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at a time when it was practicable for all manufacturers to achieve full compliance. Phase-in authority, however, would permit the Department to phase-in the standard over a several-year period. This approach would assure some improvement in motor vehicle safety at the earliest possible moment. Of course, the percentage of production selected would be applicable to all manufacturers.

In conclusion, we believe, as a general matter, that the gradual phase-in of an increasing percentage of a manufacturer's production to the requirements of a standard requiring major design changes would be beneficial to both manufacturers and the public. It would minimize a manufacturer's cost by permitting him to make the necessary changes in accordance with his normal model changeover, and the public would be afforded added vehicle safety earlier than otherwise possible.

The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the submission of this proposed legislation to the Congress.

Sincerely,

CLAUDE S. BRINEGAR.

By Mr. EAGLETON:

S. 2969. A bill to require a reduction in motor vehicle insurance premiums in the District of Columbia, and for other purposes. Referred to the Committee on the District of Columbia.

Mr. EAGLETON. Mr. President, over the years, as the accident rate increased for residents of the District of Columbia so did the cost of auto insurance. To do so was only fair. By the same token, as accident rates decrease for residents of the District, so also should the cost of auto insurance. That, too, is only fair.

Today I am introducing the "fair auto insurance rates bill" for the District of Columbia. This legislation would call for an across-the-board reduction in automobile insurance rates of 10 percent. The effective date of this reduction would be retroactive to January 1, 1974, with a refund of any money paid in excess of this amount.

After the initial reduction, the Mayor of the District of Columbia is directed to conduct a detailed study of the rates of motor vehicle accidents, fatalities, injuries, property damage, and claim payments made by motor vehicle insurers. This study would be carried out at least every 60 days until no appreciable change occurs for 120 days.

The Mayor will also possess the authority to adjust premium rates for motor vehicle insurance in order to keep them abreast of changes that might occur in automobile accident rates in the District.

Mr. President, since November 1973, I have supported the reduction of auto insurance rates to stay abreast of drops in accident rates that might occur due to gas conservation efforts. During that time the auto insurance industry, on the whole, has not moved expeditiously toward establishing fair premium rates.

When gas conservation first began, I wrote letters to the three major auto insurance associations asking them to agree to lower the cost of auto insurance if accident rates dropped. The one association that responded said—

We all hope that reduced speeds will result in the saving of lives, but evidently you are ill informed or ill advised if you conclude that this results in substantial reductions of the damages that go into the development of auto insurance rates.

The next auto insurance industry response to the issue came in the form of a detailed study by the insurance institute for highway safety. Some of the arguments presented in this study were a disappointment to those of us who hoped that the insurance industry would react reasonably.

For example, the study said:

(1) "It should be noted that decreased travel speeds result in increased travel times and increased 'time exposure' to fixed environmental hazards along the way. This increased time exposure will increase traffic density."

(2) On car pooling: "Increased occupancy rates would mean that the chances of injury in a given crash are increased."

(3) On the drop in fatality rates: "People often change their behavior or claimed behavior in the desired direction as a result of being studied rather than as a result of the changed conditions. Therefore, caution is necessary before interpreting any early changes in losses."

The statements do not respond to the facts of decreases in accident and injury rates; they reflect only the industry's bias against reduced premium rates, whatever the facts may show.

The auto accident data compiled since gas conservation efforts began indicates that the few concessions some companies have begun to make—such things as reduced rates to car poolers or promised future distributions of windfall profits—simply do not meet the goal of equitably apportioning the savings resulting from the gasoline shortage.

Across the country State insurance commissioners are holding factfinding hearings about gas conservation and auto insurance rates. They are calling on insurance companies to pass along any windfall profits to the insured and some are requiring companies to reduce their rates. I hope that consideration of my bill by Congress will help to spark discussion of this issue on a national level—though it directly affects only the District of Columbia.

On February 22 and 25, the Senate District of Columbia Committee will hold hearings on the bill I am introducing today. These hearings will include testimony of experts from all across the country. We hope to obtain a clear understanding of how the American public is altering its driving habits due to the energy crisis. We also hope to learn how these alterations have affected automobile insurance rates.

The American people have taken the brunt of the negatives resulting from the energy crisis. They have had to pay more for their gasoline, when they can get it. They have had to live in cooler homes. They have had to limit or eliminate their weekend driving trips.

The people should reap the benefits occurring from these sacrifices in the form of reduced automobile insurance rates. It is incumbent on us in the U.S. Con-

gress to be sure that they receive this benefit as soon as possible and to the maximum extent practicable.

By Mr. PACKWOOD:

S. 2970. A bill to amend the Social Security Act to provide adequate financing of health care benefits for all Americans. Referred to the Committee on Finance.

COMPREHENSIVE HEALTH INSURANCE ACT

Mr. PACKWOOD. Mr. President, today I have the honor of introducing the Comprehensive Health Insurance Act, a far-reaching proposal developed by the administration to insure that all Americans have access to health insurance coverage at affordable prices.

All Americans consider good health care at reasonable prices to be among the basic necessities of life, but for too many of our citizens, this has been an unrealized necessity. Many have no access to the health care delivery system. Many more, especially the low-income and those considered "high risk," have no access to health insurance coverage. And in this time of rising costs, I dare say no American has not at some time or another shuddered at the possibility of an unexpected serious illness or accident, and the financial disaster which too often results.

Mr. President, as we approach our Bicentennial anniversary, I believe it particularly appropriate that we begin active consideration of this landmark legislation, which if enacted, will guarantee access to health care financing for all Americans. As the President pointed out in his health message, barriers to good health care are barriers to equal opportunity, and in my judgment, this Nation cannot afford to allow either to continue.

From time to time, as we take up this vital legislation, I will be discussing various aspects of the Comprehensive Health Insurance Act, and would also welcome any and all questions and comments on the details of the bill, which of course are not fixed in stone.

At this point, I ask unanimous consent that the Comprehensive Health Insurance Act, the President's landmark health message, and a fact sheet on the bill be printed in the Record following my remarks.

There being no objection, the bill and material were ordered to be printed in the Record, as follows:

S. 2970

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 "Comprehensive Health Insurance Act of 1974."

TITLE I—NATIONAL HEALTH CARE BENEFITS PROGRAM

SEC. 101. The Social Security Act is amended by striking out title XVIII and inserting in lieu thereof the following new title XVIII:

"TITLE XVIII—HEALTH CARE BENEFITS

"FINDINGS AND DECLARATION OF PURPOSE

"Sec. 1800. (a) The Congress hereby finds that—

"(1) many Americans are not now re-

ceiving adequate health care because of inability to pay the cost of such care;

"(2) the lack of adequate protection against the cost of health care prevents or seriously interferes with the ability of many Americans to secure necessary health care for themselves and their families or requires them to deplete their resources substantially or completely in order to secure such care;

"(3) as a result, the national health is seriously and adversely affected and this in turn seriously affects the general welfare;

"(4) to protect the national health and, consequently, the general welfare, it is necessary to assure that adequate protection against the cost of necessary health care is provided by requiring employers to provide health care plans for their employees and assisting the States to provide health care plans for persons to whom employee health care plans are not available; and

"(5) to require this only of employers engaged in interstate commerce would impose an unreasonable burden on such commerce.

"(b) It is therefore the purpose of this title to provide adequate protection against these costs by requiring all employers to offer health care plans to their employees; and to assist the States in making similar plans available to individuals in need of such protection.

"PART A—EMPLOYEE HEALTH CARE BENEFITS "HEALTH CARE PLANS REQUIRED

"Sec. 1801. (a) Every employer shall provide to each of his employees under the age of 65 whose place of employment is in a State certified by the Secretary under section 1861, and who was employed by him for not less than—

"(A) 25 hours per week for ten weeks, or
"(B) 350 hours,

in the preceding thirteen consecutive calendar weeks, a reasonable opportunity, as determined under regulations prescribed by the Secretary, to obtain coverage for himself and the members of his family under the age 65 under, at the option of the employee—

"(1) an employee health care insurance plan approved under this title or an assisted health care insurance plan obtained by the employer pursuant to part B,

"(2) a group practice prepaid health care plan approved under this title, or

"(3) an individual practice prepaid health care plan approved under this title, except that the Secretary may by regulation specify circumstances in which an employer need not offer an employee an opportunity to obtain coverage under a group practice or individual practice prepaid health care plan because such a plan is not available. The employer must offer the same health care plans to all employees in the same locality, as determined under regulations prescribed by the Secretary, except for such exceptions as the Secretary may, by regulation, provide. For purposes of the first sentence of this subsection, there shall be counted only those hours of service performed within the United States or service performed outside the United States by an American citizen for an American employer.

"(b) An employer who has an employee to whom he is required to provide the opportunity to obtain coverage under a health care plan under subsection (a) shall provide the same opportunity to each of his employees employed at the same place of employment who is not otherwise entitled to that opportunity because of the hours of work requirement imposed under subsection (a) and was employed by him for not less than 25 hours in the preceding calendar week.

"(c) Any bargaining agent recognized as an exclusive bargaining agent under the laws of the United States or any State, may exercise, on behalf of the employees for

whom it is recognized as the exclusive bargaining agent, the options which must be offered to employees under this section, including the option to decline coverage under any health care plan approved under this title or provided pursuant to part B.

"EMPLOYER CONTRIBUTIONS

"Sec. 1802. (a) An employer required by section 1801(a) to provide an employee the opportunity to obtain coverage for himself and the members of his family under the age of 65 under a health care insurance plan shall, if the employee obtains such coverage, contribute to the cost of that coverage, during the period that the employer is required by section 1801(a) to provide the opportunity to obtain coverage under the plan, and for 90 days after the employer is no longer required by section 1801(a) to provide that opportunity, an amount equal to at least 75 percent of the cost of that coverage, as determined under regulations prescribed by the Secretary. An employer must pay the contributions required by this section, in the case of a plan provided by a carrier, directly to the carrier or an employee health and welfare fund.

"(b) An employer required by section 1801(a) to provide an employee the opportunity to obtain coverage for himself and the members of his family under the age of 65 under a prepaid health care plan shall, if the employee obtains that coverage, contribute to the cost of that coverage, during the period that the employer is required by section 1801(a) to provide the opportunity to obtain coverage under the plan and for 90 days after the employer is no longer required by section 1801(a) to provide that opportunity, an amount equal to the amount he would be required to contribute under subsection (a) to coverage under a health care insurance plan.

"INFORMATION FOR EMPLOYEES

"Sec. 1803. An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall advise the employee of the plans and arrangements for the financing or provision of health care offered by the employer, the benefits they provide, their cost, and the means by which coverage under any of them can be secured. The employer shall also provide the employee with information concerning the availability of health care benefits pursuant to part B.

"UNAPPROVED PLANS PROHIBITED

"Sec. 1804. An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall neither provide that employee with an opportunity to secure, nor contribute toward the cost of, coverage under any plan or arrangement for the financing or provision of health care other than a health care insurance plan approved under this title or obtained pursuant to part B or a prepaid health care plan approved under this title, except that—

"(1) the employer may offer the employee the opportunity to obtain coverage under a special employee health care program approved under this title, and

"(2) the employer may offer the employee the opportunity to obtain coverage under a plan or arrangement for the financing or provision of health care not approved under this title or obtained under part B if acceptance of coverage under the plan or arrangement is not a condition of obtaining coverage under any health care plan offered by the employer pursuant to section 1801 and the employee has obtained coverage under such a health care plan.

"DISCRIMINATION ON THE BASIS OF HEALTH STATUS PROHIBITED

"Sec. 1805. (a) No employer may discriminate against an individual with respect

to the opportunity for employment, or the compensation, terms, condition, or privileges of employment, because of the individual's health status or the health status of his dependents, except when directly related to the capacity of the individual to perform his duties as an employee.

"(b) An employer required by section 1801 to provide an employee with an opportunity to obtain coverage under a health care plan shall not offer the employee a financial inducement to, or condition the employee's employment on, rejection of coverage under the plan.

"EXCLUDED EMPLOYERS

"Sec. 1806. The provisions of this section shall not apply to the United States Government, the government of the District of Columbia, a foreign government, or an international organization described in section 210(a)(15), or any agency or instrumentality of such a government organization.

"PART B—GRANTS TO STATES FOR HEALTH CARE BENEFITS PROGRAMS

"APPROPRIATION

"Sec. 1821. For the purpose of assisting each State to provide adequate health care benefits to individuals who are otherwise unable to obtain such benefits, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for provision of health care benefits.

"STATE PLANS FOR PROVISION OF HEALTH CARE BENEFITS

"Sec. 1822. (a) A State plan for the provision of health care benefits must—

"(1) provide that—

"(A) the members of any family residing in the State who are not entitled to federal health care benefits under part C of this title, are not covered under a health care plan pursuant to part A of this title, and have an aggregate annual income of less than—

"(I) 52.5% of the income class base, as determined under section 1825(b)(5), in the case of a one member family group, or

"(II) 75% of that income class base, in the case of a more than one member family group; and

"(B) the members of any family residing in the State who are not entitled to health care benefits under part C of this title and are not eligible for coverage under a health care plan pursuant to part A; shall be eligible for health care benefits under the plan;

"(2) provide that any employer subject to the requirements of part A of this title shall be eligible to obtain health care benefits under the plan for the purpose of providing such benefits, pursuant to the requirements of part A, to his employees whose place of employment is within the State.

"(3) provide that the benefits under the plan for any family group described in clause (1) shall be the opportunity for the family group—

"(A) to obtain coverage under an assisted health care insurance plan, or

"(B) at the option of the family group, to have the State pay to any prepaid health care plan approved under this title under which the family group has obtained coverage at a rate which the State determines is reasonable, on behalf of the family group, an amount equal to the cost to the State of providing coverage under an assisted health care insurance plan, as determined under regulations prescribed by the Secretary;

"(4) provide that the benefits provided

to an employer described in clause (2) shall be—

"(A) the opportunity for each employee of the employer whose place of employment is within the State, and to whom the employer is required by part A to offer the opportunity to obtain coverage under a health care insurance plan, to obtain coverage for himself and the members of his family under the age of 65 under an assisted health care insurance plan, and

"(B) in the case of any such employee who elects instead to obtain coverage under a prepaid health care plan made available by the employer pursuant to part A of this title at a rate which the State determines is reasonable, to have the State pay to such plan, on behalf of the employer and employee, an amount equal to the cost to the State of providing coverage under an assisted health care insurance plan, as determined under regulations prescribed by the Secretary;

"(5) provide that the eligibility of family groups for benefits under the plan, the premium, deductible, coinsurance, and related requirements applicable to eligible family groups, and the eligibility of employers to obtain benefits under the plan shall be determined by the public agency designated by the Secretary;

"(6) provide that the opportunity to obtain coverage under an assisted health care insurance plan shall be provided (A) through arrangements with one or more carriers pursuant to which—

"(I) the carrier will offer coverage under the plan to all eligible family groups and offer to provide the plan to all eligible employers, and

"(II) the State will pay the carrier an amount equal to payments made by the carrier under the plan and the cost of necessary and proper administration, less any premium, deductible and coinsurance payments and other amounts received by the carrier in connection with administration of the plan, as determined under regulations prescribed by the Secretary, or, (B) directly by the State if the Secretary so authorizes;

"(7) provide that any premium, deductible or coinsurance payment or other amounts owed to the State or paid by the State pursuant to an arrangement with a carrier shall be a debt owed to the State, and that the State shall make reasonable efforts to collect such debts;

"(8) provide that if any member of a family group described in clause (1) (A) which is receiving health care benefits under the plan is an employee to whom an employer is required by section 1801 to offer the opportunity to obtain coverage under a health care insurance plan, the employer shall be required to pay the State the amount the employer would be required to contribute if the employee obtained coverage under the health care insurance plan offered by the employer;

"(9) provide that the State will, in the third quarter of each calendar year, determine, in accordance with regulations prescribed by the Secretary, the estimated average premium for coverage for the succeeding calendar year, in the State, under an employee health care insurance plan approved under this title, of an employee with one or more family members under the age of 65;

"(10) provide that the State will comply with such requirements as the Secretary may, by regulation, impose for the purpose of assuring cooperation among the States in the administration of State plans approved under this part;

"(11) provide that the State will not impose any premium tax on any premiums for health care plan coverage obtained under the State plan;

"(12) provide that the State will comply,

and will require any carrier participating in the administration of the State plan to comply, with such requirements as the Secretary may, by regulation, prescribe for the purpose of controlling access to information of the State plan;

"(13) provide that the State will make such reports, in such form and containing such information, as the Secretary may require, and comply with such provisions as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(14) contain such other provisions as the Secretary may determine are necessary to carry out the purposes of this part.

