, present, and future—the Speaker of the House of Representatives, the Honorable CARL ALBERT. [Applause, the Members rising.]

Mr. ALBERT. I thank the distinguished gentleman from Arizona (Mr. RHODES) for his kind words. I appreciate what he has so generously said. I accept his congratulations with humility.

My colleagues of the Congress, I come before you not only with a feeling of deep humility, but with a feeling of determination which I have not known or felt before during my years in the Congress. I am humble, because I have been given the honor of picking up, for the third time, the gavel of the House of Representatives in this chamber which, as the gentleman from Arizona (Mr. RHODES) has rightly said, houses the greatest deliberative assembly in all the world.

I am grateful from the bottom of my heart for the honor which my colleagues have bestowed upon me. Many are worthy of this position, just as all of you are worthy of seats in the House of Representatives. Yet, although many of our constituents are desirous of seats in the House of Representatives, it is you, my colleagues, who are in the extraordinary position of being among the relatively few who have been so chosen during the long history of this republic.

I am proud of this House as an institution. I am proud of the record that has been made here by men and women whose lives have left an imprint upon that great phenomenon which we call the history of the United States. Serving in a constant line of membership, from the day the Congress was first elected in 1789, have been men whose influence on our history was attributable to the service they rendered their country in the House of Representatives.

Few Members of this House, during its long and historic span, have held the gavel as Speaker, an honor, and an opportunity for public service solely within the gift of the Members of each Congress as they assemble, freshly chosen every 2 years by the American people. This office is unique in its constitutional roots, and, in my judgment, exceeded in its importance by no other office in the world.

I give you my pledge that I will serve all the Members of the House with an open mind, fairly, and frankly, in the spirit of candor, and irrespecitve of party affiliation. I interpret the duties of the Speaker not only to help advance the progress of the majority party, but also to protect and respect the individual rights of every Member and the rights, under the rules and precedents of the House, of the minority.

To the distinguished minority leader, JOHN RHODES do I especially give my peldge. JOHN said he ran for the office of Speaker; Jerry Ford who also ran for it several times said that all he ever wanted to do in life was to be Speaker, and I think he told the truth. I always beat him, but he leapfrogged the office, and look what he got into.

I congratulate all of my colleagues in this Congress on your election. Have you ever stopped to realize that you are the choice of 213 million Americans? Have you ever stopped to think that you hold the only Federal positions in the United States which may be acquired solely by exercise of the suffrage and in no other manner? This is the place where no one has ever been a Member who was not elected by his peers. We are truly the Representatives of the people.

I welcome the new Members. We have a lot of them this year. I know most of them and I am impressed with them. They come, as I am sure most of us have come, determined that in their time and in their generation they will do their part to fulfill the responsibilities of this body. I recommend to you that you learn the rules of the House of Representatives and that you learn to know the Members of the House of Representatives. Look to the right or look to the left from where you are sitting or standing; until you come to know each other, you cannot have any comprehension of how many of your colleagues have extraordinary talents, extraordinary integrity, and extraordinary devotion to duty. My experience has been that the competence of the men and women here in the House of Representatives has more strongly impressed me than that of any I have encountered elsewhere in my private, public, or school life.

Our solemn task is to legislate for the American people, the people who elected us, and to pass laws, as those old and familiar words went that we learned in childhood, to provide for the common defense, establish justice, promote the general welfare, insure domestic tranquillity, and secure the blessings of liberty to ourselves and our posterity. These are the hallowed words of the American Constitution which we swear, you and I, to uphold. Remember this as long as you are here, and I am sure that you will: These resounding words of our Constitution call us to the performance of our duties. As guides to what we do here, we need no other, because there are no better.

Our people demand of us that we legislate well, that we legislate with dispatch, meeting four-square the complex and varied miseries that afflict our country. Legislate we shall, because legislate we must; the country is looking to us for the measures now so desperately needed.

We shall act in accordance with the clear and direct language of the Constitution's article 1, section 1:

All legislative powers herein granted shall be vested in a Congress of the United States.

Last month, just before we adjourned after a very long, difficult, and trying year, I appointed a task force to draft an economic recovery program based on a polling of Members, and the help and concurrence of committee chairmen, a program on which we could act quickly. Yesterday we announced the details of that program. The task force report is the most comprehensive statement ever made at the beginning of a new Congress on behalf of the majority party in the House of Representatives. It reinforces our commitment to act immediately to counter our Nation's acute and growing economic problems. The short-term program is aimed directly at the immediate problems facing America today: Rising joblessness, with good people, trained people without work—jobless Americans whose numbers are increasing day by day; eroded consumer purchasing power; the imperative need for some form of energy conservation and the development of new energy supplies, looking toward our independence, at the earliest possible time, from ransom payments for foreign oil. This last problem is no easy one; it is not one for which there can be an overnight solution.

Sooner than the expiration of the 90-day period, before the end of March, I ask the Committee on Ways and Means to report, the Committee on Rules to give a rule, and the House to pass tax relief legislation for millions of low- and middle-income Americans.

I welcome the President's new position that he will now support a tax cut, thus enhancing the chances and likelihood of getting quicker action in this most important area.

The House must act to reverse the devastating upward trend of interest rates, to infuse new life into the Nation's homebuilding industry, to stimulate agricultural production, to develop a comprehensive program of energy conservation, to formulate a workable system for monitoring price increases, and to halt the alarming surge of unemployment, by putting our working people back to work, where they ought to be and where they belong.

Unemployment is causing havoc in our country's economy and anguish among our Nation's citizens. More important, those without jobs cannot provide themselves and their families with the necessities of life. Those with low incomes during this unbearable and unprecedented inflation cannot pay their grocery, rent, and utility bills. Medical costs cannot be met by most Americans without a system of national health insurance. I have assured the chairman of the appropriate committee that a national health insurance bill should be among the first bills considered.

Our country wants us to act. Our country wants us to act quickly; our country wants us to act effectively. Quick and effective action is absolutely necessary in an era beset by the combined scourges of inflation, recession, and energy shortages.

These are not partisan issues, they are national afflictions that require action now, by us. If we are to fulfill our purpose, which is to legislate effectively, the majority and minority must unite whenever and wherever we can, and always in the public interest. This is an American battle; not a Democratic battle, not a Republican battle, not a congressional battle, not an administration battle. We earnestly seek a close and harmonious working relationship with the executive branch. We ask its advice; we solicit its recommendations; we want its cooperation. We must work together for our country, because our country deserves the best of all of us.

I pledge from the bottom of my heart that I will work to the very limits of the ability the Good Lord has given me, that I will be as helpful as I know how, as we strive in this session of the Congress to return the American people to a state of high employment and economic growth. Without that national strength we cannot be free, and without freedom we cannot be the kind of Americans we know ourselves to be.

[Applause, the Members rising.]

I am now ready to take the oath of office.

I ask the dean of the House of Representatives, the Honorable WRIGHT PATMAN of Texas, to administer the oath of office.

Mr. PATMAN then administered the oath of office to Mr. ALBERT, of Oklahoma.

SWEARING IN OF MEMBERS

The SPEAKER. According to the precedent, the Chair will swear in all Members of the House at this time.

If the Members will rise, the Chair will now administer the oath of office.

The Members-elect and Delegates-elect and the Resident Commissioner-elect, rose and the Speaker administered the oath of office to them.

The SPEAKER. The gentlemen and gentlewomen are now Members of Congress.

The Chair recognizes the gentleman from California (Mr. PHILLIP BURTON).

MAJORITY LEADER

Mr. PHILLIP BURTON. Mr. Speaker, as chairman of the Democratic Caucus, I have been directed to report to the House that the Democratic Members have selected as majority leader the gentleman from Massachusetts, the Honorable THOMAS P. O'NEILL, JR.

The SPEAKER. The Chair now recognizes the gentleman from Illinois (Mr. ANDERSON).

MINORITY LEADER AND MINORITY WHIP

Mr. ANDERSON of Illinois. Mr. Speaker, as chairman of the Republican conference, I am directed by that conference to officially notify the House that the gentleman from Arizona, the Honorable JOHN J. RHODES, has been selected as the minority leader of the House; and that effective January 1, 1975, the gentleman from Illinois, the Honorable ROBERT H. MICHEL, has succeeded to the office of minority whip.

ELECTION OF CLERK OF THE HOUSE, SERGEANT AT ARMS, DOORKEEPER, POSTMASTER, AND CHAPLAIN

Mr. PHILLIP BURTON. Mr. Speaker, I offer a resolution (H. Res. 1) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 1

Resolved, That W. Pat Jennings, of the Commonwealth of Virginia, be, and he is hereby, chosen Clerk of the House of Representatives;

That Kenneth R. Harding, of the Commonwealth of Virginia, be, and he is hereby, chosen Sergeant at Arms of the House of Representatives;

That James T. Molloy, of the State of New York, be, and he is hereby, chosen Doorkeeper of the House of Representatives;

That Robert V. Rota, of the Commonwealth of Pennsylvania, be, and he is hereby, chosen Postmaster of the House of Representatives;

That Rev. Edward G. Latch, D.D., of the State of Maryland, be, and he is hereby, chosen Chaplain of the House of Representatives.

Mr. ANDERSON of Illinois. Mr. Speaker, I shall offer a substitute for the resolution just offered by the gentleman from California, but before doing so, request that there be a division of the question on the resolution so that we may have a separate vote on the office of the Chaplain.

The SPEAKER. The question is on agreeing to the portion of the resolution providing for the election of the Chaplain.

That portion of the resolution was agreed to.

SUBSTITUTE AMENDMENT OFFERED BY MR. ANDERSON OF ILLINOIS

Mr. ANDERSON of Illinois. Mr. Speaker, I offer a substitute amendment for the remainder of the resolution.

The Clerk read the substitute amendment, as follows:

AMENDMENT OFFERED BY MR. ANDERSON OF ILLINOIS AS A SUBSTITUTE FOR THE REMAINDER OF H. RES. 1

H. RES. 1

Resolved, That Joe Bartlett, of the State of Ohio, be, and he is hereby, chosen Clerk of the House of Representatives;

That Walter P. Kennedy, of the State of New Jersey, be, and he is hereby, chosen Sergeant at Arms of the House of Representatives;

That William R. Bonsell, of the Commonwealth of Pennsylvania, be, and he is hereby, chosen Doorkeeper of the House of Representatives;

That Tommy Lee Winebrenner, of the State of Indiana, be, and he is hereby, chosen Postmaster of the House of Representatives.

The SPEAKER. The question is on the substitute amendment offered by the gentleman from Illinois (Mr. ANDERSON).

The substitute amendment was rejected.

The SPEAKER. The question is on the resolution offered by the gentleman from California (Mr. PHILLIP BURTON).

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER. Will the officers elected present themselves in the well of the House?

The officers-elect presented themselves at the bar of the House and took the oath of office.

NOTIFICATION TO SENATE OF ORGANIZATION OF THE HOUSE

Mr. O'NEILL. Mr. Speaker, I offer a resolution H. Res. 2 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 2

Resolved, That a message be sent to the Senate to inform that body that a quorum of the House of Representatives has assembled; that CARL ALBERT, a Representative from the State of Oklahoma, has been elected Speaker; and W. Pat Jennings, a citizen of the Commonwealth of Virginia, Clerk of the House of Representatives of the Ninety-fourth Congress.

The resolution was agreed to.

A motion to reconsider was laid on the table.

COMMITTEE TO NOTIFY THE PRESIDENT OF THE UNITED STATES OF THE ASSEMBLY OF THE CONGRESS

Mr. O'NEILL. Mr. Speaker, I offer a resolution (H. Res. 3) and ask for its immediate consideration.

The Clerk read the resolution as follows:

H. RES. 3

Resolved, That a committee of two Members be appointed by the Speaker on the part of the House of Representatives to join with a committee on the part of the Senate to notify the President of the United States that a quorum of each House has been assembled, and that Congress is ready to receive any communication that he may be pleased to make.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER. The Chair appoints as members of the committee on the part of the House to join the committee on the part of the Senate to notify the President of the United States that a quorum of each House has been assembled, and that Congress is ready to receive any communication that he may be pleased to make, the gentleman from Massachusetts (Mr. O'NEILL) and the gentleman from Arizona (Mr. RHODES).

AUTHORIZING THE CLERK TO INFORM THE PRESIDENT OF THE ELECTION OF THE SPEAKER AND THE CLERK OF THE HOUSE OF REPRESENTATIVES

Mr. MAHON. Mr. Speaker, I offer a resolution (H. Res. 4) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 4

Resolved, That the Clerk be instructed to inform the President of the United States that the House of Representatives has elected Carl Albert, a Representative from the State of Oklahoma, Speaker; and W. Pat Jennings, a citizen of the Commonwealth of Virginia, Clerk of the House of Representatives of the Ninety-fourth Congress.

The resolution was agreed to.

A motion to reconsider was laid on the table.

RULES OF THE HOUSE

Mr. O'NEILL. Mr. Speaker, I offer a resolution (H. Res. 5) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 5

Resolved, That the Rules of the House of Representatives of the Ninety-third Congress, together with all applicable provisions of the Legislative Reorganization Act of 1946, as amended, the Legislative Reorganization Act of 1970, as amended, and the Congressional Budget and Impoundment Control Act of 1974, be, and they are hereby adopted as the Rules of the House of Representatives of the Ninety-fourth Congress, with the following amendments as part thereof, to wit:

(1) In Rule I, add the following new clause at the end thereof:

"8. He shall have the authority to designate any Member, officer or employee of the House of Representatives to travel on the business of the House of Representatives, as determined by him, within or without the United States, whether the House is meeting, has recessed or has adjourned, and all expenses for such travel may be paid for from the contingent fund of the House on vouchers solely approved and signed by the Speaker."

(2) In Rule VIII, the first sentence of clause 2 is amended by inserting "by the House or Committee of the Whole" immediately after the first comma.

(3) In Rule X, the first sentence of clause 1 (e) (1) is amended:

(1) by striking out "twenty-three" in the matter preceding subdivision (A) and inserting in lieu thereof "twenty-five"; and

(2) by striking out "eleven" in subdivision (C) and inserting in lieu thereof "thirteen".

(4) In Rule X, clause 1(f) is amended by striking out "Committee on Commerce and Health" and inserting in lieu thereof "Committee on Interstate and Foreign Commerce", by redesignating clause 1(f) as clause 1(l) and by redesignating all subclauses following 1(e) accordingly.

(5) In Rule X, clause 1(k) is amended by adding at the end thereof the following new subclauses:

"14. Measures relating to the raising, reporting and use of campaign contributions for candidates for office of Representative in the House of Representatives and of Resident Commissioner to the United States from Puerto Rico."

"15. Measures relating to the compensation, retirement and other benefits of the Members, officers, and employees of the Congress."

(6) In Rule X, clause 1 is amended:

(1) by striking out paragraph (m), by redesignating paragraphs (n) through (w) as paragraphs (m) through (v), respectively, by striking out the provisions "Except as provided in clause 1(q)(4)" as they appear in clauses 1(k)(4) and (5) of Rule X and inserting "Except as provided in clause 1(p)(4)"; and

(2) by adding at the end of paragraph (m), as so redesignated by this section, the following:

"(19) Communist and other subversive activities affecting the internal security of the United States."

All property and records of the Committee on Internal Security are hereby transferred to the Committee on the Judiciary and shall be available for use by the latter committee to the same extent as if such property and records were originally that of the Committee on the Judiciary.

Such staff members of the Committee on Internal Security as the chairman of that committee for the 93rd Congress may designate after consultation and agreement with the chairman of the Committee on the Judiciary shall, without reduction in compensation, be transferred and appointed to the Committee on the Judiciary as additional members of the staff of the Committee on the Judiciary for the period of the 94th Congress, and shall be paid from the contingent fund of the House."

(7) In Rule X, the last sentence of clause 1(t), relating to the jurisdiction of the Committee on Small Business, is amended to read as follows:

"In addition to its legislative jurisdiction under the preceding provisions of this paragraph (and its general oversight function under clause 2(b)(1)), the committee shall have the special oversight function provided for in clause 3(g) with respect to the problems of small business."

(8) In Rule X, relating to the jurisdiction of the Committee on Standards of Official Conduct, strike out clause 1(u)(4).

(9) In Rule X, the fourth sentence of clause 2 is amended to read as follows:

"Each such committee having more than twenty members shall establish an oversight subcommittee, or require its subcommittees, if any, to conduct oversight in the arena of their respective jurisdiction, to assist in carrying out its responsibilities under this subparagraph."

(10) In Rule X, clause 4(a)(1)(C) is amended to read as follows:

"(C) Hearings pursuant to subdivision (A), or any part thereof, shall be held in open session, except when the committee, in open session and with a quorum present, determines by rollcall vote that the testimony to be taken at that hearing on that day may be related to a matter of national security: Provided, however, that the committee may by the same procedure close one subsequent day of hearing. A transcript of all such hearings shall be printed and a copy thereof furnished to each Member, Delegate, and the Resident Commissioner from Puerto Rico."

(11) In Rule X, clause 4(i) is amended to read as follows:

"Each standing committee of the House which is directed in a concurrent resolution on the budget to determine and recommend changes in laws, bills, or resolutions under the reconciliation process shall promptly make such determinations and recommendations, and report a reconciliation bill or resolution (or both) to the House or submit such recommendations to the Committee on the Budget, in accordance with the Congressional Budget Act of 1974."

(12) In Rule X, clause 6(c) is amended to read as follows:

"Each standing Committee of the House of

Representatives, except the Committee on the Budget, that has more than twenty members shall establish at least four subcommittees."

(13) In Rule X, strike out clause 6(g) and redesignate clause 6(h) as 6(g).

(14) In Rule XI, clause 2(a)(1) is amended to read as follows:

"(1) shall be adopted in a meeting which is open to the public unless the committee, in open session and with a quorum present, determines by rollcall vote that all or part of the meeting on that day is to be closed to the public."

(15) In Rule XI, clause 2(e) is amended to read as follows:

"Each committee shall keep a complete record of all committee action which shall include a record of the votes on any question on which a rollcall vote is demanded. The result of each such rollcall vote shall be made available by the committee for inspection by the public at reasonable times in the offices of the committee. Information so available for public inspection shall include a description of the amendment, motion, order or other proposition and the name of each Member voting for and each Member voting against such amendment, motion, order, or proposition, and whether by proxy or in person, and the names of those Members present but not voting."

(16) In Rule XI, clause 2(f) is amended by inserting before the period the following: "unless such committee, by written rule adopted by the committee, permits voting by proxy and requires that the proxy authorization shall be in writing, shall assert that the Member is absent on official business or is otherwise unable to be present at the meeting of the committee, shall designate the person who is to execute the proxy authorization, and shall be limited to a specific measure or matter and any amendments or motions pertaining thereto; except that a member may authorize a general proxy only for motions to recess, adjourn or other procedural matters. Each proxy to be effective shall be signed by the member assigning his or her vote and shall contain the date and time of day that the proxy is signed. Proxies may not be counted for a quorum.

(17) In Rule XI, clause I, clause 2(g) is amended to read as follows:

"(1) Each meeting for the transaction of business, including the markup of legislation, of each standing committee or subcommittee thereof shall be open to the public except when the committee or subcommittee, in open session and with a quorum present, determines by rollcall vote that all or part of the remainder of the meeting on that day shall be closed to the public: *Provided, however,* that no person other than members of the committee and such congressional staff and such departmental representatives as they may authorize shall be present at any business or markup session which has been closed to the public. This paragraph does not apply to open committee hearings which are provided for by clause 4(a)(3) of Rule X or by subparagraph (2) of this paragraph, or to any meeting that relates solely to internal budget or personnel matters.

(2) Each hearing conducted by each committee or subcommittee thereof shall be open to the public except when the committee or subcommittee, in open session and with a quorum present, determines by rollcall vote that all or part of the remainder of that hearing on that day shall be closed to the public because disclosure of testimony, evidence, or other matters to be considered would endanger the national security or would violate any law or rule of the House of Representatives: Provided, however, that the committee or subcommittee may by the same procedure vote to close one subsequent day of hearing.

(3) Each committee of the House, (except the Committee on Rules) shall make public announcement of the date, place and subject matter of any committee hearing at least one week before the commencement of the hearing. If the committee determines that there is good cause to begin the hearing sooner, it shall make the announcement at the earliest possible date. Any announcement made under this subparagraph shall be promptly published in the Daily Digest.

(4) Each committee shall, insofar as is practicable, require each witness who is to appear before it to file with the committee (in advance of his or her appearance) a written statement of the proposed testimony and to limit the oral presentation at such appearance to a brief summary of his or her argument.

(5) No point of order shall lie with respect to any measure reported by any committee on the ground that hearings on such measure were not conducted in accordance with the provisions of this clause; except that a point of order on that ground may be made by any member of the committee which reported the measure if, in the committee, such point of order was (A) timely made and (B) improperly overruled or not properly considered.

(6) The preceding provisions of this paragraph do not apply to the committee hearings which are provided for by clause 4(a)(1) of Rule X."

(18) In Rule XI, the first sentence of clause 2(1)(6) is amended to read as follows:

"A measure or matter reported by any committee (except the Committee on Rules in the case of a resolution making in order the consideration of a bill, resolution, or other order of business), shall not be considered in the House until the third calendar day (or the tenth calendar day in the case of a concurrent resolution on the budget), excluding Saturdays, Sundays, and legal holidays following the day on which the report of that committee upon that measure or matter has been available to the Members of the House."

(19) In Rule XI, clause 2(m)(2)(A) is amended to read as follows:

"A subpena may be issued by a committee or subcommittee under subparagraph (1)(B) in the conduct of any investigation or activity or series of investigations or activities, only when authorized by a majority of the members of the committee, and authorized subpenas shall be signed by the chairman of the committee or by any member designated by the committee."

(20) In Rule XI, clause 4(a) is amended to read as follows:

"The following committee shall have leave to report at any time on the matters herein stated, namely: The Committee on Appropriations—on general appropriation bills; the Committee on the Budget—on the matters required to be reported by such committee under Titles III and IV of the Congressional Budget Act of 1974; the Committee on House Administration—on enrolled bills, contested elections, and all matters referred to it of printing for the use of the House or the two Houses, and on all matters of expenditure of the contingent fund of the House; the Committee on Rules—on rules, joint rules, and the order of business; and the Committee on Standards of Official Conduct—on resolutions recommending action by the House of Representatives with respect to an individual Member, officer, or employee of the House of Representatives."

(21) In Rule XI, clause 5 is amended by striking out paragraph (d) and inserting in lieu thereof the following:

"(d) From the funds provided for the appointment of committee staff pursuant to primary and additional expense resolution—

(1) The chairman of each standing subcommittee of a standing committee of the House is authorized to appoint one staff member who shall serve at the pleasure of the subcommittee chairman.

(2) The ranking minority party member of each standing subcommittee on each standing committee of the House is authorized to appoint one staff person who shall serve at the pleasure of the ranking minority party member.

(3) The staff members appointed pursuant to the provisions of subparagraphs (1) and (2) shall be compensated at a rate determined by the subcommittee chairman not to exceed (A) 75 per centum of the maximum established in paragraph (c) of clause 6 or (B) the rate paid the staff member appointed pursuant to subparagraph (1) of this paragraph.

(4) For the purpose of this paragraph, (A) there shall be no more than six standing committees of each standing committee of the House, except for the Committee on Appropriations, and (B) no member shall appoint more than one person pursuant to the above provisions.

"(5) The staff positions made available to the subcommittee chairman and ranking minority party members pursuant to subparagraphs (1) and (2) of this paragraph shall be made available from the staff positions provided under clause 6 of Rule XI unless such staff positions are made available pursuant to a primary or additional expense resolution."

(22) In Rule XI, clause 6(a)(5) is amended to read as follows:

"The foregoing provisions of this paragraph do not apply to the Committee on Appropriations and to the Committee on the Budget."

(23) In Rule XI, clause 6(b)(4) is amended to read as follows:

"The foregoing provisions of this paragraph do not apply to the Committee on Appropriations and to the Committee on the Budget."

(24) In Rule XI, clause 6(d) is amended to read as follows:

"Subject to appropriations hereby authorized, the Committee on Appropriations and the Committee on the Budget may appoint such staff, in addition to the clerk thereof and assistants for the minority, as it determined by majority vote to be necessary, such personnel, other than minority assistants, to possess such qualifications as the committee may prescribe."

(25) In Rule XX, clause 3 is amended to read as follows:

"A report from the Committee on Appropriations accompanying any general appropriation bill making an appropriation for any purpose shall contain a concise statement describing fully the effect of any provision of the accompanying bill which directly or indirectly changes the application of existing law."

(26) In Rule XXVIII, add the following new clause:

"6. Open Conference Meetings

"Each conference committee meeting between the House and Senate shall be open to the public except when the managers of either the House or Senate, in open session, determine by a rollcall vote of a majority of those managers present, that all or part of the remainder of the meeting on the day of the vote shall be closed to the public: Provided that this provision shall not become effective until a similar rule is adopted by the Senate."

(27) In Rule XLIII, paragraph 6 is amended to read as follows:

"A Member of the House of Representatives shall keep his campaign funds separate from his personal funds. Unless specifically provided by law, he shall convert no campaign funds to personal use in excess of reimbursement for legitimate and verifiable prior campaign expenditures and he shall expend no funds from his campaign account not attributable to bona fide campaign purposes."

(28) In Rule XLIII, insert immediately after paragraph 8 the following new paragraph.

"9. A Member, officer or employee of the House of Representatives shall not discharge or refuse to hire any individual, or otherwise discriminate against any individual with respect to compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin."

Mr. O'NEILL (during the reading). Mr. Speaker, I ask unanimous consent that further reading of the resolution containing the amendments as they are printed be dispensed with.

The SPEAKER. Is there objection to the gentleman from Massachusetts

Mr. BAUMAN. Mr. Speaker, reserving the right to object, I wonder if the gentleman from Massachusetts can tell us whether or not, in his usual gracious and magnanimous manner, he might allow or at least give us some assurances that the minority will have time to discuss the numerous rule changes that are embodied in this pending resolution.

Mr. O'NEILL. Mr. Speaker, if the gentleman will yield, I have not had any requests for time, but the gentleman can be assured that we will give all the Members sufficient time. I will yield for the purposes of debate only.

Mr. BAUMAN. Mr. Speaker, further reserving the right to object, I will be glad to make a request on behalf of the gentleman from Tennessee (Mr. QUILLEN), or I may suggest that he make his own request that the minority may have 30 minutes. Will the gentleman agree to that?

Mr. O'NEILL. Mr. Speaker, I will yield only for the purposes of debate, but I will yield as much time as the other side may wish to have.

Mr. BAUMAN. Mr. Speaker, further reserving the right to object, will the gentleman yield 30 minutes to the gentleman from Tennessee in order to protect the minority?

Mr. O'NEILL. Mr. Speaker, that might be considered if that is the way they desire it to be and if it is within the rules.

The answer is: No. I would prefer to yield to Members as they ask me to yield.

Mr. BAUMAN. Then the gentleman will not yield time, a definite amount of time to the minority?

Mr. O'NEILL. No.

Mr. BAUMAN. Then I shall object.

The SPEAKER. Is there objection to the request of the gentleman from Massachusetts?

Mr. BAUMAN. Mr. Speaker, I object.

The SPEAKER. Objection is heard.

The Clerk will proceed with the reading of the resolution.

CALL OF THE HOUSE

Mr. SYMMS. Mr. Speaker, I object to the proceedings on the ground that a quorum is not present, and I make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

Mr. O'NEILL. Mr. Speaker, I move a call of the House.

A call of the House was ordered.

The call was taken by electronic device, and the following Members failed to respond:

[Roll No. 3]

Archer	Harkin	Mollohan
Beard, R.I.	Harsha	Nix
Byron	Hastings	Oberstar
Carney	Hughes	Patman
Cederberg	Jeffords	Pike
Collins, Tex.	Jenrette	Pressler
Diggs	Kemp	Sarbanes
Erlenborn	Landrum	Stephens
Evans, Colo.	McHugh	Stuckey
Fisher	Madigan	Udall
Gaydos	Michel	Young, Alaska
Goldwater	Minish	

The SPEAKER. On this rollcall 396 Members have recorded their presence by electronic device, a quorum.

By unanimous consent, further proceedings under the call were dispensed with.

RULES OF THE HOUSE

The SPEAKER. The Chair recognizes the gentleman from Massachusetts (Mr. O'NEILL).

Mr. O'NEILL (during the reading). Mr. Speaker, I ask unanimous consent that further reading of the resolution be dispensed with.

It is my understanding that copies of the resolution are available and on the floor. I appreciate the fact that while we are operating at the present time under the general parliamentary rules, because the resolution which would take effect is the rules for the 94th Congress, I had been asked earlier if I would yield to the gentleman for half an hour. I did not know at that time if yielding for half an hour meant that I yielded for all purposes. After consultation, it is my understanding that I may yield to any Member at any time, yielding for the purpose of debate only, and if any gentleman on the other side of the aisle wants time from me, I would be happy to yield and yield for purposes of debate only.

The SPEAKER. Is there objection to the request of the gentleman from Massachusetts?

Mr. BAUMAN. Mr. Speaker, reserving the right to object, I yield to the gentleman from Tennessee (Mr. QUILLEN).

Mr. QUILLEN. Mr. Speaker, I wonder if the distinguished majority leader would yield to me, and let me yield the time to Members on this side of the aisle?

Mr. O'NEILL. I will yield to the gentleman as much time as the gentleman desires up to 30 minutes. It is my understanding that it is his understanding that it is for the purposes of debate only.

Mr. QUILLEN. For the purposes of debate only.

Mr. O'NEILL. Technically, the gentleman would have to be on his feet, but I would not call a thing like that on him.

Mr. QUILLEN. I appreciate that.

Mr. BAUMAN. Mr. Speaker, I want to thank the distinguished gentleman from Massachusetts for his courtesy. I withdraw my reservation of objection.

The SPEAKER. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

The SPEAKER. The gentleman from Massachusetts (Mr. O'NEILL) is recognized for 1 hour.

Mr. O'NEILL. Mr. Speaker, this resolution, of course, is the resolution of the Rules of the House of the 94th Congress. There are many amendments that are technical and which conform with House Resolution 988, the committee reform bill of last year. Most of the changes, of course, are votes that have been taken in the Democratic caucus. The various changes along the line are as follows:

No. 1 is an amendment which gives the Speaker the authority to permit travel on behalf of the House.

No. 2 permits pairing in the Committee of the Whole. As the Members know, we do have pairing in the House at the present time.

No. 3 increases the size of the Budget Committee by two. We have passed a resolution saying that the committees shall be 2-to-1 plus 1. This is above the party ratio in the House.

Amendment 4 changes back the name of the Committee on Commerce and Health, which we called the committee in the Hansen report, to the Committee on Interstate and Foreign Commerce, and redesignates the subclauses accordingly.

Amendment No. 5 places jurisdiction over campaign contributions back in the Committee on House Administration and give the Committee on House Administration jurisdiction with the Committee on Post Office and Civil Service over the Members' compensation and retirement and also over compensation of the officers and employees of the House.

Amendment No. 6 transfers jurisdiction from the Committee on Internal Security to the Committee on the Judiciary, with conforming changes. It transfers the files and the staff from the Committee on Internal Security to the Committee on the Judiciary.

Amendment No. 7 is a technical change relating to oversight responsibility of the Small Business Committee.

Amendment 8 transfers campaign contributions to the Committee on House Administration.

Amendment 9 changes the Hansen provisions requiring any committee having more than 15 members to establish an oversight subcommittee, to require such subcommittees in committees larger than 20 members.

No. 10 is the Fascell amendment concerning open committee hearings.

No. 11 is a technical change to reflect a printing error in the Hansen resolution in the last Congress. That is a technical change.

Amendment 12, the Hansen resolution required each committee having more than 15 members to have at least four subcommittees. It changes this requirement to committees larger than 20 members.

Amendment 13 is a technical change relating to a printing error in House Resolution 988, the Hansen report, in the last Congress.

Amendment 14 relates to the adoption of committee rules in open session, but permits a committee to close its meeting for that day by rollcall vote only.

No. 15 relates to proxy voting.

No. 16 permits proxies in committees under controlled conditions.

The 17th amendment is the Fascell amendment on open committee hearings, plus technical changes to reinsert material omitted from the Hansen resolution of the last Congress. Paragraphs 3 to 6 were inadvertently omitted last year in the printing.

Amendment 18 is a technical correction to correct a printing error in House Resolution 988 of the last Congress.

Amendment 19 is the same thing, and reinserts a clause that was inadvertently left out of House Resolution 988.

No. 20 is a technical correction to reinsert a phrase omitted in the Hansen bill.

No. 21 is a change in rule XI on staffing, the Brooks amendment in the caucus. It is my understanding that Mr. BROOKS and Mr. THOMPSON have discussed with the Members on the opposite side of the aisle this amendment change.

Numbers 22, 23 and 24 are all technical corrections to the Hansen resolution.

No. 25 is a technical correction relating to changes in existing law in general appropriation bills. It perfects the Dingell amendment adopted on the floor during consideration of H. Res. 988.

No. 26 is the Fascell amendment relating to open conference meetings.

No. 27 makes a minor change in the rule relating to the code of official conduct relating to the use of campaign funds.

No. 28 adds a nondiscrimination clause to the code of conduct rule.

This is a brief résumé of the resolutions. They are in the hands of the leadership on the other side.

Mr. Speaker, for the purpose of debate only I yield as much time as he desires to the gentleman from Tennessee (Mr. QUILLEN).

Mr. QUILLEN. Mr. Speaker, I thank the distinguished majority leader for yielding.

Mr. Speaker, I yield myself such time as I may consume.

The distinguished Speaker, a moment ago, when he spoke after being sworn in as Speaker of the 94th Congress, indicated we must legislate with all the power of this House. I would like to add that we must legislate, but not hastily, not to the point we overlook what we are about to do today in changing the rules of the House.

The Congress passed last October a massive reorganization act. In that measure, which was passed by the House overwhelmingly, the Committee on Internal Security of the House was to be retained as a standing committee of the House. Under the rules which have been proposed and ably explained by the distinguished majority leader, the Committee on Internal Security would go to the Committee on the Judiciary, and that is against the vote of the overwhelming majority of the House that it be retained, and it should be retained. In transferring internal security to the Committee on the Judiciary today this body does not have an opportunity for a separate vote yea or nay. Again this resolution is a closed rule. We will only have an opportunity to vote down the previous question, and then an opportunity to retain this great committee that has served admirably over the years as a standing committee of the House.

Second, the House in its reorganization vote did away with proxy voting. I think that we should do away with proxy voting. When the chairman of a committee can carry the proxies in his pocket and go to the meetings and vote all the proxies, this is not good government. I think the membership of that committee should be there in person and vote on this matter in person. But under the rule that has been proposed here today, a form of proxy voting would be allowed, in the committees of this Congress, when under the reorganization passed in October it was abolished.

I think we must legislate in the House, not with haste, but with deliberation, giving the matter every consideration.

There are other changes in the rules that I certainly support.

However, I do not think that we should act in haste. The minority party has had no input in the proposed rules.

Under the rules of the House, I think that this House today should adopt the rules of the last Congress, provide that they must go to the Committee on Rules for a period of 30 days, let the minority party have an input in the matter, allow the Committee on Rules to makes its deliberations, and then bring to the floor of the House a measure which we can all support, Republicans and Democrats alike.

So, Mr. Speaker, I think today that it would be well, when we get through with our debate, that we vote down the previous question so that we will have an opportunity to give more careful consideration to the proposed changes.

I think we ought to have careful consideration of proxy voting and the status of the Internal Security Committee. I think we should adopt the rules of the House from the previous Congress and let the Committee on Rules do its job and bring forth a measure for all Americans and for the people of this country, which the distinguished Speaker spoke about a moment ago.

Mr. Speaker, I yield 5 minutes to the distinguished minority leader, the gentleman from Arizona (Mr. RHODES).

Mr. RHODES. Mr. Speaker, I recognize the fact that it is one of the functions of the majority to promulgate the rules of the legislative body, and there is no doubt but what that authority exists. This is exactly where it should be. The majority has the responsibility of putting forth the legislative program, and as I have often said to my good friends on the majority side, the minority side acts as the faithful and trustworthy anvil upon which they may pound out their legislative program.

However, it would be, I think, very nice and it would facilitate the work of the House tremendously if, when there are to be significant changes in the rules, the minority could be notified prior to the time when we come to the floor of the House.

I recognize also the fact that we have not been back here too long, but nevertheless some of these rules, which are rather sweeping in nature and in their changes, certainly have been thought about. They were certainly not far from inception in the fertile brains of some of the Members of the majority, and it seems to me that perhaps the Members of the minority could and should have been apprised of their existence and of exactly what they would accomplish.

Also I cannot help but feel very strongly about the fact that the provision on proxy voting which we think is so important was sticken from the rules by action of the Democratic Caucus.

Mr. Speaker, I have been on committees in which proxy voting was allowed, and I have been on committees in which proxy voting was not allowed, and, believe me, the members of the committee upon which proxy voting was not allowed paid much more attention to what was going on and the attendance was much better in the committee sessions than it was in the committee sessions where the opposite was the case. I am not in favor of proxy voting except in very unusual circumstances.

It seems to me that it would have been well for the majority, if it indeed desired to make some change in the provision of proxy voting, changes in the Hansen proposal, to have adopted the old rules of the House, with a delegation of authority or of duty to the Committee on Rules to look over that particular part and to report back at some time in the future as to whether or not changes were to be desired.

I also happen to believe in open conferences between the House and the Senate, and I think many of us who have served on conference committees between the House and the Senate will know what I mean when I say that many times in those conferences I was in hopes that somebody other than a Member of either body could have been present to see how irresponsibly some of the Members act and the irresponsible positions which are taken on matters which are of some vital importance. I do not believe that those positions would be taken if indeed the conferences were open and the press could be there to report actions which are not in accordance with the best traditions and the best interests of the country.

Also I will vote in favor of this position, that is, I will actually not vote for the previous question because of the provision regarding the demise of the Committee on Internal Security.

If a standing committee of the House is to be killed, it seems to me that it should occur after a hearing in the Committee on Rules and after the Members who feel strongly one way or another have been heard on the matter. After that, the Committee on Rules could report out a provision either voting the committee up or voting it down and let the Members of the House take their stand on that question and that question alone. That was not done.

It is for these reasons, Mr. Speaker, that I find myself in the position of advocating and, yes, voting against the previous question so that we can offer

an amendment to accomplish these things which I have mentioned and to give the Committee on Rules a chance to bring forth a set of rules and regulations after due arbitration, after they have been able to take testimony, and after they have been able to think the matter completely through.

Mr. QUILLEN. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from Illinois (Mr. ANDERSON).

Mr. SCHULZE. Mr. Speaker, will the gentleman yield?

Mr. ANDERSON of Illinois. I yield to the gentleman from Pennsylvania (Mr. SCHULZE).

Mr. SCHULZE. Mr. Speaker, I thank the gentleman from Illinois for yielding.

On this first opportunity to address my colleagues as a Member of Congress, I regret that I am compelled to object to the procedure under which the rules of this great body have come before us for consideration. Copies of this resolution, establishing the procedures under which this people's body will be bound to operate during the next 2 years, have just been made available for examination. The changes to be enacted today are the result of a secret caucus held by the majority party and which none of us on the minority side have had an opportunity to scrutinize. I believe that our respective constituencies are tired of secrecy and subterfuge and that it is only proper that all Members have the opportunity to review the proposed resolution, to hold a free and open debate on its provisions, and to offer pertinent amendments to it.

We are operating under a closed situation today which prevents adequate debate and thwarts the democratic process. It is this very situation which I had hoped to avoid in the future by introducing an amendment to the Rules of the House of Representatives. My amendment would allow for open debate on, and amendment to, all legislation to come before the House except for those bills dealing with revenue. The text of my amendment reads as follows:

Clause 23 of the Rule XI of the Rules of the House of Representatives is amended by adding at the end thereof the following: "The Committee on Rules shall not report any resolution which provides for an order of business for consideration by the House of any public bill or resolution but which prohibits or otherwise limits the offering of any amendments thereto, except that, with respect to a resolution providing for an order of business for consideration by the House of any public bill or resolution raising, reducing, or otherwise affecting or pertaining to the revenues, the committee may authorize the offering of such number of amendments to such areas of subject matter of such public bill or resolution as the committee shall specify in the resolution which it reports."

There are several reasons which have been cited in the past to justify the use of the closed rule. The first of these is that careful committee consideration, scrutiny, and revision has been given to the bill which generally has been reported with the concurrence of most of the members of a committee. Needless to say, the House of Representatives does legislate substantially through its committees. It is impossible for each Member to become an "instant expert" in every subject, and our committee structure allows for the development by each Member of an expertise in those areas under the jurisdiction of his committee. This does not preclude, however, a Member having substantial background and knowledge of subjects outside the purview of his committee. To prohibit a Member from offering an amendment and bringing up for debate any pertinent matter, simply because he is not a member of the appropriate committee, is to muzzle the majority of those serving in the House of Representatives on both sides of the aisle on any bill subjected to the closed rule. To those who argue that the closed rule prevents the introduction of "frivolous" amendments, I would simply respond that I have a great deal of confidence in the judgment of my colleagues. I do not believe that my colleagues here today would take their responsibilities so lightly. In addition, any amendment may be put to the test by calling for the "yeas" and "nays."

The second justification commonly given for use of the closed rule is that possibility of a national emergency requires a procedure under which bills can be expedited. We saw the enactment of several such "emergency" laws during the depression, a time of economic crisis in the days of the New Deal, and I believe that we are still suffering the effects of these hastily enacted proposals. Would it not be far better to apply ourselves at such a critical time to a free and full scrutiny and discussion of every aspect of a given bill? Only by subjecting legislation to the test of open and thorough debate are we assured of enacting sound law. Certainly, emergency situations call for prompt and decisive action, but this does not preempt thoughtful and painstaking consideration.

Another reason frequently given for use of the closed rule is that revenue bills, because of their integrated and technical nature, cannot be written on the House floor. In the words of the late Everett Dirksen:

Members of the House, we have brought you an integrated bill. If you are going to kick it around, it will be like taking the mainspring out of a watch. It will not work.

In his book, "The House Rules Committee," (1963), James A. Robinson reported that closed rules "are preserved for revenue measures and occasional other complex bills." You will note upon examination that my amendment, the one I had planned to introduce today, does exempt resolutions "raising, reducing, or otherwise affecting or pertaining to the revenues."

It is also noteworthy, in discussing this procedure as it applies to our situation today, that no use of the closed rule has been found for consideration of matters pertaining to congressional reorganization. During the last Congress, exhaustive debate and amendment was permitted in connection with the committee reform amendments. At a time when a national constituency for congressional reform is materializing, when congressional reform is the subject of so much discussion, it is ironic that the membership of this representative body allows for this high-handed and arrogant procedure in the adoption of its rules. Now is the time for open and public debate to be made a part of the RECORD.

It is also interesting that although the majority party adopted reforms at the outset of the 93d Congress in relation to the closed rule as contained in the Preamble and Rules of the Democratic Caucus, that in May of last year, when the Democratic Caucus voted to permit a modified closed rule on a major bill coming out of Ways and Means, a schism developed in the majority ranks. The first time this reform was put to the test, a number of the Democratic Caucus announced that they would not comply. Would it not be better to bring this subject of the closed rule up for discussion by all Members of the House of Representatives, regardless of party affiliation, and out from behind closed doors for free and public debate?

I suggest that there is time for consideration and reform of the Rules of the House of Representatives in a proper and democratic manner. To subject ourselves to this ridiculous time limit and "gag" rule on the crucial question as to how we are going to conduct the business of this House as the people's representatives over the next 2 years is shortsighted and irresponsible.

Mr. ANDERSON of Illinois. Mr. Speaker, I urge defeat of the previous question on this Democratic Caucus rules resolution so that we might offer instead a resolution readopting the rules of the previous Congress and instructing the Rules Committee to report back additional rules recommendations within 30 days under an open rule. I think it is high time we expose this absurd biennial rules exercise for the constitutional and legislative travesty it represents. This is a one-party, 1-hour, no-amendment resolution and furthermore, it is a double-backtrack on reforms adopted in this body just last October. I am referring, of course, to the proxy vote ban and providing the minority with one-third of investigative staff funds.

Mr. Speaker, until this House adopts its new rules, we are operating under what is called, "general parliamentary law." And, as the annotated Constitution in the front of our rules manual points out—

The general parliamentary law as understood in the House is founded on Jefferson's Manual.

Jefferson prefaces his manual with a statement on the importance of parliamentary rules, and I quote:

As it is always in the power of the majority, by their numbers to stop any improper measures proposed on the part of their opponents, the only weapons by which the minority can defend themselves against similar attempts from those in power are the forms and rules of proceeding . . . by a strict adherence to which the weaker party can only be protected from those irregulari-

ties and abuses which these forms were intended to check, and which the wantonness of power is but too often apt to suggest to large and successful majorities.

Mr. Speaker, I would submit that if we are now operating under general parliamentary law, the basis of which is Jefferson's Manual, from which I have just quoted, then we are indeed violating its first law by permitting only the majority to dictate those rules which are ostensibly designed to protect the minority.

One would logically think that if our rules are designed to protect the minority against the arbitrary and capricious exercise of power by the majority, the minority should have some say in the formulation of those rules. And yet we have had none and we can have none under this procedure.

It is not simply that we object to certain provisions contained in this resolution—provisions which strip away reforms adopted in the last Congress—but that the minority has certain of its own reform proposals which it would like to offer. These were drafted by our Task Force on Reform under the able chairmanship to the gentleman from Minnesota (Mr. FRENZEL). These include further opening committee meetings, completely banning closed House-Senate conferences and broadcasting House floor sessions. I am sure other Members, on both sides of the aisle, would like to make some input into the rules of procedure under which we will operate for the next 2 years. And yet, under this procedure and this resolution, they will have no such opportunity.

I would remind my colleagues that this procedure not only violates the spirit of general parliamentary law, but of the Constitution as well. Article I, section 5, reads, "Each House may determine the rules of its proceedings." Each House means just that—the full House—and not just the majority of the majority party caucus. Under this 1-hour, closed resolution, the full House is effectively being denied its right to fully and freely determine its own rules.

In conclusion, Mr. Speaker, I make my appeal for defeat of the previous question, not on a partisan basis, but on an institutional basis. For surely the integrity of the proceedings of the full House is being interfered with by this most undemocratic procedure.

We hear much about how the "winds of change" are sweeping the House; of how this is a reform-minded Congress. And yet, I would suggest we have no right to lay claim to the reform mantle if we adopt this resolution which abolishes two reforms and prevents a majority from working its will, freely and openly. If the aim of reform is to democratize and open the House, maximize opportunities for a majority of Members while protecting the rights of the minority, then this resolution is a self-defeating and anti-reform in its approach. If, on the other hand, the previous question is defeated, as I hope it will be, I intend to offer a resolution to readopt the rules of the last Congress and instruct the Rules Committee to come back in 30 days with additional recommendations, with adequate opportunity for debate and for amendment. Vote down the previous question and vote up a more democratic and comprehensive reform resolution.

Mr. QUILLEN. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Minnesota (Mr. FRENZEL).

Mr. FRENZEL. Mr. Speaker, there are many reasons why I urge a vote against the previous question and against these rules. But most simply stated the reasons boil down to one: The rules do not achieve needed reforms and in fact cancels important reforms noted by this House last year.

As chairman of the Republican House Task Force on Reform and Rule Changes, I have had the opportunity to review the procedures and Rules of the House. My task force made many recommendations for improvement, and, because we supected the retrenchment proposed today, we made a few specific proposals to hold the reforms of last year.

The rules presented today are a good example of the difference between the promises of the majority Members and their delivery on those promises.

Reforms have been promised. The majority has characterized itself as a reform group. But what it has produced is counterreform. There are some good ideas, some meritorious proposals and even some real improvements in these rules, but there are failures of omission in important reform areas, and a backslide on proxy voting and minority staffing.

Reform is desired by all parties. It is achievable only if all Members actually have a chance to participate. Rulemaking by an elite group is not, and cannot be, reform. Even worse, these rules come before us in a manner inconsistent with a fair, open, and democratic process. They were devised in the darkness of a secret Democrat caucus, agreed to under the odious "unit rule" that most Democrats repudiated in 1968, and are presented under a rule of restricted debate without opportunity for amendment. If that is what the winds of reform in the new two-thirds Democratic Congress are blowing up, the country and the House is in for some serious tornado damage.

The reinstatement of proxy voting is the worst feature of the new rules. The House voted out proxies in 1974 by a strong majority. The transfer of a Representative's precious right to vote to another person is abhorrent to the principles of representative government.

The proxy right was described today as "limited." Actually, the rules allow a proxy by any member "unable to attend" the committee meeting. That is pretty uncontrolled as far as I am concerned.

Proxies reinforce the potential for abuse inherent in a system already overdependent on the absolute powers of committee chairmen, and allow a few highly placed Members to control legislation, without the complete and thorough committee work needed to produce good legislation. They allow, in fact sustain, the double track system of committee assignment. They encourage absence and are subject to abuse, or, just as bad, allegations of abuse. I have to oppose any rules which allow the use of proxy voting. Proxies may be a convenience of the majority party, but so is the seniority system or absolute powers of chairmen or gag rules, and all are conveniences that ought to pass from our scene.

Minority staffing is greatly improved in these rules. We may well be allowed more staff that we really need on some committees. We are pleased with the consideration and happy to accept some crumbs from the Democrat table. Nevertheless, these rules back down from the policy adopted by the Congress in the Reorganization Act of 1970, and again by this House in 1974 in House Resolution 988; that is, that the minority should have one-third of congressional staff.

Last year there were, excepting the House Administration Committee, about 1,000 congressional staff employees of which about 130, or 13 percent, were minority employees. Under these rules, the minority share would rise in 19 committees, to about 204. At the same time majority employees will increase also, and we will still be left with about 20 percent of congressional staff, or less.

So, while proxies and staffing represent two giant steps in reverse from reform, it is also disappointing to see that the proposed rules miss many other reform possibilities like truly open conference committees, control of suspension bills, better scheduling, electronic press coverage of House sessions, and others. The proposed rules would allow the Senate conferees to close any conference committee.

It is true that the rules contain improvements, but these fall far short of expectations. But perhaps most important is that fact that the self-anointed reformers had to bring these rules to us under the no-amendment, limited-debate process, and with a binding unit-rule direction of their caucus.

On this side of the aisle, we believe that rules should be considered carefully in the sunlight of one of our standing committees, and presented on the floor under open rule, with opportunity to amend and time to debate. We believe the democratic processes demand no less.

Those who vote against the previous question and the rules may do so for a variety of reasons, but most will do so because they object to the antireform nature of the rules themselves and to the way in which they are presented. A vote for the rules is a vote for proxy voting, for secret, binding caucus votes, against fair minority staffing, and against other reforms in our rules. This will not be the only vote on these matters, but it should be carefully described here so the difference between promise and delivery, between that that is said and what is done, will be clearly understood.

I urge a vote against the previous question, so all Members, not just the elite, may participate in the consideration of, and vote on, all the rules changes needed to make real improvement in House procedures. To record the chance for reform that has been wasted, I also urge a vote against the rules.

Mr. WIGGINS. Mr. Speaker, will the gentleman yield?

Mr. FRENZEL. I yield to the gentleman from California.

Mr. WIGGINS. Mr. Speaker, if I may have the attention of either the gentleman from Florida or the gentleman from Massachusetts (Mr. O'NEILL), the majority leader, I would state that on page 3 of the drafted resolution that rule X is scheduled for amendment, and it provides in general that hearings will be open except when they are closed by a majority vote. And then it provides that a copy of the transcript of all such hearings will be made available to all Members.

I would ask if my understanding is correct that there is no intention to require the furnishing of copies of transcripts of matters involving national security to be delivered to the Members, and that they would not be so delivered?

Mr. O'NEILL. Mr. Speaker, since the gentleman from California has directed the question to me, let me say that if necessary I will yield additional time to the gentleman from Minnesota, but let met say that the gentleman from Florida (Mr. FASCELL), the author of the amendment, is here, and I am sure that that gentleman will be the proper one to answer the question.

Mr. FASCELL. Mr. Speaker, if the gentleman would yield, I would say that the gentleman from California is absolutely correct. The proviso in this section is a provision which applies only to the first sentence. The last sentence relates to the entire paragraph. I will restate the proposition. It is the same as the gentleman from California has stated. It was not the idea or the purpose of this rule to make transcripts available of a national security matter conducted in a closed hearing. The only purpose of the change is to make a transcript available of all open hearings.

Mr. WIGGINS. Mr. Speaker, I thank the gentleman.

The SPEAKER. The time of the gentleman has expired.

Mr. QUILLEN. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Florida (Mr. FREY).

Mr. BAUMAN. Mr. Speaker, will the gentleman yield?

Mr. FREY. I yield to the gentleman from Maryland.

Mr. BAUMAN. I thank the gentleman for yielding.

I should like to direct a question to the majority leader or to whomever on the other side might respond. On page 2 of the printed copy of the amendments designated change (5), it appears to me that an attempt is being made to grease the skids for a congressional pay raise. This proposed language gives the Committee on House Administration concurrent jurisdiction with the Committee on Post Office and Civil Service on congressional compensation, retirement, and other benefits of the Members. Previously, Post Office and Civil Service had exclusive power in this area and this gives such jurisdiction to two different committees. I should like to know why two different committees need the same jurisdiction over these goodies and what this is eventually possibly going to cost the taxpayers?

Mr. O'NEILL. Mr. Speaker, will the gentleman yield?

Mr. FREY. I yield to the gentleman from Massachusetts.

Mr. O'NEILL. I thank the gentleman for yielding.

May I say that this amendment was offered by the gentleman from Texas (Mr. ECKHARDT). I know he will be delighted to respond.

Mr. BAUMAN. Mr. Speaker, will the gentleman yield?

Mr. FREY. I yield to the gentleman from Maryland.

Mr. BAUMAN. The gentleman from California (Mr. PHILLIP BURTON) seems prepared to answer.

Mr. PHILLIP BURTON. Mr. Speaker, will the gentleman yield?

Mr. FREY. I yield to the gentleman from California.

Mr. PHILLIP BURTON. I think it was felt desirable to have more than one avenue for the consideration of this type of legislation. We also felt that because the Committee on House Administration does work on the salaries of the Members and staff, they could better coordinate all of these matters by also having jurisdiction along with the Committee on Post Office and Civil Service.

Mr. BAUMAN. Mr. Speaker, if the gentleman will yield further, I think all of us can draw our own conclusions, and I fear the taxpayers are going to suffer as a result.

Mr. FREY. Mr. Speaker, I think the theme of this Congress is probably going to be protestant performance promised by the majority and lacking performance. I think we have seen a good start of it already.

We are debating a rule which was born in silence and born with a gag. Those of us on our side who have worked on reform for a period of time have spent some time on proposals which we think were worthwhile, but we find we are not able to present them because of the way that this rule was presented.

These queer proposals not only do two things which we think are not being done correctly, but also we think we should discuss broadcasting of floor sessions, which I think all of us are interested in and which I think should be discussed, but again we find we are unable to take this up.

I think the Speaker said quick proper action is necessary during this session of Congress, and we agree with him. We also think the word "fairness" should be added. I do not think this rule will give us that. It is sad if we are to start this Congress by adopting rules which are unfair and which are going to limit the things which are good for this country.

I think there are those of us on the other side who feel that there are things which should be discussed which will help us adopt rules which will allow us to look at these matters and permit fairness for both sides and not just one party.

Mr. QUILLEN. Mr. Speaker, I yield to the gentleman from New York (Mr. FISH) such time as he may consume.

Mr. FISH. Mr. Speaker, I am sorry to see that the very first action of the new Congress has been a demonstration of the willful action of "king caucus." To flex their muscle, our colleagues across the aisle have forced the repeal of many provisions of the Committee Reform Amendments of 1974 just passed at the end of the 93d Congress.

Particularly disturbing to me are the amendments regarding minority staffing and proxy voting. The majority has taken away with one hand what it gave with the other.

The Reform Amendments of 1974 guaranteed that the minority would be able to increase their committee staff up to one-third of the total committee staff. This provision represented a great step forward for responsible legislation that would guarantee the representation of all points of view.

In today's action the caucus retained the minority staffing provisions for professional staff but rescinded the guarantee with respect to investigatory staff. This is the second time that the Democratic majority has hypocritically reversed the reform promises it made prior to an election.

In the 1970 Legislative Reorganization Act, the minority was guaranteed one-third of the investigatory funds of each committee. And in 1971, as today, the first action of the Democrats was to rescind their preelection vote.

This should not be a partisan issue in terms of Republicans versus Democrats. Minority representation is an issue at the root of our democratic process. All points of view should be represented in the legislative decisionmaking process.

Mr. Speaker, the inherent evil in proxies has been debated frequently in the Chamber. They operate against accountability, attendance and participation. A proxy cannot compromise or contribute to a committee's deliberation. Each of these evils is magnified when one party has overwhelming control of this body. We acted wisely last fall in outlawing proxies. The action now of the Democratic Caucus is a step backward.

I hope that the chairmen of our committees will have a better disposition toward the necessity of balanced representation and voluntarily abandoning the use of proxies than their caucus does. The chairmen can individually restore what the caucus has so imperiously withdrawn.

Mr. QUILLEN. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Pennsylvania (Mr. BIESTER).

Mr. BIESTER. Mr. Speaker, these rules in several areas represent not reform but retreat from reform, for example particularly in the area of proxy voting, but if the rules represent some retreat from reform, the process by which they will be adopted is an insult to the whole purpose of reform. On this floor, in this open forum before the American people, no amendments will be allowed, but in a secret forum in which they were passed, the Democratic

Caucus, presumably amendments were permitted. In other words, the real legislative process took place in secret, behind closed doors. Forcing the product of that process upon the minority and all the Members in this House represents the secret abuse of apparently unbridled power.

If we are proud of this House and its open process, we should trust it and show that trust by defeating the previous question and permitting the House to pass these rules. These rules will govern all Members of this House and all the Members should have a full right in helping to pass them.

Mr. QUILLEN. Mr. Speaker, I yield one minute to the distinguished gentleman from Virginia (Mr. BUTLER).

Mr. BUTLER. Mr. Speaker, I was impressed by the remarks of the Speaker concerning the surprising latent talents of our membership. I assure the Speaker every Member's constituency was well aware of his talent and his judgment when he was elected. It is his personal judgment and his talent that each Member is elected for and expected to bring to bear upon each question which comes before him, whether in committee or on the floor.

The judgment of the individual cannot be assigned or delegated. That is why in my judgment proxy voting is totally foreign to the theory of representative government and I will vote against the previous question so that the House may express itself on this question.

Mr. QUILLEN. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Ohio (Mr. ASHBROOK).

Mr. ASHBROOK. Mr. Speaker, I think it is appropriate in this brief time that we consider exactly what we are doing and exactly how we are doing it. The overwhelming majority of this body in the past has voted to continue the work of the Internal Security Committee. Now a secret majority somewhere has ordained that we will abolish the Internal Security Committee but without a direct vote. The very people who supposedly were swept into office on a promise to be open and candid are now going to be in a position to accomplish something indirectly without voting on it.

However, I think the American people will clearly understand that a vote for the previous question is a vote to kill the Internal Security Committee regardless of how you try to paint it at home. A vote against the previous question is a vote to allow the membership at least to vote up or down on that important issue and I urge the Members to vote "no" on the previous question.

As the Members know, there is no opportunity for amendment or debate on this issue unless the previous question is voted down. I urge such a vote.

Mr. QUILLEN. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. DERWINSKI). Pending that, I yield to the distinguished gentleman from New Hampshire (Mr. CLEVELAND).

Mr. CLEVELAND. Mr. Speaker, I join my Republican colleagues, many of whom have served with me on the Republican Task Force on Congressional Reform, in urging a vote against the previous question.

It seems shocking to me that the Democratic leadership who are riding the winds of reform would bring this resolution to the floor under these circumstances. I understand that copies of this resolution were not available until little more than an hour ago and the record should show that it contains at least 28 separate and distinct proposals. My colleagues have already detailed some of the more important steps backward that the resolution embodies.

To me the most serious step backward is the fact that major changes in our previous rules are being repealed and other major steps being taken under a closed rule with no opportunity for amendment or real debate.

Even worse, the resolution is the product of a secret and not very well attended Democratic Caucus. At least one of the reported votes revealed that less than half the members of the caucus were participating. On previous occasions there has been comment about the growing power of the Democratic Caucus—Anderson Special Order, CONGRESSIONAL RECORD, June 19, 1974. In my opinion, the practice of legislating by secret caucus bodes ill for the future of representative government. There is no question that if the caucus is permitted to dominate this Congress, we may have minority rule.

A majority of the House voted against proxies, voted to give the minority a fair break on staffing, and they have consistently voted to sustain the House Committee on Internal Security. All this and other matters are now being undone by this technique of bringing a long, involved resolution with 28 separate sections to a vote under a gag rule with no possibility for amendment unless the previous question is defeated. In view of remarks made earlier on the floor about the serious problems facing this country and the obvious requirements that Congress work on these problems openly and fairly, it seems strange to me to be faced just a few hours later with the parliamentary situation which is presented to us now.

Mr. DERWINSKI. Mr. Speaker, I have a question to direct, if I may, to the distinguished gentleman from California (Mr. PHILLIP BURTON). When the distinguished gentleman from Maryland asked a moment ago about subparagraph 15 of paragraph 5 on page 2 dealing with measures relating to compensation, retirement, and other benefits for Members and so forth, I frankly did not understand the point of the gentleman's response. Would the gentleman clarify for me exactly what the Committee on House Administration will do with compensation benefits for Members?

Mr. PHILLIP BURTON. Of course, I am in no position to anticipate efforts of the House Administration Committee, any more than any of us are, with reference to any other committee.

There is some sentiment that because they have been charged with the responsibility of dealing with the staffs of Members and have developed a thoughtful record in that respect, it might be useful that they be in a position to also be able to coordinate along optional lines with the distinguished Committee on Post Office and Civil Service.

Mr. DERWINSKI. Mr. Speaker, I am the ranking Member of that committee. I have no quarrel at all with the Committee on House Administration having jurisdiction over compensation for officers and employees of the House; but financial compensation of Members of the House is tied to that of Members of the Senate, tied to that of Federal judges, and also tied to Ambassadors. What possible vehicle would the Committee on House Administration be for compensation? Should the House Administration Committee act it would have to be in some way approved by the other body. I just do not understand the possible function of the Committee on House Administration in this area. I wish to record my opposition to this particular development.

Mr. PHILLIP BURTON. Mr. Speaker, it was in this area that the recommendation of the Committee on House Administration was foreclosed with respect to changes in the circumstances of the Members of the House. We do not consider it to be unduly burdensome that this optional committee jurisdiction be conferred upon the Committee on House Administration, in light of their demonstrated experience in this general area.

Mr. BAUMAN. Mr. Speaker, will the gentleman yield?

Mr. QUILLEN. I yield to the gentleman from Maryland.

Mr. BAUMAN. Mr. Speaker, I would observe that in this matter of expenses that the committee has jurisdiction over could very well be used in lieu of a pay raise.

Mr. Speaker, it is evident to me from the language contained in the proposed amendment to rule X, clause 1(k) that the proposal to create dual jurisdiction over compensation, retirement, and benefits for Members in both the Post Office and Civil Service Committee and the House Administration Committee is a backdoor route to a congressional pay raise. I strongly object to this, particularly at a time when the American people are being asked to make sacrifices as part of the battle to solve our economic problems.

Most of us on the minority side of the aisle had no opportunity to examine these proposed rules changes until we arrived on the floor today. The "pay raise amendment" I have referred to is probably one of the reasons we have been kept in the dark. Prior to my service in Congress, the House abdicated its responsibility and transferred to the House Administration Committee the sole power to increase many of our office and staff benefits without ever having to ask the full House for its approval. It is perhaps conceivable that this new amendment to the rules will allow the House Administration Committee to authorize the payment of a per diem allowance for

House Members in a sum of, say, $100 a day, which would produce in effect, an enormous pay raise. If the committee has such power, as I suspect it might, this would allow Members to avoid all responsibility when they should be subjected to a rollcall vote on such issues.

We have heard a great deal about "confidence in Government" and "openness" in our proceedings from the other side of the aisle and now we are confronted with a new spigot added to the congressional plumbing to further drain away the taxpayers' money. I hope my prediction is wrong, but I suspect that I will be able to say, "I told you so." I will vote against the previous question and the rule because of this pay raise amendment if for no other reason.

COMMITTEE ON INTERNAL SECURITY

Mr. Speaker, I also intend to oppose the previous question and these rules unless we adopt an amendment which will continue the existence of the House Committee on Internal Security. In their fury to adhere to liberal dogma, the Democratic Caucus, behind closed doors, has voted to end this useful legislative forum. It is perhaps a symptom of the myopia of our times that the one committee in the Congress that has consistently fought against communism and other subversive elements is now being rewarded by abolition. The destruction of this committee has long been a primary goal of the Communist Party of the United States. I did not think I would see the day that the House would put its stamp of approval on such a proposal.

It is doubly disturbing to me that we would abolish this committee without permitting the House to have a direct vote on the issue. This permits Members to cloak their stand on this issue in secrecy and avoid facing a rollcall. The American people should understand, and the constituents of each of our districts should understand, that the way a Member votes on the previous question can certainly be interpreted as a stand on the continued existence of the Committee on Internal Security.

I, therefore, seek to defeat the previous question and failing this to oppose the rules.

Mr. QUILLEN. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Michigan (Mr. BROWN).

Mr. BROWN of Michigan. Mr. Speaker, if the past is prolog, then certainly this debate is an exercise in futility. This is the second time that my colleagues to my right in public session of Congress have adopted reforms in open session and then have proceeded in closed session behind closed doors to repeal the reform that they adopted in open session.

It really is very disturbing after having been very impressed with the Speaker's remarks upon his inauguration again as Speaker to find this action taking place. I do not think, if I can suggest to my colleagues on that side of the aisle, that the public, the media, are going to let you persist in procedures which at best are inconsistent and I think, at worst, fraudulent.

The SPEAKER. All time of the gentleman from Tennessee has expired.

Mr. O'NEILL. Mr. Speaker, for purposes of debate only I yield such time as he may consume to the gentleman from Massachusetts (Mr. DRINAN).

Mr. DRINAN. Mr. Speaker, I thank the distinguished majority leader for yielding to me.

Mr. Speaker, as we witness the historic event of the passing of the Committee of the House which never should have been formed, it is important in my judgment to note several of the understandings that emerged in the Democratic Caucus which on January 13, 1975, agreed to the phasing out of the House Internal Security Committee.

In that caucus, I, along with Congressman DON EDWARDS of California, proposed the following resolution:

To amend the Rules of the House of Representatives to transfer the jurisdiction of the Committee on Internal Security to the Committee on the Judiciary

Resolved, That (a) clause 1 of Rule X of the Rules of the House of Representatives is amended—

(1) by striking out paragraph (m) and by redesignating paragraphs (n) through (w) as paragraphs (m) through (v), respectively; and

(2) by striking out "and counterfeiting" in subparagraph (3) of paragraph (m), as redesignated by paragraph (1) of this section, and inserting in lieu thereof "counterfeiting, and sabotage and other overt acts affecting internal security".

(b) Paragraphs (k)(4) and (k)(5) of clause 1 of Rule X of the Rules of the House of Representatives are each amended by striking out "clause 1(q)(4)" and inserting in lieu thereof "paragraph (p)"

SEC. 2. Clause 2 of Rule XIII of the Rules of the House of Representatives is amended by striking out "clause 22" and inserting in lieu thereof "clause 4(a)".

During the discussion of the Drinan-Edwards resolution, Congressman ICHORD proposed the following substitute:

Resolved, That clause 1 of Rule X of the Rules of the House of Representatives is amended

(1) by striking out paragraph (m) and by redesignating paragraphs (m) through (v), respectively; and

(2) by adding at the end of paragraph (m), as so redesignated by this section, the following:

"(19) Communist and other subversive activities affecting the internal security of the United States."

SEC. 2. All property and records of the Committee on Internal Security are hereby transferred to the Committee on the Judiciary and shall be available for use by the latter committee to the same extent as if such property and records were originally that of the Committee on the Judiciary.

SEC. 3. Such staff members of the Committee on Internal Security as the Chairman of that Committee for the 93d Congress may designate in consultation with and with the approval of the chairman of the Committee on the Judiciary shall, without reduction in compensation, be transferred and appointed to the Committee on the Judiciary as additional members of the staff of the Committee on the Judiciary for the period of the 94th Congress, and shall be paid from the contingent fund of the House.

I raised several questions concerning the meaning and import of the Ichord substitute. Among other things, I raised the question of the number of members of the staff of the House Internal Security Committee that Mr. ICHORD might recommend to the House Judiciary Committee to be retained during the course of the 94th Congress. Mr. ICHORD declined to specify any particular number but did mention that the entire staff of House Internal Security Committee ranged from 30 to 40 personnel.

During the discussion on the Ichord substitute an amendment authored by Congressman BOB ECKHARDT, of Texas, was accepted. That amendment made it unequivocally clear that the Ichord substitute did not commit the chairman of the Judiciary Committee to accept even one member of the staff of the House Internal Security Committee for any period of time. The Eckhardt amendment stated clearly that no member of the staff of the House Internal Security Committee will be employed by the House Judiciary Committee unless first there is a clear acceptance on a voluntary basis of such employee by the chairman of the House Judiciary Committee. It is my judgment and I think the judgment of the chairman of the House Judiciary Committee that there is no need for any member of the staff of the House Internal Security Committee to be transferred to the House Judiciary Committee—even for the duration of the 94th Congress.

With the exception of the proposed transfer of personnel from the Internal Security Committee to the House Judiciary Committee, Congressman EDWARDS and I acquiesced in the language and formulation of the substitute offered by Chairman ICHORD. There is, nonetheless, a serious question of the acceptability of the language of the Ichord substitute. That language places within the jurisdiction of the House Judiciary Committee the duty of investigating and legislating with respect to "Communist" activities which are stated to be subversive. This language raises, of course, a fundamental issue of the first amendment in that it places within the Rules of the House of Representatives the conclusion that the "Communist" Party in the United States is "subversive." Such language at best is duplicative and at worst it is in violation of the spirit of the first amendment. The language is duplicative because the entire House, in late 1974, had already accepted that part of the Hansen committee reform proposals which conferred on the House Judiciary Committee jurisdiction over "internal security." That mandate is in the rules of the House for the 94th Congress in section 215, No. 19.

It is also understood in the debate leading to the transfer of the total jurisdiction of the House Internal Security Committee to the House Judiciary Committee that the latter group is under no obligation whatsoever to establish a separate subcommittee to deal with treason, espionage, and problems related to internal security. Indeed, as noted above, it is not certain that the transfer of the jurisdiction of the House Internal Security Committee as ratified by the caucus of the Democratic majority on January 13, 1975, did in fact, add a single thing to that which is already within the jurisdiction of the Judiciary Committee. In view of the fact that the House Judiciary Committee may investigate problems re-

lated to internal security only insofar as they relate to overt attacks or to crimes such as treason and espionage, it would seem that the appropriate officials within the House Judiciary Committee could assign any new jurisdiction obtained by the House Judiciary Committee as a result of the Hansen proposal and the transfer of the work of the Internal Security Committee to one or more of the existing subcommittees of the House Judiciary Committee which have crime within their mandate.

Section 2 of the Ichord substitute transfers without any reservation all of the documents and files of the House Internal Security Committee to be the property forever of the House Judiciary Committee. All of these documents remain, of course, as documents of the House of Representatives and under the rules of the House are available for the inspection of any Member.

In due course, it is my judgment that it should be proposed that all of these documents be transferred to the archives where they will be unavailable to the general public for some 50 years. These documents, being the property of the House of Representatives, are not within the mandate of the Freedom of Information Act. Nonetheless, they are always available to Members of the House. Members may in the future, as they have been able to do in the past, obtain for any constituent or any other person, any file maintained by the House Internal Security Committee on this particular individual or any group in which he has an interest.

Theoretically these files could assist the House Judiciary Committee in its new task of conducting investigations which might be necessary to acquire knowledge that would be helpful in the framing of new laws related to espionage or new procedures that would be needed in order to make the enforcement of these laws more efficient. It is my judgment, however, that the material in these files merely duplicates public records and is, moreover, a melange of hearsay, irrelevant events, and misinterpretation of activities in such a way as to imply guilt by association to individuals or to organizations.

Mr. Speaker, no account of the demise of the House Internal Security, formerly known as the House Un-American Activities Committee, would be complete without a notation of the extraordinary work done by the National Committee Against Repressive Legislation—NCARL. The work of this group, headed by Mr. Frank Wilkinson, and many others devoted to the preservation of the civil liberties of Americans, has been uniquely valuable to Members of this Congress who have sought to excise from the dignity and majesty of the House that self-inflicted wound called HUAC–HISC which now after 30 or more years will no longer be an embarrassment and indeed a disgrace to the Congress of the United States.

Mr. O'NEILL. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. FORD).

Mr. FORD of Michigan. Mr. Speaker, I was glad that I was on the floor to hear the remarks of the gentleman from Michigan (Mr. BROWN).

I had the distinct pleasure of serving in two legislative bodies with Mr. BROWN before we came to Congress. In both those bodies, Republicans had a two to one majority. Perhaps that is why the procedure we are going through here today seems so familiar to both of us.

I am glad to see that the gentleman from Michigan approaches the proceedings today with the same good grace as I did the proceedings in those other bodies.

Mr. BROWN of Michigan. Mr. Speaker, will the gentleman yield?

Mr. FORD of Michigan. I yield to my colleague from Michigan.

Mr. BROWN of Michigan. Mr. Speaker, can the gentleman suggest to me one instance—one instance in which the complete turnabout that has occurred on this floor at the start of the last two sessions occurred in the Michigan legislature? One instance?

Mr. FORD of Michigan. There never was a change in the Michigan Legislature. The Republicans wrote the rules for us and told us about them afterwards. That is certainly not the case here today.

Mr. O'NEILL. Mr. Speaker, for purposes of debate only I yield such time as he may consume to the gentleman from Florida (Mr. YOUNG).

Mr. YOUNG of Florida. Mr. Speaker, I rise in opposition to House Resolution 5, establishing a new set of rules for the 94th Congress. Adopting this package at the very beginning of a new Congress actually represents a major step backward and is contrary to the spirit of reform which should infuse such a new beginning.

As my colleagues will recall, the 93d Congress established a Select Committee on Committees at the beginning of its first session. This select committee was directed to prepare a sweeping package of reforms of the House Rules and the House committee structure so as to make the Congress more responsive to America's needs today and to the desire of the people for a more open legislative process.

The select committee worked for more than a year and a half on the drafting of House Resolution 988, the Committee Reform Amendments, the first major reforms in the House structure in almost 30 years. After considerable delay, House Resolution 988 was considered last October, and though seriously weakened, finally passed the House.

The rules package before us today negates this 2 years of hard work and the majority vote of the 93d Congress on House Resolution 988 by eliminating some of its most important provisions. It recreates the authority for use of the proxy vote in committees and it allows meetings of conference committees to be closed by vote of either the House or the Senate conferees. With one stroke, the great strides forward for responsible government, "Government in the Sunshine," are deleted.

During consideration of House Resolution 988 last year, the House voted 246 to 164 to retain the House Internal Security Committee as constituted. Yet now the House is asked to vote up and down on a rules package today which kills HISC as a separate standing committee, without a separate vote on the committee itself.

Finally, in granting the House Administration Committee concurrent jurisdiction with the Post Office and Civil Service Committee over proposed congressional pay raises, House Resolution 5 could stymie the efforts of those who would block such pay raises. Under the Salary Act of 1967, either House or Senate must enact a resolution of disapproval in order to block congressional or Federal pay raises. Previously, the House Post Office and Civil Service Committee reported such a resolution to the House for an up or down vote. Under House Resolution 5, after the Post Office and Civil Service Committee reports such a resolution, it is referred to the House Administration Committee—where it can languish unconsidered while the new raises go into effect automatically. The old act is bad enough, with its "approval by silence" clause. The new system is even worse—a glorified means of "buckpassing."

All of the foregoing are procedural questions of the greatest importance. Yet the rule on House Resolution 5 prohibits a separate vote on each of these issues, indeed, it even prohibits any amendment of the package. This is an abuse of the "closed rule" of the worst sort. It cancels out 2 years of work by the select committee, it denies a voice to reform efforts, and it says to the American people that this new Congress is unwilling even to adopt the reforms of its predecessors.

As I read the newspapers, listen to the radio, and watch television analyses of the new Congress, I have been overwhelmed by the expectation of reform permeating the Nation. It has been widely anticipated that this will be a "reform Congress," one which will once again take up the reins of leadership for the Nation and work to get the country going again.

Yet here today we have before us a rules package embodying large strides backward: reinstatement of a proxy authority, allowing Members to vote in absentia; closure of all-important conference meetings while legislation affecting the future of the Nation is drafted; under-the-table abolition of a committee which has handily survived every single open vote on its funding and future; and de facto approval of future congressional pay raises.

Mr. Speaker, I submit that this is not reform but regression, and I urge my colleagues to vote "no."

Mr. O'NEILL. Mr. Speaker, for purposes of general debate only I yield 5 minutes to the gentleman from Missouri (Mr. ICHORD).

Mr. ICHORD. Mr. Speaker, the substitute resolution which I introduced and which was adopted by the Democratic Caucus transferring the legislative jurisdiction and investigatory power of the House Committee on Internal Security to the Judiciary Committee is consistent with the position I have maintained throughout the debate over the Hansen committee efforts and the Bolling committee efforts to transfer the jurisdiction to the Judiciary Committee and the Committee on Government Operations, respectively. It has always been my posi-

tion throughout the perennial battles over the continuation of the Internal Security Committee and its funding that the issue should be "not what committee is to do the work but whether or not the work should be done."

The House Committee on Internal Security when it was established in 1969 by the House was given legislative and investigatory jurisdiction over subversive activities and subversive activities were defined as those activities which would overthrow or undermine the Government of the United States by force, violence, and unlawful means. Mr. Speaker, there are some extremists who see a subversive behind every bush but there are other extremists who are just as foolish, if not more foolish, who refuse to recognize that there are thousands of revolutionaries in our midst and that there are such things as subversive activities.

There are others, equally foolish in my opinion who believe that the Congress has no responsibility in the field of subversion; that the Congress should leave the matter up to FBI, the CIA, and other executive security agencies. Every government has the basic right to take precautionary measures to protect itself and most certainly this free and democratic Government has that right. It is the responsibility of Congress to inform itself, to assess the aims, objectives, and numbers of the 56 organizations in this country that are classified by the FBI as subversive, to pass the necessary and constitutional laws to control the threat, and to see that the executive agencies are duly, fairly, and efficiently enforcing those laws. Americans have the right to change their Government through the free political processes but they do not have the authority to change it through force, violence, treachery, or unlawful means.

This is what occurred in the democratic caucus. The gentleman from California (Mr. EDWARDS) and the gentleman from Massachusetts (Mr. DRINAN) introduced a resolution purporting to transfer the jurisdiction of the House Committee on Internal Security to the House Judiciary Committee. However, the proposal would only have given the House Committee on Judiciary jurisdiction over "overt acts affecting the internal security." It would not have given the Judiciary Committee jurisdiction over conspiratorial acts. It would not have given the committee, for example, jurisdiction over the activities of the Communist Party U.S.A. and the Socialist Workers Party, the Trotskyite Communists, who advocate revolution by force and violence, if necessary, when the time is ripe.

I introduced and the caucus adopted my substitute resolution which gives the House Judiciary Committee specific jurisdiction over Communist and other subversive activities affecting the internal security of the United States. The substitute resolution also provided that the property and records of the House Committee on Internal Security shall be transferred to the Committee on the Judiciary as well as the present staff, as agreed upon by the chairman of the two committees. I would point out to the Members that the language of jurisdiction is the same language that was worked out between me and the members of the Bolling select committee. In effect the language will require the Committee on the Judiciary to establish a Subcommittee on Internal Security.

It is my belief that the language coupled with the political exigencies of the times will assume that the work will be done.

I say to the Members of the House that I am greatly concerned and alarmed at the trend in this country both on the national level and at local levels toward a general degradation of intelligence and security in this area. The last 2 years have seen the abolition of the Internal Security Division in the Department of Justice, the demise of the Subversive Activities Control Board, the elimination of the Attorney General's subversive list, and a general downgrading of capabilities throughout the intelligence community. Intelligence activities of the local police units are under nationwide attack as well as intelligence activities of the FBI and the CIA.

Under the circumstances existing in the country today and the political circumstances existing in this body today, I feel that the Committee on Judiciary is in a position to do as good a job or a better job than is a separate committee. For this reason I intend to continue to support my substitute resolution. The House Judiciary Committee, I would point out, has the legislative jurisdiction, not possessed by the House Committee on Internal Security, to keep subversion under more adequate control. I would admonish the House Committee on Judiciary that it is assuming a tremendous responsibility.

Détente or rather the euphoria of détente is the primary cause of the downgrading of intelligence activities. But détente does not change the fact that we vote almost $90 billion annually for the defense of the United States primarily because of the threat of the foreign policy and the military might of the Soviet Union. It does not change the fact there are several thousand revolutionaries in this country, competent and well-trained, under the discipline and control of the Communist Party Soviet Union. It does not change the fact that there are thousands others, who although not under the discipline and control of the CPSU, do share the same objectives, and are determined to effect revolution, by force and violence if necessary, when the time is opportune. And it does not change the fact that there are approximately 15,000 people scattered throughout some 21 "Revolution Now" groups such as the Symbionese Liberation Army, Venceramous, and others who are under the constant surveillance of the FBI. Several of the bombings and police killings are the work of these groups.

I realize there are many who feel that the House Committee on Judiciary will not do the necessary work because of the more liberal philosophy of that committee. However, I would point out, fortunately in my opinion, that most of the members of the Judiciary Committee do not share the feelings of the gentleman from Massachusetts (Mr. DRINAN). The House Committee on Judiciary by this resolution is mandated to do the work and it is my intention as a Member of this body to do everything in my power to see that this most vital work is continued.

Mr. O'NEILL. Mr. Speaker, I yield 2 minutes, for the purpose of debate only, to the gentleman from Missouri (Mr. RANDALL).

Mr. RANDALL. Mr. Speaker, I take this time to say a word of praise for my fellow Missourian, DICK ICHORD. There have been many battles over the continuation of this committee, during the past several years. But even to the last, I had hoped the committee might not be abolished. I must say it came as a surprise to some of us that the gentleman from Missouri (Mr. ICHORD), offered in caucus his substitute amendment, which transferred staff and files of the Internal Security Committee to the House Judiciary Committee.

Perhaps the case of DICK ICHORD can be likened to a war hero who said on the battlefield he never tried to do the impossible and always had the wisdom to yield to the inevitable. In the caucus debate yesterday, Mr. ICHORD said that he had made an estimate of the vote in caucus and he felt that the votes were simply not there to continue the House Internal Security Committee, and that his best course was to yield to the inevitable. He stated both for the record of the caucus and privately to some of his friends that the best that could be done under the existing circumstances was to try to pass an amendment that would insure that the Judiciary Committee employ some of the staff of the Internal Security Committee who had acquired experience in the investigating of subversives, and also try to preserve some of the files of the committee which were the result of a lot of work in the past.

As my colleague from Missouri leaves the chairmanship, I think all of us who are his fellow members should recognize that he did not have an easy job, but rather one that took a large measure of courage to perform. He was subjected repeatedly to personal abuse. Yet he believed in the importance of the work of his committee. He went on working hard to perform the duties assigned to the committee; and carry on the investigations of subversive activities in the United States.

After the vote yesterday in caucus, one of my colleagues observed in our conversation that the House Internal Security Committee was terminated because it was a relic of the cold war in an era of détente. I promptly corrected his conclusion by saying that while the committee was active during the cold war, there was plenty of work for it or some successor committee to do in these days of so-called détente, which many of us believe is not a genuine détente at all. What we must continue to do is no longer listen to what the Communist world says in its pleasant talk of détente, but look instead to what it does not only in Eastern Europe but in the Middle East and elsewhere in the world.

It was brought out in the debate in caucus yesterday that Chairman ICHORD has protected many witnesses against defamation of their character when they appeared before his committee. DICK ICHORD has been fair; he has been a good chairman.

Mr. Speaker, I shall take at full face value the good intentions of my colleague from Missouri (Mr. ICHORD), and if he votes aye on the previous question, which in effect ratifies the package of action taken yesterday by the Democratic Caucus, I will reluctantly join him in the vote in favor of the previous question. In voting in that manner it should never be construed that there is not yet work to do in the field of internal security, simply because the separate committee has been abolished and the jurisdiction of the committee transferred to what it is hoped will be a subcommittee of the Judiciary Committee. At stake in voting against the previous question, in order to obtain a separate vote on the Internal Security Committee is the possible rejection of a list of House reforms that comes in a package after several days of work by the caucus. Right or wrong, the success of a separate vote would create a parliamentary situation and raise procedural questions which might or could jeopardize such other successes as staffing reform, proxy voting, and the reversal of closed sessions of conference committees, and also other beneficial changes.

Now Mr. Speaker, I hope that, since the ball has now been passed to the Committee on the Judiciary and supposedly a subcommittee created, that the membership of the Judiciary Committee will recognize they have a job to do and proceed to perform the job assigned to them.

For my part I shall watch very carefully the activity of the new Judiciary Subcommittee, or the work of any existing subcommittee to which the jurisdiction and the files of the Internal Security Committee will be transferred. Perhaps the Judiciary Committee does not want the job, but it has it, and there are going to be some of us that are going to raise the issue again and again if it does not do the job that has been done by the House Internal Security Committee. If for some reason the membership of the House Judiciary Committee does not do the job, I predict it will not be very long, just 2 short years, until this issue will be back on the floor of the House, and that there will be reenacted either a House Internal Security Committee or some separate but similar committee, by whatever name it may be called.

As the gentleman from Missouri leaves the chairmanship of the House Internal Security Committee we should salute him and extend to him our highest commendation for his important, dedicated, and effective work during the years he has served as chairman.

Mr. ROUSSELOT. Mr. Speaker, will the gentleman yield?

Mr. RANDALL. I yield to the gentleman from California.

Mr. ROUSSELOT. Mr. Speaker, I appreciate the gentleman's comments. I think it has been difficult for many of us to fully realize the tremendous amount of pressure the gentleman from Missouri (Mr. ICHORD) and the gentleman from Ohio (Mr. ASHBROOK) have been under during tenure on this committee. As a matter of fact so have all the members of the Committee on Interior Security been unfairly maligned.

The gentleman from Missouri (Mr. ICHORD) mentioned the "Mad Bomber" from Los Angeles, Calif. It is true that the "Mad Bomber" came from a radical group, which incidentally has been properly identified as such by the Committee on Internal Security.

In my judgment, it is a major mistake for the House of Representatives to take action today which would in effect—abolish the Committee on Internal Security. Just last October this body overwhelmingly supported the retention of the House Committee on Internal Security with full and complete debate during consideration of the reorganization act. Today we are not being given an adequate opportunity to discuss the issue because the rule does not permit that discussion. The Democratic Caucus has seen fit to send this proposal to the floor on a muzzled basis.

The House Committee on Internal Security fulfills an important and continuing function on behalf of the Congress and the American people to keep ourselves as Representatives and the American people as a whole totally informed on the activities of radical elements and pressure groups which would try to undermine our free Republic. This parmanent committee has performed the necessary function of recommending legislation which was very much needed for our national security and has participated in improving legislation by adding important amendments to bills recommended by other House committees.

The action here today under this procedure is deceptive and improper. I am, therefore, constrained to vote against the motion on the previous question which would end all debate. Under this rule we have been denied the right of the correct legislative process. If the previous question on this rule is not voted down, I will be further constrained for many reasons to vote against the acceptance of House Resolution 5. First, this action would be extremely detrimental to the position taken by the House last October in supporting the Hansen resolution. Second, I believe that several Members have made an excellent case today that vote by proxy in committees is wholly unacceptable as it is a procedure which has been and will continue to be abused. As Members of Congress we were sent here by the electorate to participate in the legislative process which provides for full debate followed by our presence to vote. This resolution is presented here today in a very hurried manner and encourages the very kind of abuses of our legislative process which many of our new Members here were sent by their voters to improve.

In addition, I am not convinced that the Judiciary Committee can with all its other assignments do the same justice to the whole subject matter of internal security that a separate committee is able to do. The present internal security committee has done an excellent job for many years under the able leadership of my colleagues Mr. ICHORD and Mr. ASHBROOK.

Mr. RANDALL. Mr. Speaker, I thank the gentleman for his remarks.

Mr. ROBINSON. Mr. Speaker, congressional reform suffered a cruel, cynical slap in the face through House action adopting rules for the new Congress restoring proxy voting in committees.

The majority party, in the first significant action on the opening day of the 94th Congress, used its numbers to overturn reform measures instituted by legislative action of the past Congress and to authorize a return to the free-and-easy absenteeism of many committee sessions, with the chairman controlling decisions through the proxies in his pocket.

The public interest was poorly served by the rules action in several other respects, notably the dismantling of the Internal Security Committee and the transfer of its important responsibilities for the oversight of subversive activity in the United States to a virtual orphan status in the Judiciary Committee.

The majority also watered down the staff support of the minority, which had been increased to a level representing an approach to fairness in the congressional reform legislation adopted last year.

The reduction in minority staffs of select and special committees offset the somewhat improved minority staff position on standing committees.

These actions—particularly the return of the faceless proxy voter to the committee rooms—do not contribute to improved management of the public business or to public confidence ir the commitment to reform which the majority leadership has professed so often.

Mr. O'NEILL. Mr. Speaker, may I inquire, does the gentleman on the other side have any further requests for time?

Mr. QUILLEN. Mr. Speaker, I have no further requests for time.

Mr. Speaker, I wish to thank the distinguished majority leader for being so thoughtful in yielding 30 minutes to this side of the aisle.

Mr. O'NEILL. Mr. Speaker, I have no further requests for time on this side. I do hope that the previous question will be ordered.

Mr. Speaker, I move the previous question on the resolution.

The SPEAKER. The question is on ordering the previous question.

The question was taken; and the Speaker announced that the ayes appeared to have it.

Mr. FRENZEL. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 247, nays 172, not voting 12, as follows:

[Roll No. 4]

YEAS—247

Abzug
Adams
Addabbo
Alexander
Ambro
Anderson, Calif.
Annunzio
Ashley
Aspin
AuCoin
Badillo
Baldus
Barrett
Baucus
Beard, R.I.
Bedell
Bergland
Bevill
Biaggi
Bingham
Blanchard
Blouin
Boggs
Boland
Bolling
Bonker
Brademas
Breaux
Breckinridge
Brodhead
Brooks
Brown, Calif.
Burke, Calif.
Burke, Mass.
Burlison, Mo.
Burton, John
Burton, Phillip
Carney
Carr
Casey
Clay
Collins, Ill.
Conyers
Corman
Cornell
Cotter
D'Amours
Daniels, Dominick V.
Danielson
Davis
de la Garza
Delaney
Dellums
Dent
Derrick
Diggs
Dingell
Dodd
Downey
Drinan
Duncan, Oreg.
Early
Eckhardt
Edwards, Calif.
Eilberg
Evans, Colo.
Evans, Ind.
Evins, Tenn.
Fascell
Fisher
Fithian
Flood
Florio
Flowers
Foley
Ford, Mich.
Ford, Tenn.
Fraser
Fulton
Fuqua
Gaydos
Giaimo
Gibbons
Gonzalez
Green
Haley
Hall
Hamilton
Hanley
Hannaford
Harrington
Harris
Hawkins
Hayes, Philip H.
Hays, Wayne L.
Hébert
Hechler, W. Va.
Helstoski
Hicks
Hightower
Holland
Holtzman
Howard
Howe
Hubbard
Hughes
Hungate
Ichord
Jacobs
Jenrette
Johnson, Calif.
Jones, Ala.
Jones, Tenn.
Jordan
Kastenmeier
Kazen
Keys
Kluczynski
Koch
Krebs
Krueger
LaFalce
Leggett
Lehman
Levitas
Litton
Lloyd, Calif.
Lloyd, Tenn.
Long, La.
Long, Md.
McCormack
McFall
McHugh
McKay
Macdonald
Madden
Mahon
Matsunaga
Mazzoli
Meeds
Melcher
Metcalfe
Meyner
Mezvinsky
Mikva
Milford
Miller, Calif.
Mineta
Minish
Mink
Mitchell, Md.
Moakley
Moffett
Mollohan
Moorhead, Pa.
Morgan
Moss
Mottl
Murphy, Ill.
Murphy, N.Y.
Murtha
Natcher
Neal
Nedzi
Nix
Nolan
Nowak
Oberstar
Obey
O'Hara
O'Neill
Ottinger
Passman
Patman
Patten
Patterson, Calif.
Pattison, N.Y.
Pepper
Perkins
Pike
Poage
Preyer
Price
Randall
Rangell
Rees
Reuss
Richmond
Riegle
Roberts
Rodino
Roe
Roncalio
Rooney
Rose
Rosenthal
Rostenkowski
Roush
Roybal
Russo
Ryan
St Germain
Sarbanes
Scheuer
Schroeder
Seiberling
Sharp
Shipley
Sikes
Simon
Sisk
Slack
Smith, Iowa
Solarz
Spellman
Staggers
Stanton, James V.
Stark
Steed
Stephens
Stokes
Studds
Sullivan
Symington
Thompson
Thornton
Tiernan
Traxler
Tsongas
Udall
Ullman
Van Deerlin
Vander Veen
Vanik
Vigorito
Waldie
Weaver
White
Whitten
Wilson, Charles, H., Calif.
Wilson, Charles, Tex.
Wirth
Wolff
Wright
Yates
Yatron
Young, Ga.
Young, Tex.
Zablocki
Zeferetti

NAYS—172

Abdnor
Anderson, Ill.
Andrews, N.C.
Andrews, N. Dak.
Archer
Armstrong
Ashbrook
Bafalis
Bauman
Beard, Tenn.
Bell
Bennett
Biester
Bowen
Brinkley
Broomfield
Brown, Mich.
Brown, Ohio
Broyhill
Buchanan
Burgener
Burke, Fla.
Burleson, Tex.
Butler
Carter
Cederberg
Chappell
Clancy
Clausen, Don H.
Clawson, Del
Cleveland
Cochran
Cohen
Collins, Tex.
Conable
Conlan
Conte
Coughlin
Crane
Daniel, Dan
Daniel, Robert W., Jr.
Derwinski
Devine
Dickinson
Downing
du Pont
Duncan, Tenn.
Edwards, Ala.
Emery
English
Erlenborn
Esch
Eshleman
Fenwick
Findley
Fish
Flynt
Forsythe
Fountain
Frenzel
Frey
Gilman
Ginn
Goldwater
Goodling
Gradison
Grassley
Gude
Guyer
Hagedorn
Hammer-schmidt
Hansen
Harsha
Hastings
Heckler, Mass.
Hefner
Heinz
Henderson
Hillis
Hinshaw
Holt
Horton
Hutchinson
Hyde
Jarman
Jeffords
Johnson, Colo.
Johnson, Pa.
Jones, N.C.
Jones, Okla.
Kasten
Kelly
Ketchum
Kindness
Lagomarsino
Latta
Lent
Lott
Lujan
McClory
McCloskey
McCollister
McDade
McDonald
McEwen
McKinney
Madigan
Mann
Martin
Michel
Miller, Ohio
Mitchell, N.Y.
Montgomery
Moore
Moorhead, Calif.
Mosher
Myers, Ind.
Myers, Pa.
O'Brien
Pettis
Peyser
Pressler
Pritchard
Quie
Quillen
Railsback
Regula
Rhodes
Rinaldo
Robinson
Rogers
Rousselot
Runnels
Ruppe
Sarasin
Satterfield
Schneebeli
Schulze
Sebelius
Shriver
Shuster
Skubitz
Smith, Nebr.
Snyder
Spence
Stanton, J. William
Steed
Steelman
Steiger, Ariz.
Steiger, Wis.
Stratton
Stuckey
Symms
Talcott
Taylor, Mo.
Taylor, N.C.
Teague
Thone
Treen
Vander Jagt
Waggonner
Walsh
Wampler
Whalen
Whitehurst
Wiggins
Wilson, Bob
Winn
Wydler
Wylie
Young, Alaska
Young, Fla.

NOT VOTING—12

Byron
Chisholm
Edgar
Harkin
Karth
Kemp
Landrum
Maguire
Risenhoover
Santini
Stephens
Waxman

So the previous question was ordered.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER. The question is on the resolution.

Mr. FRENZEL. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 259, nays 150, not voting 22, as follows:

[Roll No. 5]

YEAS—259

Abzug
Adams
Addabbo
Alexander
Ambro
Anderson, Calif.
Andrews, N.C.
Ashley
Aspin
AuCoin
Badillo
Baldus
Barrett
Baucus
Beard, R.I.
Bedell
Bennett
Bergland
Bevill
Biaggi
Bingham
Blanchard
Blouin
Boggs
Boland
Bolling
Bonker
Brademas
Breaux
Breckinridge
Brodhead
Brooks
Brown, Calif.
Burke, Calif.
Burke, Mass.
Burleson, Tex.
Burlison, Mo.
Burton, John
Burton, Phillip
Carney
Carr
Casey
Chisholm
Clay
Collins, Ill.
Conyers
Corman
Cornell
Cotter
D'Amours
Daniels, Dominick V.
Danielson
Davis
de la Garza
Delaney
Dellums
Derrick
Diggs
Dingell
Dodd
Downey
Drinan
Duncan, Oreg.
Early
Eckhardt
Edwards, Calif.
Eilberg
English
Evans, Colo.
Evans, Ind.
Evins, Tenn.
Fascell
Fisher
Fithian
Flood
Florio
Flowers
Foley
Ford, Mich.
Fountain
Fraser
Fulton
Fuqua
Giaimo
Gibbons
Gonzalez
Green
Gude
Haley
Hall
Hamilton
Hanley
Hannaford
Harkin
Harrington
Harris
Hawkins
Hayes, Philip H.
Hays, Wayne L.
Hébert
Hechler, W. Va.
Hefner
Helstoski
Henderson
Hicks
Hightower
Holtzman
Howard
Howe
Hubbard
Hughes
Hungate
Ichord
Jacobs
Jarman
Jenrette
Johnson, Calif.
Jones, Ala.
Jones, N.C.
Jones, Okla.
Jones, Tenn.
Jordan
Karth
Kastenmeier
Kazen
Keys
Kluczynski
Koch
Krebs
Krueger
LaFalce
Landrum
Leggett
Lehman
Levitas
Litton
Lloyd, Calif.
Lloyd, Tenn.
Long, La.
Long, Md.
McCormack
McDade
McFall
McHugh
McKay
Macdonald
Madden
Maguire
Mahon
Mann
Matsunaga
Mazzoli
Meeds
Melcher
Metcalfe
Meyner
Mezvinsky
Mikva
Milford
Miller, Calif.
Mineta
Minish
Mink
Mitchell, Md.
Moakley
Moffett
Mollohan
Moorhead, Pa.
Morgan
Moss
Mottl
Murphy, Ill.
Murphy, N.Y.
Murtha
Natcher
Neal
Nedzi
Nix
Nolan
Nowak
Oberstar
Obey
O'Hara
O'Neill
Ottinger
Passman
Patman
Patten
Patterson, Calif.
Pattison, N.Y.
Pepper
Perkins
Peyser
Pickle
Pike
Poage
Preyer
Price
Randall
Rees
Reuss
Riegle
Risenhoover
Roberts
Roe
Rogers
Roncalio
Rooney
Rose
Rosenthal
Rostenkowski
Roush
Roybal
Russo
St Germain
Sarbanes
Scheuer
Schroeder
Seiberling
Sharp
Shipley
Sikes
Simon
Sisk
Slack
Smith, Iowa
Solarz
Spellman
Staggers
Stanton, James V.
Stark
Steed
Stephens
Stokes
Stratton
Studds
Sullivan
Symington
Taylor, N.C.
Teague
Thompson
Thornton
Traxler
Tsongas
Ullman
Van Deerlin
Vander Veen
Vanik
Vigorito
Weaver
Whalen
White
Whitten
Wilson, Charles H., Calif.
Wilson, Charles, Tex.
Wolff
Wright
Yates
Yatron
Young, Ga.
Young, Tex.
Zablocki
Zeferetti

NAYS—150

Abdnor
Anderson, Ill.
Andrews, N. Dak.
Archer
Armstrong
Ashbrook
Bafalis
Bauman
Beard, Tenn.
Bell
Biester
Bowen
Brinkley
Broomfield
Brown, Mich.
Brown, Ohio
Broyhill
Buchanan
Burgener
Burke, Fla.
Butler
Byron
Carter
Cederberg
Chappell
Clancy
Clausen, Don H.
Clawson, Del
Cleveland
Cochran
Cohen
Collins, Tex.
Conable
Conlan
Conte
Coughlin
Crane
Daniel, Dan
Daniel, Robert W., Jr.
Derwinski
Devine
Dickinson
Downing
Duncan, Tenn.
du Pont
Edwards, Ala.
Emery
Erlenborn
Esch
Eshleman
Fenwick
Findley
Fish
Flynt
Forsythe
Frenzel
Frey
Gilman
Ginn
Goldwater
Goodling
Gradison
Grassley
Guyer
Hagedorn
Hammer-schmidt
Hansen
Harsha
Hastings
Heckler, Mass.
Heinz
Hillis
Hinshaw
Holt
Horton
Hutchinson
Hyde
Jeffords
Johnson, Colo.
Johnson, Pa.
Kasten
Kelly
Ketchum
Kindness
Lagomarsino
Latta
Lent
Lott
Lujan
McClory
McCloskey
McCollister
McDonald
McEwen
McKinney
Madigan
Martin
Michel
Miller, Ohio
Mitchell, N.Y.
Montgomery
Moore
Moorhead, Calif.
Mosher
Myers, Ind.
Myers, Pa.
O'Brien
Pettis
Pressler
Pritchard
Quie
Quillen
Railsback
Regula
Rhodes
Rinaldo
Robinson
Rousselot
Runnels
Ruppe
Sarasin
Satterfield
Schneebeli
Schulze
Sebelius
Shriver
Shuster
Smith, Nebr.
Snyder
Spence
Stanton, J. William
Steiger, Ariz.
Steiger, Wis.
Stuckey
Symms

Talcott	Waggonner	Winn
Taylor, Mo.	Walsh	Wydler
Thone	Wampler	Wylie
Treen	Whitehurst	Young, Alaska
Vander Jagt	Wilson, Bob	Young, Fla.

NOT VOTING—22

Annunzio	Minish	Skubitz
Dent	Nedzi	Steelman
Edgar	Nix	Udall
Ford, Tenn.	Rangel	Waxman
Gaydos	Richmond	Wiggins
Holland	Rodino	Wirth
Kemp	Ryan	
Miller, Calif.	Santini	

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. O'NEILL. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to extend their remarks concerning the resolution concerning the adoption of the rules.

The SPEAKER. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Sparrow, one of the clerks, announced that the Senate had passed resolutions of the following titles:

S. Res. 1. Resolution that a committee consisting of two Senators be appointed by the Vice President to join such committee as may be appointed by the House of Representatives to wait upon the President of the United States and inform him that a quorum of each House is assembled and that the Congress is ready to receive any communication he may be pleased to make; and

S. Res. 2. Resolution that the Secretary inform the House of Representatives that a quorum of the Senate is assembled and that the Senate is ready to proceed to business.

COMPENSATION OF CERTAIN MINORITY EMPLOYEES

Mr. RHODES. Mr. Speaker, I offer a resolution (H. Res. 6) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 6

Resolved, That pursuant to the Legislative Pay Act of 1929, as amended, six minority employees authorized therein shall be the following-named persons, effective January 3, 1975, until otherwise ordered by the House, to-wit: Joe Bartlett, Walter P. Kennedy, William R. Bonsell, Tommy Lee Winebrenner and John J. Williams to receive gross compensation of $36,000.000, respectively; and Martha H. Phillips to receive gross compensation of $29,545.60 per annum.

HOUR OF MEETING OF HOUSE OF REPRESENTATIVES

Mr. MADDEN. Mr. Speaker, I offer a resolution (H. Res. 7) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 7

Resolved, That until otherwise ordered, the daily hour of meeting of the House of Representatives shall be at 12 o'clock meridian.

The resolution was agreed to.

A motion to reconsider was laid on the table.

AUTHORIZING ADMINISTRATION OF OATH OF OFFICE TO HONORABLE WILBUR D. MILLS

Mr. WAGGONNER. Mr. Speaker, I offer a resolution (H. Res. 8) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 8

Whereas Wilbur D. Mills, a Representative-elect from the State of Arkansas, from the Second District thereof, has been unable from sickness to appear in person to be sworn as a Member of the House, and there being no contest or question as to his election: Therefore be it

Resolved, That the Speaker, or deputy named by him, be, and he is hereby, authorized to administer the oath of office to said Wilbur D. Mills at the Naval Medical Center, Bethesda, Maryland, and that the said oath, when administered as herein authorized, shall be accepted and received by the House as the oath of office of the said Wilbur D. Mills.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER. Pursuant to the authority of House Resolution 8, 94th Congress, the Chair appoints the gentleman from Louisiana (Mr. WAGGONNER) to administer the oath of office to the Honorable WILBUR D. MILLS.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

WASHINGTON, D.C.,
December 30, 1974.

Hon. CARL ALBERT,
Speaker, House of Representatives.

DEAR MR. SPEAKER: I have the honor to transmit herewith a sealed envelope from the White House, received in the Clerk's Office at 2:52 p.m. on Friday, December 27, 1974, and said to contain a message from the President wherein he transmits the Seventh Special Message to the Congress on the Deferral of Funds, concerning 19 deferral reports.

With kind regards, I am,

Sincerely,

W. PAT JENNINGS,
Clerk, House of Representatives.
By W. Raymond Calley

REPORTS ON DEFERRALS—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 94–10)

The SPEAKER laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, referred to the Committee on Appropriations and ordered to be printed.

To the Congress of the United States:

In accordance with the provisions of Title X of the Congressional Budget and Impoundment Control Act of 1974 (Public Law 93–344), I am transmitting supplementary reports that revise eleven deferral reports sent to the Congress in September and October of this year. I am also transmitting herewith reports on eight new deferrals for the fiscal year 1975.

Details of these deferrals are contained in the reports attached to this message.

GERALD R. FORD.

THE WHITE HOUSE, *December 27, 1974.*

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., January 2, 1975.

Hon. CARL ALBERT,
The Speaker,
U.S. House of Representatives.

DEAR MR. SPEAKER: I have the honor to transmit herewith a sealed envelope from the White House, received in the Clerk's Office at 12:30 P.M. on Tuesday, December 31, 1974 and said to contain a message from the President wherein he transmits the Sixth Annual Report on the National Housing Goal.

With kind regards, I am

Sincerely,

W. PAT JENNINGS,
Clerk, U.S. House of Representatives.
By W. RAYMOND COLLEY,
Deputy Clerk.

SIXTH ANNUAL REPORT ON NATIONAL HOUSING GOAL—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 94–18)

The SPEAKER laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, referred to the Committee on Banking and Currency and ordered to be printed.

To the Congress of the United States:

I herewith transmit the Sixth Annual Report on the National Housing Goal as required by Section 1603 of the Housing and Urban Development Act of 1968.

GERALD R. FORD.

THE WHITE HOUSE, *December 31, 1974.*

COMMUNICATION FROM THE CLERK OF THE HOUSE—SENATOR JAMES L. BUCKLEY, ET AL., VERSUS HON. FRANCIS R. VALEO, SECRETARY, U.S. SENATE, ET AL.

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., January 7, 1975.

Hon. CARL ALBERT,
The Speaker,
U.S. House of Representatives.

DEAR MR. SPEAKER: On this date, both as Clerk of the United States House of Representatives, and as an Ex Officio Member of the Federal Election Commission upon its appointment and qualification, I have been served a Summons and a copy of the Complaint for Declaratory and Injunctive Relief, the Application for a Three-Judge

Court, and the Motion to Reduce Defendants' Time to Answer from Sixty Days to Thirty Days, that was filed in the United States District Court for the District of Columbia. The Complaint, Application and Motion are in connection with the civil action brought by Senator James L. Buckley, former Senator Eugene J. McCarthy, Congressman William A. Steiger, Mr. Stewart Rawlings Mott, the Committee for a Constitutional Presidency, the Conservative Party of the State of New York, the New York Civil Liberties Union, Inc., the American Conservative Union, Human Events, Inc., v. Hon. Francis R. Valeo, Secretary, U.S. Senate, Hon. W. Pat Jennings, Clerk, U.S. House of Representatives, Hon. Elmer B. Staats, Comptroller General of the United States, Hon. William B. Saxbe, Attorney General of the United States, and the Federal Election Commission, c/o Hon. Francis R. Valeo, Ex Officio Member of the Federal Election Commission, and c/o Hon. W. Pat Jennings, Ex Officio Member of the Federal Election Commission, Civil Action No. 75–0001, U.S. District Court for the District of Columbia.

This action was instituted against the Clerk of the House in his capacities under the Federal Election Campaign Act of 1971, Public Law 92–225, 86 Stat. 3, and the Federal Election Campaign Act Amendments of 1974, Public Law 93–443, 88 Stat. 1263, and seeks declaratory and injunctive relief against certain provisions of both the aforementioned statutes.

It is my purpose to inform you that in accordance with House Resolution 12 of January 3, 1973, I intend to make arrangements for my defense as provided for the Officers of the U.S. House of Representatives under 2 U.S.C. 118. Further, upon the appointment and qualification of the Federal Election Commission, I intend to transmit said Summons, Complaint, Application and Motion to the Commission for such action as they deem appropriate. In addition, at this time, because of my dual capacities under the two aforementioned statutes, I am respectfully reserving my right to appoint Special Counsel for my defense as prescribed by Public Law 93–145 of November 1, 1973.

Copies of the Summons, Complaint, Application and Motion under consideration are herewith attached, and the matter is presented for such action as the House in its wisdom may see fit to take.

With kind regards, I am

Sincerely,

W. PAT JENNINGS,
Clerk, U.S. House of Representatives.

The SPEAKER. The Clerk will report the subpena.

The Clerk read as follows:

[In the U.S. District Court for the District of Columbia, civil action file No. 75–0001]

SUMMONS IN A CIVIL ACTION

James L. Buckley, et al., Plaintiffs v. Francis R. Valeo, et al., Defendants.

To the above named Defendant: W. Pat Jennings.

You are hereby summoned and required to serve upon Brice McAdoo Clagett plaintiffs' attorney, whose address is 888 Sixteenth Street, NW., Washington, D.C. 20006, an answer to the complaint which is herewith served upon you, within 60 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

JAMES F. DAVEY,
Clerk of Court.

———,
Deputy Clerk.

Date: January 2, 1975.

OFFICE OF THE CLERK,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., January 7, 1975.

Hon. EARL J. SILBERT,
U.S. Attorney for the District of Columbia, U.S. Courthouse, Washington, D.C.

DEAR MR. SILBERT: I am enclosing certified copies of the Summonses and Complaint for Declaratory and Injunctive Relief, an Application for a Three-Judge Court, and a Motion to Reduce Defendants' Time to Answer from 60 to 30 days in Civil Action No. 75–0001 filed against me both as Clerk of the U.S. House of Representatives and as Ex Officio Member of the Federal Election Commission, in the United States Court for the District of Columbia and served upon me in my official capacity as Clerk of the House of Representatives by a U.S. Marshall on this date.

In accordance with Title 2, U.S. Code, Sec. 118, I respectfully request that you take appropriate action, as deemed necessary, under the "supervision and direction of the Attorney General" of the United States in defense of this suit against an officer of either House of the Congress of the United States.

Since this action was brought against me as Clerk of the House in my capacity as Supervisory Officer under the Federal Election Campaign Act of 1971, P.L. 92–225, and as Ex Officio Member of the Federal Election Commission under the Federal Election Campaign Act Amendments of 1974, P.L. 93-443. I reserve the right to appoint at any time a co-counsel for my defense under Public Law 93–145 of November 1, 1973.

I am also sending you a copy of the letter that I forwarded this date to the Attorney General of the United States.

With kindest regards, I am

Sincerely,

W. PAT JENNINGS,
Clerk,
U.S. House of Representatives.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
U.S. REPRESENTATIVES,
Washington, D.C., January 14, 1975.

Hon. CARL ALBERT,
The Speaker, U.S. House of Representatives.

DEAR MR. SPEAKER: Under Rule III, Clause 4 (Section 647) of the Rules of the House of Representatives, I herewith designate Mr. W. Raymond Colley, Deputy Clerk, to sign any and all papers and do all other acts for me under the name of the Clerk of the House which he would be authorized to do by virtue of this designation, except such as are provided by statute, in cases of my temporary absence or disability.

If Mr. Colley should not be able to act in my behalf for any reason, then Mr. Benjamin J. Guthrie, Assistant to the Clerk, shall similarly perform such duties under the same conditions as are authorized by this designation.

These designations shall remain in effect for the 94th Congress or until revoked by me.

Sincerely,

W. PAT JENNINGS,
Clerk,
U.S. House of Representatives.

REPORT OF COMMITTEE TO NOTIFY THE PRESIDENT

Mr. O'NEILL. Mr. Speaker, your committee on the part of the House to join a like committee on the part of the Senate to notify the President of the United States that a quorum of each House has been assembled and is ready to receive any communication that he may be pleased to make has performed that duty. The President asked us to report that he will be pleased to deliver his message at 1 p.m., Wednesday, January 15, 1975, to a joint session of the two Houses.

JOINT SESSION OF CONGRESS—STATE OF THE UNION MESSAGE

Mr. O'NEILL. Mr. Speaker, I offer a concurrent resolution (H. Con. Res. 1) and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 1

Resolved by the House of Representatives (the Senate concurring), That the two Houses of Congress assemble in the Hall of the House of Representatives on January 15, 1975 at 1 o'clock p.m. for the purpose of receiving such communication as the President of the United States shall be pleased to make to them.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

AUTHORIZING SPEAKER TO DECLARE RECESSES TOMORROW

Mr. O'NEILL. Mr. Speaker, I ask unanimous consent that on Wednesday, January 15, 1975, the Speaker be authorized to declare recesses subject to the call of the Chair.

The SPEAKER. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair would like to make a statement concerning the introduction and reference of bills today.

As Members are aware, they have the privilege today of introducing bills. Heretofore on the opening day of a new Congress, several thousand bills have been introduced. It will be readily apparent to all Members that it may be a physical impossibility for the Speaker to examine each bill for reference today. The Chair will do his best to refer as many bills as possible, but he will ask the indulgence of Members if he is unable to refer all the bills that may be introduced. Those bills which are not referred and do not appear in the RECORD as of today will be included in the next day's RECORD and printed with a date as of today.

The Chair has advised all officers and employees of the House that are involved in the processing of bills that every bill, resolution, memorial, petition, or other material that is placed in the hopper must bear the signature of a Member. Where a bill or resolution is jointly sponsored, the signature must be

that of the Member first named thereon. The bill clerk is instructed to return to the Member any bill which appears in the hopper without an original signature. This procedure was inaugurated in the 92d Congress. It has worked well, and the Chair thinks that it is essential to continue this practice to insure the integrity of the process by which legislation is introduced in the House.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair desires to make an announcement.

After consultation with the majority and minority leaders, and with their consent and approval, the Chair announces that on tomorrow, when the Houses meet in joint session to hear an address by the President of the United States, only the doors immediately opposite the Speaker and those on his left and right will be open.

No one will be allowed on the floor of the House who does not have the privilege of the floor of the House.

Due to the large attendance which is anticipated, the Chair feels that the rule regarding the privilege of the floor must be strictly adhered to.

Children of Members will not be permitted on the floor and the cooperation of all the Members is requested.

PROCEDURES IN RELATION TO THE PRODUCTION OF WITNESSES AND DOCUMENTS IN COURTS OF JUSTICE

Mr. O'NEILL. Mr. Speaker, I offer a resolution (H. Res. 9) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 9

Whereas, by the privileges of this House no evidence of a documentary character under the control and in the possession of the House of Representatives can, by the mandate of process of the ordinary courts of justice, be taken from such control or possession except by its permission: Therefore be it

Resolved, That when it appears by the order of any court in the United States or a judge thereof, or of any legal officer charged with the administration of the orders of such court or judge, that documentary evidence in the possession and under the control of the House is needful for use in any court of justice or before any judge or such legal officer, for the promotion of justice, this House will take such action thereon as will promote the ends of justice consistently with the privileges and rights of this House; be it further

Resolved, That during any recess or adjournment of the Ninety-fourth Congress, when a subpena or other order for the production or disclosure of information is by the due process of any court in the United States served upon any Member, officer, or employee of the House of Representatives, directing appearance as a witness before the said court at any time and the production of certain and sundry papers in the possession and under the control of the House of Representatives, that any such Member, officer or employee of the House, be authorized to appear before said court at the place and time named in any such subpena or order, but no papers or documents in the possession or under the control of the House of Representatives shall be produced in response thereto; and be it further

Resolved, That when any said court determines upon the materiality and the relevancy of the papers or documents called for in the subpena or other order, then said court, through any of its officers or agents shall have full permission to attend with all proper parties to the proceedings before said court and at a place under the orders and control of the House of Representatives and take copies of the said documents or papers and the Clerk of the House is authorized to supply certified copies of such documents that the court has found to be material and relevant, except that under no circumstances shall any minutes or transcripts of executive sessions, or any evidence of witnesses in respect thereto, be disclosed or copied, nor shall the possession of said documents and papers by any Member, officer, or employee of the House be disturbed or removed from their place of file or custody under said Member, officer, or employee; and be it further

Resolved, That a copy of these resolutions be transmitted by the Clerk of the House to any of said courts whenever such writs of subpena or other orders are issued and served as aforesaid.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PROVIDING FOR THE PAYMENT OR REIMBURSEMENT OF EXPENSES INCURRED BY STAFF PERSONS ACCOMPANYING MEMBERS-ELECT AT ORGANIZATIONAL CAUCUSES AND CONFERENCES

Mr. O'NEILL. Mr. Speaker, I offer a resolution (H. Res. 10) and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 10

Resolved, That (a) each Member-elect (other than an incumbent Member reelected to the ensuing Congress) who attends a caucus or conference called under section 202 (a) of House Resolution 988, Ninety-third Congress, and each incumbent Member reelected to the ensuing Congress who attends any such caucus or conference convening after the adjournment sine die of the Congress in the year involved, shall be entitled to designate one staff person to be paid for one round trip between that person's place of residence, provided such place of residence is in the district which the Member-elect or incumbent Member represents, and Washington, District of Columbia, for the purpose of accompanying that Member-elect or incumbent Member to such caucus or conference.

(b) Each Member-elect (other than an incumbent Member reelected to the ensuing Congress) who attends a caucus or conference called under such section 202(a) shall be entitled to designate one staff person who shall in addition be reimbursed on a per diem or other basis for expenses incurred in accompanying the Member-elect at the time of such caucus or conference for a period not to exceed the shorter of the following—

(1) the period beginning with the day before the designated date upon which such caucus or conference is to convene and ending with the day after the date of the final adjournment of such caucus or conference; or

(11) fourteen days.

SEC. 2. (a) Payments and reimbursements to staff persons under the first section of this resolution shall be made as provided (with respect to staff) in the regulations prescribed by the Committee on House Administration with respect to travel and other expenses of staff. Reimbursements shall be paid on special voucher forms prescribed by the Committee on House Administration.

(b) Additional funds, if any, for staff allowances and office space for use by Members-elect (other than an incumbent Member reelected to the ensuing Congress) shall be authorized by the Committee on House Administration.

The resolution was agreed to.

A motion to reconsider was laid on the table.

APPOINTMENT AS MEMBERS OF HOUSE OFFICE BUILDING COMMISSION

The SPEAKER. Pursuant to the provisions of 40 U.S.C. 175 and 176, the Chair appoints the gentleman from Massachusetts, Mr. O'NEILL, and the gentleman from Arizona, Mr. RHODES, as members of the House Office Building Commission to serve with himself.

EXTENDING TIME WITHIN WHICH THE PRESIDENT MAY TRANSMIT BUDGET MESSAGE AND THE ECONOMIC REPORT TO THE CONGRESS

Mr. MAHON. Mr. Speaker, I ask unanimous consent for the immediate consideration of the joint resolution (H.J. Res. 1) extending the time within which the President may transmit the Budget Message and the Economic Report to the Congress.

The Clerk read the title of the joint resolution.

The SPEAKER. Is there objection to the request of the gentleman from Texas?

Mr. BROWN of Michigan. Mr. Speaker, reserving the right to object, I would ask that the gentleman from Texas explain the necessity for this resolution.

Mr. MAHON. The resolution would give the President additional time in which to make his submission of the budget to the Congress. The President has asked for the additional time to submit his budget. Under the law he has to submit it within 15 days, but this will give him a little additional time, until February 3. It is a routine kind of thing that we have often done before.

Mr. BROWN of Michigan. If the gentleman would further respond, Mr. Speaker, the request with respect to the report of the Joint Economic Committee is the same; is that correct?

Mr. MAHON. The gentleman is correct and the date would be extended to February 4.

Mr. BROWN of Michigan. I thank the gentleman.

Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER. Is there objection to the request of the gentleman from Texas?

There was no objection.

The Clerk read the joint resolution, as follows:

H.J. RES. 1

Resolved by the Senate and House of Representatives of the United States of America in Congress Assembled, That (a) notwithstanding the provisions of section 201 of the Act of June 10, 1922, as amended (31 U.S.C. 11), the President shall transmit to the Congress not later than February 3, 1975, the Budget for the Fiscal Year 1976, and (b) notwithstanding the provisions of section 3 of the Act of February 20, 1946, as amended (15 U.S.C. 1022), the President shall transmit to the Congress not later than February 4, 1975, the Economic Report; and (c) notwithstanding the provisions of clause (3) of section 5(b) of the Act of February 20, 1946 (15 U.S.C. 1024(b)), the Joint Economic Committee shall file its report on the President's Economic Report with the House of Representatives and the Senate not later than March 30, 1975.

The SPEAKER. The question is on the engrossment and third reading of the joint resolution.

The joint resolution was ordered to be engrossed and read a third time, was read the third time and passed, and a motion to reconsider was laid on the table.

THE PEOPLE'S CONCERN: THE ECONOMY

(Mr. DE LA GARZA asked and was given permission to address the House for 1 minute, to revise and extend his remarks and include extraneous matter.)

Mr. DE LA GARZA. Mr. Speaker, like other Members I have spent most of the past month in my congressional district talking with the people I represent here. I found, as I have no doubt other Members have found, that the people generally are concerned and deeply worried about what the continued downward trend of the economy means to them individually. Their stories reveal the human distress that lies behind the dreary statistics which darken the pages of our newspapers day after day.

The official figures show that the unemployment rate rose in December to its highest point in 13 years—up to 7.1 percent of the total labor force from 6.5 percent in November. The figure is doubtless higher now, for massive layoffs of workers in a wide variety of industries have continued in recent weeks and are still continuing, and very unfortunately it is always higher than the norm in my congressional district.

Fewer workers on the job inevitably result in lower production in our industrial plants. Nearly half of the firms belonging to the National Association of Purchasing Management reported declining output in December—the highest proportion since 1958.

New construction contracts are running 20 percent below those of a year ago. Home building is a disaster area, although millions of our citizens are inadequately housed.

Prices received by farmers dropped 3 percent between the middle of November and the middle of December. Beef cattle producers are having to slaughter calves, because it would cost more to feed them to maturity than the price they would bring on the market.

The fishing industry, also of importance to my South Texas district, is threatened with ruin by a combination of unrealistically low prices and sky-high fuel costs.

Mr. Speaker, without belaboring the point, it is clear that such facts as these give evidence that the country is in a recession of serious proportions.

Its gravity is intensified by the further fact that overall living costs have risen to a painfully high point. At the same time that farmers and cattlemen and fishermen face falling prices for the fruits of their toil, at the same time that millions of men and women are jobless, the cost of the necessities of life places a heavy burden not only on low-income groups but on middle-income groups as well. Most family budgets have been thrown badly out of kilter during the past year.

Action to turn the economy around is essential. And it must come early in this session of Congress.

There is, I feel sure, little or no disagreement among my colleagues about this necessity. No doubt there will be differences of opinion about what steps should be taken and how far they should go. It is my hope and expectation that such differences can be resolved equitably and without delay.

In this connection, I have been disturbed by some predictions appearing in the press of a coming struggle between the Members of Congress and the executive department to gain partisan credit for whatever is done to reverse the downward trend of the economy. I trust that events will prove the inaccuracy of such forecasts. It would be tragic if efforts to end the recession were turned into a contest for political advantage. This is not a time and should not be the subject for competition between the legislative body and the administration, or between the two political parties.

It is our country—the country of all Americans—that is in trouble. Commonsense calls for a determined, cooperative effort to tackle the root causes. Political considerations of any kind must not be permitted to lead to blind opposition or blind support of any seriously proposed legislative measures. Each one should be examined closely to determine if it will help to get the necessary job done.

The President has made known some of his plans to bolster the economy and to take further steps to deal with the energy problem and will present them formally to the Congress tomorrow in his state of the Union message. House leaders have outlined a program of their own. The President's plans and the congressional program are not far apart in some respects. I have no doubt that, in the best traditions of this body, they will receive serious and thoughtful consideration.

Mr. Speaker, all of us here or nearly all are fresh from our constituencies. We know that America is confronted with problems of the utmost urgency in the state of the economy, the energy supply shortage, and the resultant exorbitant prices for fuel, and the agricultural sector. I have briefly reviewed the existing situation not for the purpose of presenting a litany of pessimism, but rather in the hope that a clear view of matters as they are will lead us to take action—and quickly—to make them better. I, for one, believe that this will be done. It is a course that demands top priority in the 94th Congress.

I append as part of my remarks several newspaper articles bearing on this subject:

[From The Washington Post]

WHAT TO EXPECT OF ECONOMY IN 1975

(Here are some of the things you can expect in 1975:)

Unemployment: Rising steadily throughout the first half of the year to a peak of about 8 per cent.

Taxes: A quick tax cut of at least $10 billion, and perhaps $20 billion, to stimulate the recession-ridden economy.

Recession: It will probably "bottom out" by the middle of the year, although the improvement may not set in for some time after that.

Prices: Nearly all forecasters agree that, by historical standards, prices will be rising exhorbitantly—but the 6 to 7 per cent expected increase will be a welcome relief from "double-digit" inflation.

Utilities: Consumers will be getting higher monthly bills for electricity, natural gas and telephones.

Interest Rates: Short-term interest rates will decline steadily throughout the year but long-term rates, such as those charged on home mortgages, will not change very much.

Home Building: Housing construction will remain seriously depressed, but most experts forecast a slight uptrend by the last several months of the year.

Wages: For those in the population who continue to work throughout the recession—most people—wages should rise 10 to 12 per cent.

Oil Prices: No one knows for sure what the oil-producing countries will do, except that no one thinks they will lower their prices. There will be pressure to take controls off domestically-produced oil, as well as off natural gas. Price controls on oil expire the middle of the year.

[From the Washington Star-News, Jan. 12, 1975]

THE 94TH COMES TO TOWN

If ever there was a national legislature needing strong minds, steady hands and a vision of America's destiny, it is the 94th Congress that convenes on Tuesday.

As the 93rd was marked by Watergate, the 94th will be measured by how well or poorly it handles the related problems of energy and the economy. There are many other issues to be dealt with, to be sure, but none so pressing as the need to pull the country out of its economic slump, stem inflation and find a key to the energy crisis.

Unless programs are devised to get production lines moving at a brisker pace and get customers back in the market place in greater numbers—and get it done soon—this country could slide into a depression that could have severe consequences to the nation's and the world's social and political orders.

We have no panaceas; indeed, there are no instant or easy solutions. But we do know that the problems cannot be solved if the White House and the Congress go charging off in separate directions, if presidential politics is allowed to get in the way of the national interest, if parochial concerns rather than the bigger picture dominate the thinking of congressional minds.

To a large extent, the economic problems will require active manipulation of such government strings as taxes, money supply and federal spending. If inflation continues out of hand, it may require government controls. But another important element in combatting the economic malaise is the restoration of public confidence, and that requires a display of leadership. If the people believe that their officials are concerned and are trying, they will feel more secure and the task of recovery will be made easier.

Leadership will be needed no less in the field of energy and, again, the solution to this multi-faceted problem will not rest entirely in statutory restraints on energy use or in federal programs to encourage research and exploration for new sources. Part of it will lie in the ability of federal officials to convince the American people that they must alter their life-style somewhat, that they must adjust to a world in which fuel supplies are growing ever shorter, that they must realize that the national economy cannot stand the continued heavy financial drain from high-priced foreign oil.

Unfortunately, leadership is something that is not always in plentiful supply on Capitol Hill. There are no legislative giants these days who can pull together the divergent views and interests of 435 House members and 100 senators. There is, however, a Democratic party responsibility to see that the members work together for the common good. For the 94th Congress, which was elected in the aftermath of Watergate and during an economic slump, is overwhelmingly Democratic. In this connection, we hope that potential or avowed candidates for the Democratic presidential nomination will curb inclinations to engage in the game of one-upsmanship. Presidential fever exerted a substantial influence on some members in the 93d Congress and the temptation to play to the crowd will be even greater as the 1976 election approaches.

As the 94th Congress will be more Democratic, so will it have a more liberal cast. That does not mean, necessarily, that it will embark on a binge of costly social legislation, for some of the new members who carried the liberal label made specific campaign promises to hold down on new spending schemes. But the temptations and the pressures will be there and it will be up to the members to resist them.

Likewise they must resist the temptation to carve overly large chunks out of the defense budget. The military establishment and its budget have long been a target of the more liberal elements on Capitol Hill and their influence will be enhanced this year. There is some fat in every budget, of course, but it would be irresponsibility of the worst sort to cut the muscle and seriously weaken this nation's defense posture.

And while we are in the area of what members of Congress should resist, we should mention the need to forego excessive attention to the details of conducting foreign policy. We agree with Secretary of State Kissinger that some of the actions of the 93d Congress impaired the flexibility that the executive branch must have in the foreign arena.

Lest we dwell too long on the negative side, there are many problems in addition to the economy and energy that call for positive action. One of them is tax reform. Aside from the probable need of a tax cut to give the economy a shot in the arm, there has been a long-standing need to eliminate loopholes and make the entire tax system more fair.

There also is a need for some kind of national health insurance. If the huge cost of a comprehensive plan is too much of a burden in these unsettled times, the Congress ought at least to enact a program to take care of the cost of catastrophic illnesses.

The new Congress should devise a substitute for the welfare mess. It needs to give attention to the Social Security system that is getting more burdensome on wage earners every year. It must bolster programs for aiding localities in building and operating the mass transit systems that are vitally needed in this time of energy crisis.

There hardly is an end, really, to the tasks that await the 94th Congress. The decisions that are made on Capitol Hill in the months ahead could well determine the fortunes of the United States for decades to come.

[From the New York Times]

A NEW CONGRESS

When the 94th Congress convenes this week it will continue what has become a modern tradition in American Government—the sharing of power between a President and a Congress of differing philosophical persuasion. The new Congress with its substantially strengthened Democratic majority is considerably more liberal than the President. But that is nothing new.

Since President Franklin D. Roosevelt lost a working majority in Congress for his New Deal program in the midterm election of 1938, there have been only two brief periods in the succeeding 36 years when a Chief Executive and the majority of the House and Senate saw eye to eye on major domestic issues.

This division of power bewilders all but the most sophisticated foreigners and often worries Americans themselves. But in a nation of such size and diversity, this divided authority may represent a reasonable balance among contending viewpoints and interest groups. In any event, history has shown that sharing of power can produce effective government.

Conflict between parties and between philosophies is not only normal but necessary. In a free society, politics is the means by which problems and ideals are articulated, disagreements expressed, and decisions worked out. Those who expect harmony or unity to prevail in Washington are expecting what political democracy cannot—and indeed, should not—provide. As long as the great conversation of self-government stays within the bounds of civility and decisions are reached within a reasonable time, the nation can well afford the din and clash of angry debate and even some self-interested partisanship.

Justice Holmes was fond of remarking: "Conflict is the core of life." Cooperation, however, is also at the center of existence. Otherwise, organized national societies would hardly be viable. In government, as in other spheres of activity, patterns of conflict and cooperation evolve. President and Congress tend to develop their own.

It is not yet clear whether President Ford intends to stress the adversary or the accommodating sides of his relationship with Congress. He begins in a position of weakness. He came into office five months ago without a personal mandate from the electorate. During these months he has suffered the fastest decline in popularity—from 71 per cent in August to 42 per cent in December—ever recorded by the Gallup Poll. His moral prestige was dimmed by the Nixon pardon, while his leadership capacity is now being severely tested by the demands of a deteriorating economy.

Congress cannot by itself govern the country; if it were to attempt to do that, it would have to choose a committee of its leaders to act in its behalf which would be tantamount to parliamentary government in the European manner. But Congress can take major initiatives in formulating national policy. The nation's three basic labor laws—the Wagner Act, the Taft-Hartley Act, and the Landrum-Griffin Act—were drafted on Capitol Hill rather than in the Executive. The Wilderness Act and several other conservation laws were formulated by members of Congress working with public-spirited citizens. Tax laws are usually much more the work of Congress than of the Treasury Department.

Congress and the President can be expected to devote most of their attention to a wide range of measures to cope with the inflation, the recession, and the energy problems. If President Ford falters on economic issues, Congress is sure to substitute its judgment for his. In the lively controversies certain to develop in the next two years, the public can benefit from the competition between the two branches.

The test will be whether the conflict produces ultimate agreement on constructive legislation or dwindles into sterile stalemate. The power is shared by President and Congress; so is the responsibility.

STRENGTHENING VOCATIONAL EDUCATION SYSTEMS

(Mr. PRESSLER asked and was given permission to address the House for 1 minute, to revise and extend his remarks, and include extraneous matter.)

Mr. PRESSLER. Mr. Speaker, today is my first day in the Congress. My first effort on the floor of this House is directed toward strengthening our vocational education systems. I do so because I believe so strongly in our Nation's need to fully utilize the talents and resources of our people. For too long we have placed too much emphasis on traditional college-type education. Our society increasingly places prestige and prominence with the white-collar type of employment, while it tends to think less of blue-collar work. We must change that.

In that vein I urge your attention and positive consideration of what I believe will be one of the major pieces of legislation from the 94th Congrses—the vocational education legislation of 1975.

It is a privilege to be a cosponsor of this important legislation with Mr. PERKINS of Kentucky and Mr. QUIE of Minnesota.

The readjustment of our educational priorities to give greater financial consideration and support to vocational instruction will be invaluable for America for several reasons.

With increasing shortages of natural resources, we must make the best use—and reuse—of all materials and all human skills and talents, which—significantly—are primary purposes of vocational education.

With the present bitter combination of economic problems facing the Nation and its people—and, it seems, the ever-growing welfare rolls—a renewal of the work ethic can be a major factor in restoring our country's fiscal health as well as its morale.

Many persons do not want or need a college education or a liberal arts degree; but they want to be productive, creative members of the community, providing for themselves and their families through their own efforts.

In South Dakota some 25,000 young men and women are getting valuable career preparation to satisfy their personal goals, and, at the same time, contribute to the country's long-range prosperity.

Thanks to more than $1.6 million in Federal funds which help support major vocational education programs in Watertown, Sisseton, Webster, Mitchell, and Sioux Falls, as well as in Lemmon, Sturgis, and Rapid City, this is possible.

This amendment, introduced by Mr. PERKINS, Mr. QUIE, and myself, would extend and expand vocational instruction in South Dakota and across America, providing practical skills and releasing creative talents in our young citizens which will help keep this Nation strong and prosperous.

CONGRESSMAN WHALEN OFFERS PLAN TO FIGHT THE RECESSION AND CURB INFLATION

The SPEAKER pro tempore (Mr. DANIELSON). Under a previous order of the House, the gentleman from Ohio (Mr. WHALEN) is recognized for 10 minutes.

Mr. WHALEN. Mr. Speaker, I am introducing today a package of bills to carry out part of the program which I urge be adopted to fight the recession and curb inflation. My proposals are:

First, to amend the Internal Revenue Code of 1954 to increase the amount of the personal exemption to $1,000—from $750—to increase the amount of the minimum and maximum standard deductions, to lower by 1 percentage point the tax rates which apply to the brackets up to $28,000, and to increase the amount of the investment tax credit from 4 and 7 percent to 10 percent;

Second, to authorize and require the President to ration gasoline and diesel fuel;

Third, to amend the Internal Revenue Code of 1954 to impose an excise tax on every new passenger automobile with respect to its weight; and

Fourth, to amend the Council on Wage and Price Stability Act to authorize the establishment of wage and price guidelines, to provide the Council with authority to suspend wage and price increases for 90 days, to provide subpena power for the Council, and to permit it to suspend from the Federal bid list for 1 year any firm which violates its guidelines.

I am inserting the statement which I released last Wednesday, January 8, which outlines my response to the economic difficulties now confronting the Nation:

STATEMENT ON THE ECONOMY

(By CHARLES W. WHALEN, JR.)

I. INTRODUCTION

In an October 7, 1974, speech I stated that the jobless rate would reach 7 percent and unemployment would replace inflation as "Public Enemy Number 1". Unfortunately, within the short period of three months both of these predictions have materialized.

My concern about the incipient recession also prompted me the next day (October 8) to reject President Ford's surtax proposal. As I observed at the time, "the President is suiting us up for the wrong game". Or, in the language of academia, in a deepening recession a tax increase runs counter to sound macroeconomic policy.

My October statement contained several recommendations designed to cope with the ills besetting our nation. Several of these already have been implemented by Congress. Others still are worthy of legislative consideration. Yet the swiftness and intensity of the current economic decline calls for stronger anti-recession palliatives than those outlined in my October 7 address.

Yet in dealing with contracting production and increasing unemployment, Congress must not overlook the still serious problem of inflation. In November, 1974, the Consumer Price Index advanced at an annual rate of 12.1 percent. Indeed, the American economy can be compared to a cancer victim who also suffers from heart disease. Each must be diagnosed and treated as a separate illness. But, at the same time, the attending physicians must be careful not to prescribe remedies which, while curing one ailment, unduly aggravate the other.

It is in keeping with the constraints suggested by the foregoing analogy that I update my October 7, 1974, paper by offering the following "prescriptions".

II. RECESSION

A. Cause of growing unemployment

As I indicated on October 7, "due to inflation each citizen, between June 30, 1973, and June 30, 1974, experienced a $102 drop in real per capita income. . . . Consumers simply are less able to buy—by approximately $22.5 billion since last year". (Note: later figures show that between September 30, 1973, and September 30, 1974 real per capita income declined by $110.) There could be only one result: dwindling purchasing power leads to reduced production; a reduced production generates higher unemployment. This sequence is as inevitable as night following day. Thus, it was not surprising when last week the Bureau of Labor Statistics revealed that nationwide unemployment had soared to 7.1 percent of the country's labor force.

B. Suggested actions

1. Increase "Take-Home" Pay

In the light of the preceding facts, it is obvious that, in order to stem the current economic decline, there must be a restoration of the consumer's ability to buy. This can best be done by increasing his take-home pay (most of which, in conformance with the "marginal propensity to consume" theory, will be re-spent). Expanding take-home pay may be accomplished in one of two ways (or a combination of the two).

First, American employees can press for higher wages in 1975. Under present circumstances this approach is deficient in two respects. (a) A portion of the salary increase will be diverted to the federal, state, and local governments in the form of withheld taxes (probably at a higher rate). (b) The increased labor costs precipitated by such wage boosts inevitably will mean higher prices, thus negating the original benefits derived from compensation advances.

Second, personal income tax rates can be trimmed. This is the preferable course today. A federal tax cut will not add directly to the cost of goods and services as would wage hikes. Further, there is considerable slack in the economy. Industry, in the third quarter, 1974, was operating at 79.4 percent of capacity (versus 83.3 percent plant utilization during the same period in 1973). Consequently, with adequate capacity to expand output, the economy can absorb a demand stimulant without a concomitant increase in price levels.

I, therefore, propose a $20 billion reduction in federal income taxes, effective January 1, 1975. Specifically, I suggest that: (a) the personal exemption be lifted from $750 to $1,000 ($9.7 billion); (b) the minimum standard deduction be raised from $1,300 to $2,000 ($3 billion); (c) the maximum standard deduction, now 15 percent or $2,000, be increased to 15 percent or $3,000 ($800 million); and (d) the rate applicable to each taxable income bracket, up to $28,000, be lowered by one percentage point ($4 billion).

Those in the lower and middle-income categories would be the principal beneficiaries of these four revisions. Also these reductions would restore most of the real per capita income lost by 200,000,000 citizens during the past eighteen months.

Jobs, of course, are created only through investment. Increased consumer demand spawned by a tax cut ultimately will result in employee callbacks and, hopefully, will create a need to expand production facilities. The latter will occur, however, only if employers are in a position to retain sufficient receipts to finance the purchase of additional buildings, machinery, and inventory. Thus, I endorse President Ford's October 8, 1974, suggestion that the investment tax credit be increased from 7 to 10 percent for industry and from 4 to 10 percent for utilities. For the coming year this would mean approximately $2.5 billion in tax relief for business organizations. In time, however, this break would disappear as depreciation and equipment "length-of-life" regulations are tightened by the Internal Revenue Service.

2. Tax Reform

As I stated on the House Floor on April 11, 1974, "Tax reform is an idea whose time has come". In my speech I delineated a series of proposals aimed at achieving a more equitable distribution of the tax burden. Unfortunately, the 93d Congress failed to act upon these and similar plans advanced by several of my colleagues.

A "fair" tax code still is essential. Therefore, any tax reduction ultimately must be coupled with tax reform. Enactment of a $20 billion tax cut must be completed within the next sixty days. This is too short a period, however, for Congress to conclude a meaningful tax reform effort. Consequently, any tax reduction adopted by the 94th Congress should contain a December 31, 1975, expiration date. The reduction then can be made permanent when tax equity has been attained.

3. Pinpoint Federal Expenditures

A two-front fiscal attack is needed to counteract the current economic slump. As previously noted, tax policy should be utilized to expand the consumer's ability to buy the stock of goods and services potentially available to him. Expenditure programs also are required to assist those already victimized by the recession. Fortunately, the 93d Congress, during its closing days, acted decisively in this area.

(a) Public employment program

In my October 7 comments I urged that in order to combat growing unemployment, a portion of the federal budget "be allocated to a program of public employment". Ten weeks later, on December 18, Congress approved legislation authorizing $2.5 billion, available through December 31, 1975, for a new emergency public service jobs program. The bill, which the President signed into law on December 31, also provides $500 million to speed-up labor-intensive federal public works projects for areas where the jobless rate is 6.5 percent or higher.

(b) Extension of unemployment benefits

At the same time, unemployment benefits were improved under the above-mentioned bill and through the Emergency Unemployment Compensation Act, which I introduced on November 26. The latter measure extends coverage for up to twenty-six weeks for 12 million workers not presently eligible for unemployment compensation. Availability would be triggered if the adjusted national unemployment rate averaged 6 percent for three consecutive months. Under the former proposal, which the President also signed on December 31, an additional thirteen weeks of assistance would be available to those

who have exhausted their regular and extended benefits (thus making them eligible for a total of fifty-two weeks of coverage). This provision becomes effective if the national insured unemployment rate reaches 4.5 percent for three consecutive months or if the state insured unemployment rate remains at 4 percent or more for thirteen weeks.

4. Ease Monetary Policy

The exercise of monetary policy falls outside the purview of Congress. Nevertheless, I reiterate my recommendation of October 7 that Federal Reserve authorities should permit a 6 to 7 percent expansion of the money supply in 1975 (the seasonally adjusted money stock grew at an annual rate of only 4 percent during the last six months). By reverting to a 6–7 percent growth policy (which it pursued during the first six months of 1974) the Federal Reserve Board of Governors will permit further ease in interest rates and will accommodate the increased borrowing requirements of the federal government necessitated by a $20 billion tax reduction. Incidentally, as was proved after the 1964 tax cut, the stimulating effect of the 1975 reduction will permit recovery of this revenue loss within two to three years.

III. INFLATION

From the preceding analysis it is apparent that the price spiral which commenced a decade ago fathered today's recession. I observed last October 7 that "as the disparity between price levels and spendable income grows, the more precipitous the decline in economic activity". Consequently, if Congress' anti-recession tools are to prove effective, the root cause of our economic malaise must not be neglected.

True, as noted by the Morgan Guaranty Trust Company (The Morgan Guaranty Survey, December, 1974), "indications are that the recession has finally halted the acceleration in final goods prices and that price weakness is rapidly becoming the rule rather than exception". Illustrative of this is yesterday's hint by General Motors and Ford that they will reduce new model prices. Congress, however, cannot rely solely upon softening labor and consumer goods markets to solve our inflationary woes. Rather, the cooling effects of contracting demand should be enhanced by initiation of the following five-point legislative package directed toward specific inflationary pressure points.

A. Encourage productivity gains

During the past six quarters output per man-hour has declined. This phenomenon, coupled with escalating hourly wages, has contributed to growing per unit production costs. If labor expenses are to be kept in bounds, worker productivity must be improved. In the long-run plant modernization must play the major role in achieving this objective. This, therefore, is the principal reason why Congress should increase the tax investment credit for manufacturing and utility firms to 10 percent.

B. Reduce energy costs

Quadrupled imported crude oil prices, plus their "pass through" effect upon wages and costs of finished goods and services, accounted for a substantial, but indeterminate, percentage of last year's cost of living advance. Moreover, oil imports added approximately $25 billion to the debit side of 1974's balance of trade ledger.

If we are to dampen one of the embers heating our price structure (and, concurrently, lessen our balance of trade burden), reduction of energy consumption is essential. To this end I advocate the adoption of two new programs.

First, oil and gas rationing should be instituted immediately. Inherent in a fuel allocation effort are three advantages not found in the other energy conservation plans now being considered. (a) Inasmuch as no price increase is mandated, it is not inflationary. (b) It provides *certainty* in terms of quantities consumed. (c) It permits equitable distribution based upon demonstrated need rather than ability to buy.

Conversely, I oppose the suggestion that an additional 10-cent, 20-cent, or 30-cent per gallon gasoline tax be collected at the pump. Such a concept contains three weaknesses. (a) By raising prices, it fans the flames of inflation. (b) Since the demand for oil is substantially less elastic than that of other commodities, a price hike offers no assurance of any significant curtailment of consumption. (c) Ability to buy, rather than need, will determine fuel allocation patterns, thereby contributing to fuel wastage.

These same defects are found in the novel idea recently advanced by Senator Edward M. Brooke (R-Mass.)—a gas tax increase with refunds to those earning less than $15,000 per year. Further, Senator Brooke's plan would create administrative complexities more excessive than those attendant to a rationing system.

Second, effective September 1, 1975, a graduated weight tax should be imposed on all new automobiles. In time this will tend to remove the "gas guzzlers" from American highways.

C. Minimize wage demands

When wages are eroded by accelerating prices, employees, understandably, seek to recapture their lost purchasing power through salary increases. Thus, as mentioned in the Prudential Economic Forecast for 1975, prices continued to move upward last year, due, in part, to the cost-push pressures emanating from the wage "catch-up" process.

As outlined earlier in this statement, a tax reduction would be a less inflationary means of "catching-up" than another round of wage boosts. This fact should be impressed upon United States labor officials by spokesmen for the Executive and Legislative branches of the federal government. In offering to raise employees' take-home pay by means of a tax cut, Administration and Congressional leaders should exact, in return, a promise from union representatives that wage demands in 1975 will be kept to a minimum.

D. Strengthen the Council on Wage and Price Stability

One of the Administration's best kept secrets is the existence of the recently established Council on Wage and Price Stability. This panel has remained in the rear echelon in the "battle" (if that is the appropriate word) against higher wages and prices. The Council should be encouraged and empowered to take a more active anti-inflationary role.

First, as I recommended on October 7, the Council should be permitted to remove from the federal bid list those firms whose price increases substantially exceed established guidelines.

Second, the Council should be authorized to conduct hearings, subpoena witnesses, and subpoena records.

Third, The Council should be granted the power to suspend proposed wage and/or price increases for a period not to exceed ninety days.

E. Restrict the growth of Federal expenditures to antirecession measures

The current wave of inflation began in 1965 when the Congress was led to believe that it could provide both "guns and butter". Today we are engaged in another war—a war against recession. Any new federal expenditure programs, such as those outlined in Section II, should focus on this battle. Adding another layer of "butter" should be avoided. Thus, while socially desirable, a costly $25–$50 billion national health insurance plan may have to be deferred until current antirecession programs are teminated. Further, as I suggested last October, the sheer size of our national defense projects, which account for 29 percent of all federal outlays (including transfer payments) marks them as primary constriction targets.

IV. WAGE AND PRICE CONTROLS?

Should wage and price controls be invoked? I cannot be counted among those who are unalterably opposed to the imposition of wage and price restraints on the American economy. In fact, I voted on August 15, 1970, to give the President the authority to introduce such controls.

Efficiently administered and vigorously enforced, wage and price controls can be an effective short-term anti-inflation weapon. This was proved by the success of Phases I and II of our most recent wage-price control experiment.

Over longer periods, however, any wage-price control vehicle becomes encumbered with barnacles. It treats the symptoms, not the causes, of inflation, thereby merely deferring the "day of reckoning". It is costly and difficult to administer. It creates dislocations within the economy (although this is true, too, of inflation). The inequities it is bound to breed ultimately destroy citizen confidence and support.

Therefore, wage and price controls should be reserved as a "last resort" measure. With price pressures abating slightly, with Congressional adoption of the aforementioned or similar anti-inflation proposals (including a ninety-day suspension authority), I am reluctant to recommend adoption of wage-price controls at this time. If, by June, it becomes evident that these approaches have not eliminated double-digit inflation, then I would endorse enactment of stand-by wage, price, rent, and profit control legislation.

V. CONCLUSION

Repairing the economy is the first order of business for the 94th Congress. Consequently, on January, 14, the first day of the new session, I shall introduce legislation encompassing the recommendations outlined in this position paper.

The swiftness of the nation's economic decline calls for immediate Congressional response. Yet the need for haste should be tempered with caution. An overdose of anti-recession serum might prove fatal to the patient who also is afflicted with inflationitis.

Whether the twin problems of inflation and unemployment can be mitigated by late 1975 depends upon what Congress does during the next sixty days. I will do all within my power to respond to this momentous challenge.

TAX REFORM—SOCIAL SECURITY EARNINGS TEST

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Alabama (Mr. EDWARDS) is recognized for 5 minutes.

Mr. EDWARDS of Alabama. Mr. Speaker, today I am introducing a bill for tax reform. I am not speaking of income taxes, but of the earnings test applicable to social security beneficiaries. This provision of the social security law in effect imposes a 50-percent tax on social security beneficaries whose income from employment exceeds $2,520 a year.

This is perhaps the most inequitable provision of the social security law.

It is inequitable, first, because it denies benefits to those who have earned them by paying into social security all their lives. It is a double affront to fairness, that, even as these workers are denied their social security benefits, they must continue to pay social security taxes on

their earnings—even though they may never receive any benefits.

Second, it is a very discriminatory tax in that it is imposed only on working beneficiaries, whether employees or self-employed. Persons who retire from their jobs but continue to have high incomes in the form of rents, dividends, interest, sales of property, pension or nonearned income, are not subject to this tax and receive full social security benefits.

Even among workers, the earnings test tax is applied unfairly. Because of the way this earnings test is administered, certain workers are penalized much more than others. Persons such as lawyers, entertainers, and accountants who are able to earn several thousand dollars in a few months and then take off the other months, get their full benefits for the months they do not work. On the other hand, an aged worker who has only the choice of working year around or not at all, begins losing social security benefits every month once he or she earns over $2,520 a year.

Third, this provision encourages workers to retire when our economy needs the output from their labors. These retired workers are then often the object of programs we dream up and fund to help them fill leisure hours with meaningful activities. Is not this a bit contradictory?

In addition to older workers, the earnings test applies to young widowed mothers and students as well as others. Does it make sense to discourage these persons from working? I think not.

I would like to remind you that this is not just a philosophical argument. This provision of law penalizes those who work because they have to, to supplement their incomes. Even with recent improvements in social security, the latest data show that the average social security benefit for a retired worker is only $187 a month or a little over $2,200 a year. This is just above the poverty threshold of 1973 and with inflation it is bound to be below the 1974 poverty level when computed.

My bill would eliminate the earnings test entirely. I believe it is against our American philosophy to penalize and discourage those who want to, and need to work.

CALL FOR LOBBYING REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. RAILSBACK) is recognized for 10 minutes.

Mr. RAILSBACK. Mr. Speaker, Government policy is not made in a vacuum. The efforts of organized groups to influence Government policy are an inseparable part of the American political process. Today, hundreds of interest groups attempt to make their views known at all levels of government. These groups are commercial, industrial, agricultural, labor, racial, ethnic, religious—virtually every facet of life. Such groups often provide valuable information to public officials which might not otherwise be available. They inform the legislative and executive branches how various Government programs are working, what adjustments need to be made, and what injustices should be remedied.

The Constitution safeguards lobbying by its guarantee of free speech and as an exercise of the right to petition for a redress of grievances. Unfortunately, this constitutionally guaranteed right has in the view of many Americans been perverted into a sordid picture of lobbyists as "sleazy, under-the-table operators." Such descriptions are grossly unfair to the vast majority of lobbyists. But, unless the activities of all lobbyists are brought out into the open, the secrecy which protects the unsavory conduct of a few will condemn the reputation of all.

Even the framers of the Constitution were well aware of the dangers and potential for corruption that accompanied the direct accessibility of diverse interests to Government officials. James Madison, writing in the Federalist, set forth the importance of divergent groups upon Government and the reasons for their development. But he also warned that special interests must never exert such influence as to prevent the development of laws insuring the greatest good for the greatest number.

Madison's concern for the "mischief of faction" has echoed through the years, and the revelations of Watergate pointed out recent corruption in the lobbying process. Lobbyists for ITT tried to influence the Government's prosecution of an antitrust suit against that company with what amounted to secret bribes and deals. Lobbyists for the milk producers engaged in numerous secret illegal activities on behalf of their clients.

Regretfully, such lobbying abuses are not new to the legislative process. Between 1913 and 1946, when the Congress passed the Regulation of Lobbying Act, there were no fewer than 10 congressional investigations of alleged lobbying abuses. Even more disturbing is the fact that since passage of the 1946 act, we have had at least that many investigations of alleged improprieties.

The 1946 Regulation of Lobbying Act—the prime law governing lobbying—was intended originally to "expose to the pitiless light of publicity" the activities of lobbyists. It was rooted in the belief that we must provide an opportunity for representation, but not for manipulation. The legislation was designed to bring lobbying of Congress out in the open. Congressmen would then be able to more adequately evaluate the pressures brought to bear on them, and the public would be able to hold accountable both Congressmen and interest groups responsible for any improprieties in the legislative process. The 1946 law seeks to accomplish this by requiring individuals and groups who lobby Congress to register and file statements regarding their activities and expenditures.

But, as the law is presently construed, large loopholes exist which allow many interests to avoid registering. Under the narrow definitions of the law as set forth by the Supreme Court, numerous organizations do not register as a lobbying group by claiming that lobbying is not the "principal purpose" for which they collect or receive funds.

The 1946 act also does not cover lobbying activities unless the Member of Congress is contacted directly by the lobbyist. Contacts with members of a congressional staff and much of the "grassroots" pressure are thus exempted.

In addition, there is virtually no enforcement of the lobbying law. It does not require the Clerk of the House or the Secretary of the Senate, to whom reports are presently made, to investigate lobby registrations and financial reports for truthfulness; nor can they require individuals or groups to register as lobbyists.

Finally, the 1946 Regulation of Lobbying Act does not cover executive branch lobbying. And yet, as we are all aware, this type of lobbying does exist, and, as the milk fund and ITT cases demonstrate, abuses can and do occur.

It may very well be that the existence of the current law is worse than no law at all. Congressional testimony back in 1970 showed that there is almost unanimous recognition of the failure of the 1946 Act. Representatives of the National Association of Manufacturers, the National Chamber of Commerce, and the District of Columbia Bar Association testified that the law had failed to prevent exploitation of the lobbying process to corrupt extremes.

Reform of the lobby law is desperately needed, and a Common Cause survey has shown that an overwhelming majority of Members of the House presently favor such an effort. In response to a questionnaire distributed to Members of the newly elected 94th Congress, 318 of the 343 responding Congressmen said they favored comprehensive disclosure of lobbying activities directed at both the Congress and the executive branch. Only two of the Members were actually opposed to new lobbying legislation. The rest were merely undecided at the time of the survey.

Also, last year, seven States passed new laws or regulations for lobby disclosure—Arizona, California, Kansas, Minnesota, Oregon, and, for the first time, Idaho and West Virginia.

I believe such developments are most encouraging, and represent the growing consensus on the need for lobby reform.

The legislation I am today introducing with my colleague ROBERT KASTENMEIER will insure that lobbying reform continue in an equitable, comprehensive manner. "The Public Disclosure of Lobbying Act of 1975" is based on the premise that those who seek to influence public policy should, themselves, be open to public scrutiny.

The bill does not in any way prevent or limit legitimate lobbying activities. It does not prescribe what a lobbyist can or cannot do. It does not restrict a lobbyist's activities.

Rather, our intent is to do away with the elements of secrecy that too often dominate lobbying activities. Such secrecy in the policymaking process under-

mines accountability and contributes to the loss of public confidence in the conduct of government.

The legislation calls for comprehensive disclosure requirements pertaining to the activities and finances of lobbyists, of those who employ lobbyists, and of those who solicit others to lobby.

The bill defines "the policymaking process" as "any action taken by a Federal officer or employee with respect to any bill, resolution, or other measure in Congress, or with respect to any rule, adjudication, or other policy matter in the executive branch." The bill defines a lobbyist as a person who receives income or makes an expenditure of $250 or more for engaging in a lobbying activity. And the bill defines lobbying as "a communication or the solicitation or employment of another to make a communication with a Federal officer or employee in order to influence the policymaking process." Specifically exempted are certain activities such as appearances before congressional committees, and the news media in the conduct of their every day business.

The Public Disclosure of Lobbying Act will remedy two major faults with the present law. The definitions of a lobbyist and lobbying process are broadened, and coverage is extended to include the Executive branch of Government.

The bill calls for registration and reporting requirements not dissimilar from the present law. The present statute, however, has no provision for maintaining or updating the status of a lobbyist. That is, if a person registered as a lobbyist 10 years ago, though he has not registered or made a report since that time, he is considered a "registered" lobbyist according to the 1946 Act. Our bill simply states that a lobbyist who has been inactive for three consecutive quarterly filing periods must file a new notice of representation when he again becomes an active lobbyist.

The bill also requires that lobbyists keep records of how much they spend for lobbying activities and that they make periodic reports of those expenditures.

To administer the law and monitor the activities of lobbyists, the legislation would establish an independent Federal Lobbying Disclosure Commission. The Commission would be responsible for making public the identity of lobbyists and the persons on whose behalf they are acting.

This Commission, as we envision it, is not dissimilar from the Federal Election Commission established when the House passed the Federal Election Campaign Act Amendments of 1974. While that Commission is empowered with similar responsibilities regarding Federal elections, the Federal Lobbying Disclosure Commission will be concerned with an area of policymaking just as vital to honest government.

We also include in our bill a new logging provision. The precedent is already there, and the recordkeeping requirements are limited to the upper level members of the executive branch. However, I am currently working with representatives of Common Cause to determine whether additional coverage of this provision is necessary and desirable.

Finally, our bill provides for sanctions that call for a fine of not more than $5,000 or imprisonment of not more than 2 years, or both, for willful falsification of any notice of representation or any report.

The Public Disclosure of Lobbying Act of 1975 continues the work of the 93d Congress in opening up the system, providing accountability in our activities, and providing needed integrity and confidence in government affairs.

The House recently took bold steps to make our governmental system more accountable and accessible to the public. In the last Congress, we decided to open up our committee meetings. As a result, in 1973, only 10 percent of all House hearings and business meetings were closed to the public—compared to more than 40 percent in 1972.

Also, last session we passed the far-reaching campaign reform law. Surely, we cannot call for explicit reform of the electoral process, and neglect the need for reform in the lobbying process.

Mr. Speaker, it has been nearly 30 years since Congress passed legislation requiring information about lobbying activities. In each of these years, there have been questions raised about the ways certain lobbyists operate, and the present law has proved totally incapable of curbing lobbying abuses. The era of Watergate eroded America's confidence in our system of government, and lobbying activities were partially to blame. Now, in the aftermath, I am convinced Congress can do much to restore public confidence by passing effective and far-reaching legislation, such as the lobbying reform measure Mr. KASTENMEIER and I are introducing this afternoon.

The Public Disclosure of Lobbying Act of 1975 is fully supported by Common Cause, and has, in the past, been sponsored by over 50 House Members. Within the next few days, I will solicit additional cosponsorship, and will also urge that hearings be held on this legislation at once. We need lobby reform.

THE HOMEOWNER'S ENERGY CONSERVATION ACT OF 1975

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maine (Mr. COHEN) is recognized for 20 minutes.

Mr. COHEN. Mr. Speaker, perhaps the most alarming and shameful fact to emerge from our national energy dialog is that as a society, we waste at least one-third of the total energy we consume. Coincidentally, this figure approximates our degree of dependence on foreign oil imports—imports that have quadrupled in price in the past year or so, greatly exacerbating our inflationary and recessionary problems. Given the fundamental relationship between adequate energy supplies at reasonable prices and the economic, political, and social well-being of the Nation, it is imperative that the central focus of any national energy policy be on paring the fat from our bloated and unbalanced energy budget. In doing so, we can achieve the dual goals of reducing our annual rate of energy growth and lessening our exposure to the arbitrary and irresponsible policies of the OPEC cartel.

The possibilities for achieving a measurable reduction in energy consumption in this country are almost endless, with the greatest opportunities lying in increasing the efficiency of the automobile and the heating and cooling of buildings. Americans have been overheating, overcooling, and overlighting their residences for years, and we are now reaping the legacy of our habit of extravagance. Inefficient residential heating and cooling systems and inadequate insulation practices have played a prominent role in perpetuating these excesses.

As one expert has put it, "most of our homes are heat sieves." Today, a vast amount of heat generated by a home heating plant promptly disappears through the walls, windows, doors and roofs. Although the Federal Housing Administration has stiffened the requirements for insulating new houses, it is nonetheless true that 90 percent of existing homes in this country are seriously deficient with regard to insulation. The average uninsulated house with 1,600 square feet of space wastes about 700 gallons of fuel oil each year; a partially insulated house waste approximately 200 gallons. In addition, home furnaces today are generally designed so that only 70 to 75 percent of the heat of combustion is actually used in heating the home. In operation, however, many home heating systems drop far below that efficiency level to 335–50 percent. Along with better maintenance, the insulation of equipment such as heat exchangers and improved ducting can do a great deal to restore or even increase the efficiency of the heating plant.

According to the recently completed "Project Independence Report,"

> Residential buildings used about 70 percent of the 18.1 quads of the energy consumed by the Household and Commercial Sector in 1972. About 72 percent of the energy consumed in residential buildings (9.0 quads) was used for heating, cooling and ventilation. Assuming the number of residential units continues to grow by about 2 percent per year, energy conservation measures aimed solely at improving the thermal efficiency of new housing would not be effective in reducing overall demand for several years. To reduce current demand, existing housing must conserve more energy through the installation of energy saving devices which improve the thermal efficiency of the residences. This installation, or retrofitting, can be effective in saving about 10 to 20 percent of the energy used in residences.

A recent survey conducted by the Washington Center for Metropolitan Studies is instructive with respect to the integral relationship between residential energy consumption and various socioeconomic factors. Three facts are particularly enlightening:

> Poor families spend roughly 15 percent of their income on natural gas, electricity and gasoline annually, while lower and middle income groups spend 7 percent and 6 percent respectively, and the affluent about 4 percent.

Almost three-quarters of all American single family homes have some insulation, although over 50% of the single family homes of the poor have no insulation at all. Only 5 percent of the houses of the affluent have no insulation.

Only 31 percent of the poor have storm windows, compared to 63 percent of the "well-to-do."

Given the economic inability of many poor and middle income homeowners to purchase and install insulation devices or improve existing heating systems, it is obvious that the job will only be accomplished if the Federal Government develops incentives to assist these groups.

In an attempt to meet this pressing need and, at the same time, implement the recommendations of many energy experts, I am today introducing two bills to provide the individual and corporate homeowner with the incentive and ability to make energy-saving improvements to his home. The first measure amends the Internal Revenue Code to permit the individual a tax credit for 25 percent of amounts paid or incurred for the installation of more effective insulation and heating equipment in existing residential structures up to $375—$750 in the case of a joint return. The bill would be especially pertinent for relatively minor improvements, such as installing storm windows and doors, which nevertheless can substantially reduce fuel consumption. While the major reward for the homeowner would be a savings in fuel costs, the tax credit would be a limited additional incentive which would also recognize the Nation's interest in and support for his actions. The importance of establishing some positive efforts to encourage reduced energy conservation in the home cannot be overstated, and the cost of this legislation in the long term would be more than offset by the benefits which would accrue to the Nation as a result of decreased energy demand.

My second measure is addressed primarily to the problem of large-scale expenditures which are often necessary to enable efficient heating of older homes or homes that are not well constructed. Fully insulating a house already built or bolstering an existing heating system can easily cost hundreds of dollars. Unfortunately, those living in homes needing these improvements are again usually the ones least able to budget for such a major expense. This second bill, therefore, establishes a low-interest loan program in the Department of Housing and Urban Development to provide Federal assistance for these expenditures. The loans would be for 10 years and would carry a 5-percent annual interest rate. They would enable the homeowner to have the funds at the time of the initial expenditure and the resulting reductions in fuel costs would in most cases more than cover the loan payments. Experts agree that this kind of home improvement generally pays for itself in reduced operating costs in from 5 to 10 years.

In summary, my legislation provides homeowners, particularly those with low or moderate incomes, with both the ability and the incentive to make major energy-saving improvements to their homes. The ultimate cost to the Government would only be the difference between the subsidized and the standard interest rates. In return, the Nation would receive a reduction of up to 4 percent in its national energy consumption. When viewed in this perspective, the investment is a very modest one.

Mr. Speaker, as former Federal Energy Administrator Sawhill observed in a recent speech, "energy conservation is not the latest Federal fad. It is a major national imperative." Specific policy recommendations and legislative proposals for attaining a significant reduction in energy use in the United States must receive the highest priority and the active encouragement of each Member of this body. Accordingly, I hope that my colleagues will join with me in helping the homeowner help himself and the country, by lending their strong support to these badly needed energy conservation measures.

INTRODUCTION OF THE ACCELERATED CAPITAL FORMATION ACT OF 1975

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. FRENZEL) is recognized for 30 minutes.

Mr. FRENZEL. Mr. Speaker, I rise today to introduce the Accelerated Capital Formation Act of 1975. This is a refined version of H.R. 8590 which I introduced in the 93d Congress.

During the last session a great deal of progress in advancing the financing method known as ESOP or the employee stock ownership plan was made. A provision for study of the ESOP plan in restructuring the Penn Central and other Northeast and Midwest railroads was included as a vital section of the Railroad Reorganization Act. In the Pension Reform Act, signed into law last Labor Day, the ESOP was given special recognition as a form of employee benefit that could also be used to attract outside financing to meet the capital requirements of an expanding enterprise. In the Trade Reform Act companies utilizing ESOP will be given special preferences in the $1 billion program of federally guaranteed loans to companies expanding or locating in areas adversely affected by foreign competition. There were at least three other major pieces of legislation being considered in the 93d Congress which, though they did not reach the floor, contained ESOP provisions; these were railroad improvement loans, energy development and the Pan Am Assistance Act.

Though a great deal of progress has been made in recent years many people have questioned just what an ESOP does. Essentially, under existing law, the ESOP makes accessible to all corporate employees the techniques of corporate finance. Without any actual cash outlay from corporate employees—as in conventional employee stock purchase programs—and without any deduction in take-home pay or fringe benefits an ESOP builds blocks of corporate shares into employee ownership while providing moneys necessary for capital requirements. It has been used to finance corporate expansion, acquire new assets, accomplish divestitures or spinoffs and finance mergers, et cetera.

A standard ESOP incorporates a deferred compensation trust—technically a qualified stock bonus trust alone or coupled with a money purchase pension trust—into the financing process itself. In one common technique the employees trust borrows funds to invest in the employer corporation. This then allows the affected employees, subject only to the trusts paying off the loan, to become beneficial owners of the companies' stock.

The employer corporation obligates itself to make annual payments into the trust in amounts sufficient to amortize the debt out of tax deductible dollars.

The tax deduction makes it possible for the corporation to build greater capital ownership into the employees than it could otherwise, and the costs of financing its growth is about the same as if it conveniently borrowed and repaid—as to principal—in after-tax dollars. After the employers stock has been paid for in this manner the trust can, if desired, be diversified by tax-free exchanges of stock for other securities, or by a public offering out of trust.

This ESOP method, simply stated, allows greater benefits to the corporation than common expansion and financing techniques and permits the employee to gain a larger share of the organization he serves than conventional profit-sharing methods.

The first known use of ESOP financing, pioneered by Louis Kelso, involved an employee buy-out of a chain of California newspapers that was threatened with takeover by a major chain in 1956. But only in the last few years has the business world at large become aware of this innovation. A number of investment banking firms are pioneering this approach and several major firms have begun to recommend ESOP's to their clients. Over 100 corporations have, largely in the last year, adopted ESOP's including two of our larger electronic manufacturers. Many smaller firms and several major unions have adopted ESOP's.

In order to facilitate the use of the ESOP technique, and thus effectively link daily employee performance with the growth and operation of a business, the bill modifies the Internal Revenue Code as follows:

First, the bill removes the present statutory limitation of 25 percent of covered compensation as the maximum amount an employer can contribute to a qualified employee stock ownership plan when such payments are used to enable the plan to repay stock acquisition debt incurred in connection with meeting the employer's capital requirements. This places the sole limitation on

financing contributions on the enterprise's capacity to service the debt out of cash flow. This reform reduces the cost of capital growth and transfers in the ownership of corporate assets, while accelerating the rate at which employees as individuals and as a group can accumulate stock of their employer and other income-yielding assets as a new and noninflationary form of employee benefit. Although treated as a tax deduction, this change would have the same impact as an investment tax credit in terms of encouraging capital spending; however, the investment tax credit increases the concentration of corporate ownership while ESOP contributions correct this economic factor.

This also rechannels corporate profits that would otherwise have gone into the corporate income tax base into productivity increases of the private sector, thus generating lower prices for consumers, expanded private payrolls, and a broadening base of taxable personal incomes and personal estates among productive workers.

Second, the bill provides a tax deduction to corporations for the amount of dividends they distribute either directly as taxable second incomes on stock held in an employee's account or which are used to repay stock acquisition indebtedness of the employees' trust. This provision also converts taxable corporate income into either taxable dividend incomes for employees to supplement their paychecks or their retirement and social security incomes or a more rapid rate of accumulation by employees of individual capital estates for their retirement security.

Third, the bill provides that a qualified employee stock ownership plan and trust shall have the tax characteristics of a charitable organization for purposes of estate, gift, and income taxes. This would encourage affluent taxpayers to make gifts to qualified trusts in order to reconnect the ownership of capital with a broader base of private individuals, namely productive employees some of whom have contributed to the building of the donor's wealth. Allocations to participants of the trust would become an immediate source of taxable second incomes—to the extent dividends are passed through the trusts—and a retirement estate for the employee-beneficiaries and their heirs. On the other hand, Government would lose no tax revenues since such contributions made to charitable organizations are already exempt from taxation, and profits from donated income-producing property are frequently accumulated tax-free within such organizations.

Fourth, the bill establishes a cutoff on further contributions in behalf of any employee when the value of the assets that employee has acquired during his working lifetime through one or more ESOP's exceeds $500,000. Such a safeguard on excessive accumulations acquired through tax deductions would be especially important in highly capital-intensive industries and would help foster more widespread and equitable sharing of ownership among Americans generally.

Fifth, the bill adds to the options of ESOP participants when distributions are made when they retire, die, or are otherwise separated from service. Although profit sharing plans are permitted to make distributions in many forms, the Internal Revenue Service has ruled that distribution from an ESOP must be made exclusively in company stock.

Although enabling employees to accumulate sizable holdings of employer stock has obvious motivational value, when an employee leaves the company and can no longer directly influence the yield on the company stock accumulated in his ESOP account, it is desirable to provide the departing employee and the remaining employees, through their ESOP, to arrange an exchange for his accumulated assets with other income-yielding assets or cash of an equivalent value. This bill would provide ESOP's the same flexibility in making distributions that is now enjoyed by profit sharing plans.

Sixth, the bill permits a repurchase option for plans of enterprises that are wholly owned by their employees, so that stock of departing employees can remain exclusively held within the employee group.

Seventh, the bill exempts lump sum distributions of income-yielding estates derived from an ESOP from any form of taxation, provided the assets are held to produce a taxable second income for the taxpayer or his beneficiaries. However, if the assets are converted into spendable income and not reinvested within 60 days, the uninvested proceeds will be taxed as ordinary income, instead of partially at the lower capital gains rate permitted under present law.

Eighth, the bill enables affected parties to seek advance IRS opinions on valuations on stock or other assets acquired by an ESOP where the parties to a financing transaction which utilizes and ESOP would be subject to serious risks or penalties if the IRS, upon subsequent audit, disagreed with the valuations or other key features of the financing plan. This is similar to the "no action" procedures already instituted by the FTC and SEC.

Ninth, the bill exempts payments to an ESOP made for financing purposes from treatment as a conventional employee benefit for purposes of any wage, salary, deferred compensation, or other employee benefit controls or guidelines that might be established under executive order, regulations, or future economic stabilization laws at the Federal or State levels. Instead, it would be treated as any other form of capital spending that would have a counterinflationary effect. In effect, it offers labor a trade-off for wage increases where wage ceilings are established.

I hope that the members of this body will carefully consider the legislation. I am hopeful that further progress can be made in this session.

A copy of the bill follows:

H.R. —

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

SECTION 1. TITLE.—This Act may be cited as the "Accelerated Capital Formation Act of 1975."

SEC. 2. PURPOSE.—The purpose of this Act is to provide incentives for accelerated financing of the formation of U.S. corporate capital and to encourage voluntary means for broadly diffusing equity ownership among employees of U.S. enterprises both (a) with respect to existing capital by means consistent with the protection of private property and (b) with respect to newly formed capital by means which extend the logic of conventional business finance to corporate employees.

SEC. 3. AMENDMENT OF INTERNAL REVENUE CODE.—The Internal Revenue Code of 1954 is amended by adding the following new Section 416 at the end of Subpart B of Part I of Subchapter D of Chapter 1:

SEC. 416.—EMPLOYEE STOCK OWNERSHIP PLAN FINANCING.

(a) DEFINITIONS. (1) "Employee stock ownership plans" means a technique of corporate finance described in Section 4975(e)(7) that utilizes stock bonus plans, or stock bonus plans coupled with money purchase pension plans, which satisfy the requirements of Section 401(a) and are designed—

(A) to invest primarily in qualifying employer securities;

(B) to meet general financing requirements of a corporation, including capital growth and transfers in the ownership of corporate stock;

(C) to build into employees beneficial ownership of qualifying employer securities;

(D) to receive loans or other extensions of credit to acquire qualifying employer securities, with such loans and credit secured primarily by a commitment by the employer to make future payments to the plan in amounts sufficient to enable such loans and interest thereon to be repaid; and

(E) to limit the liability of the plan for repayment of any such loan to payments received from the employer and to qualifying employer securities, and dividends thereon, acquired with the proceeds of such loan, to the extent such loan is not yet repaid.

(2) For purposes of this section, the term "employer securities" means securities issued by the employer corporation, or by an affiliate of such employer.

(3) For purposes of this section, the term "qualifying employer securities" means common stock, or securities convertible into common stock, issued by the employer corporation, or by an affiliate of such employer.

(b) Special Deductions. (1) In addition to the deductions provided under section 404(a), there shall be allowed as a deduction to an employer the amount of any dividend paid by such employer during the taxable year with respect to employer securities, provided—

(A) such employer securities were held on the record date for such dividend by an employee stock ownership plan; and

(B) the dividend received by such plan is distributed, not later than 60 days after the close of the plan year in which it is received, to the employees participating in the plan, in accordance with the plan provisions; or

(C) the dividend received by such plan is applied, not later than 60 days after the close of the taxable year, to the payment of acquisition indebtedness (including interest) incurred by the plan for the purchase of qualifying employer securities.

(2) Notwithstanding the limitations of section 404(a), there shall be allowed as a deduction to an employer the amount of any contributions paid on account of a taxable

years (as described in section 404(a)(6)) to an employee stock ownership plan, provided such contributions are applied to the payment of acquisition indebtedness (including interest) incurred by the plan for the purchase of qualifying employer securities.

(3) For purposes of sections 170(b)(1), 642(c), 2055(a), and 2522, a contribution, bequest, or similar transfer of employer securities or other property to an employee stock ownership plan shall be deemed a charitable contribution to an organization described in section 170(b)(1)(A)(vi), provided—

(A) such contribution, bequest, or transfer is allocated, pursuant to the terms of such plan, to the employees participating under the plan in a manner consistent with section 401(a)(4);

(B) no part of such contribution, bequest or transfer is allocated under the plan for the benefit of the taxpayer (or decedent), or any person related to the taxpayer (or decedent) under the provisions of Section 267(b), or any other person who owns more than 25% in value of any class of outstanding employer securities under the provisions of Section 318(a); and

(C) such contribution, bequest or transfer is made only with the express approval of such employee stock ownership plan.

(c) *Treatment of Participants.* (1) Qualifying employer securities acquired by an employee stock ownership plan through acquisition indebtedness incurred by the plan in connection with the financing of capital requirements of the employer corporation or its affiliates must be allocated to the accounts of the participating employees to the extent that contributions and dividends received by the plan are applied to the payment of such acquisition indebtedness (including interest), in accordance with the terms of the plan and in a manner consistent with Section 401(a)(4).

(2) Upon retirement, death or other separation from service, an employee participating under an employee stock ownership plan (or his beneficiary, in the event of death) will be entitled to a distribution of his nonforfeitable interest under the plan in employer securities or other investments allocated to his account, in accordance with the provisions of such plan. If the plan so provides, the employee (or beneficiary) may elect to receive all or a portion of the distribution from the plan in—

(A) employer securities, other than qualifying employer securities;

(B) cash;

(C) a diversified portfolio of securities;

(D) a non-transferable annuity contract; or

(E) any combination of the above.

(3) An employee stock ownership plan may provide for the required repurchase of qualifying employer securities from an individual receiving a distribution thereof if all other of such outstanding employer securities, whether or not acquired through the plan, are subject to repurchase from non-employee shareholders under similar circumstances.

(4) Upon receipt of a lump sum distribution, as described in Section 402(e)(4)(A), from an employee stock ownership plan, an individual may exclude from gross income that part of the distribution which consists of employer securities or other assets, if income producing, held or reinvested within 60 days in income producing assets of equivalent value, for the purpose of providing the individual with dividends or other forms of realized income from such assets. Upon subsequent sale or disposition of any employer securities or other assets distributed by an employee stock ownership plan to the extent that proceeds realized from such sale or disposition are not reinvested within 60 days in income producing assets, the total amount of such proceeds (or the fair market value of any such securities or assets that are transferred without adequate consideration) shall be treated as ordinary income to the individual.

(5) An employee receiving a distribution under paragraph (b)(1)(B) of this Section shall be subject to taxation under Section 402(a)(1), and the provisions of Section 116 shall not apply to such distribution.

(6) A contribution by an employer which is deductible under paragraph (b)(2) of this Section, or a contribution described in paragraph (b)(3) of this Section, shall not be included in the meaning of annual addition under Section 415(c)(2).

(7) No contribution to an employee stock ownership plan may be allocated for the benefit of any participant if the value of the total accumulation of employer securities and other investments under the plan for the benefit of that participant equals or exceeds $500,000, less the amount of any such accumulation for that participant under any other employee stock ownership plans.

(d) *Special Provisions.* (1) The acquisition or holding of qualifying employer securities and the incurring of acquisition indebtedness by an employee stock ownership plan shall be deemed to satisfy the requirements of Section 404(a)(1) of the Employee Retirement Income Security Act of 1974 provided that—

(A) the requirements of Section 408(b)(3) and 408(e) of such Act are satisfied; and

(B) the same standards of prudence and fiduciary responsibility that corporate management must exercise with respect to its shareholders are satisfied.

(2) Upon application by an employee stock ownership plan, the Secretary of the Treasury or his delegate shall issue an advance opinion as to whether a proposed transaction involving that employee stock ownership plan will satisfy all the requirements described in paragraph (1) of this subsection, and any such opinion shall be binding upon the Secretary.

SEC. 4.—*Effect of Economic Stabilization.*— Payments by an employer to an employee stock ownership plan as defined in Section 416(a)(1) of the Internal Revenue Code of 1954, for the purpose of enabling such plan to pay acquisition indebtedness incurred for the purchase of qualifying employer securities or other contributions to such plan shall not be treated as compensation, fringe benefits or deferred compensation payments for the purposes of any laws, executive orders or regulations designed to control, establish guidelines or otherwise stabilize employee compensation or benefits, but shall be treated as the equivalent of debt service payments made in the normal course of financing the capital requirements of that employer.

EXTENDING PROVISIONS OF VOTING RIGHTS ACT OF 1965

The SPEAKER pro tempore (Mr. DANIELSON). Under a previous order of the House, the gentleman from New Jersey (Mr. RODINO) is recognized for 5 minutes.

Mr. RODINO. Mr. Speaker, this afternoon I rise to introduce legislation which will undoubtedly be among the most important to be considered by the 94th Congress. The legislation proposes to extend for 10 years those temporary provisions of the Voting Rights Act of 1965, which are scheduled to expire in August of this year.

As originally enacted in 1965, the temporary provisions of the act were to be effective for only a 5-year period. However in 1970, the Congress found that the job which those provisions were created to perform had yet to be accomplished and, on the basis of that finding, renewed the temporary provisions until August 1975. I suggest that now in 1975, the accomplishment of that job is still far from complete. There is no question but that those whose rights are protected by the temporary provisions of the act cannot yet be pointed to as full and active participants in this country's precious electoral process. Their need for the special coverage of the act continues, and we cannot ignore that need by allowing those provisions to die.

Many of you will ask "why 10 years, why not 5 or at least some lesser number." My response to those of you is simply this: I believe that the voting problems which the Voting Rights Act of 1965 is designed to eliminate have in the past been tremendously underestimated by the Congress. I believe that our calculations as to the time it would take to bring excluded citizens into full political participation were in many respects unrealistic. The 15th amendment, guaranteeing the right to such full participation, was ratified in 1870, and it is important that we remain cognizant of the fact that, for very many of those nearly 100 years between that ratification and the enactment of the Voting Rights Act, minority citizens in this country were faced with unconstitutional barriers to voting of the severest magnitude. While for the earliest covered jurisdictions this could mean that they will be subject to the act's special provisions for 20 years, it is important that we realize that such a period is certainly not unreasonable when considering the many years of discrimination we are attempting to overcome. Moreover, as I indicate below, the gains yet to be made in those earliest covered jurisdictions are quite substantial.

I also point out to you that section 5, one of the most important temporary provisions of the act, has only actually been implemented since the end of 1971 and even now there is evidence that some jurisdictions have yet to come into compliance with that section. Thus, we are in effect talking about far less than a 20-year period as far as a crucial provision of the act is concerned.

Another very important factor in favor of a 10-year extension is the need for the special protections of the act during the redistricting and reapportionment which will take place subsequent to the 1980 Decennial Census. Since 1971, by virtue of section 5, the Justice Department has objected to at least 57 redistricting plans which have been submitted for review by the covered jurisdictions. Clearly, such objections indicate that section 5 protections, which are described in more detail below, ought to be available through the next period of significant redistricting.

The legislation which I introduce today also establishes a permanent nationwide ban on literacy tests and other similar devices. In 1970, when the Congress extended the temporary provisions of the original 1965 enactment, it also established a temporary nationwide ban on such tests and devices, with that temporary ban also scheduled to expire in Auguest of 1975. Now that we have for all practical purposes come through this experimental 5-year period without any evidence whatsoever that governments have been burdened by the temporary suspension, I urge that we now perma-

nently ban the use of such tests and devices.

At this point, I would like to briefly put into some historical perspective the legislation which I offer today. As many of you may know, the Voting Rights Act of 1965 had been hailed by many to be the most effective civil rights law ever passed. At the time that the act became law, blacks in the South—which is one of the major sections of the country to which the act's temporary provisions apply—were severely disenfranchised. For example, in 1964, only 6.7 percent of the black voting age population of Mississippi was registered, compared to 70.2 percent of the white voting age population.

The Congress was faced with reams and reams of evidence documenting the attempts of State and local election officials to deprive the South's black citizenry of access to the ballot. Although the Congress had attempted to respond to the situation in the Civil Rights Acts of 1957, 1960, and 1964, those responses in fact did not rise to the level of the urgency of the need. Because the voting rights provisions of those acts still placed major reliance on a case-by-case litigation approach, the path to achieving full voting rights continued to be laden with many hours spent in time-consuming litigation, as well as numerous efforts on the part of local governments and officials to create new barriers to voting as old ones were being voided by the courts.

Thus, it was against this backdrop that the 89th Congress was to consider the Voting Rights Act of 1965. However, any look into the past to understand the nature of the circumstances surrounding the enactment of this important piece of legislation would not be complete unless we also focus to some extent on the tragic violence which was perpetrated upon black marchers in Selma, Ala., on March 7, 1965. It was on this day, to which some have referred as "Bloody Sunday," that blacks who were attempting to march from Selma to Montgomery, Ala., in order to dramatize the denial of the right to vote, were viciously attacked by State and local law enforcement officers. Describing the incident, the London Times of March 9, 1965, stated the following:

> At least 67 Negroes were injured, some of them seriously, in Selma yesterday when state and local law enforcement officers waded into them with clubs, bullwhips, and ropes beneath a smoke-screen of tear gas as they set out for the state capitol of Montgomery as a protest over difficulties in registering for the vote.
>
> Mr. John Lewis, the chairman of the student non-violent co-ordinating committee, was in the hospital today with a possible fractured skull, and 17 other Negroes were detained with broken arms or legs or other injuries. One of Selma's doctors said the Good Samaritan Hospital looked last night as though there had been a moderate disaster, and a hospital official was quoted as saying there was a great deal of pain and suffering among the wounded, most of whose injuries appeared to be the result of heavy blows.

President Lyndon Baines Johnson, one week later, on March 14, 1965, made a dramatic appearance before a special session of Congress to urge speedy enactment of voting rights legislation. During that March 1965 appearance, President Johnson told the Congress that—

> The harsh fact is that in many places in this country men and women are kept from voting simply because they are Negroes. No law we now have on the books . . . can ensure the right to vote when local officials are determined to deny it.

Approximately 5 months later, on August 6, 1965, President Johnson signed into law the Voting Rights Act of 1965.

While some may have already been familiar with the events which I have just related, I am certain that others were not. Today, we are embarking upon the consideration of the renewal of a piece of legislation that is both real and symbolic and it is only when one is made to relive the events which led to its enactment that the awesomeness of our task can be fully appreciated.

Before going on to discuss in detail the facts which unquestionably manifest the continued need for the temporary provisions of the Voting Rights Act, I would first like to describe those various provisions of the act and their effect. The Voting Rights Act of 1965 is an intricate piece of legislation which embodies both permanent and temporary provisions. The permanent provisions have general application while the temporary provisions, which are scheduled to expire in August of this year, have special application or special coverage. Among those temporary special coverage provisions is section 4. That section provides for an automatic formula or "trigger" by which certain States or political subdivisions are made subject to special remedies afforded by the act. In addition to establishing the trigger which delineates those jurisdictions which are specially covered, section 4 also establishes one of the special remedies applicable to such jurisdictions; namely, the suspension of literacy tests and similar devices.

Section 5 of the act, another temporary provision applicable to the specially covered jurisdictions, requires that those jurisdictions submit for preclearance to the Attorney General or to the U.S. District Court for the District of Columbia all changes in "any voting qualification, or prerequisite to voting, or standard, practice or procedure with respect to voting." In recent years, section 5 has become one of the most widely used provisions of the act. That section disallows, unless approved by the Attorney General or the U.S. District Court for the District of Columbia, any changes affecting voting in the specially covered jurisdictions. Theoretically, in this way, there could be no change in voting procedures in those jurisdictions unless it has been demonstrated that those changes would not have a discriminatory effect.

Also, again in those jurisdictions which are specially covered, by virtue of sections 6 through 9 of the act, the Attorney General of the United States is authorized to provide for the appointment of Federal registrars and poll watchers. Federal registrars, also known as examiners, may be sent to covered jurisdictions at the Attorney General's direction if the Attorney General has received 20 meritorious written complaints alleging voter discrimination or if the Attorney General believes that the appointment of examiners is needed to enforce 15th amendment rights. It is the duty of Federal registrars, once assigned, to list those persons in the jurisdiction who satisfy State voting qualifications which are consistent with Federal law. That list is sent on a monthly basis to local election officials who are to enter the names of the listed persons on the official registration rolls. Federal observers or poll watchers may also be appointed in those covered jurisdictions which have been designated by the Attorney General for the appointment of Federal examiners. It is also at the request of the Attorney General that Federal observers or poll watchers are appointed. It is the duty of these poll watchers to observe whether all eligible persons are allowed to vote and whether all ballots are accurately counted.

Thus, one can readily observe that those special temporary provisions of the act, which are now in danger of permanent extinction unless Congress acts and acts quickly, provide what actually amounts to an arsenal of readily available and potentially highly effective remedies. The automatic trigger or coverage creates, in certain areas of the country, an automatic ban on the use of literacy tests and, with respect to those same areas, authorizes the Attorney General to review voting changes for potentially discriminatory impact prior to their effectiveness and to direct the appointment of Federal registrars and poll watchers.

I should point out here that if the legislation which I propose today is enacted into law, there will be in effect throughout the entire country a permanent nationwide ban on literacy tests. Therefore, that aspect of the special coverage arsenal of remedies would no longer be of the same significance, since it would no longer be only within the specially covered jurisdictions that such tests would be suspended—since 1970, there has, of course, been a 5-year nationwide suspension of such tests—but instead it would be throughout the entire country that a permanent nationwide ban would go into effect. Thus, the total effect of the extension legislation which I propose would be to create such a permanent nationwide test ban and, with respect to the specially covered jurisdictions, to continue for an additional 10 years—until August 1985—the section 5 preclearance requirement and the Attorney General's authority to direct the appointment of Federal examiners and registrars to those covered jurisdictions.

Having frequently alluded above to what have been termed "covered" or "specially covered" jurisdictions, it is important that I now describe how the special coverage trigger operates and those jurisdictions which it has brought under the act's special coverage. Section 4(b) of the act, as originally adopted in 1965, provided that those States, or political subdivisions within States which would not be covered as a whole, which used a test or device and had less than 50 percent registration or turnout at the time of the Presidential election of 1964 would be covered. Based on that formula, in 1965 and early 1966, the following were found to be specially cov-

ered jurisdictions: the entire States of Alabama, Alaska, Georgia, Louisiana, Mississippi, South Carolina, and Virginia; 40 of the 100 counties in North Carolina; 4 of the 14 counties in Arizona; Honolulu County, Hawaii; and Elmore County, Idaho. Taking advantage of the "bailout" suit provisions of section 4(a) of the act, which provide that a jurisdiction can exempt itself from special coverage if, in a request for a declaratory ruling, it can convince the District Court for the District of Columbia that it has not used a test or device in a discriminatory manner for 5—since 1970, 10—years, the State of Alaska; Wake County, N.C.; Elmore County, Idaho; and Navajo, Apache, and Coconino Counties, Ariz., sued for and were granted exemption.

The Voting Rights Act Amendments of 1970 retained special coverage over those jurisdictions listed above which had not been exempted and amended the trigger to also include those jurisdictions which used a test or device and had less than 50 percent registration or turnout at the time of the Presidential election of 1968. Therefore, new jurisdictions brought under special coverage by the 1970 amendments included three boroughs of New York City—namely, Manhattan, Brooklyn, and the Bronx—Campbell County, Wyo.; Monterey and Yuba Counties in California; and five additional counties in Arizona—Cochise, Mohave, Pima, Pinal, and Santa Cruz. Although exempted after 1965, the following counties were recovered in 1970: Elmore County, Idaho, and Apache, Coconino, and Navajo Counties in Arizona. By virtue of facts only recently brought to light, certain New England towns have also been covered as well.

Mr. Speaker, for several reasons I have felt it necessary to describe in some detail the operation of the act's trigger and the jurisdictions which are thereby covered. First, I believe it important for the Members of this body to realize and understand exactly which areas of the country are specially affected by the temporary provisions now slated for expiration; and second, I believe that the extensive listing in which I have just engaged unquestionably counters those who have urged in the past and who will undoubtedly urge again that the special provisions of the Voting Rights Act of 1965 amount to regional legislation. There is no question but that Congress was, indeed, faced with evidence, both during the enactment and the renewal of the act, which focused on problem areas—areas in the South which were brought to our attention as having significant barriers to voting on account of race or color.

However, especially at the time of the 1970 amendments, the coverage has clearly been broadened to include other areas of the country. Therefore, despite their frequent urgings to the contrary, the Southern States do not shoulder the burden alone. Areas in New England, New York City, California, and Arizona are also subject to section 5 preclearance requirements and to Attorney General designation for the appointment of Federal examiners and observers.

The thrust of my remarks thus far has been toward bringing our task into historical perspective and outlining those provisions which will be under consideration and how they operate. It is now time to turn to the crux or heart of the matter—the case for the continued need for the special provisions of the Voting Rights Act of 1965. As I alluded to earlier, the Voting Rights Act has justifiably been termed by many to be the most effective civil rights legislation ever enacted. Even though there are those of us who believe that the gains which have thus far been achieved under that legislation could have been greater, there is no denying that the gains have been great nevertheless.

Between the years 1964 and 1972, more than 1 million new black voters were registered in the seven covered Southern States. This represented a percentage increase from about 29 percent to over 56 percent of eligible blacks registered. Additionally, the number of black elected officials in those areas has skyrocketed. Prior to passage of the Voting Rights Act, there were well under 100 black elected officials in the covered Southern States and as of April 1974, that number had increased to 964. Specifically, we can further observe that the State of Mississippi, which now has 191 black elected officials, has more such officials than all other States except Michigan. In short, the gains under the act have been undeniable and truly significant.

But, Mr. Speaker, I say to you and to the other distinguished Members of this body, that there is also no denying that the job intended to be accomplished by the Voting Rights Act has not yet been done. The goals envisioned at the time of its enactment and renewal have yet to achieve fruition. As Assistant Attorney General J. Stanley Pottinger recently stated, in turning from arguments against extension to those in favor of extension—

> Some of the gains of the past 10 years are more apparent than real.

For example, of the 191 black Mississippi officeholders, most are located in heavily majority black counties or districts and only one of those officeholders serves in the Mississippi Legislature, even though Mississippi has a black voting age population of 31.4 percent.

In fact, when one makes a review of each and every State, comparing the percentage of black elected officials with the percentage of black voting age population, I believe that it is of utmost significance that the seven Southern States covered by the act rank as the highest seven States in terms of having the largest disparity between numbers of black officials and numbers of blacks of voting age. This, essentially, is the breakdown as of April 1974: Alabama had a 23 percent black voting age population, while it had only 3.7 percent black elected officials; Mississippi had a 31.4 percent black voting age population with only 4.0 percent black elected officials; North Carolina had a 19.4 percent black voting age population with 2.9 percent black elected officials; South Carolina had a 26.3 percent black voting age population and had only 3.8 percent black elected officials; and Virginia had a 16.6 percent black voting age population with 1.8 percent black elected officials.

Only one black Representative has been elected to serve in Congress from among the seven covered Southern States. Also, while blacks have, in fact, begun to serve in Southern State legislatures, county commissions, school boards and city councils, in those areas, no blacks hold statewide office.

Additionally, I believe that it is important to note that, with respect to black registration in the seven Southern States covered by the act, that job, too, has yet a way to go before this body can stand by and allow the special provisions of the Voting Rights Act to fade away into extinction. It has been estimated that blacks still lag approximately 15 percentage points behind whites in terms of registration in the South. In 1972, it was estimated that there were well over 2.5 million blacks still unregistered in all of the 11 Southern States. Based on 1971–72 estimates, the gap in Alabama between black and white registration, with the white rate, of course, exceeding that of the black rate, was 23.6 percentage points. Those same estimates indicate that in Louisiana, that gap was 20.9 percent and in North Carolina, that gap was 15.9 percent. Data available through 1974, indicates that in Louisiana, blacks are still trailing 16 percentage points behind whites in terms of registration and in North Carolina, that disparity has, in fact, increased to 17.8 percent since 1972.

I should also point out that in Louisiana, as of 1974, of the 64 parishes in that State, 36 of those parishes had a 15-percent greater disparity between black and white registration, with blacks trailing in that count. In some of those 36 parishes, blacks were as many as 40 percentage points behind whites in registration. In North Carolina, data available in 1974 indicates that of the 39 counties in that State covered by the act, in 20 of these counties, blacks lagged 15 percent or greater behind whites in registration, with that disparity in some counties being more than 30 percent.

As most have undoubtedly observed, in making this analysis of the progress achieved under the Voting Rights Act and our continued need for the act, I have focused on the nature of the gains which have been made in the seven Southern States which are covered by the act. I should note that this has been because it is those States which are the primary areas among those earliest covered. It is those States which have been subject to the special provisions of the act for the longest period of time.

Therefore, when we can observe, as I believe we have, that even in those longest covered areas the need for the act's special provisions and protections yet persists, there can be no doubt that it is now incumbent upon this body to insure

that those provisions and protections do not cease.

In concluding, I find that we have essentially come full circle. We began with the tragic violence which marred the 1965 march from Selma to Montgomery and the unbelievable level of disenfranchisement which plagued the black citizens living in the South at that time. We then shared some hope and rejoicing in the passage of the Voting Rights Act and the tremendous gains which it has wrought. But we wind up at a point where a fair and accurate reading of the evidence leaves us no choice but to conclude that too much rejoicing at this juncture would be none other than premature. There are no laurels upon which we can now rest, for large numbers of minority citizens in areas covered by this act have yet to be registered. They have yet to play a part in sending to the national and local halls of government persons representing their districts and regions.

I urge that we all now take time to carefully consider and study the legislation which I bring before you today. It is not the abhorrent monster which unjustifiably plagues and harasses certain regions of the country, as some would have us believe. It is simply a tool which has worked and which hopefully will continue to work to insure that in this great land of ours no artificial barriers to voting will be placed in the paths of our minority citizens. Only where all citizens have fair and equitable access to the ballot, will faith in our governmental institutions endure. By urging the passage of this legislation, I ask only that that faith be allowed to survive.

VOTING RIGHTS EXTENSION LEGISLATION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. EDWARDS) is recognized for 5 minutes.

Mr. EDWARDS of California. Mr. Speaker, I rise this afternoon to speak as a cosponsor and supporter of the voting rights extension legislation which has just been introduced by the distinguished chairman of the Committee on the Judiciary. Like the chairman, I believe that there is much left to be accomplished by those special temporary provisions of the Voting Rights Act which are now slated for expiration during August of this year.

I was a member of the Committee on the Judiciary when that act first became law in 1965, and in 1970, I served on the subcommittee which considered and held hearings on the Voting Rights Act amendments. At the time those amendments were under consideration, it was felt that the temporary provisions of the act had not actually run their full course in terms of bringing about the full enfranchisement of the Nation's minorities residing in the specially covered jurisdictions. Accordingly, those provisions, then scheduled to expire in August of 1970, were extended until August of 1975. Again, I find that we are still faced with a task that is far from complete.

The paramount importance of this legislation is unquestioned. It focuses on the very heart of what it means to be a citizen in this country. The ballot, the right to vote, is undoubtedly the most precious right which is bestowed upon the American citizenry and, to the extent that there may be any abridgement of that right because of a citizen's race or color, then the very fiber of our democratic process is endangered.

While recently reflecting upon this matter within the context of the many economic ills which have beset us, it became abundantly clear to me that should this body fail to extend the protections afforded by the special provisions of the Voting Rights Act, we would essentially be adding insult to injury where the minority residents of the covered jurisdictions are concerned. While both minority and nonminority residents of those jurisdictions are undoubtedly suffering from the current spiraling rates of unemployment and inflation, we should all be cognizant of the fact that minority citizens as a whole are suffering the greatest.

With total unemployment in this country now at an astounding level of over 7 percent, recent figures indicate that for minorities, that figure is an even more astounding 12.8 percent. I say this only to suggest that these minority citizens, who are now suffering the greatest job exclusion, cannot now be subject to a similar exclusion at the polls. When their very lives and well-being are at stake during this severe economic crunch, we simply cannot snatch away from them the right to choose those who will make the critical economic decisions affecting their lives. I ask only that we keep these factors in mind.

While the chairman has emphasized in this statement the great distance which there is yet to go in terms of achieving full voting rights for those protected by the act's special coverage, I believe it just as important to note the terribly fragile nature of the gains which have in fact already been achieved. The evidence is such that it would certainly appear that if the temporary provisions of the Voting Rights Act are allowed to expire, those gains could be swept away as though by a whirlwind, that whirlwind of course having been helped along by this Congress failure to extend those protections which the act now provides.

One of the most important of the temporary provisions of the Voting Rights Act is section 5. That section requires that in each of the specially covered jurisdictions, before any change affecting voting can take place, the change must be submitted for approval or preclearance to either the Attorney General or the U.S. District Court for the District of Columbia. In proposing the change, the State or subdivision has the burden of demonstrating that its purpose or effect is not the denial or abridgement of the right to vote on account of race or color and, unless that burden is met, the change cannot take place. Clearly, the significance of this provision and its effectiveness in terms of preventing lapses back into the "old ways" under the guise of new practices or laws, cannot be overstated. In short, section 5 is a safeguard against new forms of discrimination.

It is only because of section 5 that many minority citizens have been able to register, to vote, to not suffer dilution of their voting power, and to run for public office. If its protections are now taken away, no longer would an Attorney General objection under that section be able to prevent those changes relating to voting which could destroy those gains. As judicially interpreted and I believe as properly intended by the Congress all voting changes, even those which may on the surface appear to be quite minimal, must be submitted for approval. Therefore, changes to be submitted include such things as changes in districting, registration times and places, polling places, boundaries, and qualifications for office.

The most important thing to note with respect to section 5 is that the Justice Department has in very recent months and years, begun to make extensive use of its objection power under that provision, because it has failed to be convinced that certain changes being proposed by the covered jurisdictions did not have discriminatory purposes or effects. In fact, for the calendar year 1974, up through the period of November 22, 1974, the Justice Department entered 41 objections opposing changes which had been submitted for section 5 review. In 1973, there were 30 such objections; in 1972, 50; and in 1971, 56.

These recent objections have been entered against changes ranging from moves in polling places, which would have placed severe burdens on minority residents, to proposed annexations, which would have had the effect of diluting minority voting strength. The objections entered related to proposed changes which covered the full range of the spectrum and I believe that what we simply cannot afford to overlook is the fact that but for section 5, those potentially discriminatory changes would have gone into effect, and the rights of many voters and potential voters could have thereby been destroyed. It should especially be noted that we are not discussing potentially discriminatory changes which were objected to several years ago but instead, many of the changes involved would have actually gone into effect as recently as 1974.

Section 5 of the Voting Rights Act is still extremely vital. It is still meaningful and up until this very day it is still being called upon, by those charged with its enforcement, to prevent the implementation of unfair voting practices. Those who would suggest that we allow that section "to die a natural death" in August of this year, have thoroughly misread the current state of affairs. That section could only die a natural death if it were in the process of dying, of becoming defunct. However, section 5 now has such vitality that if we were to in fact allow its expiration in August, such an act would amount to nothing less than some form of actionable homicide.

Two other important points should be made with respect to that provision of the Voting Rights Act. First, it was not until 1971 that the Justice Department began applying the proper burden-of-proof standard with respect to section 5 submissions, and it was also not until that year that the Department for the first time adopted regulations for implementing section 5. To allow that provision to expire in August would mean that we would have essentially offered its protections for only 4 of the 10 years which Congress intended as its duration.

Second, it is noted that while section 5 does require the submission of all proposed changes related to voting by the covered jurisdictions, there has been some indication that certain of the covered jurisdictions have made such changes without making the required submissions. Therefore, to the extent that we have been able to point to a great many benefits flowing from section 5, despite the apparent failures of all to comply, there can be no question but that if the act is extended and such failures detected and brought into compliance, those benefits would increase significantly.

I wish further to point out that there has also been a notable amount of recent activity under sections 6 and 8 of the Voting Rights Act. Those provisions authorize the Attorney General to direct the appointment of Federal examiners—registrars—and observers—poll watchers—to the covered jurisdictions. If those jurisdictions are no longer specially covered by virtue of our failure to amend section 4(a) of the act prior to August next, then the Attorney General loses his authority to direct such appointments.

As recently as October 31, 1974, the Attorney General has directed the appointment of Federal examiners or registrars to a county in the State of Alabama. Also, in 1974, counties in Georgia and Mississippi, as well as a parish in Louisiana, were designated for examiners. Data on 1974 activity also indicates that during that year, 234 Federal observers were appointed to serve in Alabama, 64 in Georgia, 56 in Louisiana, and 76 in Mississippi.

Thus, much like the situation with respect to section 5, sections 6 and 8, relative to their special application to covered jurisdictions, are far from defunct. Therefore, we must not allow their special coverage to expire while the continued need for the services of such Federal officers is so readily apparent.

Finally, it is noted that while it would appear that physical violence and threats against blacks who are active in the political process have certainly diminished, such violence and intimidation has not completely disappeared. For example, affidavits on file in currently ongoing Mississippi court proceedings, make serious allegations of telephone threats, harassment, and actual physical violence against black candidates and campaign workers. These allegations relate to incidents occurring in 1970 and after. There are also reports of physical violence having been perpetrated against blacks during the general election in Humphreys County, Miss., on November 2, 1971. A black candidate for supervisor in that election reported that on election day, whites with shotguns were riding around on pick-up trucks. Another individual described the same incident as follows:

[T]rucks occupied by armed white men hovered about the polls.

It is my belief that such recent occurrences of physical violence and intimidation, fewer in number though they may be, should definitely be considered as we review the possibility of minority losses in those political gains which have thus far been made in the covered jurisdictions. Such events should alert us to what may be a pervasive desire on the part of some residents in those jurisdictions to deprive blacks of the votes and offices which they have attained. While I certainly do not intend to blanketly attribute such ill-will to the many fair-minded residents of those areas, I nevertheless urge that we simply cannot ignore these events as meaningless. For as long as any such incidents are taking place in the covered areas, I believe that it would be utterly reckless for this body to allow the special protections of the Voting Rights Act to expire. To do so would be to risk the many victories and successes of that act to which we now point with pride.

In concluding, Mr. Speaker, I ask only that my colleagues take the time to make a fair appraisal of the legislation which has been introduced today. The issue is actually quite simple. Does the need still exist for the temporary provisions of the Voting Rights Act? I believe that a fair reading of the facts which have been put before you and of others which will unfold as this matter is being considered can only lead one to conclude that the extension proposed today must be passed.

Thank you.

THE YOUNGEST POPULIST

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. GONZALEZ) is recognized for 5 minutes.

Mr. GONZALEZ. Mr. Speaker, since 1962 I have had the pleasure of serving with my colleague and dean of the Texas Democratic Delegation in Congress, WRIGHT PATMAN, on the House Banking and Currency Committee. He has been chairman of that committee since 1963.

I have always admired Chairman PATMAN's great wisdom, his perseverance, and his continuing long efforts in behalf of the people, but have never felt that he has quite yet been given the opportunity which he should have.

Therefore, it was very gratifying to read in Sunday's Washington Star-News an article by consumer advocate Ralph Nader which sums up the case for Chairman PATMAN quite well.

I would like to share Mr. Nader's remarks with you:

[From the Washington Star-News, Jan. 12, 1975]

THE YOUNGEST POPULIST

(By Ralph Nader)

That old Texas populist, Wright Patman, has been in Congress for 46 years—longer than anyone else in both Houses. He came to Washington in March 1929—a few months before the stock market crash that launched the depression.

Unlike other progressives of that period, Patman concentrated on money and banks as his specialty in the House of Representatives.

He angered the banks and their powerful congressional supporters almost from the day he was first elected. Imagine a freshman congressman taking on Treasury Secretary Andrew Mellon for practicing like a big banker instead of a public official. The old guard on Capitol Hill didn't like to imagine so they kept Patman off the Banking Committee until the late thirties. This obstruction, in turn, kept him from becoming chairman until 1963.

Now for the first time in his steadfast career, Patman has a sympathetic Banking Committee chairman over in the Senate in Sen. William Proxmire, D-Wis. Over and over again in the past, the wily bank nemesis would be stymied either because bills he got through the House, such as the one last year to have the Federal Reserve audited by the General Accounting Office, would never get through the Senate or because a majority of his own bank-indentured committee members blocked him.

In September 1972, Patman wanted to launch an investigation into the Watergate matter by issuing subpoenas to suspected contributors, campaign committees and banks to trace the money. All the Republicans and five Democrats on his committee joined to block the inquiry. As he has shown so often in his career, Patman was right too soon.

At the mere age of 78, Patman stood on the House floor that memorable day in 1972 to deny Wilbur Mills, for the first time, a request for unanimous consent to ram through that session's outrageous "Christmas tree" of tax-loophole bills.

Only Rep. Les Aspin, D-Wis., had the courage to stand with Patman in a move that began the downfall of Mills' power in the House.

Whether the issue deals with consumer credit, credit unions, bank mergers, the secret power of the Federal Reserve, the bank holding company movement or adequate credit for housing, Patman remains the youngest populist of them all.

With a more consumer minded committee, following the retirement or defeat of several big banking allies last November, Patman will be permitted more leeway to push for fundamental changes in the nation's financial institutions and the reduction of taxpayer subsidies to the banks, which have totaled many billions of dollars.

For decades, the hardworking chairman of the House Banking Committee has warned Americans about the close interlocks between banks and other corporations, and between banks and the federal banking agencies that are supposed to regulate them.