"(b) The Secretary shall approve any plan submitted by a State certified by the Secretary under section 1861 which fulfills the requirements specified in subsection (a).

"(c) The Secretary shall, by regulation, prescribe the criteria and standards for determining the State of residence of family groups for purposes of this part, which regulations shall provide that each family group residing in the United States shall have a State of residence.

"PAYMENT TO STATES

"Sec. 1823. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 1976, an amount equal to the net expenditures under the State plan during that quarter, less

"(A) the State contribution for that quarter, and

"(B) an amount which bears the same ratio to the payments made during that quarter under part C with respect to individuals described in section 1831(a) in income classes I, II, and III who reside in the State which would not have been made if those individuals were in income class IV, as the State contribution for that quarter bears to the net expenditures under the State plan during that quarter.

"(b) (1) For purposes of subsection (a), the net expenditures under a State plan during any quarter shall be the total amount expended during that quarter under the State plan, including amounts found necessary by the Secretary for proper and efficient administration of the plan, less the total of the debt payments, employer payments, and other amounts received by the State during that quarter in connection with administration of the plan.

"(2) For purposes of subsection (a), the State contribution for any quarter in the first calendar year in which there is in effect in the State a plan approved under this part shall be—

"(A) one-fourth of the total non-federal expenditures, other than expenditures related to the provisions of skilled nursing home facility services, home health services, intermediate care facility services, inpatient hospital services in institutions for mental diseases and psychiatric hospitals, and dental services, under the plan of the State approved under title XIX for fiscal year 1975; plus

"(B) ten percent of the product of—

"(I) the per capita income of the State divided by the per capita income of the United States; and

"(II) the net expenditures under the State plan during that quarter (as determined under paragraph (1)), less one-fourth of the total federal and nonfederal expenditures, other than expenditures related to the provision of skilled nursing home facility services, home health services, intermediate care facility services, inpatient hospital services in institutions for mental diseases and psychiatric hospitals, and dental services, under the plan of the State approved under title XIX for fiscal year 1975.

"(3) For purposes of subsection (a), the State contribution for any quarter in a calendar year beginning after the first calendar year in which there is in effect in the State a plan approved under this part shall be—

"(A) one-fourth of the State contribution under the plan of the State approved under this part for the first calendar year in which there is in effect in the State a plan approved under this part; plus

"(B) twenty-five percent of the product of—

"(I) the per capita income of the State divided by the per capita income of the United States; and

"(II) the net expenditures under the State plan during that quarter (as determined under paragraph (1)), less one-fourth of the net expenditures under the State plan during the first calendar year in which there is in effect in the State a plan approved under this part.

"OPERATION OF STATE PLANS

"Sec. 1824. If the Secretary, after reasonable notice and an opportunity for hearing to a State which has a plan approved under this part, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1822; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"REQUIREMENTS FOR ASSISTED HEALTH CARE INSURANCE PLANS

"Sec. 1825. (a) An assisted health care insurance plan must meet all of the requirements for approval of an employee health care insurance plan contained in section 1841, other than the requirements contained in subsections (c), (d), (e), (f), (g) (6), (g) (7), (g) (8), and (h) thereof.

"(b) (1) An assisted health care insurance plan must charge as a premium for each calendar year an amount equal to the following percentages of the estimated average premium for coverage for such year, in the State, under an employee health care insurance plan approved under this title, of an employee and the members of his family under the age of 65—

"(A) in the case of family groups described in section 1822(a) (1) in income class III, 20% for one member groups, and 50% for more than one member groups;

"(B) in the case of family groups described in section 1822(a) (1) in income class IV, 40% for one member groups, and 100% for more than one member groups;

"(C) in the case of family groups described in section 1822(a) (1) in income class V, 60% for one member groups, and 150% for more than one member groups; and

"(D) in the case of employees of employers described in section 1822(a) (2), 60% for employees without any family members under the age of 65, and 150% for employees with one or more family members under the age of 65.

No premium shall be charged in the case of family groups described in section 1822(a) (1) in income classes I and II.

"(2) (A) An assisted health care insurance plan must, subject to paragraph (4), impose, with respect to all items and services other than outpatient drugs and biologicals, and other blood and blood products, a per in-

dividual per calendar year deductible equal to the following percentages of the deductible base—

"(I) in the case of family groups described in section 1822(a)(1) in income class II, 33 1/3 %;

"(II) in the case of family groups described in section 1822(a)(1) in income class III, 66 2/3 %; and

"(III) in the case of family groups described in section 1822(a)(1) in income classes IV and V, and employees of employers described in section 1822(a)(2), 100 %; except that no further deductible shall be imposed under this paragraph in any calendar year after three members of a covered family group or employee and his family satisfy the deductible requirement for that year. No such deductible shall be imposed in the case of family groups described in section 1822(a)(1) in income class I.

"(B) The plan must, subject to paragraph (4), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual per calendar year deductible equal to the following percentages of the deductible base—

"(I) in the case of family groups described in section 1822(a)(1) in income class II, 16 2/3 %; and

"(II) in the case of family groups described in section 1822(a)(1) in income classes III, IV, and V, and employees of the employers described in section 1822(a)(2), 33 1/3 %.

No such deductible shall be imposed in the case of family groups described in section 1822(a)(1) in income class I.

"(C) The plan must impose, with respect to blood and blood products, such deductible as the Secretary may, by regulation, prescribe.

"(D) The deductible base shall be \$150 for calendar year 1976 and 1977, and the amount determined under subparagraph (E) for years after 1977.

"(E) The Secretary shall, during November of 1977 and of each year thereafter, determine and promulgate the per individual deductible to be applied under this paragraph for the following calendar year. The deductible shall be computed by increasing or decreasing \$150 by the same percentage (rounded to the nearest one-tenth of one percent) by which the actuarial value of an employee health care insurance plan approved under this title for the year in which the determination is made exceeds or is less than such actuarial value for calendar year 1976. If the deductible derived from such computation is not a multiple of \$6, it shall be reduced to the next lower multiple of \$6.

"(3) An assisted health care insurance plan must impose, subject to paragraph (4), a coinsurance requirement equal to—

"(A) in the case of family groups described in section 1822(a)(1) in income class I, 10 per centum;

"(B) in the case of family groups described in section 1822(a)(1) in income class II, 15 per centum;

"(C) in the case of family groups described in section 1822(a)(1) in income class III, 20 per centum; and

"(D) in the case of family groups described in section 1822(a)(1) in income classes IV and V, and employees of employers described in section 1822(a)(2), 25 per centum; of expenses in excess of any applicable deductible.

"(4) An assisted health care insurance plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals the following percentages of annual income—

"(A) in the case of family groups described in section 1822(a)(1) in income class I, 6 per centum;

"(B) in the case of family groups described

in section 1822(a)(1) in income class II, 9 per centum;

"(C) in the case of family groups described in section 1822(a)(1) in income class III, 12 per centum; and

"(D) in the case of family groups described in section 1822(a)(1) in income class IV, 15 per centum.

In the case of family groups described in section 1822(a)(1) in income class V, and employees of employers described in section 1822(a)(2), the plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals 10.5 per centum, in the case of one member family groups and employees without any family members under the age of 65, or 15 per centum, in the case of more than one member family groups and employees with one or more family members under the age of 65, of the income class base for that calendar year, as determined under paragraph (5). The plan must provide that any deductible or coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to this part or part C will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan have been met.

"(5)(A) The income class of a family group described in section 1822(a)(1) for any calendar year must be determined on the basis of the family group's income for that year.

"(B) In the case of one member family groups, the income limits of the classes must be—

"(I) for income class I, less than 17.5 per centum of the income class base;

"(II) for income class II, at least 17.5 per centum of the income class base, but less than 35 per centum of that base;

"(III) for income class III, at least 35 per centum of the income class base, but less than 52.5 per centum of that base;

"(IV) for income class IV, at least 52.5 per centum of the income class base, but less than 70 per centum of that base; and

"(V) for income class V, at least 70 per centum of the income class base.

"(C) In the case of more than one member family groups, the income limits of the classes must be—

"(I) for income class I, less than 25 per centum of the income class base;

"(II) for income class II, at least 25 per centum of the income class base, but less than 50 per centum of that base;

"(III) for income class III, at least 50 per centum of the income class base, but less than 75 per centum of that base;

"(IV) for income class IV, at least 75 per centum of the income class base but less than 100 per centum of that base; and

"(V) for income class V, at least 100 per centum of the income class base.

"(D) The income class base shall be \$10,000 for calendar years 1976 and 1977, and the amount determined under subparagraph (E) for years after 1977.

"(E) The Secretary shall, during November of 1977 and of each year thereafter, determine and promulgate the income class base to be applied under this paragraph for the following calendar year. The base shall be computed by increasing or decreasing \$10,000 by the same per centum (rounded to the nearest one-tenth of one per centum) by which the average of the taxable wages of all employees as reported to the Secretary under title II for the first quarter of the calendar year in which the determination is made exceeds or is less than such average for the first quarter of calendar year 1976. If the base derived from such computation is not a multiple of \$100, it shall be reduced to the next lower multiple of \$100.

"(c) An assisted health care insurance plan must provide that coverage under the plan will continue to be available to a covered employee of an employer described in section 1822(a)(2), and the members of his family under the age of 65, to whom the plan is offered pursuant to section 1801(a) for 180 days after the employer is no longer required by section 1801(a) to offer the plan to the employee, at the same premium rate at which coverage under the plan is available to employees of the employer.

"(d) An assisted health care insurance plan must provide—

"(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

"(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full and associate participating providers for all items and services without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those limitations and deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that 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.

"PART C—FEDERAL HEALTH CARE BENEFITS

"ELIGIBILITY FOR AND NATURE OF BENEFITS

"Sec. 1831. (a)(1) The Secretary shall establish a Federal health care benefits program under which an individual residing in a State certified by the Secretary under section 1861 who—

"(A) has attained the age of 65, and

"(B) is entitled to monthly insurance benefits under section 202, or would be entitled, upon application, to such benefits if all employment subject to the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 were covered employment for the purpose of determining entitlement to such benefits, or is a qualified railroad retirement beneficiary, shall be entitled to Federal health care benefits under part C of title XVIII.

"(2) For purposes of paragraph (1)—

"(A) an individual shall be deemed entitled to monthly insurance benefits under section 202, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month, and

"(B) the term 'qualified railroad retirement beneficiary' means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is

certified by the Railroad Retirement Board on the month in which he ceased to meet the requirements of section 21 of the Railroad Retirement Act of 1937.

"(b) The benefits provided under the program shall be the opportunity, at the option of the individual—

"(1) to obtain coverage under the Federal health care insurance plan, or

"(2) to have the Secretary pay to any prepaid health care plan approved under this title under which the individual has obtained coverage at a rate which the Secretary determines is reasonable, on behalf of the individual, an amount equal to the cost to the Government of providing coverage under a Federal health care insurance plan, as determined under regulations prescribed by the Secretary.

"FEDERAL HEALTH CARE INSURANCE PLAN

"Sec. 1832. (a) The Federal health care insurance plan shall be an insurance plan which meets all the requirements for approval of an employee health care insurance plan contained in section 1841, other than the requirements contained in subsections (c), (d), (e), (f), (g)(6), (g)(7), (g)(8), (g)(9), and (h) thereof.

"(b)(1) The Federal health care insurance plan shall charge as a premium for each calendar year an amount equal to 15% of the amount which the Secretary determines is the estimated average cost of coverage for that year under the plan of an individual in income class IV, except that no premium shall be charged in the case of individuals in income classes I and II. Premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulation provide. All premium payments shall be deposited in the Treasury to the credit of the Federal Health Care Benefits Trust Fund.

"(2) (A) The Federal health care insurance plan shall, subject to paragraph (4), impose with respect to all items and services other than outpatient drugs and biologicals, and other blood and blood products, a per individual per calendar year deductible equal to the following percentages of the deductible base, as determined under section 1825 (b)(2)—

"(I) in the case of individuals in income class II, 33½ per centum; and

"(II) in the case of individuals in income classes III, IV, and V, 66½ per centum.

No such deductible shall be imposed in the case of individuals in income class I.

"(B) The plan shall, subject to paragraph (4), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual per calendar year deductible equal to the following percentages of the deductible base, as determined under section 1825(b)(2)—

"(I) in the case of individuals in income class II, 16½ per centum; and

"(II) in the case of individuals in income classes III, IV, and V, 33½ per centum.

No such deductible shall be imposed in the case of individuals in income class I.

"(C) The plan shall impose, with respect to blood and blood products, such deductible as the Secretary may, by regulation, prescribe.

"(3) The Federal health care plan must impose, subject to paragraph (4), a coinsurance requirement equal to—

"(A) in the case of individuals in income class I, 10 per centum;

"(B) in the case of individuals in income class II, 15 per centum;

"(C) in the case of individuals in income classes III, IV, and V, 20 per centum;

of expenses in excess of any applicable deductible.

"(4) The Federal health care insurance plan shall provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the

deductible and coinsurance amounts imposed under the plan equals the following percentages of annual income—

"(A) in the case of individuals in income class I, 6 per centum;

"(B) in the case of individuals in income class II, 9 per centum;

"(C) in the case of individuals in income class III, 12 per centum.

In the case of individuals in income classes IV and V, the plan shall provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductible and coinsurance amounts imposed under the plan equals 7.5 per centum of the income class base for that calendar year, as determined under section 1825(b)(5). The plan shall provide that any deductible for coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to part B will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan have been met.

"(5) The income class of an individual shall be determined on the basis of the same standards as those prescribed in section 1825 (b)(5) for the determination of the income class of a family group described in section 1822(a)(1), with an individual being considered, for that purpose, a one member family group.

"(c) The Federal health care insurance plan shall provide—

"(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

"(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full and associate participating providers for all items and services without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those limitations and deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that 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.

"USE OF CARRIERS IN ADMINISTRATION OF FEDERAL HEALTH CARE INSURANCE PLAN BENEFITS

"Sec. 1833. (a) The Secretary is authorized to enter into contracts with carriers for the administration of benefits under the Federal health care insurance plan. Each such contract shall contain such terms and conditions not inconsistent with this part as the Secretary may find necessary or appropriate.

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

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

"(3) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with efficient and effective administration of the program established by this part.

"(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under the federal health care insurance plan, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

"(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer described in paragraph (1) of this subsection.

"SOURCE OF PAYMENTS TO PROVIDERS OF SERVICES AND PREPAID HEALTH CARE PLANS

"Sec. 1834. The Secretary shall pay the amounts which he determines should be paid under this part to providers of items and services and prepaid health care plans, prior to audit or settlement by the General Accounting Office, from the Federal Health Care Benefits Trust Fund.