He has made concrete and understandable what he means when he says that the people's money must be used for the people's interests. His audiences understand what banking concentration is, when he says that the nation has just over 14,000 commercial banks, but the 50 largest have more assets and deposits than all the rest.

Ten years ago, Patman arranged for the publication of a "Primer on Money" to educate citizens about money and the banking system in clear language. It was distributed in the tens of thousands and is still available free from his office.

The new Congress provides Patman with the best climate in years for the lengthy menu of hearings and legislative proposals that he and his staff have been preparing. Unlike so many venerable, status quo-type, congressional chairmen, Wright Patman can be permitted to view the current session as possibly his finest hour.

NEW INTERAGENCY COMMITTEE ON RESOURCE RECOVERY IS FORMED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. VANIK) is recognized for 5 minutes.

Mr. VANIK. Mr. Speaker, for some time I have been skeptical that the Federal Government was doing all it could to promote resource recovery practices. Without a genuine commitment to materials conservation on the Federal level, it is difficult to see how resource recovery can, in fact, become a national goal.

Specifically, last March 15 I wrote to the Administrator of the General Services Administration to recommend the establishment of an interagency panel to investigate the problems of the recovery and reuse of waste lubricating oil. In earlier correspondence with the GSA, I discovered that the Agency was unaware of the quantities of waste oil generated by the Federal fleet or even the way in which that oil was disposed. At the same time, various other agencies including the Bureau of Mines in the Department of the Interior, the Defense Supply Agency, the Department of the Army, the Environmental Protection Agency, the Federal Energy Administration in addition to the GSA have been conducting research into the waste oil problem.

In response to my inquiry, an informal meeting was called by GSA to discuss Federal programs on waste oil recovery. As an outgrowth of that meeting, it was agreed that an Interagency Committee on Resource Recovery should be established to investigate disposal problems not only to waste oil but also of other potentially valuable materials, including scrap tires, metals, paper, and other scrap material.

Recently, GSA Administrator Arthur Sampson invited the heads of 14 other Federal agencies to participate in this interagency committee. I am hopeful that the response to this invitation will be enthusiastic. In addition, I am optimistic that the new Interagency Committee will aggressively fulfill its mandate to improve the Federal Government's efforts of recovering valuable resources from waste material.

Thinking my colleagues may be interested, I am submitting copies of my recent correspondence from the GSA for the RECORD:

GENERAL SERVICES ADMINISTRATION,
Washington, D.C., April 5, 1974.

Hon. CHARLES A. VANIK,
House of Representatives,
Washington, D.C.

DEAR MR. VANIK: Thank you for your letter of March 15, 1974, suggesting that the General Services Administration initiate an inter-agency group to study, evaluate and make recommendations regarding the Government's waste oil problems.

We agree that the Federal Government has an obligation to demonstrate leadership in developing programs for the successful reclamation of waste oil, and we believe that implementing your suggestion to form an inter-agency study group will provide the necessary impetus to launch an effective approach to the problem.

In keeping with your suggestion, the General Services Administration will contact the other agencies working on waste oil recovery and invite them to participate in an inter-agency group which will coordinate the Federal Government's waste oil recovery efforts.

We very much appreciate your interest in this matter, and will keep you advised of our progress.

Sincerely,

ARTHUR W. SAMPSON,
Administrator.

GENERAL SERVICES ADMINISTRATION,
Washington, D.C., January 10, 1975.

Hon. CHARLES A. VANIK,
House of Representatives,
Washington, D.C.

DEAR MR. VANIK: We are pleased to advise you that in response to your suggestion that the General Services Administration initiate an interagency group to study, evaluate and make recommendations regarding the Government's waste oil problems, an Interagency Committee on Resource Recovery was established on December 17, 1974.

The enclosed letter was sent to 13 agencies inviting them to participate on the new committee. Following the replies from the agencies, the first meeting of the Committee will take place in the early part of 1975. Subcommittees will then be set up to provide advice regarding recovery of resources from each of several waste materials, such as waste paper, waste oil and scrap tires.

The Federal Government has a responsibility to take a leadership role in the protection of the environment, and we believe the resource recovery activities to be coordinated by the Interagency Committee will make an important contribution to this effort. If you have any questions or if we can be of any other assistance, please let us know.

Sincerely,

LARRY F. ROUSH,
Acting Assistant Administrator.

GENERAL SERVICES ADMINISTRATION,
Washington, D.C., December 17, 1974.

Hon. EARL L. BUTZ,
Secretary of Agriculture,
Washington, D.C.

DEAR MR. SECRETARY: In response to the growing public and congressional interest in resource recovery, and in recognition of the significant impact which increased resource recovery can have on our national energy conservation and environmental protection efforts, the General Services Administration is establishing an Interagency Committee on Resource Recovery. The Committee will provide advice regarding a concerted Federal effort to improve recovery of resources, including energy, from waste materials. The Committee will coordinate ongoing studies, consider potential areas for joint endeavors, and recommend specific proposals for improving the Federal Government's resource recovery efforts.

On June 13, 1974, an informal meeting was held at GSA to discuss waste oil recovery problems. Representatives from the Federal Energy Administration, Environmental Protection Agency, Defense Supply Agency, Department of the Army, Bureau of Mines, and GSA attended. The consensus was that since waste oil was but one of many disposal problems, an Interagency Committee on Resource Recovery should be established with subcommittees formed to deal with waste oil, scrap tires, metals, paper, and other scrap materials.

Agencies being invited to participate initially in the Interagency Committee are listed on the enclosure. The Committee will be chaired by the Assistant Commissioner, Office of Personal Property Disposal, Federal Supply Service, GSA.

We would appreciate your support and the participation of your agency in this endeavor and invite you to designate a person or persons to represent your agency on the committee.

Sincerely,

ARTHUR F. SAMPSON,
Administrator.

INVITED PARTICIPANTS: INTERAGENCY COMMITTEE ON RESOURCE RECOVERY

1. Department of Transportation.
2. Department of the Interior.
3. Department of Health, Education, and Welfare.
4. Department of Defense.
5. Department of Agriculture.
6. Department of Commerce.
7. Environmental Protection Agency.
8. Federal Energy Administration.
9. Federal Trade Commission.
10. National Academy of Sciences.
11. U.S. Postal Service.
12. Water Resources Council.
13. Atomic Energy Commission.
14. General Services Administration.

CANCER AND WOMEN

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Illinois (Mrs. COLLINS) is recognized for 15 minutes.

Mrs. COLLINS of Illinois. Mr. Speaker, cancer: The very word strikes terror in the hearts of men, women, and children everywhere. No one is safe from this dread disease. From 1971 through 1974 it is estimated that almost 1.4 million persons died of some form of cancer. The American Cancer Society predicts that in 1975 another 365,000 persons will die because of this disease. We can expect cancer to claim 1,000 persons per day or one person every minute and a half. One out of every six deaths in America is caused by this ubiquitous enemy, cancer.

Until recently, breast and uterine cancer, two of the major killers of women, received little or no congressional attention. In the 93d Congress I introduced legislation (H.R. 12154) to provide a post-mastectomy breast prosthesis as part of the items and services covered by medicare. I am happy to say that Commissioner Cardwell of the Social Security Administration has finally relented and allowed this coverage. Fortunately, there is no longer any need for the reintroduction of H.R. 12154.

Now, uterine cancer demands our attention. One of the tragedies of this type of cancer is that it would not prove fatal if it were only discovered in time. Many years ago, Dr. George Papanicolaou developed a test—the Pap test—from which doctors can readily determine whether a woman has or is developing cancer of the uterus or cervix. Yet, in order to be fully effective in combating cancer, the Pap test must be given at regular intervals.

After much scientific experimentation, the American Cancer Society has been able to determine that certain types of women can be classified as "high risk" for cancer of the uterus or the cervix: They are women who are from low-income backgrounds, who have never had regular check-ups, who have borne children, or who have a history of early sex-

ual intercourse with multiple partners. It is these same women who are economically, educationally, or medically indigent and/or over 65 years of age who are the least likely to have had the Pap test. Thus, many women who are most in need of this test either do not know about it, or cannot afford it.

The American Cancer Society warns that there will be 46,000 new cases of uterine cancer causing 11,000 deaths in 1975. Though the 5-year survival rate for localized uterine cancer is 82 percent, this drops drastically to 44 percent if the cancer has spread beyond the uterus before treatment. The fatality rate will decline if the Pap test is available to all women on a regular basis.

Therefore, today I have introduced legislation which will help provide for the early detection of uterine and cervix cancer by including the Pap test under medicare. This legislation was introduced last year by Congresswoman GRIFFITHS and Senator BAYH and received broad support both in Congress and around the country. The need for such legislation increases greatly every year. I am hopeful that a major effort will be made in the 94th Congress to pass this legislation and bring the Pap test to all women. Many lives are depending on us.

FREEDOM FIGHTERS' MEDICAL CARE LEGISLATION REINTRODUCED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. ANNUNZIO) is recognized for 5 minutes.

Mr. ANNUNZIO. Mr. Speaker, today, January 14, the 1st day of the 94th Congress, I am reintroducing my bill to provide hospital and medical care to members of the armed forces of Poland and Czechoslovakia who were allied or associated with the United States in World War I and World War II.

During these struggles against totalitarianism, many citizens of Poland and Czechoslovakia fought with great courage against nations at war with the United States. Many of these veterans emigrated to America after the war and became citizens who have enriched our Nation immeasurably through their talent and dedication to the ideals of freedom.

This bill gives the recognition of a grateful nation to these men of bravery in the allied war effort by providing that they be eligible for Veterans Administration medical and hospital benefits on the same terms as war veterans of the U.S Armed Forces. This bill is limited to persons who have been American citizens for at least 10 years and who participated in armed conflict with an enemy of the United States during World War II while serving in the armed forces of Poland and Czechoslovakia. Also, they must not be entitled to equivalent care or services provided by a foreign government or ally of the United States.

Passage of these limited benefits is supported by the Illinois division of the American Legion, the National Council of the Veterans of Foreign Wars, the 82d Airborne Division Association, Inc., the 101st Airborne Division Association, and also by the Combined Veterans Association of Illinois, which embraces the following organizations: AMVETS, the Catholic War Veterans, the Italian-American War Veterans, the Jewish War Veterans, the Marine Corps League, the Navy Club, the Military Order of the Purple Heart, the Paralyzed Veterans of America, the Polish Legion of American Veterans, the United Spanish-American War Veterans, the Veterans of Foreign Wars of the United States, and the Veterans of World War I. It is also supported by the Service Employees International Union, and many other groups and individuals.

Mr. Speaker, several Allied countries, including Canada, Britain, Australia, and New Zealand, have granted full veteran privileges to the Polish veterans who settled in their lands. However, the United States has not, despite the fact that we already provide medical and hospital benefits to World War II veterans of the Philippine Armed Forces, even if they are not U.S. citizens. Yet, the heroic sacrifices that were made by the Poles and Czechs who are now American citizens were the same as Philippine nationals.

During the 93d Congress, on August 5, 1974, this legislation was passed overwhelmingly by the House of Representatives by a vote of 341 to 40. The bill was then referred to the Senate Veterans Affairs Committee of which Senator VANCE HARTKE of Indiana is the chairman, and there it lay for almost five solid months, until December 20, when the 93d Congress ended and the bill died.

Mr. Speaker, when we consider this long overdue legislation to provide medical benefits for the few remaining freedom fighters who have not yet been overtaken by the infirmities of old age, we must keep in mind the moral aspect and the spirit of our laws—a spirit which for Americans always has meant recognition for sacrifices made in behalf of the American cause. This is part of the American heritage—and an integral part of the thinking of every American from the earliest days of the founding of our Republic.

It is this same spirit that is reflected in the provisions of my freedom fighters medical care legislation and I, therefore, strongly urge the support of my colleagues for favorable action on this crucial bill early in the 94th Congress in order that these limited benefits may be made available to those men who fought so heroically along with the American and allied forces during two world conflicts for the preservation of our freedoms.

The text of my bill follows:

H.R. —

A bill to amend title 38, United States Code, to provide hospital and medical care to certain members of the armed forces of nations allied or associated with the United States in World War I or World War II.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 109 of title 38, United States Code, is amended by adding at the end thereof the following:

"(c)(1) Any person who served during World War I or World War II as a member of any armed force of the Governments of Czechoslovakia or Poland and participated while so serving in armed conflict with an enemy of the United States and has been a citizen of the United States for at least ten years shall, by virtue of such service, and upon satisfactory evidence thereof, be entitled to hospital and domiciliary care and medical services within the United States under chapter 17 of this title to the same extent as if such service had been performed in the Armed Forces of the United States unless such person is entitled to, or would, upon application thereof, be entitled to, payment for equivalent care and services under a program established by the foreign government concerned for persons who served in its armed forces in World War I or World War II.

"(2) In order to assist the Administrator in making a determination of proper service eligibility under this subsection, each applicant for the benefits thereof shall furnish an authenticated certification from the French Ministry of Defense or the British War Office as to records in either such Office which clearly indicate military service of the applicant in the Czechoslovakian or Polish armed forces and subsequent service in or with the armed forces of France or Great Britain during the period of World War I or World War II.".

CONSUMER PRICE INDEX FOR THE ELDERLY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. BINGHAM) is recognized for 5 minutes.

Mr. BINGHAM. Mr. Speaker, today I am introducing legislation to create a Consumer Price Index for the elderly to be used in determining social security cost-of-living increases to more accurately meet inflation's impact on social security recipients.

The CPI is the bellwether for increases in social security benefits. Section 215(i)(1)(B) of the Social Security Act provides that automatic increases shall be determined and paid when the CPI exceeds 3 percent of the last computation period.

The need for a CPI for the elderly is compelling. The CPI prepared by the Bureau of Labor Statistics is a statistical measure of the changes in the prices of goods and services bought by urban wage and clerical workers. The index includes food, clothing, housing, transportation, health and recreation, and miscellaneous items.

The problem for senior citizens arises from the fact that they spend a larger proportion of their income than the average person for such items as food, housing, and health, and that it is in these three areas that inflation has run especially rampant. For example, the elderly on the average spend 34 percent of their income on food, as against 22.4 percent for the population as a whole. In the case of health, the percentage is 12 percent for the elderly, or more than double the average.

The bill I am introducing would make two changes in existing law:

First, it would require the Secretary of Labor, through the Bureau of Labor Statistics, to develop a Consumer Price Index for the elderly which would accurately reflect the actual increases in the cost of goods and services purchased by the aged, as opposed to the general CPI which is geared to reflect such increases for urban and clerical workers.

Second, after development, this new CPI for the elderly would be utilized to determine the annual cost-of-living increase in social security benefits. The regular CPI would continue to be computed and in any computation the higher of the CPI or the CPI for the elderly would oe used as the guide for determining social security benefit increases.

Only in this way can we reasonably assure social security recipients that cost of living benefit increases accurately reflect added costs of needed goods and services.

STATE OF THE UNION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. ADDABBO) is recognized for 30 minutes.

Mr. ADDABBO. Mr. Speaker, I would like to speak briefly to the Members of the House about my personal views of the state of the Nation as we convene for the 94th Congress.

We shall hear from the President tomorrow and that speech will provide the Congress with the necessary details for its deliberations. But those of us who have been out on the streets of America in recent weeks know only too well that our country has serious problems that must be dealt with as quickly as possible.

Let us make no mistake. The problems of America today are immense and they are complicated beyond belief. There are no easy solutions before us. There is no guarantee that our party has better ideas than their party, or that any of us are wise enough to choose the right path. All we can do, those of us who have been chosen by the people to represent them, is to hope that our best instincts prove correct. We can work ourselves as hard as possible, seek every available bit of information before locking ourselves into a fixed path and we can respect other points of view, because, as we begin, it is just possible that they might be right and we may be wrong.

As we look at the economy, we see respected economists arguing with each other as to the way to correct the malaise. As we watch the unemployment picture deteriorate, we again see the so-called experts fighting amongst themselves as to its cure. As President Ford said last night, our options are very limited.

We who sit in this Chamber are obligated to do the best we can for the people we represent. That is all we can do in the end. We must try our best, using reason rather than passion.

I would hope that as we debate these vital matters in months to come, we can eliminate contentiousness and partisanship as much as possible. Our Nation needs leadership today, not gamesmanship. Now, as to the issues as I see them.

From what I have seen over the holiday recess in my own congressional district, the Nation faces no sterner test in the coming months than coping with the many economic problems that now beset the Nation.

I would hope that the President, when he details in his state of the Union message his proposals for fighting these economic woes, has the gumption to do what is necessary to cure them. No matter how drastic the remedy might be, no matter how greatly all of us must suffer, we, the people of this Nation, can no longer endure not knowing the full extent of our problems. It will be better for all of us if the President offers the Nation a candid and accurate assessment of our problems and realistic means of dealing with them. As the polls would indicate the people of this Nation have no confidence in being fed pap simply because of the bad taste of the medicine. Let us have the worst put out where we can analyze it. Then we shall know how to deal with it.

As the President indicated in his speech last night, the role of Congress will be greatly expanded this year and next. I firmly believe the Congress has the obligation to act boldly and responsibly, whether it be in agreement with, or in opposition to, the proposals set forth by the President. No longer is it a simple case of partisan politics: it can literally become a matter of the Nation's survival as the most important free Nation in the world.

My own views I will present here in capsule form, a preview of legislation I will sponsor and support in the coming year. Some proposals are supported by the Democratic task force; others are not. No matter which, the following proposals are ones I believe are needed to relieve the plight of the people, even if their passage would cause us as citizens some difficulties in continuing life as we have known it up to now.

Our first priority is the question of the oil crisis. Our Nation is being strangled to death by the oil-producing nations and though our options are limited, we must respond immediately.

It would be insane, and self-defeating as well, to contemplate military action against the oil-producing nations. That leaves as our best available option the decision to cut our national dependence on imported oil supplies.

We have adequate supplies of oil within this Nation if we will only cut our annual consumption of oil to live within our means. The Federal Government must see to it that those limitations are not breached and I call upon the President to make that his first priority in the new year.

I propose massive Federal subsidies for all forms of mass transit, including buses, trains, and airplanes, so that fares can be forced downward as an attractive alternative to driving. I urge passage of legislation early this year which would mandate that all future automobiles sold in this Nation get a minimum of 20 miles to the gallon of gasoline.

I recommend that the use of neon signs be strongly curtailed in daytime hours and after 10 p.m. at night. I propose that all exportation of petroleum products be banned until the crisis is over, especially by the military. I propose that a thorough investigation of all utility rates be undertaken by the Federal Government, to be followed by a freeze on further rate hikes, or a reduction in rates if the investigation so deems.

I propose to mandate that the Federal Government use its full power to investigate business and industry to determine unfair and monopolistic practices, and to prosecute where it is needed. I propose forbidding any major exportation of foodstuffs which would have any bearing on increasing domestic food supplies. Along that line, I recommend that all farm subsidies be ended, to be replaced with an agriculture policy which would call for full utilization of every available acre of farmland and provide incentives to farmers to increase their annual yield, particularly of grains. I urge legislation that would require oil companies to divert adequate supplies of raw petroleum products toward fertilizer production to be made available to all farmers at a reasonable cost.

I seek specific legislation from the Congress as early as possible to beef up the money available through the Small Business Administration for the Nation's small businesses so they can expand their operations and work force, rather than let it shrink as most are now doing.

I propose a substantial tax cut and meaningful tax reform in the next few months, each of which it appears Congress will act upon. There is no question that the Congress must end tax loopholes.

I favor legislation to force the Federal Reserve Board to lower interest rates in order to stimulate housing construction, a move that would provide employment and decent shelter for millions of Americans.

I favor passage of a comprehensive national health insurance bill so that no American faces financial disaster due to the catastrophic costs of medical care.

And finally, I favor an exhaustive overview of all Federal programs so that antiquated or unnecessary programs can be eliminated. We must make every dollar count in our Federal spending over the next few years. We must maintain an adequate defense posture and we must provide money for education and social programs which in this day and age are equally as necessary and we must remove from the Federal payroll people with frivolous functions such as studies of the habits of vague insects, or those whose office ceased to effectively function years ago.

We must judiciously cut our military spending and I will say at this time I am not pleased at all with the proposed military budget that will be transmitted to the Congress by the President.

I must also say to the House that this Nation can no longer afford the overwhelming expense of the all-volunteer Army. Singlehandedly, it has shot up cost

of the military budget by an alarming figure and it will grow like a cancer each and every year unless we reduce the amenities now provided.

All of this, and more, must be passed by the Congress in months to come. Much of what I have talked about today will be introduced in legislation in my name or by my action. If others come up, within committees on which I serve, with better proposals, or bills that stand a better chance of passing promptly, I will not hesitate to support those measures.

If the President's proposals are adequate to combat our problems, I will gladly support his idea. If they are inadequate, by my sights at least, I will not hesitate to modify them for better, as I see it.

We can no longer afford to sit back as a Congress and wait for the President and his administration to act. We have millions of people unemployed, and public service jobs we have provided can only help so many for so long. We must insure that the Nation's free enterprise system begins to function again as we know it can.

We are not so desperate that we will trade the gains in ecology and consumerism for additional production. We must maintain the strides we have made while providing the means for legitimate businessmen to be able to see a fair and equitable chance of redeeming their investments with a profit. We want businesses to grow so that today's workers and the new crop that comes from our schools each year can find decent and meaningful employment.

We have much to do and little time in which to do it. So I would hope that we will not waste time in meaningless wrangling, but get down to the work that we know has to be done. I am ready to proceed and I know that my colleagues on both sides of the aisle are ready to move, as well. Thank you.

RECOMPUTATION OF MILITARY RETIRED PAY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California (Mr. ANDERSON) is recognized for 5 minutes.

Mr. ANDERSON of California. Mr. Speaker, I am today reintroducing legislation to provide for the recomputation of military retired pay. I have sponsored recomputation legislation in the three preceding Congresses, and I regret that the House of Representatives has not yet acted on this important issue.

In the past, I have supported full recomputation of military retired pay—a return to the previous system of basing retired pay on active duty pay scales. I still believe in that principle. However, today I have reintroduced a compromise proposal—a one-time recomputation of military retired pay. Such a measure has been adopted by the Senate; and the major military organizations, active duty and retired, have agreed to accept a "one-shot" recomputation as the final resolution of this question.

In brief, this legislation would provide a one-time recomputation of military retired pay, based on the rates of pay in effect on January 1, 1972. Any future increases in retired pay would be based on the Consumer Price Index. There would be immediate recomputation for disability retirees with a rating of 30 percent or more, and for retirees who are 60 years of age or older. For the remaining present retirees, recomputation would occur when they reached age 60, and it would be based on the January 1, 1972, pay scales with any subsequent cost of-living raises. Pre-1949 disability retirees would have the option to remain under the current retirement laws or to come under this legislation, at their actual degree of disability.

The principle of recomputing military retired pay based on active duty pay was incorporated in the American Military Retired Pay System from the time of the Civil War to 1958, with short exceptions. All military personnel who served before June 1, 1958, did so with the expectation that this principle would continue to be followed. It is quite likely that the recomputation feature of the retirement system was largely responsible for the decision of many to make the military a career.

Although there was no signed contract with the U.S. Government promising that this system would be continued after service was completed, there certainly was a moral obligation on the part of the Government not to reduce the entitlement after it was earned.

The hundreds of thousands of retired career personnel, both Regular and Reserve, who served in several wars believed that their Government would continue to honor that obligation by preserving their entitlement to those rights earned under laws existing during their active service. Repeated governmental statements concerning the matter strengthened this belief.

However, in 1958, Congress abandoned the recomputation principle and substituted an across-the-board 6-percent increase for retired personnel. In 1963, Congress offered a one-time recomputation to those who were retired prior to the 1958 changes, or a 5-percent cost-of-living increase, whichever was greater. The cost-of-living system of adjusting retired pay is in effect today.

Although changes have been made in the system in an effort to protect the retiree from the rapid rate of inflation, they have not done so. The average retiree's pay has increased by 93.9 percent since 1958, while active duty pay has increased by 180.3 percent during the same period. A tremendous gap in retired pay has grown between the retirees of the same grade and years of service, depending upon when they retired.

Many of the lower grade retirees who served their country well for 20 or 30 years through two or three wars are in dire straits. They served at times when pay scales were very low and raises few and far between. Their retired pay is small, they pay taxes on it, and end up with less than what many people get who never did anything for their country, who will not work, who pay no taxes, and who live off other people's money.

The many retired military men and women who have served our country, and who have given of their minds, bodies and years—none of which can be replaced—certainly deserve no less than equity in their retired pay. Full recomputation would best provide such equity. But the one-time recomputation I am introducing today would go a long way toward making restitution for the Government's breach of faith in 1958 when the traditional military retirement formula was changed.

THE LATE MARVIN M. KARPATKIN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. RANGEL) is recognized for 5 minutes.

Mr. RANGEL. Mr. Speaker, in the middle of the flurry of activity surrounding the opening of the 94th Congress, I must take this opportunity to announce with deep regret the death of one of the Nation's most prominent civil libertarians. Marvin M. Karpatkin died Monday while jogging outside his home on Riverside Drive in New York.

A graduate of Brooklyn College in 1949 and Yale Law School in 1952, Marvin formed a law firm in New York with his wife. This firm was concerned chiefly with representing those young men who sought legal counsel in their dealings with the Selective Service. He was always willing to represent all those who for whatever reason were conscientiously opposed to participating in military operations. Several times he appeared before the Supreme Court to argue that these young men should be allowed to exercise their constitutional rights with regard to the military.

His concern for seeing that individuals are allowed to freely and without interference exercise their civil liberties extended over the blacks' struggle to achieve equality. In the early 1960's when the civil rights cause needed all the allies it could possibly get, Marvin Karpatkin made the trip to Mississippi to defend the civil liberties of black people in the face of much tension. The assistance he provided in terms of legal expertise and the moral commitment to the cause of justice which his actions demonstrated will long be remembered within the black community.

At a time when lawyers have had to defend their integrity in the light of recent actions taken by other lawyers who were sworn to uphold and enforce the laws, Marvin Karpatkin was a sterling example of what all those lawyers should

have been. His presence in and out of the courtroom will be most definitely missed. I take this opportunity to extend my very heartfelt sympathy to his wife, Rhoda, and their three children.

COMPREHENSIVE CHILD DEVELOPMENT ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. OTTINGER) is recognized for 5 minutes.

Mr. OTTINGER. Mr. Speaker, I am introducing legislation today which is known as the Comprehensive Child Development Act of 1975. Our former colleague and my predecessor, Representative Ogden Reid, labored long and hard for the passage of this bill. Mr. Reid, during the 92d Congress, finally achieved his goal of passage by the Congress, but his efforts were stymied by former President Nixon, who vetoed the Reid bill.

This bill is designed to strengthen family life in America and to insure that parents are entered into a partnership with State, local, and Federal Government in the task of providing quality day care, educational development, and a stimulating and healthy environment for millions of children in the Nation today who need these services.

For those children, only the kind of care and development proposed by day care advocates across the country for years will help the youth of America grow to adulthood as fine citizens of the United States. It is these goals to which my bill addresses itself.

This legislation is of supreme importance, not only to my constituents or to the people of New York State, but to families across the Nation. Nothing is more important to the well-being of America than the strength of the family unit and it is thus my hope that my colleagues will join me in supporting the Comprehensive Child Development Act of 1975.

MALPRACTICE CRISIS AND MEDICARE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. ROSTENKOWSKI) is recognized for 5 minutes.

Mr. ROSTENKOWSKI. Mr. Speaker, I have today introduced legislation which would deal with two related problems. The first problem is the rapidly worsening crisis in malpractice insurance as it affects our physicians and hospitals and their patients.

This is a problem which most Americans have probably not yet even heard of, but which nonetheless is beginning to threaten the stability of the entire health care system. The problem of medical malpractice claims and the soaring costs of the medical malpractice insurance that doctors and hospitals must pay if they are to continue to render care is worsening much faster than was thought possible only a few months ago. The vastly increased costs for such insurance ultimately must be met through charges to patients and to medicare and the other programs paying for the costs of health care.

But the problem is even more severe than that. Not only are malpractice insurance premiums rising dramatically, but in addition, doctors in some localities are facing the prospect of being unable to obtain insurance at any price. The companies that provide this insurance consider malpractice a risky, uncertain area. It represents only a small proportion of their business in many cases. Where State insurance commissioners will not allow premiums to rise by the major amounts these companies believe to be needed, they more and more are just saying that they will withdraw from the market. In a number of States—of which a few are California, Michigan, and Maryland—the problem is reaching crisis proportions, and the difficulties are also spreading rapidly to other parts of the Nation.

The threat of malpractice suits hangs over the heads of doctors even where the complete loss of malpractice insurance is not an immediate danger. Doctors consistently report that they feel it necessary to engage in "defensive medicine"—by ordering excessive diagnostic tests, calling in consultants, and practicing in a manner that greatly increases the costs to patients and to insurance programs like medicare. Doctors practice in this expensive, defensive way not for the benefit of patients, but only out of necessity, they believe, to protect themselves against malpractice suits and to aid in their defense if they are sued. These practices increase the cost of health care, including medicare, and need to be solved before we embark on national health insurance.

Unfortunately, nobody really seems to have the solution to the serious and complex problems involved in malpractice.

I am, therefore, proposing an urgent, rapid effort to seek an interim solution through an expert study whose results are to be reported to the Congress no later than July 1 of this year. I would expect early action on these recommendations.

My bill calls for the Office of Technology Assessment to arrange with the National Academy of Sciences for the conduct of such a study that will include recommendations for a course of action aimed at getting us through the crisis period that seems to lie just ahead.

Recent experience has convinced me that the ponderous bureaucracy at HEW simply cannot move swiftly enough to get this study going on the schedule that the urgency of the present situation requires. Therefore, the arrangements for the study would be made by an organization of the Congress—the Office of Technology Assessment.

The bill also calls for the National Academy of Sciences, under contract with OTA, to conduct a more thorough study of the malpractice problem and of alternatives to the present malpractice insurance system and to include recommendations aimed at producing long-range and permanent solutions. In considering possible solutions, the Academy would give special attention to provisions that would encourage "assignment" of medicare claims, for example, by making the availability of Federal help contingent on accepting medicare assignments. This would protect beneficiaries against having to pay doctor bills higher than medicare allowances—a situation which now characterizes more than half of all medicare bills. The report of this more thorough study would be submitted no later than May 1, 1976.

In the past, malpractice insurance has not been viewed as a Federal responsibility. The current crisis, however, is becoming nationwide. The impact it will have on programs such as medicare, and ultimately national health insurance, makes it necessary for the Federal Government to seek solutions and to be prepared to act to bring them about. If the malpractice insurance system collapses and there is no adequate replacement, it will be not just doctors and hospitals who will suffer; it will also be all of us who are or may become patients. We must act now, and vigorously, to seek a solution.

The second problem which my legislation would correct is a situation which results from a technical error in the last social security benefit increase.

From its beginning, part B of medicare—which covers doctor bills and certain other services—has been financed by premium deductions from benefits paid to beneficiaries and from Government contributions out of Federal general revenues.

The premiums were intended to increase automatically each year as costs of the program rose, but even so, beneficiaries would get a bargain because the Government contribution always amounts to at least half the cost of this part of the medicare program.

In 1972, to protect beneficiaries against unduly rapid increases in the part B premium, the law was amended to permit the premium to be raised only if monthly social security benefits had been raised in the past year, and by permitting the premium to rise no higher than the same percentage as the benefit increase. That is what the Congress intended; and on that basis, the current $6.70 premium should be increased as of this coming July 1. Social Security Administration actuaries have estimated that an adequate actuarial rate would be $7.50. Unfortunately, in modifying the provisions for automatic cash benefit increases, Public Law 93-233—passed in December 1973—inadvertently failed to make a needed conforming change in the medicare law and this has prevented such premium increases from taking place. My bill would correct this technical flaw so as to permit this and future increases to take place in accordance with congressional intent.

I realize that there will be concern about permitting a premium increase to take effect at a time when the elderly like other Americans are suffering the effects of inflation.

First, however, it should be remem-

bered that the current situation was not intended by the Congress. Second, it should be kept in mind that the premium could rise by no more than the percentage by which cash social security benefits have gone up. Moreover, the modest increase in the monthly premium that is needed would be much easier for the elderly to bear than the major increases in daily hospital charges that the Administration has proposed the elderly be required to pay, and will be only a small part of the increase in cash benefits which they will get in early July.

Mr. Speaker, I intend to do whatever is necessary to move this legislation through my committee with the dispatch the situation requires and I ask the support of Members in meeting this objective.

UNIVERSAL AND UNCONDITIONAL AMNESTY: THE TIME IS NOW

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from New York (Ms. ABZUG) is recognized for 10 minutes.

Ms. ABZUG. Mr. Speaker, it has now become clear that the "earned reentry" program offered by President Ford to war resisters has done little to reintegrate these young people into our society. Less than 1 percent of those eligible for the program have applied for it—some 800 men out of more than 100,000 eligible.

The Clemency Board feels that this lack of response is due to a misunderstanding of the program. On the contrary, I believe that the war resisters understand it all too well. They know that clemency is only strained mercy and not amnesty, which would wipe the books clean. They know that there are strings attached to this program, such as alternate service—which they could have chosen in the first place. They know that those who apply must reaffirm their loyalty to the country—and they do not feel that they have ever been disloyal. Most of them have already served months or years, either in jail, in exile, in the underground, or in the Armed Forces. Their rejection of the war in Vietnam was a matter of conscience, with which some 80 percent of the American people eventually came to agree. Why should they now pay a further price for having been right too early?

If the United States is to have the contribution that these people can make to a society with a conscience, we must offer them nothing less than universal, unconditional amnesty. The bill I introduce today is an improved version of my earlier bill, H.R. 236. Two ad hoc hearings and one formal hearing before a subcommittee on the Judiciary have been held on this bill. Subsequently the clemency program came—and went. Let us not neglect any longer our responsibility to those who helped us see the light on Vietnam. The Congress has power equal to the Executive, to issue a general amnesty. Let us act upon this question soon.

My bill, H.R. 236, later H.R. 5195, cosponsored by Representatives DELLUMS, CONYERS, and MITCHELL, is the only bill proposing unconditional and universal amnesty. It requires no punitive alternative service, no loyalty oath, no showing of repentance. It would extend not just to draft evaders but to deserters and antiwar demonstrators as well—to those who violated any Federal, State, or local law in the course of essentially nonviolent war protest. It is unfair to grant amnesty to draft resisters while denying it to deserters, who simply developed their moral awareness after entry into the service rather than before. I oppose case-by-case study of deserters, since many of them are less well educated and less well able to articulate their motives, even though they are totally sincere.

Further, the bill grants a thorough restoration of rights to war resisters. Those imprisoned would be released, further prosecution restrained, police records expunged, and other than honorable discharges converted to discharges with no coding or other indication of reasons for discharge. Citizenship would be restored to anyone who renounced it because of the war.

Administration of amnesty would be granted directly and automatically except in cases of violations involving injury or destruction of property. A Presidential commission would review these cases and grant amnesty if the actions were motivated by opposition to the war.

There are minor changes in this new bill. Certain acts considered criminal in the UCMJ but not in civilian life—such as the use of contemptuous words—are also amnestied. The Commission—to be appointed by the President with the advice and consent of the Senate—would include women and members of minority groups. The right of exiles to visit their families would be granted, as well as citizenship for naturalized exiles, if requested.

Nothing less than this will restore these people to productive lives in the United States.

INTRODUCTION OF A BILL ESTABLISHING A JOINT COMMITTEE ON NATIONAL SECURITY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Wisconsin (Mr. ZABLOCKI) is recognized for 10 minutes.

Mr. ZABLOCKI. Mr. Speaker, I have reintroduced a bill today which would establish a Joint Congressional Committee on National Security. It is my understanding that this bill, which I originally introduced in the first session of the 93d Congress, will be introduced in the other body by the distinguished gentleman from Minnesota, the Honorable HUBERT HUMPHREY.

This bill is in large measure a result of my efforts over the years in trying to reassert the constitutional rights and responsibilities of Congress in the conduct of our Government's foreign policy.

Along these lines, the 93d Congress had made a great step forward in the enactment of the War Powers Act over a Presidential veto. As you yourself have indicated, Mr. Speaker, the War Powers Act returns to the Congress its constitutionally mandated power to declare war.

It was during the extensive hearings on the war powers resolution by the National Security Policy Subcommittee of the House Foreign Affairs Committee, which I chair, that the desirability of a Joint Committee on National Security was once again made clear.

Noted repeatedly during those hearings was the executive branch's reluctance to share certain information with the legislative branch. The War Powers Act is aimed at correcting that deficiency as well as reestablishing the balance between the legislative and executive branches in the war-making area envisioned by the Founding Fathers in the Constitution. The bill which I am introducing today complements my war powers legislation in that it will allow Congress to address itself in a more comprehensive way to a thorough and ongoing analysis and evaluation of our national security policies and goals.

In addition, Mr. Speaker, the current controversy and allegations of illegal and improper domestic surveillance by the Central Intelligence Agency underscores the urgency of establishing a Joint Congressional Committee on National Security.

It is abundantly clear that the continuing dimunition of Congress' role in foreign policy is a direct result of this communication breakdown. For too many years the Executive has failed to share with Congress the kind of adequate information needed in matters involving national security. In short, there is no proper and adequate forum for a regular and frank exchange between the Congress and the Executive on the vital issues affecting our national security.

The bill which I am introducing today is intended to correct that problem by endowing the proposed joint committee with three main functions:

First, to study and make recommendations on all issues concerning national security. This would include review of the President's report on the state of the world, the defense budget, and foreign assistance programs as they relate to national security goals, and U.S. disarmament policies as a part of our defense considerations.

Second, to study and make recommendations on Government practices of classification and declassification of documents.

Third, to conduct a continuing review of the operations of the Central Intelligence Agency, the Department of Defense and State, and other agencies intimately involved with our foreign policy.

Given those primary functions it should also be pointed out that the Joint Committee on National Security would operate in the national security area in much the same manner which the Joint Economic Committee functions in the economic field.

Another important and distinguishing feature of the Joint Committee on National Security would be the composition of its membership. Reflecting ap-

propriate individual and committee jurisdictions, it would include the following: the Speaker of the House of Representatives, the majority, and minority leaders of both Houses, and the charimen and ranking minority members of the House and Senate Committees on Appropriations, Foreign Affairs, and Foreign Relations, Armed Services, and the Joint Committee on Atomic Energy. Rounding out the 25-member joint committee would be three Members from both the House and Senate appointed respectively by the Speaker of the House and the President of the Senate. As you can see, the bipartisan membership would include the experienced authority of Congress with the majority party having three members more than the minority.

Finally, Mr. Speaker, I think it is important to point out what this proposed Joint Committee on National Security would not do. First and foremost, it would not usurp the legislative or investigative functions of any present committees. Rather, it would supplement and coordinate their efforts in a more comprehensive and effective framework. Nor would this new joint committee in any way usurp the President's historic role as Commander in Chief. Neither would it place the Congress in the position of adversary to the executive branch.

As I said at the outset, the need for greater cooperation between the Congress and the executive in the national security area has been evident for too long. We have not had an adequate mechanism in our national security apparatus for proper and meaningful consultation between the two branches. The aim of this bill is to provide that mechanism and thereby allow for the formulation of a truly representative national security policy.

FEDERAL EMPLOYEES GIFT DISCLOSURE ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. KOCH) is recognized for 5 minutes.

Mr. KOCH. Mr. Speaker, one of the major issues raised in the confirmation hearings of Vice President NELSON ROCKEFELLER was gift giving by public officials. While not necessarily illegal, such gifts and interest free loans from one public official to another cannot help but cause a feeling of obligation to the donor by the recipient. And in Government, this can be especially dangerous.

Today, the first bill I am introducing is one that will require full public disclosure of gifts given and received by appointed and elected public officials. The bill, entitled the Federal Employees Gift Disclosure Act, would require Federal employees to submit annually to the Federal Register a listing of gifts, loans, or contributions to other public officeholders, whether Federal, State or local, where the total value given to an individual during any year is in excess of $500. Likewise the bill would require disclosure of gifts received from any one source exceeding $500. The bill would apply to gifts given or received during the Federal employee's periods of service, the year prior to public service and the year after leaving such service.

Gifts to and from members of an individual's immediate family would be exempt from the reporting requirement. I am including this exemption because I believe that the gifts a Federal official might make to a spouse or child, for instance, would constitute an unwarranted invasion of privacy and would not involve the types of conflict of interest we want to avoid.

Mr. Speaker, while calling for this disclosure, I must confess a certain ambivalence. Since coming to Congress in 1969, I have worked hard to protect individuals' right to privacy. And, I believe that like all Americans, public officeholders are entitled to some privacy. A balance must be struck however, between the privacy rights of these individuals and the public's right to know of private actions by public officeholders that affect public policy. I know that many Members of Congress objected to providing their tax returns to the media because they contained information relating to their private lives, such as medical expenses and alimony payments, which they did not want to disclose. While I made public my tax return, I can understand their feelings. In the instance of a public official's gift, disclosure may intrude on the privacy of some of the gift's recipients who are private citizens. At this point, however, on balance I think full disclosure is necessary.

While Federal legislation cannot force disclosure by State or local employees without unfairly penalizing the State and local agencies by withholding Federal funds, I would hope that State and local jurisdictions would apply regulations and penalties similar to those in the Federal Employees Gift Disclosure Act.

Gifts per se to or from public officials are not evil. But because they are public officials, the public has the right to determine the circumstances surrounding such gifts and whether any impropriety is attached to them.

I urge the support of my colleagues for this important legislation.

THE NATIONAL HEALTH CARE SERVICES REORGANIZATION AND FINANCING ACT—H.R. 1

(Mr. ULLMAN asked and was given permission to extend his remarks at this point in the RECORD, and to include extraneous matter.)

Mr. ULLMAN. Mr. Speaker, I am submitting to the Congress today legislation titled the "National Health Care Services Reorganization and Financing Act." Its aim is to create a better health-care system for the Nation, and it is a new version of a bill I originally introduced in the 92d Congress. The basic principles and philosophy of the bills are identical. The objectives—to reorient our system of health delivery and to bring into being a more equitable system of financing health services for all the population—remain unchanged.

In recent years, the imperatives and pressures for the enactment of such a measure have increased. Economic stringencies and governmental controls over the health-care industry, however temporary, further revealed the gaps and inequities in the present system. For the sake of the immediate future and for generations to come, these serious problems must not be left unattended. I am personally persuaded, as a result of hearings on national health insurance in the Ways and Means Committee during the last two Congresses, and after months of weighing the provisions and implications of my own proposal, that the Congress can no longer postpone major decisions to assure the availability of health services to all persons in the United States.

I continue to regard my proposal, as I would any legislative proposal, to be an invitation to comment and thought, providing a direction and philosophy I firmly believe to be right. I trust that it will draw the attention and interest of the Congress, the health industry, and the general public. It contains an important new concept, an administrative entity known as the health care corporation or HCC. The HCC, as the coordinator of community health resources, represents an exciting new concept of responsible localism. As a member of the Advisory Commission on Intergovernmental Relations, I have been deeply concerned with the strengthening of State and local resources in the administration of Federal programs.

In my opinion, the National Health Care Services Reorganization and Financing Act offers the most realistic solution to health care delivery, regulation and financing among the dozen or so that have been proposed. It is implementable now because the structure it defines is based on existing resources but with the guidelines and incentives for putting an end to the present fragmentation and duplication of services, their uneven distribution, and their lack of accessibility in many rural and urban areas. It provides for considerable expansion of outpatient services and their broader utilization.

None of the other proposals for national health insurance could fulfill this potential. Either they are attempts to resolve the serious problems of health services in a piecemeal fashion, or they would create a monolithic, bureaucratic system which in the end would be prohibitive in cost. Most do not interweave provisions for financing health care with incentives for restructuring the delivery of services. And some, worse still, would only perpetuate existing inadequacies and infuse more money into outmoded mechanisms.

We need desperately to pull it all together, to approach the development of a better health system anew, to resolve the problems of financing and delivery of services interrelatedly. If we fail to bring about this convergence, we will fail to better serve the public interest, and I believe that in the long run we will have

wasted human, financial, and material resources.

I am impressed not only with mounting public concern over the cost and delivery of health services, but also with the sincere concern of health professionals and professional organizations. Many are striving for a more effective health services delivery system even though changes and controls would unquestionably impose complications on their activities.

The American Hospital Association has been most helpful in the realistic establishment of goals, concepts and methods, and has provided technical staff assistance in designing the total concept of a coordinated, equitably financed system.

The bill calls for the consolidation of the major Federal health programs and the incorporation of medicare and medicaid within a program of national health insurance. It also provides for a new Department of Health, to be headed by a Secretary for Health responsible to the President. In addition, it includes greater detail and necessary technical information for changes in the financing of health services. It emphasizes the responsibility of the individual for his own health, but provides the framework for better health care and financing for everyone.

Certain principles of the bill I am introducing today deserve special mention, beginning with the recognition of health care as an inherent right of every person. Others, without order of priority, include the following:

Health services and the delivery system, as well as its financing, must be pluralistic, inclusive of both private and public sectors of the health field, and must be predicated on carefully designed Federal incentives and subsidies to assist and assure the cooperation of the various components of the health industry;

The rights of every individual to choose among providers of health services and underwriters of health insurance benefits must be preserved;

The same scope of comprehensive health benefits must be available to all;

The same high level of quality of care must be available to all; and

The Federal Government must assume responsibility for the cost of health care for first, the nonworking poor, second, the elderly, and third, to the extent needed to assure their capability to purchase services, the working poor, but with assurances that the program does not create disincentives to productive employment.

Inherent in each of these principles, whether in terms of use of health services or payment for them, is the principle that every individual has a responsibility for the maintenance of his own health and, to the extent that he is able, to contribute to his share of the cost of care. There are numerous corollary principles, which I shall not describe here, such as those relating to the dignity of the individual, and the relationship of health and the environment.

The health care corporation which would be the coordinating unit of the system at the local level would provide a geographically based system for synthesizing and coordinating local health resources. These corporations would be built upon the existing delivery system, but with mandatory reorganization and reorientation to meet local needs, under the supervision of newly mandated State health commissions.

HCC's would be organized in a variety of ways, determined largely by community needs, custom, and precedent. They would grow out of the community, providing for citizen or consumer representation on their governing boards and being accountable to the public. It is expected that they would primarily be organized by health care providers—hospitals, doctors, dentists, as well as nursing homes and community health organizations—working with the community to establish a more effective, coordinated system.

Every HCC would have to provide, within a State plan administered by the State health commission and approved by the Secretary of the Department of Health, a comprehensive benefit program for all persons in its service area who wished to register. After the first 5 years of operation, it would be required to offer as an option to its registrants, services on a capitation basis of payment, or so much per person per year, a method of payment that requires providers of service to accept a direct responsibility for utilization and cost of services. Among its responsibilities, the HCC would be charged with encouraging the development and use of outpatient services, and for seeing that the most appropriate service would be provided for patients in the most effective, least costly way.

Every employer would be required to purchase for his employees and their families a comprehensive level of benefits as prescribed in the legislation and within regulations issued by the Secretary of Health, paying at least 75 percent of the premium costs. The employees would pay a maximum of 25 percent. For individuals and their families who registered with HCC's, the Federal Government would contribute 10 percent of premium costs to assist the self-employed and small employers in meeting premium payments, my proposal also includes a special tax credit mechanism.

Newly formed independent State health commissions, appointed by State Governors, would approve HCC's for operation and approve charges for service. These same commissions would develop State health plans subject to the approval of the Secretary; control the rates charged by health care providers and health insurance carriers; issue certificates of need and approve health service areas; and review and approve provider budgets. Thus State government would play a central role in the national program, obviating a large bureaucratic operation in Washington.

I should like to emphasize that the legislation provides for multiple sources of financing to assure a basic level of health care benefits for all persons, including catastrophic health insurance benefits. For persons unable to pay, in part or in full, the Federal Government would purchase the specified level of coverage established for all persons through general Federal revenues, with individual contributions scaled inversely to income levels and family size. Health services to the aged would continue to be financed through a combination of the social security tax mechanism and general Federal revenues. Since parts A and B of the medicare program would be merged, premium contributions by individuals for part B would be eliminated. Payroll financing, therefore, would be restricted approximately to its present levels, with additional costs paid through general Federal revenues.

In sum, this bill would meet the following objectives, upon a 5-year implementation of the national program following congressional enactment:

All persons, regardless of age or income, would be entitled to the same broad package of benefits:

Everyone would be insured against the cost of catastrophic illness;

The Federal Government would pay for the health care costs of the poor and the elderly, and part of the costs for all others;

Special benefits for children up to age 12 would be provided—medical, dental, and eye care;

Outpatient care would be emphasized in order to relieve the burden of unnecessary use of costly inpatient care facilities;

Through the capitation method of payment for care, incentives for keeping costs down would be broadly introduced at the community level;

Health education programs, in support of the principle that the individual has a responsibility for the maintenance of his own health, would be available through health care corporations in every geographic service area in the national effort to raise health levels, increase knowledge about nutrition, and bring better understanding of the management of illness in the family.

How such a national program would affect American families is, of course, the most important question. Any legislative proposal can itemize what its author believes needs to be done, but this hardly assures that what is envisioned can take place. However, I believe that this legislation, since its objectives are based on existing resources and on developments in the delivery of health services already in the making, is totally realistic. Health care providers in recent decades have increasingly concerned themselves with how to contain costs yet at the same time keep pace with the numerous advances of medical science and strive for an increasing volume of services of higher quality. They have struggled, against steep odds, and without a coordinated national effort, to plan sensibly so that our legacy to coming generations will neither be a system inadequate to the needs nor one so uncoordinated as to be costly beyond bounds.

From the public's point of view there also are many problems to be faced, the foremost being the increasing cost of health care and the inaccessibility for many to needed services. The public generally finds it anomalous that in a Nation founded on democratic ideals and in which resources are plentiful, there con-

tinue to be serious gaps in health care. The public seeks a stronger voice in how health services should be provided. However, it is fair to say, recognizing the lack of a coordinated system is in large part to blame, that public awareness of health is far less than it could be and that a sizable educational program is needed if individuals are to avail themselves of health services in the most timely, effective, and consequently, most economical way. We have by no means put to use all of the health knowledge that is at hand, nor can we claim to have practiced what we know.

To conclude, I wish again to acknowledge the complexity of my proposal, but also to say that it must necessarily be so, for there is no simple solution to the Nation's health problems. Then I would like to draw attention to the legislation's provisions, following enactment, for a 5-year period for the development of State plans, the establishment of HCC's, and the establishment of a department of health. This would be a period of development and experimentation with the various organizational forms of health care corporations, time for the combining of parts A and B of medicare and the incorporation at the Federal level of medicaid.

The legislation I propose would coordinated our health services in a way that would bring improved health care for all Its aim, immediate as well as long range, is the containment of health care costs and the removal of the real possibility that a family's resources can be totally depleted as a result of the cost of serious illness.

I believe that this bill is the most flexible of all of the major health proposals that you will be considering this session. I trust that its flexibility will attract your interest and support, and, above all, your participation in its development.

The following is a section-by-section analysis of the bill:

SECTION-BY-SECTION ANALYSIS—H.R. 1

To establish a new program of health care delivery and comprehensive health care benefits (including catastrophic coverage) to be available to all residents of the United States. The plan will be financed by payroll deductions, employer contributions and tax credits.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that this Act divided into titles, parts and sections, may be cited as the "National Health Care Services Reorganization and Financing Act."

FINDINGS AND DECLARATION OF PURPOSE

Section 2(a) states that in recognizing health care as an inherent right of each individual and of all the people of the United States, and that in fulfilling this right each individual shares the responsibility for protecting his or her health and for obtaining care when required, Congress declares that health service must be so organized and financed as to make them readily available to all, without regard to race, creed, color, sex, or age, and without regard to any person's ability to pay; that health services must enhance the dignity of the individual and promote better community life; and that it is a function of government to see that these ends are attained.

(b) states that the Federal Government, acting through a new Department of Health established to deal exclusively with health and related matters, has the responsibility to include financial assistance to the public in obtaining health care services in accordance with these principles:

(1) the Federal Government should require all employers to contribute to the purchase of Comprehensive Health Care Benefits for their employees;

(2) the Federal Government should purchase or subsidize, through tax credits and deductions and other ways, health insurance for those unable to pay for it, in whole or in part;

(3) social insurance should continue to finance health care for the aged;

(4) to encourage participation by individuals in new health delivery and benefit programs, the Federal Government should provide a financial incentive.

(c) Calls for reorganization of the methods of delivery, and methods of financing health services, to be accomplished through a nationwide system of independent Health Care Corporations embodying specific principles.

(1) each corporation must provide through its own resources, or through affiliations with qualified institutional and professional providers, five levels of comprehensive health care: health maintenance services, and primary, specialty, restorative and palliative and terminal care;

(2) through a system of independent corporations, every individual would be provided an opportunity to register and, where possible, to have a choice of Health Care Corporations;

(3) Health Care Corporations should be locally established and operated, but subject to State regulation through State Health Commissions and to national standards of quality and scope of services.

This section also states that with the Federal financial assistance in developing corporations and needed outpatient and home health care program facilities, the system can become operative within five years after enactment of legislation.

(d) Provides that:

(1) in the fifth year following enactment, every person residing in the United States will be eligible to participate in the program;

(2) every individual will be entitled to the services established in the Act if he has registered with a Health Care Corporation and has obtained health benefit coverage from a qualified insurance carrier, or has had it provided on the basis of income or age;

(3) coverage will be provided without cost to persons in the lowest income bracket and at reduced cost to persons in higher income brackets specified in this Act;

(4) coverage will be provided through payroll taxes and general revenues to persons who have attained the age of 65.

(e) Appropriate philanthropic support for health care should be continued and expanded, especially in support of experimental and innovative efforts to improve the health delivery system and access to health care services. Nothing herein is intended to eliminate or limit philanthropic support or incentives for such support for Health Care Corporations and health care institutions.

DEFINITIONS

Section 3 defines the term "Comprehensive Health Care Benefits" as the benefits described in Title I part B; the term "State" as including the District of Columbia, Puerto Rico, the Virgin Islands, and Guam; the term "United States" (when used in a geographical sense) as meaning the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam; the term "Governor" as including the Mayor of the District of Columbia; and the term "Secretary" as the Secretary of Health.

TITLE I—FINANCING OF NATIONAL HEALTH SERVICES

Section 100. Title I may be cited as the "National Health Care Services Financing Act."

PART A—EMPLOYER REQUIREMENTS AND ENTITLEMENT TO BENEFITS

Employer benefit requirements

Section 101(a) amends the Social Security Act to require that employers have an approved health care plan for their employees (and their families). The new Section 232 of Title II of the Social Security Act:

(a) requires every employer within the meaning of this title to provide for each of his employees (and members of their families) coverage equivalent to Title XVIII benefits (both Parts A and B) and Section 125 Catastrophic Expense Benefits during the third and fourth full fiscal years after enactment and to provide Comprehensive Health Care Benefits coverage beginning on the first day of the fifth full fiscal year of enactment.

(b) lists the situations in which the provision of subsection (a) do not apply—

(1) (A) to any employer which is the United States or any agency or instrumentality thereof;

(B) in the case of individuals or members of the same families who have multiple employers, all of the employers except the employer paying the highest total taxes under Section 3111 (a) of the Internal Revenue Code of 1954;

(2) with respect to an employee (or member of an employee's family) who is entitled to health insurance benefits under Title XVIII.

(c) provides that the employer's contributions must be at least the actuarial equivalent of 75 per cent of the premium cost of benefits equivalent to the Medicare coverage during the third and fourth full fiscal years and of the premium cost of Comprehensive Health Care Benefits coverage beginning on the first day of the fifth full fiscal period. This requirement shall in no way prohibit an employee choosing to register with a Health Care Corporation operating in whole or in part on a capitation basis.

(d) provides that low-income or medically indigent persons or family members who make premium contributions in connection with their employment are entitled to refunds to the extent such contributions exceed the amount they would otherwise be required to contribute under section 106 for coverage under section 102.

(e) stipulates that the period of coverage extends from the date of involuntary termination until the employee becomes eligible for unemployment compensation benefits or until the expiration of 14 days from such termination, whichever occurs first.

Section 101(b) amends Title IX of the Social Security Act by adding at the end thereof a new section which requires the Secretary of Labor in accordance with regulations prescribed in consultation with the Secretary of Health to purchase coverage as defined in subsection 101(a) for every individual who is receiving benefits under any federal or state unemployment compensation law for the individual and members of his family.

ENTITLEMENT TO SUBSIDIZED BENEFITS

Section 102(a) specifies that every individual who is a resident of the U.S. including the District of Columbia and Puerto Rico, is eligible for full or partial Federal contribution to the premium cost of qualified Comprehensive Health Care Benefits (CHCB).

(b) obligates the Secretary to contract with carriers for coverage in behalf of the aged, the low-income, and the medically indigent.

(c) allows all others who are eligible for

the program, and those (other than the aged) who are eligible but choose not to enroll in an HEW-contracted plan, to obtain a Federal subsidy of 10 per cent of the premium cost incurred for the purchase of qualified CHCB, irrespective of the source of payment, if the individual (and his family) is registered with an approved Health Care Corporation or with any other similar organization that demonstrates it meets standards prescribed by the Secretary. If existing coverage is broader than CHCB, an actuarial equivalent of CHCB will be utilized to determine the amount of the subsidy.

(d) refers to definitions of the low-income and medically indigent income classes.

INCOME CLASSES

Section 103(a) defines a low-income person or family as a single individual (i.e., one who is not a member of a "family" as defined) or a low-income family in income class 1; a medically indigent person or family as a single individual or family in income classes 2, 3, or 4; and the remainder of the population as falling in income class 5.

(b) establishes the following table of income classes for the above-defined categories:

TABLE OF INCOME CLASSES [1]—FAMILY SIZE AND INCOME RANGES

Col. I	Col. II	Col. III
Income class	Single individual	Family of 2
1	0 to $2,000	0 to $3,000.
2	$2,001 to $3,000	$3,001 to $4,500.
3	$3,001 to $4,500	$4,501 to $6,000.
4	$4,501 to $6,000	$6,001 to $7,500.
5	Above $6,000	Above $7,500.

Col. I	Col. IV	Col. V
Income class	Family of 3	Family of 4 or more
1	0 to $4,500	0 to $6,000.
2	$4,501 to $6,000	$6,001 to $7,500.
3	$6,001 to $7,500	$7,501 to $9,000.
4	$7,501 to $9,000	$9,001 to $10,500.
5	Above $9,000	Above $10,500.

[1] These amounts are to be adjusted under sec. 104, according to increases in the Consumer Price Index

PERIODIC REVISION OF INCOME CLASSES

Section 104 provides for an increase by the Secretary in the initially fixed dollar amounts of the income class tables, the premium contributions by the medically indigent, the copayments, and the catastrophic expense benefit expenditures limits, whenever in any calendar year the monthly average of the Consumer Price Index for the July-September quarter exceeds by 3 percent or more the monthly average of the CPI for the corresponding quarter of the base year. The increase would be effective for any "coverage year" that begins in the next fiscal year of the United States. (A "coverage year" is defined by section 122 with respect to an individual, as a 12-month period of CHCB coverage of the individual under an insurance contract or prepayment plan that coincides with a 12-month (annually renewable) term of that contract or plan.)

DETERMINATION OF INCOME LEVEL

Section 105(a) provides that for the purposes of this part the rate of an individual's (or family's) income shall be determined on the basis of his adjusted gross income (or the family's combined adjusted gross (income), as defined in accordance with regulations prescribed by the Secretary in consultation with the Secretary of the Treasury, for the calendar year preceding the coverage year, except that the Secretary may by regulation exclude items of income that are not reasonably available for living expenses and include items that are reasonably available for living expenses although not included in adjusted gross income, and may by regulation provide for redetermination of an individual's or family's rate of income on a more current basis when necessary to prevent serious hardship or inequity.

(b) defines the term "family" as (1) a husband and wife and their dependent unmarried children under 19 or (2) an individual and his or her dependent unmarried children under 19, and defines the terms "child" and "dependent" (as applied to a child) as having the same meaning as in sections 151 and 152 of the Internal Revenue Code.

PREMIUM CONTRIBUTIONS FOR FEDERALLY CONTRACTED COVERAGE

Section 106(a) specifies the contributions to premiums for Federally-contracted CHCB coverage to be made by the individuals or families in the 3 income classes of the medically indigent (i.e., income classes 2, 3, and 4), with the amounts rising as income rises. (Section 103(b) contains the table of income classes.) The amounts of contributions initially are $50 for a single individual and $125 for a family in income class 2, $100 and $250 respectively in income class, 3, and $150 and $375 in income class 4. In the case of a family (in any such income class) in which there is only one member under 65, the contribution rate of a single individual applies. The amounts set initially by section 106(a) (as well as the income ranges in the income class table) would be adjusted according to increases in the Consumer Price Index under section 104.

(b) requires that individual or family premium contributions by the medically indigent for Federally-contracted coverage be paid to the carrier in accordance with the Secretary's regulations and that there shall be no recourse against the United States in the event of delinquency or default in the payment of such contributions.

INCOME TAX DEDUCTIONS

Section 107 permits individual taxpayers to deduct 100 percent, without dollar limit, of the amounts paid by them as premiums for insurance contracts or prepayment plans approved by State Health Commissions for CHCB reduced by the amount allowable to the taxpayer as a credit for coverage purchased for himself.

TAX CREDITS

Section 108(a) creates a new Section 42 of the Internal Revenue Code and changes old Section 42 to Section 43. New Section 42 of the Internal Revenue Code:

(a) allows a credit to an employer who pays an average premium for CHCB in excess of 4 percent of the average wages for his employees. The credit is applicable only to a limit of 10 employees.

(b) allows a credit to any resident of the United States who is not covered under either Section 232 of the Social Security Act or Section 102(b). The credit is the excess of the aggregate amount of premiums paid for CHCB coverage for himself and his family over 10 percent of that aggregate amount plus 4 percent of his adjusted gross income.

(c) provides for the Secretary of the Treasury to prescribe necessary regulations.

Section 108(b) provides for the changes needed in the table of sections of the Internal Revenue Code because of the addition of the credit for CHCB coverage provisions.

Section 108(c) changes Section 6401(b) of the Internal Revenue Code to allow for refunds where the credits exceed taxes.

LIMITATION OF MEDICAID TO SUPPLEMENTATION OF UNIFORM HEALTH BENEFITS

Section 109(a) provides that, beginning with the effective date of part A of title I of this bill (creating entitlement to Comprehensive Health Care Benefits coverage), the State plan under Title XIX of the Social Security Act (of a participating State under title II of the bill) shall not be required to cover, and there shall be no Federal matching for expenditures for, services or items that are covered by Comprehensive Health Care Benefits and that are furnished to an individual who is entitled to such coverage under section 102 of the bill and who either is a resident of a service area of the State designated in accordance with section 225 or is in fact registered with a health care corporation that holds a certificate of approval for another service area.

(b) requires the Secretary to prescribe the minimum scope of services to be included in a State plan under title XIX of the Social Security Act (instead of the requirements of section 1903(a)(13) of that Act) on and after the effective date of part A of title I of the bill, with a view to supplementing the coverage of Comprehensive Health Care Benefits.

PART B—CONTENT OF COMPREHENSIVE HEALTH CARE BENEFITS

Payment for comprehensive health care benefits

Section 121(a) stipulates coverage for CHOB entitles the beneficiaries to have payment made by his carrier to his provider for all medically necessary or appropriate services and items at the provider's approved predetermined charges. Providers would receive the full amount of such charges from the carrier; the carrier would bill the beneficiary for the dollar amounts related to copayments, and certain non-covered services (with the residual risk of nonpayment accruing to the provider) as provided in part C of the bill. Special reference to HCC's operating on a capitation basis is made in Sec. 135.

(b) stipulate that copayments that are the obligation of beneficiaries shall be paid to the carrier.

Definition of comprehensive health care benefits

Section 122(a) describes Comprehensive Health Care Benefits as consisting of the following components: outpatient services; inpatient services; and catastrophic expense benefits. The Secretary is authorized to issue from time to time such further regulations to adjust the application of these benefits to best carry out the purposes of this Act.

In addition, this section defines, among other things, the terms coverage year, benefit period and regulations as they relate to CHCB.

(b) states in tabular form the actual benefits to be included in the CHCB package. Emphasis is on outpatient services, including a wide range of health maintenance benefits. Cost sharing (in addition to premium contributions by the medically indigent) would be achieved through copayments and a limitation on the number of inpatient institutional care days and outpatient physician visits. Copayments would be removed through the catastrophic expenses provisions, once the covered individual or family reached the predetermined expenditure limit ceilings. Once the catastrophic expense provisions apply the limitations would be removed on the number of physician visits (except for mental illness in a non-HCC environment), the number of inpatient hospital care days (except for mental illness, alcoholism, and drug dependence in a non-HCC environment) and the number of days under outpatient institutional care programs for mental illness, alcoholism, and drug dependence.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS

I. SERVICES AND ITEMS COVERED	II. COPAYMENTS AND LIMITATIONS
A. Outpatient services	
1. Periodic Health Evaluation	
a. Screening tests and examinations, as prescribed by regulations under section 126, followed by physical examination by a physician or physicians when indicated by the screening.	No copayment. Within such limits as may be prescribed by regulation under section 126.
b. All Immunizations	No copayment and no limitation.
c. Well-Baby Care (for infants under age 5)—	No copayment.
(i) during 1st 12 months following birth;	8 visits.
(ii) during next 12 months;	4 visits.
(iii) during next 3 years.	2 visits per coverage year.
d. Dental Services	
The following professional dental services, including drugs and supplies that are conmmonly furnished, without separate charge, as an incident to such professional services:	Items d (i) and (ii) in column I apply initially only to children born not more than 7 years before the effective date of this subpart. For those initially covered, the benefits extend through age 12.
(i) Oral examination, including (I) prophylaxis (with flurida application at appropriate ages). (II) dental x-rays, and (III) in accordance with regulations, other accepted preventive dental procedures.	No copayment. 1 examination per coverage year.
(ii) To the extent prescribed by regulation under section 126 and not covered under (i), above, dental care other than orthodontia; but including, insofar as the Secretary finds that resources of facilities and personnel make practicable, routine extractions, dental fillings, and appropriate prosthetic appliances.	Copayment 20% of charges.
e. Vision Services (in accordance with regulations under section 126).	For individuals through age 12.
(i) Professional services in routine eye examination, including procedures performed (during the course of an eye examination) to determine the refractive state of the eyes and procedures for furnishing prosthetic lenses, provided either by an opthalmologist or other physician skilled in diseases of the eye or by an optometrist (whichever the patient may select).	No copayment. 1 visit per coverage year (including therein a follow-up verification of conformity of prescribed lenses with a prescription issued during the visit).
(ii) Eyeglasses, with prescription lenses, including the fitting thereof, and including lenses and frames as needed.	Copayment 20% of charges. Initially, one set of eyeglasses (including frame and lenses); thereafter, only newly prescribed lenses (but not frames) as required (but not more often than once a coverage year) because of a change in the condition of the eyes. Standards to be established by regulations promulgated by the Secretary in accordance with section 126.
2. Physicians' Services, and Services of Other Qualified Health Professionals and Allied Health Personnel.	
Where not otherwise covered under this table—	For physicians' services, a copayment for each visit of two dollars. Copayments under this paragraph for services in facilities involved in clauses c. and d. below apply only to services of attending physician.
a. Physicians' services (including radiotherapy) on an outpatient basis in any appropriate setting (including home calls), and services in any such setting under a physician's supervision by allied health personnel (as defined in regulations).	Limited to 10 visits per coverage year. Except that, in accordance with regulations, no limit on the number of visits shall apply to services preceding or following inpatient care in cases (such as surgery or pregnancy and obstetrical care) in which a single combined approved charge is made by the provider for such outpatient and inpatient services. 20% copayment. Copayment requirement waived for registrants of Health Care Corporations.
b. Diagnostic procedures on an outpatient basis (when not covered under subparagraph a.), including diagnostic tests, prescribed or ordered by a physician in connection with services referred to in paragraph a.	No separate limitation. No separate copayment. No separate limitation.
c. Hospital or outpatient-center services (not included above) rendered to outpatients and incidental to physicians' services covered under paragraph 1.	No separate copayment. No separate limitation.
d. Supplies, materials, and use of facilities and equipment in connection with the foregoing services, including drugs administered or used as a part of services covered in paragraph 1, 2, or 3.	20% copayment.
e. Ambulance services.	Covered only when other methods of transportation are contraindicated by the patient's condition, and only to the extent provided in regulations.
3. Other Outpatient Services	
a. Outpatient Institutional-Care Program for Physical Disability, Mental Illness, Alcoholism, or Drug Abuse and Dependence.	A two dollar copayment, per day, except that copayments may, by regulation, be waived for treatment of drug abuse and drug dependence. (No separate copayment for physicians' services applies under this subparagraph, whether or not such services are charged for separately.)
Such day-care or other part-time services and other items as may be specified in regulations under section 126, furnished to patients, other than inpatients, under a program for the rehabilitation of the physically disabled or the treatment of mental illness, alcoholism, or problems of drug abuse and drug dependence.	Limited to visits or sessions on 3 days under such a program in lieu of each day of inpatient hospital care allowable during a benefit period (under paragraph B.1.a. below) for the treatment of physical disability, mental illness, alcoholism, or drug abuse or drug dependence.
b. Drugs, Prosthetic Devices, and Medical Equipment	
(i) Drugs (other than those covered under paragraph A.1., A.2., or B.1 of this table) dispensed to patients other than inpatients.	For each drug prescription, and each refilling of such a prescription, a one dollar copayment. Covered only if (1) the drug (whether or not it is subject to a prescription requirement under any law other than this title) has in fact been prescribed by a physician and is listed under its established name (as defined in section 502(e) of the Federal Food, Drug, and Cosmetic Act) in a list established for the purposes of this title by the Secretary under section 126(c), and (2) in the case of a drug listed under section 126(c)(2)(B), the disease or

TERMS OF COMPREHENSIVE HEALTH CARE SERVICES—Continued

I. SERVICES AND ITEMS COVERED	II. COPAYMENTS AND LIMITATIONS
(ii) Prosthetic devices (including hearing aids) prescribed by a physician and not otherwise covered in this table.	condition for which the drug has been prescribed is one for the treatment of which the drug is designated in that list as appropriate.
(iii) In accordance with regulations, durable medical equipment (not otherwise covered) as described in section 1861(s)(6) of the Social Security Act, certified by a physician as being medically required.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126.
c. Home Health Care Services:	
(i) Intensive Home Health Care Services—Services and items defined in section 128(d)(2)(A) furnished to patients who require an intensive level of professionally coordinated medical services that can be provided through a structured home care service in lieu of institutional inpatient care.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126; and subject to criteria for payment prescribed under that section.
(ii) Intermediate Home Health Care Services—Services and items as are defined by section 128(d)(2)(B) and regulations thereunder.	For each visit, a two-dollar copayment.
(iii) Basic Home Health Care Services—Services and items as are defined by section 128(d)(2)(C) and regulations thereunder.	Coverage under (i), (ii), or (iii) is limited to a total of 200 days in any benefit period. The certification and recertification requirements of section 1835(a)(2) of the Social Security Act, with such modification (if any) as the Secretary may by regulation prescribe, may be applied by the carrier.
B. Inpatient services	
1. Institutional Services:	
a. Inpatient Hospital Care	
Items and services defined by section 128(e) as "inpatient hospital care."	A five dollar copayment, per day. Coverage is limited to 90 days of inpatient hospital care received in any benefit period.
b. Post-Hospital Extended Care	
Extended care services (as defined in section 128(b)) furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days. For the purpose of the preceding sentence, the second sentence of section 1861(i) of the Social Security Act shall apply.	A two-dollar-and-fifty-cent copayment, per day. Limited to 30 days of such care received in any benefit period.
c. Nursing Home Care.	
Nursing home care as defined in section 128.	A two-dollar-and-fifty-cent copayment, per day. Coverage shall be limited to 120 days of such care received in any benefit period.
2. Physicians' Services and Ancillary Health Care.	
Those physicians' services to inpatients which are not included as "institutional services" under paragraph B.1. a., b., or c.	A two dollar copayment, per visit, of the attending physician only. In accordance with regulations under section 126, in the case of services (such as surgery or pregnancy and obstetrician care) in which a single charge is made by the corporation for the attending physicians' services combined with any preceding or following outpatient services related thereto, a copayment of 10% of such combined charges shall apply. Copayments for physicians' services under this paragraph are in addition to the daily copayments for institutional care.
	No separate limitations.
C. Catastrophic expense benefits	
Section 125 defines the conditions under which these benefits become effective in any coverage year with respect to any individual or family. To summarize: In the case of a low-income person or low-income family (class 1), these benefits are effective immediately. In the case of medically indigent persons or families (classes 2–4), they become effective when the person or family has incurred in a coverage year, for premium contribution, copayments, and certain other expenditures combined, a total expenditure equal to an amount determined by applicaton of a table in section 125. In the case of individuals or families in income class 5, these benefits apply when a variable expenditure limit is reached, determined by taking 10% of the individual's or family's income. The dollar figures in the tables and the absolute expenditure limit may be adjusted by the Secretary on an annual basis, whenever the Consumer Price Index is more than 3% above the index for the base period (see sections 104 and 124).	For elimination of certain limits on coverage for Physicians' Services and Inpatient Hospital Services when Catastrophic Expense Benefits take effect in a coverage year, see section 125. Outpatient care for mental illness is limited to those cases in which active medical treatment (as defined in the last sentence of Section 123(a)) is provided.

The definition of institutional services for inpatients includes, for benefit purposes, physicians' services, such as those of radiologists and pathologists, which are held out as generally available to all inpatients of an institution, regardless of the method by which the Health Care Corporation compensates the physicians.

Limitations and exclusions

Section 123(a) lists the limitations and exclusions, including the exclusion of services that are not medically necessary or appropriate; treatment of TB, mental illness, alcoholism, and drug dependence, when these illnesses are not in an acute phase and subject to active medical treatment; purely custodial care; cosmetic surgery (except for prompt repair of accidental injury or improvement of functioning of a malformed member of the body); and certain other services or items.

(b) excludes from CHCB services for which payment is made through workmen's compensation or motor vehicle insurance.

(c) excludes from CHCB (1) charges for items or services (other than emergency services) furnished by a Federal provider, except (under arrangements with the HCC) one that functions as a community institution, or (2) charges by providers for services required to be furnished at public expense by Federal law or contract with the Federal government.

(d) defines the difference between semi-private and private institutional accommodations and excludes carrier payment for charges in excess of the semi-private rate unless the more expensive accommodations were required for medical reasons.

(e) limits carrier payment to approved charges for covered services, or items where the provider has furnished to an individual services, or items in excess of or more expensive than those covered by CHCB. (However, part C permits the HCC, to the extent authorized by the Secretary's regulations, to have the carrier make payment for non-covered services when billed by the provider, subject to refund if the individual does not reimburse the carrier.)

Copayment provisions

Section 124(a) outlines the conditions under which copayments, when indicated in the benefit table, for services or items furnished by the HCC, become the obligation of the registrant for payment to his carrier, or in the instance of an individual not registered with an HCC, by the individual to the provider. Nominal copayments must be paid except by low-income persons or where the out-of-pocket expenditure ceiling has been reached and catastrophic benefits are in effect (see Table of Special Expenditure Limits).

(b) specifies the applicable dollar amounts and refers to the benefit table for the applicable percentage amounts, of copayments related to the various categories of benefits included in the CHCB package. The dollar amounts set initially by this section would be adjusted according to increases in the Consumer Price Index.

Catastrophic expense benefits

Section 125(a) stipulates that all copayments would cease, and that except as noted under sec. 122(b) restrictions on the number of physicians' visits and inpatient hospital care days, and outpatient institutional care days under programs for physical disability, mental illness, alcoholism, and drug dependence (except for extended care and nursing home care days) would become inapplicable when the catastrophic expense benefits provision is in effect.

(b) describes the conditions under which catastrophic expense benefits would take effect. These benefits would be instituted automatically for the low-income persons and families (i.e., those in income class 1), so that no out-of-pocket expenditures would be required to be incurred for this group. As income rises above that category, individuals or families would be required to incur an increasing amount of out-of-pocket expenditures before catastrophic expense benefits take effect, with the actual amounts specified in the Special Expenditure Limit Table.

SPECIAL EXPENDITURE LIMIT TABLE

Income class	Expenditure limit under 65	Expenditure limit 65 and over
2	$250	$125
3	500	250
4	750	375

The dollar amounts initially set for the expenditure limit table would be adjusted according to increases in the Consumer Price Index. For individuals or families in income class 5, the special expenditure limit varies according to level of income, with the exact limit set at 10 percent of income as defined by regulations.

Expenditures creditable toward this ceiling include (1) premiums for CHCB coverage (whether paid by the individual or in his behalf by an employer), (2) copayments related to covered services (including a three-month carry over provision) and (3) expenditures for covered services rendered beyond the specified limits on physician visits (excluding mental illness), on inpatient hospital care days, and on outpatient institutional care days under programs for physical disability, mental illness, alcoholism, or drug dependence.

Regulations for comprehensive health care benefits

Section 126(a) calls for the issuance of regulations by the Secretary to implement the benefit table, in addition to regulations and standards required in other sections of the bill.

(b) provides guidelines for the Secretary in developing regulations relating to health maintenance benefits, in particular, specification of the services that the Secretary may wish to require in the periodic health evaluation portion of CHCB. Special attention through the development of regulations is also given to dental services and vision services, under the expectation that the Secretary shall prescribe the scope of benefits for these services, and allow for future increases, based on the availability of resources.

(c) provides guidance to the Secretary in other key areas of CHCB, including the establishment of the national categories of drugs for outpatient care. The Secretary is directed to list those categories which he finds to be necessary for the treatment of diseases or conditions requiring drug therapy of such duration and cost as commonly to impose substantial financial hardship, and also list the diseases for which drugs are required for treatment, diseases deemed by the Secretary of special importance to the public health, e.g. V.D. With respect to the latter drug categories, ambulatory benefits extend only to categories of drugs for diseases or conditions thus listed with respect to it. This section also requires the Secretary to develop special regulations and standards relating to CHCB categories of "prosthetic devices and medical appliances" and to the special outpatient institutional care programs related to the treatment of physical disability, mental illness, alcoholism and drug dependence.

Phasing of benefits

Section 127 requires the Secretary to submit recommendations for the expansion of benefits after the first five years of the program and to give special consideration to the expansion of dental and vision service benefits.

OTHER DEFINITIONS

Section 128 defines the terms "drugs", "extended care services", "nursing home care", "skilled nursing care", "supervision for palliative or terminal care", "home health care services", "inpatient hospital care", "physician" (by cross reference to section 1861(r) of the Social Security Act) "physicians' services" and "attending physician".

PART C—CARRIERS FOR COMPREHENSIVE HEALTH CARE BENEFITS

Definition of "carrier"

Section 131 broadly defines carriers as nongovernmental organizations that underwrite insurance for the cost of health care, or provide health benefit plans of the service type, in consideration of predetermined premiums. Approved Health Care Corporations qualify under the definition if they charge for covered health care on an annually predetermined capitation basis in accordance with section 246(b).

Determination of qualified carrier; health card

Section 132 establishes qualifications for carriers, essentially that they must be authorized in each State for whose residents they operate health benefit prepayment plans or insurance at group rates, must comply with Section 133, must meet any special Federal standards in the case of a contract with Health and must, with respect to coverage (under other contracts) for which a Federal premium contribution is requested, accord to the Department and its agents the same informational rights and access to records that the Department is entitled to in the case of coverage purchased by the Secretary.

Requirement that carriers participate under State plan

Section 133 requires that a carrier agree to participate in a coverage pool if so required (in accordance with provisions of a State plan pursuant to Section 234(b)(7) in order to qualify for a contract with the Department or for issuance of CHCB coverage eligible for a federal premium subsidy under Section 102(c).

Conditions of approval of carrier contracts or plans for Federal premium subsidy

Section 134 provides that the Secretary shall for the purpose of the Federal premium subsidy under Section 102 approve a carrier prepayment plan or contract only if it is in conformity with applicable State standards and regulations and contains payment provisions and protective provisions (specified in Section 234(b)(7)).

Contracts with health care corporations on capitation basis

Section 135 makes it possible for HEW to enter into a contract with a Health Care Corporation that operates on the basis of predetermined capitation charges to provide Comprehensive Health Care Benefits to which registrants are entitled under Section 102(b). The copayment component of the corporation's capitation charges or any separate copayments charged for by the corporation, would not be paid by the Secretary but collected by the corporation directly from the registrant. Corporations are also required to establish record and payment centers and to issue identical membership cards to all of their registrants to prevent discrimination on account of economic status at the point of service.

Effect of nonpayment

Section 136(a) sets forth requirements for premium contributions and special premiums to be paid in advance to carriers by or on behalf of individuals.

(b) contains provisions for termination of benefit coverage (subject to a grace period) in the event of nonpayment with respect to the above.

Enrollment under contracts with carriers

Section 137(a) vests authority in the Secretary to establish regulations for the enrollment of registrants entitled to Department of Health-purchased Comprehensive Health Care Benefits.

(b) limits the types of enrollment to enrollment by a registrant for himself only or for himself and his spouse and other registrants who are members of his family. The conditions for change in type of enrollment are left to regulations. The individual enrolling for himself and his family is held liable for premium contributions related to family coverage.

(c) specifies that to the optimum extent open enrollment periods under this section and open registration periods for Health Care Corporations shall be coordinated, and than a corporation's registration center shall provide information concerning enrollment.

Reports by, and audits of, carriers

Section 138 states that contracts shall require carriers to make such reports as the Secretary finds necessary, to keep essential records, and to assure the correctness and verification of its reports.

Jurisdiction of courts

Section 139 invests U.S. district courts with original jurisdiction, concurrent with the Court of Claims, of a civil action or claim against the United States concerning this part of the Act.

Prospective regulations

Section 140 specifies that contract regulations, or amendments thereto, or to this title, shall not apply until the next contract year if their applications would increase the obligations or adversely affect the rights of a contracting carrier unless made applicable by the contract itself or by amendment thereto.

TITLE II—REORGANIZATION OF NATIONAL HEALTH SERVICES

SHORT TITLE

Section 200. Title II may be cited as the "National Health Services Reorganization Act."

PART A—FEDERAL ADMINISTRATION

ESTABLISHMENT OF DEPARTMENT OF HEALTH

Section 201 (a) establishes a new executive department to be known as the Department of Health hereafter referred to as the Department. Also provides for the appointment of a Secretary of Health, with the advise and consent of the Senate.

(b) establishes the position of Under Secretary to be appointed by the President with the advise and consent of the Senate.

(c) establishes seven Assistant Secretaries and a General Counsel, appointed by the President with the advise and consent of the Senate.

(d) establishes a Chief Medical Officer, appointed by the President with the advise and consent of the Senate. This appointment shall be without regard to political affiliation, and the term of appointment shall be for six years.

TRANSFERS TO SECRETARY AND CHIEF MEDICAL OFFICER

Section 202. (a) Except as provided in subsection (b), there are transferred to the Sec-

retary all functions of the Secretary of Health, Education, and Welfare under the following laws and provisions of law:

(1) The Public Health Service Act.

(2) The Family Planning Services and Population Research Act of 1970.

(3) The Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970.

(4) Section 232 of the National Housing Act (relating to mortgage insurance for nursing homes).

(5) Title XI of the National Housing Act (relating to mortgage insurance for group practice facilities).

(6) The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

(7) Section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

(8) The Controlled Substances Act.

(9) The Act of August 3, 1954 (42 U.S.C. 2001–2004(a)) (relating to hospital and other health facilities for Indians).

(10) The Act of August 16, 1957 (42 U.S.C. 2005–2005(f)) (relating to community hospitals for Indians).

(11) Chapter 175 of title 28 of the United States Code (relating to civil commitment and rehabilitation of narcotic addicts).

(12) Chapter 314 of title 18 of the United States Code (relating to sentencing of narcotic addicts to commitment for treatment).

(13) Title III of the Narcotic Addicts Rehabilitation Act of 1966 (relating to civil commitment of persons not charged with any criminal offense) and section 602 of such Act.

(14) The Federal Cigarette Labeling and Advertising Act.

(15) The Federal Food, Drug, and Cosmetic Act.

(16) The Federal Hazardous Substances Act.

(17) The Poison Prevention Packaging Act of 1970.

(18) The Fair Packaging and Labeling Act.

(19) The Act of March 2, 1897 (21 U.S.C. 41–50) (relating to tea importation).

(20) The Act of March 4, 1923 (21 U.S.C. 61–64) (relating to filled milk).

(21) The Act of February 15, 1927 (21 U.S.C. 141–149) (relating to importation of milk).

(22) The Federal Caustic Poison Act.

(23) The Flammable Fabrics Act.

(24) The Federal Coal Mine Health and Safety Act of 1969 (other than title IV thereof).

(25) The District of Columbia Medical Facilities Construction Act of 1968.

(26) The Occupational Safety and Health Act of 1970.

(27) The Lead-Based Paint Poisoning Prevention Act.

(28) Titles XVIII, XIX, II, and V of the Social Security Act insofar as such titles relate to the provision of health care services.

(29) The District of Columbia Medical and Dental Manpower Act of 1970.

(30) The Drug Abuse Office and Treatment Act of 1972.

(b) The function of the Secretary of Health, Education, and Welfare respecting (1) the commissioned Regular Corps and Reserve Corps of the Public Health Service, (2) the administration of section 329 of the Public Health Service Act (relating to assignment of health personnel of the Public Health Service to critical need areas), and (3) the administration and operation of health care delivery facilities of the Public Health Service shall be exercised by the Chief Medical Officer under the supervision and direction of the Secretary of Health.

(c) Within 180 days, the President may transfer to the Secretary any other function if the Office of Management and Budget determines such functions relate to the above functions, or otherwise relate to health.

REDESIGNATION OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Section 203. (a) States that the Department, Secretary, Undersecretary, Assistant Secretaries, General Counsel, and Assistant Secretary for Administration of HEW, shall respectively be designated as of Education and Welfare.

(b) Provides all references to Department of Health, Education, and Welfare in law, regulation, document, or other record shall be re-designated accordingly.

ADMINISTRATIVE PROVISIONS

Section 204(a) authorizes the Secretary, subject to title 5, U.S.C., to appoint, employ, fix the compensation of and prescribe duties and authority for such personnel as are necessary to carry out the functions of the Department;

(b) the Secretary is authorized by section 3109 of title 5, U.S.C., to obtain services of individuals, but at rates not to exceed the daily equivalent of the rate in effect for grade GS–18 of the General Schedule, unless otherwise specified in an appropriate Act;

(c) the Secretary is authorized to delegate and re-delegate functions and make such rules and regulations as are necessary to carry out his functions;

(d) authorizes the Director of the Office of Management and Budget to transfer positions, personnel, assets, liabilities, contracts, property, records, authorizations, allocations and other funds employed, held, used, arising from available or to be made available in connection with functions transferred in section 202;

(e) personnel transferred under subsection (d) of this section shall be without reduction in classification or compensation for 1 year;

(f) when all functions of any office or agency are transferred, such office or agency shall lapse;

(g) authorizes a capital working fund for administrative operations of the Department, including a central supply service for stationary and equipment; central mail, messenger, telephone and other communication services; document reproduction; office space; graphics and visual aid; and central library services. Authorizes appropriations for this fund;

(h) authorizes approval of a seal of office by the Secretary;

(i) authorizes the Secretary to provide for, construct or maintain for employees and their dependents stationed at remote localities the following: emergency medical services and supplies, food and other subsistence supplies, mess facilities, motion picture equipment and film for recreation and training, and living and working quarters and facilities.

These services shall be at prices reflected reasonable value as determined by the Secretary;

(j) authorizes the Secretary to accept, hold, administer, and utilize gifts and bequests of real or personal property, for the purpose of aiding or facilitating the work of the Department;

(k) authorizes the Secretary to appoint such advisory committee as may be appropriate and provide per diem and travel expenses as provided under Federal law;

(l) authorizes the Secretary to contract for research, and disseminate reports on such research.

ANNUAL REPORT

Section 205 directs the Secretary to submit an annual report on activities of the Department in the preceding fiscal year, to the President for submission to Congress.

SAVINGS PROVISIONS

Section 206 stipulates that all existing and presently effective orders, determinations, rules, regulations, permits, contracts, certificates, licenses and privileges issued prior to transfer of functions shall continue in effect until modified, terminated, superceded, set aside or repealed by the Secretary, the Courts or by operation of the law. This shall not affect pending proceedings, either administrative or judicial, which shall continue to judgment as if this part had not been enacted. The Secretary may need to keep a previously existing office in existence during pending litigation.

CODIFICATION

Section 207 directs the Secretary to submit to Congress within two years a proposed codification of all laws which contain functions transferred to the Secretary.

DEFINITION

Section 208 defines "function" as including power and duty.

CONFORMING AMENDMENTS

Section 209 changes all code references to the Department of Health, Education, and Welfare and inserts appropriate references to the Department of Health.

EFFECTIVE DATE: INITIAL APPOINTMENT OF OFFICERS

Section 210 sets a minimum of 90 days after enactment for effective date. Officers provided for may be appointed at any time after the date of enactment.

PART B—FEDERAL ADMINISTRATION OF HEALTH CARE PROGRAMS

FUNCTIONS AND RESPONSIBILITIES OF THE SECRETARY

Section 211(a) charges the Secretary with responsibility for the planning, administration, operation, coordination, and evaluation of all health care programs under this Act.

(b) specifically charges the Secretary with responsibility for—

(1) continuous review of the activities of State Health Commissions;

(2) liaison with all Federal agencies administering health or health-related programs, and with private national accrediting and other agencies concerned with standards of care and qualifications of health personnel, including the approval and listing of certifying bodies;

(3) responsibility for annual reports, to be transmitted through the Secretary of HEW to the President, first to evaluate the progress of State plans and the development of Health Care Corporations, and thereafter, to evaluate the national program, including recommendations for legislation, if any;

(4) dissemination to State governments, providers of service, and the public, of all pertinent information about the national program; and to State governments, providers of service, and potential sponsors of Health Care Corporations, information concerning the organization and responsibilities of such corporations.

REGULATIONS OF THE SECRETARY

Section 212(a) authorizes the Secretary of Health to prescribe all further regulations that it considers necessary to implement this Act.

(b) further authorizes the Secretary to prescribe by regulation—

(1) standards of accounting, reporting and billing for Health Care Corporations;

(2) the method(s) to be used in determining the financial requirements of institutional health care providers, including operating and capital requirements, and for non-institutional providers, all reasonable fees, salaries, or other compensation for services;

(3) standards of quality and safety, such standards to require as a minimum that hospitals, extended care facilities, and home health agencies meet the applicable requirements contained in title XVIII of the Social Security Act, and that nursing homes meet

such requirements as the Secretary finds appropriate;

(4) standards relating to the qualifications and use of paramedical personnel as assistants to physicians and dentists; and

(5) standards for the determination of qualified carriers under Section 232.

(6) standards of confidentiality of information, permitting disclosure of clinical and financial data only as specified in regulations by the Secretary, but only to extent necessary for administration of the program.

(7) standards for development by State Health Commissions of prospective payment methods.

NATIONAL HEALTH ADVISORY COUNCIL

Section 213(a) establishes a National Health Services Advisory Council, whose Chairman shall be the Secretary of Health, with 20 other members to be appointed by the Secretary.

Members of the Council shall include representatives of health care providers, not less than half of the members shall be representatives of consumers of health care services. Members are to be appointed for four-year staggered terms, with five members appointed each year.

Council members representing providers shall be outstanding in fields related to medical, hospital, and health activities, or be representatives of organizations of professional health personnel. Consumer representatives shall not be engaged in or have financial interest in furnishing health services and shall be persons knowledgeable about health needs and the problems of providing health services.

(b) authorizes the Advisory Council to appoint professional or technical committees; and states that the Council, its members, and its committees may hire staff as authorized by the Secretary. The Council shall meet not less than four times each year and as often as the Secretary deems necessary.

(c) charges the Council with:

(1) advising the Secretary on general policy, and

(2) studying the activities of State Health Commissions, and Health Care Corporations, and other health care providers in order to recommend changes to the Secretary. The Council shall make an annual report to the Secretary which shall be transmitted to Congress with a report by the Secretary on any administrative recommendations of the Council that have not been followed. The Secretary shall report to Congress his views of the Council's recommendations for legislation.

(d) provides that the Council's members and members of its committees shall be compensated for their work at rates fixed by the Secretary but not more than the daily rate for grade GS–18 of the General Schedule; and that they will be reimbursed for travel expenses.

STUDIES OF DELIVERY AND FINANCING OF HEALTH CARE

Section 214(a) requires the Secretary of Health to make a continuing study of the operations under this title, including all of the aspects of services of health care providers, the effectiveness of supervision by State Health Commissions, and the financing of services through insurance. The Secretary further authorized to study alternative methods of furnishing and financing health care services, and methods of improving the delivery of health services.

(b) authorizes the Secretary to conduct the functions under this section through contract and to make grants to public or other nonprofit agencies for this purpose.

(c) requires the Secretary to publish the results of its studies from time to time.

UTILIZATION OF STATE AGENCIES

Section 215(a) authorizes and encourages HEW to make arrangements with State Health Commissions which will enable the commissions:

(1) to contract, as agent and in the name of the Department of Health, with the health insurance carriers approved by the Secretary; and

(2) to perform other functions that the Secretary may deem appropriate.

(b) requires the Department to pay State Health Commissions for their administrative costs pursuant to the arrangements above.

FEDERAL FINANCING RESPONSIBILITIES FOR HEALTH SERVICES

Section 216(a) amends (effective January 1 or July 1, whichever comes first, at least 6 months after the date of enactment of this Act) the Social Security Act to:

(1) make available to all persons eligible for Part A of Title XVIII also eligible for Part B of that Title, and to finance Part B contributions through appropriations from general Federal revenue.

(2) provide for annual appropriations by the Federal government for health insurance benefits that are equal to Title XVIII benefits (with no obligations for copayments or deductibles) for all those eligible under income class 1 as defined in Section 103(a)(1).

(3) provides that no premium or similar amount shall be payable by any individual eligible for benefits under (1) and (2) above.

(b) provides that effective on the first day of the third full fiscal year that begins after this Act is enacted, the Federal government will make annual appropriations in behalf of the program outlined in Title I to meet the following estimated cost for the fiscal year:

(1) expansion of Title XVIII benefits to include Section 125 Catastrophic Expense Benefits for the Aged:

(2) prepaid coverage equivalent to Title XVIII benefits and Section 125 Catastrophic Expense Benefits for persons under 65 who are low income persons or members of low income families and the net cost, after deducting the contribution required of them of this coverage for persons who are under 65 who are medically indigent or members of medically indigent families; and

(3) the cost of providing a 10 per cent premium subsidy for those individuals in Income Class 5 under Section 102(c) who register with Health Care Corporations.

Appropriations are also authorized to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for additional costs incurred under this subsection.

(c) provides that effective on the first day of the fifth fiscal year that begins after the calendar year in which this act is enacted, the Federal government will make annual appropriations in behalf of the program outline in Title I, to meet the following estimated costs for the fiscal year:

(1) prepaid coverage for Comprehensive Health Care Benefits for persons under 65 who are low-income persons or members of low-income families;

(2) the net cost, after deducting the contribution required of them, of such coverage for persons under 65 who are medically indigent or members of medically indigent families;

(3) the net cost, after deducting the contribution from the Title XVIII Part A trust fund, of such coverage for aged persons; and the added cost of those 65 and over who are either low-income persons or members of low-income families, or are medically indigent persons or members of medically indigent families;

(4) the cost of providing a 10 per cent premium subsidy for those individuals in Income Class 5 (as defined in Section 102(c)) who register with Health Care Corporations;

(5) the cost of health benefits provided to those receiving unemployment compensation benefits under Section 906 of the Social Security Act;

(6) the cost of establishing or maintaining a reserve of 5 per cent of the foregoing costs; and

(7) the cost of administration incurred by HEW in providing the coverages in (1), (2), and (3).

(d) states that the Secretary shall estimate the costs of (a) and (b) and make requests to Congress for necessary annual appropriations.

CONTRACTING AUTHORITY OF THE SECRETARY

Section 217(a)(1) states that the Secretary shall provide prepaid coverage, through contracts with carriers for the benefits to which individuals and their families (i.e., the aged, the low-income, and the medically indigent) are entitled under Section 103.

(2) permits the Secretary to establish qualifying standards for carriers in addition to those set forth in this part of the Act.

(b)(1) permits the Secretary to negotiate and enter into (A) contracts with a carrier or carriers to provide Comprehensive Health Care Benefits for all individuals in the above-mentioned categories; (B) contracts with qualified carriers which have underwritten a prepayment plan for a Health Care Corporation operating wholly or primarily on a predetermined capitation charge basis; and (C) direct contracts with Health Care Corporations under Section 135 if the corporations operate on a predetermined capitation charge basis and as such qualify as carriers.

(2) permits the Secretary to authorize State Health Commissions to act as his agents in contracting with carriers described in (1).

(3) exempts contracts under this part from any provision of law requiring competitive bidding and from such other requirements of law as the Secretary may waive. It requires the Secretary, however, to communicate to all qualified carriers a description of the coverage he desires, the requirements and provisions of this title and regulations, and to invite these carriers to submit proposals. The paragraph lists some of the factors which the Secretary is to consider in negotiating contracts, such as the carriers' experience with group health insurance or prepayment plan coverage. It further provides that the Secretary may require the contracting carrier to reinsure with other carriers, and states that he shall enter into a contract with a combination of carriers only if this does not result in high premium rates and only if it best serves the purposes of this title. The term "combination of carriers" is defined.

FEDERAL RESPONSIBILITY FOR DEVELOPMENTAL GRANTS

Section 218(a) states it to be a responsibility of the Secretary to promote and assist the establishment, as soon as practicable, of the system of comprehensive health care delivery contemplated by this title, this to be accomplished through a variety of means of financial and technical assistance in the planning and development of Health Care Corporations, including the provision of incentives for use of the capitation method of payment for health care and the development and improvement of outpatient care centers, particularly in poverty and rural areas, and for the development of home health care agencies.

(b) authorizes the Secretary to recommend necessary appropriations for each fiscal year to carry out this responsibility.

AUTHORIZATION OF DEVELOPMENTAL FINANCIAL ASSISTANCE

Section 219(a) authorizes the Secretary to:

(1) make grants for planning, organizing, developing, and establishing Health Care Corporations, including their affiliation agreements with providers of health care;

(2) enter into contracts to pay all or part

of the operating deficits of these corporations during their establishment or expansion;

(3) make grants to such corporations or their affiliated public or nonprofit providers for the initial operation of new outpatient care centers or new or expanded services in outpatient care centers or new or expanded home health care agencies; and

(4) make grants for major health maintenance, diagnostic, or therapeutic equipment, data processing systems or equipment, or central service equipment, needed for the initial operation of Health Care Corporations.

(b)(1) requires the Secretary, in making the above grants and/or contracts, to take into consideration existing health care resources and systems, and relative needs of States and areas within States; and requires the Secretary to make equitable distribution of such assistance.

(2) states that not more than 15 percent of the appropriations made for such grants or contracts may be spent in any one State.

(3) states that in awarding such contracts during the first five years for which funds have been appropriated, the Secretary shall give priority to corporations that (a) operate primarily on predetermined capitation charges, or (b) are in the process of converting primarily to that basis, or (c) agree to operate on or convert to primarily that basis if awarded such a contract. After the 5-year period, the Secretary may award contracts only to such corporations.

(4)(a) states that a grant or contract shall not be awarded when there is a State plan approved under this part of the Act, unless the State Health Commission has recommended approval of the application and has certified:

(1) in the case of start-up funds for a Health Care Corporation, that such a corporation is needed in the area involved, consonant with the State plan;

(2) in instances of a contract to meet for a reasonable period operating deficits of a Health Care Corporation, that the corporation applicant satisfies the definition of a Health Care Corporation and has been, or upon approval of the contract by the Secretary will be, approved by the commission;

(3) in the case of grants for the initial operation or equipping of outpatient care centers or for the expansion of such centers, or for major equipment, that the corporation satisfies the requirements referred to in paragraph (2) above, and that the outpatient care center or major equipment involved is needed for the effective discharge of the functions of the respective Health Care Corporation under the State plan.

(c) declares that in a state in which there is not yet an approved State plan but in which a State Health Commission and a State Advisory Council have been established, the Secretary shall not make a grant or contract under the foregoing sections unless the commission, the State planning agency, if any, and the appropriate areawide health planning agency (if it is different from the State planning agency) have had an opportunity to review and comment on the application. This paragraph also defines "appropriate areawide health planning agency" as that agency referred to in Section 314(b) of the Public Health Service Act or, if there is no such agency, another public or nonprofit private agency or organization (if any) performing similar functions.

GRANTS FOR STATE PLANS

Section 220(a) authorizes the Secretary to make grants to State Health Commissions for all or part of the cost of developing State plans, including the expenses of State Advisory Councils, and the cost of dissemination of information about the proposed plan, and of public hearings.

(b) authorizes appropriations for grants under this section for each fiscal year in the period beginning with the fiscal year of enactment and ending with the close of the 3rd full fiscal year.

(c) requires the Secretary to pay to each State with an approved plan a percentage of the expenditures for the administration of the plan, beginning with 90 per cent during fiscal years ending before the effective date of the benefit program of this Act (Section 101 and 102), and diminishing to 85 per cent during the next two fiscal years and to 75 percent thereafter. With respect to Federal functions as agent of the Secretary (see Section 234(b)(10)) the Federal percentage is fixed at 100.

FINANCIAL ASSISTANCE UNDER OTHER PROGRAMS

Section 221(a)(1) states that the Secretary shall, to the optimum extent, use other programs of financial assistance in the field of health care to promote the purposes of this Act.

(2) authorizes the Secretary, notwithstanding any other provision of law, to give highest priority to the needs of Health Care Corporations in the administration of such other programs, particularly in urban or rural poverty areas.

(b)(1) requires the Secretary to develop and disseminate informational materials about the availability of assistance under this part of the Act.

(2) states that the Secretary, on request, may provide advice, counsel, and technical assistance to Health Care Corporations and others named in this part in preparing applications and meeting requirements for grants and contracts.

PENALTIES FOR FRAUD

Section 222(a) provides for any individual, provider of health care, carrier or other person who knowingly or willingly makes or causes to be made any false statement or representation of a material fact in the application of any benefit or any grant or other payment under this Act or makes false statements or fails to disclose or who willingly converts such benefit or payment to any other use or purpose shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year or both.

(b) provides a similar penalty for any provider of health care or other person who furnishes items or services to an individual for which payment is made under this Act for a kick-back or bribe or furnishing of such services or a rebate of any fee or charge.

(c) provides a $2,000 fine or imprisonment for not more than 6 months or both for false statements or misrepresentations of a material fact with respect to the conditions or operation of any organization, institution, or facility in order that it may qualify as a carrier or provider of health care for purposes of this Act.

PART C—STATE FUNCTIONS

General conditions of State participation

Section 231 requires that in order for its residents to participate in the provision of Comprehensive Health Care Benefits that are financed or assisted by Federal funds, a State (1) must accept the provisions of this title and establish a newly-constituted and independent agency to carry out its provisions, this agency to be headed by a governing body to be known as the State Health Commission; (2) must establish a State Advisory Council; and (3) must have the Secretary's approval of a State plan submitted by the State Health Commission under section 234 for carrying out the State's responsibilities. (See also sec. 238 Federal Exercise of State Functions in Cases of Noncompliance by States.)

State health commissions

Section 232(a) establishes the following requirements, among others, for State Health Commissions: a membership of three or five commissioners (depending upon the State law establishing the commission) appointed by the governor, for staggered terms (renewable) of six years. Not more than two members of a three-member commission, nor more than three members of a five-member commission, shall be members of the same political party. The governor shall designate one of the members as chairman.

(b) lists the principal qualifications of and requirements for State health commissioners. It provides that commissioners should be chosen not primarily for their experience in health affairs, but for their ability to bring effective and objective policy direction to the commission's affairs, and it requires that (1) health professionals shall not constitute a majority of the membership of a State Commission; (2) commissioners shall serve full-time and not be engaged in any other business; (3) the chairman and the commissioners shall be salaried at levels comparable to those of heads of State executive departments; (4) commissioners may be subject to removal only for causes listed in this section; and (5) commissioners (and other officers or employees of the commission) may not hold any official or contractual relation with, or have any pecuniary interest in, any Health Care Corporation or provider of health care under the regulatory jurisdiction of the State Health Commission. This regulation is not to bar persons having such a relation or interest from serving as members of the State Advisory Council.

State Advisory Council

Sec. 233 states that members of the State Advisory Council shall consist of (1) persons broadly representative of providers of health care in the State, including but not limited to representatives of Health Care Corporations, other nongovernmental and public organizations, and representatives of schools and institutions concerned with education or training of persons in the health professions and ancillary occupations, and (2) not less than an equal number of persons representative of consumers of health care who are neither providers nor have a financial interest in providing care, are familiar with the State's health care needs, and have knowledge of the problems of providing health care.

State health care plans

Sec. 234(a) states the requirements for State plans: (1) conformity with subsection (b) below; (2) submission of the plan in detail to the Secretary by the State Health Commission; (3) preparation of the plan Council; and (4) in the case of submission of the initial plan to the Secretary, or of a submission for annual renewal of the Secretary's approval after major revision of the plan, prior to reasonable opportunity to the public to express its views of the plan.

(b) itemizes the State plan requirements, including the following:

(1) designation of the State Health Commission as sole administrative agency for the plan;

(2) evidence of the Commission's authority to carry out the plan;

(3) provision for adequate consultation with the State Advisory Council;

(4) statement of qualifications for personnel responsible for administration of the plan;

(5) provision of methods for efficient administration, including personnel merit system standards consistent with those of the Civil Service Commission (but the Secretary shall have no authority with respect to the selection, tenure, and salary of individuals if employed in accordance with the merit system methods); and provision for utilization of qualified professional medical personnel and other professional personnel;

(6) provision for the designation of preferred service areas by applicant Health Care Corporations (in keeping with section 245);

approval for each such area of one or more Health Care Corporations (in accordance with section 235); and inclusion of a program for the completion of these initial designations and approvals (including creation of governmental corporations if necessary to carry out the policy of this Act to provide every individual with an opportunity to register and, when possible, to have a choice of Health Care Corporations) as well as registration of eligible individuals with approved Health Care Corporations, not later than the end of the fourth fiscal year that begins after the calendar year in which the bill is enacted;

(7) provision of State arrangements to assure group coverage for Comprehensive Health Care Benefits at reasonable rates, for themselves or their employees, to all residents not entitled to HEW-purchased coverage, and for effective enforcement of these arrangements (subject to review by the Secretary wtih respect to enforcement of Federal regulations); and provision for regulation of the premium rates of carriers (except under contracts negotiated directly by the Secretary) by the State Health Commission or one to which it delegates that function or alternatively, by the State's insurance department; provision for other regulation and supervision of the carriers by the State Health Commission (including, for Comprehensive Health Care Benefits, a required standard provision for temporary continuation of coverage for the family in the event of the primary insured's death); and provision for hearings, before the Commission, on claims of Health Care Corporations against carriers, and for adjudicating such claims;

(8) provision for optimum use or adaptation of various Federally-aided programs developed for the State and at regional and local levels with respect to comprehensive health planning;

(9) provision that when requested by the Secretary the State Health Commission will, in behalf of the Secretary, contact with qualified carriers for CHCB coverage (other than coverage negotiated and contracted directly by the Secretary) required to be financed by Federal purchase; act as fiscal agent of the Secretary in transactions with carriers;

furnish to the Secretary all information necessary for prospective estimates of government appropriations for implementation of this Act; and review and make recommendations with respect to applications for grants under Part A of this title or for other Federal aid administered by the Secretary;

(10) after consultation with health care providers and consistent with regulations by the Secretary, develop and implement a system or systems of uniform accounting, reporting and billing to be utilized by providers, carriers, and the Commission;

(11) inclusion of a program whereby the State can cooperate with HEW in a nationwide system for the collection of health data;

(12) protection of individual registrants or applicants for registration through safeguards on the use or disclosure of identifying information collected under paragraph (11) above;

(13) evaluation, at least annually, of the effectiveness of the activities of the State Health Commission of Health Care Corporations and other health care providers;

(14) provision that the Commission will make reports of such evaluations of effectiveness, as well as such other reports as the Secretary may require; and

(15) provision that the Commission will review the State plan at least annually and submit modifications to the Secretary.

(c) requires the Secretary to approve a State plan meeting the above-stated requirements, except that the Secretary is directed not to approve a State plan if the plan or other State law, or the practice of a State licensure or regulatory authority—

(1) prevents or limits Health Care Corporations from providing services to registrants through the employment of licensed medical or other health care practitioners by the corporation or other nonprofit providers; or through group practice or other arrangements;

(2) deprives any Health Care Corporation of its rights to designate its preferred service area and of its right of appeal for change in such service area, in accordance with the provisions of this Act;

(3) disqualifies a physician on the staff of an HCC from serving on the governing board of a Health Care Corporation or of an institutional provider thereof;

(4) prevents health care practitioners from employing or arranging with assistants under their supervision to perform health care functions for which they are trained; and

(5) prevents or limits carriers from offering coverage of health care provided in accordance with (1), (2), (3), or (4) above unless the Secretary finds that the State prohibition or restriction is consistent with the purposes of this title.

(d) stipulates that, with certain minor exceptions, the approval of a State plan shall be for one calendar or one fiscal year, whichever the Secretary determines.

Designation of health care areas

Section 235(a) requires each State Health Commission to make a study and survey with a view to approval of service areas for applicant Health Care Corporations and establishes criteria to be considered for that purpose, including the following: size and distribution of population, and patterns of illness among population groups in various parts of the State; existing health care resources, their potential for sponsoring or participating in Health Care Corporations, and their distribution in relation to need for health care; local governmental structures; transportation; patterns of organization for the delivery of care and patterns of use; and requires the Commission, in that connection to set a date for initial applications of Health Care Corporations indicating their preferred service areas (or statements of intention by proposed sponsors of such corporations) to assist the Commission in its study.

(b) require, in addition to (a), that the Commission consult representatives of the general public; of public and private health care institutions or their organizations; or medical and other health care profession (including representatives of group practice): of appropriate State and local government agencies; where appropriate, of State Health Commissions in adjoining States; and other interested groups and individuals.

(c)(1) obligates the Commission to publish, as part of the State plan, its survey findings and the designation of service areas for Health Care Corporations. The Commission is required to conduct public hearings on its proposal and thereupon to issue initial designations.

(2) states that the Commission may, in cooperation with another State, designate jointly a service area or areas that include parts of both States.

(d) permits subsequent amendment of a designated service area under subsection (c) either on the Commission's own initiative or on petition of Health Care Corporations or other concerned parties, but requires that final action on the amendment may be taken only after reasonable notice and opportunity for a fair hearing.

Regulatory functions of State health commissions

SEC. 236(a) requires that a State plan shall, in addition to requirements above—

(1) stimulate the organization of Health Care Corporations through every means available and provide for cooperative arrangements with other State commissions in jointly or reciprocally approving corporations to serve joint or adjoining service areas;

(2) provide for authorizing the incorporation (or admission into the State from another State) of Health Care Corporations, either through the Commission or other appropriate State agency;

(3) provide for the evaluation of the application of any corporation for approval to operate as a Health Care Corporation in a service area or areas approved by the Commission in accordance with Section 235, and describes the procedure for granting approval and issuing a certificate of approval for the service area or areas involved;

(4) provide that in areas, in whole or in part, where more than one Health Care Corporation has been approved the Commission may, if necessary, restrict the number of individuals to be registered by each corporation, residents to be accepted for registration within that number on a first-applied-first-accepted basis;

(5) limit the charges of approved Health Care Corporations and other licensed providers to charges and rates prospectively approved by the Commission; and require that services are not duplicative or excessive, that charges for physicians' service (such as radiologists and pathologists) which are generally available to all inpatients of an institution, be included as part of institutional service charges and not as separate physicians' charges (regardless of the method of payment to the physician), the purpose being to require no additional copayment from the patient for such services; require that the budgets of Health Care Corporations, and other institutional providers be prepared as prescribed by the Secretary; and provide that all providers are entitled to a fair hearing if dissatisfied with a decision of the Commission with respect to its charges;

(6) provide for effective enforcement, by the Commission, of the responsibility of Health Care Corporations and other licensed providers as defined in this Act, assuring that with respect to Health Care Corporations their services be of not less than the scope, quality, and comprehensiveness required by this title, including standards prescribed by the Secretary, and requirements for the provision of services by Health Care Corporations as prescribed in Sections 243 and 244 of this title, and for other providers, requirements for the provision of services similar to those specified in Section 244 as defined by regulations;

(7) prohibit the construction of health care facilities, or changes in major services, or their establishment through rental of major equipment or existing structures, by Health Care Corporations or other providers except when authorized by the Commission on the basis of a finding of need;

(8) authorize the Commission to adjudicate controversies between corporations, affiliated providers, and non-affiliated providers.

(9) provide for a fair hearing, before the Commission, of any individual not accepted for registration by an approved Health Care Corporation of whose service area he claims to be a resident; or with respect to a monetary claim of at least $100 by a registrant against a corporation or carrier; or to any individual who alleges that the corporation has failed to fulfill its obligations under this Act and that the failure is part of a pattern of conduct;

(10) provide for review and approval of peer review systems of approved Health Care Corporations and continued surveillance over their operations; and

(11) provide for implementation of comparable peer review systems for services performed by providers not affiliated with Health Care Corporations.

(b) recognizes that compliance with the procedures set forth in Sections 1863 through 1865 of the Social Security Act are to be employed in establishing compliance with this Act for Health Care Corporations and non-affiliated providers.

(c)(1) authorizes the Commission to take prompt corrective action whenever it determines that a Health Care Corporation has failed to fulfill all of its obligations; and states that the corporation is entitled to opportunity for a hearing with respect to the Commission's decision in this regard, the outcome subject to judicial review as provided by State law. However, initiation of a proceeding for judicial review shall not operate as a stay of the Commission's decision unless so ordered by the court.

(2) states that paragraph (c)(1) notwithstanding, the Commission may give its order immediate effect, subject to reversal or modification following judicial review, if it decides that a corporation's failure to function creates an imminent hazard to the health of its registrants.

(3) empowers the Commission, in addition to its authority for corrective action above, to revoke (following fair hearing) its certificate of approval for operation by the corporation in its service area and to approve for service in that area another Health Care Corporation or corporations, or, in lieu of this, to bring the delinquent corporation into compliance through appointment of a receiver or other effective means. The order of the Commission shall be subject to judicial review in a State court.

(d) authorizes the Commission to take corrective action whenever it determines that any provider not affiliated with a Health Care Corporation has failed to fulfill the obligations set forth in this Act, this action to include suspension of payment for services performed under Comprehensive Health Care Benefits. Appeals procedures outlined in (c) apply to this provision.

Judicial review

Section 237 (a) states that any State dissatisfied with the Secretary's action under section 238 (other than subsection (c)(3)) may obtain judicial review of the action, and establishes requirements for the petitioning of such review.

(b) provides that the findings of fact of the Secretary, if supported by substantial evidence, shall be conclusive on the court, but that the court, for good cause shown may remand the case to the Secretary to take further evidence.

(c) provides that the judgment of the court shall be final, subject to review by the Supreme Court, and that the commencement of proceedings under this section shall not, unless ordered by the court, operate as a stay of the Secretary's action.

Federal exercise of State functions in cases of noncompliance by States

Section 238(a) deals with the authority of the Department of Health in the case of any State which has not established a State Health Commission in conformity with Section 232 and submitted an approvable State plan prior to the third fiscal year beginning after the calendar year of enactment of this Act. It grants authority to the Secretary in such an instance to appoint commissioners, hire staff, and assume all functions of a State commission in compliance with the provisions of this Act, and in that event to utilize for that purpose any Federal funds available for administration of State plans under the Act.

(b) Stipulates that the Secretary shall not refuse approval of a State plan without reasonable notice to the State, and opportunity for hearings; and that, when an application for renewal of approval of the State plan is pending, the Secretary may temporarily postpone expiration of its last approval until it has come to a decision concerning renewal.

(c)(1) describes the instances under which the Secretary may withdraw approval of a State plan which, no longer complies with Section 234(c), and may withhold further payments (or may, in its discretion, suspend approval of parts of a plan and limit payments thereby), until it is satisfied that there will no longer be such a failure to comply.

(2) states that the Secretary may postpone action under (1) to allow necessary time for compliance.

(3) provides that in addition to or in lieu of taking action under (1) the Secretary may request the Attorney General to institute a civil action by the United States against the State to enforce the requirements of this part.

(4) permits the Secretary, when he has withdrawn approval of a State plan, to exercise the functions and use the funds referred to in subsection (a).

Cooperative interstate activities and uniform laws

Section 239(a) states that the Secretary shall:

(1) encourage and assist the States and their State Health Commissions with interstate agreements and approvals with respect to Health Care Corporations, including the establishment of joint health service areas; and

(2) shall assist in the development of model State legislation in the areas covered by this Act.

(b) provides for Congressional consent to any two or more States that wish to enter into agreements as cited above.

Other administrative procedures

Sec. 240 amends section 505(a)(2) of the Social Security Act to require that the State agency required to administer, or supervise the administration, of a State plan under title V of the Social Security Act be the "State Health Commission" (rather than the "State health agency") of the State (in the case of any State that is a participating State under Title I of the bill). (The amendment would not supersede the grandfather clause of section 505(a)(2) which allows the crippled children's service portion of a State plan to continue to be administered (or supervised) by a welfare agency in the case of a State which on July 1, 1967, provided for administration of its crippled children's service plan by that agency.

PART D—HEALTH CARE CORPORATIONS

Incorporation and State approval

Sec. 241. (a) defines a Health Care Corporation as a nonprofit private or governmental corporation organized to furnish services (through its own resources or through affiliation with other providers, nonprofit or for-profit) to registrants, and to engage in education, research, and other activities related to the furnishing of personal health services. The section specifies that the governing board of the Health Care Corporation must have effective and equitable representation of the corporation's registrants and of its affiliated institutional and professional providers.

(b) requires that a Health Care Corporation must be found by the State Health Commission to satisfy the requirements in (a) above and must be approved by the Commission for service in a designated service area or areas of the State (in accordance with Sections 235 and 236) upon a finding that the corporation is well organized under professionally competent management, has adequate resources in facilities and personnel, and has given satisfactory assurance of financial responsibility.

Registration with health care corporations

Section 242(a) specifies that the corporation shall register all residents, within the designated service area for which it has been approved by the State Health Commission, who seek registration during a period of open registration; and that the corporation shall make reasonable effort to register those residents of the area who have failed to apply for registration.

(b) Permits the Health Care Corporation to recruit and register persons outside of its designated service area if its quota of registrants has not been filled;

(c) state that, in accordance with regulations of the Secretary, a registrant may effect registration for his or her spouse and their children under 19;

(d) requires the corporation to disseminate to the public information about its operations and its services, including registration information in detail; that it must disseminate information about benefit coverages; assist individuals in establishing entitlement to coverage purchased by the Secretary and in obtaining other coverage;

(e) sets the registration period at 12 months; permits termination of registration with change in residence or for such cause as may be approved by the State Health Commission.

Undertaking to furnish services

Section 243(a) states that the Health Care Corporation shall provide all of the services for which registrants have Comprehensive Health Care Benefits coverage and which are medically necessary (or, in the case of health maintenance services, medically appropriate).

(b) permits the corporation to contract for services through (an) affiliated provider(s)—hospital(s), skilled nursing facility(ies), nursing home(s), or home health care agency(ies); physicians, dentists, podiatrists, or optometrists, or combinations of these, such as partnerships, clinics, or group practice organizations; or other kinds of providers designated in regulations. Providers may affiliate with more than one Health Care Corporation, but must designate one such affiliation as primary.

(c) permits the provision of drugs, devices, appliances and equipment to ambulatory patients, and ambulance and other emergency transportation services through providers not affiliated with the corporation; it states that medical and other services of a specialized nature, with permission of the State Health Commission, may be provided through arrangements with other Health Care Corporations or with providers that are not affiliated with the Health Care Corporation.

(d) emphasizes health maintenance (including health education) for all registrants, assurance of continuity of care, and to the greatest extent possible, the provision of care on an outpatient basis. Health maintenance services are to be periodically scheduled; outpatient services furnished in centers and in physicians' offices; emergency care, including ambulance service, to be available at all times.

(e) requires that a system of outpatient care centers be developed by the Health Care Corporation, these centers to provide health maintenance services and community-based services such as home care, medical social services, and well-baby clinics and mental health clinics. These centers are to be related to institutional and other providers in order to provide necessary laboratory and other diagnostic services and referral and transfer of patients to facilities providing more comprehensive services.

(f) stipulates that the Health Care Corporation must review services provided for registrants in time of emergency by other corporations or providers and, upon approving the charges, submit them to the carriers responsible for payment. Not included are payments for services rendered to registrants who leave their place of residence expressly to obtain health care, unless by arrangement with the corporation.

(g) stipulates that the corporation shall

so far as practicable furnish necessary emergency health services to persons not registered with it and may furnish other services to such persons when it can do so without interference to service to its registrants.

Quality of services

Section 244(a) fixes the responsibility on the Health Care Corporation for the quality of all health services it provides, or had provided in its behalf, including responsibility for compliance with standards of quality and comprehensiveness prescribed by the Secretary. The corporation is made responsible for maintaining controls on utilization of services; for continuing appraisal of the effectiveness of services; and for identifying problems that require planning for additional services. To these ends the corporation is required to have a system of comprehensive peer review by physicians (and dentists in the case of dental services) which covers all services provided by the corporation and its affiliates. The corporation is required to maintain a program of continuing education for its physicians, dentists and nurses.

(b) requires that all medical policies of the corporation be established with the advice of physicians and all dental policies with the advice of dentists; that all medical judgments must be made by or under the supervision of physicians, and dental judgments by or under the supervision of dentists.

(c) encourages participation of physicians in all aspects of policy formulation and operation of the Health Care Corporation.

Participation of professional practitioners

Section 245(a) requires the corporation, so far as practicable, to provide opportunity to all practitioners (physicians, dentists, podiatrists, and optometrists) in its approved service area to furnish services in its behalf. The corporation is required to annually review the scope of services of each practitioner in accordance with his training, experience, and professional competence as determined through peer review. A practitioner must be able to enlarge the scope of his services through in-service training.

(b) stipulates that the corporation may not discriminate in selecting practitioners on any ground unrelated to professional qualifications, but may in initial recruitment give preference to local practitioners as between equally qualified persons.

(c) requires the corporation to permit each practitioner to select, consistent with the requirements for the corporation established by the Act, the form of practice in which he wishes to engage.

Charges by health care corporations and other providers

Sec. 246(a) requires that charges made by a Health Care Corporation be made at rates fixed prospectively and approved by the State Health Commission. These may be revised under circumstances that would create hardship, with Commission approval.

(b) states that charges shall consist of an annual capitation amount per registrant or registrant family, or of itemized charges for separate services or units of service. With approval of the Commission, the corporation may vary its methods of determining charges; capitation charges, except for variations based on size and composition of families, must be uniform for all registrants to whom they are applicable, other than registrants having coverage under government-purchased contracts. After three years of operation, the corporation must submit to the State Health Commission a plan to commence two years thereafter for offering capitation rates to its registrants who choose to purchase coverage directly from the corporation. This plan must be implemented by making this option to all registrants five years after the HCC's incorporation.

(c) specific that the corporation's charges shall meet its financial requirements as determined in accordance with regulations and with systems of accounting as prescribed by the Secretary. This section states that the corporation must justify to the Commission the rates it pays to affiliated providers, and must justify the budgets of any affiliated providers on which these rates are based. In cases where an affiliated provider contracts with more than one Health Care Corporation, the corporation with which it has a primary affiliation becomes responsible for the justification of budgets and rates.

(d) affirms that in reviewing rates the corporation and the Commission must assure that services are provided without unnecessary duplication and that services are not excessively costly.

Continuing personal health records

Section 247(a) requires the maintenance by the Health Care Corporation of a personal health record for each registrant and states that these records must be readily available to the medical and other staff of the corporation and its affiliated providers, and that they must make it possible for the Commission to carry out its statistical responsibilities, including those related to the utilization and cost of health services.

(b) states that the corporation must be equipped to promptly transmit personal health records of registrants to appropriate providers.

(c) requires transfer of personal health records from corporation to corporation when registrants transfer; and transmission of information from personal health records to corporations and providers when they furnish emergency services to the registrant of a Health Care Corporation.

(d) restricts the disclosure of health information without consent of the registrant to purposes necessary to the administration of the corporation, the State plan, or benefit coverage and provides up to a $1,000 penalty or one year of imprisonment or both for violation of this confidential information.

Participation by registrants; health education

Section 248(a) requires corporations to establish methods by which registrants may express their views about the program and performance of the corporation and the health needs of the community, in addition to representation on the corporation's governing board; requires that such opportunity be available to groups of registrants (geographic, economic, or other), and to the extent practicable, to individual registrants; and that advisory committee representation be afforded registrants in general, with subcommittees or separate committees formed for representatives of groups whose interests may differ from those of other registrants.

(b) requires that the corporation undertake a program of continuing health education for its registrants, with special emphasis directed toward low income and medically indigent registrants, affording representation to registrants in the formation of such a program. The section defines the scope of such a program and further requires collaborative efforts in community-wide health education with governmental and private agencies. It also requires the corporation, so far as practicable, to provide assistance to registrants in overcoming language or educational handicaps in obtaining access to health care.

NONDISCRIMINATION; COMPLAINTS

SEC. 249. (a) bars discrimination by the corporation in recruitment, registration, and in provision of services (subject to medically appropriate differentiations, or as specifically authorized in this title), on the ground of race, creed, color, national origin, age, sex, occupation, economic status, or condition of health.

(b) requires the establishment of complaint procedures for registrants or for persons whose applications for registration have been refused. Records of complaints and their disposition must be available for inspection by the Commission.

(c) requires the establishment of procedures for the settlement of disputes with affiliated providers and other providers with whom the corporation has made arrangements for services to its registrants.

Responsibilities for manpower and for research

Section 250(a) requires a corporation to coordinate determination of its manpower needs and those of its affiliated providers; coordinate recruitment and allocation of such personnel; and determine qualification and performance standards for such personnel, to be at least equal to standards of recognized professional organizations, Corporations are required to conduct in-service training programs and to encourage these among affiliated providers and to encourage the use of physician assistants and other supportive technical and nonprofessional personnel under professional supervision.

(b) states that the corporation shall engage in continuing research concerning the health services, and concerning their quality, effectiveness, and cost. Results of such research are to be available to the State Health Commission and the Secretary for their use.

Records and reports

Section 251 specifies that corporations shall keep records with respect to such areas as financing, utilization of services, and the results of peer review, and require that affiliated providers do the same, all such records to meet reporting requirements of the Commission, in accordance with regulations of the Secretary and to be available for inspection by the Commission.

PART E—SPECIAL STUDY OF METHODS FOR MEETING SUPPLEMENTAL CAPITAL NEEDS OF HEALTH CARE CORPORATIONS AND RELATED HEALTH CARE ORGANIZATIONS

Findings and purpose

Section 261 indicates that Congress finds a need for additional sources of supplemental capital and other funding in order to assure a more rational distribution of funds and meet the health care needs of the nation without undue cost to individuals in communities which have the greatest need.

SEC. 262. (a) requires that National Health Services Advisory Council to conduct a full and complete study and investigation of methods for supplying supplemental capital and other funding for Health Care Corporations and related health care organizations, with the objective of developing a national program for supplying such funding, giving special emphasis to areas of high priority health care needs, both rural and urban.

(b) requires the Council to give particular consideration to the utilization of special taxing mechanisms such as a value-added tax, or tax credits, as means of financing comprehensive benefits for beneficiaries of the national program.

(c) The Council shall give particular consideration in this study of developing a program which—

(1) establishes and utilizes, as its basic source of funds, a national trust fund consisting of either a designated portion of the premiums collected for Comprehensive Health Care Benefits Coverage, a tax on such premiums, appropriated funds, or amounts received from other sources, public or private;

(2) provides for the distribution of amounts in the trust fund to State Health Commissions in a manner reflecting population, per capita income, and health needs for allocation by the State Commissions;

(3) recognizies the need for adequate planning for health care services and facilities, and makes such planning a condition of assistance:

(4) encourages and facilitates the continu-

ing provision of funds for these purposes from sources other than the trust fund, and effectively coordinates the utilization of the amounts provided from such other sources with the amounts distributed from the trust fund;

(5) leaves to each State Health Commission the determination of how funds distributed to such commission are to be allocated and utilized;

(6) is subject to such provisions, conditions and limitations as may be necessary or appropriate to assure that the purpose of this part will be effectively carried out.

(d) Requires the Council to submit to the Secretary for transmission to the Congress within one year after the effective date of the Act, a full and complete report of its study together with findings and recommendations and with detailed specifications for any legislation which it finds may be required to carry out such recommendations. The Secretary shall include his own comments and views on the Council's recommendations in the transmission of the report to Congress. This study is independent of studies made by the Secretary in Section 214, and of the annual report of the Council under Section 213(c).

TITLE III—EFFECTIVE DATES

TRANSITIONAL EFFECTIVE DATES

Section 301(a) except as otherwise provided in the section and in section 302 (including any amendments made by it to existing law) shall be effective upon the date of the enactment of this Act.

(b) sections 211, 216(a), 218, 219, 220, and 221 and parts c and d of Title II shall take effect upon the first January 1 or July 1 which occurs 6 months or more after the date of enactment of this Act.

(c) Section 216(b), 238 (with respect to States which have not complied with Sections 232 and 234), and the amendments made by Section 101 shall take effect on the first day of the third fiscal year which begins after the date of enactment of this Act.

FULL OPERATION OF PROGRAM

Section 302. The program under this Act shall be fully in operation, and the benefits of part B of Title I shall be fully effective and available (in lieu of any benefits which would otherwise be available under Title XVIII of the Social Security Act), in accordance with all the provisions of this Act, on and after the first day of the fifth fiscal year which begins after the date of enactment of this Act.

I include a copy of the bill, as follows:

H.R. 1

A bill to establish a new program of comprehensive health care benefits (including catastrophic coverage) and health care delivery to be available to all residents of the United States, financed by payroll deductions, employer contributions, and tax credits, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, divided into titles, parts, and sections in accordance with the following table of contents, may be cited as the "National Health Care Services Reorganization and Financing Act".

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FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) Recognizing that health care is an inherent right of each individual and of all of the people of the United States, and that in fulfilling this right each individual shares the responsibility for protecting his or her own health and for obtaining health care when required, the Congress finds and declares that health services must be so organized and financed as to make them readily available to all, without regard to race, creed, color, sex, or age, and without regard to any person's ability to pay; that the services must be so provided as to enhance the dignity of the individual and promote better life for all; and that it is a function of Government to assure that these ends are attained.

(b) The Congress finds that the functions of the Federal Government, exercised primarily through a new Department of Health established to deal exclusively with health and related matters, should include financial assistance to members of the public in obtaining health care services in accordance with the principles—

(1) that the Federal Government should require all employers to contribute to the purchase of Comprehensive Health Care Benefits for their employees;

(2) that the Federal Government should assume the cost of purchasing or subsidizing, through tax credits and deductions and in other ways, health insurance for those unable to pay for it, or unable to pay in full;

(3) that social insurance should continue to finance hospital care for the aged; and

(4) that to encourage participation by individuals in new health delivery and benefit programs, the Federal Government should provide a financial incentive.

(c) The Congress further finds that achievement of these purposes requires substantial modification of the organization and methods of delivery of health services and the methods of financing them, and that these purposes will best be served by the creation of a nationwide system of independent Health Care Corporations embodying the principles—

(1) that each corporation should combine,

either in its own structure or by affiliation, institutions and professionals qualified to furnish the entire range of health services, and should provide to its registrants an integrated and comprehensive program of health services, emphasizing preventive and outpatient care and embracing health maintenance services, primary care, specialty care, rehabilitative care, and palliative and terminal care;

(2) that such independent corporations should span the Nation, so that every resident of the country will have the opportunity to register with a corporation and, where practicable, a choice among corporations; and

(3) that such corporations should be locally established and operated, but should be subject to State regulation through State Health Commissions and to national standards of quality and scope of services.

The Congress finds that, with assistance from the Federal Government to members of the public and also in the development of Health Care Corporations and the creation of needed outpatient facilities and home health care programs, such a system of health care delivery and comprehensive benefits can become operative nationwide within five years after the enactment of this Act.

(d) Pursuant to the foregoing findings, and to carry out the foregoing declarations, the Congress by the enactment of this Act declares and provides—

(1) that all persons residing in the United States will be eligible to participate in the program created by this Act, beginning in the fifth year after its enactment;

(2) that each person so participating will be entitled to receive from a Health Care Corporation services as described in this Act, if he has registered with the corporation and has obtained a qualified health benefit coverage from a carrier, or on the basis of his income or his age has been provided with such a coverage;

(3) that such coverage will be provided without cost to persons in the lowest income bracket and at reduced cost to persons in the other income brackets specified in this Act; and

(4) that such coverage will be provided through payroll taxes and general revenues to persons who have attained the age of 65.

(e) It is the intent of the Congress that appropriate philanthropic support for health care be continued and expanded under the program created by this Act, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services. Nothing in this Act, therefore, is intended nor may be construed to eliminate or limit philanthropic support or incentives for such support for Health Care Corporations and health care institutions.

DEFINITIONS

SEC. 3. For the purposes of this Act—

(1) the term "Comprehensive Health Care Benefits" means the benefits described in part B of title I;

(2) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(3) the term "United States", when used in a geographical sense, means the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam;

(4) the term "Governor" includes the mayor of the District of Columbia; and

(5) the term "Secretary" means the Secretary of Health.

TITLE I—FINANCING OF NATIONAL HEALTH SERVICES

SHORT TITLE

SEC. 100. This title may be cited as the "National Health Care Services Financing Act".

PART A—EMPLOYER REQUIREMENTS AND ENTITLEMENT TO BENEFITS

REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR EMPLOYEES

SEC. 101. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR EMPLOYEES

"SEC. 232. (a) Under regulations prescribed by the Secretary of Health (subject to subsection (b)), every person who is an employer within the meaning of this title shall be required—

"(1) during the period beginning on the transitional effective date specified in section 301(c) of the National Health Care Services Reorganization and Financing Act and ending on the day before the effective date specified in section 302 of such Act, to provide benefits under such Act equivalent to the hospital insurance benefits available under part A of title XVIII of this Act and the supplementary medical insurance benefits available under part B of such title, and in addition to provide Catastrophic Expense Benefits coverage under and in accordance with section 125 of the National Health Care Services Reorganization and Financing Act, for each of his employees and for the members of the family of each such employee; and

"(2) from and after the effective date specified in section 302 of the National Health Care Services Reorganization and Financing Act, to provide Comprehensive Health Care Benefits coverage (as provided or made available under such Act) to each such employee and for the members of the family of each such employee.

"(b) The provisions of subsection (a) shall not apply—

"(1)(A) with respect to any employer which is the United States or any agency or instrumentality thereof; or

"(B) in any case where the employed member of a family has two or more employers, or where two or more members of the family each have one or more employers, with respect to any such employer other than the one whose total taxes paid under section 3111(a) of the Internal Revenue Code of 1954 on account of the employment of such member or members is greatest; or

"(2) with respect to any employee (or member of an employee's family) who is entitled to health insurance benefits under title XVIII.

"(c) For purposes of this section the employer's contribution must be at least the actuarial equivalent of 75 percent of the premium cost of the coverage provided by him for his employees as required by subsection (a). The requirement for an employer's contribution shall not in any way prohibit the employee from choosing to register with a Health Care Corporation operating in whole or in part on a capitation basis.

"(d) In any case where an individual who is a low-income person or a member of a low-income family, or who is a medically indigent person or a member of a medically indigent family, is provided with Comprehensive Health Care Benefits coverage by an employer under this section, and in connection therewith is required to make a contribution toward the premium cost of such coverage which exceeds the amount of the premium contribution which he would be required to make under section 106 of the National Health Care Services Reorganization and Financing Act if he were entitled to such coverage under section 102 of that Act rather than under this section, such individual shall be entitled, upon application therefor filed at such time and in such manner and form as the Secretary shall by regulations prescribe, to a premium contribution refund in the full amount of such excess.

"(e) The period of coverage of any employee whose employment is involuntarily terminated shall extend from the date of such termination until the employee becomes eligible for unemployment compensation benefits or until the expiration of 14 days from such termination, whichever first occurs."

(b) Title IX of the Social Security Act is amended by adding at the end thereof the following new section:

"REQUIREMENT OF COMPREHENSIVE HEALTH CARE BENEFITS COVERAGE FOR INDIVIDUALS RECEIVING UNEMPLOYMENT COMPENSATION BENEFITS

"SEC. 909. Every individual who is receiving benefits under any Federal or State unemployment compensation law, and the members of his family, shall be entitled under the National Health Care Services Reorganization and Financing Act (while such individual is eligible for and receiving such benefits)—

"(1) during the period beginning on the transitional effective date specified in section 301(b) of the National Health Care Services Reorganization and Financing Act and ending on the day before the effective date specified in section 302 of such Act, to coverage in the form of (A) benefits under such Act equivalent to the hospital insurance benefits available under part A of title XVIII of this Act and the supplementary medical insurance benefits available under part B of such title, and (B) Catastrophic Expense Benefits coverage under and in accordance with section 125 of the National Health Care Services Reorganization and Financing Act; and

"(2) from and after the effective date specified in section 302 of the National Health Care Services Reorganization and Financing Act, to Comprehensive Health Care Benefits coverage as provided or made available under such Act.

The Secretary of Labor, in accordance with regulations prescribed in consultation with the Secretary of Health, Education, and Welfare, shall purchase such coverage for, and determine the methods by which (and the terms and conditions under which) it is to be made available to, such individuals and members. There are authorized to be appropriated to the Secretary of Labor such sums as may be necessary to carry out this section."

ENTITLEMENT TO BENEFITS FEDERALLY SUBSIDIZED

SEC. 102. (a) Every individual who is a resident of the United States shall, as provided in this section and under the conditions and to the extent otherwise specified in this part, be entitled—

(1) in cases specified in subsection (b), to coverage for Comprehensive Health Care Benefits (as described in this part) contracted for by the Secretary, or

(2) in cases specified in subsection (c), to a Federal contribution to the premium cost of coverage for such benefits under an approved insurance contract or prepayment plan to which the Secretary is not a party.

(b) Such an individual shall be entitled to such coverage contracted for by the Secretary with a carrier under section 217, with respect to any period for which he is not provided with Comprehensive Health Care Benefits coverage by an employer under section 232 of the Social Security Act, if he—

(1) has attained the age of 65, or

(2) is under 65 but is a low-income person or a member of a low-income family, or

(3) is under 65 but is a medically indigent person who complies, or a member of a medically indigent family which complies, with the requirement of section 106 with respect to contributions to premiums for such coverage.

(c)(1) Every other individual referred to in subsection (a) who is registered with an

approved Health Care Corporation in a participating State, or with any other organization providing comprehensive health care and services which is engaged in the delivery of such care and services to a defined population group established through open enrollment and has demonstrated such standards as the Secretary may prescribe in order to assure that it will be operated and its services delivered in an effective manner consistent with the purposes and provisions of this Act, shall be entitled to a Federal subsidy of 10 percent of the amount of premium charged by a qualified carrier (as determined under section 132) at an approved group rate for prepaid coverage of the individual for Comprehensive Health Care Benefits under an approved insurance contract or prepayment plan to which the Secretary is not a party. Payments under this subsection shall, upon certification by the Secretary, be made to the carrier.

(2) As used in this subsection, (A) the term "approved group rate" means a group rate prescribed or approved (for the coverage referred to in paragraph (1)) by the State Health Commission (or its delegate agency) under the State plan (approved under part C of title II) of the participating State of which the individual concerned is a resident or, in the case of coverage under an employer plan, the State in which the individual is employed; (B) the term "approved insurance contract or prepayment plan" means an insurance contract or prepayment plan that is approved by the Secretary under section 134; and (C) the term "premium" does not include special premiums payable, in accordance with the provisions referred to in section 134, by a registrant to a carrier to cover the copayment component of capitation charges paid by the carrier to the registrant's Health Care Corporation.

(3) If the coverage of the insurance contract or prepayment plan for an individual (or an individual and his family) entitled to a contribution under paragraph (1) includes Comprehensive Health Care Benefits but also includes benefits greater than those required for Comprehensive Health Care Benefits coverage and a combined premium rate is charged by the carrier for the total coverage, the Federal contribution payable under paragraph (1) shall be based on that portion of the total premium which, in accordance with actuarial principles, is attributable to coverage for Comprehensive Health Care Benefits for that individual (or him and his family) and shall be determined in accordance with regulations of the Secretary.

(4) Entitlement to a contribution under paragraph (1), and the amount thereof, shall be determined without regard to whether the cost of the remainder of the premium is borne (or whether in the absence of that contribution the cost of that portion of the premium which is equal to the contribution would be borne) by the covered individual, by his employer, or by any other person or agency.

(d) For definitions of "low-income person", "low-income family", "medically indigent person", "medically indigent family", and "family", see sections 103 through 105.

INCOME CLASSES

SEC. 103. (a) For purposes of this part—

(1) the terms "low-income person" and "low-income family" mean, respectively, a single individual or family in income class 1;

(2) the terms "medically indigent person" and "medically indigent family" mean, respectively, a single individual or family in income class 2, 3, or 4;

(3) all persons or members of families not in income class 1, 2, 3, or 4 are classified as being in income class 5;

(4) the term "income class", with respect to a single individual or a family, means for any coverage year the individual's or family's income class as determined by application of—

(A) the table set forth in subsection (b) of this section, or

(B) if containing higher dollar amounts, the redetermined income class table promulgated by the Secretary for that year under section 104; and

(5) the term "single individual" means an individual who is not a member of a "family" within the meaning of section 105.

(b) (1) The income class table referred to in subsection (a) (4) (A) is as follows:

TABLE OF INCOME CLASSES

Column I	Column II	Column III	Column IV	Column V
	Family size and income ranges			
Income class	Single individual	Family of 2	Family of 3	Family of 4 or more
1	$0 to $2,000	$0 to $3,000	$0 to $4,500	$0 to $6,000.
2	$2,001 to $3,000	$3,001 to $4,500	$4,501 to $6,000	$6,001 to $7,500.
3	$3,001 to $4,500	$4,501 to $6,000	$6,001 to $7,500	$7,501 to $9,000.
4	$4,501 to $6,000	$6,001 to $7,500	$7,501 to $9,000	$9,001 to $10,500.
5	Above $6,000	Above $7,500	Above $9,000	Above $10,500.

PERIODIC REVISION OF INCOME CLASSES

SEC. 104. (a) Not later than December 31 of each calendar year (after the year in which this Act is enacted), the Secretary shall, in accordance with subsection (b), redetermine and promulgate—

(1) the dollar amounts in the table of income classes under section 103(b);

(2) the amounts of annual premium contributions to be required of medically indigent persons and medically indigent families under section 106;

(3) the dollar amounts of copayments under section 122; and

(4) for Catastrophic Expense Benefits, the dollar amounts for the special-expenditure limits under section 125.

(b) The redetermined amounts shall be the same as the amounts specified in the respective sections cited in subsection (a) unless the average of the Consumer Price Index for the months of July, August, and September of the calendar year in which the redetermination is made exceeds by 3 percent or more the average of that index for the corresponding months of the year in which this Act is enacted. In the latter event, the Secretary shall adjust each of the amounts so specified by increasing it by the same percentage as the percentage increase (referred to in the preceding sentence) in the average of the Consumer Price Index, after rounding the latter percentage to the nearest multiple of 0.1 percent (or to the next higher multiple if the percentage is an odd multiple of 0.05 percent) and rounding each dollar amount so obtained—

(1) for the table of income classes, to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50),

(2) for premium contributions to be made by medically indigent persons and medically indigent families, to the nearest multiple of $10 (or to the next higher multiple if the amount to be rounded is an odd multiple of $5),

(3) for copayments, to the nearest multiple of 25 cents (or to the next higher multiple if the amount to be rounded is an odd multiple of 12½ cents), and

(4) for the special-expenditure limits for Catastrophic Expense Benefits, to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50).

(c) The amounts as so redetermined and promulgated in any calendar year (whether or not the same as the amounts specified in the sections cited in subsection (a)) shall be effective for any coverage year that begins in the fiscal year beginning in the following calendar year.

(d) As used in this section, the term "Consumer Price Index" means the Consumer Price Index (All Items—United States City Average) published monthly by the Bureau of Labor Standards of the Department of Labor.

DETERMINATION OF INCOME LEVEL

SEC. 105. (a) For the purposes of this part, the rate of income of a single individual or a family shall be determined on the basis of his adjusted gross income (in the case of a single individual) or the family's combined adjusted gross income (in the case of a family), as defined in accordance with regulations prescribed by the Secretary in consultation with the Secretary of the Treasury or his delegate, for the calendar year preceding the coverage year with respect to which the determination is made; except that—

(1) the Secretary may prescribe regulations (A) excluding from the amount thus determined items of income that are not reasonably available for living expenses, and (B) including therein items that are reasonably available for living expenses although not included in adjusted gross income, and

(2) the Secretary may by regulation provide for redetermination of an individual's or family's rate of income on a more current basis when necessary to prevent serious hardship or inequity.

(b) For the purposes of this part—

(1) the term "family" means (A) a husband and wife (not divorced or judicially separated), or (B) such spouses and their dependent unmarried children under 19, or (C) an individual and his or her dependent unmarried children under 19; and

(2) the terms "child" and "dependent" (as applied to a child) have the meanings assigned them in sections 151 and 152 of the Internal Revenue Code of 1954.

PREMIUM CONTRIBUTIONS FOR FEDERALLY CONTRACTED COVERAGE

SEC. 106. (a) (1) In the case of medically indigent persons and members of medically indigent families referred to in section 102(b)(3), entitlement to coverage contracted for by the Secretary shall be subject to the condition that the individual or family concerned, or another person or agency on the individual's or family's behalf, contribute to the carrier's annual premium charge for such coverage.

(2) (A) The annual amount of contribution so required with respect to such an individual or family shall be—

(i) $50 for a single individual, and $125 for a family, in income class 2;

(ii) $100 for a single individual, and $250 for a family, in income class 3;

(iii) $150 for a single individual, and $375 for a family, in income class 4;

except that in the case of a family (in any such income class) in which only one member is under the age of 65, the amount of contribution required under the foregoing clause applicable to that income class shall

be the amount specified in that clause for a single individual, and except that if, by reason of an increase in the Consumer Price Index, higher contribution amounts are promulgated under section 104 by the Secretary with respect to single individuals or families in income class, 2, 3, or 4 for any coverage year, those amounts shall apply for that year.

(B) For determination of income classes, see section 103.

(b) Annual contributions under this section shall be payable, by or on behalf of the individual or family concerned, to the carrier under whose contract with the Secretary the individual or family is enrolled, in such installments and in such manner as may be prescribed by the Secretary by regulation. There shall be no recourse against the United States under this title on account of any delinquency or default in the payment of such contributions. For effect of delinquency or default on coverage, see section 136.

INCOME TAX DEDUCTIONS BY INDIVIDUALS

SEC. 107. Section 213(a)(2) of the Internal Revenue Code of 1954 (relating to individual's deduction for medical insurance expense) is amended to read as follows:

"(2) the sum of—

"(A) an amount (not in excess of $150) equal to one-half of the expenses (other than those deductible under subparagraph (B)) paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents (as defined in section 152), and

"(B) in the case of a taxpayer who at any time during the taxable year is covered under an insurance contract or prepayment plan approved by the appropriate State Health Commission under title II of the National Health Care Services Reorganization and Financing Act, an amount equal to—

"(i) all the expenses paid by the taxpayer during the taxable year for Comprehensive Health Care Benefits coverage (as defined in section 122 of the National Health Care Services Reorganization and Financing Act) for the taxpayer and members of his family, reduced by

"(ii) the amount allowable to the taxpayer as a credit for the taxable year under section 42(b)."

INCOME TAX CREDITS FOR CERTAIN PAYMENTS BY EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS FOR COVERAGE

SEC. 108. (a) Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1954 (relating to credits against tax) is amended by redesignating section 42 as section 43 and by inserting after section 41 the following new section:

"SEC. 42. EMPLOYER CREDIT FOR NATIONAL HEALTH SERVICES COVERAGE PAYMENTS IN EXCESS OF 4 PERCENT OF WAGES; COMPARABLE CREDIT FOR THE SELF-EMPLOYED

"(a) CREDIT FOR EMPLOYERS.—In the case of any employer to whom section 232(a) of the Social Security Act applies, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to—

"(1) the amount by which (A) such employer's share of the average premiums payable for the coverage for such taxable year of his employees to whom such section 232 (a) applies, exceeds (B) 4 percent of the average wages paid by such employer to employees for such taxable year, multiplied by

"(2) the number of such employees (not in excess of 10).

"(b) CREDIT FOR SELF-EMPLOYED INDIVIDUALS AND CERTAIN OTHER INDIVIDUALS.—

"(1) ALLOWANCE OF CREDIT.—In the case of an individual who—

"(A) is a resident of the United States, and

"(B) is not provided Comprehensive Health Care Benefits coverage either by an employer under section 232 of the Social Security Act or by the Secretary of Health under section 102(b) of the National Health Care Services Reorganization and Financing Act,

there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year the amount determined under paragraph (2).

"(2) AMOUNT OF CREDIT.—The amount of the credit allowable under this subsection to any individual for any taxable year shall be an amount equal to the excess of—

"(A) the aggregate amount of premiums paid by such individual during such taxable year to a qualified carrier (as determined under section 132 of the National Health Care Services Reorganization and Financing Act) at an approved group rate for prepaid coverage of such individual and his family for Comprehensive Health Care Benefits under an approved insurance contract or prepayment plan to which the Secretary of Health is not a party, over

"(B) the sum of—

"(i) 10 percent of the aggregate amount of premiums referred to in subparagraph (A), and

"(ii) 4 percent of the adjusted gross income of such individual for the taxable year.

"(c) REGULATIONS.—The Secretary or his delegate shall prescribe such regulations as may be necessary to carry out the purposes of this section. Such regulations shall include, in the case of the credit allowable by subsection (a), rules relating to determining the number of employees of an employer for the taxable year, the wages of the employees, and the premiums payable under the National Health Care Services Reorganization and Financing Act, as well as the method for determining such wages (and the average thereof)."

(b) The table of sections for such subpart A is amended by striking out the item relating to section 42 and inserting in lieu thereof the following:

"SEC. 42. Employer credit for National Health Services coverage payments in excess of 4 percent of wages; comparable credit for the self-employed.

"SEC. 43. Overpayments of tax."

(c) Section 6401(b) of such Code (relating to refund where credits exceed tax) is amended—

(1) by striking out "and 667(b)" and inserting in lieu thereof ", 42 (relating to employer credit for National Health Services coverage payments in excess of 4 percent of wages; comparable credit for the self-employed), and 667(b)"; and

(2) by striking out "31 and 39" and inserting in lieu thereof "31, 39, and 42".

LIMITATION OF MEDICAID TO SUPPLEMENTATION OF COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 109. (a) On and after the effective date of entitlement to benefits under this part, a participating State (as defined in section 234(d)(2) shall, notwithstanding any provision of title XIX of the Social Security Act (relating to grants to States for medical assistance programs), not be required to provide in its State plan under that title for paying under that plan for any service or item (set forth in section 122) that is covered by Comprehensive Health Care Benefits and is furnished to an individual who is entitled to such coverage under section 102. Any amount expended by such a participating State for furnishing any such service or item to such an individual on or after that date (whether or not the service or item is in fact covered under that State plan) shall be disregarded in determining the amount of any payment to be made to the State under title XIX of that Act.

(b) The Secretary shall, with a view to supplementing (so far as practicable), through State plans under title XIX of the Social Security Act, the coverage of Comprehensive Health Care Benefits for individuals referred to in subsection (a), prescribe by regulation the minimum scope of services and items that shall (in lieu of the requirements of section 1902(a)(13) of that Act) be included, on and after the date referred to in subsection (a), in a State plan as a condition of approval under title XIX of that Act.

PART B—COMPREHENSIVE HEALTH CARE BENEFITS

PAYMENT FOR COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 121. (a)(1) Except as provided in paragraph (2), coverage of a registrant for Comprehensive Health Care Benefits shall entitle beneficiaries to have the carrier pay, in accordance with section 152(b) but subject to the limitations of this part, the approved predetermined charges of Health Care Corporations and other providers for services and items (set forth in section 122) furnished to him and covered by such benefits, or, in those instances in which subsection (b)(3) applies, the charges (approved and submitted to the carrier in accordance with section 243(f) of another Health Care Corporation or provider that furnished to him covered services or items. Such coverage is subject to the carrier's right (as provided in section 132(b)) to reimbursement from the beneficiary in the amount of the copayments (if any) payable under this part, and subject to the other provisions of this part.

(2) In the case of registrants of an approved Health Care Corporation that operates on a capitation charge basis, coverage for Comprehensive Health Care Benefits shall entitle the registrant to have the covering carrier (or the Secretary where the registrant is enrolled under a contract of the Secretary with the corporation under section 135) make payment of capitation charges (instead of fee-for-service charges) on his behalf in accordance with the applicable provisions of part C of this title. The conditions under which, the manner in which, and the extent to which the amounts of copayments provided for in this part, or the actuarial equivalent of such copayments, is to be paid and collected in such cases, is also governed by part C of this title.

(3) For payment by the carrier to the Health Care Corporation for certain charges not covered by Comprehensive Health Care Benefits, see section 135.

(b) Copayments that are the obligation of beneficiaries shall be paid to the carrier in the amounts specified in the benefit table in section 122, and subject to changes in the sections 104 and 124.

DEFINITION OF COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 122. (a)(1) Comprehensive Health Care Benefits shall, subject to other provisions of this title, consist of benefits for (A) Outpatient Services, (B) Inpatient Services, and (C) Catastrophic Expense Benefits, as described or referred to in the benefit table set forth in subsection (b) and in other provisions of this title. In addition to specific requirements for the issuance of regulations in the table and in other provisions of this part, the Secretary is authorized to issue from time to time such further regulations governing and otherwise adjusting the application of the table as in his judgment will best carry out the purposes of this Act.

(2) For the purposes of the table and of the subsequent provisions of this part—

(A) the term "coverage year" with respect to an individual means a 12-month period of Comprehensive Health Care Benefits coverage of the individual under a qualified carrier's insurance contract or prepayment plan which coincides with a 12-month (annually renewable) term of that contract or plan; and the Secretary shall by regulation provide for application of the table to an in-

dividual whose initial enrollment under such a contract or plan occurs after the beginning of a then current 12-month term of the contract or plan or who is enrolled under a carrier contract with the Secretary that has a shorter initial term;

(B) the term "benefit period" with respect to an individual means a period of consecutive days—

(i) beginning with the first day (not included in a previous benefit period) that occurs during a coverage year and on which he is furnished covered inpatient hospital services, post-hospital extended care services, nursing home care, home health care services, or services under an outpatient institutional-care program for physical disability, mental illness, alcoholism, or drug abuse or drug dependence (as provided in paragraphs A.3.a. and B.1, respectively, of the benefit table), and

(ii) ending with the close of the first period of 60 consecutive days thereafter (whether or not in the same coverage year) on which he is not receiving any of the care or service referred to in clause (i);

(C) the term "regulations" refers to regulations of the Secretary,

(D) the term "outpatient services" means services listed under the heading "Outpatient Services of Health Care Corporations" in the benefit table (including such services to patients confined to the home) and furnished to individuals who are not inpatients covered for services under paragraph B of such table; and

(E, the term "home health care services" means the comprehensive coordinated home care services and the intermediate and basic home health services listed in the benefit table under the heading "Home Health Care Services" and furnished to individuals who are not in-patients covered for services under paragraph B of such table.

For other definitions of terms used in the table, see section 128.

(b) The table referred to in subsection (a) is as follows:

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS

I—SERVICES AND ITEMS COVERED	II—COPAYMENTS* AND LIMITATIONS
a. outpatient services	
1. Periodic Health Evaluation.	
a. Screening tests and examinations, as prescribed by regulations under section 126, followed by physical examination by a physician or physicians when indicated by the screening.	No copayment. Within such limits as may be prescribed by regulation under section 126.
b. All Immunizations.	No copayment and no limitation.
c. Well-Baby Care (for infants under age 5)—	No copayment.
(i) during 1st 12 month following birth;	8 visits.
(ii) during next 12 months;	4 visits.
(iii) during next 3 years.	2 visits per coverage year.
d. Dental Services	
The following professional dental services, including drugs and supplies that are commonly furnished, without separate charge, as an incident to such professional services:	Items d (i) and (ii) in column I apply initially only to children born not more than 7 years before the effective date of this subpart. For those initially covered, the benefits extend through age 12.
(i) Oral examination, including (I) prophylaxis (with fluoride application at appropriate ages), (II) dental X-rays, and (III) in accordance with regulations, other accepted preventive dental procedures.	No copayment. 1 examination per coverage year.
(ii) To the extent prescribed by regulation under section 126 and not covered under (i), above, dental care other than orthodontia; but including, insofar as the Secretary finds that resources of facilities and personnel make practicable, routine extractions, dental fillings, and appropriate prosthetic appliances.	Copayment 20% of charges.
e. Vision Services (in accordance with regulations under section 126)	For individuals through age 12.
(i) Professional services in routine eye examination, including procedures performed (during the course of an eye examination) to determine the refractive state of the eyes and procedures for furnishing prosthetic lenses, provided either by an ophthalmologist or other physician skilled in diseases of the eye or by an optometrist (whichever the patient may select).	No copayment. 1 visit per coverage year (including therein a follow-up verification of conformity of prescribed lenses with a prescription issued during the visit).
(ii) Eyeglasses with prescription lenses, including the fitting thereof, and including additional lenses and frames as needed.	Copayment 20% of charges. Initially, one set of eyeglasses (including frame and lenses); thereafter, only newly prescribed lenses and frames as required (but not more often than once a coverage year) because of a change in the condition of the eyes. Standards to be established by regulations promulgated in accordance with section 126.
2. Physicians' Services, and Services of Other Qualified Health Professionals and Allied Health Personnel.	
When not otherwise covered under this table—	
a. Physicians' services (including radiotherapy) on an outpatient basis in any appropriate institutional or noninstitutional setting (including home calls), and services in any such setting under a physician's supervision by allied health personnel (as defined in regulations).	For physicians' services, a copayment for each visit of two dollars. Copayments under this paragraph for services in facilities involved in clauses c. and d. below apply only to services of attending physician. Limited to 10 visits per coverage year. Except that, in accordance with regulations, no limit on the number of visits shall apply to services preceding or following inpatient care in cases (such as surgery or pregnancy and obstetrical care) in which a single combined approved charge is made by the provided for such outpatient and inpatient services.
b. Diagnostic procedures on an outpatient basis (when not covered under subparagraph a.), including diagnostic tests, prescribed or ordered by a physician in connection with services referred to in paragraph a.	20% copayment. Copayment requirement waived for registrants of Health Care Corporations.
c. Hospital or outpatient-center services (not included above) rendered to outpatients and incidental to physicians' services covered under paragraph 1.	No separate limitation. No separate copayment. No separate limitation.
d. Supplies, materials, and use of facilities and equipment in connection with the foregoing services, including drugs administered or used as a part of services covered in paragraph 1, 2, or 3.	No separate copayment. No separate limitation.
e. Ambulance services.	20% copayment. Covered only when other methods of transportation are contraindicated by the patient's condition, and only to the extent provided in regulations.
3. Other Outpatient Services.	
a. Outpatient Institutional-Care Program for Physical Disability, Mental Illness, Alcoholism, or Drug Abuse and Dependence.	A two-dollar copayment, per day, except that copayments may, by regulation, be waived for treatment of drug abuse and drug dependence. (No separate copayment for physicians' services applies

Footnote on following page.

TABLE OF COMPREHENSIVE HEALTH CARE BENEFITS—Continued

I—SERVICES AND ITEMS COVERED—Continued	II—COPAYMENTS* AND LIMITATIONS—Continued
Such day-care or other part-time services and other items as may be specified in regulations under section 126, furnished to patients, other than inpatients, under a program for the rehabilitation of the physically disabled or the treatment of mental illness, alcoholism, or problems of drug abuse and drug dependence.	Limited to visits or sessions on 3 days under such a program in lieu of each day of inpatient hospital care allowable during a benefit period (under paragraph B.1.a. below) for the treatment of physical disability, mental illness, alcoholism, or drug abuse or drug dependence.
b. Drugs, Prosthetic Devices, and Medical Equipment	
(i) Drugs (other than those covered under paragraph A.1., A.2., or B.1. of this table) dispensed to patients other than inpatients.	For each drug prescription, and each refilling of such a prescription, a one dollar copayment. Covered only if (1) the drug (whether or not it is subject to a prescription requirement under any law other than this title) has in fact been prescribed by a physician and is listed under its established name (as defined in section 502(c) of the Federal Food, Drug, and Cosmetic Act) in a list established for the purposes of this title by the Secretary under section 126(c), and (2) in the case of a drug listed under section 126(c)(2)(B), the disease or condition for which the drug has been prescribed is one for the treatment of which the drug is designated in that list as appropriate.
(ii) Prosthetic devices (including hearing aids) prescribed by a physician and not otherwise covered in this table.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126.
(iii) In accordance with regulations, durable medical equipment (not otherwise covered) as described in section 1861(s)(6) of the Social Security Act, certified by a physician as being medically required.	Copayment 20% of charges. Covered only if listed in, and in accordance with, regulations under section 126; and subject to criteria for payment prescribed under that section.
c. Home Health Care Services.	
(i) Intensive Home Health Care Services—Services and items defined in section 128(d)(2)(A) furnished to patients who require an intensive level of professionally coordinated medical services that can be provided through a structured home care service in lieu of institutional inpatient care.	For each visit, a two-dollar copayment. Coverage under (i), (ii), or (iii) is limited to a total of 200 days in any benefit period. The certification and recertification requirements of section 1835(a)(2) of the Social Security Act, with such modification (if any) as the Secretary may by regulation prescribe, may be applied by the carrier.
(ii) Intermediate Home Health Care Services—Services and items as are defined by section 128(d)(2)(B) and regulations thereunder.	
(iii) Basic Home Health Care Services—Services and items as are defined by section 128(d)(2)(C) and regulations thereunder.	
B. Inpatient services	
1. Institutional Services	
a. Inpatient Hospital Care	
Items and services defined by section 128(e) as "inpatient hospital care."	A five-dollar copayment, per day. Coverage is limited to 90 days of inpatient hospital care received in any benefit period.
b. Post-Hospital Extended Care	
Extended care services (as defined in section 128(b)) furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days. For the purpose of the preceding sentence, the second sentence of section 1861(i) of the Social Security Act shall apply.	A two-dollar-and-fifty-cent copayment, per day. Limited to 30 days of such care received in any benefit period.
c. Nursing Home Care	
Nursing home care as defined in section 128.	A two-dollar-and-fifty-cent copayment, per day. Coverage shall be limited to 90 days of such care received in any benefit period.
2. Physicians' Services	
Those physicians' services to inpatients which are not included as "institutional services" under paragraph B.1a., b., or c.	A two-dollar copayment, per visit of the attending physician only. In accordance with regulations under section 126, in the case of services (such as surgery or pregnancy and obstetrical care) in which a single charge is made by the corporation for the attending physicians' services combined with any preceding or following outpatient services related thereto, a copayment of 10% of such combined charges shall apply. Copayments for physicians' services under this paragraph are in addition to the daily copayments for institutional care. No separate limitations.
C. Catastrophic expense benefits	
Section 125 defines the conditions under which these benefits become effective in any coverage year with respect to any individual or family. To summarize: In the case of a low-income person or low-income family (class 1), these benefits are effective immediately. In the case of medically indigent persons or families (classes 2–4), they become effective when the person or family has incurred in a coverage year, for premium contributions, copayments, and certain other expenditures combined, a total expenditure equal to an amount determined by application of a table in section 125. In the case of individuals or families in income class 5, these benefits apply when a variable expenditure limit is reached, determined by taking 10% of the individual's or family's income. The dollar figures in the tables and the absolute expenditure limit may be adjusted by the Secretary on an annual basis, whenever the Consumer Price Index is more than 3% above the index for the base period (see sections 104 and 124).	For elimination of certain limits on coverage for Physicians' Services and Inpatient Hospital Services when Catastrophic Expense Benefits take effect in a coverage year, see section 125. Outpatient care for mental illness is limited to those cases in which active medical treatment (as defined in the last sentence of section 123(a)) is provided. Psychoanalysis is excluded under catastrophic coverage, except in those cases in which it is utilized for the treatment of severe functional disability for which no feasible alternative modes of therapy exist.

*The initial amounts of the dollar copayments are subject to changes in the Consumer Price Index as determined under sections 204 and 224.

LIMITATIONS AND EXCLUSIONS

SEC. 123. (a) Notwithstanding any other provision of this title, Comprehensive Health Care Benefits shall not cover charges for—

(1) services or items that are not medically necessary (or, in the case of health maintenance services under paragraph A.1. of the benefit table, medically appropriate), as determined in accordance with regulations and subject to such requirements for certification and recertification by physicians as are specified in this part or in regulations;

(2) inpatient treatment of tuberculosis, mental illness, alcoholism, or problems of drug abuse or drug dependence, unless the condition of the patient is in an acute phase and subject to active medical treatment;

(3) custodial care, other than health-related custodial care;

(4) cosmetic surgery or charges incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(5) personal comfort items;

(6) drugs not prescribed, except when administered by or under the immediate supervision of a physician; or

(7)(A) treatment of flat-foot conditions and the prescription of supportive devices therefor, or

(B) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care).

For purposes of paragraph (2), "active treatment" must be (i) characterized by a written and individualized plan that is based on diagnoses; (ii) based on goals relative to arrest, reversal, or amelioration of the disease process or illness and aimed at restoring the individual's adaptive capacity to the maximum extent possible; (iii) based on objectives relating to such goals; (iv) comprised of defined services and activities; (v) specific as to the means to measure the progress or outcome; and (vi) clear as to periodic review and revision of the plan.

(b) Comprehensive Health Care Benefits shall not cover any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to that item or service under a workman's compensation law or plan of the United States or a State or under a motor vehicle insurance policy or plan. Any payment by the carrier under coverage under this title with respect to any item or service shall be conditioned on reimbursement to the carrier when notice or other information is received that payment for the item or service has been made under such a law, policy, or plan.

(c) Comprehensive Health Care Benefits shall not cover—

(1) charges for items or services (other than emergency services in accordance with section 243(f)) furnished by a Federal provider of services, except a provider of services which the appropriate State Health Commission determines is providing services (by arrangement with a Health Care Corporation or otherwise in accordance with part D of title II) as a community institution or agency; or

(2) charges of a Health Care Corporation or other provider for any item or service which the corporation or provider is obligated by a law of, or contract with, the United States to render at public expense.

(d)(1) If the bed and board furnished as part of inpatient institutional services is in accommodations more expensive than semiprivate accommodations, the amount taken into account for purposes of payment with respect to such care under Comprehensive Health Care Benefits coverage may not exceed an amount equal to the approved charges of the Health Care Corporation or nonaffiliated institutional provider for such services if furnished in semiprivate accommodations unless the more expensive accommodations were required for medical reasons.

(2) If the bed and board furnished as part of inpatient services is in accommodations other than, but not more expensive than, semiprivate accommodations and the use of such other accommodations was neither at the request of the patient nor for a reason consistent with the purposes of this Act (as determined under regulations), the amount of the payment, if any, with respect thereto shall in no event be greater than the corporation's or nonaffiliated provider's approved charge for bed and board in the accommodations furnished.

(3) For purposes of this subsection, the term "semiprivate accommodations" means two-bed, three-bed, or four-bed accommodations.

(e) If, in any other case, items or services are furnished to an individual in excess of, or more expensive than, items or services with respect to which payment may be made under Comprehensive Health Care Benefits coverage, there shall be taken into account, for purposes of payment by the carrier, only the approved charges of the corporation or other provider with respect to which such payment may be made.

COPAYMENT PROVISIONS

SEC. 124. (a) Except to the extent that Health Care Corporations operate on a predetermined capitation charge basis and do not impose separate charges for services and other items covered by Comprehensive Health Care Benefits at the time such services and items are furnished to a covered individual, and except when Catastrophic Expense Benefits are in effect as determined under section 125, coverage for Comprehensive Health Care Benefits is subject to the payment, by the covered individual or on his behalf by another person or agency, of copayments in the case of services or items with respect to which copayments are specified in the benefit table set forth in section 122, but only if the individual is not a low-income person or a member of a low-income family (as defined in section 103). As provided in sections 121 and 132(b), the amount of such copayments shall not be deducted by the carrier from payment to the Health Care Corporations and other providers for covered services and other items but shall be recovered by the carrier as provided in those sections, without recourse against the corporations and providers.

(b) In those cases in which the table in section 122 specifies as the required copayment a stated percentage of charges with respect to a covered service or item, the amount of the copayment shall, subject to section 123, be equal to that percentage of the approved charges of the provider involved for the covered service or item. In those cases in which the copayment in the table is stated as a dollar amount, if, by reason of an increase in the Consumer Price Index, a higher amount is promulgated for any coverage year under section 104 by the Secretary with respect to any copayment item than the amount specified in the table of benefits for that item, the amount so promulgated shall apply with respect to that year.

CATASTROPHIC EXPENSE BENEFITS

SEC. 125. (a) When Catastrophic Expense Benefits are in effect as a part of coverage for Comprehensive Health Care Benefits with respect to a covered individual in a coverage year, (1) copayments that would otherwise be required to be made by or on behalf of that individual shall not be required with respect to services or items furnished in that coverage year on or after the effective date of those benefits, and (2) the benefit limits shown in column II of the benefit table for physicians' services, and services of other qualified health professionals and allied health personnel (paragraph A. 2. a.), for outpatient institutional-care programs for physical disability, mental illness, alcoholism, or drug abuse or drug dependence (paragraph A. 3. a.), for inpatient hospital care (paragraph B. 1. a.), and for home health care services (paragraph A. 3. c.) become inapplicable during that period for those classes of services and care except as otherwise indicated in that column.

(b)(1) In the case of a covered individual who is (or whose family is) in income class 1, with respect to a coverage year, Catastrophic Expense Benefits shall automatically be in effect during the entire year as part of his coverage for Comprehensive Health Care Benefits.

(2) In the case of any covered individual (or his family) in income class 2, 3, or 4, Catastrophic Expense Benefits shall become effective in a coverage year when the sum of creditable expenditures incurred by him, or incurred by him and all other members of his family in the case of an individual who is a member of a family, equals the amount of a special expenditure limit determined as in the table below (or the amount redetermined by the Secretary for that year under section 104).

SPECIAL EXPENDITURE LIMIT TABLE

Income class	Expenditure limit under 65	Expenditure limit 65 and over
2	$250	$125
3	500	250
4	750	375

(3) In the case of an individual and his family who are in income class 5, the special expenditure limit beyond which Catastrophic Expense Benefits are to take effect shall vary according to the level of income, with the exact limit set at 10 percent of the individual's or family's income (as defined in accordance with the regulations prescribed by the Secretary in consultation with the Secretary of the Treasury or his delegate). The income base to which the 10 percent is to be applied shall be rounded to the nearest multiple of $100 (or to the next higher multiple if the amount to be rounded is an odd multiple of $50).

(4) The following expenditures incurred by a covered individual, or incurred by him and other members of his family in the case of an individual who is a member of a family, shall be counted as creditable expenditures in determining under paragraph (2) whether and when Catastrophic Expense Benefits become effective with respect to him in a coverage year:

(A) Expenditures incurred for premiums, or contributions to premiums, for Comprehensive Health Care Benefits coverage (for that year) of that individual, or of him and other members of his family.

(B) Expenditures incurred in that year for copayments under Comprehensive Health Care Benefits coverage, and expenditures for copayments incurred in the last 3 months of the immediately preceding coverage year under such coverage.

(C)(i) Expenditures incurred in the coverage year involved for charges for physicians' services, and services of other qualified health professionals and allied health personnel, described in column I of paragraph A.2. of the benefit table, or for outpatient institutional care for physical disability, mental illness, alcoholism, or drug abuse or drug dependence as described in paragraph A.3.a. in that column, or for inpatient hospital care or physicians' services to inpatients described in paragraph B.1.a. or B.2. in that column, if those charges were excluded from coverage under such paragraph solely be-

cause of the applicable limitations in column II of the benefit table on the number of visits per coverage year or on the number of days of care per benefit period, and (ii) like expenditures incurred in the last 3 months of the immediately preceding coverage year and applied toward the applicable expenditure limit or limits under this section for that year.

(5) For the purposes of this section—

(A) expenditures are (whether or not payment is or has been made) deemed to be incurred—

(i) in the case of the individual's contributions to premiums, when payment is due; or

(ii) in the case of copayments, and of charges described in paragraph (4)(C), when the service or item giving rise to the copayment or charge was provided unless payment is sooner made; and

(B) expenditures are deemed to be incurred by a covered individual (unless they are Federal payments) if paid or payable by the covered individual or on his behalf by another person or agency.

REGULATIONS FOR COMPREHENSIVE HEALTH CARE BENEFITS

SEC. 126. (a) In addition to any other regulations and standards with respect to the coverage of Comprehensive Health Care Benefits and the various classes thereof, payment of charges to Health Care Corporations for services and items covered thereby, collection of copayments by carriers as provided in section 121(a), and 132(b) and other matters relating to such benefits, the Secretary shall issue regulations on the matters required by this section. Section 140, relating to regulations affecting the rights and obligations of carriers, shall also apply to regulations under this part.

(b) The Secretary shall issue regulations amplifying the provisions of the benefit table with respect to Health maintenance benefits covered by paragraph A. 1. of the benefit table and in particular shall—

(1) in the light of the special emphasis of this Act on the obligation of Health Care Corporations for health maintenance, prescribe the coverage of Comprehensive Health Care Benefits with respect to periodic health evaluation as comprehensively as resources of facilities and personnel will permit and with a view to keeping in step with modern developments in this field, and in this connection consider—

(A) insofar as the frequency of evaluations for particular age groups is concerned, the provision of one appropriate evaluation per coverage year for individuals aged 65 or older, one every second year for those aged 19 to 64 inclusive, and one every five years for those aged 5 to 18 inclusive; and

(B) insofar as the components of such evaluations are concerned, including in such coverage, as the Secretary may deem medically appropriate and practicable for the different age, sex, and other patient groups, regularly scheduled complete histories, blood tests, serologies, urinalyses, and other appropriate chemical laboratory tests, chest X-rays; electrocardiograms; Papanicolaou smear tests; rectal and proctoscopic examinations; glaucoma tests; and hearing tests; and

(2) issue regulations with respect to the coverage of paragraph A. 1. e. of the benefit table for vision services.

(c) The Secretary shall issue standards and other regulations with respect to coverage under paragraphs A. 2. and A. 3. and paragraph B. of the benefit table, and in particular shall—

(1) define the physicians' and other services, and the drugs and other items, that are to be covered as benefits under paragraph A. 3. a. of the benefit table in outpatient institutional-care programs for physical disability, mental illness, alcoholism, or problems of drug abuse and drug dependence, including considerations of appropriate transportation services for those who are physically disabled, and set forth such criteria for these benefits as will encourage the establishment and use of such programs on a sound basis and lessen the need for inpatient treatment of these conditions; and waive, or provide for the waiver, of copayments in such programs for the treatment of drug abuse and drug dependence to the extent that the Secretary finds that such waiver is desirable in order to encourage the use of these programs by persons who are in need of such treatment;

(2) for the purpose of coverage of drugs under paragraph A. 3. b. (i) of the benefit table, establish and keep current, on the basis of determinations of the Secretary with respect to the safety and efficacy of the drugs involved—

(A) a list of the categories of drugs that the Secretary finds to be appropriate for the treatment of diseases or conditions requiring drug therapy of such duration and cost as commonly to impose financial hardship; and

(B) a list that (i) designates diseases and conditions, requiring intensive drug therapy (with drugs other than those listed under subparagraph (A)), which the Secretary finds to be of especial importance to the public health, and (ii) specifies with respect to each such disease or condition the category of drugs which the Secretary finds to be appropriate for the treatment thereof;

(3)(A) designate prosthetic devices (including such devices not included under section 1861(s) of the Social Security Act and including hearing aids) to be covered under paragraph A. 3. b. (ii) of the benefit table, and (B) prescribe the conditions for coverage of durable medical equipment (as described in section 1861(s) of the Social Security Act) under paragraph A. 3. b. (iii) of that table (including criteria for determining whether payment for expensive purchased equipment shall be made on a rental-equivalent basis);

(4)(A)(i) prescribe regulations for determining what is to be counted as a visit in the case of physicians' services covered under paragraph A. 2. a. of the benefit table and physicians' services covered under paragraph B. 2. of the table; (ii) prescribe regulations (I) exempting from the limits on the number of visits under paragraph A. 2. a. of the table physicians' services preceding or following inpatient care in cases (such as surgery, or pregnancy and obstetrical care) in which a single combined charge is made, by the provider involved, for any outpatient and inpatient services, and (II) providing for copayments in such case in an amount equal to a percentage of the combined coverage charges for outpatient and inpatient physicians' services as specified in column II of paragraph B. 2. of the table; and

(5) prescribe regulations, referred to in column II of paragraph A. 3. c. of the benefit table, with respect to the nature and number of visits to be counted for home health services coverage purposes.

PHASING OF ADDITIONAL BENEFITS

SEC. 127. The Secretary shall submit to Congress recommendations for the expansion of benefits after the program is in operation as specified in section 302. The Secretary shall give special consideration to the expansion of benefits for dental and vision services based on the availability of resources.

OTHER DEFINITIONS

SEC. 128. For the purposes of this Act:

(a) The term "drug" means a drug within the meaning of section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, as now in force or as hereafter amended, including any product of a kind subject to licensing under section 351 of the Public Health Service Act.

(b) The terms "extended care services" and "nursing home care" mean, respectively, services and items specified as such in regulations of the Secretary (including, in the case of extended care services, the services specified in section 1861(h) of the Social Security Act) for the respective classes of institutions, if the services are—

(1) furnished to patients who require active inpatient treatment but are not in an acute phase of illness and who currently either require primarily convalescent or restorative services or require primarily health-related custodial care;

(2) furnished under arrangements for the transfer of patients among inpatient care facilities as medically appropriate; and

(3) furnished by an institution which (A) meets the requirements of paragraphs (1) through (9) of section 1861(j) of the Social Security Act (defining the term "skilled nursing facility" for purposes of title XVIII of that Act), (B) meets such other conditions relating to the physical facilities or to the safety or quality of care of patients as the Secretary may by regulation prescribe for the respective classes of institutions, and (C) is not an institution primarily for the care and treatment of mental illness or tuberculosis.

(c) The terms "skilled nursing care" and "supervision for palliative or terminal care" means that component of comprehensive health care which—

(1) is furnished to a patient who has a non-curable disease diagnosed by a physician (as defined in section 1861(r)(1) of the Social Security Act) as still requiring medical or nursing care (or both), for palliation or as terminal care, through extended care services or nursing home care or home health care services or physicians' home calls;

(2) has the purpose of maintaining the well-being of that patient to the maximum degree possible; and

(3) involves a patient who either—

(A) is bedridden, or unable to get into and out of bed without assistance, or

(B) requires nursing care procedures (such as complicated dressing, irrigations, or intravenous medications) that cannot be performed by the patient or by nonnursing personnel (such as a family member or companion), or

(C) experiences frequent episodes of sudden acute illness requiring emergency treatment that cannot be controlled by medication (such as uncontrolled diabetes, epilepsy, paroxysmal tachycardia, or fibrillation), or

(D) requires constant physical restraints to prevent injury to himself or others (as in the case of senile patients or patients who suffer from certain mental illnesses).

(d)(1) The term "home health care services" means (subject to paragraph (3)) the three different concentrations of health care services furnished to an individual in his home or place of residence by an affiliated hospital, home health agency, or outpatient center specified in paragraph (2) if—

(A) they are furnished to an individual who is under the care of a physician;

(B) they are furnished by a Health Care Corporation either directly or through the home care department of an affiliated hospital provider or through an affiliated provider that is a "home health agency" as defined in section 1861(o) of the Social Security Act (but not excluding an agency or organization that is primarily for the care and treatment of mental illness);

(C) they are furnished under a plan, established and periodically reviewed by a physician, for furnishing them to the individual; and

(D) they are, except as otherwise provided in paragraph (2), furnished on a visiting basis in a place of residence used as the individual's home.

(2) The different concentrations of home health care services referred to in paragraph (1) are—

(A) intensive home care services, the fur-

nishing of which involves the professional coordination by a registered nurse of a complex of health services, under medical direction, that may include—

(i) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(ii) physical, respiratory, occupational, or speech therapy;

(iii) medical social services by referral of a physician;

(iv) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(v) diagnostic and therapeutic items or services, furnished by a hospital or outpatient center, which are ordinarily furnished to inpatients of the hospital, to the extent they are medically appropriate and it is feasible to provide them to patients in their homes;

(vi) drugs, medical supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of inpatients, to the extent they are necessary to carry out the physician's plan of treatment for the patient and it is feasible to provide them to patients in their homes;

(vii) such physicians' services in the hospital or outpatient center (such as those of radiologists and pathologists) as are held out as generally available to all inpatients of a hospital and which are charged for by the hospital or outpatient center as part of its services;

(viii) medical services provided by an intern or a resident-in-training in a provider institution to a patient in his place of residence or an outpatient center; and

(ix) ambulance or other special transportation services when other methods of transportation are contraindicated by the patient's condition to transport the patient from a provider institution to his place of residence or from his place of residence to a hospital or outpatient center to receive services the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his place of residence;

(B) intermediate home health care services, including the following items and services provided either directly or through an affiliated home health agency provider as specified in paragraph (1)(B):

(i) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(ii) physical, occupational, or speech therapy;

(iii) medical social services under the direction of a physician;

(iv) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(v) medical supplies (other than drugs), and the use of medical appliances and equipment, while under the plan referred to in paragraph (1)(C);

(vi) medical services provided by an intern or resident-in-training in an affiliated home health agency provider; and

(vii) any of the foregoing items and services—

(I) which are provided on an outpatient basis, under arrangements made by the Health Care Corporation or home health agency referred to in paragraph (1)(B), at a hospital, skilled nursing facility, or rehabilitation center, and

(II) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in the place of residence referred to in paragraph (1)(D); or which are furnished at that hospital, facility, or center while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service except ambulance service when other methods of transportation are contraindicated by the patient's condition, and only to the extent provided in regulations; and

(C) basic home health services, which are furnished either directly or through an affiliated home health agency provider as specified in paragraph (1)(B) to individuals requiring "palliative and terminal care", including the following:

(i) part-time or intermittent nursing provided by or under the supervision of a registered professional nurse;

(ii) medical social service including counseling;

(iii) part-time or intermittent home health aide services assigned and supervised by a registered professional nurse; and

(iv) medical supplies (other than drugs), and the use of medical appliances and equipment, while under the plan referred to in paragraph (1)(C).

(3) Notwithstanding the provisions of paragraphs (1) and (2), the term "home health care services" does not include any item or service if it would not be included under "inpatient hospital care" (as defined in subsection (e)) if furnished to an inpatient of a hospital.

(e) The term "inpatient hospital care" means the following items and services furnished to an inpatient of a hospital and, except as otherwise specified, by the hospital:

(1) Bed and board.

(2) Such physicians' services in the hospital (such as those of radiologists and pathologists) as are held out as generally available to all inpatients of a hospital and which are charged for by the hospital as part of its services.

(3) Such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients.

(4) Such other diagnostic or therapeutic items or services, furnished by the hospital, as are ordinarily so furnished to inpatients of the hospital.

(f)(1) The term "physician" means, except when otherwise specified, a physician as defined in section 1861(r) of the Social Security Act.

(2) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls.

(3) The term "attending physician" means, with respect to a patient, the physician having primary responsibility for the patient's medical care.

PART C—CARRIERS FOR COMPREHENSIVE HEALTH CARE BENEFITS

DEFINITION OF "CARRIER"

SEC. 131. As used in this Act, the term "carrier" means—

(1) a voluntary association, corporation, partnership, or other nongovernmental organization that is engaged in providing, paying for, or reimbursing the cost of, health care under insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of predetermined premiums or other periodic charges payable to the carrier; and

(2) a Health Care Corporation approved by a State Health Commission under a State plan approved by the Secretary under this Act, to the extent that the corporation charges for covered health care on an annually predetermined capitation basis in accordance with section 246(b).

DETERMINATION OF QUALIFIED CARRIER; HEALTH CARD

SEC. 132. A carrier is a qualified carrier for the purposes of this Act if—

(1)(A) the carrier is authorized to operate health benefit prepayment plans or insurance at group rates in each State for whose residents it provides, or proposes to provide, coverage under this Act, is in compliance with section 133, and meets such additional standards as the Secretary may establish, including, in the case of contracts with the Secretary under sections 102 and 106, any special standards established for the purposes of those sections; and

(B) with respect to coverage for which a premium contribution by the Secretary is requested under section 102(c), the carrier agrees to accord to the Secretary and his agents the same rights to information and access to the carrier's records as is required to be accorded to them under section 141; and

(2) the carrier provides, consistent with section 212(b)(6), that—

(A) an account will be established against which a covered individual may charge the cost of obtaining items and services covered under this Act, without regard to the copayment requirements applicable under this Act;

(B) payment for items and services covered under this Act, other than emergency services, will be made only on the basis of charges against that account;

(C) payment will be made on the basis of charges against the account for items and services covered under this Act at the applicable payment rates; and, unless the account is in default, payment will be made to participating providers for all items and services, without reduction on account of the copayment requirements applicable under this Act and the covered individual will be billed the portion of any payment properly chargeable to him on account of those copayment requirements; and

(D) credit will be available with respect to any bill submitted to a covered individual pursuant to subparagraph (C) and interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary, with no recovery being made from any individual or entity to whom payment has been made because of the failure of a covered individual to pay any such bill; and an account will not be regarded as in default unless payment of amounts due under the account, or any other such account established with respect to the covered individual pursuant to the requirements of this title, is 90 days in arrears.

REQUIREMENT THAT CARRIERS PARTICIPATE UNDER STATE PLANS

SEC. 133. A carrier shall not be qualified for award of a contract with the Secretary under section 102 or 106 or for issuance of Comprehensive Health Care Benefits coverage eligible for a premium subsidy under section 102(c), unless the carrier agrees, if required by the appropriate State Health Commission (or its delegate agency) of a State, to participate in a coverage pool in accordance with provisions therefor contained in the State plan pursuant to section 234(b)(7), or unless the carrier is in fact such a participant.

CONDITIONS OF APPROVAL OF CARRIER CONTRACTS OR PLANS FOR FEDERAL PREMIUM SUBSIDY

SEC. 134. The Secretary shall, for the purpose of any premium contribution under section 102, approve an insurance contract or prepayment plan of a carrier (including such a contract or plan under State plan provisions referred to in section 234(b)(7) only if the insurance contract or prepayment plan—

(1) is in conformity with applicable regulations and standards prescribed under the State plan (approved under part C of title II) of the appropriate participating State;

(2) provides for 12-month coverage terms;

(3) does not permit any exclusion from, or limitation with regard to, coverage of an

individual because of health status (pre-existing, current, or future), economic status, race, sex, occupation, age, or establishment of any other condition inconsistent with regulations of the Secretary, but this paragraph shall not be construed to preclude reasonable classification of risks for premium rate purposes in accordance with actuarial principles; and

(4) contains such provisions as the Secretary may prescribe or approve relating to coordination of the coverage under the insurance contract or prepayment plan involved with overlapping or duplicative coverages under other insurance contracts or prepayment plans.

CONTRACTS WITH HEALTH CARE CORPORATIONS ON CAPITATION BASIS

SEC. 135. In the case of a Health Care Corporation that operates on the basis of predetermined capitation charges (approved by the appropriate State Health Commission), the Secretary may, if satisfied as to the corporation's financial responsibility to qualify as a carrier for itself under this section, provide the coverage for Comprehensive Health Care Benefits under this Act to which registrants of the corporation are entitled under section 102(b), by entering (directly or through the State Health Commission as the Secretary's agent as authorized by section 217(b)(2)) into a contract with the corporation, whereby the Secretary, in consideration of the corporation's undertaking to provide (or, when authorized under part D of title II, pay for) the services and items covered by such benefits, agrees that there shall be paid by the Secretary to the corporation, with respect to those registrants of the corporation who enroll under the contract, the same amounts that a third-party carrier would be required to pay under a contract with the Secretary, except that a contract under this section—

(1) shall authorize the Secretary in the case of a Health Care Corporation that does impose separate charges equivalent to copayments in addition to capitation charges, to deduct, from any capitation payments otherwise payable by the Secretary to the corporation on behalf of an individual enrolled under the contract, the value (as determined on the basis of actuarial principles) of any copayments to which the covered registrants would be subject under part B of this title if the corporation imposed separate charges equivalent to copayments;

(2) shall not, in the case of a Health Care Corporation that imposes separate charges equivalent to copayments in addition to capitation charges, undertake to pay those charges to the corporation;

(3) shall provide that the corporation shall itself collect from a registrant (or from others on his behalf) all copayments and premium contributions (in the form of capitation charges) payable by the registrant, and shall keep for the registrant the record of such copayments and contributions incurred by him (or his family) and notify him when he has reached the applicable expenditure limit under section 125 giving rise to Catastrophic Expense Benefits; and

(4) shall require the corporation to establish, in accordance with regulations or with provisions in the contract, effective procedures (through such means as establishment of a separate record and payment center and issuance of identical membership cards to all its registrants, regardless of whether they have benefit coverage purchased by the Secretary) that will prevent persons who furnish health services or items for the corporation from identifying those registrants who enjoy coverage purchased by the Secretary and discriminating against them on that account.

Any reference in this part to premiums, or contributions to premiums, shall be deemed to include capitation amounts paid by the Secretary, or contributions to capitation charges by registrants, respectively, under contracts made under this section.

EFFECT OF NONPAYMENT OF PREMIUMS

SEC. 136. (a) Premium contributions and special premiums payable pursuant to section 106, by individuals referred to therein who are enrolled under a contract under this title, shall be paid by or on behalf of the registrant to the carrier (from sources other than the Secretary) in periodic installments in advance in a manner and at the time or times prescribed in regulations of the Secretary but not less often than quarterly nor more often than monthly.

(b) In the event of nonpayment of a contribution or special premium installment, when due, to the carrier by or on behalf of an individual, the benefit coverage to which the overdue installment relates shall, upon notice by the carrier in accordance with regulations of the Secretary, end unless payment is made prior to the expiration of a grace period (not in excess of 90 days) prescribed by the regulations, except that (1) the manner and order of termination of coverage of family members in the event of partial delinquency or default in family contribution installments payable under section 106 shall be determined in accordance with regulations, (2) delinquency or default in contribution installments under section 106 shall not affect the coverage of any family member who has attained the age of 65, and (3) delay in payment shall not give rise to termination of coverage if attributable to an act or omission of a Federal officer or employee used as a conduit for transmitting such installments.

ENROLLMENT UNDER CONTRACTS WITH CARRIERS

SEC. 137. (a) The Secretary may by regulations consistent with other provisions of this Act, prescribe the time or times at which, the manner in which, and the conditions under which individuals may (1) enroll, under a contract made under this part, for Comprehensive Health Care Benefits coverage purchased by the Secretary to which under section 102 they are entitled, or (2) change enrollment under one contract to enrollment under another.

(b) The regulations under this section shall permit enrollment by an individual for himself only, or for himself and his spouse and other individuals who are members of his family (as defined in section 105(b)), and shall prescribe the times at which, the manner in which, and the conditions under which a change from one such type of enrollment to another may be made. An individual enrolling for himself and family shall be liable for any premium contributions on which entitlement to family coverage is conditioned.

(c) To the optimum extent, (1) open enrollment periods under this section and open periods for registration with Health Care Corporations approved by State commissions under approved State plans under this Act shall be closely coordinated, to the end that registration and enrollment, and changes therein, may be effected concurrently, and (2) registration centers of Health Care Corporations shall function also as centers at which to apply for, and obtain information concerning, enrollment.

REPORTS BY AND AUDITS OF CARRIERS

SEC. 138. Consistent with section 212(b)(6), each contract with a carrier under this title, including contracts with Health Care Corporations qualifying as carriers and contracting with respect to their registrants, shall require the carrier to make such reports, in such form, and containing such information as the Secretary or his agents may require to carry out their functions under this Act, and to keep such records and afford such access thereto as the Secretary or his agents may find necessary to assure the correctness and verification of the reports and otherwise to carry out its functions under this Act.

JURISDICTION OF COURTS

SEC. 139. The district courts of the United States shall have original jurisdiction, concurrent with the Court of Claims, of a civil action or claim against the United States founded on this part.

PROSPECTIVE REGULATIONS

SEC. 140. Regulations, amendments to regulations, or amendments to this Act, issued or enacted during an annual contract term under this title, shall not, to the extent that their application would increase the obligations or adversely affect the rights of the contracting carrier, apply to that contract until the next contract year unless made applicable by the contract or by amendment thereto.

TITLE II—REORGANIZATION OF NATIONAL HEALTH SERVICES

SHORT TITLE

SEC. 200. This title may be cited as the "National Health Care Services Reorganization Act".

PART A—DEPARTMENT OF HEALTH

ESTABLISHMENT OF DEPARTMENT

SEC. 201. (a) There is established at the seat of government an executive department to be known as the Department of Health (hereinafter in this Act referred to as the "Department"). There shall be at the head of the Department a Secretary of Health (hereinafter in this Act referred to as the "Secretary"), who shall be appointed by the President, by and with the advice and consent of the Senate.

(b) There shall be in the Department an Under Secretary, who shall be appointed by the President, by and with the advice and consent of the Senate. The Under Secretary (or, during the absence or disability of the Under Secretary, or in the event of a vacancy in the office of Under Secretary, an Assistant Secretary or the General Counsel, determined according to such order as the Secretary shall prescribe) shall act for, and exercise the powers of, the Secretary during the absence or disability of the Secretary or in the event of a vacancy in the office of Secretary. The Under Secretary shall perform such functions as the Secretary shall prescribe from time to time.

(c) There shall be in the Department seven Assistant Secretaries and a General Counsel, who shall be appointed by the President by and with the advice and consent of the Senate, and who shall perform such functions as the Secretary shall prescribe from time to time.

(d) There shall be in the Department a Chief Medical Officer who shall be appointed by the President, by and with the advice and consent of the Senate, without regard to political affiliation and solely on the basis of fitness to perform the duties of the position. The term of office of the Chief Medical Officer shall be six years, except that an individual serving as Chief Medical Officer may upon the expiration of his term of office continue to serve until his successor shall have been appointed and qualified.

TRANSFERS TO SECRETARY AND CHIEF MEDICAL OFFICER

SEC. 202. (a) Except as provided in subsection (b), there are transferred to the Secretary all functions of the Secretary of Health, Education, and Welfare under the following laws and provisions of law:

(1) The Public Health Service Act.

(2) The Family Planning Services and Population Research Act of 1970.

(3) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

(4) Section 232 of the National Housing Act (relating to mortgage insurance for nursing homes).

(5) Title XI of the National Housing Act (relating to mortgage insurance for group practice facilities).

(6) The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

(7) Section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

(8) The Controlled Substances Act.

(9) The Act of August 5, 1954 (42 U.S.C. 2001–2004a) (relating to hospital and other health facilities for Indians).

(10) The Act of August 16, 1957 (42 U.S.C. 2005–2005f) (relating to community hospitals for Indians).

(11) Chapter 175 of title 28 of the United States Code (relating to civil commitment and rehabilitation of narcotic addicts).

(12) Chapter 314 of title 18 of the United States Code (relating to sentencing of narcotic addicts to commitment for treatment).

(13) Title III of the Narcotic Addict Rehabilitation Act of 1966 (relating to civil commitment of persons not charged with any criminal offense) and section 602 of such Act.

(14) The Federal Cigarette Labeling and Advertising Act.

(15) The Federal Food, Drug, and Cosmetic Act.

(16) The Federal Hazardous Substances Act.

(17) The Poison Prevention Packaging Act of 1970.

(18) The Fair Packaging and Labeling Act.

(19) The Act of March 2, 1897 (21 U.S.C. 41–50) (relating to tea importation).

(20) The Act of March 4, 1923 (21 U.S.C. 61–64) (relating to filled milk).

(21) The Act of February 15, 1927 (21 U.S.C. 141–149) (relating to importation of milk).

(22) The Federal Caustic Poison Act.

(23) The Flammable Fabrics Act.

(24) The Federal Coal Mine Health and Safety Act of 1969 (other than title IV thereof).

(25) The District of Columbia Medical Facilities Construction Act of 1968.

(26) The Occupational Safety and Health Act of 1970.

(27) The Lead-Based Paint Poisoning Prevention Act.

(28) Titles XVIII, XIX, II, and V of the Social Security Act insofar as such titles relate to the provision of health care services.

(29) The District of Columbia Medical and Dental Manpower Act of 1970.

(30) The Drug Abuse Office and Treatment Act of 1972.

(b) The functions of the Secretary of Health, Education, and Welfare respecting (1) the commissioned Regular Corps and Reserve Corps of the Public Health Service, (2) the administration of section 329 of the Public Health Service Act (relating to assignment of health personnel of the Public Health Service to critical need areas), and (3) the administration and operation of health care delivery facilities of the Public Health Service shall be exercised by the Chief Medical Officer under the supervision and direction of the Secretary of Health.

(c) Within one hundred and eighty days of the effective date of this part the President may transfer to the Secretary any function not transferred to the Secretary by subsection (a) of this section, if the Director of the Office of Management and Budget determines such function (1) relates primarily to functions transferred by such subsection to the Secretary, or (2) otherwise relates to health.

REDESIGNATION OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SEC. 203. (a) The Department of Health, Education, and Welfare, the Secretary of Health, Education, and Welfare, the Under Secretary of Health, Education, and Welfare, the Assistant Secretaries of Health, Education, and Welfare, the General Counsel of the Department of Health, Education, and Welfare, and the Assistant Secretary of Health, Education, and Welfare for Administration shall on and after the effective date of this part be known and designated as the Department of Education and Welfare, the Secretary of Education and Welfare, the Under Secretary of Education and Welfare, the Assistant Secretaries of Education and Welfare, the General Counsel of the Department of Education and Welfare, and the Assistant Secretary of Education and Welfare for Administration, respectively.

(b) Any reference in a law, regulation, document, or other record of the United States to the Department of Health, Education, and Welfare or an office the title of which is redesignated by subsection (a) of this section shall be held and considered to be a reference to the Department of Education and Welfare or to such office as so redesignated.

ADMINISTRATIVE PROVISIONS

SEC. 204. (a) In addition to the authority contained in any other Act which is transferred to the Secretary, the Secretary is authorized, subject to the provisions of title 5, United States Code, relating to appointments in the competitive service and to classification and General Schedule pay rates, to select, appoint, employ, and fix the compensation of such officers and employees, including investigators, attorneys, and hearing examiners, as are necessary to carry out his functions and to prescribe their authority and duties.

(b) The Secretary may obtain services as authorized by section 3109 of title 5, United States Code, but at rates for individuals not to exceed the daily equivalent of the rate in effect for grade GS–18 of the General Schedule, unless otherwise specified in an appropriation Act.

(c) The Secretary may, in addition to the authority to delegate and redelegate contained in any other Act, in the exercise of the functions transferred to the Secretary by this part, delegate any of his functions to such officers and employees of the Department as he may designate, may authorize such successive redelegations of such functions as he may deem desirable, and may make such rules and regulations as may be necessary to carry out his functions.

(d) So much of the positions, personnel, assets, liabilities, contracts, property, records, authorizations, allocations, and other funds employed, held, used, arising from, available or to be made available, in connection with the functions transferred by section 202 as the Director of the Office of Management and Budget shall determine shall be transferred to the Secretary. Except as provided in subsection (e), personnel engaged in functions transferred under this part shall be transferred in accordance with applicable laws and regulations relating to transfer of functions.

(e) The transfer of personnel pursuant to subsection (d) of this section shall be without reduction in classification or compensation for one year after such transfer.

(f) In any case where all of the functions of any office or agency are transferred pursuant to this part, such office or agency shall lapse.

(g) The Secretary is authorized to establish a working capital fund to be available without fiscal year limitation, for expenses necessary for the maintenance and operation of such common administrative services as he shall find to be desirable in the interest of economy and efficiency in the Department, including such services as a central supply service for stationery and other supplies and equipment for which adequate stocks may be maintained to meet in whole or in part the requirements of the Department and its agencies; central messenger, mail, telephone, and other communications services; office space, central services for document reproduction, and for graphics and visual aids; and a central library service. The capital of the fund shall consist of any appropriations made for the purpose of providing capital (which appropriations are hereby authorized) and the fair and reasonable value of such stocks of supplies, equipment, and other assets and inventories on order as the Secretary may transfer to the fund, less the related liabilities and unpaid obligations. Such fund shall be reimbursed in advance from available funds of agencies and offices in the Department, or from other sources, for supplies and services at rates which will approximate the expense of operation, including the accrual of annual leave and the depreciation of equipment. The fund shall also be credited with receipts from sale or exchange of property and receipts in payment for loss or damage to property owned by the fund. There shall be covered into the United State Treasury as miscellaneous receipts any surplus found in the fund (all assets, liabilities, and prior losses considered) above the amounts transferred or appropriated to establish and maintain such fund.

(h) The Secretary may approve a seal of office for the Department, and judicial notice shall be taken for such seal.

(i) In addition to the authority contained in any other Act which is transferred to and vested in the Secretary, as necessary, and when not otherwise available, the Secretary is authorized to provide for, construct, or maintain the following for employees and their dependents stationed at remote localities:

(1) Emergency medical services and supplies;

(2) Food and other subsistence supplies;

(3) Messing facilities;

(4) Motion picture equipment and film for recreation and training; and

(5) Living and working quarters and facilities. The furnishing of medical treatment under paragraph (1) and the furnishing of services and supplies under paragraphs (2) and (3) of this subsection shall be at prices reflecting reasonable value as determined by the Secretary, and the proceeds therefrom shall be credited to the appropriation from which the expenditure was made.

(j) The Secretary is authorized to accept, hold, administer, and utilize gifts and bequests of property, both real and personal, for the purpose of aiding or facilitating the work of the Department.

(k) The Secretary is authorized to appoint, without regard to the provisions of title 5, United States Code, relating to appointments in the competitive service, such advisory committees as may be appropriate for the purpose of consultation with and advice to the Department in performance of its functions. Members of such committees, other than those regularly employed by the Federal Government, while attending meetings of such committees or otherwise serving at the request of the Secretary, may be paid compensation at rates not exceeding those authorized for individuals under subsection (b) of this section, and while so serving away from their homes or regular places of business, 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.

(l) (1) The Secretary is authorized to enter into contracts with educational institutions, public or private agencies or organizations, or individuals for the conduct of research into any aspect of the problems related to the programs of the Department which are authorized by statute.

(2) The Secretary may from time to time disseminate in the form of reports or publications to public or private agencies or organizations, or individuals, such information as he deems pertinent on the research carried out pursuant to this subsection.

(3) Nothing contained in this subsection

is intended to amend, modify, or repeal any provision of law administered by the Department which authorizes the making of contracts for research.

ANNUAL REPORT

SEC. 205. The Secretary shall, as soon as practicable after the end of each fiscal year, make a report in writing to the President for submission to the Congress on the activities of the Department during the preceding fiscal year.

SAVINGS PROVISIONS

SEC. 206. (a) All orders, determinations, rules, regulations, permits, contracts, certificates, licenses, and privileges—

(1) which have been issued, made, granted, or allowed to become effective in the exercise of any function transferred by this part, and

(2) which are in effect at the time this part takes effect,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or repealed by the Secretary, by any court of competent jurisdiction, or by operation of law.

(b) This part shall not affect any proceeding pending at the time this section takes effect before any officer, any function of whom is transferred by this part; but such proceedings, to the extent that they relate to functions so transferred, shall be continued before the Department. Such proceedings, to the extent they do not relate to functions so transferred, shall be continued before the officer before whom they were pending at the time of such transfer. In either case orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this part had not been enacted; and orders issued in any such proceedings shall continue in effect until modified, terminated, superseded, or repealed by the Secretary, by a court of competent jurisdiction, or by operation of law.

(c)(1) Except as provided in paragraph (2)—

(A) the provisions of this part shall not affect suits commenced prior to the date this section takes effect, and

(B) in all such suits proceedings shall be had, appeals taken, and judgments rendered, in the same manner and effect as if this part had not been enacted.

No suit, action, or other proceeding commenced by or against any officer in his official capacity shall abate by reason of the enactment of this part. Causes of action, suits, actions, or other proceedings may be asserted by or against the United States or such official of the Department as may be appropriate and, in any litigation pending when this section takes effect, the court may at any time, on its own motion or that of any party, enter an order which will give effect to the provisions of this subsection.

(2) If before the date on which this part takes effect any officer in his official capacity is a party to a suit, and under this part any function of such officer is transferred to the Secretary, then such suit shall be continued by the Secretary (except in the case of a suit not involving functions transferred to the Secretary, in which case the suit shall be continued by the officer who was a party to the suit prior to the effective date of this part).

(d) With respect to any function transferred by this part and exercised after the effective date of this part, reference in any other Federal law to any officer, any function of whom is so transferred shall be deemed to mean the officer in whom this title vests such function after such transfer.

(e) Orders and actions of the Secretary in the exercise of functions transferred under this part shall be subject to judicial review to the same extent and in the same manner as if such orders and actions had been by the officer exercising such functions, immediately preceding their transfer. Any statutory requirements relating to notice, hearings, action upon the record, or administrative review that apply to any function transferred by this part shall apply to the exercise of such function by the Secretary.

(f) In the exercise of the functions transferred under this part, the Secretary shall have the same authority as that vested in the officer exercising such functions immediately preceding their transfer, and the Secretary's actions in exercising such functions shall have the same force and effect as when exercised by such officer.

CODIFICATION

SEC. 207. The Secretary is directed to submit to the Congress within two years from the effective date of this part a proposed codification of all laws which contain functions transferred to the Secretary by this part.

DEFINITION

SEC. 208. For purposes of this part, the term "function" includes power and duty.

CONFORMING AMENDMENTS

SEC. 209. (a) Section 19(d)(1) of title 3, United States Code, is amended by striking out "Secretary of Health, Education, and Welfare" and inserting in lieu thereof "Secretary of Education and Welfare", and by inserting before the period at the end thereof the following: ", Secretary of Health".

(b) Section 101 of title 5, United States Code, is amended by striking out "Health, Education," in the antepenultimate paragraph and inserting in lieu thereof "Education" and by inserting below the last paragraph the following:

"The Department of Health".

(c) Subchapter II (relating to executive schedule pay rates) of chapter 53 of title 5 of the United States Code is amended as follows:

(1) Section 5312 is amended by striking out "Health, Education," in paragraph (10) and inserting in lieu thereof "Education", and by adding below paragraph (12) the following:

"(13) Secretary of Health."

(2) Section 5314 is amended by striking out "Health, Education," in paragraph (6) and inserting in lieu thereof "Education", and by adding below paragraph (60) the following:

"(61) Under Secretary of Health."

(3) Section 5315 is amended by striking out "Health, Education," in paragraphs (17) and (41) and inserting in lieu thereof "Education", and by adding after paragraph (104) the following:

"(105) General Counsel, Department of Health.

"(106) Assistant Secretaries of Health (7)."

(4) Section 5316 is amended by striking out "Health, Education," in paragraphs (24), (51), (52), and (53) and inserting in lieu thereof "Education".

(5) Paragraph (43) of section 5316 is amended by striking out ", Education, and Welfare".

(6) Section 5317 is amended by striking out "34" and inserting in lieu thereof "36".

EFFECTIVE DATE; INITIAL APPOINTMENT OF OFFICERS

SEC. 210. (a) This part and the amendments made by this part shall take effect ninety days after its enactment, or on such prior date after enactment of this Act as the President shall prescribe and publish in the Federal Register.

(b) Any of the officers provided for in this part may (notwithstanding subsection (a)) be appointed in the manner provided for in this part, at any time after the date of enactment of this Act. Such officers shall be compensated from the date they first take office, at the rates authorized by this part. Such compensation and related expenses of their offices shall be paid from funds available for the functions to be transferred to the Department pursuant to this part.

PART B—FEDERAL ADMINISTRATION OF HEALTH CARE PROGRAMS

FUNCTIONS AND RESPONSIBILITIES OF THE SECRETARY

SEC. 211. (a) The Secretary shall be charged with responsibility for the planning, administration, operation, coordination, and evaluation of all programs transferred to him under part A of this title as well as the health care program under this Act.

(b) With respect to the program under this Act, the Secretary shall be specifically charged with responsibility for—

(1) continuous review of the activities of State Health Commissions;

(2) liaison with all Federal agencies administering health or health-related programs, and with private national accrediting and other agencies concerned with standards of care and qualifications of health personnel, including the approval and listing of certifying bodies;

(3) annual reports, to be transmitted through the Secretary to the President, first to evaluate the progress of State plans and the development of health care corporations, and thereafter to evaluate the national program, including recommendations for legislation, if any; and

(4) dissemination to State governments, and to providers of service and the public, of all pertinent information about the national program, and to State governments, providers of service, and potential sponsors of health care corporations of information concerning the organization and responsibilities of such corporations.

REGULATIONS OF THE SECRETARY

SEC. 212. (a) In addition to regulations specifically required or authorized by this title, the Secretary is authorized to prescribe such further regulations, not inconsistent with law, as he deems necessary to the efficient administration of the title. Regulations shall be issued in accordance with the provisions of section 553 of title 5, United States Code.