"FEDERAL HEALTH CARE BENEFITS TRUST FUND

"Sec. 1835. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Health Care Benefits Trust Fund' (hereinafter in this section referred to as the 'trust fund'). The trust fund shall consist of such gifts and bequests as may be made as provided in section 201(1)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the trust fund for the fiscal year ending June 30, 1976, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) the taxes imposed by section 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages from employment in States certified by the Secretary under section 1861 reported to the Secretary of the Treasury or his delegate pursuant to Subtitle F of such code after December 31, 1975, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to wages, which wages shall be certified by the Secretary of

Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income earned in States certified by the Secretary under section 1881 reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code after December 31, 1975, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

"(1) hold the Trust Fund;

"(2) report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years;

"(3) report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such

obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

"(f) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

"AUTHORIZATION OF APPROPRIATIONS TO THE TRUST FUND

"Sec. 1836. There is authorized to be appropriated to the Federal Health Care Benefits Trust Fund from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

"(1) payments made or to be made during the fiscal year from the Trust Fund with respect to individuals described in section 1831(a) in income classes I, II, and III which would not have been made or would not be made if those individuals were in income class IV,

"(2) the additional administrative expenses resulting or expected to result from the making of those payments, and

"(3) any loss in interest to the Trust Fund resulting from the making of those payments, in order to place the Trust Fund, at the end of the fiscal year, in the same position in which it would have been if those payments had not been made.

"PART D—REQUIREMENTS FOR APPROVAL OF HEALTH CARE PLANS AND SPECIAL EMPLOYEE HEALTH CARE PROGRAMS AND FOR CERTIFICATION OF PROVIDERS

"REQUIREMENTS FOR APPROVAL OF EMPLOYEE HEALTH CARE INSURANCE PLANS

"Covered Services

"Sec. 1841. (a) (1) To be approved under this title, an employee health care insurance plan must provide, subject to the succeeding provisions of this section, for pay-

ment for the following items and services, for each covered individual—

"(A) inpatient hospital services;

"(B) physicians' services;

"(C) medical and other health services;

"(D) home health services;

"(E) post-hospital extended care services;

"(F) outpatient drugs and biologicals;

"(G) routine dental services for individuals under the age of 13;

"(H) developmental vision care services, as defined in regulations prescribed by the Secretary, routine eye and vision examinations, and eyeglasses, for individuals under the age of 13; and

"(I) hearing aids and examinations therefor, for individuals under the age of 13.

The items and services described in the preceding sentence include, but are not limited to, items and services related to mental health care, including alcoholism and drug abuse.

"(2) Notwithstanding the provisions of paragraph (1), the plan must provide that payment will not be made for items and services—

"(A) which are not reasonable and necessary for the diagnosis or treatment of congenital defect, illness, or injury or to improve the functioning of a malformed body member; except for family planning and maternity items and services, routine dental services for individuals under the age of 13, routine eye and vision examinations and eyeglasses for individuals under the age of 13, hearing aids and examinations therefor for individuals under the age of 13, and well child care for individuals under the age of 6;

"(B) which are eyeglasses or eye examinations therefor, or hearing aids or examinations therefor, except for children under the age of 13;

"(C) for which the individual furnished such items or services has no legal obligation to pay and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(D) which are not provided within the United States, except for emergency inpatient hospital and physicians' services;

"(E) which constitute personal comfort items;

"(F) which are orthopedic shoes or other supportive devices for the feet, except for individuals under the age of 6;

"(G) which are custodial care;

"(H) which are cosmetic surgery or provided in connection therewith, except as required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member;

"(I) which are provided by immediate relatives of the individual or members of his household;

"(J) which are—

"(I) the treatment of weak, strained, or flat foot conditions and the prescription of supporting or corrective devices therefor, except when provided to individuals under the age of 6,

"(II) routine foot care; and

"(K) kidney dialysis or transplantation items and services, unless provided by a kidney dialysis or transplantation center or facility which meets such requirements as the Secretary may by regulation provide; or

"(L) to the extent that payment has been made, or can reasonably be expected to be made, with respect to those items and services, under a workmen's compensation law or plan of the United States or a State.

"Coverage Limits

"(b) To be approved under this title, an employee health care insurance plan may not impose any limits with respect to the items and services for which payment must

be provided under subsection (a), except that payment for—

"(1) post-hospital extended care services shall be limited to 100 days per calendar year;

"(2) home health services must be limited to 100 visits per calendar year;

"(3) inpatient hospital services for the treatment of mental illness shall be limited to 30 days per calendar year, with each day of partial hospitalization, as defined in regulations prescribed by the Secretary, counting as one-half day of inpatient services;

"(4) services provided on an outpatient basis for the treatment of mental illness shall be limited to the amount determined under this subsection per calendar year, and payment for such services other than services provided on an outpatient basis in a comprehensive community care center, as defined in regulations prescribed by the Secretary, shall be limited to one-half of that amount; and

"(5) routine eye and vision examinations, eyeglasses, hearing aids and examinations therefor, family planning and prenatal and postnatal items and services, and well child care shall be subject to such limitations as the Secretary may by regulation provide.

In November of each year, the Secretary shall determine the limit to be imposed under clause (4), for the following calendar year, which limit shall be the estimated cost of 30 outpatient visits to a private practitioner for the treatment of mental illness.

"Deductibles and Coinsurance

"(c) (1) To be approved under this title an employee health care insurance plan must, subject to paragraph (3), impose, with respect to all items and services other than outpatient drugs and biologicals, and blood and blood products, a per individual, per calendar year, deductible equal to the deductible base for that calendar year, as determined under section 1825(b)(2), except that no further deductible shall be imposed under this sentence in any calendar year after three members of a covered family satisfy the deductible requirement for that year. The plan must, subject to paragraph (3), impose, with respect to outpatient drugs and biologicals, other than blood and blood products, a per individual, per calendar year deductible equal to one-third of the deductible base for that calendar year, as determined under section 1825(b)(2). The plan must impose, with respect to blood and blood products, such deductible as the Secretary may by regulation provide.

"(2) The plan must impose, subject to paragraph (3), a coinsurance requirement of 25 per centum of expenses in excess of any applicable deductible.

"(3) The plan must provide that no further deductible or coinsurance requirement will be imposed in any calendar year after the total of the deductibles and coinsurance imposed under the plan equals 10.5 per centum, in the case of employees without any family members under the age of 65, or 15 per centum, in the case of employees with one or more family members under the age of 65, of the income class base, as determined under section 1825(b)(5). The plan must provide that any deductible or coinsurance amount charged against a covered individual under any other health care insurance plan approved under this title or provided pursuant to part B or C will be taken into account in determining if the deductible and coinsurance requirements imposed under the plan, have been met.

"Extended Coverage

"(d) To be approved under this title, an employee health care insurance plan must provide that coverage under the plan will continue to be available to a covered employee to whom the plan is offered by an employer pursuant to section 1801(a), and the

members of his family under the age of 65, for 180 days after the employer is no longer required by section 1801(a) to offer the plan to the employee, at the same premium rate at which coverage under the plan is available to employees of the employer.

"Coverage in the Event of Failure to Pay Premium

"(e) To be approved under this title, an employee health care insurance plan must provide that coverage under the plan will not be terminated because of the failure to pay for such coverage until such payment is 90 days in arrears and notice has been given to the individuals whose coverage is to be terminated.

"Health Card

"(f) To be approved under this title, an employee health care insurance plan must provide—

"(1) that an account will be established against which a covered individual may charge the cost of obtaining items and services covered under the plan, without regard to the deductible and coinsurance requirements applicable under the plan;

"(2) that payment for items and services covered under the plan, other than emergency services, will be made only on the basis of charges against that account;

"(3) that payment will be made on the basis of charges against the account for items and services covered under the plan at the applicable reimbursement rates; and that, unless the account is in default, payment will be made to full participating providers for all items and services, and to associate participating providers for outpatient drugs and biologicals, without reduction on account of the deductible and coinsurance requirements applicable under the plan and the covered individual will be billed the portion of any payment properly chargeable to him on account of those deductible and coinsurance requirements; and

"(4) that credit will be available with respect to any bill submitted to a covered individual pursuant to clause (3) and that interest will accrue on amounts owed on any bill, in accordance with regulations prescribed by the Secretary; that no recovery will be made from any individual or entity to whom the plan has made payment because of the failure of a covered individual to pay any such bill; and that 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.

"Other Requirements

"(g) To be approved under this title, an employee health care insurance plan must provide—

"(1) that payment will be made for items and services in accordance with the applicable reimbursement rates and standards, as determined pursuant to section 1861;

"(2) that, except for emergency services, payment will be made for items and services only to individuals and entities certified as participating providers;

"(3) that the provisions of part B of title XI shall apply to payments for items and services under the plan;

"(4) that payment will not be made for items and services in violation of any order of the Secretary pursuant to section 1122;

"(5) that no individual may be covered under more than one health care plan approved under this title or obtained pursuant to part B or C, and that in the event of coverage under more than one plan, payment will be made, or items and services provided, under only one such plan, as determined under regulations prescribed by the Secretary;

"(6) that the portion of the premium for

coverage under the plan which represents the cost of providing coverage in excess of \$10,000 per individual per calendar year will be the same for all coverage under the plan and any other employee health care insurance plan of the carrier or self-insured employer approved under this title;

"(7) that the rates applicable to coverage under the plan will be the same for all employees of any employer to whom the plan is provided, except that the rate for coverage of employees without any family members under the age of 65 will be 40 per centum of the rate for coverage of employees with one or more family members under the age of 65;

"(8) that the access to information obtained in connection with administration of the plan will be controlled in accordance with such requirements as the Secretary may, by regulation, prescribe;

"(9) that any contract or arrangement with an employer under which the plan is offered to employees of the employer pursuant to section 1801 will have a term of not more than one year, and will expire on December 31; and

"(10) that such uniform reporting methods and statistical procedures as the Secretary may require will be utilized in administration of the plan, and the Secretary will be furnished such information derived from the use of such methods and procedures as he may require to carry out the purposes of this title.

"Modification of Requirements

"(h) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to employee health care insurance plans offered to employees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF GROUP PRACTICE PREPAID HEALTH CARE PLANS

"Benefits

"Sec. 1842. (a) To be approved under this title, a group practice prepaid health care plan must provide—

"(1) for the provision, within the geographic area served by the plan, to covered individuals, of at least those items and services described in subsection (a) of section 1841, without regard to the provisions of subsections (c) through (h) of that section (other than any deductible imposed with respect to blood and blood products) and with no lower limitations than those described in subsection (b) of that section, and for payment for the provision of at least those items and services, within that area, when the provision of the items and services is beyond the control of the covered individual;

"(2) for the provision of, or payment for the provision of, at least those items and services, outside the geographic area served by the plan, when it is medically necessary that an item or service be provided to a covered individual before he can return to the geographic area served by the plan, and

"(3) that the plan will be compensated for the provision of, and payment for, those items and services, solely on a predetermined periodic rate basis, except for such copayments by covered individuals as the Secretary may, by regulation, authorize.

"Organizational Requirements

"(b) For a group practice prepaid health care plan to be approved under this title, the organization through which items and services are provided to covered individuals within the geographic area served by the plan must—

"(1) provide physicians' services (other than infrequently used services, as determined under regulations prescribed by the

Secretary) through physicians who are employees or partners of the organization, or through arrangements with one or more groups of physicians engaged in the coordinated practice of their profession for the organization; and

"(2) meet such requirements concerning its organizational structure and financial arrangements as the Secretary may, by regulation, prescribe for the purpose of assuring that—

"(A) the organization bears the responsibility for the efficient and effective utilization of health care resources to meet the health care needs of covered individuals,

"(B) the individuals, groups, and institutions within the organization or cooperating with it in the provision of health care services to covered individuals share in that responsibility, and

"(C) the organization provides clearly identifiable focal points of responsibility for the performance of all managerial, administrative, and service functions.

"Other Requirements

"(c) To be approved under this title, a group practice prepaid health care plan must provide that—

"(1) coverage under the plan will continue to be available to a covered employee to whom the plan is offered by an employer pursuant to section 1801(a) and the members of his family under the age of 65 for 180 days after the employer is no longer required by section 1801(a) to offer the plan to the employee, at the same rate at which coverage under the plan is available to employees of the employer;

"(2) coverage under the plan of employees to whom the plan is offered by an employee pursuant to section 1801 will not be terminated because of the failure to pay for such coverage until payment is 90 days in arrears and notice has been given to the individuals whose coverage is to be terminated;

"(3) the provisions of part B of title XI shall apply to items and services provided under the plan;

"(4) items and services will not be provided in violation of any order of the Secretary pursuant to section 1122;

"(5) no individual may be covered under more than one health care plan approved under this title or obtained pursuant to part B or C, and that in the event of coverage under more than one plan, payment will be made, or items and services provided, under only one such plan, as determined under regulations prescribed by the Secretary;

"(6) the rate applicable to coverage under the plan will be the same for all employees of any employer to whom the plan is provided, except that the rate for coverage of an employee without any family members under the age of 65 will be 40 per centum of the rate for coverage of an employee with one or more family members under the age of 65;

"(7) any contract or arrangement with an employer under which the plan is offered to employees of the employer pursuant to section 1801 will have a term of not more than one year, and will expire on December 31; and

"(8) such uniform reporting methods and statistical procedures as the Secretary may require will be utilized in administration of the plan, and the Secretary will be furnished such information derived from the use of such methods and procedures as he may require to carry out the purposes of this title.

"Modification of Requirements

"(d) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to group practice prepaid health care plans offered to em-

ployees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF INDIVIDUAL PRACTICE PREPAID HEALTH CARE PLANS

"Requirements for Approval

"Sec. 1843. (a) For an individual practice prepaid health care plan to be approved under this title—

"(1) the plan must meet the requirements imposed by section 1842(a) through (c) with respect to group practice prepaid health care plans, other than the requirements imposed by section 1842(b)(1); and

"(2) the organization through which items and services are provided to covered individuals within the geographic area served by the plan must provide physicians' services (other than infrequently used services, as determined under regulations prescribed by the Secretary) through arrangements with physicians engaged in the practice of their profession on an individual practice basis.

"Modification of Requirements

"(b) The Secretary may, by regulation, make such modifications in the requirements imposed by this section as he determines are appropriate with respect to individual practice prepaid health care plans offered to employees whose place of employment is outside the United States.

"REQUIREMENTS FOR APPROVAL OF SPECIAL EMPLOYEE HEALTH CARE PROGRAMS

"Sec. 1844. For a special employee health care program to be approved under this title—

"(1) the program must provide for the provision, or payment for the provision, to covered individuals, of at least those items and services described in subsection (a) of section 1841;

"(2) so much of the program as provides for payment for the provision of items and services must meet all of the requirements imposed by and pursuant to section 1841(b) through (h) with respect to employee health care insurance plans approved under this title, except that the program may have lower limitations and deductible and coinsurance requirements than those required by section 1841(b) and (c);

"(3) so much of the program as provides for the provision of items and services must meet all of the requirements imposed by and pursuant to either section 1843 with respect to group practice prepaid health care plans approved under this title, or section 1844 with respect to individual practice prepaid health care plans approved under this title; and

"(4) the employer must contribute toward the cost of providing coverage under the program to an employee at least as much as he would be required to contribute under section 1802 if the employee elected coverage under a health care insurance plan approved under this title.

"REQUIREMENTS FOR CERTIFICATION OF PROVIDERS

"Full Participating Providers

"Sec. 1845. (a) To be certified as a full participating provider, an individual or entity must—

"(1) agree to accept the payments made by health care insurance plans and special health care programs approved under this title or provided pursuant to part B or C, on the basis of charges against accounts established pursuant to the requirements of section 1841(f), as the sole means of obtaining payment for so much of the charges for the provision of items and services to individuals covered under those plans and programs as are payable under the plans;

"(2) agree to accept the payments made by health care insurance plans and special health care programs approved under this

title or provided pursuant to part B or C, on the basis of valid charges against accounts established pursuant to the requirements of section 1841(f), as payment in full for the provision of items and services covered, without regard to the deductible and coinsurance requirements described in section 1841(c), under the plans and programs to individuals covered under the plans and programs, except for any reduction in the amount of any such payment because an account is in default;

"(3) agree not to accept payment for the provision of any item or service from more than one health care insurance plan or special health care program approved under this title or provided pursuant to part B or C; and

"(4) be otherwise eligible, under the provisions of this title, to provide one or more items or services covered under health care insurance plans approved under this title or provided pursuant to part B or C, as determined under regulations prescribed by the Secretary.