(b) In addition to authority otherwise conferred by this title, the Secretary is authorized to prescribe by regulation—

(1) standards for systems of accounting that can provide guidance to State Health Commissions in developing such systems adapted to individual State needs, such systems to determine the reasonableness of the budgets and charges of Health Care Corporations and other providers of health care; and standards for a national system or systems of reporting and billing;

(2) the method or methods to be used, and the elements to be considered, in determining, for the purposes of section 246, the financial requirements of Health Care Corporations and other providers, including—

(A) for such corporations and for institutions—

(i) requirements for direct and indirect expenses for patient care services, including such services to indigents with respect to whom payment by or for the patient is waived in whole or in part by the corporation or institution, but reduced by the amount of any grants (including income from endowments) earmarked by the donor or reserved by the governing body of the corporation or institution for payment for such services;

(ii) requirements to defray any deficit of approved education or training programs and of approved research programs;

(iii) requirements for minor remodeling of facilities;

(iv) requirements for current operating needs (working capital) or to meet contingencies;

(v) requirements for allowable interest on funds borrowed;

(vi) requirements to meet other operating expenses required to meet standards imposed under this Act, such as patient's education programs;

(vii) requirements of specific price level depreciation to establish and perpetuate a revolving fund to meet ongoing expenditures for the purchase of major moveable equipment;

(viii) requirements of general price level depreciation on other plant and equipment facilities for the maintenance and preservation of the corporation's or institution's assets;

(ix) requirements for prospective accumulation of funds or current payments for construction, replacements, major modernization, or expansion of plant, equipment, and services, for which a certificate of need has been granted, and debt amortization of these projects in those years when the expenditures for those projects exceed the sum of depreciation payments under clauses (vii) and (viii), provided that the corporation or institution makes assurances to the State health commission that the total payments for these financial requirements over the life of the facilities will not exceed their general price level depreciation charges;

(x) requirements for a return (including but at no less a rate than the interest on debt capital) on total assets employed in the provision of institutional health services, with the Secretary determining annually a reasonable rate after consideration of rates of return on investments of comparable risk, and with such rate of return being included as a factor in developing prospective rates in the case of investor-owned institutions, or serving as a basis for developing amounts that will be included in determining the prospective rate or amount for not-for-profit providers in order to give appropriate recognition to the risk assumed under a prospective payment method;

(xi) provisions to assure that grants, gifts, and income from endowments and income earned on grants, gifts, and income from endowments will not be deducted from operating costs when computing reimbursable costs, except that—

(I) if the grant, gift, or endowment income was designated by the donor for paying or subsidizing specific operating costs, it may be deducted from the particular operating costs specified by the donor; and

(II) if the grant, gift, or endowment income was not restricted as to its use and is comingled with other funds, the income from the investment of the grant, gift, or endowment income may be deducted from the interest expense when computing reimbursable costs, but only to the extent that interest expense is not exceeded; and

(xii) provisions to assure that grants, gifts, and income from endowments and income earned on grants, gifts, and income from endowments will not be utilized for facilities or services which have not been granted a certificate of need as provided for in section 236(a)(7); and

(B) for individual providers or groups of providers, all reasonable fees, salaries, or other compensation for needed professional and related services;

(3) standards of quality and standards of safety for all facilities of, and all services furnished by, Health Care Corporations (including facilities of, and services furnished by, affiliated providers or other providers acting under arrangements with such corporations) and other providers; such standards to require, as a minimum, that hospitals, skilled nursing facilities, and home health agencies (including units of Health Care Corporations performing the functions of any such institutions) meet the applicable statutory requirements, pertaining to quality and safety, contained in title XVIII of the Social Security Act, and that other nursing homes meet such of the foregoing requirements as the Secretary finds appropriate;

(4) standards relating to the use of allied health professionals as assistants to physicians and dentists, and relating to the qualifications of such personnel;

(5) standards for the determination of qualified carriers under section 132;

(6) standards relating to confidentiality of information, including standards protecting the rights of patients to the confidentiality of information concerning their clinical and financial status, and permitting disclosure of such information only as specifically authorized by regulations of the Secretary and then only to the extent needed for purposes directly related to the administration of the program;

(7) consistent with section 212(b)(2) and after consultation with providers of services and organizations of such providers, carriers, and other interested parties and organizations, standards for the development by State Health Commissions of prospective payment methods, including (A) review of the provider's budget and its proposed charges (including review and examination of other data and such inspection as may be deemed appropriate); (B) negotiations between the provider and the appropriate carrier or carriers within the State acting on their own behalf and the Secretary's; (C) a system of target rates for groups of providers; (D) a formula approach based on factors such as cost for admission; and (E) other appropriate methods.

NATIONAL HEALTH SERVICES ADVISORY COUNCIL

SEC. 213. (a) There is hereby established a National Health Services Advisory Council (hereinafter in this section referred to as the "Council"), which shall consist of the Secretary, who shall serve as Chairman of the Council, and twenty members, 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 appointed members shall include persons who are representative of providers of health services, and of persons (who shall constitute not less than one-half 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 the 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, paramedical, hospital, or other health activities, or who are representative of organizations or associations of professional health personnel; and 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 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 Secretary for carrying out their respective functions. The Council shall meet as frequently as the Secretary 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 Council (1) to advise the Secretary on matters of general policy in the administration of this title and in the formulation of regulations (including prior review of and comment on such regulations, upon their issuance and upon any subsequent changes therein, before the publication of such regulations or changes in the Federal Register), and (2) to study the operation of this title and the activities of State Health Commissions, Health Care Corporations, and other providers, with a view to recommending any changes in the administration of this title or in its provisions which may appear desirable. The Council shall make an annual report to the Secretary on the performance of its functions, and the Secretary shall transmit the report to the Congress, together with a report by the Secretary 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 Council and members of technical or professional committees, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary but not exceeding the daily equivalent of the rate specified at the time of such service for grade GS-18 of the General Schedule; and while so serving away from their places of residence they shall be entitled to receive actual and necessary traveling expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5, United States Code, for persons in the government service employed intermittently.

STUDIES OF DELIVERY AND FINANCING OF HEALTH CARE

SEC. 214. (a) The Secretary shall make a continuing study of the operation of this title, including the adequacy, quality, and utilization of services furnished by Health Care Corporations and other providers, the effectiveness of peer review and cost controls, the effectiveness of supervision of such corporations by State Health Commissions, the financing of services through insurance and otherwise, and all other aspects of the system of health care created pursuant to this title. The Secretary is authorized, also, to make studies and conduct research in regard to alternative methods of furnishing and financing health care (including methods followed in other countries), and of methods of enhancing, through financial incentives or otherwise, the quality of care and the economy and efficiency of its delivery

(b) The Secretary may carry out his functions under this section directly or through contracts, and he is authorized to make grants to public or other nonprofit agencies or institutions for studies and research which he deems likely to further the purposes of this section.

(c) The Secretary shall from time to time publish the results of studies and research conducted pursuant to this section.

UTILIZATION OF STATE AGENCIES

SEC. 215. (a) The Secretary may, and to the optimum extent determined by him to promote efficient administration of this title shall, make arrangements with State Health Commissions (in accordance with section 234(b)(9)) whereby the commission involved (directly or through arrangements approved by the Secretary with another State agency or agencies) will—

(1) subject to the applicable provisions of part C of title I, contract, as agent and in the name of the Department of Health, with carriers approved by the Secretary, as pro-

vided in paragraphs (1) (B) and (C) of section 217(b); and

(2) from time to time perform such other functions for or on behalf of the Secretary, other than the issuance of Federal regulations and standards, under this title as the Secretary may deem appropriate.

(b) The Secretary shall, in accordance with section 220, pay the State Health Commission the cost of the proper and efficient administration of their functions under arrangements made with them pursuant to subsection (a).

FEDERAL FINANCING RESPONSIBILITIES FOR HEALTH SERVICES

SEC. 216. (a) Notwithstanding any provision to the contrary in title XVIII of the Social Security Act or in any other law, effective with respect to items and services furnished (and periods occurring) on or after the first transitional effective as specified in section 301(b) and before the effective date for full operation of the program under this Act as specified in section 302—

(1) every individual who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act shall be automatically enrolled in the supplementary medical insurance program established by part B of such title (with such coverage period, and subject to such other terms and conditions, as may be prescribed by the Secretary in regulations);

(2) every resident of the United States who is a low-income person or a member of a low-income family (as those terms are defined in section 103(a)(1) of this Act), and who is not otherwise entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act or enrolled in the supplementary medical insurance program established by part B of such title, shall, under regulations prescribed by the Secretary (but without regard to age, insured status, or any other eligibility requirements, or any coinsurance, copayment, or deductible requirements, which might otherwise apply), be provided by the Secretary, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate), with benefits under this Act equivalent to the hospital insurance benefits available under part A of title XVIII of the Social Security Act and the supplementary medical insurance benefits under part B of such title; and

(3) no premium or similar amount shall be payable by any individual for or on account of his enrollment in or coverage under the insurance program established by part B of such title XVIII, or for or on account of the provision to him of benefits under paragraph (2) of this subsection.

There are authorized to be appropriated from time to time to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate) sums equal to (A) the cost of the additional benefits paid from such funds by reason of paragraph (2), and (B) the total premiums which, but for paragraph (3), would be payable by all individuals for or on account of enrollment in or coverage under the insurance program established by part B of such title XVIII or the benefits provided to them under paragraph (2).

(b) Effective with respect to items and services furnished (and periods occurring) on or after the second transitional effective date as specified in section 301(c) and before the effective date for full operation of the program under this Act as specified in section 302—

(1) every individual described in paragraph (1) or (2) of subsection (a) shall be provided by the Secretary (in addition to the benefits provided such individual under subsection (a)) with Catastrophic Expense Benefits coverage under and in accordance with section 125 of this Act;

(2) every resident of the United States who is a medically indigent person or a member of a medically indigent family (as such terms are defined in section 103(a)(2) of this Act), and who is not otherwise entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act or enrolled in the supplementary medical insurance program established by part B of such title, shall, under regulations prescribed by the Secretary (but without regard to age, insured status, or any other eligibility requirements which might otherwise apply), be provided by the Secretary, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate), with benefits under this Act equivalent to the hospital insurance benefits available under part A of title XVIII of the Social Security Act and the supplementary medical insurance benefits available under part B of such title, and in addition shall be provided with Catastrophic Expense Benefits coverage under and in accordance with section 125 of this Act at premium rates determined under section 106; and

(3) any other individual who registers with a Health Care Corporation shall be entitled to the 10-percent premium subsidy under section 102(c).

There are authorized to be appropriated from time to time to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (as may be appropriate) sums equal to the additional costs incurred by such Funds by reason of benefits under this subsection.

(c) There are authorized to be appropriated for each fiscal year beginning on or after the effective date specified in section 302, for the purpose of financing the program set forth in title I of this Act, an amount sufficient to pay (on the basis of estimates for such fiscal year)—

(1) the cost of providing prepaid coverage for Comprehensive Health Care Benefits to persons who are under the age of 65 and are low-income persons or members of low-income families;

(2) the net cost, after deducting the contribution to be required of them, of providing such coverage to persons who are under the age of 65 and are medically indigent persons or members of medically indigent families;

(3)(i) the added cost, resulting from their low incomes or their medical indigence, of providing such coverage to persons who have attained the age of 65 years and who either are low-income persons or members of low-income families or are medically indigent persons or members of medically indigent families, and (ii) the added cost of Comprehensive Health Care Benefits available to those eligible for benefits under part A of title XVIII of the Social Security Act;

(4) the cost of providing the 10-percent premium subsidy under section 102(c) for all individuals who register with Health Care Corporations and purchase Comprehensive Health Care Benefits privately (or for whom such benefits are purchased by private sources);

(5) the cost of providing the subsidy under section 232(c)(1) of the Social Security Act for employers whose costs under the program exceed those specified in such section;

(6) the cost of health benefits provided for individuals receiving unemployment compensation benefits, and for members of their families, as described in section 906 of the Social Security Act;

(7) the cost of establishing or maintaining a reserve equal to 5 percent of the foregoing costs; and

(8) the cost of administration incurred by the Secretary in providing these coverages.

(d) For each fiscal year the Secretary shall estimate the costs referred to in subsections (a), (b), and (c) by projections based upon the costs in the second preceding fiscal year, or (in the case of the first two fiscal years involved) upon the Secretary's estimate of the costs that would have been incurred in such second preceding fiscal year if this title had been in effect. Each projection shall take account of the then current rate of change in the cost of health services, expected changes in the low-income population and the medically indigent population, trends in the utilization of health services, and other factors which the Secretary finds relevant; and, in projecting aggregate contributions to be made by medically indigent persons and families, shall take account of the then current rate of change in the Consumer Price Index.

CONTRACTING AUTHORITY OF THE SECRETARY

SEC. 217. (a)(1) The Secretary shall, through contracts with carriers, provide the prepaid coverage for the benefits to which aged, low-income, and certain other individuals and their families are entitled under section 102.

(2) In addition to the qualifying requirements for carriers specifically set forth in this title, the Secretary may establish further qualifying standards for carriers (or classes thereof).

(b)(1) The Secretary may negotiate and enter into (A) contracts with a carrier or carriers to administer Comprehensive Health Care Benefits for all individuals entitled to benefits under section 102; (B) contracts with qualified carriers which have underwritten a prepayment plan for a Health Care Corporation operating wholly or primarily on a predetermined capitation charge basis; and (C) direct contracts with Health Care Corporations under section 135 if the corporations operate on a predetermined capitation charge basis and as such qualify as carriers.

(2) The Secretary may authorize State Health Commissions to act as his agent in contracting with carriers as described in paragraph (1).

(3) Contracts under this part are exempted from any provision of law requiring competitive bidding and from such other requirements of law as the Secretary may waive. The Secretary is required, however, to notify all potentially qualified carriers a description of the contract requirements he desires and the requirements and provisions of this title and regulations, and to invite these carriers to submit proposals. Among the factors which the Secretary is required under this title to consider in negotiating and approving contracts shall be the carriers' experience with group health insurance or prepayment plan coverage. The Secretary may require the contracting carrier to subcontract with other carriers, and he shall enter into a contract with a combination of carriers only if this does not result in higher administrative costs and only if it best serves the purposes of this title. The term "combination of carriers" or "combination", as used in this section, means (i) a group of qualified carriers that have entered into a joint venture or other cooperative arrangement for the purpose of administering coverage under a contract under this part, or (ii) a corporation (which itself is a qualified carrier) designated or caused to be created by a group of qualified carriers for the purpose stated in clause (1); and any further reference in this part to a "carrier" shall be deemed to include reference to such a combination.

FEDERAL RESPONSIBILITY FOR DEVELOPMENTAL GRANTS

SEC. 218. (a) It is one of the purposes of this part to establish the responsibility of the Secretary to encourage, promote, and assist the establishment, as soon as practicable, of the comprehensive health care delivery system contemplated by this title, by providing financial and technical assistance for

the early planning, development, establishment, and initial operation of Health Care Corporations, including incentives for use of the capitation payment method for health care, for the development and improvement of outpatient care centers, particularly in poverty and rural areas, and for the development of home health care agencies.

(b) There are authorized by the Secretary to be appropriated for each fiscal year, for carrying out the purpose stated in subsection (a), such sums as may be necessary. Sums so appropriated for grants or contracts for any fiscal year shall remain available for obligation until the close of the succeeding fiscal year.

AUTHORIZATION OF DEVELOPMENTAL FINANCIAL ASSISTANCE

SEC. 219. (a) For the purpose stated in section 218, the Secretary is authorized, in accordance with the provisions of this part, to make—

(1) grants for planning, organizing, developing, and establishing Health Care Corporations (or for any one or more of such activities), including affiliation or other arrangements (if any) of such a corporation with providers of health care, in conformity with part D of this title;

(2) contracts, in connection with the establishment or substantial expansion of Health Care Corporations, to pay for a reasonable period all or part of any operating deficits of such corporations;

(3) grants to Health Care Corporations, or to public or nonprofit providers affiliated therewith, for the initial operation of (A) new outpatient care centers, (B) new or expanded services in (or based in) outpatient care centers, or (C) new or expanded home health care agencies; and

(4) grants for major health-maintenance, diagnostic, or therapeutic equipment, data processing systems or equipment, or central-service equipment, needed for initial operating capability of Health Care Corporations.

(b)(1) In making grants and contracts under this part, the Secretary (A) shall take into account existing health care resources and health care delivery systems in the several States, the relative need of the States and areas within the States for such assistance, and their populations, and (B) shall have due regard to the achievement, consistently with the purposes of this title and this part, of an equitable distribution of such assistance.

(2) Not more than 15 percent of the appropriations made for grants or contracts under this part may be expended in any one State.

(3) In making grants and awarding contracts during the first five fiscal years for which funds have been appropriated under this part, the Secretary shall give priority to the applications of corporations that (A) operate primarily on the basis of predetermined capitation charges, or (B) are in the process of converting to primarily that basis, or (C) agree to operate on or convert to primarily that basis if awarded such a grant or contract. After that period, the Secretary may award such grants and contracts only to such corporations.

(4)(A) A grant or contract shall not be made or awarded under the preceding provisions of this part when there is in effect, for the State that includes the area involved in the application for such assistance, a State plan approved under part C, unless the State Health Commission has recommended approval of the application and has certified—

(1) in the case of an application for a grant under subsection (a)(1) of this section, that there is need for a Health Care Corporation in the area involved (or of an additional Health Care Corporation if one approved under part C has already been assigned to the area);

(2) in the case of an application for a contract under subsection (a)(2) of this section or section 221, that the applicant (A) is a Health Care Corporation in conformity with section 241(a), and (B) has been approved, or upon the Secretary's approval of the application for the contract will be approved, by the Commission under part D; or

(3) in the case of an application for a grant under subsection (a)(3) or (a)(4), that (A) the Health Care Corporation which is the applicant or involved in the application is in conformity with section 241(a) and has been, or upon approval of the grant application by the Secretary will be, approved by the Commission under part C; and (B) the outpatient care center or services thereof, the home health care agency, or the equipment or system, for which the grant is sought, is needed for the effective discharge of the corporation's functions under the State plan.

(c)(1) In the case of a State for which there is not yet in effect a State plan approved by the Secretary under part C but in which a State Health Commission and a State Advisory Council have been established in conformity with that part, the Secretary shall not make a grant or contract under the foregoing sections of this part unless the Commission, the State planning agency (if any) designated or established for the State as required under section 314(a)(2)(A) of the Public Health Service Act (if it is a separate agency from the commission), and the appropriate areawide health planning agency (if it is different from the State planning agency) have had an opportunity (in accordance with regulations of the Secretary) to review and comment on the application for the grant or contract.

GRANTS FOR STATE PLANS

SEC. 220. (a) In order to facilitate and expedite the submission of State plans to the Secretary pursuant to section 234, the Secretary is authorized to make grants to State Health Commissions for all or part of the necessary cost of developing and preparing such plans, including (but not limited to) the expenses of their State advisory councils consulted in connection therewith, the cost of disseminating to the public and to others information concerning a proposed plan, and the cost of public hearings thereon.

(b) There are authorized to be appropriated for grants under this section such sums as may be necessary for each fiscal year in the period beginning with the fiscal year in which this Act is enacted and ending with the close of the third full fiscal year after this Act is enacted.

(c)(1) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title an amount equal to the Federal percentage of the sums expended for the proper and efficient administration of the State plan. Such payments and payments under grants pursuant to this section may be made in installments (not less often than quarterly) and may be made in advance (on the basis of estimates) or by way of reimbursement, with necessary adjustments on account of prior overpayments or underpayments.

(2) The Federal percentage, for the purpose of paragraph (1), shall be 90 percent with respect to sums expended by a State during fiscal years ending prior to the effective date of the benefit program under this Act (as set forth in sections 101 and 102), 85 percent with respect to sums so expended during the next two fiscal years, and 75 percent with respect to sums expended thereafter; except that with respect to sums expended by the State for proper and efficient administration pursuant to provisions of the State plan contained therein in compliance with section 234(b)(10) the Federal percentage shall always be 100 percent.

FINANCIAL ASSISTANCE UNDER OTHER PROGRAMS

SEC. 221. (a)(1) In administering other programs of financial assistance in the field of health care (including construction of facilities for health care) the Secretary and, on recommendation of the Secretary, other Federal agencies shall to the optimum extent utilize those programs to promote the purposes of this Act.

(2) Notwithstanding any other provision of law, the Secretary may, and such other agencies when requested by the Secretary shall, in the administration of such other programs, give (or require agencies and organizations assisted to give) highest priority to the needs of Health Care Corporations, particularly in areas determined by the Secretary to be urban or rural poverty areas.

(b)(1) The Secretary shall prepare and widely disseminate, through publications and otherwise, information concerning the availability of assistance under this part.

(2) The Secretary may upon request provide advice, counsel, and technical assistance to Health Care Corporations and other interested organizations and agencies in preparing applications, and in meeting the requirements of this part and of the Secretary, for grants and contracts authorized by this part.

PENALTIES FOR FRAUD

SEC. 222. (a) Any individual, provider of health care, carrier, or other person who—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit, or any grant or other payment, under this Act,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his or its initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other person in whose behalf he or it has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for a particular use or purpose and having received it, knowingly and willfully converts such benefit or payment or any part thereof to any other use or purpose,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Any provider of health care or other person who furnishes items or services to an individual for which payment is or may be made under this Act and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any organization, institution, or facility in order that it may qualify as a carrier or a provider of health care for purposes of this Act shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both.

PART C—STATE FUNCTIONS

GENERAL CONDITIONS OF STATE PARTICIPATION

SEC. 231. (a) States will be in compliance with this Act if, and only if, in conformity with the requirements of this part, (1) the

State (A) has accepted the provisions of this Act and created, as a newly constituted and independent establishment within the executive branch of the State government, a State agency for carrying out the responsibilities devolving upon the State under this Act headed by a multimember governing body hereinafter in this title referred to as the "State Health Commission" (or as the "State commission" or the "commission"), and (B) has vested in such agency the exclusive authority on behalf of the State to establish and maintain appropriate standards and requirements for all hospitals, nursing facilities, and other institutional health care facilities in the State and to provide for the licensing of such facilities; (2) there has been established in that agency a State Advisory Council; and (3) there is in effect an approval, by the Secretary, of a State plan submitted by the State Health Commission under section 234 for carrying out the State's responsibilities under this title.

(b) For Federal exercise of State functions in cases of noncompliance by States, see section 238.

STATE HEALTH COMMISSIONS

SEC. 232. (a) The State Health Commission of a State shall be composed of three or five members (whichever number may be authorized under the law of its creation) appointed by the Governor of the State for staggered terms, which shall be renewable. Each term shall be for six years, except as necessary in the case of initial appointments to meet the requirement of staggered terms, and except in the case of a member appointed to fill a vacancy occurring before the expiration of the term of his predecessor. Not more than two members of a three-member commission, nor three members of a five-member commission, shall be members of the same political party. The Governor shall designate one of the members of the commission to serve as chairman.

(b)(1) It is the sense of the Congress that the members of a State Health Commission should be chosen, not primarily from the standpoint of specialized experience in the subject-matter fields within the commission's jurisdiction, but rather with a view to their ability to bring to the affairs of the commission broad gaged, highly qualified, effective, and disinterested policy direction. Persons representative of the health care providers shall not constitute a majority of the membership of the commission.

(2) During his term of membership, no member of the commission shall engage in any other business, vocation, or employment.

(3) The chairman and other members of the commission shall receive salaries at levels comparable to the compensation of the head of a principal executive department of the State.

(4) No member of the commission shall during his term of office be subject to removal except for dereliction of duty, corruption, incompetency, or conviction of a crime involving moral turpitude, or for a cause stated in paragraph (5) of this subsection.

(5) Any individual, while in the employ of or holding any official or contractual relation to or affiliation with a Health Care Corporation or any other corporation or provider of health care under the regulatory jurisdiction of the State commission, while in any manner pecuniarily interested in any such corpoartion or provider, shall be disqualified from being a member, officer, or employee of the commission; except that if such disqualification by reason of pecuniary interest arises otherwise than voluntarily while such individual is such a member, officer, or employee, the individual may be permitted to remain in office or employment if within a reasonable time he divests himself of that pecuniary interest. The preceding sentence shall not apply to membership on the State Advisory Council by an individual who discloses his interest in or relation to a corporation or provider, nor shall it apply to any individual solely because he is a registrant of a Health Care Corporation or a beneficiary member of or subscriber to another provider of health care.

STATE ADVISORY COUNCILS

SEC. 233. The Advisory Council to the State Health Commission of a State, which shall consult with the commission in the development and carrying out of the State plan, shall be appointed by the Governor of the State and consist of (1) persons broadly representative of health care providers (including health organizations) in the State (including but not limited to persons representative of Health Care Corporations when organized and approved, hospitals and other health care institutions, other nongovernmental and public organizations, societies and groups of health professionals, and schools and institutions particularly concerned with education or training of persons in the health professions and ancillary occupations), and (2) not less than an equal number of persons who are representative of consumers of health care and (A) neither are providers nor have a pecuniary interest in the provision of such care, (B) are familiar with the needs of the various segments of the State's population for such care, and (C) are experienced in dealing with problems associated with the provision of such care.

STATE HEALTH CARE PLANS

SEC. 234. (a) In order to be approvable under this part of any year the State plan of any State must—

(1) meet the requirements of subsection (b);

(2) have been submitted to the Secretary by the State Health Commission (constituted and operating in conformity with the preceding sections of this part) at such time and presented in such detail, and contain or be accompanied by such information, as the Secretary deems necessary;

(3) have been prepared in consultation with the State Advisory Council; and

(4) have been submitted to the Secretary only after the commission has afforded to the general public of the State a reasonable opportunity for presentation of views on the plan in the case of submission of the plan for initial approval or for annual renewal of approval after major revision of the plan.

(b) The State plan must—

(1) designate the State Health Commission of the submitting State as the sole agency for the administration of the plan, except as otherwise authorized by this part;

(2) contain or be supported by satisfactory evidence that the commission has the authority to carry out the plan in accordance with this part;

(3) provide for adequate consultation with the State Advisory Council in carrying out the plan;

(4) set forth, in such detail as the Secretary may prescribe, the qualifications for personnel having responsibilities in the administration of the plan;

(5) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan, including (A) methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208(a) of the Intergovernmental Personnel Act of 1970 (Public Law 91-648), and (B) provision for utilization of qualified professional medical personnel (particularly in connection with the development or administration of standards of quality and utilization of health care) and of allied health professionals and other qualified professional staff; but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(6)(A) provide for the designation of preferred service areas by applicant Health Care Corporations in accordance with the requirements of section 245 and for approval in each such area of one or more Health Care Corporations in accordance with section 235;

(B) include, with respect to existing and proposed Health Care Corporations, their affiliated providers of health care, and other such providers, (i) provisions incorporating the requirements of part D of this title, and (ii) the provisions required by section 236;

(C) provide, in accordance with sections 235 and 236, for cooperation with other States in the administration of the plan, and in particular authorize cooperative arrangements with adjoining States with respect to (i) joint service areas and (ii) establishment, admission, and approval of Health Care Corporations for service in such joint areas or for serving separate areas in the cooperating States; and

(D) include a program for completing (i) the initial approval of Health Care Corporations for service in designated areas (including, if necessary to carry out the purpose stated in section 2(c)(2), the creation of governmental Health Care Corporations), and (ii) the initial registration of eligible individuals with such approved corporations, not later than the close of the fourth fiscal year that begins after the calendar year in which this Act is enacted;

(7)(A) include such provisions for effective arrangements or procedures as will assure an opportunity to obtain group coverage for Comprehensive Health Care Benefits at reasonable rates, for themselves or their employees, to all residents of the State who are not entitled to coverage of such benefits purchased by the Secretary, and provide for the effective enforcement of these arrangements and procedures by the commission (subject to review by the Secretary with respect to enforcement of Federal regulations);

(B) provide for regulating the premium rates of carriers issuing group health benefit prepayment plans or insurance contracts for residents of the State (except under contracts negotiated and made directly by the Secretary), except that the plan may—

(i) vest in the State agency primarily charged by State law with regulating the business of insurance in the State, or

(ii) authorize the commission to delegate to that or another appropriate State agency, the function of regulating the premium rates for such prepayment plans or insurance contracts charged by carriers (other than Health Care Corporations acting as carriers for their own registrants);

(C) provide, consistently with regulations and standards of the Secretary relating to Comprehensive Health Care Benefits coverage, for the regulation and supervision of such carriers and such plans and contracts by the commission, including in the case of group coverage for Comprehensive Health Care Benefits the establishment, by the commission, of required standard provisions whereby, in the event of interruption or termination (by death or otherwise) of a covered individual's status as a member of the employee or other group that the plan or contract covers, the individual (or covered members of his family in case of his death) will have the privilege of continuing coverage under the plan or contract for a specified period (not less than 30 days) that the commission deems reasonable; and

(D) provide (subject to any regulation by the Secretary or interpretations thereunder with respect to contracts with carriers or

otherwise with respect to coverage for Comprehensive Health Care Benefits)—

(i) for granting an opportunity for a fair hearing, before the commission, to any approved Health Care Corporation or nonaffiliated provider whose claim against a carrier for payment of charges for services or items furnished to a registrant of the corporation or a nonregistrant covered by the carrier for Comprehensive Health Care Benefits, or for payment of capitation charges with respect to a thus covered registrant in the case of a Health Care Corporation or other comprehensive health care delivery organization operating on a capitation charge basis, has been denied by the carrier in whole or in part, and

(ii) for adjudicating the claim;

(8) provide effective methods and procedures for (A) optimum utilization or adaptation, in the administration of the plan submitted under this section, of (i) such plans as have been or will be developed for the State pursuant to subsection (a) of section 314 of the Public Health Service Act, (ii) the State plan approved under subsection (d) of that section, (iii) any comprehensive plans developed under subsection (b) of that section for regions, metropolitan areas, or other local areas wholly or partly within the State, and (iv) relevant plans developed under any other programs, and (B) coordination (or at the State's option, consolidation in the case of planning at State level) of planning under the plan submitted under this section with ongoing or projected planning activities under those subsections or programs;

(9) provide that, if and to the extent requested by the Secretary, the commission (directly or through appropriate arrangements, approved by the Secretary, with another appropriate State agency or agencies) will perform, for or on behalf of the Secretary, any or all of the following functions:

(A) as authorized by section 215, contract, as agent of the Secretary, with qualified carriers for Comprehensive Health Care Benefits coverage in the State required under this Act to be financed by Federal purchase of such coverage from a carrier;

(B) act as fiscal agent of the Secretary in transactions with carriers (or classes thereof) in the State, including (if and to the extent that the Secretary assumes this function) the collection or receipt, and transmittal to carriers, of premium contributions by beneficiaries of federally purchased Comprehensive Health Care Benefits coverage (or by others on their behalf) when such contributions are required by or pursuant to this Act;

(C) furnish to the Secretary such timely information and prospective estimates as the Secretary may find necessary for developing its estimates of costs and required Government contributions under section 216;

(D) review, and make recommendations with respect to, applications to the Secretary for grants under appropriate sections of part B of this title, and, when requested, review and make recommendations with respect to applications to the Secretary for grants or contracts under other provisions of law administered by the Secretary, act as agent for the Secretary in investigating and certifying compliance with the terms and conditions of such grants or contracts, and make payments from Federal funds thereunder; and

(E) perform such other functions for or on behalf of the Secretary as he may reasonably request;

(10) develop and implement, after appropriate consultation with health care providers and consistent with the regulations of the Secretary, a system or systems of uniform accounting, reporting, and billing to be utilized by providers, carriers, and the commission within the State;

(11)(A) consistent with section 212(b)(6), in cooperation with the Secretary, and in accordance with such methods as may be recommended for the design and implementation of a nationwide cooperative system for producing comparable and uniform health-related information and statistics, function as a center, for the State, for the collection (from Health Care Corporations and other providers, health benefit prepayment plans and private health insurance companies, and other sources), retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, including data on the fiscal operations of such corporations, plans, and companies and including data of the kinds enumerated in section 305 of the Public Health Service Act, and (B) require such corporations and providers, and such plans and companies doing business in the State, to make statistical and other reports of such information and data to the commission;

(12) consistent with section 212(b)(6), provide safeguards that restrict to purposes directly connected with the administration of the plan the use or disclosure of identifying information concerning (A) individuals with respect to whom information is obtained in carrying out the State plan provisions required by paragraph (11), or (B) individuals who are registrants or applicants for registration under this Act or who claim eligibility for Comprehensive Health Care Benefits coverage by a carrier;

(13) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the health-related and economic effectiveness of the activities of the commission and of Health Care Corporations (including their affiliated providers) and other providers under the commission's regulatory authority, including a review and comparative evaluation of data on utilization of health care services (including drugs) provided by Health Care Corporations and other providers;

(14) provide that the commission will make such annual and other reports (including reports of evaluations made pursuant to the provisions contained in the plan in accordance with the preceding paragraph) as the Secretary may from time to time reasonably require, and comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports; and

(15) provide that the commission will from time to time, and in any event not less often than annually, review the plan and submit to the Secretary any modification thereof which it considers necessary.

(c) The Secretary shall approve any State plan and any modification thereof which complies with subsections (a) and (b); except that he shall not grant such approval if the plan or modification or other State law (statutory or otherwise) or the practice of a State licensure or regulatory authority under color of law—

(1) prevents or limits Health Care Corporations (approved by the commission under the plan) or other health care institutions from undertaking to provide covered health care to registrants (and to others at its election) or patients (A) through direct employment of medical or other licensed health care practitioners by the corporation or other nonprofit providers, or (B) through prepaid group practice (as defined by regulations of the Secretary) or other arrangements by the corporation or other providers with such practitioners or groups thereof (whether such arrangements be on a capitation, fee-for-service, or other basis); or

(2) deprives any Health Care Corporation of its right to designate its preferred service area and of its right of appeal for change in such service areas, in accordance with the provisions of this Act; or

(3) disqualifies from service on the governing board of a Health Care Corporation or institutional provider thereof a physician who is on the staff of the Health Care Corporation or such provider or is an affiliated provider of the Health Care Corporation; or

(4) prevents or limits such practitioners from employing or arranging with appropriately trained assistants under their supervision to perform, consistently with standards of the Secretary prescribed under section 212(b)(4), health care functions commensurate with their qualifications and training; or

(5) prevents or limits carriers from offering coverage of health care provided in accordance with paragraph (1), (2), (3), or (4),

unless the Secretary determines, in accordance with regulations issued by him, that the prohibition or restriction is consistent with the purposes of this title.

(d)(1) An approval of a State plan submitted to the Secretary under this part shall, unless renewed, or unless sooner withdrawn or suspended under this part, be in effect for a period of one calendar or fiscal year, whichever the Secretary determines, except that the initial approval may be for the remainder of the fiscal or calendar year then current or, where deemed appropriate by the Secretary, may be made effective until the end of the succeeding year.

(2) For the purposes of this Act, a State with respect to which there is in effect an approval of a State plan by the Secretary under this part, or with respect to which the Secretary is performing the functions that he is authorized to perform under section 238(a) or (c)(4), is a "participating State".

DESIGNATION OF HEALTH CARE AREAS

SEC. 235. (a) As soon as practicable after its organization, the State Health Commission of each participating State shall conduct a study and survey with a view to the approval of service areas for applicant Health Care Corporations as a basis for the issuance of certificates of approval by the commission (in accordance with section 236(a)(3)), with the objective of affording to all the people in the State equal and ready access to the full range of comprehensive health care of high quality provided for in this title and, where practicable, a choice among Health Care Corporations. In making its study and survey, the commission shall give appropriate consideration to (1) the size and distribution of the State's population and the incidence of illness or disease in population groups in different regional, metropolitan, or other local areas (or parts thereof) of the State, (2) existing health care organizations, institutions, or resources for the provision of health care, their potential for sponsoring or participating in the organization of Health Care Corporations, and their distribution in relation to the need for care, (3) local governmental structures, (4) transportation facilities, (5) patterns of organization for the delivery of health care, (6) patterns of use of health care, and (7) other relevant factors. To assist in its study and survey, and especially in connection with its consideration and evaluation of the factors referred to in clause (2) of the preceding sentence, the commission shall set a date by which shall be filed with it applications by Health Care Corporations for certificates of approval for operation in areas defined in the respective applications (or statements of intention, by proposed sponsors of such corporations, to file such applications). No such certificate shall be granted under section 236 until a final regulation has been issued under the last sentence of subsection (c)(1) of this section.

(b) In addition to making the study and survey referred to by subsection (a), and before approving applications for certificates of approval, the commission shall consult with persons representative of the general public, representatives of public and private

hospitals and other health care institutions or their organizations, representatives of the medical and other health care professions, including persons representative of health care practitioners engaged or employed in prepaid group practice, representatives of appropriate State and local governmental agencies, State commissions in adjoining States (where appropriate), and other interested groups and individuals.

(c)(1) After its study, survey, and consultation, the commission shall publish a proposed regulation setting forth its findings and approvals of Health Care Corporations and the service areas proposed, which need not coincide with the areas of existing municipalities or political subdivisions of the State. The commission shall give reasonable public notice of its proposal and of a public hearing or hearings on the proposal and shall, after such hearing or hearings, by final order confirm the regulation or issue a revised regulation.

(2) In carrying out this section the commission may, in accordance with cooperative arrangements referred to in section 234(b)(6)(C), designate jointly with another State or States a service area or areas that include parts or all of such States.

(d) The commission may, either on its own motion or on petition of any interested Health Care Corporation or other interested provider of health care, an interested registrant or organization representing registrants, or any other interested person, amend or repeal a final regulation issued under subsection (c), but final action on a proposal under this subsection may (upon request of an interested person filing objections to the action proposed, specifying with particularity the changes desired, and stating reasonable grounds therefor) be taken only by decision on the record made after reasonable notice and opportunity for a fair hearing.

REGULATORY FUNCTIONS OF STATE HEALTH COMMISSIONS

SEC. 236. (a) For the purposes of part D of this title and of paragraph (6) of section 234(b), a State plan shall, in addition to complying with section 235—

(1) provide for (A) stimulating and encouraging the organization of Health Care Corporations (as defined in section 241(a)) where needed, by (i) giving information and advice to providers of health care and other potential sponsors as to the requirements for organization of such corporations and for commission approval of such corporations for service, (ii) giving technical assistance to sponsors in meeting such requirements, and (iii) in appropriate cases recommending to the Secretary grants or contracts under part A of this title; and (B) in accordance with cooperative arrangements referred to in section 234(b)(6), cooperating with State Health Commission or other States in jointly (or concurrently) or reciprocally admitting and approving Health Care Corporations for service, especially in joint or adjoining service areas of the respective States;

(2) provide for authorizing the incorporation in the State, or admission from other States, of nonprofit corporations and, at the State's option, of governmental corporations that can under the law of the State qualify as Health Care Corporations in accordance with section 241(a), but this function may at the option of the State be vested in an authority of the State other than the State Health Commission if this will not substantially permit the duplication of functions of the commission or impede the objectives of this Act;

(3)(A) provide for evaluation of the application of any corporation (incorporated in or admitted to the State in accordance with paragraph (2)) for approval to operate as a Health Care Corporation in a service area or areas approved by the commission in accordance with section 235;

(B) provide for granting such approval (evidenced by a certificate of approval) if (after reasonable notice and opportunity for hearing to the applicant, to any other corporation which holds or has applied for a certificate of approval for the service area or areas involved, and to the public) the commission finds—

(i) that the applicant qualifies as a Health Care Corporation in conformity with section 241(a) and satisfies the requirements of clauses (2) and (3) of section 241(b),

(ii) that there is need for the facilities and services to be provided by the applicant in the area or areas covered by the certificate,

(iii) if another Health Care Corporation or corporations already holds a certificate of approval for a service area covered by the certificate, that the additional operation of the applicant in that area will be economically feasible and will promote the purpose of giving a choice to registrants as stated in section 2(c)(2), and

(iv) if there is also pending before the commission the application of another Health Care Corporation for approval of its operation in a service area included in the certificate granted to the first-mentioned applicant, that in the review process the two applications have been jointly considered and either (I) that approval is also granted to the other applicant or (II) that for reasons stated in the commission's findings approval to the other applicant is denied; and

(C) provide that any certificate of approval granted by the commission is subject to revocation or amendment in accordance with subsection (c) of this section or upon revision of the approved service area or areas, covered by the certificate, under the provisions included in the State plan in accordance with section 235;

(4) provide, with respect to any service area for which more than one Health Care Corporation is approved and in which the combined capacity of all such corporations is sufficient to serve adequately all residents of the area but in which the separate capacity of one or more (but less than all) of such corporations can serve adequately only a reasonable proportion of the area's residents, for allowing any such corporation (whose capacity is thus limited) to restrict to a number approved by the commission the number of individuals whom it will accept for registration, and requiring the corporation in that event to accept, in such manner as may be required by the commission, residents of the area up to that number for registration on a first-applied first-accepted basis; but the plan shall preclude any action or procedure under this paragraph that does not assure the adequate provision, on a nondiscriminatory basis, of all the benefits of this Act to all the residents of the area who desire to register;

(5)(A) provide for limiting all charges of approved Health Care Corporations and other licensed providers for health services and items to the kinds of charges and the rates that are prospectively approved by the commission. The commission, in accordance with the principles and requirements of sections 212(b)(2), 212(b)(7) and 246, and after consultation with providers of services and organizations of such providers, carriers, and other interested parties and organizations shall develop and make available to providers of services one or more methods of obtaining payment on a prospective basis for services furnished under this Act, with such methods including budget review; negotiated rates; target rates; formula; or any other method consistent with the regulations of the Secretary. Where more than one method is available, providers will have the option of electing to utilize any one of such prospective payment methods. Once a provider elects a particular method, it may not alter its election without prior approval of the commission. Where the commission finds that the number of providers electing a prospective payment method promulgated in accordance with this paragraph is not sufficient to provide an adequate basis for either the operation or evaluation of that method, or that method does not achieve improved results, then the commission shall withdraw that method and allow the electing providers to select another method within 30 days of notice of such withdrawal;

(B) require that the prospective rates established through the methods noted in subparagraph (A) do not (i) make provision for services that are excessive or unnecessarily duplicative, or (ii) take into account any actual or proposed capital expenditures (as defined in regulations of the Secretary) related to construction or rental of health care facilities by or for the provider for which the commission has not granted a certificate of need when required under the plan;

(C) require that charges for physicians' services, such as those of radiologists and pathologists, that are held out as generally available to all inpatients of an institution, be included as part of institutional-service charges and not as separate physicians' services charges (regardless of the method of payment to the physician);

(D) require that the provider's budgets, proposed charges, and other necessary reports be prepared in accordance with accounting principles, consistent with sections 212(b)(1) and 234(b)(10), designed to bring about uniform methods of determining institutional costs and financial requirements; and

(E) provide for granting an opportunity for a fair hearing to any health care provider which is dissatisfied with a decision of the commission with respect to the provider's proposed charges;

(6) provide for effective enforcement, by the commission, of the responsibility of approved Health Care Corporations and other licensed providers to (A) provide the necessary health care and items for which the registrants have Comprehensive Health Care Benefits coverage, (B) assure that such care be of not less than the scope, quality, and comprehensiveness required by this Act, including regulations and standards of the Secretary prescribed under part B of this title, (C) in the instance of Health Care Corporations, perform the functions specified in sections 243 and 244 with respect to services furnished by others to registrants while absent from their place of residence or in emergencies, and (D) in the instance of nonaffiliated providers, perform functions similar to those specified in section 244, as specified in regulations;

(7) prohibit the construction, modernization, or expansion of facilities and services of hospitals, skilled nursing facilities, nursing homes, or other health care facilities, or the establishment of such facilities through rental of major equipment or existing structures, by Health Care Corporations or other providers, except when authorized by a certificate of need by the commission;

(8) authorize the commission in its discretion to adjudicate, at the request of an approved Health Care Corporation or a provider affiliated with it, or a nonaffiliated provider, a controversy between the corporation and the provider with respect to any matter within the regulatory or supervisory authority of the commission;

(9) provide for granting an opportunity for a fair hearing before the commission (A) to any individual who is not accepted for registration by an approved Health Care Corporation of whose approved service area he claims to be a resident; or (B) with respect to a monetary claim by a registrant against a provider or against a carrier under whose prepayment plan the individual is covered for Comprehensive Health Care Benefits, or by a provider or a carrier against the individual relating to the provision of health

care or to such coverage, where the claim has been denied (in whole or part) or is not acted upon with reasonable promptness and the amount in controversy is $100 or more; or (C) to any individual who alleges a substantial failure of the provider with respect to the provider's obligations to provide health care to the individual, and alleges facts showing that the failure is part of a pattern of similar conduct;

(10) provide for review and approval of peer review systems of approved Health Care Corporations and for continuous surveillance over the performance of approved Health Care Corporations in relation to their obligations under this Act, and enforcement of those obligations as provided for in this section; and

(11) provide for review and approval of peer review systems of nonaffiliated providers and for continuous surveillance over the performance of such providers in relation to their obligations under this Act, and enforcement of those obligations as provided in this section.

(b) If a Health Care Corporation or nonaffiliated provider complies with the procedures set forth in sections 1863 through 1865 of the Social Security Act, such provider shall be deemed to meet the standards relating to comparable elements established by this Act and regulations thereunder.

(c)(1)(A) Whenever the State Health Commission determines that there is a failure on the part of an approved Health Care Corporation (whether owing to its own acts or omissions or those of a provider furnishing services on its behalf) to fulfill all obligations assumed by the corporation or placed upon it by this Act, the commission shall by order direct the corporation to take prompt corrective action.

(B) If the corporation, within such reasonable period as may be required by the commission by regulation, requests a hearing on the commission's order and states reasonable grounds for objecting to the decision, the commission shall give the corporation reasonable notice and opportunity for a hearing with respect to the commission's decision and, if a hearing is held, shall on the basis of the record at the hearing render a decision, subject to such judicial review on the record as may be provided by applicable State law. Initiation of a proceeding for judicial review shall not operate as a stay of the commission's decision unless so ordered by the court.

(2) Notwithstanding paragraph (1), where the failure of a Health Care Corporation to comply with its obligations is so gross as in the judgment of the commission to create an imminent hazard to the health of registrants, the commission may give its order immediate effect, subject to later reversal or modification if so determined after hearing or after judicial review.

(3) In addition to the authority of the commission to order corrective action to be taken as above provided, the State plan shall, in the event of a substantial failure of the corporation to fulfill its obligations, empower the commission, after reasonable opportunity for a fair hearing, (A) to revoke its certificate of approval for operation by the corporation and issue for the service area involved a certificate of approval to another Health Care Corporation, or corporations, or (B) in lieu of such revocation, to take effective action (through appointment of a receiver for the corporation or other appropriate means) to bring the corporation into compliance with its obligations and provide its registrants with the health care services to which they are entitled. The order of the commission shall, when final, be subject to judicial review in a State court of competent jurisdiction on the basis of the record before the commission, and the findings of fact of the commission shall, if supported by substantial evidence in the record when considered as a whole, be binding on the court.

(d) The commission is authorized to take corrective action whenever it determines that any provider not affiliated with a Health Care Corporation has failed to fulfill the obligations set forth in this Act, this action to include suspension of payment for services performed under Comprehensive Health Care Benefits. The appeal procedures outlined in subsection (c) shall apply with respect to action taken under this subsection.

JUDICIAL REVIEW

SEC. 237. (a) Any State that is dissatisfied with a final action of the Secretary taken under section 238 (other than subsection (c)(3) thereof) may obtain judicial review of such action by filing, within sixty days after such action, a petition for review with the United States court of appeals for the circuit in which the State is located. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary or any officer designated by him for that purpose. The Secretary shall thereupon file in the court the record of the proceedings on which it based its action, as provided in section 2112 of title 28, United States Code. Upon the filing of the petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record the Secretary may modify or set aside its order.

(b) The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

FEDERAL EXERCISE OF STATE FUNCTIONS IN CASES OF NONCOMPLIANCE BY STATES

SEC. 238. (a) In the case of any State which has not established a State Health Commission in conformity with section 232, and submitted to the Secretary an approvable State plan pursuant to section 234, prior to the third fiscal year that begins after the calendar year in which this Act is enacted, the Secretary may, until such a State plan has been submitted to and approved by him under this title, assume and exercise, through the Department of Health, with respect to the area of that State, those functions which would be required or authorized by this title to be exercised by the State Health Commission of that State if there were in effect a State plan approved under this title, and may utilize for that purpose any funds available under this title for payments for the administration of State plans. In any case in which the Secretary invokes the authority contained in the preceding sentence, any State law or practice that under section 234(c) would preclude approval of a State plan under this title shall be inoperative.

(b)(1) The Secretary shall not finally refuse to approve a State plan submitted to it under this title except after according to the State reasonable notice and opportunity for hearing.

(2) If, at the scheduled expiration of the effective period of approval of a State plan, there is pending before the Secretary an application of the State for renewal of the approval, the Secretary may, by order, temporarily postpone the scheduled expiration date until its decision on the application for renewal.

(c)(1) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Health Commission administering a State plan approved under section 234(c), determines—

(A)(i) that the plan has been so changed that it no longer complies with the provisions of section 234(b), including any provision of this title incorporated therein by reference, or (ii) that in the administration of the plan there is a failure to comply substantially with any such provision;

(B) that there is a failure to comply with any requirement of section 232; or

(C) that the State law or practice is such as, under the provisions of section 234(c), would preclude approval of the plan;

the Secretary shall by order withdraw approval of the plan and withhold further payments under section 220(c) (or, in the Secretary's discretion, suspend approval as to the part or parts of the plan affected by a failure determined under clause (A) or (B) of this paragraph and limit payments to those payable with respect to other parts), until the Secretary is satisfied that there will no longer be any such failure to comply or, in a case described in clause (C), until the plan is approvable under section 234(c), and shall forthwith notify the Commission of the order.

(2) If in the judgment of the Secretary it would better promote the purposes of this title to do so, he may postpone the effective date of his order under paragraph (1) for such reasonable period as he finds appropriate to allow necessary time for compliance with the requirements of this title.

(3) In addition to or in lieu of issuing an order pursuant to paragraph (1), the Secretary may request the Attorney General to institute a civil action by the United States against the State to enforce the requirements of this title.

(4) Whenever the Secretary has withdrawn approval of a State plan pursuant to paragraph (1), he may, with regard to the State involved, exercise the functions and use the funds referred to in subsection (a).

COOPERATIVE INTERSTATE ACTIVITIES AND UNIFORM LAWS

SEC. 239. (a) The Secretary (1) shall encourage and assist the States and their State Health Commissions in carrying out cooperatively with other States their respective functions in accordance with part C, including the making of agreements between States for that purpose with respect to the establishment, admission (into jurisdictions other than those of incorporation), and approval of Health Care Corporations, the establishment of joint health care areas and assignment of such corporations thereto, the exchange of information, and other matters, and (2) shall develop and encourage the enactment of model State legislation in the fields covered by this title.

(b) The consent of the Congress is hereby given to any two or more States to enter into agreements of the kinds referred to in subsection (a), not in conflict with any provision of this Act or regulation of the Secretary thereunder or with any other law or treaty of the United States.

OTHER ADMINISTRATIVE PROCEDURES

SEC. 240. (a) Effective on and after the effective date of part A of title I of this Act, the Secretary is authorized and directed, notwithstanding any provision of title V of the Social Security Act, to provide by regulation for limiting the use (directly or indirectly) of Federal funds under title V of the Social Security Act for personal health services and items (or for reimbursement for expenditures for such services or items) in participating States (as defined in section 234(d)(2) of this Act) in such manner as will avoid to the maximum extent practicable the use of such funds for personal

health services or items for individuals to the extent that these individuals are entitled under section 102(b) of this Act to Comprehensive Health Care Benefits coverage for like services and items.

(b)(1) Section 505(a)(2) of the Social Security Act is amended (A) by striking out "State health agency" the first time these words occur and inserting in lieu thereof "State Health Commission (established in accordance with section 231 of the National Health Care Services Reorganization and Financing Act)", and (B) by striking out "State health agency" the second time these words occur and inserting in lieu thereof "State Health Commission".

(2) The amendments made by paragraph (1) shall, with respect to any State, become effective on the date on which the State becomes a participating State (as defined in section 234(d)(2) of this Act).

PART D—HEALTH CARE CORPORATIONS

INCORPORATION AND STATE APPROVAL

SEC. 241. (a) A Health Care Corporation is a nonprofit private or governmental corporation which (1) is organized for the purpose of furnishing (through its own facilities and personnel or through other providers, nonprofit or for-profit comprehensive and coordinated personal health services to persons registered with the corporation, furnishing personal health services to other persons to the extent authorized by this title, and engaging in educational, research, and other activities related or incidental to the furnishing of personal health services; and (2) provides (or will provide after the period of organization and initial registration) effective and equitable representation, on its governing board, of the registrants with the corporation and of the affiliated institutional and professional providers furnishing services on its behalf.

(b) A Health Care Corporation is eligible, for the purposes of this title, to furnish services in a State only if it is approved by the State Health Commission of the State for operation in an approved service area or areas of the State (under the provisions of the State plan in accordance with sections 235 and 236), upon a finding by the commission (1) that the corporation conforms to the provisions of subsection (a), (2) that it has an adequate organization under professionally competent management and adequate resources in facilities and personnel (including resources available to it through contracts with affiliated providers), to meet the requirements of this part and of regulations prescribed thereunder and requirements prescribed by the State Health Commission, and (3) that it has given assurances (including assurances of financial responsibility), satisfactory to the commission, that in operation it will meet all such requirements.

REGISTRATION WITH HEALTH CARE CORPORATIONS

SEC. 242. (a) A Health Care Corporation shall, in accordance with regulations of the State Health Commission—

(1) register with the corporation all persons (or such number of persons as may be required by the commission pursuant to section 236(a)(4)), resident in the service area approved for it by the commission, who apply for such registration during a period of open registration fixed by the commission, or apply therefor after termination of registration with another corporation pursuant to subsection (e);

(2) make all reasonable efforts, on a continuing basis, to procure the registration of persons resident in the area who, having failed to apply for registration, have been assigned by the commission to the corporation for recruitment; and

(3) within its capacity to furnish services, register with the corporation all persons assuming residency in the approved service area after the end of the period of open registration fixed under paragraph (1).

(b) Within its capacity to furnish services and with the approval of the commission, the corporation may recruit and register persons (whether or not residents of the area) whom it is not required by subsection (a) to recruit or register.

(c) In such cases and such manner as may be specified in regulations of the Secretary, a registrant may effect registration on behalf of his or her spouse and children under 19 years of age.

(d) The corporation shall make available, and shall employ all reasonable means to disseminate throughout its approved service area, full information about its operations, including descriptions of the services it furnishes and places where they are furnished, and including information about the methods and times of registration; and information about the benefit coverages (both those purchased by the Secretary and others) available to residents of the area, and the methods of obtaining such coverage. It shall assist registrants and applicants for registration to establish entitlement to coverage purchased by the Secretary under section 102, and to obtain other coverage as appropriate.

(e) Registration with a Health Care Corporation shall be effective for a period of twelve months, except that a registrant may terminate his registration if he changes his place of residence or for such other cause as may be approved by the State Health Commission.

UNDERTAKING TO FURNISH SERVICES

SEC. 243. (a) A Health Care Corporation shall assume responsibility for making available and furnishing to each registrant with the corporation, and to any other person to the extent required by regulations of the Secretary, all services for which he has Comprehensive Health Care Benefits coverage and which are medically necessary (or, in the case of health maintenance services, medically appropriate). The acceptance of a registration shall constitute an obligation of the corporation to the registrant to furnish all such services, either through the facilities and personnel of the corporation, through affiliated providers meeting the requirements of subsection (b), or through other providers in accordance with subsection (c).

(b) Services may be provided through an affiliated provider who, by contract with the Health Care Corporation, has undertaken (1) to furnish on behalf of the corporation a portion of the services for which the corporation is responsible, and (2) to cooperate and (to the extent practicable) participate in discharging all other responsibilities of the corporation under this part. Affiliated providers may be hospitals, skilled nursing facilities, nursing homes, or home health care agencies (hereafter referred to collectively as "institutional providers"); physicians, dentists, podiatrists, or optometrists; combinations of the foregoing, such as partnerships, clinics, or group practice organizations, which may include appropriate allied health professionals and technical or other supporting personnel; or other providers of kinds designated in regulations of the Secretary. The services of an affiliated provider may, but need not, be furnished exclusively on behalf of one Health Care Corporation. A provider may be affiliated with two or more Health Care Corporations, but in the case of an affiliated institutional provider shall designate one affiliation as the provider's primary affiliation for the purpose of maintaining quality of services, control over the utilization of services, and continuing appraisal of the effectiveness of services.

(c) Drugs, devices, appliances, and equipment may be furnished to outpatients and to home health care patients, and ambulance and other emergency transportation services may be furnished, through providers not affiliated with the corporation, under arrangements which the commission finds assure adequate availability of such items and services. Medical and other services of specialized nature, which the commission in accordance with regulations of the Secretary finds cannot practicably be furnished by a Health Care Corporation or its affiliated providers, may be furnished through arrangements with or referral to other Health Care Corporations or other providers.

(d) The organization of the services furnished by or on behalf of the corporation shall emphasize health maintenance (including health education) of registrants, assure continuity of care and referral of patients to such services and at such time as may be medically appropriate, and to the greatest extent possible provide care on an outpatient basis. All services shall be made as readily available as is practicable to all registrants within the approved service area of the corporation, and the corporation shall (in accordance with regulations of the Secretary) maintain a system of scheduling periodic health maintenance services for each registrant and reminding him thereof. Outpatient care shall be furnished in centers and physicians' offices conveniently accessible throughout the area. Emergency care, including ambulance service within the approved service area of the corporation, shall be available at all times.

(e) The corporation shall as rapidly as practicable develop, by affiliation with existing organizations or otherwise, a system of outpatient care centers throughout its approved service area, utilizing hospital medical staffs and other physicians practicing in the area, and staffing the centers with physicians, appropriate allied health professionals, and other ancillary personnel to furnish primary medical care. To the extent practicable, the corporation shall also furnish through or in conjunction with such centers health maintenance services and community-based services such as home care, medical social services, and the services of well-baby clinics and mental health clinics. Centers shall be so related to institutional or other providers as to assure the availability of necessary laboratory and other diagnostic services, and the ready referral and transfer of patients to facilities providing more comprehensive services when medically necessary or appropriate.

(f) Whenever services for which the corporation is responsible under subsection (a) are furnished by another Health Care Corporation to a registrant who is absent from his place of residence, or are furnished in an emergency by any provider (wherever situated) who is not affiliated with the corporation or acting under arrangements with it, the corporation shall review a report of the services rendered and the charge therefor and shall submit it to the carrier responsible for its payment; or, if it is itself the carrier or is otherwise responsible for payment, shall pay the charge. This subsection shall not be applicable in the case of a registrant who, otherwise than pursuant to arrangement by the corporation, has left his place of residence for the purpose of obtaining health services.

(g) The corporation shall so far as practicable furnish necessary emergency health services to persons not registered with it, and may furnish other services to such persons when it can do so without interference with services to its registrants.

QUALITY OF SERVICES

SEC. 244. (a) A Health Care Corporation shall assume responsibility (1) for the quality of all services furnished by it either through its own facilities and personnel or by providers affiliated or acting under arrangements with it, and for compliance with standards of quality and comprehensiveness prescribed by the Secretary, (2) for maintaining controls upon the utilization of all such services, (3) for continuing appraisal,

through medical audits and otherwise, of the effectiveness of such services, and (4) for identifying problem areas requiring planning for additional services. For these purposes the corporation shall maintain a system (approved by the commission) of comprehensive peer review by a group or groups of physicians (and a group or groups of dentists in the case of dental services) selected from its staff and from affiliated providers and their staffs, embracing services furnished by affiliated providers as well as services furnished directly by the corporation, and shall require similar review by a staff committee or committees of each hospital and skilled nursing facility affiliated with it. The corporations shall, through an appropriate staff committee or committees, maintain a program of continuing professional education of physicians, dentists, and nurses (and, to the extent the corporation deems desirable, of other professional personnel) furnishing services on its behalf.

(b) All medical policies of the corporation shall be established with the advice of physicians, and all dental policies with the advice of dentists. All medical judgments related to health care shall be made by or under the supervision of physicians, and all dental judgments by or under the supervision of dentists.

(c) The corporation shall encourage the participation of physicians in all aspects of its policy-formulation and operation (including budget review and long-range planning), both in administrative and in advisory capacities.

PARTICIPATION OF PROFESSIONAL PRACTITIONERS

SEC. 245. (a) Within the limits of its need for physicians, dentists, podiatrists, and optometrists (hereafter referred to collectively as "practitioners"), and so far as is consistent with the furnishing of the highest practicable quality of care, a Health Care Corporation shall provide opportunity to all practitioners practicing in its approved service area to furnish services on its behalf, either (at the election of the corporation) as members of its professional staff or as affiliated providers. It shall fix, and review annually, the scope of services which each practitioner may so furnish, in accordance with his training, experience, and professional competence as determined, pursuant to rules of the corporation, through peer review of his credentials and performance. A practitioner who desires to enlarge the scope of services assigned him shall be assisted through in-service training in acquiring added experience and professional competence, and his assigned scope of service shall be reconsidered from time to time.

(b) In selecting practitioners to furnish services on its behalf and in fixing the scope of services which each may furnish, the corporation shall not discriminate on any ground unrelated to professional qualifications; but in carrying out the purpose of subsection (a) in its initial recruitment of practitioners the corporation may give preference, as between equally qualified persons, to those who at the time are practicing in its approved service area.

(c) The corporation shall so organize the services furnished by practitioners on its behalf as to meet the purposes of sections 243 and 244. To the extent consistent with such organization it shall permit each practitioner to elect the form or forms of practice (individual office practice, group practice, or other form of practice) in which he wishes to engage.

CHARGES BY HEALTH CARE CORPORATIONS AND OTHER PROVIDERS

SEC. 246. (a) All charges by a Health Care Corporation or other provider for health services shall be made at rates fixed by the corporation or other provider for a twelve-month period and approved by the commission. Rates applicable to a particular fiscal period may be revised before the end of the period only on the basis of events, occurring subsequent to the approval, which the commission finds (1) could not reasonably have been foreseen at the time of approval, and (2) will, if the rates are not revised, impose severe financial hardship on the corporation or other provider.

(b) Such charges shall consist either of an annual amount for each registrant or registrant family (hereafter referred to as a "capitation amount"), or of itemized charges for separate services or units of service. With the approval of the commission, the corporation or other provider may use one method of determining charges for some services or with respect to some registrants and the other method for other services or with respect to other registrants; except that after three years of operation a Health Care Corporation must submit to the State Health Commission a plan to commence two years thereafter for offering capitation rates to its registrants who choose to purchase coverage directly from the corporation. Except for reasonable variations (in accordance with regulations of the Secretary) based on the size and composition of families, capitation amounts shall be uniform for all registrants to whom they are applicable, other than registrants having coverage under contracts purchased by the Secretary.

(c) Charges of the corporation or other provider, by whichever method determined, shall be at rates estimated to be sufficient for the fiscal period to meet the financial requirements of the corporation or other provider, to enable it to fulfill its responsibilities under this part. The financial requirements shall be determined in accordance with regulations, and with systems of accounting, consistent with sections 212(b) and 234(b)(10).

(d) The corporation and the commission, in developing and reviewing the rates to be paid to providers, shall seek to assure that adequate services are available without unnecessary duplication or other excessively costly or excessive services.

CONTINUING PERSONAL HEALTH RECORD

SEC. 247. (a) In a manner consistent with the requirements relating to confidentiality in subsection (d), a Health Care Corporation shall develop, and keep current, a continuing personal health record for each registrant of the corporation, in such form, consistent with regulations of the Secretary, as may be required by the commission for the purposes (1) of making medical histories and other pertinent data readily available to the medical and other staff of the corporation and its affiliated providers, and (2) of enabling the corporation to meet requirements of the commission for gathering and reporting health care statistics, including statistics on the utilization and cost of health services.

(b) The corporation shall, to the greatest extent practicable, equip its facilities, and assure that facilities of its affiliated providers are equipped, for the prompt transmission, to appropriate members of the staffs of all such facilities, of the personal health records of its registrants.

(c) Whenever a registrant with one Health Care Corporation transfers his registration to another such corporation, his personal health record shall be transferred to the latter corporation. To such extent as may be required by regulations of the Secretary, a Health Care Corporation shall make available to other Health Care Corporations, and other providers (not affiliated with it), who furnish emergency or other health services to its registrants, information from the personal health records of the registrants.

(d) Consistent with section 212(b)(6), personal health records, information contained therein, and other information concerning individual registrants or applicants for registration shall be used or disclosed, without the consent of the individual, only (1) in accordance with this section, or (2) for purposes necessary to the administration of the Health Care Corporation, the State plan, or any benefit coverage pursuant to this title. Any person who violates any provision of this subsection shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

PARTICIPATION BY REGISTRANTS; HEALTH EDUCATION

SEC. 248. (a) A Health Care Corporation shall establish methods by which (in addition to their representation on its governing board) registrants may express their views with regard to the policies and operation of the corporation, the health needs of the community, and the need for any modification or expansion of the services furnished by the corporation. The corporation shall take all practicable steps to assure that this opportunity is readily available to all substantial groups (geographic, economic, or other) of registrants, and to the extent practicable, to individual registrants. The corporation shall establish an advisory committee representative of registrants in general, and subcommittees or separate committees representative of any groups whose interests may differ materially from those of other registrants. Through such committee or committees, the corporation shall seek a continuing evaluation by its registrants of its program and performance.

(b) In a manner consistent with the purpose of assuring that individuals are responsible for protecting their own health and for learning to utilize the health services available to them in the most effective manner, the corporation shall undertake a program of continuing health education, with special emphasis directed toward low-income and medically indigent registrants. The program shall be designed and conducted with the advice and participation of representatives of the registrants, for the purpose of overcoming lack of information and correcting misinformation on the part of registrants about personal health matters, encouraging their interest in healthful living, proper nutrition, and the avoidance of illness, and enabling them to make more responsible and effective use of health maintenance services and, when illness occurs, of the diagnostic and therapeutic services available to them. Corporations shall provide, to registrants in need thereof, assistance in overcoming language or educational handicaps in obtaining access to health care. In carrying out this subsection the corporation shall collaborate with governmental and private agencies engaged in communitywide health education.

NONDISCRIMINATION; COMPLAINTS

SEC. 249. (a) In recruitment and registration a Health Care Corporation shall not discriminate on the ground of race, creed, color, national origin, age, sex, occupation, economic status, or condition of health. Subject to such differentiations as are medically necessary or appropriate or are specifically authorized by this title, the corporation and other providers shall not discriminate on any of the foregoing grounds in furnishing services on behalf of the corporation.

(b) The corporation shall establish adequate procedures for the receipt and disposition of complaints by registrants with respect to services furnished them, failure to furnish services or to pay for services furnished by others, or the propriety of charges made by the corporation; and complaints by persons whose applications for registration have been refused. The corporation shall, to such extent and in such form as may be required by the commission, maintain records of such complaints and of their disposition, and shall make such records available for inspection by the commission.

(c) The corporation shall establish adequate procedures for the settlement of disputes with affiliated providers, with other providers having arrangements with the corporation for the furnishing of health care to its registrants, and with nonaffiliated providers.

RESPONSIBILITIES FOR MANPOWER AND FOR RESEARCH

SEC. 250. (a) A Health Care Corporation shall coordinate among its own staff and the staffs of its affiliated providers determination of the needs for the several classes of health personnel, and the recruitment and allocation of such personnel; shall set qualification and performance standards for such personnel, which shall at least equal standards established or recommended by recognized professional organizations; and shall conduct within its own organization and encourage in its affiliated providers such programs of inservice training as it finds necessary or useful in meeting manpower needs, improving the quality of care, and promoting upward mobility within the several health professions and occupations. To the extent permitted by the law of the State in accordance with section 234(c)(4), and consistent with regulations of the Secretary and good professional practice, the corporation shall encourage the use of physician assistants, allied health professionals, and other supportive technical and non-professional personnel, under appropriate professional supervision, to increase the productivity of its medical and dental staff and of affiliated providers and their staffs.

(b) The corporation, in addition to a continuing evaluation of its own performance, shall engage or participate in planning for additional services to respond to identified problem areas and in continuing research concerning the organization and methods of delivery of health services, and concerning their quality, effectiveness, and cost. The results of such research shall be made available to the commission and the Secretary for such dissemination as the commission or Secretary may deem proper.

RECORDS AND REPORTS

SEC. 251. Consistent with section 212(b)(6), a Health Care Corporation shall keep such records, and on behalf of itself and its affiliated providers make such reports to the commission, as the commission, in accordance with regulations of the Secretary, shall require with respect to financial matters, the utilization of services, the results of peer review of quality, and other matters; and shall require that its affiliated providers keep such records and furnish it with such information as may be necessary for this purpose. The corporation and its affiliated providers shall make the records required pursuant to this section available for inspection by representatives of the commission when necessary for the purpose of verification of such reports.

PART E—SPECIAL STUDY OF METHODS FOR MEETING SUPPLEMENTAL CAPITAL NEEDS OF HEALTH CARE CORPORATIONS AND RELATED HEALTH CARE ORGANIZATIONS

FINDING AND PURPOSE

SEC. 261. The Congress finds that existing health care institutions in the United States have traditionally obtained their funding for health resource development from a variety of sources, including philanthropy, Federal grants, third-party reimbursement, borrowing, and local bond issues, with the result that the funding of such institutions has been neither adequate, consistent, coordinated, nor equitably distributed. It is the purpose of this part to provide for the development of a more rational approach for supplying the supplemental capital and other funding needed by the health care industry in order to assure a more rational distribution of funds and thereby to meet more effectively the health care needs of the Nation without causing undue cost to individuals in communities which have the greatest health need.

SPECIAL STUDY

SEC. 262. (a) The National Health Services Advisory Council (hereinafter in this section referred to as the "Council"), established by section 213 of this Act, shall conduct a full and complete study and investigation of methods for supplying supplemental capital and other funding for Health Care Corporations and related health care organizations in the United States, with the objective of developing a national program for supplying such funding, giving special emphasis to areas of high priority health care needs both rural and urban which will effectively carry out the purpose of this part.

(b) In conducting its study and investigation under subsection (a), the Council shall give particular consideration to the utilization of special taxing mechanisms such as a value-added tax, or tax credits, as means of financing comprehensive benefits for beneficiaries of the national program.

(c) In conducting its study and investigation under subsection (a), the Council shall also give particular consideration to the development of a program which—

(1) establishes and utilizes, as its basic source of funds, a national trust fund consisting of any or all of the following: (A) a designated portion of the premiums collected for comprehensive health care benefits coverage, (B) a tax on such premiums or on such premiums and all other premiums paid for health insurance coverage, (C) appropriated funds, and (D) amounts received from other sources, public or private;

(2) provides for the distribution of amounts in the trust fund to State health commissions in a manner reflecting population, per capita income, and health care needs, for allocation by such commissions within their respective States to health care corporations and other health care organizations, in the form of grants, loans, or combined grants and loans, on the basis of per capita income, urgency of health care needs in the light of available or potentially available health care resources, and other factors calculated to assure the concentrated expenditure of the available funds in high need areas;

(3) recognizes the need for adequate planning for health care services and facilities, and makes such planning a condition of assistance;

(4) encourages and facilitates the continuing provision of funds for these purposes from sources other than the trust fund, and effectively coordinates the utilization of the amounts provided from such other sources with the amounts distributed from the trust fund;

(5) leaves to each State health commission, under general regulations of the Secretary, the determination of how the funds distributed to such commission are to be allocated and utilized within the State which it represents; and

(6) contains or is subject to such other provisions, conditions, and limitations as may be necessary or appropriate to assure that the purpose of this part will be effectively carried out.

(d)(1) The Council shall submit to the Secretary, for transmission to the Congress no later than one year after the effective date of this Act as specified in section 301(a), a full and complete report of its study and investigation under this section together with its findings and recommendations and with detailed specifications for any legislation which it finds may be required to carry out such recommendations. The Secretary, in transmitting such report to the Congress, shall include his own comments thereon and his views with respect to the Council's legislative recommendations and specifications.

(2) The special study and investigation conducted by the Council under this section shall be independent of the studies made by the Secretary under section 214; and the report of the Council under this section shall be separate and distinct from its annual report under section 213(c).

TITLE III—EFFECTIVE DATES

TRANSITIONAL EFFECTIVE DATES

SEC. 301. (a) Except as otherwise provided in this section and sections 210 and 302, this Act (including any amendments made by it to existing law) shall be effective upon the date of its enactment.

(b) Sections 211, 216(a), 218, 219, 220, and 221, and parts C and D of title II, shall take effect upon the first January 1 or July 1 which occurs six months or more after the date of the enactment of this Act.

(c) Section 216(b), section 238 (with respect to States which have not complied with sections 232 and 234), and the amendments made by section 101 shall take effect on the first day of the third fiscal year which begins after the date of the enactment of this Act.

FULL OPERATION OF PROGRAM

SEC. 302. The program under this Act shall be fully in operation, and the benefits under part B of title I shall be fully effective and available (in lieu of any benefits which would otherwise be available under title XVIII of the Social Security Act), in accordance with all of the provisions of this Act, on and after the first day of the fifth fiscal year which begins after the date of the enactment of this Act.

GENERAL LEAVE

Mr. ULLMAN. Mr. Speaker, I ask unanimous consent that all Members may extend their remarks on the national health care bill, and to include extraneous matter.

The SPEAKER. Is there objection to the request of the gentleman from Oregon?

There was no objection.

THE TAX AND LOAN ACCOUNT INTEREST ACT

(Mr. SEIBERLING asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. SEIBERLING. Mr. Speaker, the Joint Economic Committee in its recent recommendations for dealing with the economy urged the Federal Government to halt its practice of depositing large amounts of the taxpayers' money in commercial banks without receiving fair compensation. Today, I am introducing a bill for that purpose.

My bill—the Tax and Loan Account Interest Act of 1975—is similar to one I introduced in the first session of the 93d Congress. It would amend the Federal Deposit Insurance Act to terminate the insurance of any bank which fails to pay interest at the Federal funds interest rate on all tax and loan accounts. If enacted, the bill would result in an estimated savings of over $350 million annually to the U.S. Treasury.

Not many people, I imagine, give a second thought to the handling of the social security and income taxes that are withheld from their paychecks. It would come as a shock to many to know that this money does not go directly to the U.S. Treasury, but to "tax and loan accounts" in commercial banks where it sits with-

out earning one cent of interest for the taxpayers until the Government withdraws it. Even more shocking is the fact that the Government allows the banks to invest the taxpayers' money and reap high rates of interest on it, not for the taxpayers but for the banks.

In 1974, the average balance in the accounts amounted to nearly $4 billion, down from previous years—in 1972 it was over $5 billion. If interest had been paid on that amount—minus withholdings for reserve requirements—the U.S. Government would have received between $350 million and $400 million—enough to pay for a year's operation of the Federal Communications Commission, the Securities and Exchange Commission, the Maritime Commission, the Smithsonian Institution, the Secret Service, and the Senate.

At a time when the Federal deficit is running at $23 billion and the acute shortage of mortgage money has compelled Congress to enact a $3 billion emergency home loan bill, the tax and loan account system approaches the outrageous. What the system amounts to is a windfall subsidization of the commercial banking industry in the United States by the Federal Government with the hard-earned money of millions of taxpaying American citizens.

Moreover, the tax and loan account system tends to favor big banks. In 1972, 44 percent of all tax and loan account deposits were held by only 102 of the Nation's approximately 14,000 commercial banks, according to a staff report of the House Subcommittee on Domestic Finance. The study reported that the 50 largest banks held more than one-third of all such deposits, and that $1.7 million was held by 11 American branches of foreign banks.

The study also noted that, despite the concentration of tax and loan account deposits in the 50 largest banks, these banks did not give priority to loans which carry out Federal programs. In the area of lending to small business, for example, the study found that in February 1972, the 50 largest banks had only 3,306 loans outstanding in conjunction with the Small Business Administration, which represents 8 million small businesses throughout the country. These loans totaled only $150 million, and were 90 percent guaranteed by the SBA. The total tax and loan account balance in the 50 banks was over $2 billion.

The primary purpose of the tax and loan account system is to minimize the potentially disruptive effect of Treasury cash operations on the banking system, money markets, and the Nation's economy. It has performed this useful function ever since it was set up in 1917. Ostensibly, the Government has allowed banks to hold the accounts without paying interest to compensate them for various banking services they perform for the Government, including holding the accounts. But the Treasury has no rational method of determining whether the value of the accounts is commensurate with the services provided by the banks. With rising interest rates in recent years, it has become obvious that the banks are being greatly overcompensated.

Last summer, the Treasury Department released the results of a 2-year study of the tax and loan account system which it began in 1972 after years of prodding by the distinguished chairman of the House Banking and Currency Committee, Hon. WRIGHT PATMAN, the GAO and others. The study indicated that the total value of the tax and loan accounts to commercial banks in calendar year 1972 exceeded the value of the services they performed for the Government by over $260 million. At today's higher interest rates, the value of the accounts would be much greater.

Moreover, the Treasury study showed vast discrepancies in the costs reported by banks for performing services for the Government, indicating the lack of a rational relationship between the real value of the services and the costs attributed to them. The costs reported by banks for handling tax and loan accounts, for example, ranged from 1½ cents per transaction to $3.10 per transaction.

This is not a very business-like method for the Government to use in handling the taxpayers' money. The Tax and Loan Account Interest Act would rationalize the system by authorizing the payment of fixed fees for certain banking services, based on a fair assessment of the value of the services. This way, the banks would receive fair compensation for their services while the Government receives fair compensation for the use of its deposits.

Last summer, the Treasury Department promised to send Congress legislation to reform the tax and loan account system, but as yet no such legislation has been received. This is particularly disappointing in view of the current economic situation. Unlike most of the money-saving proposals being debated today, reform of the tax and loan account system seems to be relatively noncontroversial. And we can no longer afford delay in considering measures to improve the Nation's economic health.

I am pleased that the House and Senate Banking Committees are planning to hold hearings on this issue this year, and am hopeful that they will result in a quick end to the tax and loan account boondoggle.

The text of the Tax and Loan Account Interest Act of 1975 follows:

A bill to amend the Federal Deposit Insurance Act to terminate the insurance of any bank which fails to pay a certain rate of interest on all tax and loan accounts.

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 "Tax and Loan Account Interest Act of 1975."

SEC. 2. The second sentence of section 8(a) of the Federal Deposit Insurance Act (12 U.S.C. 1818(a)) is amended by inserting "or fails to pay interest (to the United States) at the Federal funds interest rate on all tax and loan accounts maintained at such bank," immediately before "the Board of Directors shall first give to the Comptroller of the Currency".

SEC. 3. The Secretary of the Treasury may enter into agreements with banks which render banking services to the Federal Government for charges to be made for the banking services which the bank performs on behalf of the Federal Government.

THE NEED FOR A NEW FOOD TECHNOLOGY

(Mr. SEIBERLING asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. SEIBERLING. Mr. Speaker, with the world's population expected to double by the end of the century, many people have begun to wonder whether our existing agricultural resources will be capable of supplying enough food for all of the world's people.

The National Academy of Sciences recently released the results of a 3-year study on this question. The study paints a grim picture for the future unless we embark on the development of new food resources now.

We cannot expect to rely on expanded farm lands or increased fertilizer applications for meeting the food needs of the future, according to the report. There are biological ceilings in nature which will constrict food production based on current food techniques.

The report warned:

For the long-range future, in addition to such controlling influences as climate, increases in agricultural output will depend largely upon research results not yet in hand.

The NAS findings must not be ignored. We must turn our research efforts toward the development of new food technologies and we must make a national commitment to their utilization in fulfilling our own food needs. This commitment may require drastic changes in our current farm production system and our eating habits.

In the 93d Congress, I introduced the Food Research and Development Act to promote the development of new food techniques designed for the future. The bill would provide funds for agricultural innovations such as single-cell protein made from waste materials, irrigation using salt water, methods of enhancing the nitrogen fixation process in plants, methods of separating protein from inedible fibers in plant leaves, and many others including those mentioned in the NAS report.

I am planning to reintroduce a revised version of the Food Research and Development Act shortly. At a time when we are already seeing millions of people throughout the world suffering from hunger and malnutrition, I do not think we can afford to wait any longer before embarking on a crash R. & D. effort to find new sources of food for the future.

For the benefit of my colleagues, an article from the New York Times on the NAS report follows:

RISE IN FARM OUTPUT SAID TO FALTER AS NEED GROWS

(By William Robbins)

WASHINGTON, Jan. 12.—The National Academy of Sciences warned in a "report to the nation" today that the upward trend of farm production was faltering at a time of in-

creasing international concern over food supplies.

At the same time, it cited a long list of "scientific frontiers" where new breakthroughs to higher yields might be found if enough effort and resources were invested in agricultural research.

Among those, it said, are efforts to produce plants with leaf structures that will make more efficient use of sunlight and carbon-dioxide, successful creation of new varieties of plants by crossing their body cells in test tubes rather than through normal reproductive processes, improvements in animal-breeding and technological progress in irrigation technology.

Although "for the next decade or so we think we perceive that the supply of food will be adequate," said the report, which focuses on the longer term, "there are clouds on the horizon that should be noted."

"The tapering trends are warnings of needs for new patterns of thought and indicate that the future may require drastic changes in our farm production system," it said.

The 199-page report, titled "Agricultural Production Efficiency," is the result of a three-year study by a 15-member committee headed by James G. Horsfall of the Connecticut Agricultural Experiment Station.

"We set out with a very simple premise: We could be living on borrowed time," Sylvan H. Wittwer, the chairman of the academy's board on agriculture and renewable resources, which helped guide the committee's study, said at a news briefing.

Both Dr. Wittwer, the head of the Agricultural Experiment Station at Michigan State University, and Marion Clawson, a committee member, said at the briefing that the study showed "we have been too complacent" about food productivity. Mr. Clawson is head of the Land and Water Division of Resources for the Future, Inc., a research organization.

WE NEED COMMITMENT

"We need a national food policy," Dr. Wittwer said. "We need a national commitment." He added that the country also needed a special project on solar energy.

The study cited a number of warning signals indicating a tapering off in the trend towards greater productivity, which increased farm output by 50 per cent between 1950 and 1971.

In the past, it said, reserves of land kept idle under farm programs had created a sense of complacency. But it noted that such acreage had now been returned to use. Any additional acreage would have to be provided through such means as land clearing and drainage or the farming of marginal acreages.

"The relative quality and availability of additional potentially arable lands need careful evaluation," the report said.

A LEVELING-OFF

Meanwhile, it said, "Department of Agriculture data indicate that both the number of persons supplied per farm worker and the number of persons supported per harvest acre are leveling off."

Many of the gains in the past have resulted from increasing applications of fertilizer, but increases in yields available through further expansion of fertilizer use appear to be slight, the study said.

While yields of corn, the major livestock-feed grain, continue to rise dramatically, the report said, recent improvements have been small for most other crops.

"One must conclude that biological ceilings will, at some future date, constitute a severe if not impenetrable barrier to further increases in yields per acre or meat production per unit of feed," he said.

The report warned: "For the long-range future, in addition to such controlling influences as climate, increases in agricultural output will depend largely upon research results not yet in hand."

But it mentioned a number of promising areas for research projects.

One of those is more efficient plant use of sunlight. The report listed efforts to produce plants with leaf structures that would provide increased exposure to the sun.

Plant growth has also been improved by enrichment of the plant atmosphere with carbon-dioxide, the report noted, and it urged research into breeding of plants that would make more efficient use of the carbon-dioxide that is naturally available.

It also described investigations seeking new ways to enrich soils. Legumes, such as peas and beans, have nitrogen-fixing bacteria associated with their root zones. The report noted that efforts were being made both to improve that process and to extend the process to cereals, and thus to produce natural supplements for commercial fertilizer.

CREATION THROUGH CULTURES

In the efforts to improve plant varieties, the report said, new plants have already been created through cell cultures rather than through normal seed processes.

To improve efficiency in animal agriculture, the report placed major emphasis on efforts to increase reproductive efficiency. Among those are attempts to achieve multiple births in beef cattle.

It also stressed research on disease control and on improving the conversion of livestock feed into meat.

Among promising new technologies, it said, is a system called trickle irrigation. The method brings water directly to the roots of plants rather than irrigating their entire environment. This saves water while increasing plant growth, but it is now too costly for other than high-value crops.

Other areas for research suggested were chemicals for improved herbicides and pesticides, improvements in Western rangelands and their more efficient use, as well as a search for new plants, including studies in the qualities of native weeds that might be developed through breeding and mutations.

REVISION OF THE BANKRUPTCY ACT

(Mr. EDWARDS of California asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. EDWARDS of California. Mr. Speaker, it was certainly not in anticipation of the dire economic conditions facing our country today, but in a realization that the existing bankruptcy laws of our country were hopelessly outdated and ill fitted to our modern consumer culture that the Congress created a National Commission on the Bankruptcy Laws of the United States. My colleague, Mr. WIGGINS, and I were privileged to serve as the appointed members of that Commission from the House of Representatives.

The Commission was created by Public Law 91-354 on July 24, 1970. The conditions which prompted the creation of the Commission were: First, the increase in the number of bankruptcies by more than 1,000 percent in the preceding 20 years; Second, the widespread feeling among bankruptcy judges, the bar and the bench, that problems of administration required substantial improvement in the act; Third, the impact on the operation of the act of the vast expansion of credit; and Fourth, the limited experience and understanding of the Federal Government and the Nation's commercial community in assessing the operation of the act.

The Commission was charged with considering the basic philosophy of bankruptcy, its causes and possible alternatives to the present system of bankruptcy administration. The Commission was directed to recommend changes in the act which would reflect and adequately meet the demands of present technical, financial, and commercial activities.

After 2½ years of research, study, public hearings and meetings, the final report of the Commission was filed with the Speaker of the House on July 30, 1973. Part II of that report took the form of a draft of a complete revision of the existing act.

I, along with Mr. WIGGINS, introduced this draft of the proposed new act on October 9, 1973.

The introduction of the proposal of the Commission set off an unprecedented round of activity among groups and individuals interested in the administration of our bankruptcy laws.

Thousands of copies of the Commission's report and H.R. 10792 were distributed throughout the country.

Major and prestigious organizations—such as the National Bankruptcy Conference, the National Conference of Bankruptcy Judges, the Commercial Law League and various interested sections of the American Bar Association, just to list a few—have spent the past 2 years studying the Commission's report and are now completing the formulation of their critique and ideas for consideration in the Congress.

The National Conference of Bankruptcy Judges formulated their own versions of a revision of the Bankruptcy Act and that too was introduced in the 93d Congress on September 12, 1974, as H.R. 16643.

As our studies have gone forward these past few years, rising costs and soaring unemployment have led thousands of our citizens to seek relief from that economically destructive duo, inflation and recession, by filing a bankruptcy court for relief.

Our job now becomes acute as well as necessary. The Administrative Office of United States Courts says that if bankruptcy petitions continue at the current rate—and there is every reason to believe they will increase—there will be a record 231,660 in the fiscal year ending June 30, 1975.

During the first 5 months of fiscal year 1975, an average of 19,325 bankruptcy petitions were filed each month. That is 29 percent more than the monthly average of 14,912 petitions in the same period last year. The previous yearly high was in 1967 when 209,329 individuals and businesses filed petitions in U.S. district courts. The intervening years had seen a slight downward trend until the dramatic reversal this year. In some parts of our country, the filing of bankruptcy petitions is up 50 percent over previous highs.

The total liabilities of firms that failed

in 1974 will almost certainly approach an historic high of $2.5 billion, already running 52 percent higher than 1973.

The bankruptcy trend is continuing, broadening and deepening, crossing all lines of endeavor and business establishments as well as including an historic high number of individuals.

The city of New York recently received, and not in jest, the advice that it should file a petition in bankruptcy.

It is obvious to even a casual observer of our economic scene that the long overdue overhaul of our bankruptcy laws must now be accelerated in order to cope with the expected drain on the present facilities and outmoded procedural and substantive bankruptcy law.

I am today, along with my colleague, Mr. WIGGINS, reintroducing H.R. 10792 and H.R. 16643. These two bills will be the nucleus of our consideration in the months ahead. We will begin hearings on the revision of the Bankruptcy Act early in February, and we hope to bring to the floor of the House a complete revision of the act, tailored to our modern needs, and one able to cope with the exigencies of our present economic troubles as soon as possible.

CRIMINAL JUSTICE INFORMATION SYSTEMS

(Mr. EDWARDS of California asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. EDWARDS of California. Mr. Speaker, the beginning of the 94th Congress occasions the reconsideration of those pieces of legislation on which we were unable to reach agreement in the 93d Congress. Some of this legislation demands, by virtue of its inherent value to our constitutional system, our prompt and unqualified attention. One such bill is that which would regulate and control the security and privacy of criminal justice information systems.

This legislation has a long history beginning in the 92d Congress. Over the past 4 years, the Committee on the Judiciary, particularly the Subcommittee on Civil and Constitutional Rights, has laboriously investigated this issue in its search for that fine balance between law enforcement needs and the right of privacy of the individual. Briefly, I will bring you up to date on the history of our work, so that this Congress will be aware of the depth of interest with which this area has been approached in the past.

In the 93d Congress, I introduced H.R. 13315, which dealt with the security and privacy of arrest records as they were disseminated by law enforcement agencies between themselves and with other organizations who have no law enforcement responsibilities.

It came to our attention that these arrest records, which carry notations of a person's arrest but frequently carry no dispositions, were being used to deny people employment, housing, credit and other necessities around which this society revolves. The abuses that were recorded in our hearings were widespread and affect a greater number of citizens than we had originally contemplated. Within the Subcommittee on Civil and Constitutional Rights of the Committee on the Judiciary, a sensitivity to these abuses developed. One needs to keep in mind that, legally, an arrest is not an occurrence of great significance, yet when given weight in future decisions concerning individuals, the practical significance can be enormous.

At the beginning of the 93d Congress, H.R. 13315 was reintroduced as H.R. 188. The subcommittee once again began a series of hearings on the subject of arrest records. During our consideration of this bill, my colleagues and I on the subcommittee had an opportunity to tour the FBI facilities in Washington, D.C. and the National Crime Information Center—NCIC. During this tour, I was struck with the efficiency with which the FBI could disseminate and retrieve information from the many local law enforcement agencies throughout the country. The records, maintained by the FBI, have been and continue to be prepared for the age of computers. The accuracy and completeness of these records is essential. More importantly, being aware of the quickness of response occasioned by computers, I realized that simple control of arrest records was not sufficient to protect the rights of individuals threatened by a massive system of criminal justice information.

As a vehicle of discussion on the regulation of criminal justice information systems, I introduced H.R. 9783 in 1973. A dialog began on the effect of computerization in the criminal justice area. Our investigation started with a scrutinization of the NCIC.

The NCIC, part of a nationwide telecommunications system, is maintained by the FBI. This system operated at first through local law enforcement control terminals—as of early 1972, there were 102 terminals, of which 48 were computerized—that put the FBI in direct touch with approximately 4,000 of the Nation's 45,000 local law enforcement agencies. The NCIC originally maintained records on stolen items and wanted persons. Then the FBI developed the computerized criminal history section—CCH—which maintains active criminal offender records. Since that time, the files of the NCIC have expanded, and continue to do so. By 1974, the Federal Government had already invested over $300 million automating criminal justice files. The FBI plans to develop their files by 1984 to include 8 million CCH files which will be instantaneously available to all participating criminal justice agencies at that time—45,000.

I continue to be shocked that the operation of this massive and most comprehensive national information center is still guided only by a statement of principle promulgated by the FBI's NCIC advisory policy board. Although recently the Board has been expanded to include a few civilian members, it is still controlled by the law enforcement rationale. Often it is stated, as crime statistics continue to burgeon, that crime can be better combated with a larger information base. But unfettered access to all information on an individual can lead to considerable abuses. An ease in obtaining information can lead to an insatiable appetite for more information, relevant or not. It is incumbent on us, the U.S. Congress, to search not for immediate restrictions, but for an honest appraisal of law enforcement necessities so infringement upon individual rights is minimal.

Attitudes toward the issue of privacy in the law enforcement area are changing, as well illustrated in 1974, by the conflict between the Justice Department and the State of Massachusetts. This conflict centered on the State of Massachusetts' refusal to join the NCIC because there were no statutory guidelines providing for the security and privacy of their records. The refusal was based on the State's own stringent privacy requirements legislated by its legislature. The fear was that once the information left the State of Massachusetts, its securiy and privacy could not be guaranteed in the federal system.

Massachusetts had followed the lead of Project SEARCH, a project funded by the Law Enforcement Assistance Administration, which developed model legislation for the security and privacy of criminal justice information. The work of Project SEARCH in this area has been extensive and of great assistance to the development of proposed legislation. The report of its special Committee on Privacy and Security, Technical Report No. 2, was the first comprehensive proposal for adopting privacy rules to the operation of computerized record systems, and therefore has had great influence on subsequent thinking on this subject.

It was in part the work of Project SEARCH that inspired the introduction of H.R. 9783. The subject was now at the center of great discussion. Shortly after the introduction of H.R. 9783, the long-awaited product of Senator Ervin's work was introduced in the Senate. This was accompanied by the introduction of the administration's version. We immediately introduced these bills in the House, H.R. 12574—the administration bill—and H.R. 12575—Senator Ervin's bill—which now became the center of our consideration. Senator Ervin was a stalwart of individual rights. His interest in the constitutional right of privacy is demonstrated by a history of leadership in this area. After attempts for passage of these bills, the 93d Congress was thwarted by the overwhelming weight of current events. The work of my subcommittee was virtually at a standstill because of my committee's attention to the impeachment inquiry of Richard Nixon. Senator Ervin vigorously tried to put together a balanced coalition in the Senate, but also was hampered by current events and an inability to reach a timely agreement.

Although Senator Ervin was unable to pass this legislation in the Senate, he was busily accumulating support for a strong version of his original privacy bill. On the closing days of the Senate, he introduced the final version of his bill on the security and privacy of criminal justice information systems. To this bill he was able to gain the support of Project SEARCH. This is most impressive when

one realizes that Project SEARCH has one gubernatorial representative from each State.

Likewise, late in the 93d Congress, the administration, through the Justice Department, introduced its latest version of legislation in this area. Over the years, the Justice Department has become more sensitized to our concerns over the potential and actual abuses of criminal justice information within law enforcement agencies and the dissemination of the information without the agencies. Their most recent bill represents that attempt to ameliorate some of our concerns.

Although neither of these bills perhaps reflects the attitude of the House of Representatives, they demonstrate the beliefs and doubts of many concerned people in the Senate, in the administration and in the House of Representatives. Therefore, today I introduce to this Congress both of these approaches to legislation. They once again will become the subject of intensive investigation so that hopefully within the year, this Congress will have found the balance between these two varying approaches that best represents the conscience of the majority of this Congress and the people they represent.

Our concern has always been to strike that fine balance between the necessity of law enforcement agencies to have access to personal information and the rights of individuals who come in contact with the system. Last year was an unusual year. Above all, it demonstrated just how precious our constitutional rights are and just how tenuous our hold may be on our rights without constant vigilance. The 93d Congress took great strides in the area of privacy, but further work is required. This Congress has a mandate from the American people to respond to the creeping deterioration of our constitutional rights and to legislate in a positive way for their protection. We must be careful not to overreact, but we must react. Even with the passage of a bill in the area of criminal justice information systems, our work has just begun, and it will continue for years to come.

THE TAX EQUITY ACT OF 1975

(Mr. CORMAN asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. CORMAN. Mr. Speaker, I am once again introducing a comprehensive tax reform bill, the Tax Equity Act of 1975, H.R. 1040 and a companion bill, H.R. 1041. Forty-six Members of the House have expressed their wish to cosponsor the Tax Equity Act with me. They are: Mr. STARK, Mr. ANDERSON of California, Mr. BADILLO, Mr. BERGLAND, Mr. BOLLING, Mr. BRADEMAS, Mr. BROWN of California, Mrs. BURKE of California, Mr. CARNEY, Mr. CLAY, Mr. CONYERS, Mr. DANIELSON, Mr. DELLUMS, Mr. DIGGS, Mr. DINGELL, Mr. DRINAN, Mr. ECKHARDT, Mr. EDWARDS of California, Mr. EILBERG, Mr. FRASER, Mr. HARRINGTON, Mr. HAWKINS, Mr. HECHLER of West Virginia, Mr. HOWARD, Mr. JOHNSON of California, Mr. KOCH, Mr. MAGUIRE, Mr. MEEDS, Mr. MITCHELL of Maryland, Mr. MOORHEAD of Pennsylvania, Mr. MOSS, Mr. NEDZI, Mr. NIX, Mr. PRICE, Mr. REES, Mr. RODINO, Mr. ROSENTHAL, Mr. ROYBAL, Mr. RYAN, Mr. SEIBERLING, Mrs. SPELLMAN, Mr. STOKES, Mr. STUDDS, Mr. THOMPSON of New Jersey, Mr. CHARLES H. WILSON of California, and Mr. WON PAT.

The Tax Equity Act has four principal objectives: To make the Federal tax structure more equitable so that every individual and corporation pays a fair share in taxes; to reduce the existing biases in the tax law in favor of certain types of saving and investment and against others; to raise new revenues to meet the costs of urgent public needs; and to simplify our baffling tax law. The current problems in the economy make the attainment of these goals more essential now than ever. Unfortunately, there has been no progress in reaching them since I first introduced an omnibus tax reform bill in 1971.

We urgently need to make Federal taxes more equitable. The American people are justifiably outraged by the news that many rich individuals and prosperous industries pay little or no Federal taxes. In 1972, there were over 100 individuals with adjusted gross income—AGI—over $200,000 who paid no Federal income tax. These champion tax-avoiders, moreover, are just the tip of the iceberg, since most tax loopholes have the effect of reducing a person's AGI below his real economic income rather than lowering his tax for a given AGI. While at one time we might have thought that Congress could avoid acting to close the loopholes that permit this tax avoidance without provoking a public outcry, this is clearly no longer true.

To study the extent of tax avoidance among wealthy Americans, the Ways and Means Committee last year examined the tax returns of 20 high-income individuals, whose names were chosen for the most part without prior knowledge about their taxes. These returns showed clearly the injustice of our tax laws. Some of the 20 paid very high tax rates because they did not make excessive use of deductions and exclusions. Most, however, paid very low effective tax rates, and two paid no tax at all on incomes over $500,000. A third tried valiantly to escape all tax by claiming $900,000 in tax shelter losses, and a fourth paid only $25,000 in tax even though his income exceeded $2 million. There was widespread use of tax shelters, percentage depletion, the capital gains deduction and gifts of appreciated property to charity—all of which would be eliminated by H.R. 1040.

Our tax system, without which our Government would collapse, depends on voluntary compliance with the tax laws, since only 2 percent of individual income tax returns are audited. If the public continues to believe that some individuals and industries pay much less than their fair share of taxes, we risk a taxpayers' revolt that could destroy our tax system.

Furthermore, it is clear that to solve our serious social problems—inflation, overreliance on energy imports, pollution, and poverty—many individual Americans are going to have to make sacrifices so that all may be better off. Americans are willing to do this, but only if they feel that everyone is tightening his belt equally. The unpopularity of the administration's surtax proposal of October 1974, resulted from the widespread and correct belief that the tax burden is now so inequitably distributed that a proportional increase in taxes, even one limited to taxes on middle and upper income families, would be unfair. Similarly, it is difficult to make a case for special tax treatment for the oil industry, even that designed to encourage exploration for new sources of energy, in light of the well-publicized and outrageous profits reaped by that industry recently.

The tax loopholes that make the Federal tax system so inequitable also make the economy less efficient. Investment decisions are increasingly being made on the basis of tax considerations rather than economic ones, so that the political power of an industry, rather than its profitability, determine how much capital it is able to attract and how quickly it is able to grow.

The investment tax credit, the asset depreciation range—ADR—system, percentage depletion, the exemption of interest from State and local government bonds, the domestic international sales corporation—DISC—provisions, and the various tax preferences afforded capital gains—these all encourage saving or investment in particular areas relative to others. The result is to intensify the demand for investible funds; but because these tax loopholes do little to increase the aggregate supply of funds, this leads only to higher and higher interest rates. Those industries that receive no tax preferences or even just get less than the average preference, but that must still pay the exorbitant interest rates caused by other industries' loopholes, are starved for capital. H.R. 1040 goes a long way toward abolishing this irrational and largely useless system and, by doing so, will make the economy grow faster.

The inefficiency of allocating investible funds through the tax system is most clear in the case of tax shelters, where the tax incentive is so strong that taxpayers can invest using little or none of their own money. Management and syndication fees eat up a large part of the tax subsidy in these areas. Investors often pay so much attention to the tax effects of their activities that they neglect to make sure that the investments are even being made, much less made profitably and efficiently.

Another major aim of H.R. 1040 is to raise a substantial amount of tax revenue from individuals and corporations that do not pay their fair share of taxes. There are many alternatives uses for this revenue. One is to put an end to persistent deficit financing. In the past 10 fiscal years, the Federal deficit on a unified basis has averaged $10.3 billion per year, and an additional $6.9 billion per year has been borrowed from Government trust funds.

Thus, the Federal Government has borrowed $172 billion over this period that could have been made available for

private investment, and this has pushed interest rates to inordinately high levels. This persistent deficit financing must stop, for the private sector needs capital to expand capacity in industries where there are shortages, to house our population, to control pollution and to achieve greater self-sufficiency in energy. Deficits will be needed in some years, like the present, to stimulate the economy, but these should be offset by budget surpluses in other years, so that over the long run the budget is balanced. Greater fiscal responsibility is a far more effective way to deal with a capital shortage than is the enactment of tax subsidies.

Congress must also make funds available to finance new and expanded Government programs either by reducing existing programs or by raising taxes. The public expects the Federal Government, in partnership with industry, to clean up the environment; and this will require a large increase in outlays. It expects better health care and a national health insurance program. Funds are also needed to improve the quality of education and for manpower training programs.

We must also make funds available to relieve the impact of inflation on low- and middle-income families. In 1975, the poverty level for a family of four will exceed $5,400; but such a family must now pay as much as $155 in Federal income tax. This is unconscionable. The provisions in H.R. 1040 that convert the personal exemption and deductions into 24-percent tax credits will remove low-income families from the income tax rolls and reduce the taxes of moderate income families.

Once the tax base is broadened, it is also important to lower rates in the upper brackets. H.R. 1040 does this by reducing the maximum tax rate on all income to 50 percent.

A final objective of H.R. 1040 is to simplify the tax laws. Their complexity, which sends millions of taxpayers to tax return preparers each spring, results largely from the host of special deductions and exclusions that have been put into the law. This bill, by repealing many of these loopholes, will greatly simplify the tax law.

Mr. Speaker, tax reform is the most urgent matter facing the 94th Congress. Nothing bears more directly on as many citizens, nor resists consensus more stubbornly than the question of how the costs of Government should be shared. But rising revenue needs and the ire of taxpayers at the inequities of our taxing system dictate that Congress can wait no longer to make essential reforms.

I urge my colleagues to examine the provisions of H.R. 1040 carefully. A summary of the bill follows. I hope that our tax laws will be reformed along the lines that H.R. 1040 proposes, for only through reforms as provided by this bill can we find our way back to fiscal responsibility and equitable tax treatment for the average American taxpayer—both necessary ingredients for a stable, prosperous and healthy economy, and for a democratic society.

A section-by-section analysis of the Tax Equity Act follows:

SUMMARY OF CONTENTS OF H.R. 1040

Section 1—Short title, etc.

This section provides that the Act may be cited as the Tax Equity Act of 1975, and the section contains a table of contents of the bill.

Section 2—Technical and conforming changes

This section provides that the Secretary of the Treasury shall, within 90 days after the date of the enactment of the Act, submit to the Committee on Ways and Means a draft of any technical and conforming changes in the Internal Revenue Code which should be made to reflect the substantive amendments made by the bill.

Section 3—Treaties

This section provides that every amendment made by the Act shall apply notwithstanding that its application may be contrary to the provisions of some treaty in effect on the date of the enactment of the Act.

TITLE I—CAPITAL GAINS AND LOSSES

Section 101—Repeal of alternative tax on capital gains

This section repeals the alternative tax on capital gains for both individuals and corporations. As a result of this section and other amendments made by title I of the bill, capital gain income (for taxable years beginning after 1975) will not receive preferential treatment and will be taxed as ordinary income. (Section 301 of the bill reduces the maximum rate of tax on individuals from 70% to 50%.)

Section 102—Tax treatment of capital gains

While capital gain income will be taxed as ordinary income under the amendments made by the bill, this section provides for a limited exemption from tax depending on the length of time the property has been held before it is sold. The exemption is granted in deference to the fact that if an asset has been held a long time, the gain measured by dollars is attributable to some extent to the declining value of the dollar and does not represent increased purchasing power for the taxpayer.

This section assumes an inflation rate of 4 percent—and provides, in effect, that in computing the gain on a sale of property, the taxpayer can add to the tax basis of the property 4 percent of the tax basis of the property (at the time of the sale) for each year the property was held after it was held for one year. More precisely, it is provided that the addition to the tax basis shall be one-third of 1 percent of the tax basis for each full month the property was held after it had been held for one year. Thus, if the property is held for less than 13 full months, nothing is added to the tax basis in computing gain. If the property is sold after being held 63 full months (5 years and 3 months) 17 percent of the tax cost (51 months at one-third of 1 percent) would be added to the basis in computing gain.

Under present law, an individual is taxed on only one-half of his capital gain if he holds the property for one day over 6 months. Under the bill, no one day can make a difference of more than one-third of 1 percent, and that percent is of the cost of the property—not the gain on its sale.

This provision for not taxing the gain to the extent attributable to inflation applies not only to capital assets but also to property used in a trade or business, such as a plant, machinery, or other depreciable equipment. It does not apply, of course, to property held for sale to customers in the ordinary course of business.

This section of the bill repeals a number of provisions in the Internal Revenue Code which become deadwood when capital gains are treated as ordinary income. Complicated provisions, such as those dealing with collapsible corporations and the recapture of depreciation deductions on sale of property at a gain, are not needed when preferential treatment of capital gains is eliminated. No greater blow can be struck for the cause of simplification of the income tax laws than to repeal, as the bill does, the preferential income tax treatment of capital gains.

Section 103—Limitation on deduction of capital losses

Under existing law, capital losses are deductible only against capital gains plus, in the case of an individual, $1,000 of other income. This section of the bill provides that capital losses of a corporation are deductible only against gains from the sale of capital assets and property used in a trade or business. In the case of an individual, capital losses will be deductible only against such gains plus $1,000 of other income. Under present law, a long-term capital loss of $2 will offset only $1 of an individual's ordinary income. Under the bill, a capital loss of $1 will offset $1 of ordinary income (subject to the $1,000 limitation). Gains from the sale of property used in a trade or business do not include gains from the sale of property held primarily for sale to customers or gain from the sale of animals.

Section 104—Capital loss carrybacks and carryovers

This provision grants relief to an individual who has an unused capital loss of at least $10,000 by allowing him to carry it back to the 3 preceding taxable years. Cases have arisen where a large capital gain in 1 taxable year is followed by a large capital loss in the following year which may never be deducted even with the unlimited carryforward.

Under present law, if a corporation has an unused capital loss of only a few hundred dollars, this unused loss must be carried back to the 3 preceding taxable years, with resulting refunds if there are net capital gains in any of the 3 years. It cannot be carried forward if it can be used up on a carryback. This section of the bill changes existing law by providing that a corporation (like an individual) cannot carry back an unused capital loss unless it exceeds $10,000.

The bill provides that the carryback is elective with the taxpayer, whether an individual or a corporation. This will make the carryback provision less of an administrative burden on the Internal Revenue Service for in many cases the taxpayer would rather not file a claim for refund of taxes paid in a prior year if the loss can be used on a carryover.

In the case of an individual, the carryover can be used to offset ordinary income up to $1,000 a year, but on a carryback the capital loss can be used only to offset capital gains. In the case of the death of an individual the bill provides that the net capital loss for the year of his death can be carried back even though the loss is less than $10,000.

Under present law, a capital loss of a corporation can be carried over only to 5 taxable years following the year of the loss. Under the bill, a corporation (like an individual) will have an unlimited carryover of a capital loss.

Section 105—Capital gain and capital loss defined

This section amends the Code by striking out the definitions of short-term and long-term capital gains and losses since under the bill no distinction is made between short-term and long-term gains and losses. However, the bill defines the terms "capital gain" and "capital loss" since the deduction of capital losses is limited as explained above. The bill retains the definition in existing law of the term "capital asset".

Section 106—Nontaxed gains; carryover of basis at death

Under present law, on the death of an individual his property receives a new basis for tax purposes—the fair market value used for

purposes of the estate tax. Unrealized capital gains are, therefore, not taxed when the executor or the heirs sell any appreciated property held by the decedent. This section of the bill provides for a carryover of the decedent's basis, but the decedent's basis in appreciated property is increased by its proportionate share of Federal and State estate taxes attributable to the amount of the appreciation. This section would apply to decedents dying after June 30, 1975.

Section 107—Tax treatment of gain on certain sales of patents

Since capital losses will continue to be deductible only against capital gains (plus an additional $1,000 in the case of an individual), it is important that ordinary income is not classified as capital gain income. Under existing law, gain on the sale by an individual of a patent is treated as capital gain even though the taxpayer is a professional inventor. This section of the bill repeals this provision, so that the sale of a patent by the person whose personal efforts created the patent will be treated as ordinary income and not capital gain income, just as the sale of a copyright produces ordinary income under existing law.

In addition, this section provides that capital gain treatment will not be granted in any case where the owner (whether a corporation or an individual) of a patent enters into an agreement (whether or not it constitutes a sale, license, or assignment) under which the seller or assignor of the patent receives payments measured by a percentage of the selling price of articles produced by the buyer or transferee of the patent or where the amounts received by the seller or transferor are measured by production, sale, or use by the assignee or licensee. Periodic receipts of this kind with respect to the sale or transfer of a patent are properly treated as royalty income rather than capital gain income.

TITLE II—INCOME DERIVED FROM EXTRACTION OF MINERALS

Section 201—Repeal of percentage depletion

This section of the bill repeals the allowance of percentage depletion for oil and gas and other minerals, effective with taxable years beginning after December 31, 1974. (The Energy Tax and Individual Relief Act reported out by the Ways and Means Committee in 1974 would have repealed percentage depletion on crude oil and unregulated gas.)

Section 202—Deduction of intangible drilling costs and other exploration and development expenditures

This section of the bill liberalizes the deduction of exploration expenditures for oil and gas. Under present law, intangible drilling and development costs are deductible as incurred, but geological and geophysical costs are capital expenditures to be recovered through the depletion allowance (or as a loss upon abandonment). This section provides that all expenses incurred for the exploration and development of all minerals, including oil and gas, are deductible at the election of the taxpayer, so long as the expenditures do not have the effect of sheltering from tax income from nonmineral sources.

To deal with the problem of the tax shelter, this section provides that the aggregate deduction for exploration and development of mineral properties during the taxable year cannot exceed the taxpayer's aggregate taxable income for the year from mineral properties (computed without regard to the deduction for exploration and development). Losses on drilling a dry hole, however, will continue to be deductible without regard to the limitation. Any amount disallowed as a deduction under this limitation will be treated as an amount expended in the following year for the exploration and development of mineral properties. In the normal situation, this limitation will not limit the deduction in the case of the taxpayer who is in the business of operating mineral properties, but it will put a stop to the current practice of peddling drilling funds as tax shelters to taxpayers who are not in the business of operating mineral properties.

Section 203—Repeal of maximum tax on certain sales of oil or gas properties

This section of the bill repeals section 632 of the Internal Revenue Code which provides that the tax imposed on an individual on his sale of an oil or a gas property discovered by him shall not exceed 33 percent of the selling price. (The Ways and Means Committee tentatively agreed to this in 1974).

Section 204—Income from mineral properties located outside the United States

Under existing law, if a taxpayer goes into a foreign country to explore for and develop oil and gas wells or a mine, the deductible costs of exploration and development can be applied against income from sources within the United States. If the venture is successful and the mineral properties produce profits, the credit for foreign income taxes imposed upon those profits will, on the basis of past experience, completely offset the U.S. tax on those profits. The net result is that the United States Treasury loses revenue on account of the exploration and development in foreign countries of mineral properties and receives no revenue (because of the foreign tax credit) when the mineral properties produce profits. Moreover, if there is a loss on account of the expropriation of mineral properties by a foreign government, the deductible loss in the usual case has the effect of reducing the income taxes otherwise payable on income from sources within the United States.

To eliminate the losses to the Treasury on account of the exploration, development, and expropriation of foreign mineral properties, this section of the bill provides—

(1) a taxpayer will not include in his tax return amounts derived from the operation of a mineral property located outside the United States.

(2) no deduction shall be allowed for amounts chargeable to income so excluded from the tax return, or for any amount expended for the exploration or development of any mineral property located outside the United States, and

(3) losses on the sale, abandonment or expropriation of mineral properties located outside the United States shall be allowed only to the extent of gains from the sale of mineral properties located outside the United States.

The exclusion from gross income will not apply to profits derived from processing minerals after reaching the so-called cutoff point used in the past for percentage depletion purposes. Thus, profits from transporting minerals or in producing gasoline or refined metals will not be exempt. In addition, the exclusion from gross income will not apply to royalties received on mineral properties located outside the United States or to dividends on stock of any corporation operating mineral properties outside the United States.

TITLE III—REFORM MEASURES AFFECTING PRIMARILY INDIVIDUALS

Section 301—50-percent maximum rate for individuals

Under present law, the maximum rate of tax on individuals is 70 percent. This section of the bill reduces the maximum rate to 50 percent. This reduction is justified in the light of the other provisions of the bill which broaden the income tax base, particularly the taxation of capital gains as ordinary income, and the elimination of the tax shelters allowed under present law.

Section 302—Credit against tax for personal exemptions and nonbusiness deductions

This section of the bill provides a credit against tax for the personal exemptions and other personal deductions of an individual, including the standard deduction, in lieu of the existing deductions from gross income for such items. Under present law, a deduction of $750 against gross income for a personal exemption is worth $525 to the taxpayer in the highest bracket, but only $105 to a taxpayer in the lowest bracket. This section of the bill provides that each taxpayer will receive the same tax benefit for his personal exemption, and that the Treasury will "contribute" the same amount to all taxpayers with respect to deductible expenditures not connected with a trade or business or for the production of income.

A credit of 24 percent of the aggregate amount of the personal deductions is allowed by this section of the bill. The personal deductions include the deductions for personal exemptions, interest and taxes on nonbusiness indebtedness (such as taxes and interest on the taxpayer's home), deductions for charitable contributions, and deductions for medical expenses. If the taxpayer would have used the standard deduction instead of itemizing his deductions, then the 24-percent credit will be applied to the amount of the standard deduction the taxpayer would have received plus the amount of his personal exemptions. The credit will not be allowable with respect to alimony payments which would continue to be deductible from gross income as under existing law.

A credit of 24 percent of the personal deductions, instead of deducting such amounts from gross income, will reduce the income taxes of taxpayers in the lower brackets. For example, a married couple with two children having an adjusted gross income below $15,300 (and assuming nonbusiness deductions of 10 percent of income) will have a reduction in their income taxes.

A limit is provided on the amount of credit which may be taken on account of interest and taxes paid on an individual's personal residence (or residences). Not more than $10,000 of such interest and taxes will qualify for the 24 percent credit. In the ordinary case this limitation will not come into play unless the residence has a value of more than $100,000 and is heavily mortgaged.

This section provides that the President may increase or decrease the 24-percent rate if he decides that it is in the public interest to do so. If he decides that taxes on individuals should be reduced for a temporary period, he could proclaim an increase in the 24-percent rate, and if he believes that the taxes should be increased for a temporary period, he could proclaim that the 24-percent rate be decreased. The increase or decrease, however, cannot exceed 2 percentage points.

Any increase or decrease in the 24-percent rate by the President would not take effect if either House of the Congress, within a 60-day period after announcement of the proposed change in rate, passes a resolution stating in substance that a change in the 24-percent rate is not favored.

This section of the bill also provides that if the taxpayer is claiming a child as a dependent (and thereby receiving a credit of $180 against tax—24 percent of $750), the parent shall include in his gross income any income received by the child during the year from a trust created by the parent, and also any dividends, interest, or royalties received by the child from any property given to him by the parent. Income which is so taxed to the parent would not be taxed to the child. This provision would not apply if the parent does not choose to claim the child as a dependent.

Section 303—Denial of certain tax preferences to shareholder-employees of closely held corporations

This section of the bill eliminates three kinds of abuses which have arisen when an employee owns the corporation which "employs" him.

A self-employed farmer cannot deduct the cost of maintaining his residence on the farm. Such items as depreciation, repairs, heat, and insurance premiums on his house are not deductible; and he cannot deduct the cost of groceries consumed on the farm by his family. But, apparently all these personal and family expenses can be deducted if he incorporates—even though he elects subchapter S so that the corporation is not subject to tax. The Tax Court recently held that an individual owning all of the stock of a corporation which owned a 35,000-acre ranch in Montana was not taxable on the value of meals and lodging furnished to his family on the ranch by the corporation (and deducted by the corporation) because it was for the convenience of his corporation that he and his wife lived on the ranch and occupied the ranch house. This section of the bill provides that a shareholder-employee of a corporation cannot exclude (under sec. 119 of the Internal Revenue Code) from gross income the value of lodging and meals furnished to him by the corporation. A shareholder-employee is defined as an employee or officer of a corporation who owns 5 percent or more of the stock of the corporation.

If a doctor, lawyer, or other self-employed individual incorporates his business and then adopts a plan for the corporation to pay all medical, dental and hospital bills of any shareholder-employee (including members of his family), under existing law the payments are deductible by the corporation and are excluded from the gross income of the shareholder-employee, even though the plan does not cover employees who own no stock in the corporation. This section of the bill provides that such family expenses paid by the corporation for the benefit of the shareholder-employee will be included in his gross income unless employees who are not shareholder-employees receive 75 percent or more of all such payments made by the corporation during the year.

In the case of any self-employed person, his deduction for pension contributions for his own benefit under an H.R. 10 plan is limited to 15 percent of his earned income, with a maximum deduction of $7,500 a year. But, if the doctor, lawyer, dentist, or other self-employed person incorporates his business, the H.R. 10 limitations do not apply unless the corporation elects to be taxed under subchapter S. This section of the bill extends the rule applicable to a shareholder of a subchapter S corporation, and provides that the shareholder-employee of any corporation must include in his gross income any amount contributed by his corporation for his benefit in exces of the H.R. 10 limits. This rule will not apply, however, if more than 75 percent of the contributions made during the year by the corporation under the pension plan are for the benefit of employees who are not shareholder-employees.

Section 304—Repeal of $100 dividend exclusion

This section repeals the provision in present law that allows an individual to exclude from gross income $100 of dividends received on corporate stocks. (The Ways and Means Committee tentatively agreed to this provision in 1974.)

Section 305—Limitation on deduction of interest on investment indebtedness

Under existing law, if an individual's interest payments on indebtedness incurred to carry property held for investment exceeds the sum of the investment income plus $25,000, one-half of the interest in excess of that sum is disallowed as a deduction. This section reduces the $25,000 figure to $5,000 and provides that all—not just one-half—of the interest in excess of the sum of the investment income plus $5,000 is to be disallowed as a deduction. The amount which is disallowed as a deduction will be treated as investment interest paid in the following taxable year.

Section 306—Disallowance of expense attending convention outside the United States

This section disallows expenses of travel (including meals and lodging) of an individual in connection with attending a convention held outside the United States. As a general rule, such expenses are incurred primarily for pleasure rather than business. Thus, expenses of lawyers attending the American Bar Convention in London in 1971 would have been disallowed if the amendment had been in effect. (The Ways and Means Committee in 1974 tentatively adopted a similar provision.)

Section 307—Deductions for expenses attributable to business use of homes, rental of vacation homes, et cetera

Last year the Tax Court held that a Government employee could deduct part of the rent he paid on his apartment because he did some of his office work at home. The court also allowed a taxpayer who resided in Los Angeles to deduct 90 percent of the cost of maintaining a second home at Palm Springs because he used the Palm Springs home for entertaining clients and prospective clients. In another case, a taxpayer (not engaged in business) was allowed to deduct a portion of the cost of maintaining her home because she prepared her income tax returns at home and kept records at home of her investment income and expenses. We learned from the report on former President Nixon's income tax returns that he deducted 25 percent of the cost of his apartment in New York City while engaged there in the private practice of law, and the deduction was not disallowed by the I.R.S. (The Ways and Means Committee in 1974 tentatively adopted a provision to terminate the allowance of deductions in such cases. H.R. 1040 adopts the statutory amendment prepared for the Committee on this matter.)

In addition, this section of the bill eliminates as tax shelters such items as beach cottages, condominiums at ski resorts, mountain cabins, yachts and the like, which the taxpayer uses for pleasure and rents when he can in order to obtain tax deductions greater than the rentals. The amendment would also apply to the rental of a house which is used by the taxpayer as his principal place of residence.

Under the amendment, deductions for depreciation, repairs, insurance, agent fees in handling rentals, etc., would be allowed as deductions only up to the amount of rentals received during the year reduced by interest and taxes paid (and deducted) on the rental property. The rentals would not be taxed (except in the unusual case where they exceed all expenses) because they would be offset by allowable deductions; but the excess costs for repairs, depreciation, insurance, etc., could not be used to shelter income from other sources.

Section 308—Farm losses

The Tax Reform Act of 1969 provided for an excess deductions account in the case of farm losses in order to eliminate some of the tax shelter afforded by the use of the cash method of accounting in the case of farming. In order to deal more effectively with the problem of farm losses as a tax shelter, this section of the bill provides that farm losses can be deducted against nonfarm income only to the extent of $10,000 a year. Any amount of a farm loss which is disallowed under this provision will be treated as an expense of farming in the following taxable year.

This limitation on the deduction of a farm loss will not apply to a taxpayer whose nonfarm income is less than $20,000.

Section 309—Computation of earnings and profits on a consolidated basis

Some conglomerate companies have been paying dividends which are not fully taxable because the parent company does not have sufficient earnings and profits to cover the distribution although the consolidated group had earnings and profits during the year greater than the amount distributed. This section of the bill provides that the earnings and profits of a parent corporation for a year shall not be less for dividend purposes than the earnings and profits of the consolidated group for the year.

Section 310—Dividend on certain sales of stock

The Tax Court held that if a transaction is described in section 304 of the Code (which can produce dividend income if stock of one controlled corporation is sold to another controlled corporation) and is also described in section 351 (dealing with tax-free exchanges), then section 351 applies and not section 304. This section of the bill changes the rule of the Tax Court case and provides that the tax-free provisions of section 351 do not apply to the extent the application of section 304 produces an amount taxable as a dividend.

Section 311—Termination of stock option provisions

Under present law, an officer of a corporation is not taxed at the time he exercises a quaiified stock option granted him for performance of services. If he sells the stock after 3 years, the compensation is taxed only as a capital gain. If he holds the stock until he dies, the compensation is never taxed. This section of the bill provides, in the case of options granted after 1974 that the compensation realized on exercise of a stock option will be taxed at the time of exercise as ordinary income.

The enactment of this amendment will be welcomed by many corporate shareholders. The liberal granting in the past of stock options has diluted, in some cases seriously, the equity ownership of shareholders of the companies who grant stock options. With the demise of tax-free stock options, management will no longer have to explain or contend to shareholders that authority to grant stock options is necessary to attract or keep "key employees". (A similar amendment was tentatively adopted by the Ways and Means Committee in 1974.)

Section 312—Disallowance of certain double deductions

Present law provides that the expenses of administering an estate can be deducted by the executor on either the income tax return or the estate tax return, but not on both. The courts have held that expenses of the executor in selling property can be deducted in the estate tax return and can also be used on the income tax return as an offset against the selling price of the property. This section of the bill provides that such selling expenses cannot be used in the income tax return as an offset to the selling price if they are deducted as an expense of administration on the estate tax return.

Section 313—Treatment of trust income payable to children of grantor

Under present law, a father can, in effect, deduct on his income tax return gifts to his children if he makes a gift out of income from stocks and agrees to do so for at least 10 years. To get that result, the parent need merely transfer stock to himself as trustee and agree to pay out to his children the income from that stock for 10 years, at which time the stock will be returned to him free of the trust. Use of short-term trusts in this manner is commonplace with affluent taxpayers who can afford to give some of their dividend income to their children.

This section of the bill provides that the income of such a trust will be taxed to the

grantor (if he has a reversionary interest) so long as the income is payable to a child who is under the age of 21 years or who is attending college and is a dependent of the taxpayer for purposes of the credit for personal exemptions.

Section 314—Deductible losses of limited partner cannot exceed investment

Limited partnership interests in syndicated tax shelters—such as drilling funds and real estate ventures—are being peddled with the sales pitch that the investor will enjoy a deduction on his income tax return of $2 for every dollar he invests in the fund or the venture. It is possible, under existing law, for a limited partner to take income tax deductions (for his share of partnership deductions) in excess of the amount which he has contributed to the capital of the partnership. This results because the existing regulations provide that a limited partner's tax basis will be increased by a portion of any partnership liability for which no partner has personal liability.

This section of the bill provides that a limited partner's share of partnership liabilities cannot exceed the difference between his actual contribution credited to him by the partnership and the total contributions he is obligated to make under the partnership agreement. The effect of this amendment will limit the deductions of a limited partner in any drilling fund or other tax shelter venture to the amount he is actually at risk.

Section 315—Repeal of exemption for earned income from foreign sources

Under present law, citizens of the United States can exclude from gross income certain amounts of income they earn in foreign countries if they are present in the foreign country for 17 out of 18 months or if they become a bona fide resident of the foreign country. The exclusion is $20,000 a year if the taxpayer meets the 17 out of 18 month test and is $25,000 a year if he is a bona fide resident of the foreign country. This section of the bill denies such exclusion from gross income in the case of taxable years beginning after the date of enactment. The foreign tax credit will prevent double taxation of the income if the foreign country also taxes the earned income. (In 1974, the Ways and Means Committee tentatively agreed to phase out this exclusion.)

Section 316—Underpayments of estimated tax

This section provides that an individual cannot base his estimated tax payments on the prior year's tax (or at the current year's rates applied to the prior year's facts) if in any one of the 3 preceding taxable years the tax shown on his return was in excess of $100,000.

Section 317—Partnership to be treated as corporation upon filing registration statement with Securities and Exchange Commission

A key element in the syndication of tax shelters is that the business venture is treated for tax purposes as a limited partnership, so the tax losses can be passed through and be deducted by the limited partners. In a recent year registered filings with the Securities and Exchange Commission of partnership tax shelter offerings in oil drilling funds, real estate programs, cattle feeding, and the like, were in excess of $3.2 billion. Perhaps any partnership which depends primarily on limited partners for the capital of the venture should be treated as a corporation—the limited partner is like the preferred shareholder of a corporation. But at a minimum, any partnership which is required under the securities laws to register its offerings with the Securities and Exchange Commission should be treated as a corporation, and this section of the bill provides that if a registration statement is filed with the SEC after July 1, 1975, and offers units of participation or other interests in a partnership, the partnership shall be treated as a corporation for taxable years ending after the date of the filing of the registration statement. The enactment of this provision would put an end to the interstate sale of large syndicated tax shelters.

TITLE IV—REFORM MEASURES AFFECTING PRIMARILY CORPORATIONS

Section 401—Repeal of investment credit

The investment credit is a massive subsidy to corporations for their purchase of machinery and equipment, nearly all of which would be purchased in the absence of the subsidy. The subsidy granted by the present 7 percent investment credit for the calendar year 1976 will amount to over $6 billion if the credit is not repealed. This section of the bill terminates the investment credit, effective with respect to property placed in service on or after January 1, 1976.

Section 402—Repeal of asset depreciation range system

In 1962, the Treasury issued guidelines specifying the number of years over which different kinds of assets could be depreciated. Through the "reserve ratio test", a direct link was maintained between the depreciation claimed by taxpayers and the actual "wearing out" of equipment. Taxpayers were not allowed to depreciate for tax purposes more rapidly than they were actually replacing the equipment.

In January, 1971, the Treasury announced some major changes. Businessmen were allowed to take guideline lives 20 percent shorter than previously. Thus, an asset which previously had a guideline life of 10 years could now be depreciated over 8 years. In addition, the reserve ratio test was repealed. These changes were given legislative approval in the Revenue Act of 1971.

This section repeals the ADR system and reinstates the reserve ratio test, for taxable years beginning after December 31, 1974.

Section 403—Depreciation deduction not to exceed book depreciation

Under present law, a corporation cannot use the LIFO method of valuing inventories for income tax purposes unless it uses the same method in reporting its earnings to shareholders. The obvious rationale of this rule is that if LIFO is not considered by a corporation as a correct method for reporting earnings to shareholders, then that corporation is not entitled to use the LIFO method in reporting its earnings on the tax return.

For a similar reason, this section of the bill provides that a corporation cannot take depreciation deductions for a taxable year in an aggregate amount in excess of the depreciation taken into account in reporting earnings for the year to shareholders. Thus, if a corporation on its books computes depreciation for equipment on a straight-line basis with a 30-year life, it cannot have a larger deduction on the tax return by using the double declining balance method or a shorter life. Moreover, in the case of a publicly held company whose annual report to shareholders is certified to by independent certified public accountants, it can generally be presumed that the charge for depreciation recorded on the books is a fair and honest estimate of the actual cost of depreciation for the year. If a larger deduction for depreciation is allowed on the tax return, then the depreciation allowance becomes a subsidy and not a reasonable allowance for the exhaustion of machinery and equipment.

In the case of an affiliated group of corporations, regulations will prescribe whether the report by the common parent corporation to its shareholders, rather than the report of subsidiaries to the parent, will be taken into account for purposes of this amendment.

Section 404—Deduction for repairs limited to amount recorded on books

This section of the bill, for the reasons set forth in the preceding section dealing with depreciation, prohibits the deduction by a corporation of an expenditure for repairs if the corporation capitalizes the expenditure on its books for the purpose of reporting to shareholders its earnings and profits for the year.

Section 405—Limitations on dividends received deductions

Subsection (a) of this section of the bill provides that the dividends received deduction cannot exceed 85 percent of taxable income (computed without regard to the net operating loss carryback). The chief effect of this is to change present law which allows a full deduction for 85 percent of dividends received if this deduction will produce or increase a net operating loss for the taxable year. The amendment also provides that any amount disallowed for the taxable year because of the net income limitation shall be allowed as a deduction for the following taxable year if there is sufficient taxable income in that year. This gives the taxpayer a carryover which he does not have under present law.

Subsection (b) provides that dividends received from an unaffiliated corporation shall be reduced (for purposes of the dividends received deduction) by the amount of any interest on indebtedness incurred or continued to purchase or carry the stock of the unaffiliated corporation. An unaffiliated corporation is any corporation except one that is a component member of a controlled group of corporations which includes the taxpayer.

This section of the bill also provides that if the aggregate amount of dividends received during the year from unaffiliated corporations (after first being reduced by any interest paid as provided in the preceding paragraph) exceeds the amount of dividends paid by the corporation during the taxable year, no dividends received deduction shall be allowed with respect to the excess. Thus, if no dividends are paid by the taxpayer, no dividends received deduction can be claimed for dividends received from unaffiliated corporations. However, the amount which is so disallowed shall be treated as a dividend received in the following year for purposes of the dividends received deduction. Moreover, if dividends paid during a taxable year exceed the dividends received during the year from unaffiliated corporations, the amount of the excess will be treated as a dividend paid in the following year for purposes of the dividends received deduction.

Section 406—Use of appreciated property to redeem stock

Under present law, if a corporation redeems stock with appreciated property; gain is recognized except in certain cases. One of the exceptions is where stock or securities are distributed pursuant to a court proceeding under the antitrust laws. This section provides that the stock or securities must have been acquired before January 1, 1970, in order for the exception to apply. It is not believed corporations which have violated the antitrust laws should have a tax benefit not available to other corporations who distribute appreciated securities.

Section 407—Recognition of gain on sales in connection with certain liquidations

If a corporation adopts a plan of complete liquidation and the liquidation is completed within 12 months, under existing law (section 337 of the Internal Revenue Code) the corporation is not taxed on gains realized on the sale of property during the period of liquidation. Gains on sale of inventory, however, are exempt from tax only if the inventory is sold in bulk to one purchaser.

This section makes three amendments to section 337. First, it is provided that section

337 shall apply only if at the time of the adoption of the plan of liquidation the corporation has less than 11 shareholders.

Second, it is provided that gain on the sale of inventory shall be taxable even though section 337 otherwise applies.

The third change deals with the problem which has been presented in some cases where shareholders of the liquidating corporation transferred, after adoption of the plan to liquidate and before the corporation distributes its tax-free gains, some or all of their stock to tax-exempt charities (usually their private foundations). This amendment of section 337 insures that one tax will be imposed in such cases by providing that if tax-exempt organizations receive X percent of the amounts distributed in liquidation, then the same percent of the gains realized by the corporation during the course of the liquidation will be subject to tax at the corporate level.

Section 408—Denial of tax-free exchanges in case of investment companies

In 1966 tax-free exchanges of appreciated stock for shares of mutual funds (so-called swap funds) were brought to an end by an amendment which provided that section 351 of the Code would not apply to transfers to an investment company. That amendment did not complete the job. For years the Massachusetts Investment Trust, and other mutual funds, have been issuing their shares to acquire all of the stock or assets of family held personal holding companies, and these exchanges are treated under section 368 as tax-free reorganizations. This is nothing but swap funding to obtain diversification plus a readily marketable security. The amendment would make such exchanges taxable and it would also make mergers of two investment companies taxable.

Section 409—Certain transactions disqualified as reorganizations

This section of the bill provides that there cannot be a tax-free reorganization if the shareholders of the smaller company involved in the transaction end up with less than 20 percent of the voting stock of the surviving corporation in a merger or of the acquiring corporation in the case of a so-called B reorganization (stock-for-stock) or a so-called C reorganization (stock-for-assets). If a conglomerate company whose stock is listed on the New York Stock Exchange issues less 20 percent of its voting stock to acquire the stock or assets of a company whose stock is not listed, it is more realistic to treat the shareholders of the unlisted company as having sold out for a marketable security rather than having taken part in a reorganization of their company. (A similar provision was contained in the House version of the Internal Revenue Code of 1954.)

Section 410—Repeal of special treatment of bad debt reserves of financial institutions

This section of the bill provides that banks and other financial institutions that now are allowed to take special deductions for reserves for bad debts will, in the case of taxable years beginning after 1975, compute any addition to a reserve for bad debts on the basis of the actual experience of the taxpayer, the rule which is applied to all other corporations.

Section 411—Repeal of deduction for Western Hemisphere trade corporations

This section of the bill repeals the special deduction now allowed domestic corporations who obtain most of their income from foreign countries in the Western Hemisphere. (The Energy Tax and Individual Relief Act reported out by the Ways and Means Committee in 1974 would have phased out the lower tax rate allowed such corporations over a five-year period.)

Section 412—Gain on liquidation of Puerto Rican subsidiary

Under present law a corporation can organize a subsidiary, incorporated in the United States, for the purpose of doing business tax-free in Puerto Rico. Under section 931, the profits will not be taxed by the United States, and under the tax holiday program offered by Puerto Rico, its profits may be exempt from tax by Puerto Rico for a period of 10 or 12 years. At the end of the tax holiday, the subsidiary can be liquidated tax-free under section 332. As a result, the profits earned during the tax holiday period and received by the parent upon the liquidation are not taxed to the subsidiary or the parent by either government. This section of the bill provides that upon the liquidation of the subsidiary, the gain on the liquidation will be taxable to the extent of the earnings and profits of the subsidiary accumulated during the period it was exempt from tax under section 931.

Section 413—Taxation of undistributed profits of foreign corporations

At the present time, American corporations do not have to pay income taxes to the Federal Government on the earnings of their controlled foreign subsidiaries so long as the earnings are undistributed. These earnings, however, are generally taken into account by the parent company in reporting earnings to its shareholders. This tax deferral constitutes an important incentive for U.S. corporations to set up plants in foreign countries. This section of the bill provides for the taxation on a current basis of the undistributed earnings of controlled foreign corporations.

Section 414—Repeal of the tax exemption for a DISC

A U.S. corporation can now set up a paper corporation (known as a DISC) and escape the corporate income tax on one-half of its profits from exports by channeling the sales through the DISC. This section of the bill would repeal the tax exemption for DISC corporations and thereby increase revenues by approximately $1 billion a year.

Section 415—Involuntary conversions

This section provides that if gain on an involuntary conversion of property is not recognized because the taxpayer purchases stock of a corporation owning property of the kind which was converted, the basis of that property in the hands of the corporation shall be reduced by the amount of gain not recognized on account of the purchase of the stock.

Section 416—Computation of underpayments of estimated tax

This section of the bill provides that a corporation cannot compute its estimated income tax payments on the basis of the prior year's tax (or on the basis of the prior year's facts and the current year's rates) if in any one of the 3 preceding taxable years the tax shown on its return was in excess of $300,000.

TITLE V—REFORMS AFFECTING INDIVIDUALS AND CORPORATIONS

Section 501—Minimum tax

This section makes a number of changes in the minimum tax. First, it repeals the provision of existing law that allows regular income taxes to be deducted from the items of tax preference. Second, the $30,000 exemption for tax preferences is reduced by the bill to $12,000.

Third, the following items are added to the list of items which constitute tax preferences:

(1) Deduction of intangible drilling and development costs for oil and gas wells.

(2) Deduction of exploration and development costs in the case of mines.

(3) Tax-exempt interest on State and local bonds (issued before January 1, 1976).

(4) The credit against the United States tax allowed for foreign income taxes.

(5) The amount of amortization for coal mine safety equipment.

Another provision is added to avoid a tax on an item of preference if the taxpayer obtained no tax benefit from the item. This provision will permit a taxpayer to elect to waive a deduction for an item of tax preference, in which case the item would not be taken into account for the minimum tax. However, such waiver can be made only at such time and subject to such terms and conditions as may be set forth in regulations promulgated by the Secretary or his delegate.

Finally, this section of the bill strikes from existing law the provisions which treat tax preferences attributable to foreign sources more favorably than preferences attributable to sources within the United States.

Section 502—Shareholder use of corporate property

Considerable uncertainty exists over the tax treatment of interest-free loans from a corporation to its controlling shareholders and the rent-free use by shareholders of corporate property. The Tax Court has held that an interest-free loan produces no taxable income to the shareholder or the corporation, even though the funds loaned by the corporation were producing taxable income prior to the loan. This section of the bill provides that an interest-free loan or a rent-free use of corporate property by a controlling shareholder shall be treated in the same manner as if the shareholder paid to the corporation a reasonable rate of interest on the loan, or a reasonable rent for use of the property, and as if the corporation then made a cash distribution of a like amount to the shareholder.

Section 503—Deduction for depreciation based on equity in rental real estate

This section provides that in the case of a building which the taxpayer rents to others, the deduction for depreciation cannot exceed the taxpayer's equity in the building and the land. That is, no additional deductions for depreciation will be allowed (including existing buildings) to the extent it would reduce the adjusted basis of the building below the unpaid balance of the mortgage on the land and building (minus the tax cost of the land). However, until the depreciation deductions equal the equity, the depreciation would be computed on the entire cost of the building and not on the amount of the equity. This amendment would not apply to a building if the primary use is by the taxpayer and not the tenants. This amendment would reduce the attractiveness of real estate ventures as tax shelters for investors.

Section 504—Charitable gifts of appreciated property

Under existing law, if capital assets which have appreciated in value are given to a private foundation, the charitable deduction is reduced by one-half of the long-term capital gain the individual would have had if he had sold the property at fair market value. However, in the case of gifts of noncapital assets to any charitable organization, the amount of the charitable deduction is reduced by the amount of the ordinary gain the taxpayer would have received if he had sold the property at fair market value. Since title I of the bill eliminates the preferential treatment of capital gain income, this section of the bill provides that if appreciated property (whether or not a capital asset) is contributed to any charitable organization, the amount of the charitable contribution shall be reduced by the amount of gain which would have been realized if the property contributed had been sold by the taxpayer at its fair market value (determined at the time of such contribution). In computing the amount of such gain, there will be excluded the amount of any gain which is exempt from tax under the provisions of section 1202 of the Code, as amended by section 102 of this bill.

Section 505—Capital expenditures in developing fruit or nut groves or vineyards

Present law requires the capitalization of expenditures incurred during the development stage in planting citrus or almond

groves. This section of the bill extends the rule of capitalization of expenses incurred before the time when the productive stage is reached in the case of any other fruit or nut grave or any vineyard planted after June 30, 1975.

Section 506—Interest and taxes during construction of rental property

A major segment of the tax shelter afforded by rental real estate is the allowance under existing law of a deduction for interest and taxes incurred during the construction period of the building. This section of the bill provides that such interest and taxes cannot be deducted, but are to be added to the cost of the building and recovered through depreciation allowances, over the life of the building.

Section 507—Treatment of prepaid interest

A distortion of taxable income can occur when there is a substantial prepayment of interest by a taxpayer who computes his tax under the cash receipts and disbursements method of accounting. (In 1974, the Ways and Means Committee tentatively adopted a provision to require the deduction of prepaid interest only by the accrual method of accounting. H.R. 1040 adopts the statutory language prepared for the Ways and Means Committee on this item.)

Section 508—Repeal of tax exemption for ships under foreign flag

This section of the bill repeals the provisions of existing law which state that a nonresident alien or a foreign corporation (even though 100 percent owned by a U.S. corporation or an American citizen) is not taxable on income derived within the United States from the operation of ships documented under the laws of a foreign country which grants an equivalent exemption to United States citizens or corporations.

Section 509—Limitations on foreign tax credit

The first amendment made by this section of the bill provides that a foreign tax credit shall not be allowed for any foreign tax on income which is excluded from the taxpayer's gross income so far as the Federal income tax is concerned. In addition, any foreign income tax paid on a gain realized by an individual or domestic corporation which is not recognized under the Internal Revenue Code would likewise be a noncreditable tax. The basic rationale for this amendment is that the foreign tax credit is supposed to eliminate double taxation on income. If the United States does not tax the income, there is no reason to give a credit for the foreign tax paid on that income by the taxpayer.

The second amendment made by this section provides that the foreign tax credit shall be subject to both the per country limitation and the overall limitation. This was the applicable rule from 1932 to 1954.

The third amendment made by this section provides two new rules with respect to the treatment of certain gains on the sale of property for foreign tax credit purposes. The first rule is that in computing taxable income for purposes of the per country and overall limitations, there shall be excluded any gain on the sale of a capital asset, or property used in a trade or business, if such gain is treated as income from sources outside the United States unless the gain is taxed by a foreign country. Most gains on sales of such property are not taxed by foreign countries and treating such gains as foreign income for purposes of the limitations can result in a reduction of the tax which the Federal Government collects on income of the taxpayer from U.S. sources.

The second rule added by the amendment is that for purposes of the limitations the U.S. tax (against which credit can be taken) shall be reduced by the U.S. tax on any gain excluded from taxable income under the first rule described above.

TITLE VI—ESTATE TAX AMENDMENTS

Section 601—Integration of estate tax rate with inter vivos gifts

The main defect of the present estate and gift tax system is that it discriminates in favor of those who give away their wealth partly through lifetime gifts and partly at death, as against those who pass on all their wealth at death. In part, this is because both the gift tax and estate tax schedules are progressive. Thus, the man who transfers property both by gift and at death gets to start at the bottom of two separate, progressive rate structures. In practice, as pointed out in the 1968 Treasury *Studies and Proposals,* this is primarily of benefit to the very rich.

Thus, if a decedent made gifts of $2 million during his lifetime and leaves $3 million at his death, the rate of tax on the $3 million starts with the bottom tax brackets and produces a much smaller tax than would be produced if the $3 million were "stacked" on top of the $2 million lifetime gifts. The result is that wealthy individuals can substantially reduce the tax on transfers of property by making substantial gifts during lifetime.

This section of the bill would integrate the estate tax rate with *inter vivos* gifts so that the tax brackets for property transferred at death are determined by the amount of taxable gifts made during the decedent's lifetime (and after 1975). Under this amendment, a tentative tax is first computed on the amount of the taxable estate at death increased by the amount of the taxable lifetime gifts (made after 1975) plus the gift tax paid by the decedent on those gifts. Then, a second tentative estate tax is computed on an amount equal to such gifts plus the gift taxes paid. The difference between the two tentative taxes constitutes the estate tax payable on the property transferred at the time of death.

Section 602—Transfers taking effect at death

Before the enactment of the 1954 Code, if a taxpayer transferred property to a trust which provided that the income should be accumulated during the grantor's life and upon his death the trustee should pay the corpus and accumulated income to his children, such a transfer was included in the decedent's gross estate as a transfer taking effect at death. The 1954 Code provided that such a transfer will be included in the gross estate only if the decedent retained a reversionary interest equal to 5 percent of the value of the property. This section of the bill strikes out the 5-percent reversionary interest test since it is completely a nonsequitur in a statute which imposes an estate tax on a lifetime transfer of an interest which can be possessed or enjoyed only by surviving the transferor. This amendment would apply to transfers made after December 31, 1974.

Section 603—Life insurance included in gross estate

Prior to the 1954 Code, life insurance on a decedent's life was includible in his gross estate to the extent he paid the premiums on the policy. In such a case it was immaterial whether he had given the policy to members of his family before his death. This section of the bill restores the premimum payment test in the case of life insurance, so that the insurance will be included in the insured's gross estate in the ratio that the premiums paid by the decedent on the insurance policy bears to all premiums paid on that policy. In applying this rule the premiums paid by the decedent before January 1, 1975, shall not be included in the numerator of the fraction but would be included in the denominator.

Section 604—Charitable deductions in the case of estate tax

The first amendment made by this section of the bill places a limitation on the charitable deduction for estate tax purposes, similar to what we have for the income tax. Under present law, a decedent can give his entire estate to a private foundation created by his will, and no Federal estate tax will be imposed. This amendment provides that the aggregate charitable deduction shall not exceed 50 percent of the gross estate reduced by the debts of the decedent and the expenses of administration.

The second amendment deals with the interplay of the charitable deduction and the marital deduction for estate tax purposes. The marital deduction cannot exceed 50 percent of the adjusted gross estate (gross estate less debts, losses, and expenses of administration). Cases have arisen where executors have claimed, in order to raise the amount of the adjusted gross estate for purposes of the marital deduction, that transfers made to charities during the decedent's lifetime were includable in the gross estate. Increasing the gross estate for such lifetime transfers produced no estate tax for the charitable deduction was increased by the same amount, but a larger maximum deduction was allowed for bequests to the surviving spouse. This amendment provides that in computing the adjusted gross estate there shall be excluded any transfer made by the decedent during his lifetime if an estate tax charitable deduction is allowed for that transfer.

Section 605—Charitable deduction for gift tax purposes

Since the enactment of the Tax Reform Act of 1969, a gift tax is imposed in certain cases if the donor gives an interest in property to charity but retains for himself an interest in the same property. Thus, if a valuable painting is given to the National Gallery of Art subject to the right of the donor to retain possession of the painting for his lifetime, a charitable deduction is not allowed for either the income tax or the gift tax. While a deduction for income tax purposes in such a case is properly disallowed, it is not believed a gift tax should be imposed on the gift to charity, so long as no third party is given an interest in the painting. This section of the bill amends section 2522 (c) of the Internal Revenue Code of 1954 to allow a charitable deduction for gift tax purposes in such a case. The amendment provides, however, that if the donor, after making such a gift to charity, thereafter transfers the interest he retained to a third party (not a charity), the donor shall then be considered as having made the transfer to charity and the third party at the same time, so that a gift tax would be imposed on the interest transferred to charity.

TITLE VII—STATE AND LOCAL OBLIGATIONS

Section 701—Repeal of exemption for interest on new issues of State and local bonds

This section of the bill provides that interest on State and local bonds issued after December 31, 1975, will not be exempt from Federal income taxation. In the case of interest on State and local obligations issued before January 1, 1976, such interest will continue to be exempt from taxation, but section 501 of the bill provides that such interest will be treated as an item of tax preference for purposes of the minimum tax.

Section 702—United States to pay 40 percent of interest yield on State and local obligations

This section provides that the Federal Government will pay 40 percent of the interest yield on State and local obligations issued after December 31, 1975. A similar provision was in the Tax Reform Act of 1969 as it passed the House. The payment of interest by the Federal Government will not apply in the case of any industrial development bond (as defined in section 103(c)(2) of the Internal Revenue Code). This section provides that upon the request of the State or local

government, the liability of the United States to pay interest to the holders of the bond shall be handled through the assumption by the United States to pay a separate set of interest coupons issued with the bond. Otherwise, the obligation of the United States to pay 40% of the interest yield will be made directly to the issuer of the obligation.

TITLE VIII—WITHHOLDING OF INCOME TAX ON DIVIDENDS AND INTEREST

Section 801—Withholding of income tax at source on dividends and interest

Income taxes are now deducted and withheld on payments of wages and salaries but not on dividends or interest. In 1962, the Ways and Means Committee decided, as a matter of fairness, that recipients of dividends and interest should pay their taxes no less than those who receive wage and salary income and the tax should be paid just as promptly. The Revenue Bill of 1962, as passed by the House, provided for the withholding of tax on dividends and interest, and this section of H.R. 1040 contains provisions substantially identical to the withholding provisions in the 1962 bill. In 1962, the committee estimated that such withholding of tax would increase annual tax collections by about $650 million. With the great increase since then in the amount of dividend and interest payments, it is believed that the withholding of tax on such income would now increase revenues more than $1 billion annually.

TABLE 1.—FEDERAL INDIVIDUAL INCOME TAX BURDEN IN 1973 UNDER PRESENT LAW AND UNDER A PROPOSAL TO SUBSTITUTE A 24-PERCENT TAX CREDIT FOR THE $750 PERSONAL EXEMPTION AND FOR NONBUSINESS DEDUCTIONS [1]—SINGLE PERSON

Adjusted gross income [2]	Income tax: Under present law	Income tax: Under the proposal
Assuming nonbusiness deductions of 10 percent of income:		
$2,050 [3]	0	0
$2,500	$63	0
$2,958 [4]	131	0
$3,000	138	$8
$3,500	217	103
$4,000	302	198
$5,000	491	408
$7,500	995	978
$8,038 [5]	1,107	1,107
$10,000	1,530	1,550
$12,500	2,059	2,145
$15,000	2,703	2,860
$17,500	3,443	3,680
$20,000	4,255	4,570
$25,000	5,895	6,410
$30,000	7 703	8,490
$4C,000	11,915	13,250
$50,000	16,415	18,810
Assuming nonbusiness deductions of 18 percent of income:		
$2,050 [3]	0	0
$2,500	63	0
$2,958 [4]	131	0
$3,000	138	8
$3,500	217	103
$4,000	302	198
$5,000	491	408
$7,500	984	966
$8,165 [5]	1,098	1,098
$10,000	1,458	1,478
$12,500	1,965	2,055
$15,000	2,509	2,692
$17,500	3,094	3,404
$20,000	3,722	4,186
$25,000	5,140	5,930
$30,000	6,730	7,914
$40,000	10,315	12,482
$50,000	14,415	17,850

[1] These burdens have been computed without use of the optional tax table.
[2] Wages and salaries.
[3] Highest level at which there is no tax under present law.
[4] Highest level at which there is no tax under the proposal.
[5] Level at which tax is the same under present law and under the proposal.

TABLE 2.—FEDERAL INDIVIDUAL INCOME TAX BURDEN IN 1973 UNDER PRESENT LAW AND UNDER A PROPOSAL TO SUBSTITUTE A 24-PERCENT TAX CREDIT FOR THE $750 PERSONAL EXEMPTION AND FOR NONBUSINESS DEDUCTIONS [1]—MARRIED COUPLE WITH NO DEPENDENTS

Adjusted gross income [2]	Income tax: Under present law	Income tax: Under the proposal
Assuming nonbusiness deduction of 10 percent of income:		
$2,800 [3]	0	0
$3,000	$28	0
$3,500	98	0
$4,000	170	0
$4,274 [4]	211	0
$5,000	322	$138
$7,500	753	613
$10,000	1,190	1,100
$12,500	1,628	1,575
$14,333 [5]	2,003	1,003
$15,000	2,150	2,170
$17,500	2,760	2,840
$20,000	3,400	3,540
$25,000	4,700	5,060
$30,000	6,200	6,800
$40,000	9,710	10,820
$50,000	13,820	15,500
Assuming nonbusiness deductions of 18 percent of income:		
$2,800 [3]	0	0
$3,000	28	0
$3,500	98	0
$4,000	170	0
$4,274 [4]	211	0
$5,000	322	139
$7,500	744	601
$10,000	1,133	1,028
$12,500	1,545	1,485
$14,773 [5]	1,955	1,955
$15,000	1,996	2,002
$17,500	2,473	2,564
$20,000	2,985	3,156
$25,000	4,100	4,580
$30,000	5,372	6,224
$40,000	8,387	10,052
$50,000	11,915	14,740

[1] These burdens have been computed without use of the optional tax table
[2] Wages and salaries.
[3] Highest level at which there is no tax under present law
[4] High level at which there is no tax under the proposal.
[5] Level at which tax is the same under present law and under the proposal.

TABLE 3.—FEDERAL INDIVIDUAL INCOME TAX BURDEN IN 1973 UNDER PRESENT LAW AND UNDER A PROPOSAL TO SUBSTITUTE A 24-PERCENT TAX CREDIT FOR THE $750 PERSONAL EXEMPTION AND FOR NONBUSINESS DEDUCTIONS [1]—MARRIED COUPLE WITH 2 DEPENDENTS

Adjusted gross income [2]	Income tax: Under present law	Income tax: Under the proposal
Assuming nonbusiness deductions of 10 percent of income:		
$4,300 [3]	0	0
$5,000	$98	0
$6,168 [4]	270	0
$7,500	484	$253
$10,000	905	740
$12,500	1,309	1,215
$15,000	1,820	1,810
$15,333 [5]	1,893	1,893
$17,500	2,385	2,480
$20,000	3,010	3,180
$25,000	4,240	4,700
$30,000	5,660	6,440
$40,000	9,080	10,460
$50,000	13,100	15,140
Assuming nonbusiness deductions of 18 percent of income:		
$4,300 [3]	0	0
$5,000	98	0
$6,168 [4]	270	0
$7,500	476	241
$10,000	848	668
$12,500	1,238	1,125
$15,000	1,666	1,642
$15,909 [5]	1,830	1,830
$17,500	2,117	2,204
$20,000	2,610	2,796
$25,000	3,680	4,220
$30,000	4,892	5,864
$40,000	7,802	9,692
$50,000	11,240	14,180

[1] These burdens have been computed without use of the optional tax table.
[2] Wages and salaries.
[3] Highest level at which there is no tax under present law.
[4] Highest level at which there is no tax under the proposal.
[5] Level at which tax is the same under present law and under the proposal.

TABLE 4.—FEDERAL INDIVIDUAL INCOME TAX BURDEN IN 1973 UNDER PRESENT LAW UNDER A PROPOSAL TO SUBSTITUTE A 24-PERCENT TAX CREDIT FOR THE $750 PERSONAL EXEMPTION AND FOR NONBUSINESS DEDUCTIONS [1]—MARRIED COUPLE WITH 4 DEPENDENTS

Adjusted gross income [2]	Income tax: Under present law	Income tax: Under the proposal
Assuming nonbusiness deductions of 10 percent of income:		
$5,800 [3]	0	0
$7,500	$245	0
$8,055 [4]	331	0
$10,000	620	$380
$12,500	1,024	855
$15,000	1,490	1,450
$16,167 [5]	1,747	1,747
$17,500	2,040	2,120
$20,000	2,635	2,820
$25,000	3,820	4,340
$30,000	5,180	6,080
$40,000	8,465	10,100
$50,000	12,380	14,780
Assuming nonbusiness deductions of 18 percent of income:		
$5,800 [3]	0	0
$7,500	238	0
$8,258 [4]	334	0
$10,000	569	308
$12,500	953	765
$15,000	1,342	1,282
$16,489 [5]	1,605	1,605
$17,500	1,787	1,844
$20,000	2,238	2,436
$25,000	3,260	3,860
$30,000	4,412	5,504
$40,000	7,217	9,332
$50,000	10,565	13,820

[1] These burdens have been computed without use of the optional tax table.
[2] Wages and salaries.
[3] Highest level at which there is no tax under present law.
[4] Highest level at which there is no tax under the proposal.
[5] Level at which tax is the same under present law and under the proposal.

THE HEALTH SECURITY ACT OF 1975 (H.R. 21)

(Mr. CORMAN asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. CORMAN. Mr. Speaker, the Health Security Act of 1975 that I am introducing today, along with 56 Members of the House of Representatives, represents more than 4 years of intensive study, development, and refinement by the Committee for National Health Insurance. This committee consists of 100 American leaders from many fields, including citizen and church groups, labor and consumer organizations, health professionals and political leaders.

House cosponsors of the Health Security Act of 1975 include at the present time: Mr. GREEN, Mr. HELSTOSKI, Mr. RANGEL, Mr. STARK, Mr. MIKVA, Ms. ABZUG, Mr. ADDABBO, Mr. ANDERSON of California, Mr. ANNUNZIO, Mr. ASHLEY, Mr. BADILLO, Mr. BINGHAM, Mr. BOLLING, Mr. BROWN of California, Mr. CARNEY, Mrs. CHISHOLM, Mr. CLAY, Mr. CONYERS, Mr. DANIELS of New Jersey, Mr. DIGGS, Mr. DRINAN, Mr. ECKHARDT, Mr. EDWARDS of California, Mr. EILBERG, Mr. FAUNTROY, Mr. FORD of Michigan, Mr. FRASER, Mr. HARRINGTON, Mr. HAWKINS, Mr. HECHLER of West Virginia, Ms. HOLTZMAN, Mr. HOWARD, Mr. KOCH, Mr. LEHMAN, Mr. MCCORMACK, Mr. MCFALL, Mr. MACDONALD, Mr. MADDEN, Mr. MEEDS, Mr. MOAKLEY, Mr. MOSS, Mr. MURPHY of New York, Mr. NEDZI, Mr. NIX, Mr. OBERSTAR, Mr. PEPPER, Mr. RODINO, Mr. ROSENTHAL, Mr. ROYBAL, Mr. ST GERMAIN, Mr. SEIBERLING, Mr. STOKES, Mr. STUDDS, Mr.

THOMPSON, Mr. UDALL, and Mr. VAN DEERLIN.

This legislation, and the national health insurance program it proposes, reflects two fundamental beliefs and objectives: First, every American should be assured access to comprehensive health care—financial and residential barriers to complete medical needs must be eliminated; and, second, along with eliminating financial and residential barriers to needed health care, a national health insurance program must introduce improvements in the organization, delivery and general quality of health care.

The health security program that this legislation would establish is needed not because we, as families or a nation, need to spend more money than we are already spending to obtain needed health and medical care. We are already spending more per capita and using more of our Nation's resources for health purposes than any other nation in the world. We do not need to spend more—but we desperately need to spend the Nation's and each family's health care dollars more effectively and less wastefully.

In fiscal year 1974, for example, total health costs in the United States were $104 billion, an increase of 10 percent over fiscal year 1973. This was during a period of price controls. Following the lifting of controls on April 30, 1974, health cost inflation accelerated to an annual rate of 18 percent, much faster even than the general inflation.

During the previous 5 years, total health costs for the country increased an average of 12.8 percent a year. The total cost increase during the past 8 years was over $56.1 billion—from $47.9 billion in fiscal year 1967 to $104 billion in fiscal year 1974. Thus, the Nation's total health bill jumped well over 100 percent in 8 years.

We simply can no longer afford the existing methods of getting and paying for health care. Soaring medical costs have outstripped the general economic growth rate and surpassed increases in wages. National health insurance is an issue today because of the rapid and uncontrollable increases in medical costs under the existing arrangements.

Over the long run, by revitalizing the existing health care system and ending the runaway costs of health care, the health security program would be far less expensive than the amount we would spend if the present arrangements were to continue.

Despite the fact that we spend more than any other nation on health care, millions of American families cannot afford or do not have access to needed medical treatment.

After 30 years of trying, private health insurance has failed to come even close to meeting the Nation's need for health protection. At the present time, private insurance pays no more than one-third of the Nation's total health costs. About 40 million Americans have no health insurance. In the next few months they will be joined by additional millions of unemployed workers who will lose their private insurance coverage as a result of recent job layoffs. In other words, because of current economic conditions, millions of families will lose the health protection that was contingent upon their employment. Under health security they would be assured that their health needs would continue to be met, even during times of unemployment, and without a demeaning means test or other conditions.

Thirty years of experience has provided clear indication that a system of private health insurance will not provide universal coverage and cannot effectively contain or direct health expenditures. If the private health insurance industry gave any indication that it could work, or that it could provide an efficient health system assuring all citizens equal access to comprehensive medical care, we would not be discussing national health insurance at the present time.

Despite medicare, medicaid, and other governmental attempts in recent years to help people finance needed medical care, many of the elderly, disabled, and poor in this country are still forced to go without needed medical treatment. Low-income Americans—especially if they are from minority groups—receive less medical care, are less likely to have health insurance coverage, and are generally less healthy than middle- and high-income Americans.

The existing mix of private insurance and Government programs maintains large gaps, in terms of people and medical services covered. The result has produced intolerable inequities in the availability, cost, and quality of health care. National health insurance will be a dismal failure if it does not remove these inequities. A primary objective of health security is to make available to the elderly and poor the same quality of health care that is available to any other American.

Existing private and Government programs provide financial incentives for people to use the most expensive components of our health system, such as hospitalization, while failing to encourage less expensive and more desirable forms of preventive medicine and outpatient care.

There are unnecessary inefficiencies, waste and administrative costs and complexities in the fragmented, disorganized, and inadequately regulated combination of private insurance and Government programs.

The fragmentation of the current system defies attempts to control runaway inflation in health costs or regulate the quality of medical care provided.

Dozens of different health insurance programs have been developed to deal with some or all of these programs. The most prominent of these proposals would guarantee increased profits for all segments of the health care industry, and guarantee a continuation of double-digit inflation in health care costs. They would retain the complexities, inefficiencies, potential for abuse, and undesirable incentives that exist under current private and governmental programs. They would not guarantee that needed health care would be available and obtainable for everyone.

The Health Security Act is the only proposal that would establish a broad system of health care financed and administered by the social security system. The aim of the program is to improve and protect the health of all Americans, while maintaining health expenditures within reasonable limits. A central objective of health security is to stop the rampant inflation in health costs we have experienced in recent years.

National health insurance is needed because many families presently cannot afford or obtain needed health care. Initially, as these families gain access to needed care under health security, some increase in the Nation's total health expenditures can be expected. The increase, however, would not be substantial. The American people would spend approximately the same amount of money, in terms of total dollars spent for health and medical care under health security as they are now spending. Total health costs would be distributed through an equitable and proven national insurance system of shared health costs administered by the Social Security Administration. The health costs of each family under health security would be predictable from year to year. All individuals would be assured access to needed care and would pay for complete medical treatment when they are well and working before illness strikes.

Health security is the only health program that, in the long run, would provide realistic mechanisms for effectively containing and directing the Nation's health expenditures. Through a long-range process that requires hospitals and physicians to set their prices in advance and then stick to them, the Nation's health costs would be effectively regulated and could be directed to meet our changing health needs. By encouraging prepaid health programs, or health maintenance organizations, preventive medical care, early diagnosis and office or outpatient treatment—where possible—it would substantially improve the quality and reduce the cost of the present health delivery system.

In contrast, a program limited to catastrophic coverage would benefit only a few families. It would not reduce existing medical expenses for most families. It would encourage continued inflation in health costs by maintaining the undesirable emphasis on expensive surgery, hospitalization, and crisis intervention. It would not reorient the health system toward less expensive and more effective forms of preventive medicine and health protection.

It has been argued that a system that does not impose deductibles and coinsurance, requiring individuals to pay first-dollar cost out-of-pocket at the time they seek medical care, will result in high rates of unnecessary use of health resources. There is no evidence that this would happen, and in Canada the evidence is to the contrary. Slight increases in utilization occurred under Canada's health system when deductibles were removed, but these soon leveled off. Canada's experience clearly demonstrates that the paper work and costs of administering deductibles results in more waste than savings.

In order to keep deductibles and coinsurance from preventing low-income families from seeking needed medical care, it would be necessary to establish and administer an incomes test. A system of deductibles and coinsurance, plus a means test for low-income families, would result in mind boggling administrative and account-keeping procedures. Somewhere, someone would have to keep an account for every covered individual and family, in order to keep track of the families' yearly income and deductible and coinsurance payments. This would increase the administrative cost of a national health program from $2 to $3 billion annually.

Under health security, because all Americans would be covered for comprehensive health needs, administration would be simplified and efficient. Doctors and hospitals would not have to waste time and money trying to determine and keep track of who is and who is not covered. There would be no deductibles and coinsurance to keep track of, and no $2 to $3 billion demeaning means test to administer. And, doctors would not be allowed to charge the patient more than the reimbursable amount for any covered service.

Health security would not change the basic relationship between the doctor and patient. Care would be provided by physicians, hospitals, and other private providers in much the same way it is done today. What would change is that every family would have the security of knowing that their basic and catastrophic health needs would be met, regardless of the general economic situation or their specific financial and employment circumstances. Patients would continue to be able to go to the doctor of their choice, but all doctors and other providers would be encouraged to emphasize preventive care, or to shift their focus from treating people who are sick, to keeping people well and out of the hospital.

The intent of health security is to make use of all qualified health providers. It would actively encourage more efficient organization of existing health manpower, provide funds for special training of needed physicians, dentists, and other health personnel, and apply financial incentives to stimulate the movement of health manpower to medically deprived areas.

American families want a health system under which they are assured that all their health needs will be met, and where the emphasis is on keeping them well and out of the hospital. They want a system that provides more convenient access to high quality medical treatment. They want to know how much they will spend for their health needs each year, to be assured that they will not be bankrupted by an unexpected serious illness, and to receive a higher return on their health care dollars. They want a health system that protects their freedom to choose their own doctor or other health provider, and which allows them substantial influence in deciding how the Nation's health resources will be used.

The 94th Congress has the opportunity, and I believe the mandate, to enact such a program. I am introducing the Health Security Act on the first day of this new Congress so there will be ample time for us to consider carefully the provisions of this bill in relation to the health needs and concerns of the American public.

I hope the Health Subcommittee of the Ways and Means Committee will begin immediately to consider the issue of national health insurance. I stand ready to work with any and all interested individuals and groups toward the establishment of a universal and comprehensive health program that meets the needs of the American public.

HEALTH SECURITY 1975 (H.R. 21): SUMMARY OF CHANGES FROM THE 1974 HEALTH SECURITY PROPOSAL

The Health Security Act of 1975 (H.R. 21) contains the following improvements in health security bills introduced in previous years:

Grants would be given to local nonprofit agencies to develop and provide social care services to benefit the aged and chronically ill. The Health Security Board which would administer the program is directed to make grants as rapidly as it is satisfied that applicants can provide the services and assure some measure of non-Federal financing.

Ceiling on payroll and individual taxes would be raised from $15,000 to $20,000.

Catastrophic protection would specifically be recognized in the preamble.

Optometrists and podiatrists would be recognized as "physicians" when functioning within board regulations, and they could write prescriptions if permitted by State Law.

Free-standing alcohol, drug abuse, family planning, and rehabilitation centers would be recognized as providers.

An amendment on employment rights in health care institutions would be incorporated.

Otherwise, the health security bill which has been before the Congress since mid-1970 would remain essentially unchanged.

HEALTH SECURITY IN BRIEF

Eligibility: Everyone living in the United States would be eligible for health security benefits.

Benefits: The health security program would pay for nearly the entire range of personal health care services including catastrophic coverage. The covered services would include full physicians' services; inpatient and outpatient hospital services; home health services; optometry and podiatry services, and devices and appliances. It would also cover, at the outset, dental care for children up to age 15 and eventually cover the entire population. And, with limitations, psychiatric services, nursing home care and drugs would be covered. It would establish large pilot projects to determine the feasibility of home maintenance care for the chronically ill or disabled.

Administration: Health security would be administered by a five-member Health Security Board as part of the Department of Health, Education, and Welfare. The Board would establish policy, standards, and regulations for the program.

Financing: The program would be financed from a health security trust fund created by a special tax on employers, employees, and the self-employed, with the entire amount matched by Federal general revenues.

Cost and quality controls: Health security would establish a Quality Control Commission to develop cost control features, including national standards for health care providers.

Payments to providers: Physicians, dentists, hospitals, nursing homes, and other health care providers would be paid in full directly from the Health Security Trust Fund. The patient could not be charged more.

Consumer participation: Health security would assure effective participation of consumers in policy, development and administration of the program on the national, State, and local levels. It would encourage consumer organizations to establish health care plans. Procedures would be built into the entire system to assure public accountability for its operation.

Manpower support: Health security would actively encourage more efficient organization of existing health manpower and provide funds for special training of health professionals and allied personnel.

Resources development fund: To improve the providing of health care, a resources development fund would be established to support innovative health programs, particularly in manpower, education, training, and group practice development.

Incentives: Financial, professional, and other incentives would be built into health security to move the health care delivery system toward organized arrangements for patient care, such as health maintenance organizations and other prepaid group practice plans or professional foundations. It would also establish programs for preventive care, early diagnosis of illness, and medical rehabilitation.

HEALTH SECURITY: DETAILED DESCRIPTION BENEFITS

Everyone living in the United States would be entitled to have all health care—with few exceptions—paid for by the Health Security Program.

The program would have no exclusions for pre-existing conditions; no limits on preventive medical services; no coinsurance; no deductibles; no waiting periods.

Here are the details of the services which would be available:

Physicians' services: Professional services by physicians, furnished in their offices or elsewhere, would be covered in full. This includes general medical and specialized services.

All major surgery and other specialized care would be covered if performed by qualified specialists.

Psychiatric services would be provided to outpatients if given for active treatment of emotional or mental disorders and if provided by comprehensive mental health organizations. Otherwise, there would be a limit of 20 consultations by a psychiatrist during a benefit period.

Dental services: At the start, health security dental benefits would be lim-

ited primarily to children up to age 15, with the coverage including preventive, diagnostic and therapeutic services.

Adults would be entitled initially to certain emergency and rehabilitative services, such as oral surgery to correct accident damage.

The age of eligibility for full dental care would be extended to persons up to age 25 during the first 5 years of the program's operation and the younger people would remain eligible throughout their lives. The increase of coverage could be accelerated if the Health Security Board believes it is feasible.

Institutional services: Health security would provide full payment for hospital services; skilled nursing home care up to 120 days per benefit period or for an unlimited time if the home is owned or managed by a hospital; other approved noncustodial health services; and, home health services.

The program would also include pathology and radiology services and all other necessary services whether furnished by a hospital or other institution or by others under arrangements with such institutions.

The program would also include recognition as providers of authorized free-standing alcohol, drug abuse, family planning and rehabilitation centers.

Drugs: Health security would cover drugs for hospital inpatients and outpatients and for persons enrolled in comprehensive group practice plans and professional foundations as long as the drugs were from an approved list.

For others, drugs would be covered if they were necessary for specified chronic diseases and conditions requiring long or costly drug therapy.

The purpose of the approved drug list—and regular reviews of the list—would be to assure the safety, effectiveness and reasonable cost of the prescribed drugs.

Devices, appliances and equipment: Health security would provide coverage of therapeutic devices, appliances—including eyeglasses, hearing aids and prosthetic devices—and equipment. An approved list of covered items would be prepared and reviewed regularly.

Other professional and supporting services—health security would cover:

First. Professional services of optometrists and podiatrists;

Second. Diagnostic services of independent pathology laboratories;

Third. Diagnostic and therapeutic services of independent radiologists;

Fourth. Mental health day-care services furnished by a health maintenance organization or comprehensive community health center, or 60 days of care furnished, during or following a benefit period, by a hospital or a center affiliated with a hospital;

Fifth. Ambulance services;

Sixth. Other professional services such as psychological counseling, physiotherapy, nutrition, social work and home care or health education when furnished as part of institutional services or through health maintenance organizations;

Seven. Diagnostic and therapeutic services of free-standing alcohol, drug abuse, family planning and rehabilitation centers.

Social care services: Grants would be provided to local nonprofit organizations to develop social care services to aid chronically ill, aged and other homebound patients. Under this section, while some measure of local financing is developed, health security would cover homemaker services, transportation and other social care services as a demonstration of the usefulness of such benefits in reducing unnecessary long-term institutional care.

ADMINISTRATION

Health security would be administered at four levels—national, regional, area and local—with some important functions carried out by States.

National: Overall health security policy and regulation would be established and carried out by a five-member, full-time Health Security Board appointed by the President and under the supervision and direction of the Secretary of Health, Education, and Welfare.

The members normally would be appointed for 5-year terms, with one member serving as chairman and with no more than three members from the same political party. The program would be administered through an Executive Director appointed by the Board.

To assist the Board in carrying out its functions and to advise and recommend various changes or actions, a 21-member National Health Security Advisory Council would be established. A majority of the membership of the Council would be consumers of health services. The Council would be authorized to appoint professional and technical committees to help carry out its functions.

The Secretary, Board and Executive Director would all work to assure effective coordination of health security with existing HEW programs—and with programs in the regions and States—for the development of health facilities and manpower resources, medical research and public and community health services.

The Health Security Board would control expenditures from the health security trust fund, establish national benefit patterns, set standards of participation and develop policy guidelines. The Board would also have the responsibility to assure effective consumer participation and public accountability at all levels.

The Board would also have responsibility for studying systems of paying for services and for planning new developments and improvements for health services.

A Commission on Quality of Health Care would be established and charged with assuring and developing standards for care of high quality.

Regional and health service areas: At the second and third level of administration for the health security program, 10 regional health security offices would be established within the regions of the Department of Health, Education, and Welfare and approximately 100 health service areas would be established paralleling the natural medical delivery patterns in the United States.

The health service areas normally would consist of a State or part of a State. Interstate areas would be established where the Board found that patterns of health service organization and patient flow made an interstate area a more practical unit of administration.

Local: As the fourth level of administration, the Health Security Board would establish in each health service area a local Health Security office and any necessary branch offices.

These offices would assist health service consumers and providers and serve an ombudsman function by investigating complaints concerning administration of the program. They would also have informational and other administrative functions.

States. States would participate in health security in a number of ways. They would participate in planning, training, coordination for quality controls and manpower increases, health education, utilization review and the inspection of providers.

The Health Security Board would establish appropriate payment arrangements with the States for the services.

To improve the supply and distribution of health personnel and facilities and the organization of health services, the Board would work with State comprehensive health planning agencies and with regional medical programs.

Existing programs affected: A number of major Federal health programs would be superseded in whole or in part by Health Security.

Medicare: Everyone 65 or over, along with the rest of the population, would be entitled to health security coverage. Because the benefits of health security would be broader than those offered under medicare, the medicare program would be terminated.

Medicaid: Most of the benefits of state medicaid programs would be available under health security. Such benefits would be deleted from medicaid, leaving it as a supplementary program to health security. States would claim partial reimbursement for medicaid services they provided which exceeded those available under health security. This would include long-term nursing home care, drugs for certain purposes, and adult dental care. Providing these services would be at the option of the individual States.

CHAMPUS: Under the civilian health and medical program of the Uniformed Services, the Defense Department reimburses civilian hospitals and private doctors for the health services of servicemen, their dependents, and retirees. Most of CHAMPUS benefits would be available under health security; CHAMPUS would provide only those benefits not covered by health security.

The Department of Defense program for care in military hospitals of servicemen, their dependents, and retirees, would continue unaffected by health security.

Workmen's compensation: Because separation of the health service benefits of workmen's compensation programs

from cash payments would unduly complicate the eligibility determination process, workmen's compensation would continue unaffected by health security.

Other programs: Maternal and child health programs, crippled children programs, Office of Economic Opportunity health programs and medical vocational rehabilitation provide a range of various services to specific groups. In addition to a personal health service component, each program covers other types of health and community service, such as research and vocational training.

Personal health services provided by these programs would be transferred to health security, while all other benefit features would remain with the existing program.

Future plans: In order to broaden the scope and benefits of health security to remove its initial limitations, the program would undertake various studies, including long-term care, coordination of Veterans' Administration health care programs with health security, and the provision of health security benefits to U.S. citizens in other countries.

FINANCING

The financing of health security would be through a health security trust fund, similar to the Social Security Trust Fund.

Fifty percent of the money would come from:

First. A 3.5 percent tax on employer payroll.

Second. A 1 percent tax on the first $20,000 a year in wages and nonearned income.

Third. A 2.5 percent tax on the first $20,000 a year of self-employment income.

The remaining 50 percent would come from Federal general revenues.

If an employer's existing obligations for the purchase of health benefits for his employees are greater than 3.5 percent of payroll, the excess would be applied toward the 1 percent which would otherwise be withheld from an employee's wages.

The first $3,000 income for persons over 60 would be exempt from health security tax.

The total of these taxes and the Government matching funds would be the total available to pay for personal health services in each fiscal year.

After setting aside contingency reserves and money for the development of additional health resources, the remaining money would be divided among the ten regions of the country. This would be done with regard for recent and current use and expenditure patterns for services covered by the program.

Initially, the Health Security Board would look to the latest expenditure figures available before the program starts, making appropriate adjustments among the regions for figures higher or lower than the average. After that, the allocation among regions would be guided by actual expenditures and estimates of what was needed to meet the program's obligations and objectives.

The Board would budget funds for each of the HEW regions in each category of covered service from the total sum allocated to the region. There would be authority for each region to determine its own needs and priorities in support of services.

Operation of the health security trust fund would be taken out of the consolidated budget, except for Government contributions to the trust funds.

COST AND QUALITY CONTROLS

The central cost control feature of the health security program is that the health care system would be anchored to a budget established in advance.

The program's main quality control feature would be the establishment of national standards for participation both for individual and institutional providers.

To develop and enforce such standards, a Commission on the Quality of Health Care would be established. It would be a quasi-independent board reporting to the Health Security Board, but with authority to appeal to the Secretary of Health, Education, and Welfare if it believes the Board has failed to implement or enforce effective quality standards.

Here are the details:

Budgeting: The health security program would establish an advance budgeting procedure for the costs of personal health services.

Each year an advance determination would be made of the total amount to be spent in the various regions on physicians' services, institutional services and other categories of service provided in local communities.

The cost of each kind of service and the overall cost of the program would be allowed to increase only on a controlled and predictable basis.

The program would use the budgetary process not merely to control costs, but also to strengthen local, State, and regional planning, stimulate more efficient institutional administration; and gradually reverse the current undesirable emphasis on inpatient hospital and other institutional services. This would be done by stressing preventive and early curative services and by making alternative levels and forms of care available outside of institutions.

In approving budgets for institutions, the program would consider recommendations and decisions of State and other health planning authorities, administrative efficiency of the institution, scope of care provided and the need to achieve an equitable distribution of resources throughout the region and country.

Wasteful duplication of services and facilities would be gradually eliminated by withdrawal of funding. Institutional budgets would be increased to allow for the provision of services needed for a balanced development of regional resources.

National standards — The national standards for provider participation would be designed to upgrade the quality of care, encourage appropriate use of health manpower and promote orderly planning of facilities.

Physicians, dentists, osteopaths, optometrists and podiatrists licensed to practice in a State when the program begins would be eligible to take part in the program as long as they meet continuing education requirements.

The Health Security Board would be authorized to establish national standards for professional personnel licensed after the program begins and to set requirements for their continuing education.

Hospitals, skilled nursing homes, home health agencies, specified free-standing centers, medical or dental foundations and health maintenance organizations would be eligible to participate if they met national standards established by the Board.

Federal law would supersede State statutes which restrict the development of group practice programs.

Institutions would be required to establish working relationships with other providers of care so that a patient would have continued and appropriate treatment. Institutions which refused to comply with local and regional plans required by the Board would not be eligible to participate in the program.

PAYMENTS TO PROVIDERS

Hospitals, skilled nursing homes, and other types of institutional providers would operate on an approved budget basis rather than being able to charge whatever they decided.

Using the precious year's fiscal experience and taking into account standards of participation, range of desirable services and quality controls required by health security, the institutions would develop proposed budgets for the next fiscal year. They would be assisted by the regional and local offices of health security in preparation of their budget requests. The budgets would be reviewed and given final approval at the regional office level.

Money allocated for payment of individuals, such as physicians, dentists, podiatrists, and so forth, would be distributed to local areas within the region. This would be done on a per capita basis with adjustments for differences in the cost of goods and services. The budgeted per capita amount for each type of covered service would be divided between the categories of providers according to the number of individuals who elected to receive care from those providers.

For example: In a city of 100,000 people, 25,000 may be enrolled in health maintenance organizations. If the amount budgeted for physicians services in that area is $65 per capita, the Board would pay the HMO's $1,625,000—$65 times 25,000—for physicians services. Since the other 75,000 individuals elected to receive care from solo, fee-for-service practitioners, the Board would create a fund of $4,875,000—$65 times 75,000—to pay all fee-for-service bills submitted by physicians in the community.

Other independent providers, such as pathology laboratories, radiology services, pharmacies and providers of appliances, would be paid through methods adapted to their characteristics.

Under health security, providers would have to agree not to charge individuals for all or part of any service provided. Payment in full would be made directly by the program to the provider or to the agency representing him. There would be no billing of the patient or indemnity payment to him.

Health maintenance organizations and

professional foundations accepting responsibility for providing or securing all covered services for a defined population would receive the total amount budgeted and negotiated as payment. They would share also in the savings they helped to achieve by preventing unnecessary hospitalization of their enrollees.

CONSUMER PARTICIPATION

Health security would rely heavily on the development of new, comprehensive care organizations such as health maintenance organization—HMO's—and other forms of prepaid group practice plans to improve consumer opportunities for better health care and provide alternatives for better patient care.

Such organizations will be required to provide or arrange for all covered services except mental and dental services. Professional foundations would be required to provide the same range of services as HMO's and to meet the same strict quality standards.

The manner in which services would be paid for recognizes the added value of the comprehensive care programs as more efficient and higher quality to, and satisfaction of, the consumer.

Consumer organizations would be encouraged to give health care a higher priority in their overall activities and to sponsor and develop comprehensive community-wide health care organizations. Along with health maintenance organizations to be developed by hospitals, physican groups, and combinations of professionals, the programs developed by consumer-sponsored organizations would be supported and recognized by health security.

The Health Security Board would assure effective participation by consumers at all levels of policy formulation and program development. There would be a majority of consumer representatives on the National Advisory Council assisting the Board in its continuing administration of the program, and on regional and local advisory councils. The makeup of the councils would have to reflect the composition of the State or community served. There would be public control of the basic policies governing the program and full public accountability for its finances and operations.

MANPOWER SUPPORT

Health Security would actively encourage more efficient organization of existing health manpower, provide funds for special training of physicians, dentists, and other health personnel, and apply financial incentives to stimulate the movement of health manpower to medically deprived areas.

Health Security would recognize costs incurred by HMO's in supporting the training and appropriate utilization of allied health professionals. It would pay the full cost of employing support personnel, such as nurse practitioners, public health nurses, nutritionists, and community health workers, thus extending the ability of physicians to provide care and giving the consumer access to a wider range of services.

Training funds could be used for the retraining of health workers to enhance or refresh skills or for new positions of greater responsibility.

Money would be available through the resources development fund to stimulate the expansion of training programs for new categories of health professionals, especially those required as members of primary health care teams—such as pediatric nurse practitioners, physicians' assistants, and dental hygienists. Emphasis would be placed upon demonstration programs for the training and placement of allied health workers, and support would be available to institutions for the special costs of educating and training minority group and economically deprived students.

The assured purchasing power of a national health program would help to overcome many of the present barriers to recruiting and holding needed health workers in disadvantaged and remote areas. Substantial efforts would be made to enhance the desirability of practice in such areas by improving local resources and providing money for special communication, transportation, and consultation costs.

In addition, special incentives would be used to increase the attractiveness of practice in rural or deprived areas for health workers and their families. There would be financial disincentives for the disproprionate clustering of physicians and dentists in a few metropolitan or suburban areas and corresponding incentives for their location in other areas.

RESOURCES DEVELOPMENT FUND

A substantial resources development fund—administered by the health security board—would help to increase the resources for services and to bring new organized programs of health service into being and to expand existing ones.

The resources development fund would be formed, first, by appropriations from Federal general revenue for the period between enactment and when benefits began, so that system improvements could get underway promptly; and, subsequently, by taking a percentage of the annual income of the trust fund—2 percent the first year, increasing in regular intervals to a maximum of 5 percent a year.

A priority would be given in grants and loans to stimulate the development and growth of health maintenance organizations. Essentially, the fund would recognize the responsibility of health security to assure the availability of covered health services, and not merely to pay for them. And, it would have concern for the development of services to meet the changing needs of people in the most effective and efficient manner, not merely to build on already overburdened and often wastefully expensive services.

INCENTIVES

Payment for services provided under health security would give special incentives to health maintenance organizations, and medical and dental foundations.

Physicians who became members of primary health care teams and established working relationships with specialists and with such patient-care resources as hospitals, skilled nursing homes, and home health facilities, would be reimbursed for the costs of such linkages and would be encouraged to extend their services through such support arrangements.

Health security would provide support for continuing studies and demonstrations of new and promising methods of organizing health services.

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H.R. 21

A bill to create a national system of health security

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

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds that—

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

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

(3) a national system of health security is the means to implement that right.

(b) The purpose of this Act is—

(1) to create a national system of health security benefits which, through national health insurance will make comprehensive health services available to all residents of the United States, will distribute the cost of health care more equitably in relation to income, and will provide major protection against catastrophic costs, and

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

INITIATION OF HEALTH SECURITY PROGRAM

SEC. 3. Health security taxes will become effective on January 1, and health services will become available on July 1, of the second calendar year after the year in which this Act is enacted. Except for the benefit and related fiscal provisions, title I of this Act is effective upon enactment. Certain federally financed or supported health programs will be terminated or curtailed when health benefits under this Act become available. Effective dates of the several provisions of this Act are set forth in sections 163, 204, 214, 221, 401 to 406 inclusive, and 409.

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TITLE I—HEALTH SECURITY BENEFITS

PART A—ELIGIBILITY FOR BENEFITS

BASIC ELIGIBILITY

SEC. 11. Every resident of the United States and every non-resident citizen thereof is eligible, while within the United States, to receive health services under this Act; except that an alien employee (as defined in regulations) of a foreign government, of an instrumentality of a foreign government exempt from the taxes imposed by section 3111 (b) of the Internal Revenue Code of 1954, or of an international organization (as defined in the International Organizations Immunity Act) is eligible only in accordance with an agreement under section 12. An alien admitted as a permanent resident and living within the United States, an alien admitted for employment and employed within the United States, or a refugee lawfully in 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 benefits of this title to persons within the United States not otherwise eligible therefor, in consideration of payment to the United States of the estimated cost of furnishing the benefits to such persons, or of an undertaking to furnish in a foreign country similar benefits to citizens of the United States, or of a combination of payment and such an undertaking.

PART B—NATURE AND SCOPE OF BENEFITS: COVERED SERVICES

ENTITLEMENT TO HAVE PAYMENT MADE FOR SERVICES

SEC. 21. Every eligible person is entitled to have payment made by the Board for any covered service furnished within the United States by a participating provider if the service is necessary or appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following, injury, disability, or disease. Participating providers are providers, described in part C, who meet the conditions stated in section 41. Covered services are services described in sections 22 to 27, inclusive, but are subject to the exclusions stated in section 28 and to limitations prescribed by or pursuant to part H (relating to the quality of care).

PHYSICIAN SERVICES

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

(b) Covered physicians' services consist of (1) primary medical services, which are the services (as defined in regulations, but including preventive services) ordinarily furnished by physicians, whether general practitioners or specialists, engaged (as determined in accordance with standards for such practice prescribed in regulations) in general or family practice for adults or for children or for both, and (2) specialized services.

(c) Psychiatric (mental health) service to an outpatient is a covered service (1) only if it constitutes an active preventive, diagnostic, therapeutic, or rehabilitative service with respect to emotional or mental disorders, and (2) only (A) if the service is furnished by a group practice organization, by a hospital, or by a community mental health center or other mental health clinic which furnishes comprehensive mental health services, or (B) if the service is furnished to a patient of a day care service with which the Board has an agreement under section 49(a) (3), or (C) to the extent of twenty consultations during a benefit period (as defined in regulations), if the service is furnished otherwise than in accordance with clause (A) or (B). In any community in which the available psychiatric services furnished otherwise than in accordance with clause (A) or (B) are found by the Board to be insufficient to meet the needs of the community, the Board may limit the coverage of such services by prescribing referral or other nonfinancial conditions in order to give priority of access to the services to those persons most in need of them.

DENTAL SERVICES

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

(b) Persons who, on the effective date of health benefits, are less than fifteen years of age are entitled to covered dental services, and will remain so entitled throughout their lives. On July 1 of each of the five years

immediately succeeding the year in which the effective date occurs, the following persons will become (and thereafter remain) entitled to such services: on July 1 of the first succeeding year, persons who are then less than seventeen years of age; on July 1 of then less than nineteen years of age; on the second succeeding year, persons who are July 1 of the third succeeding year, persons who are then less than twenty-one years of age; on July 1 of the fourth succeeding year, persons who are then less than twenty-three years of age; and on July 1 of the fifth succeeding year, persons who are then less than twenty-five years of age.

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

(d) The Board is authorized, if it finds that the availability of funds and of facilities and personnel makes it possible, to provide by regulation for acceleration of the entitlement (by age groups) to covered dental services as set forth in subsection (b). Not later than seven years after the effective date of health benefits, the Board shall by regulation provide that entitlement to dental services shall be extended, over such period of time and by such age or other groupings as it finds calculated to make the best use of available resources and personnel, to all persons not otherwise entitled to such services; and it may thereafter, from time to time, amend such regulations on the basis of further experience in the furnishing of dental services as covered services. In exercising its authority under this subsection the Board shall seek to encourage the furnishing of dental services as a part of comprehensive health services, or the furnishing of them by organizations furnishing comprehensive dental services (which meet requirements set forth in regulations under section 104(a)); and to that end, the Board may limit additional entitlement to dental services, in whole or in part and temporarily or permanently, to services so furnished.

INSTITUTIONAL SERVICES

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

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

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

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

(2) In all participating skilled nursing homes having in effect affiliation agreements under section 52(b),

if the Board finds that adequate funds and resources are available therefor and that such action will not lead to excessive utilization of nursing home services.

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

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

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

PHARMACEUTICAL BENEFITS

SEC. 25. (a) The Board shall establish and disseminate (and review at least annually) (1) a list of drugs for use in participating institutions, groups practice organizations, and individual practice associations, and (2) a list (for use outside such institutions, organizations, and associations) 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), the furnishing of a drug to an eligible person is a covered service if it is furnished by or on prescription of a participating physician or dentist, or by or on prescription of a physician or dentist acting on behalf of a participating institutional or other provider.

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

(c) The list of diseases and conditions referred to in subsection (a)(2) shall include those chronic diseases and conditions for which drug therapy, because of its duration and cost, commonly imposes substantial financial hardship; and may include other diseases and conditions for which the Board finds costly drug therapy 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 qualification, 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 shall establish and disseminate (and review at least annually) lists of the therapeutic devices, appliances, and equipment (including eyeglasses, hearing aids, and prosthetic appliances), or classes thereof, which it finds are important for the maintenance or restoration of health or of employability or self-management. The Board shall take into consideration the efficacy, reliability, and cost of each item listed, and shall attach to any item such conditions as it deems appropriate with respect to the circumstances under which or the frequency with which the item may be prescribed. In establishing and revising lists under this section the Board shall seek to avoid a rate of expenditure for the furnishing of devices, appliances, and equipment in excess of 2 per centum of the rate of expenditure for all covered services.

(b) The furnishing of a device, appliance, or equipment prescribed by a participating physician or dentist, or by a physician or dentist acting on behalf of a participating institutional or other provider, is a covered service if the item appears on a current list established under subsection (a) and the prescription falls within any conditions attached, on the list, to the prescribing of that item. 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 had determined may not be furnished as covered services.

OTHER PROFESSIONAL AND SUPPORTING SERVICES

SEC. 27. (a) To the extent provided in regulations, the following are covered services:

(1) the professional services of optometrists in the examination, diagnosis, and treatment of conditions of the vision system;

(2) the professional services of podiatrists;

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

(4) the care of a patient in a mental health day care service (A) for not more than sixty full days (or its equivalent) during or following a benefit period (as defined in regulations), when furnished by a hospital or a service affiliated with a hospital, or (B) if furnished by a group practice organization or by a community mental health center or other mental health center which furnishes comprehensive mental health services, or (C) if furnished by a mental health day care service with which the Board has an agreement under section 49(a)(3);

(5) in addition to the services available from hospitals, mental health centers, or other providers, the active treatment of a person with an established diagnosis of alcoholism or drug abuse, as an outpatient, in a free-standing ambulatory center (that is, a center the services of which are not furnished on behalf of another provider) with which the Board has an agreement under section 49(a)(5) for the treatment of persons with such diagnosis;

(6) in addition to the services available from other providers, family planning services furnished by a free-standing family planning center with which the Board has an agreement under section 49(a)(6);

(7) in addition to the services available from other providers, rehabilitation services furnished by a free-standing rehabilitation center with which the Board has an agreement under section 49(a)(7); and

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

(b) Supporting services (such as psychological, physiotherapy, nutrition, social work, or health education services) are covered services when they are furnished on behalf of an institutional provider or when, with the approval of the Board, they are furnished on behalf of a group practice organization or individual practice association, or of an organization, agency, or center with which the Board has an agreement under section 49(a); but only if the persons furnishing the supporting services are compensated on a salary, stipend, or capitation basis by the provider on whose behalf they are furnished.

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 to an eligible person, shall nevertheless be treated as covered services in accordance with this part unless and until a determination has been made pursuant to the workmen's compensation law that the services are covered by that law, and any resulting overpayment under this title shall, when payment is made under the workmen's compensation law, be recouped in the same manner as other overpayments.

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

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

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

(e) The Board may by regulation exclude from covered services medical or surgical procedures (and services incident thereto) which it finds both (1) are essentially experimental in character, and (2) because of cost or because of shortage of qualified personnel or facilities 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 who has enrolled in a participating group practice organization or in a participating individual practice association, and are within the range of services which the organization or association has undertaken to furnish, or (2) they are primary physicians' services or covered dental services and are furnished by another provider to a person who has chosen to be on the list of a physician or a dentist electing to be paid by the capitation method. Regulations under this subsection shall permit termination of the enrollment referred to in clause (1), or of the choice referred to in clause (2), after the enrollment or choice has been in effect for twelve months, or at an earlier time for such reasons as may be specified in the regulations.

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

PART C—PARTICIPATING PROVIDERS OF SERVICES

IN GENERAL; AGREEMENTS WITH THE BOARD

SEC. 41. (a) A person, corporation, or other entity furnishing any covered service is a participating provider if he or it (1) is a qualified provider of that service, as determined in accordance with this part, and meets such requirements as are prescribed by or pursuant to part H (relating to the quality of care), (2) furnishes the service as an independent provider and not (as employee or otherwise) on behalf of another provider entitled under part E to payment for the service, and (3) has filed with the Board an agreement (A) that services to eligible persons will be furnished without discrimination on the ground of race, color, or national origin, (B) that no charge will be made for any covered service other than for payment authorized by this title, (C) that the provider will furnish such information and reports as may be required under this title for the making of payments, or as the Board may reasonably require for utilization review by professional peers or for statistical or other studies of the operation of the title (including information and reports required for the purposes of the Commission on the Quality of Health Care), and will permit such examinations of records as may be necessary for verification of information on which payments are based, and (D) in the case of an institutional provider, a group practice organization, an individual practice association, or other provider specified in regulations of the Board, that it will comply with such requirements as the Board finds necessary to assure to the employees of the provider protection of employment rights and working conditions, including the right to collective bargaining, equal, as nearly as may be, to the protection generally available to industrial employees under Federal law or under the law of the State in which the provider is situated.

(b) Participation of a provider may be suspended or terminated pursuant to section 132 or section 134.

(c) If a provider subject to clause (D) of subsection (a)(3) is merged, consolidated, or otherwise reorganized in a manner affecting the employment or rights of its employees, the Board shall require, as a condition of participation by the merged, consolidated, or reorganized provider, that it undertake to comply with reasonable requirements of the Board for the protection of the pre-existing rights, benefits, and privileges of the employees of the provider or providers involved in the merger, consolidation, or reorganization. If a provider subject to clause (d) which is an agency of a State or local government, is closed, the Board is authorized, for the purpose of this subsection, to treat the closure as a consolidation with such other agency or agencies of the same unit of government as it finds will perform the principal functions of the provider which has been closed.

PROFESSIONAL PRACTITIONERS

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

(b) For the purposes of this title—

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

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

(3) a doctor of optometry or podiatry qualified in accordance with subsection (a) is a physician when furnishing services which are covered services in accordance with regulations issued under section 27(a) and which helps legally authorized to furnish in the State in which he furnishes them.

GENERAL HOSPITALS

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

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

(b) maintains adequate clinical records on all patients;

(c) has bylaws in effect with respect to its staff of physicians, and has filed with the Board an agreement that in granting or maintaining medical staff privileges it will not discriminate on any ground unrelated to professional 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 51; and

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

PSYCHIATRIC HOSPITALS

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

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

(b) which satisfies the requirements of subsections (b) through (h) 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; and

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

SKILLED NURSING HOMES

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

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

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

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

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

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

(f) maintains adequate clinical records on all patients;

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

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

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

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

HOME HEALTH SERVICE AGENCIES

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

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

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

(c) maintains adequate clinical records on all patients;

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

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

GROUP PRACTICE ORGANIZATIONS

SEC. 47. (a) A group practice organization (a type of health maintenance organization) is a qualified provider if—

(1) it is a public or other nonprofit organization which furnishes health services to persons enrolled in the organization;

(2) it provides at least annually an open enrollment period of not less than thirty days, during which all eligible persons living within a defined service area (or living near enough thereto to have reasonably ready access to the services of the organization), up to the capacity of the organization to furnish services, are accepted for enrollment in the order in which they apply, except that priority may be given to persons living within the service area; and it does not terminate any enrollment because of the enrollee's health status or his need or demand for health services, or for any other reason except repeated and serious violation of reasonable rules of the organization;

(3) it undertakes to provide to its enrollees, at its expense and in accordance with paragraphs (4) and (5), all of the covered services described in part B, including such supporting services as the Board may have approved under section 27(b); except that it may exclude some or all mental health services or dental services if it assures referral of its enrollees to providers of such excluded services when medically appropriate and maintains arrangements with such providers for the availability of the services to its enrollees;

(4) all physician services, and dental services if the organization undertakes to provide them, are (except for infrequently used services) furnished by a medical group which meets the following conditions, or by two or more groups each of which meets such conditions—

(A) the group consists of physicians, or of physicians and dentists, with or without other professional health personnel, sufficient in number and possessing among them the necessary qualifications to furnish all covered physician services and the dental service (if any) which the group practice organization undertakes to provide (except infrequently used services); and

(B) the members of the group (i) as their principal professional activity practice their profession as a group responsibility in furnishing services to enrollees of the group practice organization, (ii) pool their income from practice as such members (unless they are compensated by salary or stipend by the group practice organization) and distribute it among themselves in accordance with a prearranged salary, percentage, or similar plan, and (iii) jointly use medical and other records, a substantial part of their major equipment, and the services of professional, technical, and administrative staff (including personnel furnishing supporting services approved under section 27(b));

(5) all services, other than physician services and dental services, which the organization undertakes to provide (except infrequently used services) are furnished through its own staff and facilities (or are furnished by others under contract, if the organization retains control of, and full responsibility for, the availability and quality of the services); except that institutional services may be provided through arrangements with other participating providers (either nonprofit or forprofit) for the availability of services;

(6) the organization encourages health education of its enrollees (including education in the appropriate use of health services) and the development and use of preventive health services, and furnishes and arranges services and (to the extent practicable) arranges its system of medical records in such a manner as to facilitate continuity of care, and to the maximum extent feasible makes all services (including emergency services at all times) readily accessible to enrollees who live in its service area;

(7) it makes available to its enrolees and to the public full information about the services it provides and their availability, and such other information about its operations and the utilization of services as the Board may by regulation require;

(8) it provides an opportunity for representatives of its enrollees to participate effectively in the formulation of policies of the organization and in the evaluation of its operation, and provides fair and effective procedures for resolving disputes between enrollees and the organization or providers with whom it has contracted or has arrangements for the furnishing of service;

(9) it provides that a committee or committees of physicians (with other health professionals where appropriate) associated with the organization promulgate professional 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);

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

(11) it assumes the financial responsibility, without benefit of insurance except in accordance with section 87(e), for assuring to its enrollees the services which it has undertaken to provide;

(12) its premiums or other charges for any services not paid for under this title are reasonable; and

(13) it undertakes, to the extent required by regulations with respect to services of the kinds it has undertaken to provide, to arrange for reciprocal out-of-area services by other group practice organizations, or to pay for health services furnished to its enrollees by other participating providers, in emergencies, within or outside the service area of the organization.

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

INDIVIDUAL PRACTICE ASSOCIATIONS

SEC. 48(a) An individual practice association (a type of health maintenance organization) is a qualified provider if—

(1) it is an organization sponsored by a county or other local medical society, with a service area coextensive with the area of its sponsoring society, which meets the conditions set forth in section 47(a) (relating to group practice organizations) other than paragraph (4) thereof;

(2) all physician services, and dental services if the association undertakes to furnish them, are (except for infrequently used serv-

ices) furnished by professional members of the association, who are compensated by whatever method or methods (including fee-for-service) may be agreed upon by the association and its professional members; and

(3) the association permits any physician (or dentist, if the association undertakes to furnish dental services) practicing in its service area, whether or not a member of the sponsoring society, subject only to criteria (approved by the Board) of professional qualifications, to become a professional member of the association to furnish services on its behalf.

(b) A professional member of an association, unless he has agreed otherwise with the association, may furnish services to persons who are not enrolled in the association, and payment for the services, if they are covered services to an eligible person, shall be made by one of the methods provided in part E for payment to independent practitioners. The payment shall be made to the professional member, except that if he is compensated by the association for services to enrollees on a salary, stipend, or capitation basis (or if he is not a participating provider) the payment shall be made to the association.

OTHER HEALTH SERVICE ORGANIZATIONS

SEC. 49. (a) Pursuant to an agreement with the Board containing such terms and conditions, and prescribing such standards, as the Board deems proper, any of the following is a qualified provider of such services as are specified in the agreement—

(1) a public or other nonprofit agency or organization (including a hospital) which furnishes all of the covered services described in part B, including such supporting services as the Board may have approved under section 27(b), except that it may exclude some or all institutional services, mental health services, or dental services if it assures referral of its patients to providers of such services when medically appropriate and maintains arrangements with such providers for the availability of the services to its patients;

(2) a public or other nonprofit center (including a satellite center established by a hospital) which (A) furnishes, as a minimum, the services of two or more physicians engaged in general or family practice, the services of nurses and supporting personnel, and basic laboratory services, which the Board finds sufficient for the primary medical care of a substantial population living in the vicinity of the center, and (B) has arrangements with other providers of services which the Board finds assured to the population served by the center, on a coordinated basis, all components of the covered health services described in part B;

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

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

(5) a free-standing ambulatory treatment center for the treatment of alcoholism or drug abuse, or both;

(6) a free-standing center for the furnishing of family planning services;

(7) a free-standing center for the furnishing of rehabilitation services; or

(8) a medical or dental group practice or clinic, a dental foundation, or another organziation or agency furnishing health services to ambulatory patients.

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

OTHER PROVIDERS

SEC. 50. (a) An independent pathology laboratory (as defined in regulations) is a qualified provider of diagnostic pathology services if (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 (as defined in regulations) 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.

(b) A provider of drugs, devices, appliances, or equipment is a qualified provider if he meets all applicable requirements established by or pursuant to the Federal Food, Drug, and Cosmetic Act and all requirements of the law of the State in which the provider is situated.

(c) A provider of ambulance or other covered transportation services is a qualified provider if he meets all applicable requirements of the law of the State in which the services are furnished.

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

UTILIZATION REVIEW

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

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

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

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

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

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

TRANSFER AND AFFILIATION AGREEMENTS

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

(b) After two years following the effective date of health benefits, a skilled nursing home or a home health service agency will be a qualified provider only if it has in effect (or there is in effect a finding under subsection (c) temporarily dispensing with) an affiliation agreement with a participating hospital or a participating group practice 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 impractible, and that the services of the skilled nursing home or the home health agency are essential to avoid a critical shortage of services to eligible persons. Such a finding shall be reviewed periodically, and shall be revoked whenever the Board finds it practicable to do so.

NEWLY CONSTRUCTED FACILITIES

SEC. 53. A psychiatric or other hospital or a skilled nursing home, or a provider operating a facility for ambulatory care, is not a participating provider if construction or substantial enlargement of the facility (whether or not in replacement of another facility) was undertaken (as defined in regulations) after December 31 of the year in which this title is enacted unless (a) the construction or enlargement is in accord with a State certificate of need, or 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, or (b) in the case of enlargement of an existing facility, the Board has found (regardless of the need for the enlargement) that the facility is needed for that purpose. (For provision relating to reduction in payments in certain cases referred to in clause (b), see section 89.)

LIMITATIONS ON MALPRACTICE JUDGMENTS

SEC. 54. In any litigation in any court of the United States or any State seeking damages for injury caused by negligence or other fault in the furnishing of any service covered by this Act, no damages shall be awarded

for the cost of remedial services for which the injured party was or is entitled to have payment made under this Act (or for which he would have been, or would be, entitled to have payment made upon obtaining the services from 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 covered services furnished by any such institution or employee to an eligible person who is not, under any Act other than this Act, eligible to receive the service from the institution or employee. The Board shall also reimburse the proper appropriation for any covered services furnished to eligible persons pursuant to section 329 of the Public Health Service Act, such reimbursement to be in lieu of payments required by section 329(b) of that Act.

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

(b) If the Board finds that a proposed corporation will meet the requirements of section 47(a) for participation as a group practice organization, but that it cannot be incorporated in the State in which it proposes to furnish services because the State law requires that a medical society approve the incorporation of such an organization, or requires that physicians constitute all or a majority of its governing board, or requires that all physicians in the locality be permitted to participate in the services of the organization, or makes any other requirements 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. The corporation shall not be deemed to be an instrumentality of the United States for purposes of exemption from any Federal or State law.

PART D—TRUST FUND; ALLOCATION OF FUNDS FOR SERVICES

HEALTH SECURITY TRUST FUND

SEC. 61. (For the text of section 61, see section 406, transferring section 1817 of the Social Security Act to this Act, redesignating it as section 61, and amending it.)

ANNUAL DETERMINATION OF FUND AVAILABILITY

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

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

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

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

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

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

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

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

SEC. 63. (a) There shall be established in the Trust Fund a health services account, a health resources development account, an administration account, and a general account (consisting of all moneys in the Trust Fund which have not been transferred to another account).

(b) For each fiscal year there shall from time to time be transferred from the general account to the health resources development account the following percentage of the amount to be available for obligation during that year (as determined pursuant to section 62(a) and (b)): for the fiscal year beginning on the effective date of health benefits, and for the next succeeding fiscal year, 2 per centum; for each of the next two succeeding fiscal years, 3 per centum; for each of the next two succeeding fiscal years, 4 per centum; and for each fiscal year thereafter, 5 per centum. Funds in the health resources development account shall be used exclusively for the purposes of part F, and shall remain available for such uses until expended.

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

(d) As amounts available for a fiscal year for the administration of this Act are determined by the Congress, the amount available for the administration of the title shall be transferred from the general account to the administration account.

(e) From time to time any necessary adjustments shall be made in the amounts transferred to the several accounts, and in allocations previously made from the health services account.

REGIONAL ALLOCATIONS FROM HEALTH SERVICES ACCOUNT

SEC. 64. (a) For each fiscal year the Board shall, not later than June 1, next preceding the beginning of the fiscal year, make allocations to the regions of the Department from the funds to be available for the fiscal year in the health services account. The allocation to each region shall be equal to the estimated aggregate expenditures in the region for services, described in part B as covered services, in the most recent twelve-

month period for which reliable data are available, adjusted to reflect the factors of change referred to in clauses (A), (B), and (C) of section 62(a)(2), and further adjusted in accordance with subsections (b) and (c) of this section.

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

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

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

DIVISION OF REGIONAL FUNDS BY CLASSES OF SERVICES

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

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

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

FUNDS FOR HEALTH SERVICE AREAS

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

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

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

MODIFICATION OF FUND ALLOTMENTS

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

INITIAL ACTIONS UNDER PART D

SEC. 68. In the determination of fund availability, regional allocations, and all other actions required by this part to be taken on a fiscal year basis, the Board may in its discretion take initial actions either for the three-month period between the effective date of health benefits and the beginning of the next fiscal year, or for the fifteen-month period between such effective date and the end of such fiscal year, making in either case appropriate adjustments in the amounts of such determinations, allocations, or other actions.

PART E—PAYMENT TO PROVIDERS OF SERVICES IN GENERAL

SEC. 81. Payment shall be made to participating providers, in accordance with this part, for covered services furnished to eligible persons. Payments shall be made from the amounts allocated from the health services account in the Trust Fund, in accordance with part D, for the respective areas and purposes.

METHODS AND AMOUNT OF PAYMENT TO PROFESSIONAL PRACTITIONERS

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

(b) Every physician engaged as an independent practitioner in the general or family practice of medicine (as determined in accordance with regulations under section 22(b)), 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 such regulations) or covered dental services, as the case may be, to persons on a list of persons who have chosen to receive all such services from the practitioner, (2) to maintain arrangements for referral of patients to specialists, institutions, and other providers of covered services; and (3) to maintain such records and make such reports of services furnished as may be required by regulations for purposes of medical audit. A practitioner electing the capitation method is entitled to be paid by the fee-for-service method for services furnished to eligible persons who are not on his list, but not (except as provided in regulations) for specialized services furnished to persons who are on his list.

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

(d) The capitation method of payment for a specified kind and scope of covered services consists of the payment to a provider of such services, of an annual capitation amount (determined for a health service area) for each person 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 hopsitals or other providers for the compensation of practitioners) to be made by the Board on a budget or stipend basis or any basis other than capitation, fee-for-service, or per case, and (2) from the remainder, to make available (for each kind of professional services) an equal per capita amount for each person resident in the area who is entitled to such services. In any area in which the Board finds that a substantial volume of services is furnished to nonresidents, it may reduce the per capita amount to such extent as it finds necessary to effect an equitable distribution of funds.

(f) The per capita amount shall constitute the annual capitation amount for purposes of payment to any organization, individual practice association, or other provider furnishing all covered services (described in

part B) of the kind for which the allotment is available. Lesser capitation amounts shall be fixed, on the basis of the relative cost of the services, for primary medical services, and, as may be required, for any scope of services, (less than comprehensive) which is furnished by any institutional or other provider. If the Board finds that the population served by a provider requires on the average, because of age distribution or other factor, a volume of services significantly greater or smaller than the average requirement of the population of the local health service area, the Board may, after consultation with the provider, make an appropriate adjustment in the capitation amount payable to him.