"Associate Participating Providers

"(b)(1) To be certified as an associate participating provider, an individual or entity must—

"(A) meet the requirements imposed by clauses (1), (3), and (4) of subsection (a) with respect to full participating providers; and

"(B) agree to accept the payments made by health care insurance plans provided pursuant to part B or C, on the basis of valid charges against accounts established pursuant to the requirements of section 1841(f), as payment in full for the provision of items and services, other than outpatient drugs and biologicals, covered, without regard to the deductible and coinsurance requirements described in section 1841(c), under the plans to individuals covered under the plans, except for any reduction in the amount of any such payment because an account is in default.

"(2) No hospital, skilled nursing facility, or home health agency may be certified as an associate participating provider.

"PART E—ADMINISTRATION AND REGULATION

"APPROVAL OF HEALTH CARE PLANS, CERTIFICATION OF PROVIDERS, ADMINISTRATION OF PLAN REQUIREMENTS, AND REGULATION OF CARRIERS, SELF-INSURED EMPLOYERS AND PROVIDERS

"Sec. 1861. (a) The Secretary shall certify under this section each State which, by statute or regulation pursuant to statute—

"(1) (A) requires each carrier or self-insured employer which provides an employee health care insurance or prepaid health care plan, and each employer which provides a special health care program, under which coverage is made available pursuant to section 1801 to an employee whose place of employment is within the State, to—

"(I) file the plan or program, or any amendment thereto, with the State not later than thirty days before the plan, program, or amendment becomes effective (or such later date as the Secretary may permit), and

"(II) keep the State currently advised of the employers to whom the plan or program is provided and the employees of such employers to whom coverage under the plan or program is made available;

"(B) provides for prompt review of each such plan, program, or amendment and determination of whether the plan, program, or amendment meets the requirements for approval under this title with respect to employees whose place of employment is within the State, and for prompt notification to the carrier and employers to whom it is known to have provided the plan or amendment, the self-insured employer, or the employer providing the special health care program, of such determination; and

"(C) provides for withdrawal, with respect

to employees whose place of employment is within the State, of the approval of any plan, program, or amendment which it determines no longer meets, or is administered in such a manner that it no longer meets, the requirements for approval under this part, and for prompt notification of the carrier and employers to whom it is known to have provided the plan or amendment, the self-insured employer, or the employer providing the special health program, of such determination;

"(2) provides for establishment of the reimbursement rates and standards applicable to payments by health care insurance plans and special health care programs approved under this title or provided pursuant to part B or C for items and services provided within the State, in accordance with such procedures and criteria as the Secretary may by regulation provide; and for dissemination of the rates and standards to affected carriers, self-insured employers, employers providing special health care programs, certified providers, and covered individuals, in accordance with such procedures as the Secretary may, by regulation, provide;

"(3) (A) provides that any individual, other than an individual who provides health care as an employee of the United States, or any of its agencies or instrumentalities, or entity, other than an entity which is controlled by the United States, or any of its agencies or instrumentalities, wishing to be certified as a full or associate participating provider with respect to items and services provided within the State may file an application for such certification;

"(B) provides for prompt review of each such application and determination of whether the applicant meets the requirements for certification under this title as a full or associate participating provider with respect to items or services provided within the State, and for prompt notification to the applicant of its determination;

"(C) provides for withdrawal of the certification of any individual or entity which it determines no longer meets the requirements for certification under this title with respect to items and services provided within the State, and for prompt notification to the individual or entity of such determination; and

"(D) provides for the dissemination of information concerning the certification of full and associate participating providers to affected carriers, self-insured employers, employers providing special health care plans, and covered individuals, in accordance with such procedures as the Secretary may, by regulation, provide;

"(4) provides for the establishment of arrangements, meeting such requirements as the Secretary may by regulation provide, under which any participating provider may determine the validity of a charge against an account established, pursuant to the requirements of sections 1825(d) and 1841(f), under an employee health care insurance plan or special health care program approved under this title for an employee whose place of employment is within the State, or under an assisted health insurance plan provided within the State pursuant to part B;

"(5) requires each carrier which provides an employee health care insurance plan to an employer with less than 50 employees whose place of employment is within the State under which coverage is made available pursuant to section 1801 to an employee whose place of employment is within the State, to offer the plan to all employers with less than 50 employees whose place of employment is within the State for the purpose of making coverage under the plan available to those employees pursuant to section 1801, and requires that the plan be

offered to all such employers under the same rating structure and at the same rates;

"(6) has in effect an agreement with the Secretary under section 1122;

"(7) (A) requires each carrier or self-insured employer which offers or provides, within the State, an employee health care insurance or prepaid health care plan approved under this title, and each employer which offers or provides, within the State, a special employee health care program, to have on file with the State a current statement of the rates, or rating plans and formulas, applicable to the plan or arrangement, containing sufficient specificity to permit determination by the State of whether such rates, or rates based on such plans and formulas, are reasonable in relation to the benefits provided;

"(B) provides for the review of all such rates and rating plans and formulas, and for subsequent disapproval and suspension of any rate determined by the State to be unreasonable in relation to the benefits provided, or any plan or formula as to which it is determined that rates based on such plan or formula are unreasonable in relation to the benefits provided;

"(8) requires that there be an annual fiscal audit of each such carrier and employer by an independent certified public accountant and that the reports of such audits be available to the public;

"(9) requires each carrier which offers or provides, within the State, any plan or arrangement for financing or provision of health care to make available to each individual to whom the plan or arrangement is offered or provided, upon request, written information concerning—

"(A) the benefits and exclusions from coverage under such plan or arrangement,

"(B) the premium rate or rates for such plan or arrangement applicable to such individual, and

"(C) the percentage of the premium rate or rates for such plan or arrangement applicable to such individual which is expected to be paid out as benefits, as determined on the basis of actuarial standards prescribed by the Secretary;

"(10) requires that, except in case of emergency or other exceptional circumstances, each certified provider of health care within the State make available, in accordance with regulations of the Secretary, to individuals covered under a health care insurance plan approved under this title or provided pursuant to part B or C who seek such care directly from the provider, information concerning the provider's charges for commonly provided services, the provider's hours of operation and other matters affecting access to his services, and the extent to which the provider is licensed, accredited, or certified by recognized licensing, accrediting, or certifying agencies or bodies;

"(11) provides for determination of when carriers of employee health care insurance plans are insolvent or impaired and when carriers of prepaid health care plans, and self-insured employers providing employee health care insurance or prepaid health care plans, domiciled in the State, are unable, because of their financial condition, to meet their obligations to covered individuals under such plans; and assures that, in the event a carrier of an employee health care insurance plan is found to be insolvent or impaired, or a carrier of a prepaid health care plan or a self-insured employer providing an employee health care insurance or prepaid health care plan is found to be unable, because of its financial condition, to meet obligations to covered individuals under the plan, under the applicable laws of the State in which the carrier or self-insured employer

is domiciled, any valid claim or obligation arising under—

"(A) employee health care insurance or prepaid health care plan coverage provided by the carrier or self-insured employer and made available pursuant to section 1801, to an employee whose place of employment is within the State, or

"(B) in the case of a carrier, a contractual obligation of the carrier to an employer under which employee health care insurance or prepaid health care plan coverage is made available pursuant to section 1801 to such an employee, will be fully paid, guaranteed, assumed, or reinsured under an insolvency or guarantee fund or other means established or regulated by the State;

"(12) provides for the coordination of benefits under health care insurance plans approved under this title or provided pursuant to part B and other insurance which provides for the financing of health care;

"(13) provides for furnishing the Secretary with such information as he may, by regulation, require concerning the activities carried out by the State under the statutes and regulations required by clauses (1) through (12); and

"(14) provides an opportunity for any aggrieved person to bring a suit in the courts of the State to—

"(A) compel the proper performance of any duty under State law related to the requirements of paragraphs (1) through (12), or to review any decision made pursuant to such a duty, and

"(B) compel any carrier, employer, or certified provider to comply with any requirement related to the requirements of paragraphs (1) through (12).

"(b) Upon his determination, in a calendar year, that a State is entitled to certification under this section, the Secretary shall so notify the State and shall certify it with respect to calendar years beginning after such calendar year.

"INFORMATION FROM EMPLOYERS

"Sec. 1862. The Secretary may require any employer to furnish such information, at such time and in such form, as he finds necessary to determine if part A applies to such employer and, if so, whether such employer is complying with the requirements of that part.

"AGREEMENTS WITH OTHER AGENCIES

"Sec. 1863. The Secretary, pursuant to agreement with the head of any Federal agency, may utilize the services and facilities of such agency in carrying out his functions under this title and may provide for payment therefor in advance or by way of reimbursement, and in such installments as may be agreed upon.

"JUDICIAL REVIEW OF CERTAIN DETERMINATIONS OF THE SECRETARY

"Sec. 1864. (a) Any State dissatisfied with a determination of the Secretary under section 1861 with respect to whether the State is meeting the requirements of section 1861 may, within 60 days after it has been notified of such determination, file a petition for review of such determination with the United States court of appeals for the circuit in which such State is located. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

"(b) The findings of fact by the Secretary, 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 certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

"(c) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be 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.

"JUDICIAL REMEDIES FOR NONCOMPLIANCE; CRIMINAL SANCTIONS

"Sec. 1868. (a) The Attorney General may bring suit to compel an employer to comply with the provisions of part A. Such a suit shall be brought in the United States district court, including any court enumerated in section 460 of title 28, United States Code, for the district in which the employer's principal place of business is located.

"(b) Any employee may bring suit to compel his employer to comply with the provisions of part A with respect to him and to recover any expenditures necessitated by his employer's failure to do so. Such suit may be brought, without regard to jurisdictional amount, in the United States district court, including any court enumerated in section 460 of title 28, United States Code, for the district in which the plaintiff's place of employment is located or such other district as may be permitted by law.

"(c) (1) Any employer who fails to comply with the requirements imposed upon employers by part A shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000 for each employee with respect to whom he failed to so comply.

"(2) Any person who fails to comply with any regulation or order issued by the Secretary pursuant to section 1862, or who submits false information to the Secretary in connection with any such order or regulation, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$1,000.

"PART F—MISCELLANEOUS PROVISIONS DEFINITIONS

"Sec. 1881. For purposes of this title—
"Inpatient Hospital Services

"(a) The term 'inpatient hospital services' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board;

"(2) 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, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by other under such arrangements; excluding, however—

"(4) medical or surgical services provided by a physician who is not an employee of the hospital; and

"(5) the services of a private-duty nurse or other private-duty attendant.

"Hospital

"(b) The term 'hospital' means, except with respect to emergency services provided outside the United States, an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treat-

ment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) maintains clinical records on all patients;

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

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

"(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

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

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

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

"Notwithstanding the preceding provisions of this subsection, such term shall not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a psychiatric hospital (as defined in subsection (c)) or unless it is a tuberculosis hospital (as defined in subsection (d)). The term 'hospital' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payments may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

"Psychiatric Hospital

"(c) The term 'psychiatric hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

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

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'psychiatric hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Tuberculosis Hospital

"(d) The term 'tuberculosis hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, med-

ical services for the diagnosis and treatment of tuberculosis;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (b);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

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

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'tuberculosis hospital' if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Physicians' Services

"(e) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office and institutional calls.

"Physician

"(f) The term 'physician' when used in connection with the performance of any function or action, means, except with respect to emergency services provided outside the United States, (1) a doctor of medicine or osteopathy, other than an intern, resident, or fellow, legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, (3) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses, or (4) except for the purposes of subsections (j), (k), (m) and (n), a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform in the State in which he performs them.

"Medical and Other Health Services

"(g) The term 'medical and other health services' means any of the following items or services—

"(1) physicians' services;

"(2) (A) services, other than physician extender services, and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

"(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) other than physician extender services, incident to physicians' services rendered to outpatients;

"(C) diagnostic services which are—

"(1) furnished to an individual as an outpatient by a hospital or by other under

arrangements with them made by a hospital, and

"(4) ordinarily furnished by such hospital, (or by others under such arrangements), to its outpatients for the purpose of diagnostic study;

"(D) outpatient physical therapy services; and

"(E) physician extender services;

"(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

"(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

"(5) surgical dressings, and splints, casts, and other devices used for a reduction of fractures and dislocations;

"(6) durable medical equipment, including dialysis equipment and supplies, iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (b) (1) or (j) (1) of this section), whether furnished on a rental basis or purchased;

"(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

"(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; and

"(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (3) unless such laboratory—

"(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality, responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

"(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2) (C) any item or service (except services referred to in paragraph (1)) which—

"(12) would not be included under subsection (a) if it were furnished to an inpatient of a hospital; or

"(13) is furnished under arrangements referred to in such paragraph (2) (C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

"Extended Care Services

"(h) The term 'extended care services' means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

"(1) nursing care provided by or under the supervision of a registered professional nurse;

"(2) bed and board in connection with the furnishing of such nursing care;

"(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

"(4) medical social services;

"(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility as are ordinarily furnished by such facility for the care and treatment of inpatients;

"(6) medical services provided by an intern, resident-in-training, or fellow of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

"(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities; excluding however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

"Post-Hospital Extended Care Services

"(1) The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer, and for so long as he remains in the skilled nursing facility providing the services and is not discharged from it. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility—

"(A) within 14 days after discharge from such hospital; or

"(B) within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or (C) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital.

An individual shall be deemed not to have been discharged from a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

"Skilled Nursing Facility

"(j) The term 'skilled nursing facility' means an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more certified hospitals and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

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

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

"(5) maintains clinical records on all patients;

"(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

"(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

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

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

"(10) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

"(11) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that, for such periods as are appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home may be waived, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities; and

"(12) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary, except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution.

The term 'skilled nursing facility' also includes a Christian Science Sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such an institution to inpatients.

"To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

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

"(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

"(C) such facility (1) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (2) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular

full-time registered professional nurse is not on duty.

"Utilization Review"

"(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (1) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (2) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual 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

"(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary. The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

"Agreements for Transfer Between Skilled Nursing Facilities and Hospitals"

"(1) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect, if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which has attempted in good faith to enter into such an agreement with a hospital sufficiently

close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

"Home Health Services"

"(m) The term 'home health services' means the following items and services furnished to an individual, confined to his home (except when receiving items and services referred to in clause (7)) and in need of skilled nursing care on an intermittent basis, or physical or speech therapy, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital; and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) 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 such place of residence, or

"(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service; excluding, however, any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

"Home Health Agency"

"(n) The term 'home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established 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 (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable

local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

"(5) meets such other conditions as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

"(6) meets such other standards and requirements as the Secretary may by regulation provide.

"Outpatient Physical Therapy Services"

"(o) The term 'outpatient physical therapy services' means physical therapy services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

"(1) who is under the care of a physician, and

"(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician (as so defined);

excluding, however—

"(3) any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital; and

"(4) any such service—

"(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

"(1) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

"(2) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (1)) it provides,

"(3) maintains clinical records on all patients,

"(4) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

"(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

"(B) if furnished by a public health agency unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or skilled nursing facility. The term 'outpatient physical therapy services' also includes speech pathology services furnished by a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency.

or by a public health agency, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

"Drugs and Biologicals"

"(p) The term 'drugs' and the term 'biologicals', except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are required by section 503(b) of the Federal Food, Drug, and Cosmetic Act to be dispensed only upon prescription, and such other drugs and biologicals as the Secretary may by regulation provide.

"Outpatient Drugs and Biologicals"

"(q) The term 'outpatient drugs and biologicals' means drugs and biologicals required by section 503(b) of the Federal Food, Drug, and Cosmetic Act to be dispensed only upon prescription and such other life saving and sustaining drugs and biologicals as the Secretary may by regulation provide, provided for an individual who is not an inpatient in a hospital or skilled nursing facility.

"Routine Dental Services"

"(r) The term 'routine dental services' means services in connection with the examination, care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth provided by a dentist or an assistant to a dentist working under his supervision, except that it does not include orthodontic services.

"Dentist"

"(s) The term 'dentist', when used in connection with the performance of any function, means a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function.

"Eyeglasses"

"(t) The term 'eyeglasses' means lenses for the correction of a vision defect, other than contact lenses, provided on the basis of an eye examination.

"Eye and Vision Examination"

"(u) The term 'eye and vision examination' means an examination for the purpose of determining the need for eyeglasses or vision care, or prescribing, fitting, or changing eyeglasses, performed by an individual who may legally perform such examination in the State in which it is performed.

"Hearing Aids and Examinations"

"(v) The term 'hearing aids and examinations' means devices for the correction of hearing defects and examinations for the purpose of determining the need for such a device, subject to such limitations and restrictions as the Secretary may by regulation provide.

"Physician Extender Services"

"(w) The term 'physician extender services' means services performed under the supervision and control of a physician by a physician's assistant, nurse practitioner, or other individual, whether or not performed in the office of such physician or at a place at which he is present, if—

"(1) the services are, related to the practice by the supervising physician of general medicine, family medicine, internal medicine, geriatrics, or such other medical specialties as the Secretary may by regulation prescribe,

"(2) the individual has—

"(A) successfully completed an appropriate training program approved by the Secretary or by an accrediting organization approved by the Secretary, or

"(B) passed a physician extender certification examination conducted by a certifying

organization approved by the Secretary which does not have as a prerequisite graduation from an accredited training program, or;

"(C) met such other proficiency requirements as the Secretary may by regulation prescribe.

"(3) the individual may legally perform the services in the State in which the services are performed,

"(4) under the law of the State in which the services are performed, the individual acts, in performing the services, as the agent or otherwise on behalf of the supervising physician or organization which employs the individual, and

"(5) the charges for such services are included in the bills of the supervising physician or the employing organization.

"Carrier"

"(x) The term 'carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization which is engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, other than a self-insured employer.

"Self-Insured Employer"

"(y) The term 'self-insured employer' means an employer who (either through outside administrators or otherwise) engages, without arrangements with a carrier, in providing, paying for, or reimbursing the cost of, health services for his employees.

"Family"

"(z) (1) The term 'employee and the members of his family' means the employee and—

"(A) his spouse, and

"(B) each parent, step-parent, unmarried child, and unmarried stepchild of the employee or the employee's spouse receiving more than one-half of his support from the employee and his spouse,

who is residing at the place of residence maintained by the employee as his home.

"(2) The term 'members of a family' means an individual and—

"(A) his spouse, and

"(B) each parent, step-parent, unmarried child, and unmarried stepchild of the individual or the employee's spouse receiving more than one-half of his support from the individual and his spouse,

who is residing at the place of residence maintained by the individual as his home. For purposes of the preceding sentence, the term 'individual' does not include any individual who is receiving more than one-half of his support from a child and his spouse or a stepchild and his spouse, and is residing at the place of residence maintained by that child or stepchild as his home, or any unmarried individual who is receiving more than one-half of his support from a parent and his spouse, or a step-parent and his spouse, and is residing at the place of residence maintained by that parent or step-parent as his home.

"(3) An individual who is determined, under regulations prescribed by the Secretary, to be temporarily absent from a place of residence for the purpose of engaging in or seeking employment or self-employment (including military service), or attending a school, college, or university, or a course of vocational or technical training, or receiving institutional care, shall be considered to be residing at that place of residence.

"Income"

"(aa) The term 'income' means all income, from whatever source derived, as determined under regulations prescribed by the Secretary, and subject to such restric-

tions and limitations as he may, by regulation, provide.

"Arrangements for certain services"

"(bb) The term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agency), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"State and United States"

"(cc) The terms 'State' and 'United States' have the meaning given to them by subsections (h) and (i), respectively, of section 210.

"Employee"

"(dd) Whether an individual is an employee of another shall be determined at common law. The term includes employees of State and local governments, and their agencies and instrumentalities.

"American employer"

"(ee) The term 'American employer' means an employer which is (1) a State or local government or an agency or instrumentality of one of the foregoing, (2) an individual who is a resident of the United States, (3) a partnership, if two-thirds or more of the partners are residents of the United States, (4) a trust, if all of the trustees are residents of the United States, or (5) a corporation organized under the laws of the United States or of any State.

"REPORT"

"Sec 1882. On or before January 15 of the year following the fiscal year in which this section is enacted, and annually thereafter, the Secretary shall prepare a report, and submit it to the President for transmission to the Congress, summarizing the activities conducted in the preceding fiscal year in compliance with the amendments to this Act made by the Comprehensive Health Insurance Act of 1974. The report shall include an appraisal of the adequacy of the program under this title to meet the health care needs of the American people, and shall make such legislative recommendations as the Secretary deems appropriate."

"EFFECTIVE DATE"

Sec. 102. (a) Except as provided in subsection (b), section 101 of this Act shall be effective on January 1, 1976, or, if later, the first day of the first calendar year commencing at least 18 months after the enactment of this Act.

(b) Notwithstanding subsection (a), the provisions of title XVIII of the Social Security Act, as in effect prior to the enactment of this Act, shall remain in effect on and after January 1, 1976, with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act, as amended by this Act, and wages and self-employment income earned in States not certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

"TRANSITIONAL PROVISIONS CONCERNING PAYMENTS TO CERTAIN EMPLOYEES"

Sec. 103. (a) If the total cash wages paid by an employer to his employees whose place of employment is within a single State, in the first year in which the amendments made by section 101 of this Act are effective with respect to those employees, or in any of the succeeding four years, when multiplied by the difference between—

(A) the ratio of (1) the cost to the employer of meeting the employer contribution requirement imposed by part A of title

XVIII of the Social Security Act, as amended by this Act with respect to those employees in that year to, (II) the total cash wages paid to those employees; and

(B) the ratio of (I) the cost to the employer of providing health benefits to his employees whose place of employment is in that State in the year preceding the year in which the amendments made by section 101 of this Act are effective with respect to those employees to, (II) the total cash wages paid to those employees in that year, exceeds 3 percent of the total cash wages paid to those employees in that year, the Secretary shall pay to the employer the following percentages of that excess—

(1) for the first year in which the amendments made by section 101 of this Act are effective with respect to those employees, 75 per centum.

(2) for the first succeeding year, 60 per cent.

(3) for the second succeeding year, 45 per cent;

(4) for the third succeeding year, 30 per cent; and

(5) for the fourth succeeding year, 15 per cent.

(b) There are authorized to be appropriated such sums as may be necessary for the Secretary to make the payments required by subsection (a).

TRADITIONAL PROVISIONS CONCERNING EMPLOYER CONTRIBUTIONS

SEC. 104. Notwithstanding the provisions of section 1802 of the Social Security Act, as amended by this Act, the employer contribution requirement imposed under section 1802 with respect to employment in a State shall be 65 percent for 3 years beginning with the date that section 1802 is applicable to employment in that State.

TRADITIONAL PROVISIONS CONCERNING ELIGIBILITY FOR FEDERAL HEALTH CARE BENEFITS

SEC. 105. (a) Anyone who resides in a State certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act—

(1) has attained the age of 65,

(2) (A) attained that age before or during the calendar year in which section 101 of this Act becomes effective under section 102(a) of this Act, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(i) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after the calendar year before the calendar year in which section 101 of this Act becomes effective under section 102(a) of this Act and before the year in which he attained that age,

(3) is not, and upon filing the appropriate application would not be, entitled to federal health care benefits under section 1831 of that Act, and is not certifiable as a qualified railroad retirement beneficiary under section 21 of the Railroad Retirement Act of 1937,

(4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary, shall (subject to the limitations of this section) be deemed, solely for purposes of section 1831 of the Social Security Act, to be entitled to monthly insurance benefits under section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which

he becomes, or upon filing the appropriate application under title II of that Act would become, entitled to Federal health care benefits under section 1831 or become certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of that month shall be deemed to have met those requirements in that month if he files the application before the end of the twelfth month following that month. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) The provisions of subsection (a) shall not apply to any individual who—

(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 210(a)(17) of the Social Security Act, or

(2) has, prior to the beginning of that first month, been convicted of any offense listed in section 202(u) of the Social Security Act.

(c) There is authorized to be appropriated to the Federal Health Care Benefits Trust Fund (established by section 1835 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments, other than payments described in section 1836(1) of the Social Security Act, as amended by this Act, made or to be made during such fiscal year from that Trust Fund with respect to individuals who are entitled to Federal health care benefits under section 1831 solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result from the making of those payments,

(3) any loss in interest to the Trust Fund resulting from the making of those payments,

in order to place that Trust Fund, at the end of the fiscal year, in the same position in which it would have been if the preceding subsections of this section had not been enacted.

TITLE II—REDUCTION IN SERVICES PROVIDED UNDER MEDICAL ASSISTANCE PROGRAMS

AMENDMENTS TO MEDICAID PROGRAM

SEC. 201. (a) Section 1902(a) of that Act is amended by—

(1) striking out the parenthetical phrase in paragraph (9);

(2) striking out "paragraph (4), (14), or (16)" in paragraph (10) and inserting "paragraph (1), (4) or (5)" in lieu thereof;

(3) striking out clause (II) in paragraph (10), inserting "and" at the end of clause (I), and redesignating clause (III) as clause (II);

(4) striking out paragraph (13) and inserting the following new paragraph in lieu thereof:

"(13) provide—

"(A) for inclusion of at least the services listed in clauses (1) and (2) of section 1906 (a), and

"(B) for payment for the items and services provided under the plan on the basis of such standards as the Secretary may by regulation prescribe;"

(5) striking out "through (5) and (7)" in paragraph (14)(A) and inserting "and (2)" in lieu thereof;

(6) striking out paragraph (15);

(7) striking out "(including drugs)" and "community pharmacy," in paragraph (23);

(8) inserting "psychiatric" before "hospitals" in paragraph (24);

(9) striking out "1861(j)" in paragraph (28) and inserting "1881(j)" in lieu thereof; and

(10) striking out "the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864 (a), or, if such agency is not" and "the State agency responsible for such licensing," in paragraph (33) (B).

(b) Section 1903(a) of such Act is amended by—

(1) striking out everything after "under the State plan" in clause (1) and inserting "plus" in lieu thereof; and

(2) striking out clause (5).

(c) Section 1903(b) of such Act is amended by striking out paragraph (1).

(d) Section 1903(g)(1) of such Act is amended by—

(1) striking out "hospital (including an institution for tuberculosis)," and "inpatient hospital services (including tuberculosis hospitals)," in the matter before clause (A); and striking out "section 1812" and inserting "title XVIII" in lieu thereof.

(e) Section 1903(i) of such Act is amended by striking out clause (1) through (3).

(f) Section 1903(l) of such Act is further amended by—

(1) striking out "hospital or" each time that it appears in clause (4); and

(2) striking out "1861(k)" each time that it appears in clause (4) and inserting "1881 (k)" in lieu thereof.

(g) Section 1903 is further amended by striking out subsections (j) and (k).

(h) The first sentence of section 1905(a) of such Act is amended by striking out everything after "all of such cost—" and inserting in lieu thereof the following:

"(1) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older;

"(2) home health care services;

"(3) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

"(4) for individuals 65 years of age or older, inpatient hospital services in an institution for mental diseases, and skilled nursing services and intermediate care facility services in an institution for tuberculosis or mental diseases;

"(5) inpatient psychiatric hospital services for individuals under 21, as defined in subsection (b); and

"(6) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary which is provided to an individual in an institution or is intended to reduce the need for institutionalization;

except that such term does not include—

"(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution);

"(B) except as otherwise provided in paragraph (5), any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases; or

"(C) any such payments with respect to care or services which must be covered under a health care insurance plan provided under part B or C of title XVIII or for any premium, deductible, or coinsurance which must be imposed under such plan."

(i) Section 1905 of such Act is further amended by—

(1) striking out subsections (e) and (g); and

(2) striking out everything after "Indian reservation" in subsection (1) and inserting "and is certified under title XVIII," in lieu thereof.

(j) Section 1910 of such Act is amended to read as follows:

"Sec. 1910. An institution certified as a skilled nursing facility under title XVIII shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a) (28)."

(k) Section 1902(b) is amended by inserting "submitted by a State certified under section 1861" after "approve any plan".

EFFECTIVE DATE

Sec. 202. The amendments made by section 201 shall be effective with respect to payments under section 1903 of the Social Security Act for quarters beginning on or after the effective date of section 101 of this Act under section 102(a) of this Act.

AMENDMENTS TO PROFESSIONAL STANDARDS REVIEW PROGRAM

Sec. 301. (a) (1) Section 1151 of the Social Security Act is amended by—

(A) inserting ", or which are provided," immediately after "(in whole or in part)";

(B) inserting ", or which are provided," immediately before "under the Social Security Act"; and

(C) inserting ", and such services will be provided" immediately after "payment for such services will be made".

(2) Section 1155(a)(1) of that Act is amended by—

(A) striking out "(subject to the provisions of subsection (g))"; and

(B) striking out "under this Act" and inserting "under title V or XIX, for which payment may be made by a health care insurance plan or special employee health care program approved under title XVIII or provided pursuant to part B or C of that title, or which are provided by a prepaid health care plan or special employee health care program approved under title XVIII," in lieu thereof.

(3) Section 1155 of that Act is further amended by striking out subsection (g).

(4) Section 1157 of that Act is amended by striking out the last sentence therein.

(5) Section 1158(a) of that Act is amended by striking out everything before clause (1) and inserting "Except as provided for in section 1159, no Federal funds appropriated under title XIX for the provision of health care items and services shall be used (directly or indirectly) for the payment for, and no health care insurance plan or special employee health care program approved under title XVIII or provided under part B or C of that title shall make payment on, any claim for the provision of any item or service, unless the Secretary pursuant to regulation determines that the claimant is without fault if—" in lieu thereof.

(6) Section 1159(a) of that Act is amended by striking out everything before "or a provider or practitioner" and inserting "Any individual entitled to benefits under title XIX or covered under a health care insurance plan or special employee health care program approved under title XVIII or provided under part B or C of that title" in lieu thereof.

(7) Section 1160(a) of that Act is amended by striking out "to beneficiaries and recipients under this Act" and inserting "to individuals eligible for benefits under title V or XIX or covered under a health care insurance plan, prepaid health care plan, or special employee health care program approved under title XVIII or provided under part B or C of that title" in lieu thereof.

(8) Section 1160(b) of that Act is amended by striking out "under this Act" and inserting "under title V or XIX, or by a health

care insurance plan or special employee health care program approved under title XVIII or provided pursuant to part B or C of that title" in lieu thereof.

(9) Section 1160 of that Act is further amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) If after reasonable notice and opportunity, for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendation to the Secretary pursuant to section 1157 (which report and recommendation shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility on behalf of a prepaid health care plan or special employer health care program approved under title XVIII has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may require the prepaid health care plan or special employee health care program to take such remedial action as he determines is appropriate, including, but not limited to, professional education, or suspension or termination of personnel."

(b) The amendments made by this section shall be effective with respect to items and services provided in States certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

AMENDMENTS TO CAPITAL EXPENDITURES REVIEW PROGRAM

Sec. 302. (a) Section 1122(a) of the Social Security Act is amended by striking out so much of such section as precedes "are not used" and inserting "The purpose of this section is to assure that Federal funds paid pursuant to titles V and XIX, payments made under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title, and payments made to prepaid health care plans and special employee health care programs approved under title XVIII" in lieu thereof.