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

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

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

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

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

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

PAYMENT TO GENERAL HOSPITALS

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

(b) The costs recognized in each hospital budget shall be those, determined in accordance with subsection (a), to be incurred in furnishing the covered services ordinarily furnished by the hospital to inpatients or outpatients, and in performing any other function ordinarily performed by the hospital and ordinarily financed from payments by or on behalf of patients (including the clinical aspects of education or training of professional or other health personnel), except as the scope of services or of other functions may be modified (1) by agreement of the Board and the hospital, (2) by application of guidelines for the clinical education or training of health personnel established pursuant to section 131 for the region or State in which the hospital is situated, or (3) by direction of the Board pursuant to section 134. The budget shall recognize any increase or decrease of cost resulting from a modification of the scope of services or of other functions, either by agreement or by direction of the Board.

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

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

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

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

PAYMENT TO PSYCHIATRIC HOSPITALS

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

PAYMENT TO SKILLED NURSING HOMES AND TO HOME HEALTH SERVICE AGENCIES

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

(b) Regulations under this section shall, for skilled nursing homes and for home health service agencies, respectively, specify the method or methods to be used, and the items to be 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. Product prices shall be so fixed as to encourage the acquisition of drugs in substantial quantities, and differing product prices for a single drug may be established only to reflect regional differences in cost or other factors not related to the quantity purchased.

(b) Payment for a drug furnished by an independent pharmacy shall consist of its cost to the pharmacy (not in excess of the applicable product price) plus a dispensing fee. The Board, after consultation with representatives of the pharmaceutical profession, shall establish (and from time to time review) 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 GROUP PRACTICE ORGANIZATIONS AND INDIVIDUAL PRACTICE ASSOCIATIONS

SEC. 87. (a) Payment to a group practice organization or to an individual practice association for covered services to its eligible enrollees shall consist of basic capitation payments plus additional payments (if any) determined in accordance with subsection (d).

(b) The basic capitation payment shall consist of a basic capitation amount multiplied by the number of eligible persons enrolled in the organization or association. The basic capitation amount shall be the sum of the appropriate capitation amount or amounts for professional services or class of services which it has undertaken to furnish.

(c) Capitation amounts for institutional services shall be based on per diem rates derived from the budgets (approved under this part) of participating institutional providers or, if the services are furnished through institutions operated by the group practice organization or individual practice association (or are furnished by contract with institutions which are not participating providers), derived from budgets prepared and approved in like manner as for participating institutions. Per diem rates shall be determined for each fiscal year, and for that year shall be modified only if the institutional budgets are amended or if modification is necessary to avoid substantial inequities.

(d) If it appears to the satisfaction of the Board (1) that the average utilization of hospital and skilled nursing home services by eligible persons enrolled in the organization or association (in whatever manner such services are provided) has, during a fiscal year, been less than the average utilization of such services under comparable circumstances by comparable population groups not enrolled either in group practice organizations or in individual practice associations, and (2) that the services provided by the organization or association have been of high quality and adequate to the needs of its enrollees, the Board shall make an additional payment to the organization or association

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. The amount of any such additional payment may be used by the organization or association for any of its purposes, including the application of such amounts to the cost of services not covered by this title.

(e) The Board shall, in accordance with regulations, make available to group practice organizations and individual practice associations, in consideration of premiums to be deducted from amounts otherwise payable to them under this section, insurance against (1) the cost, in excess of an amount fixed by the Board (which shall be not less than $5,000), of services furnished during a calendar year to any one enrollee, (2) some or all of the cost of institutional services provided through arrangements with other participating providers in accordance with section 47 (a)(5), and (3) some or all of the cost, for which the organization or association is responsible in accordance with section 47 (a)(13), of services provided by other participating providers. Premium rates for such insurance shall reflect the expected utilization of services by the enrollees of the oragnization or association insured.

(f) In addition to the payments required by this section, the Board may pay to a group practice organization the cost of clinical education or training provided by the organization (otherwise than in a hospital) which the Board finds to be in accordance with guidelines established pursuant to section 131 for the region or State in which the organization is situated.

PAYMENT TO OTHER PROVIDERS

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

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

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

REDUCTION IN PAYMENTS ON ACCOUNT OF UNNECESSARY CAPITAL EXPENDITURES

SEC. 89. Whenever the Secretary, pursuant to section 1122 of the Social Security Act (relating to reduction in Federal reimbursement in cases of unnecessary capital expenditures) issues a direction to the Board with respect to any health care facility owned or operated by a participating provider, the Board shall reduce accordingly amounts otherwise payable under this part to the provider.

METHODS AND TIME OF PAYMENT

SEC. 90. The Board shall periodically determine the amount which should be paid under this part to each participating provider of services (with adjustment for payments by one participating provider to another), and the provider shall be paid, from the health services account in the Trust Fund, at such time or times as the Board finds appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, the amount so determined, with adjustments on account of underpayments or overpayments previously made (including appropriate retrospective adjustments following amendment of approved institutional budgets). Payment may be made in advance in such cases and to such extent as the Board finds necessary to supply providers with working funds, on such terms as it finds sufficient to protect the interests of the United States.

PART F—DEVELOPMENT FUND

SUBPART 1—PLANNING; FUNDS TO IMPROVE SERVICES AND TO ALLEVIATE SHORTAGES OF FACILITIES AND PERSONNEL

PURPOSE OF SUBPART 1

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

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

(2) after the effective date, to reinforce the operation of the health security program under this title as a mechanism for the continuing improvement of the supply and distribution of health personnel and facilities and the organization of health services, and to that end to assist in meeting those costs of improvement of personnel, facilities, and organization that are not met either through the normal operation of the health security program under this title or from other sources of public or private assistance.

(b) With respect to health facilities and the organization of health services, the Board shall be guided by the national health priorities established by section 1502 of the Public Health Service Act, the guidelines issued by the Secretary under section 1501 thereof, and State health plans which have been developed for the respective States and found by the Secretary to be adequate under title XV of that Act. Pending findings of adequacy of State health plans, the Board shall be guided by planning of the Secretary pursuant to section 102(a) of this Act.

(c) With respect to the education and training of health personnel, the Board shall be guided by planning of the Secretary pursuant to section 102(b) of this Act.

PLANNING BY THE SECRETARY

SEC. 102. (a) Pending findings of adequacy of State health plans, the Secretary shall conduct within the Department studies addressed to identification of the most acute shortages and maldistributions of facilities and the most serious deficiencies in the organization for delivery of services covered under this Act, and of means for the speedy alleviation of these shortcomings. In carrying out this function, the Secretary shall consult with, and utilize the experience and recommendations of, existing State, regional and local health planning agencies, and State and local planning agencies and centers for health planning established pursuant to title XV of the Public Health Service Act.

(b) The Secretary shall have the continuing duty of planning for improvement of the supply and distribution of health personnel. He shall conduct such planning on a national, regional, state, or local basis as he may consider most appropriate for each kind of personnel, and in consultation with planning agencies referred to in subsection (a) to such extent as he deems desirable, and with appropriate professional organizations.

GENERAL POLICIES AND PRIORITIES

SEC. 103. (a) In providing assistance under this subpart, 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 group practice organizations meeting the requirements of section 47(a), (2) the development or expansion of agencies, organizations, and centers described in section 49(a) (1) or (2) to furnish services to persons in urban and rural areas who lack ready access to such services, (3) the recruitment and training of professional personnel to staff such organizations, agencies, and centers, (4) the recruitment and training of subprofessional and nonprofessional personnel (including the development and testing of new kinds of health personnel) to assist in the furnishing of such services, to engage in education for personal health maintenance, and to furnish liaison between such organizations, agencies, or centers and the people they serve, (5) the strengthening of coordination and linkages among institutional services (including linkages with educational institutions), among non-institutional 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, (6) the strengthening of coordination and cooperation between hospital medical staffs and hospital administrators, and (7) the inclusion of dental services in systems of comprehensive health care.

(b) Funds available to carry out this part shall not be used to replace other Federal financial assistance, or to supplement the appropriations for such other assistance except to meet specific needs of the health security program under this title (such as the training of physicians or medical students for the general or family practice of medicine). In administering other programs of federal financial assistance the Secretary and other officers of the executive branch, on recommendation of the Board, shall to the extent possible utilize those programs to further the objectives of this part. To this end the Board, on such terms as it finds appropriate, may lend to an applicant or grantee not more than 90 per centum of the non-Federal funds required as a condition of assistance under any such program, and may pay all or part of the interest in excess of 3 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) group practice organizations which meet or will meet the requirements of section 47(a), (2) public or other non-profit agencies, organizations, and centers described in section 49(a) (1) and (2), and (3) nonprofit organizations furnishing comprehensive dental services, which meet requirements set forth in regulations of the Board.

(b) The Board is authorized to make grants (1) to any public or non-profit 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) of this section; 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) of this section to assist in meeting the cost of constructing (or other-

wise 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) of this section and which has been either newly established or substantially enlarged, to pay all or a part of any operating deficits, for not more than five years in the case of an organization described in subsection (a)(1), and until not later than the effective date of health security benefits in the case of an agency or organization described in subsection (a)(2) or (a)(3). Any such contract shall condition payments upon the contractor's making all reasonable effort to avoid or minimize operating deficits and (if such deficits exist) making reasonable progress toward becoming self-supporting.

RECRUITMENT, EDUCATION, AND TRAINING OF PERSONNEL

SEC. 105. The Board shall promptly establish (and from time to time review) schedules of priority for the recruitment, education, and training of personnel to meet the most urgent needs of the health security program. The schedules may differ for different parts of the United States.

(b) The Board is authorized to provide, to physicians and medical students, training for the general or family practice of medicine and training in any medical specialty 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 assistance is not available for such education or training; and if other assistance is available but the Board deems it inadequate to meet the increased need attributable to the health security program, it may, with the approval of the Secretary, provide such education or training pending action by the Congress on a recommendation promptly made by the Secretary to increase the authorization of appropriations (or, if the authorization is deemed adequate, to increase the appropriations for such other assistance).

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

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

(f) The Board shall undertake to recruit and train professional practitioners who will agree to practice, in urban or rural areas of acute shortage, in group practice organizations or in agencies, organizations, or centers referred to in section 49(a)(1) or (2). A practitioner who agrees to engage in such practice for at least five years and who enters upon practice in the area before the effective date of health benefits may until that date be paid a stipend to supplement his professional earnings, and in an appropriate case the Board may make a commitment to compensate the practitioner after that date in accordance with section 82(c).

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

(h) In administering this section the Board shall seek to encourage the education and training, for the health professionals 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.

(i) Training which the Board is authorized by this Section to provide shall include retaining, either to refresh and enhance skills of trainees for positions they already hold or to equip them for positions of greater responsibility.

SPECIAL IMPROVEMENT GRANTS

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

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

LOANS UNDER PART F

SEC. 107. (a) Loans authorized under this part shall be repayable in not more than twenty years, shall bear interest at the rate of 3 per centum per annum, and (subject to the provisions of subsection (b)) shall be made on such other terms and conditions as the Board deems appropriate. Amounts paid as interest on any such loan or as repayment of principal shall, if the loan was made from funds appropriated pursuant to section 120(a), be covered into the Treasury as miscellaneous receipts, and if the loan was made from funds in the health resources development account, be deposited in the Trust Fund to the credit of that account.

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

RELATIONS OF PARTS E AND F

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

SUBPART 2—PROGRAMS OF PERSONAL CARE SERVICES

PURPOSE OF SUBPART 2

SEC. 111. (a) The purpose of this subpart is to encourage and assist in the development of community programs for maintaining in their own homes, by means of comprehensive health and personal care services, persons, who, by reason of disability or other health-related causes, would in the absence of such assistance require in-patient institutional services or might be expected to require such institutional services in the near future.

(b) It is the intent of the Congress that a grant under section 112 be made in any community to an eligible applicant which satisfies the Board that the applicant will be able (1) to develop, reasonably promptly, comprehensive services in accordance with this subpart, and (2) to develop non-Federal sources for the financing thereof to such extent as the Board finds appropriate in light of the economic resources of the community and resources otherwise available to it for this purpose.

GRANTS

SEC. 112. (a) The Board is authorized to make grants, for the development and conduct of programs in accordance with this subpart, to participating public or other nonprofit hospitals or group practice organizations, or to other public or non-profit agencies or organizations which the Board finds qualified to conduct such programs. Each program shall be designed to serve a substantial population, defined in the grant, in either an urban or a rural community.

(b) A grant under this section may be made to pay a part or all of the estimated cost of a program (including start-up cost) for a period of not more than four years, payable in such installments as the Board may determine, and may provide for meeting a decreasing share of the cost over the period of the grant. A grant shall be irrevocable except for nonperformance by the grantee or violation of the terms of this subpart or of the grant, or for other cause which would justify the termination or rescission of a contract. If it appears during the period of the grant that the cost of the program will exceed the estimate, the Board may increase prospectively the amount of the grant.

SCOPE OF SERVICES AND ELIGIBILITY THEREFOR

SEC. 113. (a) The services to be provided shall include, in addition to all covered health services (other than inpatient institutional services) described in part B (which may be provided by arrangement with participating providers), such groups or combinations of services as the Board deems necessary or appropriate to enable persons, found eligible for the services in accordance with subsection (b), to continue to live in their own homes or other noninstitutional places of residence. The personal care services may include homemaker and home help serv-

ices, home maintenance, laundry services, meals-on-wheels and other nutrition services, assistance with transportation and shopping, and such other services as may be appropriate in particular cases. The Board may prescribe different ranges of services in different programs.

(b) For each program the Board shall prescribe criteria (consistent with section 111(a) for the approval of the application for assistance, and such criteria may be different in different programs, but all programs shall be required to assure adequate coordination with all agencies in the community furnishing health or personal care services to beneficiaries of the program. Each grant shall require the grantee to establish, or arrange for the services of, a committee to screen applications for assistance under the program, in accordance with the applicable criteria, and no assistance shall be given until an application has been approved by the committee. The committee shall also maintain a constant review of utilization of the services provided by the program, and assistance to any person shall be terminated whenever the committee finds that he no longer meets the applicable criteria. The composition of the committee shall be subject to approval by the Board, and it shall include at least one physician, one professional nurse, one professional social worker, three representatives of the users of the services, and such other qualified persons as the Board may prescribe.

EVALUATION

SEC. 114. Each grant shall require the grantee to establish procedures for the evaluation of the program, with respect both to the benefits accruing to persons receiving assistance and to the fiscal impact of the program on the health security system. The Board shall also make its own evaluation of each program, and shall include a summary thereof in its annual report to the Congress.

RECOMMENDATIONS TO THE CONGRESS

SEC. 115. Before the end of the third calendar year after the enactment of this Act, the Board shall transmit to the Congress a comprehensive report on the operation of this subpart and the Board's evaluation of such operation, and shall submit its recommendation of (a) methods for the development, as widely and rapidly as practicable, of personal care services in communities lacking programs therefor or lacking adequate programs, to the end that such services in lieu of institutional care be made generally available throughout the United States, and (b) methods for the continuing financial support of such services; together with the Board's recommendations with respect to the proper role of the health security system in providing long-term institutional care and in providing personal care services in lieu thereof.

SUBPART C—AVAILABILITY OF FUNDS

AUTHORIZATION OF APPROPRIATIONS; EXPENDITURES FROM TRUST FUND

SEC. 120. (a) For the purposes of this part there are hereby authorized to be appropriated $200,000,000 for the fiscal year beginning on July 1 of the year in which this title is enacted, and $400,000,000 for the succeeding fiscal year. Funds appropriated under this subsection shall remain available until expended.

(b) For the purposes of this part, the Board is authorized, after the effective date of health benefits, to make expenditures from the health resources development account in the Trust Fund, established pursuant to section 63.

PART G—ADMINISTRATION

ESTABLISHMENT OF THE HEALTH SECURITY BOARD

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

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

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

DUTIES OF THE SECRETARY AND THE BOARD

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

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

(c) The Board shall from time to time conduct studies of the adequacy and equity of the financing of the national system of health security established by this Act and shall, with the approval of the Secretary, report its findings to the Congress, together with any recommendations for amendment of this Act or of the provisions of the Internal Revenue Code of 1954 pertaining to such financing. The first report under this subsection shall be submitted not later than two years after the effective date of health benefits, and thereafter reports shall be submitted at intervals not greater than four years.

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

(e) 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.

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

(g) The Secretary is authorized to establish on the staff of the Board, and to fix the compensation for, not more than fifty positions in the professional, scientific, and executive service, each such position being established to effectuate those research and development activities of the Board which require the services of specially qualified scientific, professional, and administrative personnel. The rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than the minimum rate of grade 16 of the General Schedule of the Classification Act of 1949, as amended, nor more than the highest rate of grade 18 of the General Schedule of such Act, and the rates of compensation for all such positions shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may designate for this purpose.

EXECUTIVE DIRECTOR; DELEGATION OF AUTHORITY

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

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

REGIONS AND HEALTH SERVICE AREAS

SEC. 124. (a) This title shall be administered by the Board through the regions of the Department (as they may be established from time to time) and, within each region, through health service areas. The areas shall be the same as the health service areas established by the Secretary under section 1511 of the Public Health Service Act, except that with the approval of the Secretary of the Board may divide an area established under section 1511 into two or more areas for purposes of this title.

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

NATIONAL HEALTH SECURITY ADVISORY COUNCIL

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

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

(c) It shall be the function of the Advisory Council (1) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations, and in the performance of the Board's functions under part D, and (2) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the title or in its provisions which may appear desirable. The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board through the Secretary, shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council for administrative action 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 in excess of the daily rate paid under GS–18 of the general schedule under section 5332 of title 5, United States Code; 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 Government service employed intermittently.

REGIONAL AND LOCAL ADVISORY COUNCILS

SEC. 126. (a) The Board shall appoint for each of the regions of the Administration 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. So far as possible, representatives of providers shall be so selected as to represent professional, subprofessional, and nonprofessional personnel, and representatives of consumers shall be so selected as to represent the major segments of the population to be served. Each council shall meet as often as its members may decide, but in no event less than four times each year. It shall be the function of each such council to advise the regional or local representative of the Board, as the case may be, on all matters directly relating to the administration of this title in the region or area, including methods and procedures followed in the handling of complaints.

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

PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEES

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

(b) The Board is authorized to appoint such experts and consultants (employed in accordance with section 3109 of title 5, United States Code), and to appoint such temporary professional and technical committees, as it deems necessary to advise it on special problems not encompassed in the assignments of standing committees appointed under subsection (a), or to supplement the advice of standing committees.

(c) In connection with its duties under section 122(c), the Board is authorized to appoint such standing or temporary committees of fiscal, actuarial, and other experts as it deems necessary.

(d) 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.

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

PARTICIPATION BY STATE AGENCIES

SEC. 128. (a) The Board shall consult from time to time with State health agencies (including agencies established pursuant to title XV of the Public Health Service Act) or other appropriate State agencies in preparing for and in administering health security benefits, with a view to coordinating the administration of this title with State and local activities in the fields of health planning, environmental health, licensure and inspection, education for the health professions and other health careers, and other fields relating to health. Insofar as practicable, the Board shall conduct such consultation through the regional offices of the Administration.

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

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

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

(a) In any State which is unable or unwilling to make inspections in accordance with subsection (b), the Board shall make such inspections either through its own personnel or through contract with an organization or organizations which it finds qualified to perform this function.

(f) Within ninety days after the completion of an inspection of any provider under subsection (b) or subsection (e), the Board shall make public in readily available place and from the findings of such inspection which pertain significantly to compliance with the qualifications and requirements established by or pursuant to part C or part H; except that if the State agency or the Board, on the basis of such inspection, has made a determination respecting compliance by the provider, the publication shall be based on such determination.

TECHNICAL ASSISTANCE TO SKILLED NURSING HOMES AND HOME HEALTH SERVICE AGENCIES

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

DISSEMINATION OF INFORMATION; STUDIES AND EVALUATIONS; SYSTEMS DEVELOPMENT; TESTS AND DEMONSTRATIONS

SEC. 130. (a) The Board shall disseminate, to providers of services and to the public, information concerning the provisions of this title, the persons eligible to receive the benefits of the title, and the nature, scope, and availability of covered services; and to providers of services, information concerning the conditions of participation, methods and amounts of compensation to providers, and other matters relating to their participation. With the approval of the Secretary, the Board may furnish to all professional practitioners information concerning the safety

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

(b) The Board shall make, on a continuing basis after the effective date of health security benefits, a study and evaluation of the 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, 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;

(3) 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;

(4) 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

(5) 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.

(d) The Board is authorized to develop, and to test and demonstrate through agreements with providers of services or otherwise, methods designed to achieve, through additional incentives or in any manner, improvement in the coordination of services furnished by providers, improvement in the adequacy, quality, or accessibility of services, or decrease in their cost; methods of peer review and peer control of the utilization of drugs, laboratory services, and other services not subject to utilization review under section 51; and methods of peer review of quality. Agreements with providers for tests or demonstrations may provide for alternative methods of reimbursement in lieu of methods prescribed by part E, but, in the case of independent professional practitioners, only in accordance with section 82(h).

GUIDELINES FOR HEALTH MANPOWER EDUCATION AND TRAINING

SEC. 131. The Board shall make a continuing evaluation of the adequacy of the various classes of professional and health personnel to furnish services under this title and, after consultation with national and other organizations concerned with education and training of such personnel, and with the approval of the Secretary, shall from time to time issue guidelines designed to relate the clinical education and training conducted by providers of services more closely to the relative need for the several classes of such personnel. The guidelines shall seek to further national health manpower objectives, but shall be adapted for each region or State to take account of the capacity of providers to conduct such clinical education or training, and (to the extent the Board deems appropriate) to take account of any special manpower needs within the region or State.

DETERMINATIONS: SUSPENSION OR TERMINATION OF PARTICIPATION

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

(b) If the Board finds that a participating provider of services no longer meets the qualifications and requirements established by or pursuant to part C and subpart 1 of part H for services of the kinds furnished by him, or for some classes of such services, or that he has intentionally violated the provisions of this title or of regulations, or that he has failed substantially to carry out the agreement filed by him pursuant to section 41(a)(3), the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the provider, or suspending or terminating it with respect to particular classes of services.

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

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

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

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

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

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

(5) furnished to eligible persons covered services which were not of a quality meeting professionally recognized standards of care,

the Board shall submit the evidence in its possession either to an appropriate professional organization or to a committee constituted by the Board after consultation with such an organization (which committee may, when the Board deems it proper, include nonprofessional persons). The Board shall request the organization or committee, with or without further investigation, to recommend what action, if any, should be taken by the Board. Taking into consideration any recommendation so made to it, the Board may issue an order suspending or terminating (absolutely or on such conditions as the Board finds appropriate) the participation of the practitioner or other provider or, in the case of a practitioner furnishing services on behalf of another provider, requiring the other provider, as a condition of continued participation, to suspend or discontinue (absolutely or on conditions) the furnishing of covered services by the practitioner.

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

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

HEARINGS: JUDICIAL REVIEW

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

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

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

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

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

(4) The court shall, on motion of the Board made before it files its answer, remand the case to the Board for further action by

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

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

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

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

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

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

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

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

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

(b) If the Board finds (1) that the services furnished by a provider of services (other than an individual professional provider) are not necessary to the availability of adequate services under this title and that their continuance as covered services is unreasonably costly, or (2) that the services are furnished inefficiently and at unreasonable cost, that effort at correction has proved unavailing, and that necessary services can be more efficiently furnished by other providers, the Board may issue a direction that on a specified 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 and development agency (if such an agency has been established pursuant to title XV of the Public Health Security Act) of the State in which the direction will be operative. No direction shall be issued under subsection (a) unless the Board finds that it can practicably be carried out by the provider to whom it is addressed.

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

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

PART H—QUALITY OF CARE

PURPOSE AND GENERAL POLICIES

SEC. 141. (a) The Board, with the advice and assistance of the Commission on the Quality of Health Care (established by section 1701 of the Public Health Service Act), shall have the continuing responsibility to maintain and enhance the quality of health care furnished under this Act, and to that end shall:

(1) prior to the effective date of health benefits, issue regulations authorized by this part, (A) to supplement the qualifications required by part C of providers of services as a condition of participation, and (B) to strengthen existing mechanisms for the control and enhancement of quality; and

(2) thereafter continuously review such regulations with a view to (A) upgrading such requirements as rapidly as the Board finds practicable, and (B) developing recommendations to the Congress for amendments of this Act designed further to assure and enhance the quality of care.

(b) In discharging its responsibility under this part, it shall be the objective of the Board to require the highest practicable quality of care that is attainable in substantially all parts of the United States. Exceptions to requirements under this part shall be permitted only when necessary to avoid critical shortages of services, and shall be reviewed from time to time and shall be eliminated whenever, and as soon as, the Board finds it practicable to do so.

(c) The Board shall assist the Commission on the quality of health care in obtaining reports and information required for the purposes of the Commission, and the Commission shall advise the Board in the development and issuance of regulations under this part and in the development of recommendations to the Congress. If the Board fails to adopt, by regulation issue under this part, a standard which the Commission has recommended be so adopted, the matter shall be reported to the Secretary and, unless he directs the Board to follow the recommendations of the Commission, the Board shall publish a statement of the recommendation and of its reasons for failing to adopt the standard.

CONTINUING PROFESSIONAL EDUCATION

SEC. 142. (a) Not later than two years after the effective date of health benefits, the Board shall by regulation establish for physicians, dentists, optometrists, and podiatrists such requirements of continuing education (taking into consideration standards approved by appropriate professional organizations) as it finds reasonable to maintain and enhance the quality of professional services furnished under this Act.

(b) Regulations under this section shall require the filing of such periodic reports as the Board finds necessary to assure that participating practitioners, and practitioners furnishing services on behalf of participating institutional and other providers, are in compliance with requirements established under subsection (a). The Board shall give warning to any particular practitioner whom such reports show to have failed to comply substantially with the requirements, and, before taking action under section 132(b), shall afford him an opportunity to explain or correct the deficiency.

MAJOR SURGERY AND OTHER SPECIALIZED SERVICES

SEC. 143. (a) Major surgery and other specialized services designated in regulations are not covered services unless they are furnished by specialists and, to the extent specified in regulations, are either emergency services or services furnished on referral by a physician engaged in general or family practice (as determined in accordance with regulations under section 22(b)).

(b) A physician is a specialist, for the purposes of subsection (a), only if he holds a certificate from the appropriate national specialty board; except that (1) a physician who possesses the qualifications requisite to such certification may furnish services as a specialist during a period of five years after attaining such qualifications (or, if later, after the effective date of health benefits), and (2) a physician may be authorized by the Board to furnish services as a specialist if (A) prior to the effective date he has engaged in furnishing such services as a specialist or as a substantial part of his medical practice, (B) he meets standards established by the Board, and (C) where appropriate, authorization to him to furnish services as a specialist is recommended by a participating hospital in which he has engaged substantially in furnishing such services.

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

(d) With respect to the performance of surgical procedures specified in regulations under subsection (c), including emergency procedures, the Board may require as a condition of payment to the provider that there be submitted to the Board a pathology report on tissue removed and a clinical abstract or discharge report of the case.

ADDITIONAL REQUIREMENTS FOR PARTICIPATION

SEC. 144. (a) No provider on whose behalf one or more physicians, dentists, optometrists, or podiatrists furnish professional services described in section 22 or section 23 or in regulations issued under section 27(a)(1) or (2) shall be a participating provider unless every practitioner furnishing such services is a qualified provider in accordance with section 42 and meets such requirements, applicable to practitioners of his profession, as are prescribed by or pursuant to this part.

(b) The Board may by regulation establish, as conditions of participation by providers other than independent professional practitioners, requirements (additional to those specified in part C and those otherwise prescribed by or pursuant to this part) which the Board finds necessary in the interest of the quality of care and the safety of eligible persons. In establishing requirements under this subsection, the Board shall take into consideration standards or criteria established or recommended by appropriate professional or other associations or organizations. The Board shall establish such requirements as it finds necessary to assure that participating hospitals and skilled nursing homes meet the requirements prescribed from time to time for accreditation by the Joint Commission on the Accreditation of Hospitals, but the authority of the Board is not limited to the requirements of the Joint Commission. Exceptions to requirements established under this subsection shall

be permitted only in accordance with section 141(b).

PROFESSIONAL STANDARDS REVIEW AND SIMILAR ORGANIZATIONS

SEC. 145. On recommendation of the Commission on the Quality Health Care, the Board may contract with a Professional Standards Review Organization heretofore designated or conditionally designated as such by the Secretary, or with an organization performing similar functions hereafter approved for the purpose by the Board, to monitor the quality of some or all institutional and other services furnished under this Act within the area of operation of such organization, and to report to the Board its findings with respect to conformity to the requirements relating to quality prescribed by or pursuant to this Act. Any such contract shall be so designed as to supplement, and not duplicate, inspections by State agencies under section 128(b) or by the Board under section 128(e). The Board shall pay to the organization, in advance or otherwise as specified in the contract, the reasonable cost of services and activities of the organization under the contract.

FINDINGS OF COMMISSION ON MEDICAL MALPRACTICE

SEC. 146. In exercising its authority under this part the Board shall give consideration to the findings, report, and recommendations of the Commission on Medical Malpractice established by the Secretary, and within the authority conferred by this or any other Act shall put into effect such of the recommendations of that Commission and such other measures as in the judgment of the Board will tend to reduce the incidence of malpractice, to lessen the cost or increase the availability of malpractice insurance, or to facilitate the speedy, equitable, and economical adjudication of malpractice claims.

PART I—MISCELLANEOUS PROVISIONS

DEFINITIONS

SEC. 161. When used in this Title—

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

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

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

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

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

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

SEC. 162. (a) There shall be in the Department of Health, Education, and Welfare, in addition to the Assistant Secretaries now provided for by law, a Deputy Secretary of Health, Education, and Welfare and an Under Secretary for Health and Science each of whom shall be appointed by the President, by and with the advice and consent of the Senate, and shall perform such functions (related to health and science, in the case of such Under Secretary) as the Secretary may prescribe. The provisions of the second sentence of section 2 of Reorganization Plan Numbered 1 of 1953 shall be applicable to such Deputy Secretary to the same extent as they are applicable to the Under Secretary of Health, Education, and Welfare and shall be applicable to the Under Secretary for Health and Science to the same extent as they are applicable to the Assistant Secretaries authorized by that section.

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

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

SEC. 163. The effective date of health security benefits under this title shall be July 1 of the second calendar year after the year in which this title is enacted, and no service or item furnished prior to that date shall constitute a covered service. Section 406, transferring and amending section 1817 of the Social Security Act and redesignating it as section 61 of this Act, shall be effective on the effective date of health benefits, and part D (including section 61) shall be effective with respect to fiscal years beginning on or after that date. In all other respects this title shall be effective upon enactment, and appropriations for the purposes of this title (including action pursuant to section 201(g) of the Social Security Act, as amended by section 406 of this Act, to make funds available on and after the effective date of health benefits) are authorized to be made prior to the effective date of health benefits.

EXISTING EMPLOYER-EMPLOYEE HEALTH BENEFIT PLANS

SEC. 164. (a) No provision of this Act other than this section, and no amendment of the Internal Revenue Code of 1954 made by this Act, shall affect or alter any contractual or other non-statutory obligation of an employer to pay for or provide health services to his present and former employees and their dependents and survivors, or to any of such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the costs of such services.

(b) Any contractual or other non-statutory obligation of the employer to pay all or part of the cost of the health services referred to in subsection (a) shall continue, and shall apply as an obligation to pay the taxes imposed on his employees by section 3101(b) of the Internal Revenue Code of 1954 (as amended by section 201(a) of this Act), but the sum of the per capita monthly amount involved in the payment of such taxes by the employer on behalf of his employees, and the per capita amount of the liability for taxes imposed on an employer by section 3111(b) of such Code (as amended by section 201(b) of this Act) shall not exceed the per capita monthly amount of the cost to the employer of providing or paying for health services (either through insurance premiums or into a fund) on behalf of persons referred to in subsection (a), for the month prior to the effective date of health security taxes (as defined in section 3121(u) of such Code, added by section 201(c) of this Act.)

(c) At least for the duration of any contractual or other non-statutory obligation of an employer referred to in subsection (a), an employer shall arrange to pay to eligible employees, former employees, and survivors referred to in subsection (a) such amounts of money by which the per capita monthly costs to the employer of providing or paying for health services referred to in subsection (a) in the month immediately preceding the effective date of health security taxes, exceed the sum of the per capita monthly costs to the employer of the taxes imposed by section 3111(b) of such Code (as amended by section 201(b) of this Act), the employer's liability referred to in subsection (b) of this section, and any other employer contributions for health insurance premiums or health benefits or services provided by the employer after the effective date of health security benefits. By agreement between the employer and his employees or their representatives, an employer may provide other benefits of an equivalent monetary value in lieu of such payments.

(d) For purposes of subsections (b) and (c), the per capita amounts and per capita costs for an employer shall be determined by dividing the aggregate amounts and the aggregate costs by the number of eligible employees, former employees, and survivors on the date as of which the determination is made.

TITLE II—HEALTH SECURITY TAXES

PART A—EMPLOYMENT TAXES

RATE AND COVERAGE

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

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

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

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

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

"(r) WAGES FOR PURPOSES OF HEALTH SECURITY TAXES.—For the purpose of section 3101(b), and for the purpose of section 1402(b) as applied to section 1401(b), the term 'wages' shall have the meaning set forth in subsection (a) of this section (as that subsection would apply to employment as defined in subsection (s)), except that in applying paragraph (1) of subsection (a) the term 'the health security contribution base (as defined in subsection (t))' shall be substituted for the term 'the contribution and benefit base (as determined under section 230 of the Social Security Act)' each place it appears therein. For the purpose of section 3111(b), the term 'wages' shall have the same meaning, except that paragraph (1) of subsection (a) shall not be applied.

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

"(1) clause (B) preceding paragraph (1) of subsection (b) shall not be applied to an employee whose principal post of duty is outside the United States;

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

employment covered by the railroad retirement system), and paragraph (17) (relating to employment by subversive organizations);

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

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

"(t) HEALTH SECURITY CONTRIBUTION BASE.—The term 'health security contribution base' means, for any calendar year, 150 percent of the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for such calendar year."

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

CONFORMING AND TECHNICAL AMENDMENTS

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

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

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

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

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

(d)(1) Section 6413(c)(1)(D) of such Code is amended by inserting "(i)" immediately after "(H)", by striking out "section 3101" and inserting "section 3101(a)" in lieu thereof, and by inserting immediately before the period at the end thereof: "; and (ii) during any calendar year beginning on or after the effective date of health security taxes (as defined in section 3121(u)) the wages received by him during such year exceed the health security contribution base (as defined in section 3121(t)) for that year, the employee shall be entitled (subject to the provision of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101(b) and deducted from the employee's wages (whether or not paid to the Secretary or his delegate), which exceeds the tax with respect to an amount of such wages received in such calendar year equal to the health security contribution base for such year."

(2) Section 6413(c)(2)(A) of such Code is amended by striking out "includes for the purposes of this subsection the amount" and inserting in lieu thereof "includes for the purposes of this subsection (i) with respect to the taxes imposed by section 3101(a), the amount"; and by striking out "determined by each such head" and inserting in lieu thereof "and (ii) with respect to the taxes imposed by section 3101(b), the amount for any calendar year equal to the health security contribution base (as defined in section 3121(7)) for such calendar year; each such amount to be determined by each such head".

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

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

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

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

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

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

EXCLUSION FROM GROSS INCOME

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

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

EFFECTIVE DATES OF PART A

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

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

TAX ON SELF-EMPLOYMENT INCOME

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

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

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

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

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

(2) by inserting, immediately after the word "wages" in each of the subclauses of clause (1), "as defined in section 3121(b))";

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

"(2) for the purposes of section 1401(b), such term shall not include that part of the net earnings from self-employment which is in excess of (A) an amount equal to the health security contribution base (as defined in section 3121(t)) for the calendar year in which the taxable year begins, minus (B) the amount of wages (as defined by section 3121(r) for the purposes of section 3101(b)) paid to such individual during the taxable year; and

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

(4) by striking out "(A)" in the sentence following clause (3), and by changing the comma following the term "section 3121(b)" in that sentence to a period and striking out the remainder of the sentence.

(c) Section 1402(d) of the Code is amended by striking out "and the term 'wages'", and striking out "AND WAGES in the subsection heading.

TAX ON HEALTH SECURITY UNEARNED INCOME

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

"SEC. 1403. TAX ON HEALTH SECURITY UNEARNED INCOME

"(a) IMPOSITION OF TAX.—In addition to other taxes, there shall be imposed for each taxable year beginning on or after the effective date of health security taxes (as defined in section 3121(u)), on the income of every individual residing in the United States whose health security unearned income (as defined in subsection (b) of this section) for the taxable year is $400 or more, a tax equal to 2.5 percent of the amount of such health security unearned income for such taxable year.

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

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

"(2) consists of self-employment income taxable under section 1401(b), or

"(3) consists of remuneration for services performed in the employ of the United States

as President or Vice President of the United States or as a Member, Delegate, or Resident Commissioner of or to the Congress, or as a member of a uniformed service on active duty, or

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

"(5) consists of payments excluded from wages taxable under section 3101(b) by reason of paragraphs (2) through (13) of section 3121(a) as incorporated in section 3121 (r), or

"(6) in the case of a taxpayer who has attained the age of 60 years before or during the taxable year, consists of any other income in an amount not exceeding $5,000."

CONFORMING AND TECHNICAL AMENDMENTS

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

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

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

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

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

"SEC. 1404. Miscellaneous provisions."

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

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

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

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

(e) Section 6017 of the Code is amended—

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

"SEC. 6107. SELF-EMPLOYMENT AND HEALTH SECURITY TAX RETURNS.";

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

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

EFFECTIVE DATES OF PART B

SEC. 214. The amendments made by sections 211, 212, and section 213 (d) and (e) (other than section 213(e)(1)) shall be effective with respect to taxable years beginning on or after the effective date of health security taxes (as defined by section 312(u) of the Internal Revenue Code of 1954, added by section 201(c) of this Act). The amendments made by section 213 (a), (b), (c), and (e)(1) shall be effective on such effective date.

PART C—INCOME TAX DEDUCTIONS FOR MEDICAL CARE

DENIAL OF DEDUCTIONS FOR SERVICES COVERED BY HEALTH SECURITY ACT

SEC. 221. (a) Section 213 of the Internal Revenue Code of 1954 (relating to income tax deductions by individuals for the cost of medical care) is amended—

(1) by inserting, immediately after the words "for medical care" in paragraph (1) of subsection (a), "(other than any amount paid for medical care covered by the Health Security Act)";

(2) by striking out, in subsection (e)(1)(C), "(including amounts paid as premiums under part B of Title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged)"; and

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

"(5) The term 'medical care covered by the Health Security Act' means health services for which the individual receiving medical care was entitled to have payment made under title I of the Health Security Act (or for which he would have been entitled to have payment made upon obtaining the services from a participating provider of services under such Act), including the costs of insurance against expenses incurred for any such services."

(b) Section 162 of such Code (relating to income tax deduction for trade or business expenses) is amended by redesignating subsection (f) as subsection (g), and inserting immediately after subsection (e) the following subsection:

"(f) No deduction shall be allowed for the cost of medical care covered by the Health Security Act (as defined in section 213(e)(5))."

(c) The amendments made by subsections (a) and (b) shall be applied with respect to medical care received on or after the effective date of health security benefits, as set forth in section 163 of the Health Security Act

TITLE III—COMMISSION ON THE QUALITY OF HEALTH CARE

STATEMENT OF PURPOSE

SEC. 301. It is the purpose of this title to improve the quality of health care in the United States by establishing a Commission on the Quality of Health Care to develop parameters and standards for care of high quality, and to promote the application of such parameters and standards in assessing and enhancing the quality of care furnished under the Health Security Act.

AMENDMENT OF THE PUBLIC HEALTH SERVICE ACT

SEC. 302. The Public Health Service Act is amended by inserting after Title XVI the following new title:

"TITLE XVII—COMMISSION ON THE QUALITY OF HEALTH CARE

"ESTABLISHMENT OF THE COMMISSION

"SEC. 1701. (a) There is hereby established in the Department of Health, Education, and Welfare a Commission on the Quality of Health Care (hereinafter in this title referred to as the 'Commission'), consisting of eleven members to be appointed by the Secretary after consultation with the Health Security Board, which shall perform the functions set forth in sections 1702 and 1703.

"(b) The Commission shall consist of persons who are especially qualified by education and experience to perform the functions of the Commission, including seven persons who are representatives of providers of health services or representatives of non-governmental organizations engaged in developing standards pertaining to the quality of health care, and four persons who are representatives of consumers of health care (who shall be persons not engaged in, and having no financial interest in, the furnishing of health services). Each member shall hold office for a term of five 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, three at the end of the first year, two at the end of the second year, two at the end of the third year, and two at the end of the fourth year after the appointment and qualification of at least six members of the Commission. A majority of the members who have been appointed and qualified shall constitute a quorum for the transaction of business.

"(c) The Secretary shall designate one of the members of the Commission to serve, at the will of the Secretary, as Chairman of the Commission.

"(d) Subject to general policies established by the Secretary, and to the availability of funds, the Commission is authorized to employ such personnel as it finds necessary, including experts and consultants employed in accordance with section 3109 of title 5, United States Code, and to appoint one or more advisory committees (including a committee on the preparation and analysis of statistics) which may include officers or employees of the United States or of State or local governments. Members of committees who are not otherwise in the full-time employ of the United States, and experts and consultants employed pursuant to this subsection, while serving on business of the Commission (inclusive of travel time), shall receive compensation at rates fixed by the Commission, but not in excess of the daily rate paid under GS–18 of the General Schedule under section 5332 of title 5, United States Code; 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 Government service employed intermittently.

"FUNCTIONS OF THE COMMISSION

"SEC. 1702. (a) The primary responsibility of the Commission shall be the initiation and continuing development of methods of assessing the quality of health care furnished under the Health Security Act and methods of utilizing such assessments for the maintenance and improvement of quality, and the submission to the Secretary and the Health Security Board of its findings and recommendations. In discharging this responsibility the Commission shall—

"(1) undertake the systematization and nationwide collection of data bearing on (A) the qualifications of health personnel and the adequacy of health facilities to furnish care of high quality, (B) the patterns of medical and other health practice in actual episodes of care, (C) the patterns of utilization of the components of the health care system, and (D) the health of patients during and at the conclusion of episodes of health care, and the relation of the foregoing elements of health care thereto;

"(2) develop from such date (on a national or regional basis, for particular population groups, or otherwise, as the Commission may deem most useful) statistical norms and ranges with respect to aspects of health care which are comprised by each of the four elements listed in paragraph (1);

"(3) develop, on the basis of these norms and ranges, such standards (together with acceptable deviations therefrom) as will afford useful gages of the quality of care and useful instruments for the control and improvement of quality; and

"(4) make recommendations to the Secretary and the Health Security Board for the use of standards developed under para-

graph (3) in the exercise by the Board of its authority under title I, part H, of the Health Security Act, or for their use in the development of recommendations to the Congress for amendment of the Health Security Act. In carrying out its duties under this subsection, the Commission shall emphasize, and give first consideration to, care furnished for those illnesses and conditions which have relatively high incidence in the population and which are relatively amendable to medical or other care.

"(b) The Commission shall, through its staff or by contract (or both), conduct a program of research with the objectives of—

"(1) improving the technology of assessing the quality of health care, with regard for both the service input and the end result of such care;

"(2) comparing the quality of health care furnished under different systems of delivery and methods of payment;

"(3) analyzing the effects of consumer health education, and of utilization of preventive health services;

"(4) continuing the studies made by the Secretary's Commission on Medical Malpractice, and appraising the effect of measures taken by the Health Security Board pursuant to section 146 of the Health Security Act; and

"(5) obtaining other information which the Commission believes will be useful in effectuating the purpose of this title and of title I, part H, of the Health Security Act.

"(c) The Commission is authorized to provide technical assistance to participating providers of health services under title I of the Health Security Act (1) in furnishing to the Health Security Board information required for purposes of the Commission, and (2) in developing and carrying out programs of quality control.

"ADVICE TO HEALTH SECURITY BOARD PENDING DEVELOPMENT OF STANDARDS

"SEC. 1703. Pending the development of standards and recommendations pursuant to section 1702(a), the Commission shall, both before and after the effective date of health benefits under title I of the Health Security Act, on the basis of such knowledge as is available from time to time, furnish advice and recommendations to the Health Security Board on the issuance of regulations under part H of such title.

"SEC. 1704. The Secretary is authorized to establish on the staff of the Commission, and to fix compensation for, not more than twenty-five positions in the professional, scientific, and executive service, each such position being established to effectuate those research and development activities of the Commission which require the services of specially qualified scientific, professional, and administrative personnel. The rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than the minimum rate of grade 16 of the General Schedule of the Classification Act of 1949, as amended, nor more than the highest rate of grade 18 of the General Schedule of such Act; and the rates of compensation for all such positions shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may designate for this purpose."

TITLE IV—REPEAL ON AMENDMENT OF OTHER ACTS REPEAL OF MEDICARE AND FEDERAL EMPLOYEE HEALTH BENEFIT STATUTES

SEC. 401. (a) Effective on the effective date of health security benefits (set forth in section 163)—

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

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

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

MEDICAID STATUTE

SEC. 402. After the effective date of health security benefits no State (as defined in section 1101(a)(1) of the Social Security Act) shall be required, as a condition of approval of its State plan under title XIX of that Act, to furnish any service which constitutes a covered service under Title I of this Act, and any amount expended for the furnishing of any such service to a person eligible for services under title I of this Act shall be disregarded in determining the amount of any payment to a State under such title XIX. The Secretary of Health, Education, and Welfare shall by regulation prescribe the minimum scope of services required (in lieu of the requirements of section 1902(a)(13) of the Social Security Act) as a condition of approval, after the effective date of health security benefits, of a State plan under such title XIX. Such minimum scope of services shall, to the extent the Secretary finds practicable, supplement the benefits available under title I of this Act, including supplementation with respect to the duration of skilled nursing home services during the benefit period and with respect to the furnishing of dental services and of drugs (appearing on the list established under section 25(b) of this Act) to persons not entitled to such services, or not entitled to such drugs, under title I of this Act.

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

SEC. 403. Funds made available under the Vocational Rehabilitation Act or under Title V of the Social Security Act shall not be used, after the effective date of health security benefits, to pay for personal health services available under title I of this Act, but they may, in accordance with regulations of the Secretary of Health, Education, and Welfare, be used (a) to pay for institutional services which are either more extensive or more intensive than the services recognized in institutional budgets approved under title I of this Act, or (b) to pay for special medical or other procedures peculiar to vocational rehabilitation, or peculiar to the correction or amelioration of defects or chronic conditions of crippled children, as the case may be.

AMENDMENT OF SECTION 1122 OF THE SOCIAL SECURITY ACT

SEC. 404. (a) Section 1122 of the Social Security Act is amended—

(1) by striking out the words "titles V, XVIII, and XIX" whenever they appear in the section and inserting in lieu thereof "titles V and XIX of this Act and title I of the Health Security Act", and striking out "title V, XVIII or XIX" in subsection (d)(2) and inserting in lieu thereof "title V or XIX of this Act or title I of the Health Security Act";

(2) by striking out the words "in determining the Federal payments" wherever they appear in subsections (d)(1) and (e) and inserting in lieu thereof "for the purpose of determining the Federal payments";

(3) by striking out in subsection (d)(1) "not include any amount" and "exclude an amount" and inserting in lieu thereof, respectively, "not include, and shall direct the Health Security Board not to include, any amount" and "exclude, and shall direct the Health Security Board to exclude, an amount";

(4) by striking out in subsection (i)(2) "the Health Insurance Benefits Advisory Council" and insert in lieu thereof "the National Health Security Advisory Council".

(b) The amendments made by subsection (a) shall be effective upon the effective date of health security benefits except that prior to that date the Secretary of Health, Education, and Welfare may issue to the Health Security Board directions for reductions in payments to be made on and after the effective date.

REPEAL OF TITLE XI, PART B, OF THE SOCIAL SECURITY ACT

SEC. 405. Part B of title XI of the Social Security Act (relating to Professional Standards Review), and section 249F of the Social Security Amendments of 1972 (which added that part to the Act) are repealed, effective on the effective date of health security benefits.

TRANSFER AND AMENDMENT OF SECTION 1817, AND AMENDMENT OF SECTION 201(g), OF THE SOCIAL SECURITY ACT

SEC. 406. (a) Section 1817 of the Social Security Act (creating the Federal Hospital Insurance Trust Fund and appropriating to the fund the proceeds of the hospital insurance payroll taxes and the hospital insurance self-employment tax) is redesignated as section 61 and is transferred to this Act, to appear under the heading "HEALTH SECURITY TRUST FUND" as the first section of part D of title I; and is amended—

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

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

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

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

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

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

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

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

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

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

(3) by striking out the words "for which the Secretary of Health, Education, and Welfare is responsible" wherever they appear in paragraph (1)(A), and inserting in lieu thereof, "for which the Secretary of Health, Education, and Welfare and the Health Security Board are responsible".

(c) All references to the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund, appearing in any Act other than this Act or the Social Security Act, shall be deemed to refer to the Health Security Trust Fund.

(d) For the effective date of subsections (a) and (b), see section 163. Subsection (c) shall be effective on and after the effective date of health benefits.

AMENDMENT OF TITLE XV OF THE PUBLIC HEALTH SERVICE ACT

SEC. 407. (a) Section 1501(a) of the Public Health Service Act is amended by striking out "within eighteen months" and inserting in lieu thereof "within twelve months".

(b) Section 1501(b) of such Act is amended by adding after paragraph (2) thereof the following sentence: "Such guidelines shall emphasize the need for prompt action to enable providers of health services better to meet the demands upon them when benefits under title I of the Health Security Act become available."

(c) Section 1503(b) of such Act is amended by striking out "and the Assistant Secretary of Health of the Department of Health, Education, and Welfare" and inserting in lieu thereof, "the Under Secretary for Health and Science of the Department of Health, Education, and Welfare, and the Chairman of the Health Security Board".

(d) Section 1513(d) of such Act is amended by striking out paragraph (1) thereof and redesignating paragraphs (2), (3) and (4) as paragraphs (1), (2) and (3), respectively.

(e) (1) Section 1413(e)(1) of such Act is amended by inserting, immediately after "1970", as comma and the following: "or made available under part F of title I of the Health Security Act,".

(2) Section 1513(e)(2) of such Act is amended by striking out "the Secretary" in the first and second sentences thereof, and inserting in lieu thereof in each instance "the Secretary or the Health Security Board"; by striking out "he" in the second sentence and inserting "the Secretary" in lieu thereof; and by inserting after "may make" in the fourth sentence "(or authorize the Health Security Board to make)".

(f) Section 1526 of such Act is repealed.

SALARY LEVELS

SEC. 408. (a) Section 5313, title 5, United States Code (relating to executive pay rates for positions at level II) is amended by adding at the end thereof the following new clause:

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

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

"(7) Under Secretary for Health and Science, Department of Health, Education, and Welfare."; and by adding at the end thereof the following new clause:

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

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

"(105) Members (other than the Chairman), Health Security Board, Department of Health, Education, and Welfare (4)."

"(106) Members, Commission on the Quality of Health Care, Department of Health, Education, and Welfare (11)."

(d) Section 5316, 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:

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

AMENDMENT OF BUDGET AND ACCOUNTING ACT

SEC. 409. (a) Section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), is amended—

(1) by striking out "The Budget" in the second sentence of subsection (a) and inserting in lieu thereof "Except as provided in subsection (d), the Budget"; and

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

"(d) The Budget shall set forth the items referred to in paragraphs (4), (5), (6), (7), (8), (9), and (12) of subsection (a) which are attributable to receipts of and expenditures from the Health Security Trust Fund, and shall set forth separately such items (commonly referred to as the 'administrative budget') attributable to all other operations of the Government."

(b) The amendments made by subsection (a) shall be effective with respect to the fiscal year beginning in the first calendar year after the calendar year in which this Act is enacted, and to all subsequent fiscal years.

TITLE V—STUDIES RELATED TO HEALTH SECURITY STUDY OF THE PROVISION OF HEALTH SECURITY BENEFITS TO UNITED STATES CITIZENS IN OTHER COUNTRIES

SEC. 501. The Secretary of Health, Education, and Welfare, in consultation with the Secretary of State and the Secretary of the Treasury, shall study (a) the practicability and the means of making prepaid health services (or prepaid indemnification for the cost of health services) available, more widely than can be done under section 12 of this Act, to citizens of the United States who are resident in other countries or are temporarily visiting such countries, by supplementing the authority for reciprocal arrangements under section 12 with authority for payments from the Health Security Trust Fund, and (b) means of equitably financing such services (or indemnification) through the extension of health security taxes; and not later than five years after the enactment of this Act shall report to the Congress his findings and recommendations.

STUDY OF COORDINATION WITH OTHER FEDERAL HEALTH BENEFIT PROGRAMS

SEC. 502. (a) The Secretary of Health, Education, and Welfare shall conduct studies of the most satisfactory means of coordinating the program for the health care of merchant seamen, the program for the health care of Indians and Alaskan natives, or both, with the system of health security benefits created by this Act; the Administrator of Veterans' Affairs and the Secretary shall conduct a joint study of the most satisfactory means of coordinating with that system some or all of the programs for the health care of veterans; and the Secretary of Defense and the Secretary of Health, Education, and Welfare shall conduct a like joint study with respect to the programs of health benefits furnished by civilian facilities and personnel to dependents of members of the Armed Forces. Reports of these studies, and legislative recommendations to achieve improved coordination, shall be submitted to the Congress not later than three years after the enactment of this Act.

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

GENERAL PROVISIONS

SEC. 503. (a) There are hereby authorized to be appropriated such sums as may be necessary for the conduct of the studies authorized by this title.

(b) In conducting such studies the Secretary of Health, Education, and Welfare, the Secretary of Defense, and the Administrator of Veterans' Affairs are each authorized (1) to appoint such experts and consultants (employed in accordance with section 3109 of title 5, United States Code) and such advisory committees as they may deem necessary; and (2) to enter into contracts with public or private agencies or organizations for the collection of information, the conduct of research, or other purposes related to the respective studies. Experts and consultants and members of advisory committees appointed under this subsection, while serving on business related to the studies (inclusive of travel-time), shall receive compensation at rates not in excess of the daily rate paid under GS-18 of the General Schedule under Section 5332 of title 5, United States Code; 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 Government service employed intermittently.

SECTION-BY-SECTION ANALYSIS OF THE HEALTH SECURITY ACT—H.R. 21

TITLE I—HEALTH SECURITY BENEFITS

Part A—Eligibility for benefits

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

Part B—Nature and scope of benefits: Covered services

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

(Section 22.) All necessary professional services of physicians (including preventive care) are covered wherever furnished, with one quantitative limitation. Psychiatric services to an ambulatory patient are covered without limit if the patient seeks care in the organized setting of a group practice organization, a hospital out-patient clinic, or other comprehensive mental health clinic. 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, however, there is a limit of 20 consultations per benefit period. In communities where psychiatric services are in especially short supply, the Board may prescribe referral or other non-financial conditions to give persons most in need of services a priority of access to solo practitioners.

(Section 23.) Comprehensive dental services (exclusive of most orthodontia) are covererd for children under age 15, with the covered age group increasing by two years each year until all those under age 25 are covered. (Persons once covered remain covered for the rest of their lives). This benefit is limited initially because, even with full use of dental auxiliaries, there is insufficient manpower to provide dental benefits to the entire population. However, the Board is authorized to expand the benefits more rapidly if availability of resources warrants, and the Board is required within seven years of the

effective date of the legislation, to establish a timetable for phasing in benefits for the entire population. To encourage the development of groupes which provide comprehensive medical and dental services or comprehensive dental services, the Board is authorized to phase in full dental benefits more rapidly for the enrollees of those groups than for the general population.

(Section 24.) In-patient and out-patient hospital services and services of a home health agency are covered for the duration of the services, and skilled nursing home services are covered for limited periods. Pathology and radiology services are specifically included as parts of institutional services, thus reversing the practice of Medicare. Domiciliary or custodial care is specifically excluded in any institution, thus necessitating the two important restrictions on payments for institutional care:

(1) Payment for skilled nursing home care is limited to 120 days per benefit period, except that this limit may be increased either when the nursing home is owned or managed by a hospital and payment for care is made through the hospital's budget, or for all nursing homes affiliated with hospitals. 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 custodial setting. If Health Security provides unlimited coverage for patients in these hospitals, it might tend to freeze the level of care instead of stimulating these institutions to upgrade their medical care performance. Therefore, the psychiatric hospital benefit is limited to 45 days of active treatment during a benefit period.

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

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

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

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

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

Supporting services such as psychological, physiotherapy, nutrition, social work and health education are covered if they are part of institutional services or are furnished by a group practice organization, individual practice association or certain public or non-profit organizations. This establishes the important principle that these and other supporting services should be provided as part of a coordinated program of health maintenance and care. Psychologists, physical therapists, social workers, etc. will not be permitted to establish independent practices and bill the program on a fee-for-service basis. This is intended to assure that whenever services of this nature are provided they are part of an organized plan of treatment and are germane to the overall care of the patient.

In addition to services available from hospitals, mental health centers or other providers, free-standing alcohol, drug abuse, family planning and rehabilitation centers would be recognized as providers if such centers have an agreement with the Board under section 49(a) (5), (6) and (7).

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

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

The Board may exclude from coverage medical or surgical procedures which are essentially experimental in nature. 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(a).) Participating providers are required to meet standards established in this title or by the Board under Part H relating to quality of care. In addition, they must agree to comply with such requirements as the Board finds necessary, to assure to their employees, employment rights and working conditions similar to the guarantees of other workers. 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 by the Commission on the quality of the care and verification of information for payments.

(b) A provider's participation may be terminated under procedures described in part G of the bill.

(c) If a provider is merged, consolidated or reorganized, pre-existing employment rights shall be subject to reasonable requirements by the Board for protection or employees' rights.

(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. A state-licensed practitioner who meets national standards will be qualified to provide Health Security covered services in any other state. (See also Section 56(a)(1)).

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

A doctor of optometry or podiatry qualified in accordance with subsection (a) is a physician when furnishing services which are covered services in accordance with regulations issued under Section 27(a) and which he is legally qualified to furnish in the state in which he furnished them.

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

(Section 44.) Psychiatric hospitals will be eligible to participate only if the Board finds that the hospital (or a distinct part of the hospital) is engaged in furnishing active diagnostic, therapeutic and rehabilitative services to mentally ill patients. Psychiatric hospitals are required to meet the same standards as those prescribed for general hospitals in Section 43, and such other conditions as the Board finds necessary to demonstrate that the institution is providing active treatment to its patients. These standards will exclude costs incurred by state mental institutions to the extent they serve domiciliary or custodial functions.

(Sections 45 and 46.) Section 45 establishes conditions of participation for skilled nursing homes similar to those established for extended care facilities under Medicare. Important differences, however, are the requirement for affiliation with a participating hospital or group practice 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.) Subsection (a) describes a group practice organization (one type of health maintenance organization) which undertakes to provide an enrolled population

either with complete health care or, at the least, with complete Health Security services (other than 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.

Other requirements are spelled out in this section: The organization must furnish medical services (and dental services if they are included) through prepaid group practice. Other services must be furnished by staff of the organization or by contractors for whom the organization assumes responsibility, except that institutional services may be provided by arrangements with other participating providers at the expense of the group practice organization. The organization must be non-profit, but it may utilize proprietary providers in fulfilling its responsibilities.

All persons living in or near a specified service area will be eligible to enroll during an annual open enrollment period, subject to the capacity of the organization to furnish care. Services must be reasonably accessible to persons living within the specified service area. Periodic consultation with representatives of enrollees is required, and they must be given opportunity to participate in policy formulation and in evaluation of operation. Professional policies and their effectuation, including monitoring the quality of services and their utilization, are to be the responsibility of a committee or committees of physicians (and other health professionals where appropriate). Health education and the use of preventive services must be stressed, and lay persons are to be employed so far as is consistent with good medical practice. Charges for any services not covered by Health Security must be reasonable. Finally, the organization must agree to pay for services furnished by other providers in emergencies, either within the service area of the organization or elsewhere, but may meet this requirement to the extent feasible through reciprocal service arrangements with other organizations of like kind.

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

(Section 48.) An individual practice association (another type of health maintenance organization) must be a nonprofit organization, sponsored by a county or other local medical society, which meets all the conditions for participation by a group practice organization other than the requirement of group practice. All physicians practicing in the area (and all dentists if dental services are furnished) must be permitted to become professional members, subject only to criteria, approved by the Board, relating to professional qualifications. For professional services to enrollees, professional members may be compensated by the foundation by whatever method, including fee-for-service, may be agreed upon by it and its members.

Subsection (b) provides that a professional member may furnish services to persons not enrolled in the association and receive payment from the Board on the same basis as independent practitioners, except that if he is paid by capitation, salary, or stipend by the association, the payment for services to non-enrollees is to be made to the association.

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

Subsection 49(a)(1) permits the participation of community health centers or the like which, though furnishing a broad range of ambulatory services, do not serve an enrolled or otherwise predetermined population and may not meet some other requirements of section 47(a). Subsection (a)(2) authorizes the Board to deal separately with the primary care portion of a system of comprehensive care where it is necessary to rely on arrangements with other providers, rather than on a unified structure, to round out the other elements of the system. Where organizations meeting the extensive requirements of section 47(a) or 48(a) are not available, these two paragraphs of section 49(a) will give the Board flexibility in furthering one of the bill's prime objectives, the development and broad availability of comprehensive services furnished on a coordinated basis.

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

If a state or local public health agency is providing preventive or diagnostic services, such as immunization or laboratory tests, the Board may under subsection (a)(4) contract with it for the continuance of these services.

In accordance with regulations, the Board may contract with free standing ambulatory treatment centers for alcoholism and/or drug abuse; for family planning services; and for rehabilitation 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. Subsection (a)(8) permits this. The Board will have wide discretion in contracting with such entities subject only to the limitation that, like other organizations described in section 49(a), the entity may not (under section 88(a)) be paid on a fee-for-service basis. Practitioners who elect that method of payment may of course pool their bills for submission to the Board, but there is no reason to contract with a unit for the payment of fees to it.

Subsection (b) makes clear that agreements with the Board under this section shall not (unless expressly so stipulated) preclude practitioners furnishing services under the agreements from furnishing other services as independent providers.

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

(Section 51.) The requirements of utilization review in hospitals and skilled nursing homes are in the main similar to those which Medicare has, since 1966, imposed with respect to services to aged patients. In Health Security the requirements will of course apply to the entire population. As in Medicare, the review is designed to serve a dual purpose: identification of certain specific misuses of the institutional services with a view to their termination, and a focusing of continuing attention and concern of the medical staff on the necessity for efficient utilization of institutional resources. Section 51(a) strengthens the educational aspect of the process by requiring specifically that records of reviews be maintained and statistical summaries of them be reported periodically to the institution and its medical staff (and, on request, to the Board). As under Medicare, the review committee will consist of two or more physicians, with or without other professional participation; and in the case of hospitals, will normally be drawn from the medical staff unless for some reason an outside group is required. For skilled nursing homes, on the other hand, section 51(c) departs from Medicare by permitting as an alternative that the Committee be established by the State or local public health agency under contract with the Board, or failing that, by the Board. If the nursing home operates under a consolidated budget with a hospital, the review will be made by the hospital committee. Like Medicare, Section 51 (d) and (e) call for review of specific long-stay cases as required by regulations, and notification to the institution, the attending physician, and the patient when a decision adverse to further institutional services is made.

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

(Section 53.) If the construction or substantial enlargement of a hospital, skilled nursing home, or ambulatory care facility has been undertaken after December 31 of the year of enactment, without either a State certificate of need or a prior approval by a planning agency designated by the governor of the State or the Board, section 53 precludes the institution from participating in the Health Security program, except that in case of enlargement, the Board may permit participation subject to reduction in reimbursement for services. This should greatly strengthen state and local planning authorities.

(Section 54.) This section prohibits double recovery in malpractice litigation by stipulating that no damages will be awarded to the injured party for remedial services which are available without cost under the Health Security 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 institutions or agencies to eligible persons who are not a part of their normal clientele. It will also provide reimbursement for services furnished by the Public Health Service under the Emergency Health Personnel Act of 1970.

(Section 56.) This section overrides, for purposes of the Health Security Program, State laws of several kinds which inhibit the utilization or the mobility of health personel, 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 non-professional personnel. For occupations such as pharmacy and professional nursing, which are subject to licensure in all States, a person can avail himself of this paragraph only if he is licensed in one State and meets the national standards; in other cases, where licensure is not universally required, compliance with national standards is sufficient. Here again, impediments to mobility created by existing licensure laws will be removed.

The restrictions which many professional practice acts impose on the use of lay assistants, and the legal uncertainties which often deter such use, discourage practices that can increase greatly, without sacrifice of safety, the volume of services which professionals can render. Accordingly, paragraph (3) of subsection (a) enables the Board to permit physicians and dentists, participating in public or non-profit hospitals and group practice 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 it concerns participating public or other non-profit hospitals and group practice organizations. These institutions may employ physicians or make other arrangements for their services, unless in the unlikely event that the lay interference with professional acts or judgments should be threatened. No conflict of interest results from such arrangements; in the non-profit setting loyalty to employer and loyalty to patient run parallel.

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

PART D—TRUST FUND; ALLOCATION OF FUNDS FOR SERVICES

(Section 61.) By section 406(a) of the present bill, section 1817 of the Social Security Act, creating the Federal Hospital Insurance Trust Fund, is amended and transferred to become section 61 of the Health Security Act. The fund will thus become the Health Security Trust Fund, succeeding to the assets and liabilities of both Medicare trust funds, and receiving the proceeds of the health security taxes imposed by title II of the Health Security Act and the authorized appropriations from general revenues equal to 100 percent of those tax receipts.

The Fund will also receive recoveries of overpayments, and receipts from loans and other agreements. To implement the role of the Trust Fund, the Managing Trustee (the Secretary of the Treasury) will make payments from the Trust Fund provided for under Title I, as the Board certifies, and with respect to administrative expenses as authorized annually by the Congress.

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

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

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

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

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

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

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

(Section 66.) These regional funds will be sub-divided among the health services areas in each region, primarily upon the basis of

the previous years' expenditure for each kind of service. Again, the Board will gradually attempt to achieve the equalization of services within each region by restraining the increase of expenditures in high cost areas and channeling funds into health service areas with a low level of expenditures.

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

(Section 68) By the time Health Security benefits become available, the Government will be operating on a fiscal year beginning on October 1, instead of July 1 as at present. This section accordingly allows the Board to make the initial determinations and allocations under this part either for the three-month period from the effective date of benefits on July 1 until the beginning of the next fiscal year or for the fifteen-month period which includes the next fiscal year.

PART E—PAYMENT TO PROVIDERS OF SERVICES

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

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

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

When necessary to assure the availability of services in a given area, subsection (c) permits paying an independent practitioner a full-time or part-time stipend in lieu of or as a supplement to other methods of compensation. This method of payment will be used selectively by the Board, mainly to encourage the location of practitioners in remote or deprived areas. Practitioners may also be reimbursed for the special costs of continuing education required by the Board and for maintaining linkages 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 (d) defines the capitation method of payment.

Subsections (e), (f), (g). These subsections describe the method to be used in applying, as between practitioners electing the various methods of payments, 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 per capita amount available for each category of service (i.e., physicians, dentists, podiatrists, optometrists) to the residents of the area. This per capita amount in each category will fix the capitation payments to organizations that undertake to provide the full range of services in that category to enrolled individuals. Lesser amounts will be fixed for more limited services. For example, if the per capita amounts available for physician and dental services are $65 and $25, respectively, primary physicians accepting capitation payments will receive the percentage of that $65 which is allocated for primary services, a medical society-sponsored individual practice association would receive the entire $65 for physician services, dentists furnishing all covered services would receive the $25 allocated for dental services, and organizations which undertake to provide all physician and dental services to enrolled individuals will receive $90 for each enrolled individual.

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

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

(Section 83.) Hospitals will be paid on the basis of a predetermined annual budget covering their approved costs. To facilitate review of these budgets, the Board will institute a national uniform accounting system. Subsection (b) stipulates that the costs recognized for purposes of the budget will be those incurred in furnishing the normal services of the institution except as changed by agreement, or by order of the Board under section 134. This will enable the Board, on the basis of State and local planning, to eliminate, gradually, 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 allows independent billing by such physicians. The institution's budget may also be increased to reflect the cost of owning or operating an affiliated skilled nursing home, or home health service agency. Hospital budgets will be reviewed by the Board, locally or regionally, which may permit participation by representatives of the hospitals in each region. Budgets may be modified before, during, or after the fiscal year if changes occur which make modification necessary.

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

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

(Section 86.) Reimbursement for drugs will be made to the dispensing agent on the basis of an official "product price" for each drug on the approved list, plus a dispensing fee in the case of an independent pharmacist. 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 cost 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.) Subsections (a) and (b) provide that a group practice organization or individual practice association will be paid a basc capitation rate multiplied by the number of elgible 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 other covered services.

Subsection (c) fixes capitation amounts for institutional services based on per diem rates derived from the budgets of participating institutional providers or institutions with which the organization or association may have a contractual agreement. The organization or association will be entitled to share in up to 75% of any savings which are achievd by lesser utilization of institutional services by its enrollees. Entitlement to such savings is conditional upon a finding by the Board that the services of the organization or association 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 the enrollees of the organization or association is less than the use of such services by comparable population groups not so enrolled but under otherwise comparable circumstances. This money may be used by the organization or association for any of its purposes, including the provision of services which are not covered under the Health Security program.

Subsection (e) directs the Board to allow organizations and associations to reinsure with the Board against catastrophic costs incurred on behalf of any one enrollee, against some or all of the costs of institutional acre which it contracts out, and against some or all of the costs of out-of-area services.

Subsection (f) permits the Board to make an additional payment to group practice organization for the cost of clinical education or training provided by the organization.

(Section 88.) Subsection (a) provides that an organization or agencies with which the Board has entered into an agreement under section 49 (such as a neighborhood health center, a non-profit mental health center, or local public health agency furnishing pre-

ventive or diagnostic services) may be paid by any method agreed upon other than fee-for-service.

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

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

(Section 89.) This section provides that the Board will reduce payments to institutional providers in accordance with findings by the Secretary that a facility or any part of a facility has not been built in compliance with the area health plan.

(Section 90.) All participating providers will be paid from the Health Services Account in the Trust Fund at such time or times as the Board finds appropriate (but not less often than monthly). The Board may make advance payment to supply providers with working funds when it deems advisable.

PART F—DEVELOPMENT FUND

SUBPART 1—PLANNING: FUNDS TO IMPROVE SERVICES AND TO ALLEVIATE SHORTAGES OF FACILITIES AND PERSONNEL

(Section 101.) This section sets forth the general purposes of subpart 1 of Part F. The subpart enables the Board, through selective financial assistance, to stimulate and assist in the development of comprehensive 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. In carrying out these functions, the Board is to be guided by the planning with respect to health facilities and the organization of services which will be conducted under the recently enacted title XV of the Public Health Services Act, when and as the new processes become operative. In the meantime it will be guided by such planning as is conducted by the Secretary under section 102. With respect to the supply and distribution of health personnel, the Board will also rely on planning conducted by the Secretary.

(Section 102.) Subsection (a) directs the Secretary, in effect, to fill in the gap in facility and services planning until the new processes can begin to produce results, addressing himself immediately to the most acute shortages and maldistribution of facilities and the most serious deficiencies in organization. He is directed to consult with, and utilize the experience and recommendations of, both existing State and local health planning agencies and the new agencies as they emerge.

Subsection (b) places on the Secretary a continuing duty to plan for improvement of the supply and distribution of health personnel, and to do this in consultation both with the health planning agencies and with appropriate professional organizations.

Thus, the bill takes advantage of the new legislation strengthening State planning agencies, focusing in them eventally the responsibility, visualized in the "Partnership-for-Health" legislation but in many States not realized as an operating reality, for pulling together all health planning efforts within their territories. Recognizing, however, that it will take time to make the new arrangements effective, the bill charges the Secretary with bringing all available experience and skills to bear on the immediate need to identify the most pressing requirements in preparation for the availability of Health Security benefits. These tasks will not be easy, but they are lent new urgency by the Health Security Program.

(Section 103.) In administering subpart 1, this section stipulates, the Board will give priority to improving comprehensive health services for ambulatory patients through the development or expansion of group practice organizations and community health centers, and primary care centers (where full service organizations are impractical), the recruitment and training of personnel, and the strengthening of coordination among providers of services. Funds will not be used to replace other Federal financial assistance, and may supplement other assistance only to meet specific needs of the Health Security program. Other Federal assistance programs are to be administered when possible to further the objectives of Part F, and the Board may provide loans or interest subsidies to help the beneficiaries of other programs to meet the requirements for non-Federal funds.

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

(Section 105.) This section contains a series of provisions to assist in the recruitment, education, and training of health personnel. The Board will establish priorities to meet the most urgent needs of the Health Security system, but the priorities will be flexible both as between different regions and from time to time. Professional practitioners will be recruited for service in shortage areas, both urban and rural, and in group practice 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 retraining. It also 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 the effective date of health benefits. Education and training are to be carried out through contracts with appropriate institutions and agencies, and suitable stipends to students and trainees are authorized. Physicians will be recruited and trained to serve as hospital medical directors. Finally, special assistance may be given, both to intitutions and to students, to meet the additional cost 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 the organizations described in section 104 to improve their utilization review, budget, statistical, or records and information retrieval systems, to acquire equipment needed for those purposes, or to acquire equipment useful for mass screening or for other diagnostic or therapeutic purposes.

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

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

SUBPART 2—PROGRAMS OF PERSONAL CARE SERVICES

(Section 111.) The purpose of this subpart is stated in this section, to encourage and assist in the development of community programs of maintaining in their own homes, by means of comprehensive health and personal care services, disabled or chronically ill persons who otherwise require or are likely to require institutional care. It is intended that a grant be made in any community that can develop a satisfactory program and such non-Federal financing as the Board finds appropriate.

(Section 112.) This section authorizes grants to public or nonprofit agencies for this purpose, each program being designed to serve a substantial urban or rural population. Grants may be made for up to four years, and shall be irrevocable except for cause.

(Section 113.) The services to be provided include, in addition to covered health services, combinations of personal care services (such as homemaker and home maintenance services, laundry, meals-on-wheels and other dietary services, help with transportation and shopping, and other appropriate services). Different services may be provided in different programs. Full coordination with existing community health or personal care programs is required. Committees are to be established, consisting of professionals and representatives of users of the services, to screen applications for assistance and monitor utilization.

(Section 114.) Grantees must evaluate their programs with respect both to benefits to users of the services and to the fiscal impact on the Health Security system. The Board is also to evaluate each program and summarize its conclusions in its annual reports to Congress.

(Section 115.) Within three years the Board is to make a comprehensive report to Congress on this program with an evaluation of its operation. The Board is to submit also its recommendations of methods of developing, as widely and rapidly as practicable, personal care services where they are then lacking, with a view to making such services generally available throughout the United States; its recommendations with respect to the continuing financial support of such programs; and its recommendations on the proper role of the Health Security program in providing long-term institutional care and in providing personal care services in lieu thereof.

SUBPART 3—AVAILABILITY OF FUNDS

(Section 120.) For the two-year "tooling-up" period, appropriations of $200 and $400 million are authorized for financial assistance. Beginning with the effective date of

health benefits, percentages of the Trust Fund expenditures will be earmarked for such assistance (section 63). From that date on, the leverage of these expending 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 method of delivery of health services.

PART G—ADMINISTRATION

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

(Section 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 over-lapping terms. Not more than three of the five appointees may be members of the same political party. A member who has served two consecutive terms will not be eligible for reappointment until two years after the expiration of his second term. One member of the Board shall serve as chairman at the pleasure of the President.

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

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

Subsection (g) authorizes the Board to establish fifty positions, carrying salaries in the GS–16 to GS–18 range, in the professional, scientific, and executive service, to meet the need for highly qualified personnel both in research and development activities and in administration. It is expected that about half of these positions would be used for high-level administrative assignments, and the other half for the most responsible professional and scientific work of the Board.

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

(Section 124.) This section provides that the program will be administered through the regional offices of the Health Security Board. It also directs the Board to establish local health service areas which shall be the same as the health service areas under the new title XV of the Public Health Service Act, except that with the approval of the Secretary the Board may divide such an area into two or more areas for the purposes of the health security program. These areas are to serve as local administrative units, with a local office in each, and perhaps suboffices. One of the responsibilities of these offices will be to investigate complaints about the administration of the program.

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

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

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

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

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

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

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

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

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

Subsection (e) directs the Board to make inspections if a State is unable or unwilling to do so.

Subsection (f) calls for the publication of the results of the inspections.

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

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

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

Subsection (d) authorizes the Board to enter into agreements with providers to experiment with alternative methods of reimbursement which offer promises of improving the coordination of services, their quality or accessibility.

(Section 131.) Severe discrepancies exist today between the national need for various kinds of health manpower and the availability of clinical facilities to train such personnel. Certain specialties (such as surgery),

in which there is a surplus of manpower, monopolize clinical training facilities to the disadvantage of specialties in short supply (such as primary or family practice), thus perpetuating the imbalance between supply and demand. This section gives the Board authority to bring the availability of clinical training facilities into balance with national or regional manpower needs by issuing training priorities for institutional providers participating in the program.

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

(Section 133.) This section establishes procedures for hearings and for judicial review, similar to those under the Social Security Act.

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

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

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

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

PART H—QUALITY OF CARE

This part authorizes the Board, and charges it with the duty, to maintain and enhance the quality of care furnished under the Act. Section 141(a) sets forth this authority and this duty, to be discharged with the advice and assistance of, and in close collaboration with, the Commission on the Quality of Health Care created by an amendment of the Public Health Service Act contained in title III of the present bill. Regulations under the part are to be issued before health security benefits become effective, and thereafter to be upgraded as rapidly as is practicable. Subsection (b) states as the objective the highest quality of care attainable throughout the nation, with exceptions to quality requirements only when, and as long as, they are necessary to avoid acute shortages of services. Subsection (c) calls for collaboration with the Commission, and stipulates that any failure to follow its recommendations shall be submitted to the Secretary and that, unless he directs the Board to adopt the recommended regulations, the reasons for not doing so must be published by the Board.

(Section 142). The Board is to issue regulations requiring continuing professional education for physicians, dentists, optometrists, podiatrists. Reports of compliance with the regulations will be required and, after warning, practitioners may be disciplined for failure to comply.

(Section 143). Subsection (a) provides that major surgery, and other procedures specified in regulations, are not covered services unless they are performed by a specialist, and (except in emergencies) are, to the extent prescribed in regulations, performed on referral by a physician engaged in general practice. Specialists, according to subsection (b) are those certified by the appropriate national specialty boards, with a five-year period allowed board-eligible physicians to obtain certification, and with a "grandfather" exception for certain physicians practicing when health security benefits go into effect.

Subsection (c) authorizes the Board to require, except in acute emergencies, consultation with an appropriate specialist, as a prerequisite to specified surgical procedures; in such cases subsection (d) enables the Board to require pathology reports and clinical abstracts or discharge reports.

(Section 144.) Subsection (a) requires that practitioners furnishing services on behalf of institutional or other providers meet the same qualifications that are demanded of independent practitioners. Subsection (b) authorizes the Board to make additional requirements, in the interest of the quality care and of safety of patients, for all providers other than professional practitioners. This is like the authority given the Secretary under the Medicare law, but with the notable difference that standards of the Joint Commission on the Accreditation of Hospitals constitute a minimum for Board requirements, rather than a maximum as under Medicare. Exceptions are permitted only, as stated in section 141, to avoid acute shortages of services.

(Section 145.) Although the provisions relating to professional standard review organizations, recently added to the Social Security Act, are repealed by section 405 of the present bill, the Board is authorized, on recommendation of the Commission on the Quality of Health Care, to use organizations previously designated by the Secretary for the purposes of monitoring the quality of services, either institutional or noninstitutional. The Board may also use for this purpose similar organizations approved by it in the future.

(Section 146.) In exercising its authority under part H the Board is directed to take into account the findings of the Secretary's Commission on Medical Malpractice, and to seek to reduce the incidence of malpractice and to improve the availability of malpractice insurance.

PART I—MISCELLANEOUS PROVISIONS

(Section 161.) This section contains definitions of certain terms used in the title.

(Section 162.) This section creates the offices of Deputy Secretary of Health, Education and Welfare and an Under Secretary for Health and Science in the Department of Health, Education and Welfare, and abolishes the office of Under Secretary of Health, Education and Welfare.

(Section 163.) This section stipulates that the effective date for entitlement for benefits will be July 1, of the second calendar year following enactment.

(Section 164.) Subsection (a) provides that an employer will not be relieved, by the enactment of the Health Security Act, of any existing contractual or other nonstatutory obligation to provide or pay for health services to his present or former employees and their families. An employer whose cost under such a contract, immediately before health security taxes go into effect, exceeds the cost to him of paying these taxes is required by subsection (b) to apply the excess, during the remaining life of the contract, first to the payment of health security taxes on behalf of his employees. If an excess still remains after meeting this obligation, and after an allowance for the cost of any continuing obligation to pay for health services not covered by Health Security, subsection (c) requires the employer to pay the amount of this remaining excess to those employees, former employees, and survivors who are beneficiaries of the pre-existing contract; but by agreement with the employees or their representatives, these funds may be applied to other employee benefits. Computations of the amounts involved are to be made on a per capita basis, as defined in subsection (d).

TITLE II—HEALTH SECURITY TAXES

Part A—Employment taxes

(Section 201.) Effective on January 1 of the second year after enactment, subsections (a) and (b) convert the existing Medicare hospital insurance payroll taxes into Health Security taxes and raise the rates to 1 percent on employees and 3.5 percent on employers. Subsection (c) sets the wage base for the employment tax at 150 percent of the Social Security wage base (or a tax base at present of $21,150 in conformity with the recent automatic increase of the Social Security tax base). This subsection also defines covered employment to include all substantial groups now excluded from social security tax coverage, except that State and local governments are excluded from the tax on employers.

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

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

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

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

(Section 211.) Effective at the beginning of the second calendar year after enactment, this section converts the existing Medicare self-employment tax into a Health Security self-employment tax, sets the rate at 2.5 percent, and sets the maximum taxable self-employment income at $23,500 (with the same upward adjustment as in the employee tax for subsequent rises in average wage levels).

(Section 212.) Effective on the same date, this section adds a new 2½ percent Health Security tax on unearned income (unless such income is less than $400 a year), subject to the same maximum on taxable in-

come as is applicable to the employee and self-employment taxes. Taxable unearned income is adjusted gross income up to the stated maximum, minus wages and self-employment income already taxed for Health Security purposes (excluding certain items of income (notably social security benefits) specifically excluded from the other taxes and excluding $5,000 in unearned income for persons over age 60.)

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

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

Part C—Income tax deductions for medical care

(Section 221.) This section amends the Internal Revenue Code so that no medical deductions shall be allowed for the cost of medical care which is covered by the Health Security Act on or after the effective date of health security benefits.

TITLE III—COMMISSION ON THE QUALITY OF HEALTH CARE

(Section 301.) The purpose of Title III is to create a Commission on the Quality of Health Care in order to improve health care in the United States. The Commission's function is:

To develop methods of measuring health care;

To develop standards for promoting health care of high quality;

To encourage the use of such measurements and standards under the provisions of the Health Security Act.

(Section 302.) This section adds to the Public Health Service Act a new Title XVII, entitled "Commission on the Quality of Health Care."

(Section 1701, Public Health Service Act.) Subsection (a) establishes a Commission on the Quality of Health Care within the Department of Health, Education and Welfare. The Commission will consist of eleven members who are to be appointed by the Secretary after consultation with the Health Security Board. The Commission is required to carry out the functions set forth under new sections 1702 and 1703.

Subsection (b) describes the requirements for the membership of the Commission. Seven of the members appointed must be representatives of health service providers or representatives of non-governmental organizations that are engaged in the process of developing standards relating to the quality of health care. Four members must be representatives of consumers who are not engaged in and have no financial interest in the delivery of health care services. Commission members will be appointed to serve five year overlapping terms. Subsection (c) requires the Secretary to designate the Chairman of the Commission, who serves at the pleasure of the Secretary. Subsection (d) authorizes the Commission to employ needed personnel and appoint advisory committees. It also stipulates the conditions of employment and rates and terms of compensation.

(Section 1702, Public Health Service Act.) Subsection (a) defines the primary responsibilities of the Commission. The Commission is directed to initiate and continuously develop methods to assess the quality of health care delivered under the provisions of the Health Security Act; and to initiate and develop ways to use such assessments in order to maintain and improve the quality of health care delivered under the Act. The Commission is required to submit its findings and recommendations to the Secretary and the Health Security Board.

Specifically, the Commission is required to:

(1) collect data on a systematic and nationwide basis that will provide information on the (A) qualifications of health personnel and the adequacy and ability of health care facilities to provide quality health care; (B) the patterns of health care practices in actual episodes of care; (C) the utilization patterns for components of the health care system; and (D) the health of patients during and at the end of actual episodes of care and the relationship of the various factors outlined above to the health of such patients;

(2) use the data it collects to develop statistical norms and ranges to describe the factors outlined in paragraph (1). Such norms and ranges may be developed on a national or regional basis, for particular population groups, or on any other basis deemed most useful by the Commission;

(3) use such statistical norms and ranges as a basis for developing standards (and acceptable deviation from such standards) that will be useful in measuring, controlling, and improving the quality of health care; and

(4) make recommendations to the Secretary and the Health Security Board on the proper use of standards developed under the provisions of paragraph (3) in connection with the Board's continuing responsibility for the maintenance and improvement of the quality of the health care delivered under the Health Security Act. Such recommendations may also be used by the Secretary or the Board when developing proposals to amend the Health Security Act.

When carrying out its duties under the provisions of this subsection, the Commission is directed to give first priority to the quality of care delivered for those illnesses or conditions which have high incidence of occurrence within the population and which are responsive to medical or other treatment.

Subsection (b) requires the Commission to conduct a broad health care research program. Specifically, the objectives of the program are to:

(1) improve technologies for assessing health care quality;

(2) compare the quality of health care under alternative health delivery systems and methods of payment;

(3) analyze the effects of consumer health education and preventive health services;

(4) continue the studies made by the Secretary's Commission on Medical Malpractice. In this respect, the Commission is also required to evaluate any of the recommendations of the Secretary's Commission which the Health Security Board has put into effect or any other measures that the Board has established, which pertain to the incidence of malpractice, malpractice insurance, or malpractice claims;

(5) obtain other information that will be useful in order to accomplish the purposes of this new title of the Public Health Service Act and title I, part H, of the Health Security Act (concerning the maintenance and improvement of the quality of health care delivered under the Health Security Act).

Subsection (c) authorizes the Commission to provide technical assistance to enable participating providers to furnish the Board with information required by it for purposes of the Commission. The Commission is also authorized to provide technical assistance to participating providers who are developing and carrying out quality control programs.

(Section 1703, Public Service Act.) This section directs the Commission, even before it has developed standards under the preceding provisions, to give advice recommendations to the Health Security Board concerning quality health care regulations.

(Section 1704, Public Health Service Act.) This section authorizes the Secretary to establish twenty-five positions on the staff of the Commission, carrying salaries in the GS-16 to GS-18 range, in the professional, scientific, and executive service, to meet the need for highly qualified personnel in the research and development activities of the Commission.

TITLE IV—REPEAL OR AMENDMENT OF OTHER ACTS

(Section 401.) This section repeals the Medicare and Federal Employee Health Benefit statutes on the date Health Security Benefits become effective, but stipulates that this shall not affect any right or obligation incurred prior to that date.

(Section 402.) This section requires that after the effective date of benefits, no State shall be required to furnish any service covered under Health Security as a part of its State plan for participation under Medicaid, and that the Federal government will have no responsibility to reimburse any State for the cost of providing a service which is covered under Health Security. After the effective date of benefits, the Secretary of HEW shall prescribe by regulation the new minimum scope of services required as a condition of State participation under Title XIX. To the extent the Secretary finds practicable, the new minimum benefits will be designed to supplement Health Security—especially with respect to skilled nursing home services, dental services and the furnishing of drugs.

(Section 403.) This section provides that funds available under the Vocational Rehabilitation Act or the Maternal and Child Health title of the Social Security Act shall not be used to pay for personal health services after the effective date of benefits, except (to the extent prescribed in regulations by the Secretary of HEW) to pay for services which are more extensive than those covered under Health Security.

(Section 404.) This section makes applicable to Health Security the provisions recently added to the Social Security Act requiring reduction in reimbursement for care in facilities which have made substantial capital expenditures found by a State planning agency to be inconsistent with standards developed pursuant to the Public Health Service Act. Because the provision will continue to apply to the residual programs under titles V and XIX of the Social Security Act, the reductions will continue to be determined by the Secretary and his determinations are made binding on the Board, as provided in section 89 of the bill.

(Section 405.) This section repeals the provisions recently added to the Social Security Act relating to professional standards review organizations. Section 145 of the bill permits the use of such organizations already designated by the Secretary, and approval by the Board and use of similar organizations in the future.

(Section 406.) Subsection (a) amends section 1817 of the Social Security Act, creating the Federal Hospital Insurance Trust Fund, and transfers it to become section 61 of the Health Security Act under the title "Health Security Trust Fund". The effect of this transfer is summarized in the description of title I, part D, of the present bill. Subsection (b) extends to the Health Security system the provisions of section 201(g) of the Social Security Act, authorizing annual Congressional determination of amounts to be available from the respective trust funds for the administration of the several national systems of social insurance. Subsections (c) and (d) contain conforming and technical provisions.

(Section 407.) This section makes a number of changes in title XV of the Public Health Service Act, which is the planning portion of the recently passed National Health Planning and Resources Development Act of 1974. Subsections (a) and (b) provide that the Secretary's guidelines on national health planning policy should be issued in twelve, rather than eighteen, months, and that they must emphasize the need for prompt action to meet the demands of the health security program. Under subsection (c) the DHEW Under Secretary for health

and science replaces the Assistant Secretary on the National Council on Health Planning and Development, and the Chairman of the Health Security Board is added to the Council. Subsection (d) strikes out a requirement of coordination with Professional Standards Review Organizations, in view of the repeal of the PSRO provisions of the Social Security Act. Review and approval or disapproval of Federal grants and contracts by health systems agencies (subject to final decision by the Secretary) is extended, by subsection (e), to include Health Security Board grants and contracts under Part F of title I. Finally, section 1526 providing for grants for State demonstrations in rate regulation is repealed, since the Health Security Board will be fixing the amount of payments to participating providers of services.

(Section 408). This section establishes the salary levels for the Deputy Secretary and the Under Secretary for Health and Science, Department of Health, Education, and Welfare, the Chairman of the Health Security Board, members of the Health Security Board and members of the Commission on the Quality of Health Care, and the Executive Director of the Health Security Board.

(Section 409.) This section removes the operations of the Health Security Trust Fund from the administrative budget of the United States, and directs that these operations be reported and projected in a separate statement, as was done with the Social Security trust funds until recently. The Government contribution to the Health Security system will continue to be shown as an expenditure in the administrative budget.

TITLE V—STUDIES RELATED TO HEALTH SECURITY

(Section 501.) This section directs the Secretary of Health, Education, and Welfare in consultation with the Secretary of State and the Secretary of the Treasury to study the coverage of health services for United States residents in other countries.

(Section 502.) Subsection (a) directs the Secretary of HEW to study means of coordinating the federal health care programs for merchant seamen, and for Indians and Alaskan natives, with the Health Security benefits program. The Secretary and the Administrator of Veterans' Affairs shall conduct a similar joint study of the means of coordinating veterans health care programs with the Health Security benefits program. A similar study is to be conducted jointly with the Secretary of Defense, relating to the program of care, in civilian facilities, of the dependents of military personnel. Reports to the Congress and any legislative recommendations arising from the studies are required within three years after the enactment of the Health Security Act.

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

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

(Section 503.) This section authorizes the appropriation of money needed for conducting the studies authorized in this title, and the use of experts and consultants and advisory committees, and of contracts for the collection of information or the conduct of research.

PER DIEM AND MILEAGE ALLOWANCE LEGISLATION

(Mr. BROOKS asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. BROOKS. Mr. Speaker, during the 93d Congress, both the House and the Senate passed legislation to increase the per diem and mileage allowances for Government employees while traveling on official business.

The President vetoed this bill, S. 3341, because of a provision that would have given disabled veterans traveling to and from veterans hospitals, who were already entitled to per diem and mileage reimbursement, the same equitable rates to which Government employees would be entitled when traveling on official business.

It is unfortunate that the President did not recognize that this legislation simply provided the equitable reimbursement for official Government travel be equally available to all, including DOD employees, Treasury employees, White House staff, and disabled veterans.

I worked for many months to get a bill that was reasonable, fair, and just. This bill met those requirements without being inflationary. It had the support of the GSA, the OMB, and the employee unions. It passed the House and Senate unanimously. There is no question the veto would have been overridden had we had the opportunity.

I am today introducing legislation virtually identical to that passed by the 93d Congress. The basic provisions of the bill are:

First. Per diem rates would be set by regulation by GSA up to $35 per day.

Second. Per diem rates for travel outside the continental United States would be set by the President.

Third. When domestic travel expenses exceed the per diem allowances, reimbursement could go to $50 per day in high cost geographic areas.

Fourth. When foreign travel expense exceeds the per diem allowance, a supplement up to $21 could be applicable.

Fifth. Mileage reimbursement would be within the following range, the exact amount to be set by periodic regulations:

Eight to eleven cents for motorcycles.

Fifteen to twenty cents for automobiles.

Eighteen to twenty-four cents for airplanes.

Sixth. Per diem and mileage reimbursements for disabled veterans entitled to such would be at the same rates as those set for Government employees.

Seventh. There would be an annual adjustment if the cost factors indicate adjustment is necessary.

Eighth. The General Services Administration would be established as the agency to set uniform per diem and mileage rates.

Mr. Speaker, the President's veto on January 3 of this long overdue legislation was ill-advised and misdirected. According to his memorandum of disapproval, the bill was vetoed because it contained a provision which would remove present flexibility for reimbursing certain disabled veterans for authorized travel in connection with their treatment. That is not correct. Under present law, certain disabled veterans are entitled to the "actual necessary expense of travel—including lodging and subsistence—or in lieu thereof an allowance based upon mileage travel—to or from a Veterans' Administration facility or other place in connection with vocational rehabilitation."

This bill simply ought to correct the injustices of the past under which disabled veterans are presently being reimbursed at the rate of 6 cents per mile. No administration witness appearing before my committee suggested that 6 cents a mile even approached the actual expenses of operating an automobile today. I am no more anxious to increase expenditures than is the President or anyone else. But, we cannot ignore the facts; and, if Government employees and disabled veterans are entitled to reimbursement for their costs, we must establish a realistic rate of reimbursement.

I hope that the 94th Congress will act quickly to correct these inequities so that the Government employees and disabled veterans will no longer have to subsidize out of their own pockets official Government travel.

PRESIDENTIAL PROTECTION ASSISTANCE ACT OF 1975

(Mr. BROOKS asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. BROOKS. Mr. Speaker, I have today introduced legislation to limit the amount of public financial support the Government may provide in the protection of private Presidential properties.

An investigation by the Government Activities Subcommittee in the last Congress found that more than $17 million in Federal funds had been spent on private properties owned or utilized by former President Nixon at San Clemente, Calif., Key Biscayne, Fla., and the Bahama Islands. These expenditures were in addition to millions of dollars paid out by the taxpayers on the White House and Camp David.

Expenditures on Mr. Nixon's private properties were devoted to improvements, maintenance, administrative support, communications facilities, and personnel. The investigation by the subcommittee uncovered the fact that $66,000 of public funds had been spent for a fence around the Key Biscayne compound designed as a replica of the fence around the White House. This fence was then concealed by a hedge which cost about $4,800. A new shuffleboard was installed at a cost of $2,000. A helipad was constructed for $412,000 and over $20,000 was spent on a shark net.

In San Clemente, a new heating system was installed in Mr. Nixon's home for $13,500; and a new sewer line for about $4,000. Landscape and landscape maintenance costs exceeded $150,000.

Thousands upon thousands of additional dollars were spent on numerous other common household items which the average homeowner would have to assume out of his own pocket.

In attempting to determine why such expenditures were made, the subcommittee discovered that Federal managerial responsibility over these expenditures was practically nonexistent. Every indication pointed to the fact that the White House had converted the Secret Service, General Services Administration, and other agencies, to the personal benefit of the former President.

In May 1974, the House Government Operations Committee voted 36 to 0 with two abstentions for a report which proposed a number of recommendations to avoid a repetition of the abuses uncovered. Several recommendations contained proposals for legislation. To implement those recommendations, I introduced legislation which, after extensive hearings and debate, passed the House on December 1974. Time did not permit its consideration by the Senate.

The bill I am introducing today is almost identical to that passed by the House with only a few minor technical changes.

Basically, the bill provides that—

The Secret Service may provide permanent security for each person or family under its protection at only one nongovernment-owned location at a time.

Expenditures for permanent installations at other privately owned properties are to be limited to $10,000 each.

Procurements are to be made by Government personnel acting on written requests and with reimbursement from the Secret Service.

Permanent improvements will have to be removed if economically feasible or if requested by the owner; if the owner does not request the removal and if they are not removed, the private owner will have to reimburse the Government in an amount equal to the increase in fair market value of his property.

Mr. Speaker, the need for this legislation has not changed. The Secret Service and the agencies which assist it need these guidelines. In drafting these guidelines, two principles have been followed which, should make this bill supportable by every Member. One, the bill does not restrict the Secret Service in carrying out its legitimate activities in protecting the security of the President to the utmost of its ability. Two, the bill does not restrict the mobility of a President other than to limit the number of permanent private homes on which public funds will be spent.

Mr. Speaker, I hope that the 94th Congress will speedily enact this legislation.

TRIBUTE TO JACK BENNY

(Mr. McCLORY asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

Mr. McCLORY. Mr. Speaker, America mourns the loss of a national institution. Upon the death on December 27, 1974, of Jack Benny, one of the greatest comedians in history has been taken from our midst. The Nation's outpouring has been that which flows only to those few persons whom the country lovingly draws to itself.

As Jack Benny occupies an especially fond place in our memories, so did he have a special place in his heart for his hometown, Waukegan, and it for him. His loss is poignantly felt there. Jack Benny and Waukegan, which is the largest city in my congressional district, have shared a unique, lifelong love affair. To Americans, they have become virtually synonymous. His loyalty to Waukegan never waivered.

Despite the national reputation and fame which came to him, Jack Benny continued his affection and attachment for his hometown. Jack Benny's career began in the Waukegan area where he played his violin in the Waukegan High School orchestra and where he joined with other classmates from Waukegan in developing a similar orchestra which played throughout the Waukegan and Lake County areas.

Jack Benny was an excellent violinist and it was not until some years after he began a career as a professional musician that his unique talents as a comedian came to light. For 6½ years he helped entertain people with his violin, never opening his mouth on the stage. Then suddenly the informal, natural wit which he had been expressing offstage became part of his act—and the violin became more of a prop than an instrument upon which to perform professionally. Nevertheless, in my opinion, Jack Benny remained an excellent violinist. He played benefit performances with the Waukegan Symphony Orchestra to help raise funds for that musical group. I heard him play a benefit program with the National Symphony Orchestra at Constitution Hall several years ago. His talents on the violin would do credit to any great musician. Still, his purpose was to benefit others, including the National Symphony Orchestra. After the performance I met him backstage—and received a warm welcome as his representative from Waukegan, Ill.

The tributes which supplement these remarks reflect a world which is sadder without Jack Benny, but which also is grateful for its memory of his uniquely magnificent humor and charity. The legacy of this pretended tightwad, who actually gave unstintingly of his time and money to so many worthy causes, has become legendary and a part of one of our Nation's greatest treasures—its humor.

This was movingly expressed in a tribute by Charles Kuralt of CBS:

And now, 72 years after Meyer Kubelsky gave his son, Benny, a $50 violin, the violin is still. Jack Benny said that playing the violin with the Philharmonic was like being alone on a desert island with Zsa Zsa Gabor and her boyfriend—you feel you're not needed. Well, we need him all right. Everything is not going well with us, and we need him, holding his hands and staring that way, showing us the humor in the human condition. Everybody's voice has become so loud. He knew the uses of silence. The times have grown so harsh, and he was so gentle. We need him. Of course, all of us with a memory still have him.

Mr. Speaker, I am inserting the following articles and eloquent tributes to Jack Benny, which exemplify those which have appeared in newspapers across the country, in the RECORD:

[From the Waukegan (Ill.) News-Sun, Dec. 27, 1974]

WAUKEGAN'S FAVORITE SON DIES; CANCER FATAL TO BENNY

(By Joe Manning)

Waukegan's favorite son, who for more than 72 years of his life entertained people, died early today,.

Jack Benny was 39.

His wife, Mary Livingston, was at his side when he succumbed in their Holmby Hills, Los Angeles, home. Before death he was visited by Johnny Carson, George Burns, Danny Kaye, Danny Thomas, Bob Hope, Frank Sinatra, Merle Oberon and Gov. Ronald Reagan.

Word of his stomach cancer and his terminal illness spread rapidly throughout the world Thursday night when announced by his manager. Benny, 80, chose to die at home.

Born Benjamin Kubelsky on Valentine's Day, 1894, he was the son of a Polish immigrant who had peddled wares from a pack on his back in and around Chicago. After marrying Emma Sachs, he opened a Genesee Street furniture store.

Benny was born in a Chicago hospital and grew up in Waukegan. He left this city when he was 17. His father, Meyer, gave Benny a $50 violin and, by the time he was eight years old, he was giving solo performances in the Barrison Theater in Waukegan. He also sold tickets and worked as an usher. He played the violin throughout grade school and high school.

In his eighth-grade graduation class were former City Clerk Edward Holmberg, former Police Chief Bart Tyrrell, businessman William Kyndburg, teacher Miss Emily Tonigan and many others who became well known locally.

By the time Benny was 16, he was a skilled violinist and a member of the orchestra at Waukegan High School. In the orchestra with him were young musicians Nathan Blumberg, Ben Schwartz, Nellie Smith, Lampe Johnson, Marie Street, Winifred Gifford, Nathan Rosenblum, Cedrick Smith and Marvey Miltimore.

He left school without receiving his diploma when he and Cora Salisbury, with whom he had become acquainted at the Barrison Theater, decided to form a vaudeville duo. She was a pianist and played in the pit orchestra. Benny was only 16.

The team of Kubelsky and Salisbury became a feature of the vaudeville circuit in a radius of 200 to 300 miles of Waukegan. When the duo broke up, Benny teamed with Lyman Woods and traveled coast to coast.

The story of how Benny got started in comedy has a number of variations, one of them told by Benny himself. The stories all agree on one point: that Benny was volunteering to perform for a benefit, something he was to do throughout his career, raising an estimated $6 million for worthy causes.

As it goes, Benny enlisted in the Navy at the beginning of World War I and was stationed at Great Lakes Naval Training Center. He volunteered for a Naval Relief Society show, the Great Lakes Review. Benny said he was told to read a few lines. He was funny and, by the time the show opened, he had a comedy part.

Another version goes that Benny was on stage when the lights went out and he carried the tense moment with his wit. Another, that the show's writer heard Benny offering quips for the entertainment of fellow cast members and put one of the lines in the show.

In any event, Benny said himself: "Up until then, for six and a half years I'd never opened my mouth on stage. I'd been a violin-

ist. People thought my violin was a gag. I went along with the gag."

In 1932, Benny appeared on the Ed Sullivan radio show. Benny was on Broadway in Earl Carroll's "Vanities." The first of millions of words he spoke over the airwaves were: "Hello folks. This is Jack Benny. There will be a slight pause for everyone to say, 'Who cares?' "

The name Jack Benny was a process of evolution. Originally he was known as Ben K. Benny, then Ben Benny. He changed it to Jack Benny because many people thought Ben Benny was Ben Bernie, a popular orchestra leader.

After the war Benny played as a comedian and master of ceremonies and gained renown as a Broadway performer in Earl Carroll and Schubert musicals. He played the Palace Theater, the summit in those days.

With the musical "Great Temptations," he went to Los Angeles in 1926 where he met a pretty sales girl, Sayde Marks. They were married in 1927 in the Clayton Hotel in Waukegan where a long-time friend of Benny's, Julias Simykin, lived. The Bennys adopted a daughter, Joan.

In 1929 he made his first movie, "Hollywood Party."

After apearing on the Sullivan show, Benny was given a radio contract in the summer of 1932. In 1942 NBC gave the popular show and Benny a lifetime option to the 7-to-7:30 p.m. spot on Sunday evenings. In 1947, he was earning $25,000 a week for the show. He always kept his jokes clean, stating: "I think there is much more humor in clean jokes."

He toured with the USO during World War II. On July 4, 1945, Benny, Ingrid Bergman, Larry Adler and Martha Tilton played before 20,000 troops in Hitler's former Sportspalast. Benny broadcast from Paris on V-J Day.