(b) Section 1122 is further amended by striking out subsection (c).

(c) Section 1122 is further amended by striking out so much of subsection (d) as follows clause (B) of paragraph (1), and subsection (e), and inserting in lieu thereof the following:

"then he shall, in determining the Federal payments to be made under title V or XIX, exclude amounts with respect to services furnished, during such period as the Secretary finds necessary in any case to effectuate the purpose of this section, in the health care facility for which such capital expenditure is made; shall notify carriers, self-insured employers, and employers which provide coverage under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title to individuals who in the judgment of the Secretary could reasonably be expected to seek services in the facility, that payments are not to be made with respect to services furnished in the facility to such individuals during such period, and direct such carriers, self-insured employers, and employers to notify such individuals of such exclusion; and shall notify carriers, self-insured employers, and employers which provide coverage under prepaid

health care plans and special employee health care programs approved under title XVIII which in the judgment of the Secretary could reasonably be expected to provide services in the facility, that items and services are not to be provided under the plan in the facility during such period.

"(2) With respect to any organization which is reimbursed primarily on a per capita basis, the Secretary shall determine, for purposes of Federal payments under titles V and XIX, the amount which in his judgment is a reasonable equivalent of the amount which would be excluded under this subsection if payment were made on some other basis.

"(3) The period referred to in paragraph (1) for which the exclusion of payment for, and provision of, services applies shall begin with respect to services provided after—

"(A) in the case of title V or XIX, the Secretary notifies the State or other recipient of Federal funds thereunder of his determination;

"(B) in the case of payments under health care insurance plans and special employee health care programs approved under title XVIII or provided pursuant to part B or C of that title, notice to those individuals covered under such plans who, in the judgment of the Secretary, could reasonably be expected to seek services in the facility involved; and

"(C) in the case of services provided under prepaid health care plans and special employee health care insurance programs approved under title XVIII, notice to the carriers, self-insured employers, and employers which provide coverage under those plans which, in the judgment of the Secretary, could reasonably be expected to provide services in the facility.

"(4) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (1), determines that an exclusion under paragraph (1) of payments for, and provision of, services furnished in any health care facility would discourage the operation or expansion of such facility (or in the case of a facility of a health maintenance organization, the operation or expansion of such organization) and such facility or organizations has demonstrated to his satisfaction that it is capable of providing comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective administration of title V, XVIII, or XIX, he shall not exclude such payments pursuant to paragraph (1) or notify carriers, self-insured employers, or employers not to make such payments or provide such services.

"(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (c) if the person had acquired it by purchase, the Secretary shall provide for such an exclusion with respect to services furnished in such facility by such person."

(d) The amendments made by this section shall be effective with respect to capital expenditures in States certified by the Secretary under section 1861 of the Social Security Act, as amended by this Act.

MISCELLANEOUS SOCIAL SECURITY AMENDMENTS

Sec. 303. (a) (1) Section 201(g)(1) of the Social Security Act is amended by—

(A) inserting ", the Federal Health Care Benefits Trust Fund," immediately after "Federal Hospital Insurance Trust Fund";

(B) striking out "with respect to title XVI" and inserting "with respect to titles XVI and XVIII" in lieu thereof, and

(C) striking out "section 1801" and inserting "sections 1801 and 1836" in lieu thereof.

(2) Section 201(1) of that Act is amended by inserting "the Federal Health Care Benefits Trust Fund," immediately after "Federal Hospital Insurance Trust Fund."

(b)(1) Section 218(e) of that Act is amended by—

(A) striking out "3101 and 3111" in paragraph (1)(A) and inserting "3101(a) and 3111(a), and in the case of a State not certified under section 1861, 3101(b) and 3111(b), respectively, in lieu thereof, and

(B) striking out "3111" in paragraph (2)(B) and inserting "3111(a), and in the case of a State not certified under section 1861, 3111(b)," in lieu thereof.

(2) Section 218(f)(3) of that Act is amended by striking out "3101 and 3111" and inserting "3101(a) and 3111(a), and in the case of a State not certified under section 1861, 3101(b) and 3111(b)," respectively, in lieu thereof.

(3) Agreements under section 218 of the Social Security Act in effect on the effective date of the amendments made by this subsection shall be deemed to be modified to the extent necessary to meet the requirements of section 218, as amended by this subsection.

(c) Subsections (a) and (b) of section 226 of the Social Security Act are each amended by inserting "residing in a State which is not certified under section 1861" immediately after "Every individual".

(d) Section 505(a)(6) of such Act is amended by striking out "which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII" and inserting "determined in accordance with methods and standards as the Secretary may, by regulation, provide" in lieu thereof.

(e) Section 1116 of such Act is amended by—

(1) inserting "or part B of title XVIII," after "part A of title IV," each time that it appears therein; and

(2) inserting "1824," after "1804."

(f)(1) Section 202(u) of that Act is amended by striking out "insurance benefits under part A of" and inserting "federal benefits under" in lieu thereof

(2) Section 202(v) of that Act is amended by striking out "part A" each time that it appears therein and inserting "the federal programs" in lieu thereof.

(g) The amendments made by this section shall be effective on the effective date of section 101 of this Act under section 102(a) of this Act.

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 304. (a) The matter before clause (1) in section 322(a) of the Public Health Service Act is amended by—

(1) striking out "without charge", and

(2) inserting ", subject to such charges as the Secretary may by regulation impose" immediately after "stations of the Service".

(b) Section 1310(a) of the Public Health Service Act is amended by inserting "whose place of employment is not within a State certified under section 1861 of the Social Security Act" immediately after "offered to its employees".

(c) The amendments made by this section shall be effective on the effective date of section 101 of this Act under section 102(a) of this Act.

AMENDMENTS TO THE RAILROAD RETIREMENT PROGRAM

SEC. 305. (a) Section 5(k) of the Railroad Retirement Act of 1937 is amended by inserting "or Federal Health Care Benefits Trust Fund, as applicable" immediately after "Federal Hospital Insurance Trust Fund".

(b)(1) Section 21(a) of that Act is amended by striking out everything after "individuals described in subsection (b) of this section to" and inserting "federal health care benefits under section 1831 of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section with respect to individuals to whom such section applies. For purposes of section 11, a determination with respect to the rights of an individual under this section shall be considered to be a decision with respect to an annuity."

(2) Section 21(c) of that Act is amended by striking out "part A" and inserting "part C" in lieu thereof.

(3) Section 21(d) of that Act and section 105 of the Social Security Amendments of 1965 are each amended by striking out the parenthetical phrase therein.

(4) Section 21(e) of the Railroad Retirement Act of 1937 is amended to read as follows:

"(e) Individuals described in subsection (b) of this section shall have the same rights to federal health care benefits with respect to health care provided in Canada as individuals to whom section 1831 of the Social Security Act applies have with respect to health care provided in the United States, and this subsection shall be administered by the Board as if the provisions of part C of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health, Education, and Welfare were to the Board, as if references to the Federal Health Care Benefits Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included Canada or a subdivision thereof, and as if title XVIII of the Social Security Act contained such modifications in its requirements and provisions as the Board determines are appropriate with respect to health care provided for shall be made from the Railroad Retirement Account in accordance with, and subject to, the conditions applicable under section 10(b) in making payment of other benefits, but only to the extent that the amount of payments hereunder provided for exceeds the amount payable pursuant to the law in effect in Canada."

(c) Section 22 of that Act is repealed.

(d)(1) The amendments made by subsection (a) shall be effective on the effective date of section 101 of this Act under section 102(a) of this Act.

(2) The amendments made by subsections (b) and (c) shall be effective with respect to individuals residing in States certified under section 1861 of the Social Security Act, as amended by this Act.

AMENDMENTS TO THE INTERNAL REVENUE CODE

SEC. 306. Effective with respect to wages in States certified under section 1861 of the Social Security Act, as amended by this Act, paragraphs (5), (6)(A), (6)(B), (6)(C), and (7) of section 3121(b) of that Code are each amended by inserting "with respect to the taxes imposed by sections 3101(a) and 3111(a)," immediately before "service" the first time that it appears in each of those paragraphs.

TITLE IV—GENERAL PROVISIONS

GENERAL SEVERABILITY

SEC. 401. If a provision enacted by this Act is held invalid, all other provisions so enacted shall remain in effect. If a provision enacted by this Act is held invalid in one or more of its applications, the provision shall remain in effect with respect to all other applications.

DEFINITION

SEC. 402. As used in this Act and in the amendments made by this Act, the term "Secretary" means, unless the context oth-

erwise requires, the Secretary of Health, Education, and Welfare.

THE WHITE HOUSE.

February 6, 1974.

To the Congress of the United States:

One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.

In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who were seeking equal opportunities in education, jobs and voting.

Now it is time that we move forward again in still another critical area: health care.

Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.

Three years ago, I proposed a major health insurance program to the Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk.

Today the need is even more pressing because of the higher costs of medical care. Efforts to control medical costs under the New Economic Policy have been met with encouraging success, sharply reducing the rate of inflation for health care. Nevertheless, the overall cost of health care has still risen by more than 20 percent in the last two and one-half years, so that more and more Americans face staggering bills when they receive medical help today.

Across the Nation, the average cost of a day of hospital care now exceeds \$110.

The average cost of delivering a baby and providing postnatal care approaches \$1,000.

The average cost of health care for terminal cancer now exceeds \$20,000.

For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.

Beyond the question of the prices of health care, our present system of health care insurance suffers from two major flaws:

First, even though more Americans carry health insurance than ever before, the 25 million Americans who remain uninsured often need it the most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage which is balanced, comprehensive and fully protective:

Forty percent of those who are insured are not covered for visits to physicians on an out-patient basis, a gap that creates powerful incentives toward high-cost care in hospitals;

Few people have the option of selecting care through prepaid arrangements offered by Health Maintenance Organizations so the system at large does not benefit from the free choice and creative competition this would offer;

Very few private policies cover preventive services;

Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers; and

Fewer than half of our citizens under 65—and almost none over 65—have major medical coverage which pays for the cost of catastrophic illness.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills—or worse. Delays in treatment can end in death or life-long disability.

COMPREHENSIVE HEALTH INSURANCE PLAN (CHIP)

Early last year, I directed the Secretary of Health, Education, and Welfare to prepare a new and improved plan for comprehensive health insurance. That plan, as I indicated in my State of the Union message, has been developed and I am presenting it to the Congress today. I urge its enactment as soon as possible.

The plan is organized around seven principles:

First, it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits;

Second, it will cost no American more than he can afford to pay;

Third, it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system;

Fourth, it uses public funds only where needed and requires no new Federal taxes;

Fifth, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the Federal Government.

Sixth, it encourages more effective use of our health care resources;

And finally, it is organized so that all parties would have a direct stake in making the system work—consumer, provider, insurer, State governments and the Federal Government.

BROAD AND BALANCED PROTECTION FOR ALL AMERICANS

Upon adoption of appropriate Federal and State legislation, the Comprehensive Health Insurance Plan would offer to every American the same broad and balanced health protection through one of three major programs:

Employee Health Insurance, covering most Americans and offered at their place of employment, with the cost to be shared by the employer and employee on a basis which would prevent excessive burdens on either;

Assisted Health Insurance, covering low-income persons, and persons who would be ineligible for the other two programs, with Federal and State government paying those costs beyond the means of the individual who is insured; and,

An improved Medicare Plan, covering those 65 and over and offered through a Medicare system that is modified to include additional, needed benefits.

One of these three plans would be available to every American, but for everyone, participation in the program would be voluntary.

The benefits offered by the three plans would be identical for all Americans, regardless of age or income. Benefits would be provided for:

- Hospital care;
- Physicians' care in and out of the hospital;
- Prescription and life-saving drugs;
- Laboratory tests and X-rays;
- Medical devices;
- Ambulance services; and,
- Other ancillary health care.

There would be no exclusions of coverage based on the nature of the illness. For example, a person with heart disease would qualify for benefits as would a person with kidney disease.

In addition, CHIP would cover treatment for mental illness, alcoholism and drug addiction, whether that treatment were pro-

vided in hospitals and physicians' offices or in community-based settings.

Certain nursing home services and other convalescent services would also be covered. For example, home health services would be covered so that long and costly stays in nursing homes could be averted where possible.

The health needs of children would come in for special attention, since many conditions, if detected in childhood, can be prevented from causing lifelong disability and learning handicaps. Included in these services for children would be:

Preventive care up to age six;

Eye examinations;

Hearing examinations; and,

Regular dental care up to age 13.

Under the Comprehensive Health Insurance Plan, a doctor's decisions could be based on the health care needs of his patients, not on health insurance coverage. This difference is essential for quality care.

Every American participating in the program would be insured for catastrophic illnesses that can eat away savings and plunge individuals and families into hopeless debt for years. No family would ever have annual out-of-pocket expenses for covered health services in excess of \$1,500, and low-income families would face substantially smaller expenses.

As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his State. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency rooms, doctors, and clinics across the country. This card could also be used to identify information on blood type and sensitivity to particular drugs—information which might be important in an emergency.

Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if any.

The entire program would become effective in 1976, assuming that the plan is promptly enacted by the Congress.

HOW EMPLOYER HEALTH INSURANCE WOULD WORK

Every employer would be required to offer all full-time employees the Comprehensive Health Insurance Plan. Additional benefits could then be added by mutual agreement. The insurance plan would be jointly financed, with employers paying 65 percent of the first three years of the plan, and 75 percent thereafter. Employees would pay the balance of the premiums. Temporary Federal subsidies would be used to ease the initial burden on employers who face significant cost increases.

Individuals covered by the plan would pay the first \$150 in annual medical expenses. A separate \$50 deductible provision would apply for out-patient drugs. There would be a maximum of three medical deductibles per family.

After satisfying this deductible limit, an enrollee would then pay for 25 percent of additional bills. However, \$1,500 per year would be the absolute dollar limit on any family's medical expenses for covered services in any one year.

HOW ASSISTED HEALTH INSURANCE WOULD WORK

The program of Assisted Health Insurance is designed to cover everyone not offered coverage under Employee Health Insurance or Medicare, including the unemployed, the disabled, the self-employed, and those with low incomes. In addition, persons with higher incomes would also obtain Assisted Health Insurance if they cannot otherwise get cov-

erage at reasonable rates. Included in this latter group might be persons whose health status or type of work puts them in high-risk insurance categories.

Assisted Health Insurance would thus fill many of the gaps in our present health insurance system and would ensure that for the first time in our Nation's history, all Americans would have financial access to health protection regardless of income or circumstances.

A principal feature of Assisted Health Insurance is that it relates premiums and out-of-pocket expenses to the income of the person or family enrolled. Working families with incomes of up to \$5,000, for instance, would pay no premiums at all. Deductibles, co-insurance, and maximum liability would all be pegged to income levels.

Assisted Health Insurance would replace State-run Medicaid for most services. Unlike Medicaid, where benefits vary in each State, this plan would establish uniform benefit and eligibility standards for all low-income persons. It would also eliminate artificial barriers to enrollment or access to health care.

As an interim measure, the Medicaid program would be continued to meet certain needs, primarily long-term institutional care. I do not consider our current approach to long-term care desirable because it can lead to over-emphasis on institutional as opposed to home care. The Secretary of Health, Education, and Welfare has undertaken a thorough study of the appropriate institutional services which should be included in health insurance and other programs and will report his findings to me.

IMPROVING MEDICARE

The Medicare program now provides medical protection for over 23 million older Americans. Medicare, however, does not cover outpatient drugs, nor does it limit total out-of-pocket costs. It is still possible for an elderly person to be financially devastated by a lengthy illness even with Medicare coverage. I therefore propose that Medicare's benefits be improved so that Medicare would provide the same benefits offered to other Americans under Employee Health Insurance and Assisted Health Insurance.

Any person 65 or over, eligible to receive Medicare payments, would ordinarily, under my modified Medicare plan, pay the first \$100 for care received during a year, and the first \$50 toward out-patient drugs. He or she would also pay 20 percent of any bills above the deductible limit. But in no case would any Medicare beneficiary have to pay more than \$750 in out-of-pocket costs. The premiums and cost sharing for those with low incomes would be reduced, with public funds making up the difference.

The current program of Medicare for the disabled would be replaced. Those now in the Medicare for the disabled plan would be eligible for Assisted Health Insurance, which would provide better coverage for those with high medical costs and low incomes.

Premiums for most people under the new Medicare program would be roughly equal to that which is now payable under Part B of Medicare—the Supplementary Medical Insurance program.

COSTS OF COMPREHENSIVE HEALTH INSURANCE

When fully effective, the total new costs of CHIP to the Federal and State governments would be about \$6.9 billion with an additional small amount for transitional assistance for small and low wage employers:

The Federal Government would add about \$5.9 billion over the cost of continuing existing programs to finance health care for low-income or high risk persons.

State governments would add about \$1.0 billion over existing Medicaid spending for the same purpose, though these added costs

would be largely, if not wholly offset by reduced State and local budgets for direct provision of services.

The Federal Government would provide assistance to small and low wage employers which would initially cost about \$450 million but be phased out over five years.

For the average American family, what all of these figures reduce to is simply this:

The national average family cost for health insurance premiums each year under Employee Health Insurance would be about \$150; the employer would pay approximately \$450 for each employee who participates in the plan.

Additional family costs for medical care would vary according to need and use, but in no case would a family have to pay more than \$1,500 in any one year for covered services.

No additional taxes would be needed to pay for the cost of CHIP. The Federal funds needed to pay for this plan could all be drawn from revenues that would be generated by the present tax structure. I am opposed to any comprehensive health plan which requires new taxes.

MAKING THE HEALTH CARE SYSTEM WORK BETTER

Any program to finance health care for the Nation must take close account of two critical and related problems—cost and quality.

When Medicare and Medicaid went into effect, medical prices jumped almost twice as fast as living costs in general in the next five years. These programs increased demand without increasing supply proportionately and higher costs resulted.

This escalation of medical prices must not recur when the Comprehensive Health Insurance Plan goes into effect. One way to prevent an escalation is to increase the supply of physicians, which is now taking place at a rapid rate. Since 1965, the number of first-year enrollments in medical schools has increased 55 percent. By 1980, the Nation should have over 440,000 physicians, or roughly one-third more than today. We are also taking steps to train persons in allied health occupations, who can extend the services of the physician.

With these and other efforts already underway, the Nation's health manpower supply will be able to meet the additional demands that will be placed on it.

Other measures have also been taken to contain medical prices. Under the New Economic Policy, hospital cost increases have been cut almost in half from their post-Medicare highs, and the rate of increase in physician fees has slowed substantially. It is extremely important that these successes be continued as we move toward our goal of comprehensive health insurance protection for all Americans. I will, therefore, recommend to the Congress that the Cost of Living Council's authority to control medical care costs be extended.

To contain medical costs effectively over the long haul, however, basic reforms in the financing and delivery of care are also needed. We need a system with built-in incentives that operates more efficiently and reduces the losses from waste and duplication of effort. Everyone pays for this inefficiency through their health premiums and medical bills.

The measure I am recommending today therefore contains a number of proposals designed to contain costs, improve the efficiency of the system and assure quality health care. These proposals include:

1. HEALTH MAINTENANCE ORGANIZATIONS (HMO'S)

On December 29, 1973, I signed into law legislation designed to stimulate, through Federal aid, the establishment of prepaid comprehensive care organizations. HMO's have proved an effective means for delivering health care and the CHIP plan requires

that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system.

2. PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S)

I also contemplate in my proposal a provision that would place health services provided under CHIP under the review of Professional Standards Review Organizations. These PSRO's would be charged with maintaining high standards of care and reducing needless hospitalization. Operated by groups of private physicians, professional review organizations can do much to ensure quality care while helping to bring about significant savings in health costs.

3. MORE BALANCED GROWTH IN HEALTH FACILITIES

Another provision of this legislation would call on the States to review building plans for hospitals, nursing homes and other health facilities. Existing health insurance has overemphasized the placement of patients in hospitals and nursing homes. Under this artificial stimulus, institutions have felt impelled to keep adding bed space. This has produced a growth of almost 75 percent in the number of hospital beds in the last twenty years, so that now we have a surplus of beds in many places and a poor mix of facilities in others. Under the legislation I am submitting, States can begin remedying this costly imbalance.

4. STATE ROLE

Another important provision of this legislation calls on the States to review the operation of health insurance carriers within their jurisdiction. The States would approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit and take other appropriate measures. For health care providers, the States would assure fair reimbursement for physician services, drugs and institutional services, including a prospective reimbursement system for hospitals.

A number of States have shown that an effective job can be done in containing costs. Under my proposal all States would have an incentive to do the same. Only with effective cost control measures can States ensure that the citizens receive the increased health care they need and at rates they can afford. Failure on the part of States to enact the necessary authorities would prevent them from receiving any Federal support of their State-administered health assistance plan.

MAINTAINING A PRIVATE ENTERPRISE APPROACH

My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.

Any insurance company which could offer those benefits would be a potential supplier. Because private employers would have to provide certain basic benefits to their employees, they would have an incentive to seek out the best insurance company proposals and insurance companies would have an incentive to offer their plans at the lowest possible prices. If, on the other hand, the Government were to act as the insurer, there would be no competition and little incentive to hold down costs.

There is a huge reservoir of talent and skill in administering and designing health plans within the private sector. That pool of talent should be put to work.

It is also important to understand that the CHIP plan preserves basic freedoms for both the patient and doctor. The patient would continue to have a freedom of choice between doctors. The doctors would continue to work for their patients, not the Federal Government. By contrast, some of the na-

tional health plans that have been proposed in the Congress would place the entire health system under the heavy hand of the Federal Government, would add considerably to our tax burdens, and would threaten to destroy the entire system of medical care that has been so carefully built in America.

I firmly believe we should capitalize on the skills and facilities already in place, not replace them and start from scratch with a huge Federal bureaucracy to add to the ones we already have.

COMPREHENSIVE HEALTH INSURANCE PLAN—A PARTNERSHIP EFFORT

No program will work unless people want it to work. Everyone must have a stake in the process.

This Comprehensive Health Insurance Plan has been designed so that everyone involved would have both a stake in making it work and a role to play in the process—consumer, provider, health insurance carrier, the States and the Federal Government. It is a partnership program in every sense.

By sharing costs, consumers would have a direct economic stake in choosing and using their community's health resources wisely and prudently. They would be assisted by requirements that physicians and other providers of care make available to patients full information on fees, hours of operation and other matters affecting the qualifications of providers. But they would not have to go it alone either: doctors, hospitals and other providers of care would also have a direct stake in making the Comprehensive Health Insurance Plan work. This program has been designed to relieve them of much of the red tape, confusion and delays in reimbursement that plague them under the bewildering assortment of public and private financing systems that now exist. Healthboards would relieve them of troublesome bookkeeping. Hospitals could be hospitals, not bill collecting agencies.

CONCLUSION

Comprehensive health insurance is an idea whose time has come in America.

There has long been a need to assure every American financial access to high quality health care. As medical costs go up, that need grows more pressing.

Now, for the first time, we have not just the need but the will to get this job done. There is widespread support in the Congress and in the Nation for some form of comprehensive health insurance.

Surely if we have the will, 1974 should also be the year that we find the way.

The plan that I am proposing today is, I believe, the very best way. Improvements can be made in it, of course, and the Administration stands ready to work with the Congress, the medical profession, and others in making those changes.

But let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington.

Let us continue to have doctors who work for their patients, not for the Federal Government. Let us build upon the strengths of the medical system we have now, not destroy it.

Indeed, let us act sensibly. And let us act now—in 1974—to assure all Americans financial access to high quality medical care.

RICHARD NIXON.

THE WHITE HOUSE, February 6, 1974.

MAJOR FEATURES OF THE COMPREHENSIVE HEALTH INSURANCE PLAN

1. STRUCTURE

A. Employee Health Insurance Plan (EHIP)

All employers would be required to offer the basic insurance plan and Health Maintenance Organization (HMO) coverage to each employee under age 65 who has met

the full-time hours of work test. Coverage extends to family members under 65. Employers may self-insure.

Election of coverage would be voluntary at the option of the employee.

The basic plan would also be available to self-employed and non-working families, individuals, and non-employer groups (e.g., unions or professional associations), through private carriers.

Employers would be required to offer coverage meeting the basic plan, and could offer optional plans supplementing the basic plan. Employers could not offer non-approved plans.

Employers would contribute 65 percent of premium expenses for covered employees, (75% after three years.) However, if an employer's payroll rises by more than 3 percent due to required contributions to coverage, then the Federal Government would pay a subsidy to the employer for employer premiums in excess of the 3 percent increase in payroll expenses. The subsidy would be 75 percent of such excess in the first year reduced by 15 percentage points each year thereafter.

The employer contribution toward coverage would begin 90 days after onset of employment and continue for 90 days after termination of full-time employment.

An individual or family which has been enrolled in an Employee Health Insurance Plan would be allowed to continue coverage under the plan, at the employer's group rate, for 90 days following the period of a required employer contribution (a total of 180 days after termination), by paying the premium in full themselves.

B. Assisted Health Insurance Plan (AHIP)

States would contract with intermediaries to offer the basic plan to all residents of the State, except those with family incomes of \$7,500 or more who are offered the Employee Health Insurance Plan.

Employers who desire to do so could offer AHIP (at 150% of the average group rate in the State) in fulfillment of the requirement to offer a mandated plan. Members of such employee groups could enroll in AHIP irrespective of income level.

Persons who would, in fact, enroll in AHIP:

- families below \$5,000 income (\$3,500 for individuals) regardless of work status
- non-working families between \$5,000 and \$7,500 income (\$3,500-\$5,250 for individuals)
- very high risk working families between

\$5,000 and \$7,500 income (\$3,500-\$5,250 for individuals)

d. non-working families with unusually high medical risks (disabled and early retirees) regardless of income

e. unusually high risk employer groups.

All persons eligible for AHIP would have the option of obtaining coverage through an approved prepaid health care plan.

The premiums, deductibles, coinsurance, and maximum liability would be related to income.

Carriers administering AHIP coverage would be reimbursed by the State on the basis of actual benefits paid for covered services, less income derived from this plan, plus a negotiated rate for administration.

Employers would be required to make a contribution to AHIP for low-income employees who elect that coverage, in the amount they would have contributed for other employees under an Employee Health Insurance Plan.

For AHIP eligibles who elect coverage through a prepaid health care plan, the State would contribute an amount equal to the cost of providing AHIP coverage.

II. BENEFIT PACKAGE

A. Reimbursable services

Hospital services, not subject to a dollar limitation.

Physician services, not subject to a dollar limitation.

Prescription drugs, out-of-hospital.

Mental health services:

Inpatient—30 full days or 60 partial days.

Outpatient—30 visits to a comprehensive community care center or private practitioner (the latter not to exceed 15 visits).

Special and preventive services for children:

Well child care up to age 6.

Eye examinations, developmental vision care, and eyeglasses up to age 13.

Ear examinations and hearing aids up to age 13.

Routine dental services up to age 13.

Other preventive services:

Prenatal and maternity services.

Family planning.

Home Health Services—100 visits per year.

Post-hospital extended care—100 days per year.

Blood and blood products.

Other medical services, as in Medicare (prosthetic devices, dialysis equipment and supplies, x-rays, laboratory, ambulance, etc.).

B. Premiums and cost-sharing (EHIP and AHIP)

EMPLOYER PLAN

Premiums for employer groups of 51 or more employees and other families and groups being offered EHIP would be negotiated between employer and other groups and the insurance carrier.

Expenses for an insured individual which exceed \$10,000 in a year cannot be attributed to the experience rating of the employee group through which the individual has obtained coverage.

Each insurance company would be required to offer the same rate to all employees in firms with 1 to 50 employees (subject to the single/family rate differential).

Rates for coverage under the plan cannot differ on the basis of family size and composition, except that there must be separate rate determinations for singles and families with the single rate being 40 percent of the family rate.

The benefit package as presently constituted would result in an approximate average group family premium of about \$600. (A single person's premium could be expected to be \$240.) The average premium required by this coverage per full-time employee is \$415.

The employer would eventually pay 75% of premium costs and employees the remaining 25%.

EHIP would not reimburse for services until the insured unit has met a deductible of \$150 per person (maximum of three deductibles per family), with a separate \$50 per person deductible on reimbursement for outpatient drugs.

After satisfying the deductible, the enrollee pays a coinsurance of 25 percent, with a maximum liability for cost-sharing (deductible plus coinsurance) of \$1,500 in a year.

There would be no per year or lifetime limitation on benefits paid by the Plan.

ASSISTED HEALTH INSURANCE PLAN (AHIP)

Premiums, deductibles, coinsurance, and maximum liability would be all income-related under the AHIP. The following schedule has been used in making cost estimates for the Comprehensive Health Insurance Act of 1974.

Annual income	Contribution	Per person deductible		Coinsurance (percent)	Maximum liability	Annual income	Contribution	Per person deductible		Coinsurance (percent)	Maximum liability
		Drugs	Other					Drugs	Other		
SINGLE						FAMILY					
I. 0 to \$1,749.....	0	0	0	10	6 percent of income.	I. 0 to \$2,499.....	0	0	0	10	6 percent of income.
II. \$1,750 to \$3,499.....	0	\$25	\$50	15	9 percent of income.	II. \$2,500 to \$4,999.....	0	\$25	\$50	15	9 percent of income.
III. \$3,500 to \$5,249.....	\$120	50	100	20	12 percent of income.	III. \$5,000 to \$7,499.....	\$300	50	100	20	12 percent of income.
IV. \$5,250 to \$6,999.....	240	50	150	25	15 percent of income.	IV. \$7,500 to \$9,999.....	600	50	150	25	15 percent of income.
V. \$7,000 plus.....	360	50	150	25	\$1,050.	V. \$10,000 plus.....	900	50	150	25	\$1,500.

¹ Based on 50 percent of average group single rate in group III, 100 percent in group IV, and 150 percent in group V. Expected average group single premium rate equals \$240.

² Contributions based on 50 percent of average group family premium rate in the State for

group III, 100 percent for group IV, and 150 percent for group V. Expected average group family premium rate equals \$600.

III. FEDERAL PROGRAMS

A. Medicare

Medicare for the Aged would be retained, with the benefits changed to conform with the mandated health plan.

Medicare would continue to be administered directly by the Social Security Administration through its own system of fiscal intermediaries.

The benefit package would include the full range of services as in EHIP and AHIP. As a result, outpatient drugs and mental health services would be covered, and the aged would have far superior protection against catastrophic expenses—complete hospitalization and maximum financial lia-

bility. (Medicare now covers 90 days of hospitalization per episode plus a lifetime reserve of 60 days.)

A Medicare beneficiary would face an annual per person deductible of \$100 on all services except outpatient drugs. The deductible for outpatient drugs would be \$50. Beneficiaries would pay 20 percent coinsurance on expenses above the deductible up to a maximum annual liability of \$750.

Medicare for the Aged would be financed from the current 1.3 percent payroll tax plus a small premium contribution by the enrollees (about \$90 per person annually, roughly equal to the current Part B premium).

Federal, State, and local government employers and employees would participate in the Medicare system and be subject to the Medicare payroll tax.

Medicare beneficiaries who are low-income would be eligible for reduced premium payments and cost-sharing. The income testing and income definitions would be tied to SSI. Dependents of Medicare beneficiaries below age 65 would be eligible to enroll in AHIP.

Medicare for the Disabled (including the kidney disease provisions) would cease as a separate program. The disabled would be eligible for AHIP coverage. Most current Medicare disabled beneficiaries would have

better protection because of the catastrophic provisions and because a high proportion would qualify for reduced cost sharing because they are low-income but have Social Security cash payments which place them beyond Medicaid eligibility.