Throughout Benny's fame, and even while he capitalized on being from some place called Waukegan, he never forgot Waukegan and made frequent visits here.

In 1937, Waukegan citizens jammed the high school auditorium to greet him. There were brass bands, marching high school cadets, and special newspaper editions. When the high school principal brought up Benny's academic career, Jack couldn't resist the gag. He slipped off his chair and crawled off stage on his hands an knees.

But, he did get his high school diploma from the Waukegan school system. In October of 1961, he appeared in a special television show commemorating the naming of Waukegan's third junior high school in his honor. Benny thought it funny that some of the children in the school didn't know who he was or why a school was being named after him. The honor overwhelmed him, and he often mentioned it when making appearances on television.

Benny's last of many visits here was in April when he performed in a benefit concert for the new Waukegan Symphony Orchestra. The appearance raised $15,550 for the orchestra, the Waukegan public school music program and his beloved junior high school.

Some of Benny's movies were "Transalantic Marry-Go-Round," "Broadway Melody," "The Big Broadcast of 1936," "The Big Broadcast of 1937," "College Holiday," "Artists and Models Abroad," "Man About Town," "Buck Benny Rides Again."

With Fred Allen, he made "Love Thy Neighbor." Other movies were "Charley's Aunt," "The Meanest Man in the World," "To Be Or Not to Be," "George Washington Slept Here" and "The Horn Blows at Midnight."

On his radio show and television series, Benny was credited with being the first comedian to good-naturedly kid the commercial plugs of his sponsors. He also was the first comedian to play straight man for other people and guests on his show. Some of those included his wife, Mary, Don Wilson, Rochester, Dennis Day, Phil Harris, Bob Crosby, Andy Devine, Sam "Schlepperman" Hearn, Mel Blanc, Artie "Mr. Kitzel" Auerbach.

Many people liked Benny more on television than on radio. He could get more laughs with a roll of his eyes and his flat, dry, goofy, deadpan expression than most comics get out of 15 minutes of fast gags.

Accompanied by his 1729 Stradivarius, Benny presented the character of the perennial fall guy, the smart aleck, the fellow who had trouble finding girlfriends, the timid man trying to be a hero. All these made him laughable and human and he took the falls and let others on his show heckle him.

Other gags were his graying, thinning hair, his pretended stinginess, his make-believe feud with Fred Allen and his sputtering, museum piece automobile.

After the cancellation of the television show in 1954, Benny continued to appear in specials and guest appearances. His next appearance was to have been an NBC special, his second retirement program, next Jan. 23.

The indefatigable comedian began playing benefit concerts in 1956 to raise money to save Carnegie Hall. When asked by violinist and friend Isaac Stern to play his own violin with the New York Philharmonic Symphony, Benny objected that the soloist should be Jascha Heifetz.

Stern replied: "But neither Heifetz nor I can draw an audience paying $100 a ticket. You can."

Benny's honors would fill pages. He won the Laurel Leaf Award of the American Composers Alliance, the March of Dimes Humanitarian Award and a Special Academy of Television Arts and Sciences Award for the best continuing performances by a male entertainer.

The Jack Benny Show won an Emmy in 1959 as the best comedy series on television. Prior to that, honors had been heaped on him for his radio show.

Benny regretted not having practiced more on the violin, for he often said that if he had stuck with it, he could have been a concert musician.

His last public appearance was Dec. 8 before the Hollywood Women's Press Club to receive its annual Louella Parsons Award for service to the film community. Already gravely ill, he was in too much pain to remain longer than a few minutes. The award was accepted by his long-time friend, George Burns.

Benny never really retired.

"You must never lose the excitement of life," he said, adding. "I don't indulge in nostalgia. To hell with the past. It's gone. Thinking about it makes you older quicker than anything. I'm only concerned with how good my last show was and how good my next two will be."

Millions cared about Jack Benny. Anyone can hum his theme song, "Love in Bloom." After 27 years on radio and 14 years in a weekly television, Jack Benny will live forever.

DEATH SHOCKS WAUKEGAN

Waukegan was shocked this morning to awaken to the news that Jack Benny is dead.

Mayor Robert Sabonjian, a long-time friend, said the community had not been prepared for the news.

"We all thought he was in good health," Sabonjian said. "We knew he had been ill, but we thought he had gotten over that."

Sabonjian ordered flags flown at half-staff for the man who quipped about Waukegan but never forgot his hometown.

A funeral service will be Sunday in California at the Hillside Memorial Cemetery in Culver City.

Sabonjian said he will attend the service.

"I think the people of Waukegan would want me to attend, to show that Waukegan is not a myth, that it does exist and that it has a heart.

The mayor said Waukegan will hold its own memorial service, but plans had not yet been firmed up.

Edwin Glenn, principal of Jack Benny Junior High School, said it might be possible to hold some sort of ceremony at the school named in Benny's honor. He said there definitely would be a service for students Jan. 6 when school reopens after the holidays.

Glenn said he met Benny the six or seven times he visited the school. He remembers well one time that Benny arrived unannounced to students. Glenn said Benny spent the lunch hour with the students in the cafeteria, talking, joking, and eating with them.

"It was a delightful time and he had a nice time," Glenn said.

The school was dedicated in 1961 and Benny attended the ceremonies with famous members of his television show. The school at 1401 Montesano St. has 850 students.

Mayor Sabonjian said Benny's contributions to Waukegan will be remembered.

"We already gave our memorial to him, Jack Benny High School, he loved it," Sabonjian said.

Benny's sister, Mrs. Florence Fenchel, lives in Chicago.

Bill Morris, one of the founding fathers of the Waukegan Symphony Orchestra, said the group was considering naming the orchestra after Jack Benny, but Benny would not hear of it even though he performed a benefit concert for it here last April.

"We owe the orchestra to Benny. It couldn't have happened without him," Morris said. Benny insisted that the orchestra be named after Waukegan, because, Waukegan was more important than Benny was, Morris said.

Benny's appearance here in April for the benefit now takes on a greater significance because it was his latest benefit for an orchestra and musicians, Morris said. Benny raised more than $6 million for musicians in his lifetime.

"Jack Benny laughed about our community," said Morris, "but he had respect for Waukegan."

Mrs. Clifford Gordon, also known as "Sudie", was related to Benny through her late husband, who was a first cousin, and through her father who was related to Benny's mother.

She knew Benny when he was just beginning in show business.

She said he wasn't expected to die so suddenly. The cancer was only just discovered and it was inoperative. His sister was with him at the time of death, she said.

The Gordon family owned the Gordon Furniture Store on 10th Street.

Mrs. Gordon said, "He was a very nice person, very, very sweet. Everybody loved him. He was a beautiful person."

[From the New York Times, Dec. 28, 1974]

JACK BENNY, 80, DIES OF CANCER ON COAST

(By Richard F. Shepard)

Jack Benny, whose brilliant gift for self-deprecating caricature brought laughter to the nation for 40 years, died at his home in Beverely Hills, Calif., early yesterday morning. He was 80 years old.

Irving Fein, Mr. Benny's manager and associate for many years, said that the comedian died of cancer of the pancreas at 2:32 A.M., New York time. The cancer was not discovered until it appeared on X-rays last Friday. Mr. Fein said that Mr. Benny's physician had said the case was inoperable.

Gov. Ronald Reagan, Frank Sinatra, Bob Hope, Danny Kaye and George Burns, who was Mr. Benny's friend for 50 years, visited the Benny home.

Funeral services have been scheduled for noon tomorrow at Hillside Memorial Cemetery in Culver City, Calif. A special tribute

to Mr. Benny will be televised by CBS tomorrow from 7:30 to 8:30 P.M.

In a telegram to the comedian's widow, President Ford said, "If laughter is the music of the soul, Jack and his violin and his good humor have made life better for all men."

Jack Benny's very special talent for the comic was, according to his own analysis, an ability to mirror the failings people recognized in themselves or their acquaintances. Decades of insistence on the air that he was only 39 years old made the joke better rather than cornier; it was one of show business' most durable bits.

Other comedians told funnier jokes. Other comedians projected their own personalities into stage situations that made an audience laugh. Other comedians were much more effective in displaying their own and lib wit. Where Mr. Benny told one joke, Bob Hope or Milton Berle could tell three in the same time.

Yet Mr. Benny was perhaps the most constantly funny of America's funny men. He was adored by the public and even the most sophisticated critics appreciated him as an outstanding comedian. The late President Kennedy once recalled that his father used to herd the family into their home's library every Sunday night to hear the Jack Benny show on radio. No one was ever excused from listening. So it was with much of America.

A PERMANENT PROP

A masterly sense of timing, worthy of the violin virtuoso he realized he would never be, made him the only performer who could evoke laughter from intervals of silence. He carefully developed a performing character as a tight-fisted, somewhat pompous fellow who walked with a mincing, almost effeminate gait, and often expressed exasperation merely by resting his chin in his hand and making his blue eyes stare, martyrlike, at his viewers. His violin became his most permanent prop, and he performed nicely for fund-raising with Isaac Stern, President Truman and the New York Philharmonic.

Just as Charlie Chaplin represented the "little fellow," Mr. Benny also caught the frustrations of the average man, maybe a middle-class American, whose aspirations always being leveled by family, friends and others.

One of his most famous bits had him being held up by a bandit who demanded "your money or your life." Silence. More silence. Silence punctuated with laughter from the audience. Then, desperately, "I'm thinking, I'm thinking."

PHILOSOPHY OF HUMOR

It was not so much in his lines and in his delivery that he scored successes. His philosophy of humor shed little light on the art but it told something about the man.

It was not the words that brought the house down. It was the peerless execution of little things that became perpetually funny clichés, such as his piqued utterance of "Human," or his fussy, angered riposte to jibbing "Now cut that out!"

"Never laugh at the other fellow; let him laugh at you," he said. "I try to make my character encompass about everything that is wrong with everybody. On the air, I have everybody's faults. All listeners know someone or have a relative who is a tightwad, show-off or something of that sort. Then in their minds I become a real character."

As a result, he was often the butt of his second bananas, who devastated him with their barbs. Eddie Anderson, as Rochester, his valet, lacked a shred of servility but always complained to the boss, man to man, about the Benny thrift. Mary Livingston, his wife, and Phil Harris, the orchestra leader, also shared in the laugh tunes. But Mr. Benny somehow came out ahead. Mel Blanc, the zany of many voices, among them "Mr. Kitzel," and Sheldon Leonard had choice supporting parts.

METICULOUS IN PREPARATION

Mr. Benny was meticulous in preparation. Although it was widely known that he possessed a ready wit and a wonderful humor, which he often demonstrated in off-the-cuff observations on off-the-air occasions, he never—well, almost never—deviated from the script his highly paid writers had created for him.

"There is no tranquilizer like a prepared script," he once explained. For years he kept a good-humored "feud" running with Fred Allen, the humorist noted for his quick wit. Once when Mr. Allen had demolished him with a line, Mr. Benny blurted out that if his scriptwriters had been there, Mr. Allen would never have gotten away with that.

He was absolutely serious about his work, in a way that many other comedians were not. At rehearsal, Mr. Benny would be sober-faced and worried about details. He was not a monster—it has always been impossible to find a colleague or even a former colleague to speak ill of him—but he was an earnest, hard-working funny man.

This was an attitude born of experience.

"TIMING THE KEY"

"I soon discovered that telling jokes was not a breeze, after all," he reminisced. Sometimes you could throw a punch line away. Other times you had to ride it hard. A pause could set up a joke—or bury it. Timing was the key."

And there was, indeed, a sort of lucky timing that determined the course of the life of this comedian out the midwest, a timing found him at the right age in the right age, an age of broadcasting that made reputations overnight, as against the age of vaudeville, when it took years.

Jack Benny was named Benjamin Kubelsky when he was born in Chicago on Valentine's day, 1894. He grew up in Waukegan, Ill., where his father, Meyer, had a store, and Mr. Benny often, for laughs, used to say that this was the town where he was born.

GOT VIOLIN AT 8

Meyer Kubelsky, a Jewish immigrant from Russia, loved music, and when his son was 8 the father gave him a $50 violin. The boy was soon giving concerts at the Town's Barrison Theater.

The young violinist quit school in the ninth grade and, at the age of 18, went into vaudeville. He worked with a woman pianist, Cora Salisbury, and soon teamed up with Lyman Woods, also a pianist. It was during an appearance with her that Mr. Benny, who then called himself Ben K. Benny, told a joke.

"The audience laughed," he later recalled. "The sound intoxicated me. That laughter ended my days as a musician, for I never again put the violin back where it belonged except as a gag."

Life became the customary round of one-night stands in the Midwest, and the young performer was not, at least not yet, the man to startle the vaudeville bookers. When World War I came along, he joined the Navy and was assigned to "The Great Lakes Review," a sailors' road show. Here his comic genius made an impression, and his decision to renounce music became irrevocable.

After the war, he embarked on the highly competitive career of the ad libber, where his greatest asset soon proved to be his instinct for proper timing. His silence was eloquent and his double-takes were the envy of his profession. By 1926, he had a part in a Broadway musical, "The Great Temptations."

LED POPULARITY POLLS

This led to the most coveted assignment of all: master of ceremonies at the Palace Theater, citadel of the two-a-day. Soon he went on to Hollywood, and in 1932, he found his most durable niche: radio. It started with a guest shot on Ed Sullivan's radio show and before the year was out, he had his own program on the National Broadcasting Company network.

From 1934 through 1936 he was the champion of the radio popularity polls, and for many years he was always among the top 10 programs. His wife, Sadie Marks, whom he married in 1927, became Mary Livingstone, the wife of the radio Jack Benny, as he had been calling himself for a number of years.

He still sawed away at his violin, and his never-completed rendition of "Love in Bloom" became a hallmark of the show. His writers alone received a total of $250,000 a year. In 1948, Mr. Benny took his show from NBC to CBS. As part of the move, CBS paid $2,260,000 for Mr. Benny's Amusement Enterprises organization, as part of a capital gains deal. He got $1,356,000 of this.

"THE BEST FORMAT"

CBS kept the radio show until 1955, when, 23 years after Mr. Benny had done his first program, it went off the air. Even earlier, however, he had made the acquaintance of the new medium, television. He had been a bit wary of the tube and his fears seemed to be substantiated by the critical reception for that first telecast, on October 28, 1950.

The critics said the show had little visual attraction, that it relied too heavily on the radio tradition. But Mr. Benny made the grade with his third telecast the next April when he drastically altered his old routines and caused one critic to observe, "Mr. Benny has the best format, no format at all."

He stepped up his television schedule from irrgeularly scheduled shows, to semiweekly programs to weekly telecasts, which lasted from 1960 to 1965. When he "retired," he found himself almost as busy as ever on television and in personal appearances. He appeared in many special telecasts. The last one, last Jan. 24, was billed as "Jack Benny's Second Farewell," because it came not many months after the first.

He began, more than ever, to play nightclubs, the Sahara in Las Vegas, the Waldorf-Astoria's Empire Room here. He worked in the Palladium. He was tireless in performing at benefit concerts on behalf of musical causes, whether to save Carnegie Hall or to keep an orchestra afloat. In 1970, it was estimated that he had raised $5-million in 14 years.

MADE MANY FILMS

Viewers of late show or midday movies occasionally glimpse Mr. Benny in many of the films he made. Among them were "Hollywood Revue of 1929" (his first), "Chasing Rainbows," "The Medicine Man," "It's in the Air," "College Holiday," "Artists and Models," "Transatlantic Merry-Go-Round," "Buck Benny Rides Again," "Charley's Aunt," "To Be or Not to Be," "George Washington Slept Here," "The Meanest Man in the World," and "The Horn Blows at Midnight."

Several years ago, when an interviewer asked him why he was making television commercials, Mr. Benny replied: "Show business has changed. I'm changing with it. There's no more class in show business today. You do everything and anything."

But he had already done everything and done it well.

He is survived by his widow, an adopted daughter, Joan Blumoff, and several grandchildren.

[From the Waukegan News-Sun, Dec. 30, 1974]

TEARS AND JOKES AT JACK BENNY FUNERAL

(By Vernon Scott)

CULVER CITY, CALIF.—His fellows said goodbye to Jack Benny Sunday with tears and gentle jokes he would have liked. Men and women who came the route he did—from vaudeville circuits to national entertainment institutions—buried the comedian on a brilliantly sunny Sunday afternoon in a cemetery packed with celebrities, fans and emotion.

George Burns, Benny's best friend, broke down in sobs three sentences into his eulogy and could not finish. Bob Hope, who met Benny on Broadway 45 years ago, carried on, mixing gentle humor with his tributes.

"He was stingy to the end," Hope said. "He was only with us 80 years, and it wasn't enough."

Burns, who with his wife Gracie Allen, was one of Benny's fellow giants of the golden days of network radio in the 1930s and 1940s, said beforehand that he did not know if he could go through with his part of the eulogy. "I told that to Mary (Livingston, Benny's widow), and she asked me to try."

"What can I tell you about Jack? I've known him 55 years . . ." Burns broke. "I can't imagine my life without him," he sobbed and returned to his seat.

Police several times had to push back the crowd of 2,000 who came to see Benny buried at Hillside Memorial Cemetery.

Pallbearers included Frank Sinatra, Gregory Peck, Milton Berle and director Billy Wilder. Mourners included a roster of the most famous names in show business and politics, including Gov. Ronald Reagan and former Sen. George Murphy, both former entertainers.

Also there was the old cast of Benny's radio show—Eddie "Rochester" Anderson, who played the gravel-voiced butler, singer Dennis Day, musician Phil Harris, announcer Don Wilson and man-of-many-voices Mel Blanc, who did the "Anaheim, Azusa and Cucamonga" railroad announcer.

Mrs. Benny, his longtime comedy partner and wife of 47 years, left the chapel but returned by the time the service began, sitting in her car to compose herself with their daughter, Joan, 30. She had said earlier, after Benny died Thursday night of a surprise cancer attack at 80, "In all the years we were together, he never gave me one bad day. not one bad moment."

Hope said Benny was revered as a genius by other comedians for his flawless sense of timing, but that Benny finally made a mistake. "His timing was all wrong. He left us all too soon."

Hope said that "If there's a Mt. Rushmore for humanitarians, the first stone face might easily resemble him. And if a stone could talk, it would say 'Well,'" a reference to Benny's ability to draw huge laughs with a silent pause and then that one exasperated word.

"How do you say goodbye to a man who was not just a good friend but a national treasure?" Hope asked.

"No one will ever replace Jack Benny."

[From the Waukegan News-Sun, Dec. 30, 1974]

JACK BENNY WAS MORE TO WAUKEGAN THAN LAUGHS

Jack Benny, the king of wit who gave so much of himself to help others despite his self-proclaimed frugality, died Thursday. His violin is stilled forever.

This comet who flashed across airwaves and into the hearts of millions was born 80 years ago, but most of his fans will always believe he was only 39 as he insisted.

He was always 39 in heart, however, and he never really retired. Benny was always thrilled with what he called the excitement of life right up to the end when cancer killed him.

We hope Jack will forgive us for looking back although he said that he didn't indulge in nostalgia, summing up his feelings with: "To hell with the past. It's gone."

Born in Chicago on Valentine's Day, 1894, Jack grew up in Waukegan. He began his long show business career in the Barrison Theater in Waukegan where he started playing the violin when he was only 8.

He played in the Waukegan High School orchestra but before he received his diploma he started out on his long and illustrious career making people laugh. In his chosen field he was one of the few geniuses.

He could spark laughter by just putting one hand to his mouth and cocking his eyebrows as he stared at his audience. When he added the punch-line, "Well," he had his listeners in the palm of his hand.

He had a ball making people laugh, but he said often that he received the most joy performing for benefits around the country. He raised an estimated $6 million for worthy causes, some of it in the town he put on the map of the world. Waukegan townspeople reciprocated by opening their hearts to him whenever he came to town and named a junior high school after him.

He appeared on radio and TV for many years but many thousands of World War II veterans remember him, best for his appearances in the field almost within sound of the big guns.

Jack won many accolades during his lifetime—the Laurel Leaf Award of the American Composers Alliance, the March of Dimes Humanitarian Award and a special Academy of Television Arts and Science Award—but his love affair with those of us who wanted to forget the cares of the world for a few minutes through his humor is his most enduring monument.

Jack never forgot his hometown, and we, and the world, will always remember him for his clean and gentle wit.

[From the Waukegan News-Sun, Jan. 11, 1975]

MR. BENNY: A FINAL ENCORE

(By Joe Manning)

The one incontrovertible truth about humor is that it is a great mystery. What causes the Pukapukans to shriek with laughter may leave the Kokomokans cold.

Yet, somehow, humor has a universal appeal and purpose.

Laughter is probably not learned but people learn very early in their lives in what situations and when it is appropriate to laugh.

Jack Benny knew the secret of putting people in those situations.

Here is part of a television special filmed at Jack Benny Junior High School in August of 1968.

Benny comes on stage:

"Thank you, thank you very, very much, ladies and gentlemen and all of my friends. I want to say first of all I am very, very happy to be back here for this occasion. And you know I was hoping they would have a fourth junior high school here called the Abraham Lincoln School because you see, when I was here in school studying history Abraham Lincoln was my favorite president. Because, I figure that any man that will walk 12 miles barefoot in the snow and return a library book to save three cents is my kind of a guy.

Enters Mayor Robert Sabonjian: "Jack, as the mayor of this city, I want you to know that we certainly appreciate all that you have done for Waukegan and I think that it's only fitting that we spent over $1,250,000 to build this monument to honor you with concrete, lumber and steel."

Benny: "Well, I want to say that I am very, very proud of that and I have relatives here who are happy about it too because, you see they are still in business here."

Sabonjian: "Really? What business are they in?"

Benny: "Concrete, lumber and steel."

Enters a Lt. Brown from Great Lakes Naval Base. He asks Benny to verify his service number and Benny does.

Lt. Brown: "Well, Mr. Benny, in checking our records we find that you have never been discharged from the Navy."

(That Benny look and pause) "What?"

Lt. Brown: "No one ever signed your discharge papers."

Benny: "What discharge papers? The war was over so I went home. It's as simple as that."

Lt. Brown: "I know, and you have been AWOL for 59 years."

Benny: (Pausing and looking) "What are you talking about?"

Lt. Brown: "I'm sorry Mr. Benny, you're going to have to serve your term."

Enter Shore Patrol which commences to take Benny away.

Benny raving: "Serve my term: Wait a minute. You're taking me back to Great Lakes? Well, this is ridiculous. At my age? No, lookit. And anyway, my name was Benny Kubelsky then. It wasn't Jack Benny. Now cut that out."

[From the Chicago Tribune, Dec. 28, 1974]

JACK BENNY, 39

The flat midwest accent is gone, the face with the slightly startled and petulant expression that brought laughter to millions is gone, Jack Benny is gone. His death came 41 years after his last acknowledged birthday, which was his 39th.

But the timbre of the drawling voice and the long drawn out, may-Heaven-preserve-us look of that put-upon man will remain in our minds for a long time. For in the minds of two generations of Americans, Jack Benny was a friend, one who came calling weekly by radio and later television. This feeling was so strong that those who later met him personally were taken aback that he regarded the meeting as an introduction rather than a reunion. They knew him so well; why in the world didn't he know them?

This closeness developed because Jack Benny was not a conventional standup comedian (altho he could deliver a monolog with enchanting grace); he was a being whose feigned flaws and foibles endeared him to audiences and made him seem real.

The Jack Benny character—a creature of penury, of small vanities involving age and appearance, and of an inescapable tendency to be the butt of others' jokes—brought him close to home for all of us.

Jack Benny was born in Chicago and raised in Waukegan, and it is hard to know whether to say he grew up with the American entertainment industry or vice versa. It is best to say that they grew together in the 63 years since he quit school in 9th grade to take a job in the pit of a theater. He became familiar everywhere from the White House to the foxholes of World War II, and as he neared 80 he continued to appear in concerts with his violin and on TV talk shows with his delightful reminiscences.

Even as he learned that death was imminent, because of stomach cancer, he was making plans for further appearances. He always liked to pretend that he never went beyond the age of 39. And because of his eternally youthful vigor and humor, we shall think of him forever as 39.

[From the Chicago Sun-Times, Dec. 28, 1974]

JACK BENNY—1894–1974

One of the things that made Jack Benny a great comic artist was his self-created style. It was a style so much his own that it was impossible to borrow from it without appearing to be a cheap imitator. Only Jack Benny could be funny the way Jack Benny was funny. His arms are crossed. His fingertips rest on his cheek. He composes his face, turns his head slowly, and announces abruptly and in mock outrage, "Well!" No one but Benny could do that.

Like other artists, Jack Benny was a master of timing. Benny, the celebrated tightwad, waits to answer the holdup man who repeatedly demands his money or his life. Finally—and at the exact monent—he replies, "I'm thinking! I'm thinking!" He was a perpetual and defiant 39. He played the violin horribly. He was vain and timid. He told his tormentors, "Now cut that out!" He kept his money in a subterranean vault.

In private life, he was a modest and generous man—generous to his wife and daughter, to his professional colleagues, and to millions of his listeners, all of whom mourn his death.

[From the Chicago Daily News, Dec. 28, 1974]

A NATION LAUGHED WITH HIM

Jack Benny quite likely might never have made it if he had started in today's world—and the world would have been vastly the poorer.

As Jack himself said, he came up in a time when if you couldn't make it in Peoria you could polish up the act and try again in Muncie and go on and up from there. "Now they throw you to the wolves, which is television. If you're bad, you're out."

Benny also grew up with the radio industry, which was made to order for the family kind of humor that became his specialty. He never did make it big in the movies, and in television—another part of the forest entirely—he made it to some extent on his momentum as the nation's top radio star.

Yet it is hard for those who weren't there through the 1930s to grasp the size of Jack Benny's talent or the stature he achieved as an institution in the entertainment world. Week after week he brought the whole nation huddling around its Atwater-Kents and Stromberg-Carlsons to hear him wage his losing verbal jousts with Don Wilson, Phil Harris, Fred Allen, Rochester, Dennis Day and his patient wife, Mary Livingston.

How did he do it? The formula was simple. Jack Benny was Everyman—especially, every little fellow, mosying and stumbling through a bewildering world. "Straight man for the whole world," Steve Allen called him, and it is not a bad line.

But he was something more and rarer than that—a born clown in the grandest sense of the word, with the shadow of sadness enhancing every funny situation and line. The real Jack Benny bore this out. He never ceased to wonder, even at the peak of his magnificient success, why and how it all came to happen to him, Benny Kubelsky of Waukegan, Ill. That it did happen to him was a fact of great benefit to a nation that, then as now, needed laughter to make the gloom bearable.

[From the Washington Post, Dec. 29, 1974]

JACK BENNY

Jack Benny, who died on Thursday at the age of 80, was one of the great American entertainers. He began his career early—as a violinist, what else?—in a Waukegan theater, having dropped out of high school, and soon was off on a vaudeville tour. To the end of his life he remained a showman, one of the few of the radio stars of the 1930s and '40s whose style and expression were congenial to the medium of television. The raised eyebrows, the look of pain (upon hearing the price of almost anything)—these turned out to be, visually, on television just what one had imagined them to be on radio: funny, utterly engaging.

Yet it was, in our view, as a giant in the age of radio that Jack Benny reached his ultimate achievement. That uniquely demanding medium was only for those sufficiently skilled craftsmen who could conjure up a whole living, visual world in the listener's imagination by means of word and sound—and silence, we would add, since the affronted pause was one of the mainstays of Mr. Benny's comic art.

That the world he conjured up remains vivid and memorable strikes us with particular force at this time of year: this was the reason (as people of a certain age will know) when Jack Benny made his annual "visit to the vault" where his savings were allegedly held under guard by an ancient retainer who didn't see him from year to year. We can hear the creaking and groaning of the hinges on the seldom opened doors now, that sound effect that signaled the passage to the vault. And we can hear too the strains of "Love in Bloom," execrably rendered by Mr. Benny, whose comic sense always told him just when to strike the first screechingly wrong note.

Jack Benny was an American institution, and the jokes with which he entertained Americans for years have passed into the folklore. In taking note of his extraordinary career and of the pleasure he gave so many people, we would add only this: His humor was without malice; it had no claws; its object of fun was himself In the world of comedy and comedians, to reach the top that way is no means achievement.

[From the New York Times, Dec. 28, 1974]

A NATIONAL INSTITUTION: TO MILLIONS IN THE 1930'S AND 1940'S, SUNDAY NIGHT AT 7 JACK BENNY AND GANG

(By John J. O'Connor)

Although he was successful on television, in nightclub and even on the stage in "one-man" shows, Jack Benny was perhaps the most enduring and astonishingly shrewd creation of radio, For anyone growing up in the nineteen-thirties and forties, Sunday night at 7 o'clock meant Jack Benny and "the gang."

Week after week, the cast regulars went through a series of thoroughly predictable routines. Week after week, listeners at home laughed along with the studio audience. The brilliantly calculated Benny persona, offering magnanimous displays of the hilariously petty, was being fixed securely in the public's affection.

His radio years began in the Depression. Radio was concentrating on entertainment. There were very few regular news formats in those days. Not surprisingly, the center of the entertainment spotlight was held by veterans of vaudeville. In addition to Jack Benny, there were Eddie Cantor, George Burns and Gracie Allen, Al Jolson, Ed Wynn, and Phil Baker.

A NATIONAL CHARACTER

By 1937, Jack Benny had edged out Eddie Cantor for top position in the "Hooper-ratings." In 1950, a couple of years before the television explosion, he was still No. 1 in the ratings. Meanwhile, he had used radio to develop a national character of rare longevity.

The vehicle consisted of nothing but sound and, with the Benny sense of faultless timing, silence. The old Maxwell auto sputtered and coughed. The endless series of locks protecting the cellar bank vault squeaked and clanked. The pay telephone and cigarette machine in the living room noisily consumed coins. The immediately recognizable Benny family was created by a group of performers standing in front of microphones.

The effect was a combination of intimacy and elusiveness, a combination still unique to radio. The disembodied voices became personal friends, perhaps vaguely linked to faces in press photographs. The contexts and settings were constructed in the imaginations of the listener. The very lack of visual literalness expanded the possibilities for radio.

All of that changed, of course, with television. The new medium proved considerably more devouring than the old. Seeing the old Maxwell was not quite as funny as hearing it. Seeing it a second time was not nearly so funny as hearing it for the 100th time. The quality of elusiveness was lost.

BLOCKBUSTER SUCCESSES

The Benny program and other radio formats did have respectable runs on television, but the medium was bestowing its "blockbuster" successes on more "visual" material—Milton Berle's muggin, Sid Caesar's skits, The pandemonium of "Laugh-In." But the blockbusters, too, were eventually devoured. None were as long-lived as the old-time radio favorites.

The Benny persona, however, survived. It did not depend on one-line jokes or energetic physical routines. He could still show up on his own specials or as a guest star getting incredible mileage out of his penny-pinching routines or deadpan silences.

On one of his last television appearances, in an Anne Bancroft special called "Annie and the Hoods," he played a psychiatrist listening to the silly prattle of a patient. He didn't utter one word. He didn't have to. The radio character had become a national institution.

[From the Washington Post, Dec. 29, 1974]

THINKING BACK ON BENNY: THE IMAGE AND THE MAN

(By Goodman Ace)

The curtain slowly descended last week on a man I first met, and fell in love with, many years ago. Even several years before he was really 39: Jack Benny.

As drama critic of the Kansas City Post, I had watched this young, unheralded man wander casually on stage in the next-to-closing spot of a vaudeville bill at the Orpheum Theater. There was a smattering of applause as he stood stage center, his violin dangling loosely at his side, he smoothed his necktie, tugged at his pocket handkerchief, looked calmly about, and then spoke softly to the orchestra leader:

"How's the show been up till now?" he asked.

"Fine," said the man in the pit.

There was a slight pause—Jack's renowned timing—and he finally said: "Well, I'll put a stop to that."

Then he went into this monologue, saying he was always glad to come to Kansas City because the girls were so beautiful. He had met one last night, he said, and they had driven around town in his car, and she suggested they stop for a midnight snack at the Muehlebach Hotel, which was Kansas City's version of the high-priced Waldorf Astoria in New York.

Another pause—that look of stark anguish—and then he said, "So I sold the car . . ." It got the big laugh that was to echo down the aisles of theaters, and over the channels of radio and television in the years ahead.

And so was born the image of his tight-fisted adulation of money, which, as we now know, he later developed into a multi-million dollar career. When I went backstage to meet him, I soon learned he was the antithesis of penurious. Throughout his life he gave freely of his time and money to help others.

The "cheap" image paid off. It paid off big, for instance, after a long radio run when Jack appeared as an unannounced guest on the Ed Sullivan variety little spot, in which Sullivan came downstage with a dollar bill in his hand.

"One of the ushers found this dollar bill in the aisle. Will the owner please come up here and . . ."

That's as far as he got, Jack Benny came down the aisle. The laugh it garnered could have ended the bit there. But there was more.

"Are you sure this is your dollar?" asked Ed.

"Yes, sir. You see, I came here a couple days ago from Los Angeles, and I had $7 in my pocket. Now I have only six."

"Well, can you call off the serial numbers?" asked Ed.

"Yes, sir," said Jack. The numbers are B58703170A," Jack recited.

Sullivan examined the bill and handed it to Jack, who left the stage to houseful of applause. When it had quieted down, Sullivan said to the audience, "He wasn't even close to the numbers, but how else can you get a guest to come on this show for a dollar? They don't call him Buck Benny for nothing."

My friendship with Jack ripened and warmed during the early years of Jack's life. I refrain from calling those the years of his struggle to acclaim. I don't recall Jack's ever struggling. He was patient and unruffled, snug and complacent, in his next-to-closing spots in vaudeville theaters across the country. With every performance he learned a little more, took out jokes that were weak, edited those that he thought were better than the response they got. As I say, patient, unruffled, knowing deep down, though he never said it, that he would make stardom.

He was one of the few comedians who knew the art of putting himself down, on stage and in public life. In an era when comics were bragging about how they killed them in Peoria, Jack was quietly polishing and refurbishing his act. He bought and paid for—paid well for—material furnished him by Al Boasberg, the most sought-after one-liner of that time.

In our leisure moments together he never talked shop. He never envied other comedians, never put down any of them, and was quick to praise those he admired, always able to find something fairly good about even the most mediocre. When asked how he had done at a certain performance, it was always "all right."

He never forgot his beginnings. When he spoke about them, the joke was always on him. For instance, the story he told me about his first trip back to Waukegan, Ill. after he had been away on the road for two years. It's possibly apocryphal, but it bears telling because it demonstrates his lack of ego, and the ability to laugh at himself.

He was walking from the railroad station to his father's place when he met a long-time friend, who saw Jack with suitcase in his hand. "Hello Jack," said the man, "leaving town?"

My admiration for Jack as a performer, as well as a friend, led me now and then to concoct jokes suitable to his impeccable style. Though I was never a member of his talented regular staff, there were times when he needed a line or two at a benefit—and he played many of them—when he lived in New York.

I remember the first joke I ever wrote for him. I was still at my job on the paper in Kansas City when I got a telegram from him in the East. It said that he was about to get his first big time break as master of ceremonies at the Palace Theater on Broadway, and he could use an opening line for the occasion?

I had never been to the Palace Theater, but I knew that the master of ceremonies came on after the opening act. I looked through Variety to see what the acts were to be on that bill, and found that Long Tack Sam, Chinese magician, would open. And so, in an era when ethnic jokes were commonplace, I sent Jack this line to say when the act was over: "Vaudeville has certainly changed. It used to take Japs or better to open."

I didn't hear from Jack immediately, and I was about to ring up no sale on my first professional joke, when Walter Winchell's column appeared in our paper and he mentioned the line. Also, Variety, in a glowing review of Jack's entire performance, quoted the line.

Then I got a letter from Jack: "Enclosed find check for $50. Your joke got lots of laughs, if you have any more send them."

Well, as much as I needed the money, I telegraphed it back with a message: "Your check got lots of laughs. If you have any more, send them."

I just didn't want to lose my amateur standing. Not with such a friend.

The last joke I wrote for him was some few years ago when he was coming to New York to appear in his one man show. He phoned me from Canada, asked me about the newspaper strike New York was having, wanted to know if any papers were being printed. I told him no, but that New Yorkers were reading a paper that was published out of town—the Christian Science Monitor. He asked if I could write a joke about the newspaper strike.

I said, "Yes, see what you think of this. You can say: 'Since I got to town I've been reading the Christian Science Monitor. The news in the Christian Science Monitor is just as bad as it is in the other papers, but you think it's better. He had me repeat it, as he carefully placed the right words in the exact sequence.

Jack was without a doubt the most appreciative and the best paying comedian a writer could work for. He sat in at every writing session, editing, contributing, suggesting. The writers were his friends, and he was their gracious employer. He was so unlike most comedians who nourish a feeling that writers are their enemies when some jokes don't go over. So unlike a comedian who once asked me. "Who are you writing against this season?"

And yet, because Jack couldn't have been there to edit, the long list of pallbearers and honorary pallbearers at his funeral today did not mention the names of his family of writers, which included Milton Josephson, John Tackaberry, Sam Perrin, George Balzar, Bill Morrow, High Wedlock and Harry Conn. He would have wanted you to know.

Although the newspaper obits say Jack Benny was 80, you have my word that his spirit was 39.

To Jack Benny, who would have been 81 next Feb. 14, and to his Mary, this, then, is my small valentine bouquet.

(Jack Benny, who will be buried today at Hillside Memorial Cemetery in Culver City, Calif., died late Thursday in his Beverly Hills home of cancer of the pancreas. Goodman Ace, a contributing editor of Saturday Review Magazine, was for many years a radio and television writer. For 18 years, in the 1930s and 1940s, he and his late wife, Jane, starred in the "Easy Aces" radio show.)

Mr. Speaker, on behalf of the distinguished mayor of Waukegan, Robert Sabonjian, members of the Waukegan City Council, and all public officials in my 13th District—particularly from Lake County—I take this occasion to convey the heartfelt respect and honor which has been expressed through thoughts and words in these recent days toward Jack Benny and his family.

Mr. Speaker, throughout his career Jack Benny has always been a decent and wholesome man who respected the interest of all regardless of race, religion, sex, or other individual characteristics. He was beloved by young and old and by those from all walks of life.

Mr. Speaker, it is most appropriate that we honor this great American today through this tribute. At the same time, let us convey to his widow and devoted wife of some 47 years, Mary Livingston, our deepest sympathy, and to express to other members of the family and his close friends our great affection and respect for the unique and youthful gentleman from Waukegan—Jack Benny—who, after completing his 39th year of life, passed from our midst on Friday, December 27, 1974, at 80 years of age.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. YOUNG of Florida) to revise and extend their remarks and include extraneous material:)

Mr. WHALEN, for 10 minutes, today.

Mr. EDWARDS of Alabama, for 5 minutes, today.

Mr. RAILSBACK, for 10 minutes, today.

Mr. COHEN, for 20 minutes, today.

Mr. FRENZEL, for 30 minutes, today.

Mr. GOLDWATER, for 30 minutes, today.

Mr. COCHRAN, for 10 minutes, today.

(The following Members (at the request of Mr. SHARP) to revise and extend their remarks and include extraneous material:)

Mr. RODINO, for 5 minutes, today.

Mr. EDWARDS of California, for 5 minutes, today.

Mr. GONZALEZ, for 5 minutes, today.

Ms. HOLTZMAN, for 10 minutes, today.

Mr. VANIK, for 5 minutes, today.

Mrs. COLLINS of Illinois, for 15 minutes, today.

Mr. FRASER, for 5 minutes, today.

Mr. ANNUNZIO, for 5 minutes, today.

Mr. BINGHAM, for 5 minutes, today.

Mr. ADDABBO, for 30 minutes, today.

Mr. ANDERSON of California, for 5 minutes, today.

Mr. DAN DANIEL, for 5 minutes, today.

Mr. RANGEL, for 5 minutes, today.

Mr. OTTINGER, for 5 minutes, today.

Mr. ROSTENKOWSKI, for 5 minutes, today.

Mr. KASTENMEIER, for 5 minutes, today.

Ms. ABZUG, for 10 minutes, today.

Mr. ZABLOCKI, for 10 minutes, today.

Mr. KOCH, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

Mr. NEDZI.

Mr. ULLMAN, in the body of the RECORD, notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost $6,255.

Mr. CORMAN and to include extraneous matter notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost $9,035.

Mr. CORMAN and to include extraneous matter notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost $2,293.50.

Mr. MCCLORY and to include extraneous matter notwithstanding the fact that it exceeds two pages of the RECORD and is estimated by the Public Printer to cost $1,390.

(The following Members (at the request of Mr. YOUNG of Florida) and to include extraneous material:)

Mr. HEINZ in three instances,

Mr. HAGEDORN in five instances.

Mr. YOUNG of Florida in five instances.

Mr. LENT in three instances.

Mr. KETCHUM.

Mr. ASHBROOK in three instances.

Mr. MCCLORY in two instances.

Mr. PRESSLER.

Mr. HORTON in two instances.

Mr. MOORHEAD of California.

Mr. MCCLOSKEY.

Mr. COHEN in three instances.
Mr. CRANE.
Mr. BEARD of Tennessee.
(The following Members (at the request of Mr. SHARP), and to include extraneous material:)
Mr. SISK in two instances.
Mr. GONZALEZ in three instances.
Mr. ANNUNZIO in six instances.
Mr. ANDERSON of California in five instances.
Mr. FRASER in 10 instances.
Mr. STUCKEY in 10 instances.
Mr. EILBERG in 10 instances.
Mr. VANIK in three instances.
Mr. ROSENTHAL in 10 instances.
Mr. REUSS in five instances.
Mr. BINGHAM in 10 instances.
Mrs. SULLIVAN.
Mr. BOLAND.
Mr. UDALL in five instances.
Mr. BENNETT.
Mr. RANGEL.
Mr. DAN DANIEL.
Mr. HUNGATE in two instances.
Mr. DOMINICK V. DANIELS in five instances.
Mr. GAYDOS in 10 instances.
Mr. SEIBERLING in 10 instances.
Mr. BROWN of California in 10 instances.
Mr. REES.
Mr. OBEY in six instances.
Ms. ABZUG in 10 instances.
Mr. KOCH in three instances.
Mr. ZABLOCKI in two instances.
Mr. MCFALL.
Mr. MOAKLEY in 10 instances.
Mr. ASHLEY.
Mrs. CHISHOLM.

ADJOURNMENT

Mr. SHARP. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 15 minutes p.m.), the House adjourned until tomorrow, Wednesday, January 15, 1975, at 12 o'clock noon.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

1. A letter from the President of the United States, transmitting notice of actions proposed to be taken under the Trade Act of 1974 (H. Doc. No. 94–8); to the Committee on Ways and Means and ordered to be printed.

2. A letter from the President of the United States, transmitting notice of his intention to exercise the authority granted in section 506(a) of the Foreign Assistance Act of 1961, as amended, to order defense articles and services for military assistance to Cambodia, pursuant to section 652 of the act; to the Committee on Foreign Affairs.

3. A letter from the Deputy Assistant Secretary of Agriculture, transmitting the annual report of the Cooperative State Research Service for fiscal year 1974, pursuant to section 10 of Public Law 88–74; to the Committee on Agriculture.

4. A letter from the Director, Office of Management and Budget, Executive Office of the President, transmitting a cumulative report on rescissions and deferrals of budget authority for fiscal year 1975 as of January 1, 1975, pursuant to section 1014(e) of Public Law 93–344 (H. Doc. No. 94–10); to the Committee on Appropriations and ordered to be printed.

5. A letter from the Deputy Director, Office of Management and Budget, Executive Office of the President, transmitting a report that the appropriation to the Department of Health, Education, and Welfare for "Indian Health Services" for fiscal year 1975, has been apportioned on a basis which indicates the necessity for a supplemental estimate of appropriation, pursuant to section 3679 (e)(2) of the Revised Statutes; to the Committee on Appropriations.

6. A letter from the Deputy Director, Office of Management and Budget, Executive Office of the President, transmitting a report that the appropriation to the Veterans Administration for "Medical Care" for fiscal year 1975, has been apportioned on a basis which indicates the necessity for a supplemental estimate of appropriation, pursuant to section 3679(e)(2) of the Revised Statutes; to the Committee on Appropriations.

7. A letter from the Chairman, Equal Employment Opportunity Commission, transmitting a report of a violation of the Antideficiency Act, pursuant to section 3679 (i)(2) of the Revised Statutes; to the Committee on Appropriations.

8. A letter from the Chairman, Equal Employment Opportunity Commission, transmitting a supplemental report on a violation of the Antideficiency Act during fiscal year 1974 by the Commission, pursuant to 31 U.S.C. 665(1)(2); to the Committee on Appropriations.

9. A letter from the Chairman, U.S. Consumer Product Safety Commission, transmitting a copy of a letter to the Office of Management and Budget concerning a fiscal year 1975 supplemental appropriation for the Commission, pursuant to section 27 (k)(1) of Public Law 92–573; to the Committee on Appropriations.

10. A letter from the Deputy Assistant Secretary of Defense (Installations and Housing), transmitting a report on military construction projects placed under contract in fiscal year 1974 in which it was necessary to exceed the amount authorized for the project by Congress by more than 25 percent or to reduce the project scope in order to award within the authorization, pursuant to section 603(d) of Public Law 93–166; to the Committee on Armed Services.

11. A letter from the Deputy Assistant Secretary of Defense (Military Personnel Policy), transmitting a report on former military and civilian officials and current Department of Defense employees who have filed reports pertaining to employment by defense contractors, covering fiscal year 1974, pursuant to section 410(d) of Public Law 91–121; to the Committee on Armed Services.

12. A letter from the Under Secretary of the Army, transmitting the annual report of the U.S. Soldiers' and Airmen's Home for fiscal year 1973, pursuant to the act approved March 3, 1883, as amended [24 U.S.C. 59]; to the Committee on Armed Services.

13. A letter from the Chairman, Defense Manpower Commission, transmitting a report on activities of the Commission; to the Committee on Armed Services.

14. A letter from the Board of Governors of the Federal Reserve System, transmitting the sixth annual report of the Board of Governors on truth in lending, covering 1974, pursuant to section 114 of the Truth in Lending Act [15 U.S.C. 1613]; to the Committee on Banking, Currency and Housing.

15. A letter from the President and Chairman, Export-Import Bank of the United States, transmitting a report on loan, guarantee, and insurance transactions to Yugoslavia, Romania, the Union of Soviet Socialist Republics, and Poland during October 1974; to the Committee on Banking, Currency, and Housing.

16. A letter from the Chairman, U.S. Consumer Product Safety Commission, transmitting a report on the safe level of lead in residential paint, pursuant to section 3 of Public Law 93–151; to the Committee on Banking, Currency and Housing.

17. A letter from the Acting Executive Director, National Commission on Productivity and Work Quality, transmitting a report on activities of the Commission; to the Committee on Banking, Currency and Housing.

18. A letter from the Chairman, Cost Accounting Standards Board, transmitting a proposed cost accounting standard entitled "Part 408—Accounting for Costs of Compensated Personal Absence," pursuant to section 719(h)(3) of the Defense Production Act of 1950, as amended by Public Law 91–379; to the Committee on Banking, Currency and Housing.

19. A letter from the Chairman, The District of Columbia City Council, transmitting the annual report concerning the District of Columbia Council's functions during the period July 1, 1973 through June 30, 1974, pursuant to section 402(10) of Reorganization Plan No. 3 of 1967 (1 DCC 238); to the Committee on The District of Columbia.

20. A letter from the Executive Secretary, Public Service Commission of the District of Columbia, transmitting the 61st annual report of the Commission, covering calendar year 1973, pursuant to section 8 of the act of March 4, 1913; to the Committee on the District of Columbia.

21. A letter from the Vice President and General Manager, Chesapeake and Potomac Telephone Co., transmitting a report of receipts and expenditures for the year 1974, pursuant to 33 Stat. 376; to the Committee on the District of Columbia.

22. A letter from the Secretary of Health, Education, and Welfare, transmitting the report of the National Center for Deaf-Blind Youths and Adults, covering calendar year 1972, pursuant to section 16(c)(2) of the Vocational Rehabilitation Act [29 U.S.C. 42(a)(2)]; to the Committee on Education and Labor.

23. A letter from the Executive Secretary, Department of Health, Education, and Welfare, transmitting notice of proposed rulemaking for the Family Educational Rights and Privacy Act of 1974, pursuant to section 431(d) of the General Educational Provisions Act, as amended by section 509(a)(1) of Public Law 93–380; to the Committee on Education and Labor.

24. A letter from the Under Secretary of Health, Education, and Welfare, transmitting notice of proposed rulemaking for the Ethnic Heritage Studies program, pursuant to section 431(d)(1) of the General Education Provisions Act, as amended [20 U.S.C. 1232 (d)(1)]; to the Committee on Education and Labor.

25. A letter from the Under Secretary of Health, Education, and Welfare, transmitting notice of proposed rulemaking for Financial Assistance for Supplementary Centers and Services, Guidance, Counseling and Testing programs, pursuant to section 431(d) of the General Education Provisions Act, as amended by section 509(a)(1) of Public Law 93–380 [H.R. 69]; to the Committee on Education and Labor.

26. A letter from the Under Secretary of Health, Education, and Welfare, transmitting notice of proposed regulations for Exemplary Projects in Vocational Education, Additional Criteria for Selection of Applicants in fiscal year 1975, pursuant to section 431(d) of the General Education Provisions Act, as amended by section 509(a)(1) of Public Law 93–380 [H.R. 69]; to the Committee on Education and Labor.

27. A letter from the Under Secretary of Health, Education, and Welfare, transmitting notice of proposed amendments to regulations governing the Veterans' Cost-of-Instruction Payments program, pursuant to section 431(d) of the General Education Provisions Act, as amended by section 509 (a)(1) of Public Law 93–380 [H.R. 69]; to the Committee on Education and Labor.

28. A letter from the Under Secretary of Health, Education, and Welfare, transmitting a report concerning regulations governing Financial Assistance for Strengthening Instruction in Academic Subjects in Public Schools, pursuant to section 431(d) of the General Education Provisions Act, as amended by section 509(a)(1) of Public Law 93–380 [H.R. 69]; to the Committee on Education and Labor.

29. A letter from the Commissioner on Aging, Department of Health, Education, and Welfare, transmitting a report on the state of the art of transportation for the elderly, pursuant to section 412(a) of the Older Americans Act of 1965, as amended; to the Committee on Education and Labor.

30. A letter from the Chairman, National Commission on Libraries and Information Science, transmitting the third annual report of the Commission, pursuant to section 5(a)(7) of Public Law 91–345, as amended; to the Committee on Education and Labor.

31. A letter from the Assistant Secretary of State for Congressional Relations, transmitting notice of the intention of the Department of State to consent to a request by the Government of Iran for permission to transfer certain aircraft to a friendly government, pursuant to section 3(a) of the Foreign Military Sales Act, as amended; to the Committee on Foreign Affairs.

32. A letter from the Assistant Secretary of Defense (Legislative Affairs), transmitting a report on the effectiveness of U.S. military aid to Israel in the Arab-Israeli war of 1973, pursuant to section 5 of Public Law 93–199; to the Committee on Foreign Affairs.

33. A letter from the Secretary of Commerce, transmitting a report on export administration for the second quarter of 1974, pursuant to the Export Administration Act of 1969, as amended [50 U.S.C. App. 2409]; to the Committee on Foreign Affairs.

34. A letter from the Comptroller, Defense Security Assistance Agency, transmitting a quarterly report foreign military sales letters of offer, pursuant to section 36(a)(1) and (2) of the Foreign Military Sales Act, as amended [22 U.S.C. 2776(a)]; to the Committee on Foreign Affairs.

35. A letter from the Comptroller, Defense Security Assistance Agency, transmitting a statement of the intention of the Department of the Air Force to sell certain defense articles to the Government of Iran, pursuant to section 36(b) of the Foreign Military Sales Act, as amended by section 45(a)(5) of Public Law 93–559; to the Committee on Foreign Affairs.

36. A letter from the Acting Comptroller, Defense Security Assistance Agency, transmitting a report on sales to less developed countries, pursuant to section 35(b) of the Foreign Military Sales Act of 1968 [22 U.S.C. 2775(b)]; to the Committee on Foreign Affairs.

37. A letter from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting copies of international agreements other than treaties entered into by the United States, pursuant to Public Law 92–403; to the Committee on Foreign Affairs.

38. A letter from the Acting Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting copies of international agreements other than treaties entered into by the United States, pursuant to Public Law 92–403; to the Committee on Foreign Affairs.

39. A letter from the Secretary of the Treasury, transmitting the combined statement of receipts, expenditures, and balances of the U.S. Government for fiscal year 1974, pursuant to 31 U.S.C. 66b and 1029; to the Committee on Government Operations.

40. A letter from the Chairman, Committee for Purchase from the Blind and Other Severely Handicapped, transmitting the annual report of the activities of the committee for fiscal year 1974, pursuant to section 1(1) of Public Law 92–28; to the Committee on Government Operations.

41. A letter from the Clerk, U.S. House of Representatives, transmitting a list of reports which it is the duty of any officer or department to make to Congress, pursuant to rules III, clause 2, of the Rules of the House of Representatives (H. Doc. No. 94–7); to the Committee on House Administration and ordered to be printed.

42. A letter from the Sergeant at Arms, U.S. House of Representatives, transmitting his annual report of funds drawn by him, the application and disbursement of the sums, and balances remaining in his hands as of January 10, 1975, pursuant to 2 U.S.C. 84; to the Committee on House Administration.

43. A letter from the Secretary of the Interior, transmitting the ninth annual report on the minerals exploration assistance program, pursuant to Public Law 85–701, as amended [30 U.S.C. 645]; to the Committee on Interior and Insular Affairs.

44. A letter from the Acting Secretary of the Interior, transmitting a plan for the assumption of the assets of Menominee Enterprises, Inc., pursuant to the requirements of section 6 of the Act of December 22, 1973, [Public Law 93–197]; to the Committee on Interior and Insular Affairs.

45. A letter from the Assistant Secretary of the Interior, transmitting descriptions of four projects tentatively selected for funding through grants, contracts, and matching or other arrangements with educational institutions, private foundations or other institutions, and with private firms, pursuant to section 200(b) of the Water Resources Research Act of 1964 [42 U.S.C. 1961b(b)]; to the Committee on Interior and Insular Affairs.

46. A letter from the Deputy Assistant Secretary of the Interior, transmitting a proposed contract with Foster-Miller Associates, Inc., Waltham, Mass., for a research project entitled "Development of Conical Stabilizers for Pilot Hole Drilling", pursuant to Public Law 89–672; to the Committee on Interior and Insular Affairs.

47. A letter from the Deputy Assistant Secretary of the Interior, transmitting notice of the receipt of three project proposals under the Small Reclamation Projects Act of 1956, pursuant to section 10 of the act [43 U.S.C. 422j]; to the Committee on Interior and Insular Affairs.

48. A letter from the Chairman, Indian Claims Commission, transmitting the final determination of the Commission in docket No. 95, the Sac and Fox Tribe of Indians of Oklahoma, the Sac and Fox Tribe of Missouri, the Sac and Fox Tribe of Mississippi in Iowa, et al., plaintiffs versus The United States of America, defendant, pursuant to 25 U.S.C. 70t; to the Committee on Interior and Insular Affairs.

49. A letter from the Chairman, Indian Claims Commission, transmitting the final determination of the Commission in docket No. 326–G, Gila River Pimea-Maricopa Indian Community, et al., plaintiff versus The United States of America, defendant, pursuant to 25 U.S.C. 70t; to the Committee on Interior and Insular Affairs.

50. A letter from the Chairman, Indian Claims Commission, transmitting the final determination of the Commission in docket No. 350–B, The three affiliated tribes of the Fort Berthold Reservation, plaintiffs, versus The United States of America, defendant, pursuant to 25 U.S.C. 70t; to the Committee on Interior and Insular Affairs.

51. A letter from the Secretary of Commerce transmitting the 62d annual report of the Secretary of Commerce for the fiscal year ended June 30, 1974, pursuant to 15 U.S.C. 1519; to the Committee on Interstate and Foreign Commerce.

52. A letter from the Secretary of Health, Education, and Welfare, transmitting the second annual report of the National Health Service Corps, covering calendar year 1973, pursuant to Public Law 92–585; to the Committee on Interstate and Foreign Commerce.

53. A letter from the Chairman, Federal Power Commission, transmitting the report on permits and licenses issued for hydroelectric projects, together with financial statements and names and compensation of employees of the Commission, for fiscal year 1974, pursuant to section 4(d) of the Federal Power Act [16 U.S.C. 797(d)]; to the Committee on Interstate and Foreign Commerce.

54. A letter from the Chairman, Consumer Product Safety Commission, transmitting technical schedules for the Commission's fiscal year 1976 budget, pursuant to section 27(k)(1) of Public Law 92–573; to the Committee on Interstate and Foreign Commerce.

55. A letter from the Chairman, U.S. Consumer Product Safety Commission, transmitting a copy of a report from the Commission to the Office of Management and Budget on salaries and expenses for the Commission's health-related programs, pursuant to section 27(k)(1) of Public Law 92–573; to the Committee on Interstate and Foreign Commerce.

56. A letter from the Chairman, U.S. Consumer Product Safety Commission, transmitting a copy of a letter from the Commission to the Office of Management and Budget proposing legislative changes required to implement the shift to the new fiscal year, pursuant to section 27(k)(2) of Public Law 92–573; to the Committee on Interstate and Foreign Commerce.

57. A letter from the Vice President for Government and Public Affairs, National Railroad Passenger Corporation, transmitting the financial report of the Corporation for the month of September 1974, pursuant to section 308(a)(1) of the Rail Passenger Service Act of 1970, as amended; to the Committee on Interstate and Foreign Commerce.

58. A letter from the Vice President for Government and Public Affairs, National Railroad Passenger Corporation, transmitting a report on the number of passengers per day on board each train operated, and the on-time performance at the final destination of each train operated, by route and by railroad, for the month of November 1974, pursuant to section 308(a)(2) of the Rail Passenger Service Act of 1970, as amended, to the Committee on Interstate & Foreign Commerce.

59. A letter from the Director, Federal Bureau of Investigation, U.S. Department of Justice, transmitting the 1974 annual report of the Bureau; to the Committee on the Judiciary.

60. A letter from the Administrator, Law Enforcement Assistance Administration, U.S. Department of Justice, transmitting the sixth annual report of the Law Enforcement Assistance Administration, covering fiscal year 1974, pursuant to section 519 of Public Law 90–351, as amended by Public Law 93–83; to the Committee on the Judiciary.

61. A letter from the Commissioner, Immigration and Naturalization Service, U.S. Department of Justice, transmitting reports concerning visa petitions approved according certain beneficiaries third and sixth preference classification, pursuant to section 204(d) of the Immigration and Nationality Act, as amended [8 U.S.C. 1154(d)]; to the Committee on the Judiciary.

62. A letter from the Commissioner, Immigration and Naturalization Service, Department of Justice, transmitting copies of orders entered in the case of certain aliens found admissible to the United States, pursuant to section 212(a)(28)(I)(ii) of the Immigration and Nationality Act [8 U.S.C. 1182(a)(28)(I)(ii)(b)]; to the Committee on the Judiciary.

63. A letter from the Commissioner, Im-

migration and Naturalization Service, Department of Justice, transmitting copies of orders entered in cases in which the authority contained in section 212(d)(3) of the Immigration and Nationality Act was exercised in behalf of certain aliens, pursuant to section 212(d)(6) of the act [8 U.S.C. 1182(d)(6)]; to the Committee on the Judiciary.

64. A letter from the Commissioner, Immigration and Naturalization Service, Department of Justice, transmitting copies or orders entered in the cases of certain aliens under the authority contained in section 13(b) of the act of September 11, 1957, pursuant to section 13(c) of the act [8 U.S.C. 1255b(c)]; to the Committee on the Judiciary.

65. A letter from the National Executive Director, American Veterans of World War II, Korea, and Vietnam, transmitting the financial statement of AMVETS as of August 31, 1974; to the Committee on the Judiciary.

66. A letter from the Chairman, Board of Directors, Future Farmers of America, transmitting the audit of the accounts of the Future Farmers of America for the fiscal year ending June 30, 1974, pursuant to section 2 and 3 of Public Law 88-504; to the Committee on the Judiciary.

67. A letter from the National Director of Administration and Services, Marine Corps League, transmitting the annual report of the league; to the Committee on the Judiciary.

68. A letter from the Secretary, Smithsonian Institution, transmitting a report on endangered and threatened plant species of the United States, pursuant to section 12 of Public Law 93-205; to the Committee on Merchant Marine and Fisheries.

69. A letter from the Director, Fish and Wildlife Service, Department of the Interior, transmitting a report on Federal and State sport fish production policies; to the Committee on Merchant Marine and Fisheries.

70. A letter from the Secretary of the Treasury, transmitting a report on the experience of Federal agencies under the program for self-insuring fidelity losses of Federal personnel, covering fiscal year 1974, pursuant to section 103 of the act of June 6, 1972 [31 U.S.C. 1203]; to the Committee on Post Office and Civil Service.

71. A letter from the Director of Personnel, Department of Commerce, transmitting a report of scientific and professional positions established in the Department as of December 1974, pursuant to 5 U.S.C. 3104(c); to the Committee on Post Office and Civil Service.

72. A letter from the Director, Administrative Office of the U.S. Courts, transmitting a report on a change in a GS-17 position allocated to the Office, pursuant to 5 U.S.C. 5114(a); to the Committee on Post Office and Civil Service.

73. A letter from the Acting Assistant Secretary of Commerce for Economic Development, transmitting the annual report of the Economic Development Administration for fiscal year 1974, pursuant to 42 U.S.C. 3217; to the Committee on Public Works and Transportation.

74. A letter from the Secretary of Transportation, transmitting the annual report on railroad-highway demonstration projects, pursuant to section 163(j) of the Federal-Aid Highway Act of 1973 (Public Law 93-87) (H. Doc. No. 94-11); to the Committee on Public Works and Transportation and ordered to be printed with illustrations.

75. A letter from the Secretary of Transportation, transmitting the annual report for fiscal year 1974 on the Urban Area Traffic Operations Improvement (TOPICS) program, pursuant to 23 U.S.C. 135(d); to the Committee on Public Works and Transportation.

76. A letter from the Secretary of Transportation, transmitting the fourth annual report of the Special Bridge Replacement Program, pursuant to section 204 of Public Law 91-605 [23 U.S.C. 144(h)] to the Committee on Public Works and Transportation.

77. A letter from the Board of Directors of the Tennessee Valley Authority, transmitting the 41st Annual Report of the Tennessee Valley Authority, covering fiscal year 1974, pursuant to 16 U.S.C. 831h; to the Committee on Public Works and Transportation.

78. A letter from the Acting Chairman, Civil Aeronautics Board, transmitting a copy of the annual report of the Board covering fiscal year 1973; to the Committee on Public Works and Transportation.

79. A letter from the Administrator of General Services, transmitting a prospectus which proposes construction of a courthouse and Federal Office Building and a parking facility in East St. Louis, Ill., pursuant to Public Buildings Act of 1959, as amended; to the Committee on Public Works and Transportation.

80. A letter from the Administrator, National Aeronautics and Space Administration, transmitting a list of the present and former NASA employees who have filed reports pertaining to their NASA and aerospace-related industry employment for fiscal year 1974, pursuant to section 6 of Public Law 91-119, as amended; to the Committee on Science and Technology.

81. A letter from the Secretary of Housing and Urban Development and the Administrator, National Aeronautics and Space Administration, transmitting a preliminary program plan for development and demonstration of solar heating and combined solar heating and cooling systems for residences, pursuant to section 12(d) Public Law 93-409; to the Committee on Science and Technology.

82. A letter from the Assistant Secretary of Defense (Installations and Logistics), transmitting a report on Department of Defense procurement from small and other business firms for July-October, 1974, pursuant to section 10(d) of the Small Business Act, as amended; to the Committee on Small Business.

83. A letter from the Secretary of the Treasury, transmitting the annual report on the state of the finances of the U.S. Government for fiscal year 1974, pursuant to 31 U.S.C. 1027; to the Committee on Ways and Means and ordered to be printed with illustrations.

84. A letter from the Secretary of Health, Education, and Welfare, transmitting the annual report on public advisory committees, pursuant to section 1114(f) of the Social Security Act; to the Committee on Ways and Means.

85. A letter from the Chairman, United States Tariff Commission, transmitting the annual report of the Commission on the operation of the trade agreements program, covering the calendar year 1973, pursuant to section 402(b) of the Trade Expansion Act of 1962; to the Committee on Ways and Means.

86. A letter from the Chairman, Atomic Energy Commission, transmitting proposed additional amounts of special nuclear material and periods of time during which such amounts may be distributed to the European Atomic Energy Community (Euratom), pursuant to section 54(a) of the Atomic Energy Act of 1954, as amended; to the Joint Committee on Atomic Energy.

87. A letter from the Chairman, Atomic Energy Commission, transmitting proposed additional amounts of special nuclear material and periods of time during which such amounts may be distributed to the International Atomic Energy Agency, pursuant to section 54(a) of the Atomic Energy Act of 1954, as amended; to the Joint Committee on Atomic Energy.

88. A letter from the Secretary of the Interior, transmitting the annual report of the Office of Coal Research, pursuant to 30 U.S.C. 667 (Public Law 86-599, Sec. 7); jointly, to the Committees on Interior and Insular Affairs and Science and Technology.

89. A letter from the Chairman, Interstate Commerce Commission, transmitting the 88th Annual Report of the Commission for the Fiscal Year 1974, pursuant to the Interstate Commerce Act (49 U.S.C. 21); jointly, to the Committee on Interstate and Foreign Commerce and Public Works and Transportation.

RECEIVED FROM THE COMPTROLLER GENERAL

90. A letter from the Comptroller General of the United States, transmitting a supplemental report on a proposed rescission of budget authority transmitted as a deferral (No. D75-48) by the President on October 4, 1974, pursuant to section 1015(b) of Public Law 93-344 (H. Doc. No. 94-14); to the Committee on Appropriations and ordered to be printed.

91. A letter from the Acting Comptroller General of the United States, transmitting his review of the proposed rescission and deferral actions contained in the message from the President dated November 26, 1974, pursuant to section 1014 (b) and (c) of Public Law 93-344 (H. Doc. No. 94-15); to the Committee on Appropriations and ordered to be printed.

92. A letter from the Comptroller General of the United States, transmitting his opinion of the legal authority for each of the deferrals of budget authority proposed by the President in his first four special messages to Congress under the Impoundment Control Act of 1974, pursuant to section 1014(b)(2)(B) of the act (H. Doc. No. 94-16); to the Committee on Appropriations and ordered to be printed.

93. A letter from the Comptroller General of the United States, transmitting a report on achievements, problems, and uncertainties in isolating high-level radioactive waste from the environment by the Atomic Energy Commission; to the Committee on Government Operations.

94. A letter from the Comptroller General of the United States, transmitting a report on the need to improve the long-term impact of the Law Enforcement Assistance Administration grant program; to the Committee on Government Operations.

95. A letter from the Comptroller General of the United States, transmitting a report on the progress and problems of Federal library support programs; to the Committee on Government Operations.

96. A letter from the Comptroller General of the United States, transmitting a report on life cycle cost estimating—its status and potential use in major weapon system acquisitions by the Department of Defense; to the Committee on Government Operations.

97. A letter from the Comptroller General of the United States, transmitting a report on efforts to stop narcotics and dangerous drugs coming from and through Mexico and Central America; to the Committee on Government Operations.

98. A letter from the Comptroller General of the United States, transmitting a report on the role of Federal assistance for vocational education; to the Committee on Government Operations.

99. A letter from the Comptroller General of the United States, transmitting a report on how management of Federal Supply Service procurement programs can be improved by the General Services Administration; to the Committee on Government Operations.

100. A letter from the Comptroller General of the United States, transmitting a report on national rural development efforts and the impact of Federal programs on a 12-county rural area in South Dakota; to the Committee on Government Operations.

101. A letter from the Comptroller General of the United States, transmitting a report on the need for a uniform method for paying interest on Government trust funds; to the Committee on Government Operations.

102. A letter from the Comptroller General of the United States, transmitting a report on the substantial staff and cost reductions possible at military telecommunications centers through use of uniform staffing standards; to the Committee on Government Operations.

103. A letter from the Comptroller General of the United States, transmitting an analysis of the Department of the Navy's comments on the recommendations of the Comptroller General for improving the management and reducing the cost of the ship transfer program; jointly, to the Committees on Government Operations and Armed Services.

104. A letter from the Comptroller General of the United States, transmitting a report on improvements needed to seed implementation of medicaid's early and periodic screening, diagnosis, and treatment program; jointly, to the Committees on Interstate and Foreign Commerce and Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

[*Submitted Jan. 2, 1975*]

Mr. RODINO: Committee on the Judiciary. Report on the activities of the Committee on the Judiciary during the 93d Congress (Rept. No. 93–1667). Referred to the House Calendar.

PUBLIC BILLS AND RESOLUTIONS

Under clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. ULLMAN:

H.R. 1. A bill to establish a new program of comprehensive health care benefits (including catastrophic coverage) and health care delivery to be available to all residents of the United States, financed by payroll deductions, employer contributions, and tax credits, and for other purposes; to the Committee on Ways and Means.

By Mr. FLYNT:

H.R. 2. A bill to establish a Department of Education; to the Committee on Government Operations.

By Mrs. SULLIVAN:

H.R. 3. A bill to authorize appropriations for the fiscal year 1975 for certain maritime programs of the Department of Commerce; to the Committee on Merchant Marine and Fisheries.

By Mr. TEAGUE:

H.R. 4. A bill to establish university coal research laboratories and to establish energy resource fellowships, and for other purposes; to the Committee on Science and Technology.

By Mr. BURKE of Massachusetts:

H.R. 5. A bill to amend the Internal Revenue Code of 1954 to encourage higher education, and particularly the private funding thereof, by authorizing a deduction from gross income of reasonable amounts contributed to a qualified higher education fund established by the taxpayer for the purpose of funding the higher education of his dependents; to the Committee on Ways and Means.

By Mr. BROOKS:

H.R. 6. A bill to revise certain provisions relating to per diem and mileage expenses of Government employees and disabled veterans, and for other purposes; to the Committee on Government Operations.

By Mr. PERKINS:

H.R. 7. A bill to revise the black lung benefit program to transfer the residual liability for the payment of benefits under such program from the Federal Government to the coal industry, and for other purposes; to the Committee on Education and Labor.

By Mr. DENT (for himself, Mr. PERKINS, Mr. FLOOD, Mr. CARNEY, Mr. SHIPLEY, Mr. BEVILL, Mr. MCDADE, and Mr. MOLLOHAN):

H.R. 8. A bill to revise the black lung benefits program to transfer the residual liability for the payment of benefits under such program from the Federal Government to the industry, and for other purposes; to the Committee on Education and Labor.

By Mr. RODINO:

H.R. 9. A bill to regulate and foster commerce among the States by providing a system for the taxation of interstate commerce; to the Committee on the Judiciary.

By Mr. MOSS (for himself, Mr. STAGGERS, Mr. DINGELL, Mr. VAN DEERLIN, Mr. ROONEY, Mr. STUCKEY, Mr. ECKHARDT, Mr. CARNEY, Mr. METCALFE, Mr. MOFFETT, and Mr. EILBERG):

H.R. 10. A bill to amend the Securities Exchange Act of 1934 to remove barriers to competition, to foster the development of a national securities market system and a national clearance and settlement system, to make uniform the Securities and Exchange Commission's authority over securities industry regulatory organizations, and for other purposes; to the Committee on Interstate and Foreign Commerce.

By Mr. MCCOLLISTER:

H.R. 11. A bill to amend the Federal Trade Commission Act to provide indemnification in certain instances by business firms to sales representatives for the unjustified termination of their jobs, and for other purposes; to the Committee on Interstate and Foreign Commerce.

By Mr. JONES of Alabama (for himself, Mr. HARSHA, and Ms. ABZUG):

H.R. 12. A bill to amend title 3, United States Code, to provide for the protection of foreign diplomatic missions, to increase the size of the Executive Protective Service, and for other purposes; to the Committee on Public Works and Transportation.

By Mr. NIX:

H.R. 13. A bill to provide for improved labor-management relations in the Federal service, and for other purposes; to the Committee on Post Office and Civil Service.

By Mrs. SULLIVAN:

H.R. 14. A bill to establish a Consumer Savings Disclosure Act in order to provide for uniform and full disclosure of information with respect to the computation and payment of earnings on certain savings deposits; to the Committee on Banking, Currency, and Housing.

By Mr. RAILSBACK (for himself and Mr. KASTENMEIER):

H.R. 15. A bill to regulate lobbying and related activities; jointly, to the Committee on the Judiciary and Standards of Official Conduct.

By Mr. PERKINS:

H.R. 16. A bill to assist the States and local educational agencies in providing educational programs of high quality in elementary and secondary schools and to assist the States in equalizing educational opportunity, and for other purposes; to the Committee on Education and Labor.

By Mr. BENNETT:

H.R. 17. A bill to authorize the establishment of the Revolution's Southernmost Battlefields National Park; to the Committee on Interior and Insular Affairs.

H.R. 18. A bill to provide for disclosures by lobbyists, and for other purposes; to the Committee on Standards of Official Conduct.

By Mr. PERKINS (for himself, Mr. QUIE, Mr. MEEDS, Mr. BELL, Mr. THOMPSON, Mr. ESCH, Mr. DENT, Mr. ESHLEMAN, Mr. BRADEMAS, Mr. PEYSER, Mr. O'HARA, Mr. SARASIN, Mr. HAWKINS, Mr. PRESSLER, Mr. FORD of Michigan, Mrs. MINK, Mr. PHILLIP BURTON, Mr. GAYDOS, Mr. CLAY, Mr. ANDREWS of North Carolina, Mr. LEHMAN, Mr. BENITEZ, Mr. BLOUIN, Mr. RISENHOOVER, and Mr. SIMON):

H.R. 19. A bill to amend the Vocational Education Act of 1963; to the Committee on Education and Labor.

By Mr. PERKINS (for himself, Mr. QUIE, Mr. CORNELL, Mr. ZEFERETTI, Mr. MOTTL, and Mr. HALL):

H.R. 20. A bill to amend the Vocational Education Act of 1963; to the Committee on Education and Labor.

By Mr. CORMAN (for himself, Mr. GREEN, Mr. HELSTOSKI, Mr. RANGEL, Mr. STARK, Mr. MIKVA, Mr. ANDERSON of California, Mr. BOLLING, Mr. BROWN of California, Mr. ECKHARDT, Mr. EDWARDS of California, Mr. FRASER, Mr. HAWKINS, Mr. HECHLER of West Virginia, Mr. MCFALL, Mr. MACDONALD of Massachusetts, Mr. MADDEN, Mr. MEEDS, Mr. MOSS, Mr. PEPPER, Mr. RODINO, Mr. ROYBAL, Mr. THOMPSON, Mr. UDALL, and Mr. VAN DEERLIN):

H.R. 21. A bill to create a national system of health security; to the Committee on Ways and Means.

By Mr. CORMAN (for himself, Ms. ABZUG, Mr. ADDABBO, Mr. ANNUNZIO, Mr. ASHLEY, Mr. BADILLO, Mr. BINGHAM, Mr. CARNEY, Mrs. CHISHOLM, Mr. CLAY, Mr. CONYERS, Mr. DOMINICK V. DANIELS, Mr. EILBERG, Mr. FAUNTROY, Mr. FORD of Michigan, Mr. HARRINGTON, and Ms. HOLTZMAN):

H.R. 22. A bill to create a national system of health security; to the Committee on Ways and Means.

By Mr. CORMAN (for himself, Mr. DIGGS, Mr. DRINAN, Mr. HOWARD, Mr. MOAKLEY, Mr. KOCH, Mr. LEHMAN, Mr. MCCORMACK, Mr. MURPHY of New York, Mr. NEDZI, Mr. NIX, Mr. OBERSTAR, Mr. ROSENTHAL, Mr. ST GERMAIN, Mr. SEIBERLING, Mr. STOKES, and Mr. STUDDS):

H.R. 23. A bill to create a national system of health security; to the Committee on Ways and Means.

By Mr. BOLAND:

H.R. 24. A bill to preserve and promote the resources of the Connecticut River Valley, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. UDALL (for himself, Mrs. MINK, Mr. HAYS of Ohio, Mr. MELCHER, Mr. RONCALIO, Mr. SEIBERLING, Mr. VIGORITO, Mr. BINGHAM, Mr. PHILLIP BURTON, Mr. DE LUGO, Mr. ECKHARDT, Mr. KASTENMEIER, Mr. MEEDS, Mr. REGULA, Mr. STEELMAN, Mr. TAYLOR of North Carolina, Mr. TSONGAS, Mr. ASHLEY, Mr. BADILLO, Mr. BRODHEAD, Mrs. COLLINS of Illinois, Mr. CORMAN, Mr. DOMINICK V. DANIELS, Mr. EDWARDS of California, and Mr. FRASER):

H.R. 25. A bill to provide for the cooperation between the Secretary of the Interior and the States with respect to the regulation of surface coal mining operations, and the acquisition and reclamation of abandoned mines, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. UDALL (for himself, Mrs. MINK, Mr. GUDE, Mr. HELSTOSKI, Mr. HICKS, Mr. HOLLAND, Mr. HORTON, Mr. KREBS, Mr. LONG of Maryland, Mr. MAZZOLI, Mrs. MEYNER, Mr. NIX, Mr. NOWAK, Mr. PEPPER, Mr. PERKINS, Mr. REES, Mr. REUSS, Mr. RIEGLE, Mr. RODINO, Mr. ROE, Mr. ROSENTHAL, Mr. ROUSH, Mr. RYAN, Mr. SARBANES, and Mr. SCHEUER):

H.R. 26. A bill to provide for the cooperation between the Secretary of the Interior and the States with respect to the regulation of surface coal mining operations, and the acquisition and reclamation of abandoned

mines, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. UDALL (for himself, Mrs. MINK, Ms. ABZUG, Mr. ADAMS, Mr. AMBRO, Mr. AUCOIN, Mr. BRADEMAS, Mrs. BURKE of California, Mr. CARNEY, Mr. DANIELSON, Mr. EILBERG, Mr. DOWNEY, Mr. EVANS of Colorado, Mr. FORD of Michigan, Mr. HARKIN, Mr. HARRINGTON, Miss HOLTZMAN, Mr. KARTH, Mr. KOCH, Mr. MILLER of California, Mr. MINETA, Mr. MITCHELL of Maryland, Mr. MORGAN, Mr. OBEY, and Mr. O'HARA):

H.R. 27. A bill to provide for the cooperation between the Secretary of the Interior and the States with respect to the regulation of surface coal mining operations and the acquisition and reclamation of abandoned mines, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. UDALL (for himself, Mrs. MINK, Mr. ANDERSON of California, Mr. DODD, Mr. OTTINGER, Mr. PRICE, Mrs. SPELLMAN, Mr. RANGEL, Mr. SMITH of Iowa, Mr. STARK, Mr. THOMPSON, Mr. VAN DEERLIN, Mr. WEAVER, Mr. YOUNG of Georgia, and Mr. ZEFERETTI):

H.R. 28. A bill to provide for the cooperation between the Secretary of the Interior and the States with respect to the regulation of surface coal mining operations, and the acquisition and reclamation of abandoned mines, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. REUSS:

H.R. 29. A bill to provide for greater homeownership opportunities for middle-income families and to encourage more efficient use of land and energy resources; to the Committee on Banking, Currency, and Housing.

By Mr. ULLMAN (for himself, Mr. TAYLOR of North Carolina, Mr. MEEDS, Mr. ADAMS, Mr. AUCOIN, Mr. BINGHAM, Mr. DON H. CLAUSEN, Mr. DE LUGO, Mr. DUNCAN of Oregon, Mr. HICKS, Mr. JONES of Oklahoma, Mr. KASTENMEIER, Mr. MCCORMACK, Mr. MILLER of California, Mrs. MINK, Mr. PRITCHARD, Mr. SEIBERLING, Mr. STEELMAN, Mr. STEPHENS, Mr. UDALL, Mr. WEAVER, and Mr. WON PAT):

H.R. 30. A bill to establish the Hells Canyon National Recreation Area in the States of Oregon, Idaho, and Washington, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. EDWARDS of California (for himself and Mr. WIGGINS):

H.R. 31. A bill to establish a uniform law on the subject of bankruptcies; to the Committee on the Judiciary.

H.R. 32. A bill to establish a uniform law on the subject of bankruptcies; to the Committee on the Judiciary.

By Mr. BURKE of Massachusetts:

H.R. 33. A bill to amend the Social Security Act and the Internal Revenue Code of 1954 to provide for Federal participation in the costs of the social security program, with a substantial increase in the contribution and benefit base and with appropriate reductions in social security taxes to reflect the Federal Government's participation in such costs; to the Committee on Ways and Means.

By Mr. ASHLEY:

H.R. 34. A bill to authorize temporary assistance to help defray mortgage payments on homes owned by persons who are temporarily unemployed or whose incomes have been significantly reduced as the result of adverse economic conditions; to the Committee on Banking, Currency and Housing.

By Mr. TEAGUE:

H.R. 35. A bill to amend the National Environmental Policy Act of 1969 in order to encourage the establishment of, and to assist, State and regional environmental research centers; to the Committee on Science and Technology.

H.R. 36. A bill to regulate commerce and improve the efficiency of energy utilization by consumers by establishing the Energy Conservation Research and Development Corporation, and for other purposes; to the Committee on Science and Technology.

By Mr. TEAGUE (for himself, Mr. MOSHER, and Mr. SYMINGTON):

H.R. 37. A bill to authorize appropriations to carry out the Standard Reference Data Act; to the Committee on Science and Technology.

By Mr. RODINO:

H.R. 38. A bill to permit the attorneys general of the several States to secure redress to the citizens and political subdivisions of their States for damages and injuries sustained by reason of unlawful restraints and monopolies; to the Committee on the Judiciary.

By Mr. RODINO (for himself and Mr. HUTCHINSON):

H.R. 39. A bill to amend the Antitrust Civil Process Act to increase the effectiveness of discovery in civil antitrust investigations, and for other purposes; to the Committee on the Judiciary.

By Mr. BINGHAM:

H.R. 40. A bill to prohibit the importation, manufacture, sale, purchase, transfer, receipt, possession, or transportation of handguns, except for or by members of the Armed Forces, law enforcement officials, and, as authorized by the Secretary of the Treasury, licensed importers, manufacturers, dealers, antique collectors, and pistol clubs; to the Committee on the Judiciary.

By Mr. THOMPSON (for himself, Mr. ANDERSON of Illinois, Mr. ANNUNZIO, Mr. ASHBROOK, Mr. BELL, Mrs. BOGGS, Mr. BRADEMAS, Mr. DIGGS, Mr. ECKHARDT, Mr. FULTON, Mr. JONES of Alabama, Mr. MILLER of Ohio, Mrs. MINK, Mr. NEDZI, Mr. PERKINS, Mr. QUIE, Mr. ROYBAL, Mr. UDALL, and Mr. WAMPLER):

H.R. 41. A bill to provide for the establishment of an American Folklife Center in the Library of Congress, and for other purposes; to the Committee on House Administration.

By Mr. ROSENTHAL (for himself, Ms. ABZUG, Mr. ADDABBO, Mr. BRODHEAD, Mr. BROWN of California, Mr. CARR, Ms. COLLINS of Illinois, Mr. CORMAN, Mr. DOMINICK V. DANIELS, Mr. DE LUGO, Mr. DOWNEY, Mr. DRINAN, Mr. ECKHARDT, Mr. EDWARDS of California, Mr. FASCELL, Mr. FISH, Mr. FRASER, Mr. GILMAN, and Mr. GUDE):

H.R. 42. A bill to amend the Federal Food, Drug, and Cosmetic Act and the Fair Packaging and Labeling Act and to otherwise require the labels on foods and food products to disclose all of their ingredients and any changes in their ingredients, their nutritional content, accurate weight data, storage information, their manufacturers, packers, and distributors, and their unit prices and to provide for uniform product grading and prohibit misleading brand names; to the Committee on Interstate and Foreign Commerce.

By Mr. HENDERSON:

H.R. 43. A bill to amend section 1006 of title 39, United States Code, relating to the eligibility of U.S. Postal Service employees for transfer to other positions in the executive branch, and for other purposes; to the Committee on Post Office and Civil Service.

By Mr. PRICE of Illinois:

H.R. 44. A bill to provide for disclosures designed to inform the Congress with respect to legislative measures, and for other purposes; to the Committee on Standards of Official Conduct.

By Mr. LUJAN:

H.R. 45. A bill relating to lands in the Middle Rio Grande Conservancy District, N. Mex.; to the Committee on Interior and Insular Affairs.

By Mr. DOMINICK V. DANIELS (for himself, Mr. ESCH, Mr. PEYSER, Mr. PERKINS, Mr. QUIE, Mr. GAYDOS, Mr. MEEDS, Mr. DENT, Mr. BADILLO, Mr. SARASIN, Mr. THOMPSON, Mr. HAWKINS, Mr. FORD of Michigan, Ms. MINK, Mr. CLAY, Mr. BIAGGI, Mr. LEHMAN, Mr. BENITEZ, Mr. RODINO, Mr. EILBERG, Mr. HELSTOSKI, Mr. MCKINNEY, Mr. METCALFE, Mr. ROSENTHAL, and Mr. NIX):

H.R. 46. A bill to provide for the development and implementation of programs for youth camp safety; to the Committee on Education and Labor.

By Mr. DOMINICK V. DANIELS (for himself, Mr. ESCH, Mr. PEYSER, Mrs. COLLINS of Illinois, Mr. SARBANES, Mr. JOHNSON of Pennsylvania, Mr. RIEGLE, Ms. ABZUG, Mr. DAVIS, Mr. REES, Mr. BROWN of California, Mr. ANDERSON of California, Mr. ADDABBO, Mr. OTTINGER, Mr. DE LUGO, Mr. HOWARD, Mr. TSONGAS, Mr. MILLER of California, Mr. SOLARZ, Mr. NOWAK, Mrs. MEYNER, Mr. FLORIO, Mr. COUGHLIN, Mr. LENT, and Mr. HALL):

H.R. 47. A bill to provide for the development and implementation of programs for youth camp safety; to the Committee on Education and Labor.

By Mr. MELCHER (for himself, Mr. ALEXANDER, Mr. ANDREWS of North Dakota, Mr. BALDUS, Mr. BAUCUS, Mr. BEDELL, Mr. BERGLAND, Mr. DUNCAN of Tennessee, Mr. HAWKINS, Mr. JONES of Tennessee, Mr. LITTON, Mr. NOLAN, Mr. OBEY, Mr. RODINO, Mr. SEBELIUS, Mr. THONE, and Mr. WEAVER):

H.R. 48. A bill to provide for the purchase of animals and animal food products for use in foreign and domestic food relief programs, and for other purposes; to the Committee on Agriculture.

By Mr. MELCHER:

H.R. 49. A bill to authorize the Secretary of the Interior to establish on certain public lands of the United States national petroleum reserves the development of which needs to be regulated in a manner consistent with the total energy needs of the Nation, and for other purposes; to the Committee on Interior and Insular Affairs.

By Mr. HAWKINS (for himself and Mr. REUSS):

H.R. 50. A bill to establish a national policy and nationwide machinery for guaranteeing to all adult Americans able and willing to work the availability of equal opportunities for useful and rewarding employment; to the Committee on Education and Labor.

By Mr. BENNETT:

H.R. 51. A bill to amend the Internal Revenue Code of 1954 to exclude from gross income certain amounts received by members of certain firefighting and rescue units; to the Committee on Ways and Means.

By Mr. BENNETT (for himself, Mr. BOB WILSON, Mr. STEIGER of Wisconsin, and Mr. MATSUNAGA):

H.R. 52. A bill to amend title 10, United States Code, to regulate the issuance of discharge certificates to members of the Armed Forces, and for other purposes; to the Committee on Armed Services.

By Mr. BENNETT:

H.R. 53. A bill to provide Federal grants to assist elementary and secondary schools to carry on programs to teach the principles of ethics and citizenship; to the Committee on Education and Labor.

By Mr. ZABLOCKI:

H.R. 54. A bill to establish a Joint Committee on National Security; to the Committee on Rules.

By Mr. CHARLES H. WILSON of California:

H.R. 55. A bill to amend title 39, United States Code, to eliminate certain restrictions

on the rights of officers and employees of the U.S. Postal Service, and for other purposes; to the Committee on Post Office and Civil Service.

H.R. 56. A bill to amend the Postal Reorganization Act of 1970, title 39, United States Code, to provide for uniformity in labor relations; to the Committee on Post Office and Civil Service.

H.R. 57. A bill to establish an arbitration board to settle disputes between supervisory organizations and the U.S. Postal Service; to the Committee on Post Office and Civil Service.

H.R. 58. A bill to amend title 10 of the United States Code in order to prohibit the exclusion, solely on the basis of sex, of women members of the armed forces from duty involving combat; to the Committee on Armed Services.

H.R. 59. A bill to prohibit discrimination by any party to a federally related mortgage transaction on the basis of sex or marital status, and to require all parties to any such transaction to submit appropriate reports thereon for public inspection; to the Committee on Banking, Currency and Housing.

By Mr. PERKINS (for himself and Mr. HALL):

H.R. 60. A bill to establish an Executive Department to be known as the Department of Education and for other purposes; to the Committee on Government Operations.

By Mr. EDWARDS of California:

H.R. 61. A bill to provide for the security, accuracy and confidentiality of criminal justice information and to protect the privacy of individuals to whom such information relates, and for other purposes; to the Committee on the Judiciary.

H.R. 62. A bill to protect the constitutional rights and privacy of individuals upon whom criminal justice information and criminal justice intelligence information have been collected and to control the collection and dissemination of criminal justice information and criminal justice intelligence information and for other purposes; to the Committee on the Judiciary.

H.R. 63. A bill to carry out the recommendations of the Presidential Task Force on Women's Rights and Responsibilities, and for other purposes; to the Committee on the Judiciary.

By Mr. ANDERSON of California:

H.R. 64. A bill to amend the Public Health Service Act to provide for the screening and counseling of Americans with respect to Tay-Sachs disease; to the Committee on Interstate and Foreign Commerce.

By Mr. CORMAN:

H.R. 65. A bill to limit the right of a State to reduce its supplementation of SSI benefits payable under title XVI of the Social Security Act as a consequence of Federal increases in such benefits (whether such increases are made under the cost-of-living adjustment provisions of such title or otherwise), and to prohibit reductions in Federal hold-harmless payments to States as a consequence of such increases; to the Committee on Ways and Means.

By Mr. ANDERSON of California:

H.R. 66. A bill to discourage the use of painful devices in the trapping of animals and birds; to the Committee on Merchant Marine and Fisheries.

H.R. 67. A bill to establish in the State of California the Madrona Marsh National Wildlife Refuge; to the Committee on Merchant Marine and Fisheries.

By Mr. BENNETT:

H.R. 68. A bill to provide for competitive bidding on Federal contracts and federally funded contracts; to the Committee on the Judiciary.

H.R. 69. A bill to amend the Internal Revenue Code of 1954 to provide that no individual shall pay an income tax of less than 10 percent of his net income which exceeds $30,000 for any taxable year; to the Committee on Ways and Means.

By Mr. DINGELL (for himself, and Mr. FORSYTHE, Mr. BREAUX, Mr. WHITEHURST, and Mr. MCCLOSKEY):

H.R. 70. A bill to establish a Federal Zoo Accreditation Board in order to insure that zoos and other animal display facilities maintain minimum standards of care for animal inventories, to provide technical and financial assistance to zoos, and for other purposes; to the Committee on Merchant Marine and Fisheries.

By Mr. ANNUNZIO (for himself, and Mr. BIAGGI, Mr. BINGHAM, Mr. BROWN of California, Mrs. CHISHOLM, Mr. COHEN, Mr. DOMINICK V. DANIELS, Mr. DENT, Mr. DERWINSKI, Mr. DINGELL, Mr. EILBERG, Mr. GAYDOS, Mr. GILMAN, Mr. HAWKINS, Mr. HELSTOSKI, Mr. KEMP, Mr. KLUCZYNSKI, Mr. MADDEN, Mr. METCALFE, Mr. MOAKLEY, Mr. MORGAN, Mr. MURPHY of Illinois, Mr. MURTHA, Mr. NEDZI, and Mr. O'BRIEN):

H.R. 71. A bill to amend title 38, United States Code, to provide hospital and medical care to certain members of the armed forces of nations allied or associated with the United States in World War I or World War II; to the Committee on Veterans' Affairs.

By Mr. ANNUNZIO (for himself, Mr. PRICE, Mr. ROE, Mr. ROSTENKOWSKI, Mr. SARBANES, Mr. JAMES V. STANTON, Mr. STRATTON, Mr. VANDER VEEN, Mr. WALSH, and Mr. ZABLOCKI):

H.R. 72. A bill to amend title 38, United States Code, to provide hospital and medical care to certain members of the armed forces of nations allied or associated with the United States in World War I or World War II; to the Committee on Veterans' Affairs.

By Mr. DOMINICK V. DANIELS:

H.R. 73. A bill to increase the contribution by the Federal Government to the costs of employees' group life and health benefits insurance; to the Committee on Post Office and Civil Service.

By Mr. DERWINSKI:

H.R. 74. A bill to authorize the Secretary of the Interior to establish national parks or national recreation areas in those States which presently do not have a national park or national recreation area; to the Committee on Interior and Insular Affairs.

By Mr. DINGELL:

H.R. 75. A bill to amend the National Environmental Policy Act of 1969 to fund and establish a nonprofit National Environmental Policy Institute, and for other purposes; to the Committee on Merchant Marine and Fisheries.

By Mr. FORD of Michigan (for himself, Mr. BRADEMAS, Mr. BROWN of California, Mr. CLAY, Mr. CONYERS, Mr. DENT, Mr. DIGGS, Mr. DINGELL, Mr. DRINAN, Mr. EDWARDS of California, Mr. FRASER, Mr. HARRINGTON, Mr. HECHLER of West Virginia, Mr. HELSTOSKI, Mr. MEEDS, Mrs. MINK, Mr. NEDZI, Mr. STARK, Mr. SEIBERLING, Mr. THOMPSON, Mr. TRAXLER, Mr. VANDER VEEN, and Mr. CHARLES H. WILSON of California.):

H.R. 76. A bill to amend the Fair Labor Standards Act of 1938, to require prenotification to affected employees and communities of dislocation of business concerns, to provide assistance (including retraining) to employees who suffer employment loss through the dislocation of business concerns, to business concerns threatened with dislocation, and to affected communities, to prevent Federal support for unjustified dislocation, and for other purposes; to the Committee on Education and Labor.

By Mr. THOMPSON:

H.R. 77. A bill to provide that employees of States and political subdivisions thereof shall be subject to the provisions of the National Labor Relations Act; to the Committee on Education and Labor.

By Mr. BENNETT:

H.J. Res. 2. Joint resolution proposing an amendment to the Constitution of the United States to prohibit compelling attendance in schools other than the one nearest the residence and to insure equal educational opportunities for all students wherever located; to the Committee on the Judiciary.

H.J. Res. 3. Joint resolution proposing an amendment to the Constitution to provide for the direct election of the President and the Vice President and to authorize Congress to establish procedures relating to the nomination of Presidential and Vice-Presidential candidates; to the Committee on the Judiciary.

H.J. Res. 4. Joint resolution to establish a Court of Ethics to hear complaints of unethical conduct in Government service; to the Committee on the Judiciary.

By Mr. BAFALIS (for himself and Mr. ABDNOR, Mr. ARMSTRONG, Mr. BURGENER, Mr. COLLINS of Texas, Mr. CONLAN, Mr. CRANE, Mr. DERWINSKI, Mr. HALEY, Mr. LOTT, Mr. LUJAN, Mr. MANN, Mr. MOORHEAD of California, Mr. ROUSSELOT, Mr. ROBINSON, Mr. SYMMS, Mr. TREEN, Mr. WALSH, and Mr. KETCHUM):

H.J. Res. 5. Joint resolution proposing an amendment to the Constitution of the United States to provide that appropriations made by the United States shall not exceed its revenues, except in time of war or national emergency; and to provide for the systematic paying back of the national debt; to the Committee on the Judiciary.

By Mr. FRENZEL:

H.J. Res. 6. Joint resolution proposing an amendment to the Constitution of the United States to provide an age limit and a single 6-year term for the President; to the Committee on the Judiciary.

By Mr. DE LA GARZA:

H.J. Res. 7. Joint resolution proposing an amendment to the Constitution of the United States to provide an age limit and a single 6-year term for the President; to the Committee on the Judiciary.

H.J. Res. 8. Joint resolution proposing an amendment to the Constitution of the United States with respect to the offering of prayer in public buildings; to the Committee on the Judiciary.

H.J. Res. 9. Joint resolution proposing an amendment to the Constitution of the United States to provide that appropriations shall not exceed revenues of the United States, except in time of war or national emergency; to the Committee on the Judiciary.

By Mr. HILLIS:

H.J. Res. 10. Joint resolution proposing an amendment to the Constitution of the United States with respect to the offering of prayer in public buildings; to the Committee on the Judiciary.

By Mr. RANDALL:

H.J. Res. 11. Joint resolution to amend title 5 of the United States Code to provide for the designation of the 11th day of November of each year as Veterans Day; to the Committee on Post Office and Civil Service.

By Mr. GUDE:

H.J. Res. 12. Joint resolution to amend the Constitution to provide for representation of the District of Columbia in the Congress; to the Committee on the Judiciary.

H.J. Res. 13. Joint resolution to require the Watergate Special Prosecution Force to make available to the public a report on all information it has concerning Richard M. Nixon in offenses against the United States; to the Committee on the Judiciary.

By Mr. HECHLER of West Virginia:

H.J. Res. 14. Joint resolution to prevent surface mining operations on public lands, and deep mining in national forests; to the Committee on Interior and Insular Affairs.

H.J. Res. 15. Joint resolution proposing an

amendment to the Constitution of the United States lowering the age requirements for membership in the Houses of Congress; to the Committee on the Judiciary.

By Mr. ROBINSON:

H.J. Res. 16. Joint resolution proposing an amendment to the Constitution relating to the continuance in office of judges of the Supreme Court and of inferior courts; to the Committee on the Judiciary.

By Mr. SHRIVER:

H.J. Res. 17. Joint resolution to create a select joint committee to conduct an investigation and study into methods of significantly simplifying Federal income tax return forms; to the Committee on Rules.

By Mr. SMITH of Iowa:

H.J. Res. 18. Joint resolution proposing an amendment to the Constitution of the United States relating to the nomination of individuals for election to the offices of the President and Vice President of the United States; to the Committee on the Judiciary.

By Mr. TREEN (for himself, Mr. COLLINS of Texas, and Mr. MOORE):

H.J. Res. 19. Joint resolution proposing an amendment to the Constitution of the United States to provide that appropriations made by the United States shall not exceed its revenues, except in time of war or national emergency; to the Committee on the Judiciary.

By Mr. YOUNG of Florida:

H.J. Res. 20. Joint resolution proposing an amendment to the Constitution of the United States; to the Committee on the Judiciary.

H.J. Res. 21. Joint resolution to amend title 5 of the United States Code to provide for the designation of the 11th day of November of each year as Veterans Day; to the Committee on Post Office and Civil Service.

By Mr. ULLMAN:

H.J. Res. 22. Joint resolution proposing an amendment to the Constitution of the United States regarding the election of the President and Vice President and the nomination of candidates for the Presidency; to the Committee on the Judiciary.

By Mr. ROUSSELOT (for himself, Mr. MCDONALD of Georgia, and Mr. SYMMS):

H.J. Res. 23. Joint resolution proposing amendment to the Constitution of the United States relative to abolishing personal income, estate, and gift taxes and prohibiting the U.S. Government from engaging in business in competition with its citizens; to the Committee on the Judiciary.

By Mr. WAGGONNER:

H.J. Res. 24. Joint resolution proposing an amendment to the Constitution of the United States relating to the busing or involuntary assignment of students; to the Committee on the Judiciary.

H.J. Res. 25. Joint resolution proposing an amendment to the Constitution of the United States with respect to participation in voluntary prayer or meditation in public buildings; to the Committee on the Judiciary.

H.J. Res. 26. Joint resolution proposing an amendment to the Constitution of the United States providing that no public school student shall, because of his race, creed, or color, be assigned to or required to attend a particular school; to the Committee on the Judiciary.

H.J. Res. 27. Joint resolution authorizing the President to proclaim the week beginning on the last Monday in September each year as Youth Appreciation Week; to the Committee on Post Office and Civil Service.

By Mr. YATES:

H.J. Res. 28. Joint resolution prescribing model regulations governing implementation of the provisions of the Social Security Act relating to the administration of social service programs; to the Committee on Ways and Means.

MEMORIALS

Under clause 4 of rule XXII, memorials were presented and referred as follows:

1. By the SPEAKER: Memorial of the Legislature of the Territory of Guam, relative to air service by Trans World Airlines to Guam; to the Committee on Public Works and Transportation.

2. Also, memorial of the Legislature of the Virgin Islands, relative to the application of the Internal Revenue Code in the Virgin Islands; to the Committee on Ways and Means.

PETITIONS, ETC.

Under clause 1 of rule XXII, petitions and papers were laid on the Clerk's desk and referred as follows:

1. By the SPEAKER: Petition of the city council of the city of Renton, Wash., relative to imposing price, wage and profit controls; to the Committee on Banking, Currency, and Housing.

2. Also, petition of Statewide Committees Opposing Regional Plan Areas, Powell Butte, Oreg., relative to the Advisory Commission on Intergovernmental Relations; to the Committee on Government Operations.

3. Also, petition of the Grand River Band of Ottawas Descendents Committee, Muskegon, Mich., relative to the plan for the use and distribution of judgment funds awarded in docket 40-K before the Indian Claims Commission; to the Committee on Interior and Insular Affairs.

4. Also, petition of the Swinomish Tribal Community, LaConner, Wash., relative to the plan for distribution of judgment funds awarded in docket No. 294 by the U.S. Court of Claims; to the Committee on Interior and Insular Affairs.

5. Also, petition of the New Mexico Philatelic Association, Albuquerque, N. Mex., relative to misleading advertising of philatelic supplies; to the Committee on Interstate and Foreign Commerce.

6. Also, petition of Gaymond E. Milligan, Houston, Tex., relative to redress of grievances; to the Committee on the Judiciary.

7. Also, petition of Clifford Barrister, New York, N.Y., relative to redress of grievances; to the Committee on the Judiciary.

8. Also, petition of the annual meeting of the Southern Division of the American Fisheries Society, White Sulphur Springs, W. Va., relative to the Anadromous Fish Conservation Act; to the Committee on Merchant Marine and Fisheries.

9. Also, petition of the Farmers Co-Operative Association, Alva, Okla., relative to Federal estate taxes; to the Committee on Ways and Means.

EXTENSIONS OF REMARKS

RX FOR CONSUMER PROTECTION

HON. BENJAMIN S. ROSENTHAL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 14, 1975

Mr. ROSENTHAL. Mr. Speaker, American consumers are forced to pay over $1 billion annually in unnecessary prescription costs because of prohibitions on retail drug price advertising, overprotective patent laws, exorbitant promotional expenditures by industry, and unreasonable markups.

These are among the findings of an 18-month study conducted by my staff in New York and in Washington.

Americans are spending some $7 billion annually on prescription drugs—about $33 for each man, woman, and child—and the evidence is strong that they are being overcharged, on the average, by at least 25 percent.

One reason for this, we found is a callous disregard for the financial plight of consumers, especially the elderly, on the part of drug manufacturers, retail pharmacists, and State pharmacy boards.

The report also documents the huge disparity in the prices for identical prescriptions at different pharmacies in the same community. We surveyed over 120 pharmacies in Queens and in the Washington, D.C., area to compare retail prescription prices under a variety of conditions. The survey revealed markups generally averaged in excess of 200 percent. Pricing was grossly inconsistent, even among stores of the same chain for the same prescription.

Price advertising of drugs, extensively used on the wholesale level, is banned on the retail level in about two-thirds of the States, including New York State. This double standard results in a wide disparity of prices for identical drugs, from store to store and, in some instances even from customer to customer at the same store. The drug retailer is able to benefit from manufacturers' vigorous price competition, but he denies that same right to the consumer.

To correct some of the glaring abuses uncovered by the study, I am introducing the following legislation:

The Prescription Drug Freshness Act, which requires the open dating of all perishable prescription drugs, showing clearly on the dispensed product's label the date beyond which the potency is diminished or the chemical composition altered by age;

The Prescription Drug Labeling Act, which requires the labeling and advertising of prescription drugs by their established—generic—name and an end to all laws prohibiting generic substitution by pharmacists;

The Prescription Drug Price Information Act, which would end all State prohibitions on retail prescription drug price advertising and require the posting of prices for the 100 most commonly prescribed drugs; and

The Prescription Drug Patent Licensing Act, which would make compulsory the licensing of new prescription drugs during the 17-year patent period.

Joining me in sponsoring these bills today are:

LIST OF COSPONSORS

Bella Abzug, Joseph P. Addabbo, George E. Brown, Jr., Cardiss Collins, James Corman, Dominick V. Daniels, Ron de Lugo, Thomas Downey, Robert Drinan, Bob Eckhardt.

Don Edwards, Dante B. Fascell, Benjamin Gilman, Ken Hechler, Robert Kastenmeier,