Reimbursement for Medicare services in a State would be based on the same system as used in that State for EHIP/AHIP services.

B. Medicaid

Medicaid would be terminated except for certain services not covered by the Comprehensive Health Insurance Act. These include (1) services in a skilled nursing facility or intermediate care facility; (2) care in mental institutions for persons under age 21 or over 65; and (3) home health services.

C. Indian Health

The Indian Health Service would continue to provide health care to eligible Indians.

Indians may also participate in State AHIP programs.

D. Veterans Administration

The VA would continue to operate a separate health care system for those eligible for VA benefits.

The VA system would be reimbursed for services not related to a disability incurred while in the military.

IV. REIMBURSEMENT POLICY

A. Healthcard

All persons (including Medicare enrollees) would receive an identification card which would be evidence of financial protection for all covered services.

Participating providers of service would be required to accept the card as evidence of coverage and would bill the indicated carrier for covered services.

The carrier would reimburse the provider and would bill the enrollee for the applicable cost-sharing.

B. Classification of providers

Full-Participating Providers—would agree to accept reimbursement through the Healthcard as payment in full for all patients (EHIP, AHIP, and Medicare). To these providers the Healthcard would reimburse the full amount of the applicable reimbursement rates (the insured amount as well as the patient's cost-sharing). All institutions would be required to be full-participating providers.

Associate-Participating Providers—would agree to accept reimbursement through the Healthcard as payment in full for all AHIP and Medicare patients, and as payment of the insured amount of an Employee Health Insurance Plan enrollee's bills. To collect the remainder of his fee for the patient, the physician would bill the patient directly.

Non-Participating Providers—would not be reimbursed from any approved plan for services provided.

V. REGULATION AND ADMINISTRATION

A. State Regulation and Administration—States must enact appropriate legislation fulfilling each of the following responsibilities to be eligible for Federal financial participation in the plan. This regulation must extend to prepaid health care plans as well as to all private carriers and self-insured employers.

Carriers and self-insured employers providing the basic plan would file their plans with the States, keeping the State advised of the employers and employees to whom the plan is provided. States would be required to provide for prompt review of the plan and determination as to whether it meets the requirements of the law.

Premium rates and rating structures would be reviewed for reasonableness (file and use procedure) for all private health insurance.

Enrollees would be guaranteed against non-coverage or nonpayment of claims related to

the basic plan resulting from carrier insolvency.

An annual CPA audit would be required for all insurance carriers offering coverage under the plan.

Carriers would be required to disclose information with regard to services covered, rates, and the relation between premiums and benefits paid. This requirement must extend to all private health insurance sold.

All capital investment over \$100,000 would be approved by a State-designated planning agency to receive reimbursement through the plan.

Medical services would be subject to Professional Standards Review Organization.

Physician reimbursement for covered services under the insurance plans would be based on amounts determined after consultation with providers and other interested parties. Physicians would be free to bill additional charges to those covered under the Employee Health Insurance Plan provided the patient is notified beforehand of such additional charges.

States would establish prospective reimbursement systems for hospitals.

Providers would make available to patients information regarding charges for most commonly given services, hours of operation and other matters affecting access to services, and extent of certification, accreditation, and licensure.

In addition to administration and participation in financing of the AHIP, States would be responsible for certifying health care providers as eligible for participation in the Comprehensive Health Insurance Plan.

B. Federal Regulations and Administration—The Federal Government would:

Establish standards for eligibility.

Define the services to be reimbursed by the plan.

Operate an expanded program of benefits for the aged.

VI. COSTS

Added Federal/State expenditures to finance the Assisted Health Insurance Plan would approximate \$8.9 billion.

Added State spending under the Government Plan would equal about \$1.0 billion. Much of this would be offset by reductions in other State health programs.

Added Federal spending would equal about \$5.9 billion.

The Federal subsidy to assist low-income employees and their employers would equal about \$0.45 billion.

The additional cost of increased benefits for the aged would be \$1.8 billion.

VII. FINANCING

A. Employee Health Insurance Plan (EHIP):

Would be financed jointly by employers and employees.

Employers would be required to make a contribution to the EHIP for those employees who qualify and enroll.

B. Assisted Health Insurance Plan (AHIP):

Costs of AHIP above the income derived from enrollees would be shared by State and Federal governments. The States share would be related to current levels of State expenditures, ability to pay, and anticipated future expenditures under The Comprehensive Health Insurance Plan in that State. The total State share would be about 25%.

C. Medicare:

The Medicare Trust Fund (plus a small premium contribution (about \$90 per year)) would pay for all services provided under the basic Medicare plan. The cost above the basic income aged would be borne by General Revenues and State contributions.

D. Medicaid:

A residual Medicaid program for long term

care services would continue with the current Federal/State Medicaid matching formula.

VIII. SPECIAL PROVISIONS TO ASSIST SMALL EMPLOYERS

The following provisions have been incorporated, which would particularly assist small employers, since they have a higher proportion of low wage workers and pay higher premiums than large employers.

Where two members of the same family are eligible for Employee Health Insurance Plan coverage, only one could accept. This provision would benefit small business, which hire a disproportionate number of secondary workers.

Each insurance company would be required to offer coverage at the same premium rate to all employees in firms with up to 50 employees. This provision would reduce the costs associated with carriers individually rating small groups. It also would minimize the adverse labor market effects against hiring high medical risk individuals.

The Federal government will subsidize the employer whose payroll costs increase by more than three percent as a result of The Health Insurance Plan. The excess over three percent will be subsidized by 75% the first year and reduced 15 percentage points each year thereafter.

By Mr. MCINTYRE:

S.J. Res. 186. A joint resolution asking the President of the United States to declare the fourth Saturday of each September "National Hunting and Fishing Day." Referred to the Committee on the Judiciary.

NATIONAL HUNTING AND FISHING DAY

Mr. MCINTYRE. Mr. President, I am privileged once again this year to introduce a resolution to give much deserved public recognition to America's outdoor sportsmen.

I am proposing legislation for the third consecutive year to set aside the fourth Saturday of September as National Hunting and Fishing Day, a day to honor the country's outdoor sportsmen for their many contributions in the areas of environmental protection, fish and wildlife preservation, and boat and hunting safety promotion.

Mr. President, to give my colleagues an idea of how quickly the celebration of Hunting and Fishing Day has grown, let me list a few statistics about last year's day alone:

More than 3,000 separate programs, representing the efforts of more than 9,000 clubs and organizations, were held on the fourth Saturday in September last year.

An estimated 12 million people either took part in or observed some Hunting and Fishing Day related program in 1973. Observances ranged from the 212,000 people who stopped by a Hunting and Fishing Day display in Wichita, Kans., to small parades and displays in such disparate areas as the suburbs of New York City and my own home State capital of Concord, N.H.

More than 500 of the Nation's mayors proclaimed National Hunting and Fishing Day.

All of the 50 State Governors issued official National Hunting and Fishing Day proclamations.

DSG

SPECIAL REPORT

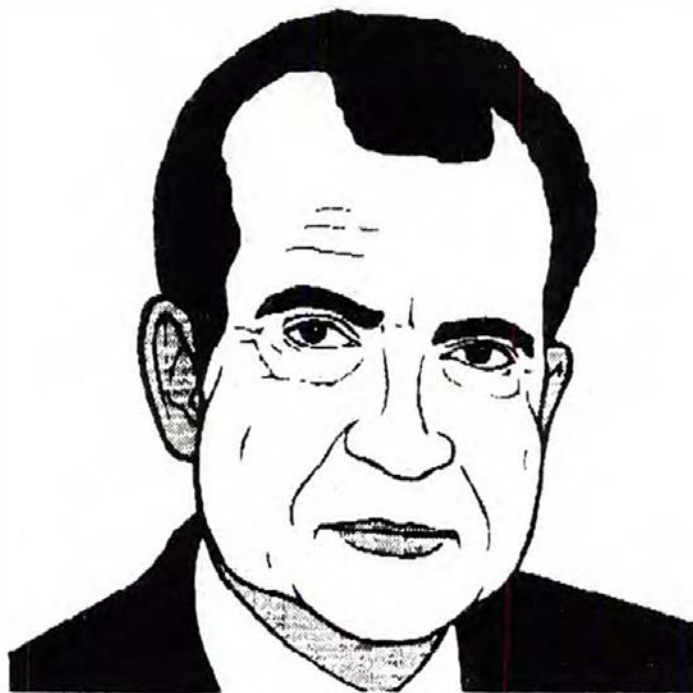
February 3, 1994

No. 103-24

HON. MIKE SYNAR (Okla.) — Chairman

SCOTT LILLY — Executive Director

President Nixon's Employer Mandate Health Reform Plan



"I propose Employee Health Insurance, covering most Americans and offered at their place of employment, with the cost to be shared by the employer and employee on a basis which would prevent excessive burdens on either."

Democratic Study Group • U.S. House of Representatives

1422 Longworth House Office Building; Washington, D.C. 20515 — (202) 225-5858

PRESIDENT NIXON'S EMPLOYER MANDATE PLAN

In both the 92nd Congress (1971-1972) and the 93rd Congress (1973-1974), President Nixon submitted national health insurance legislation to Congress. In the 92nd Congress, the Nixon Administration's bill was known as the National Health Insurance Partnership Act (H.R. 7741; S. 1623). In the 93rd Congress, the Nixon Administration's bill was known as the Comprehensive Health Insurance Act (H.R. 12684; S. 2970). Although there were minor differences between the two proposals, both proposals included a requirement that all employers offer employees a standardized package of health insurance benefits and that employers pay a significant portion of the premium.

This DSC Special Report simply reprints, from the Weekly Compilation of Presidential Documents, the text of President Nixon's message to Congress on February 6, 1974, transmitting his 1974 legislative proposal. Examination of this presidential message is instructive in the current debate on health care reform.

First, in reading the text of this message to Congress, one is struck by the similarities between President Nixon's description of the problems of the U.S. health care system in 1974 and President Clinton's description of its problems in 1994. President Nixon's observations include:

- "The overall cost of health care has risen by more than 20 percent in the last two and a-half years, so that more and more Americans face staggering bills when they receive medical help."
- "For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a

catastrophic illness can mean catastrophic debt."

- "Even though more Americans carry health insurance than ever before, the 25 million Americans [now 37 million Americans!] who remain uninsured often need it most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes."

- "Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers."

- "[The] gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills—or worse. Delays in treatment can end in death or lifelong disability."

Secondly, in reading this text, one is also struck by the similarities between the national health insurance plan submitted by President Nixon in 1974 and the one recently submitted by President Clinton. Among its many features, the Nixon plan:

- Requires every employer to offer all full-time employees the Comprehensive Health Insurance Plan (a standardized package of health insurance benefits). The insurance plan would be jointly financed, with employers paying 65% of the premium for the first three years and 75% there-

after. Employees would pay the balance of the premiums.

- Provides federal subsidies to certain employers, to ease the burden on employers who face significant cost increases;
- Provides that every American who participates in the program would receive a Healthcard. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency rooms, doctors, and clinics across the country;
- Expands the Medicare program to include prescription drugs; and
- Replaces the state-run Medicaid program for acute-care services with a program providing uniform benefits for low-income Americans across the country.

Text of President Nixon's Message to Congress Transmitting the Comprehensive Health Insurance Act, February 6, 1974

To The Congress of the United States:

One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.

In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who were seeking equal opportunities in education, jobs and voting.

Now it is time that we move forward again in still another critical area: health care.

Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic,

racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.

Three years ago, I proposed a major health insurance program to Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk.

Today the need is even more pressing because of the higher costs of medical care. Efforts to control medical costs under the New Economic Policy have been met with encouraging success, sharply reducing the rate of inflation for health care. Nevertheless, the overall cost of health care has still risen by more than 20 percent in the last two and one-half years, so that more and more Americans face staggering bills when they receive medical help today:

- Across the Nation, the average cost of a day of hospital care now exceeds \$110.
- The average cost of delivering a baby and providing post-natal care approaches \$1,000.
- The average cost of health care for terminal cancer now exceeds \$20,000.

For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.

Beyond the question of the prices of health care, our present system of health care insurance suffers from two major flaws:

First, even though more Americans carry health insurance than ever before, the 25 million Americans who remain uninsured often need it most and are most unlikely to obtain it. They include many who work in seasonal or transient

occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage which is balanced, comprehensive and fully protective:

- Forty percent of those who are insured are not covered for visits to physicians on an outpatient basis, a gap that creates powerful incentives toward high-cost care in hospitals;
- Few people have the option of selecting care through prepaid arrangements offered by Health Maintenance Organizations so the system at large does not benefit from the free choice and creative competition this would offer;
- Very few private policies cover preventive services;
- Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers; and
- Fewer than half of our citizens under 65 — and almost none over 65 — have major medical coverage which pays for the cost of catastrophic illness.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills — or worse. Delays in treatment can end in death or lifelong disability.

Comprehensive Health Insurance Plan

Early last year, I directed the Secretary of Health, Education, and Welfare to prepare a new and improved plan for comprehensive health insurance. That plan, as I indicated in my

State of the Union message, has been developed and I am presenting it to the Congress today. I urge its enactment as soon as possible.

The plan is organized around seven principles:

First, it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits;

Second, it will cost no American more than he can afford to pay;

Third, it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system;

Fourth, it uses public funds only where needed and requires no new federal taxes;

Fifth, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the Federal Government;

Sixth, it encourages more effective use of our health care resources;

And finally, it is organized so that all parties would have a direct stake in making the system work — consumer, provider, insurer, state governments and the Federal Government.

Broad and Balanced Protection for All Americans

Upon adoption of appropriate Federal and state legislation, the Comprehensive Health Insurance Plan (CHIP) would offer to every American the same broad and balanced health protection through one of three major programs:

- Employee Health Insurance, covering most Americans and offered at their place of employment, with the cost to be shared

by the employer and employee on a basis which would prevent excessive burdens on either;

- Assisted Health Insurance, covering low-income persons, and persons who would be ineligible for the other two programs, with Federal and State government paying those costs beyond the means of the individual who is insured; and,

- An improved Medicare Plan, covering those 65 and over and offered through a Medicare system that is modified to include additional, needed benefits.

One of these three plans would be available to every American, but for everyone, participation in the program would be voluntary.

The benefits offered by the three plans would be identical for all Americans, regardless of age or income. Benefits would be provided for:

- hospital care;
- physicians' care in and out of the hospital;
- prescription and life-saving drugs;
- laboratory tests and X-rays;
- medical devices;
- ambulance services; and,
- other ancillary health care.

There would be no exclusions of coverage based on the nature of the illness. For example, a person with heart disease would qualify for benefits as would a person with kidney disease.

In addition, CHIP would cover treatment for mental illness, alcoholism and drug addiction, whether that treatment were provided in hospitals and physicians' offices or in community-based settings.

Certain nursing home services and other convalescent services would also be covered. For example, home health services would be

covered so that long and costly stays in nursing homes could be averted where possible.

The health needs of children would come in for special attention, since many conditions, if detected in childhood, can be prevented from causing lifelong disability and learning handicaps. Included in these services for children would be:

- preventive care up to age six;
- eye examinations;
- hearing examinations; and,
- regular dental care up to age 13.

Under the Comprehensive Health Insurance Plan, a doctor's decisions could be based on the health care needs of his patients, not on health insurance coverage. This difference is essential for quality care.

Every American participating in the program would be insured for catastrophic illnesses that can eat away savings and plunge individuals and families into hopeless debt for years. No family would ever have annual out-of-pocket expenses for covered health services in excess of \$1,500, and low-income families would face substantially smaller expenses.

As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his state. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency rooms, doctors, and clinics across the country. This card could also be used to identify information on blood type and sensitivity to particular drugs — information which might be important in an emergency.

Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if any.