The original documents are located in Box 12, folder "Health" of the Loen and Leppert Files at the Gerald R. Ford Presidential Library.

Union Calendar No. 53

94TH CONGRESS
1ST SESSION

H. R. 4114

[Report No. 94–137]

IN THE HOUSE OF REPRESENTATIVES

MARCH 4, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. WIRTH, Mr. CARTER, Mr. BROYHILL, Mr. HASTINGS, and Mr. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

APRIL 10, 1975

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To amend the Public Health Service Act to revise and extend the National Health Service Corps program.

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

EXTENSION OF CURRENT AUTHORITY THROUGH FISCAL YEAR 1975

SECTION 1. Section 329 (h) of the Public Health Service Act is amended by striking out "and" after "1973;" and by inserting before the period a comma and the following: "and $16,000,000 for the fiscal year ending June 30, 1975".

REVISION OF NATIONAL HEALTH SERVICE CORPS PROGRAM

SEC. 2. (a) (1) Part C of title III of the Public Health Service Act is amended by inserting immediately below the heading for such part the following:

"Subpart I—General Provisions".

(2) Sections 331 and 332 of part D of such title are redesignated as sections 338 and 339, respectively.

(b) Part C of title III of the Public Health Service Act is amended by striking out section 329 and inserting in lieu thereof the following:

"Subpart II—National Health Service Corps Program

"NATIONAL HEALTH SERVICE CORPS

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this subpart referred to as the 'Corps') which (1) shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate, and (2) shall be utilized by the Secretary under this subpart to improve the delivery of health services to medically underserved populations.

"(b) (1) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps. Such programs shall include the

wide dissemination of written information on the Corps and visits to such schools and entities by personnel of the Corps.

"(2) The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling to and from their places of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

"(3) Commissioned officers and other personnel of the Corps assigned under section 331 to provide health services ~~for medically underserved populations shall not be included in determining whether any limitation on the number of personnel which may be employed by the Department of Health, Education, and Welfare has been exceeded.~~ *for medically underserved populations shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.*

"(c) (1) The Secretary ~~shall~~ *may,* under regulations prescribed by him, adjust the monthly pay of each physician and dentist member of the Corps who is directly engaged in the delivery of health services to a medically underserved population as follows:

"(A) During the first thirty-six months in which such a member is so engaged in the delivery of health

services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowance will provide a monthly income ~~competitive with the average monthly income from an established practice of a member of such member's profession with equivalent training.~~ *competitive with the average monthly income from a practice of an individual who is a member of the profession of the Corps member, who has equivalent training, and who has been in practice for a period equivalent to the period during which the Corps member has been in practice.*

"(B) During the period beginning upon the expiration of the thirty-six months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances is equal to or exceeds the monthly income he received for the last of such thirty-six months, the member shall receive in addition to his monthy pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

For purposes of subparagraphs (A) and (B), the term 'monthly pay' includes special pay received under chapter 5 of title 37 of the United States Code.

"(2) In the case of a member of the Corps who is

directly engaged in the provision of health services to a medically underserved population in accordance with a service obligation incurred under the Public Health Service and National Health Service Corps Scholarship Training Program, ~~the provisions of paragraph (1) shall apply to such member~~ *the adjustment in pay authorized by paragraph (1) may be made for such a member only* upon satisfactory completion of such service obligation and the first thirty-six months of his being so engaged in the delivery of health care shall, for purposes of paragraph (1) (A), be deemed to begin upon such satisfactory completion.

"DESIGNATION OF MEDICALLY UNDERSERVED POPULATIONS:

"SEC. 330. (a) For purposes of this subpart—

"(1) the term 'medically underserved population' means (A) the population of an urban or rural area (which need not ~~have to~~ conform to the geographical boundaries of a political subdivision and which should be a rational area for the delivery of health services) which the Secretary determines has a critical health manpower shortage, or (B) a population group determined by the Secretary to have such a shortage; and

"(2) the term 'State' includes Guam, American Samoa, and the Trust Territory of the Pacific Islands.

"(b) (1) The Secretary shall designate the medically

underserved populations in the States. In ~~designating~~ *determining whether to designate a population as* a medically underserved population, the Secretary shall take into account the following:

(A) The recommendations of each health systems agency designated under section 1515 for a health service area which includes all or any part of the area in which *the* population under consideration for designation resides.

"(B) If such area is within a health service area (or areas) for which no health systems agency has been designated, the recommendations of the State health planning and development agency designated under section 1521 for the State (or States) in which such area is located.

"(C) Ratios of available health manpower to the population under consideration for designation.

"(D) Indicators of the population's access to health services.

"(E) Indicators of the health status of the population.

"(F) Indicators of such population's need and demand for health services.

"(2) Any person may apply to the Secretary (in such manner as he may prescribe) for the designation (in accordance with the second sentence of paragraph (1)) of a population as a medically underserved population.

"ASSIGNMENT OF CORPS PERSONNEL

"SEC. 331. (a) (1) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health services for a medically underserved population *only* if—

"(A) the State health agency of each State in which such population is located or the local public health agency or any other public or nonprofit private health entity serving such population makes application to the Secretary for such assignment, and

"(B) (i) the local government of the area in which such population resides certifies to the Secretary that such assignment of Corps personnel is needed for such population, and

"(ii) any State and district medical, osteopathic, or dental society for such area, or any other appropriate health society (as the case may be) for such area, makes such a certification to the Secretary.

"(2) The Secretary may not approve an application under paragraph (1) (A) for an assignment unless the applicant agrees to enter into an arrangement with the Secretary in accordance with subsection (b) and has afforded—

"(A) each health systems agency designated under

section 1515 for a health service area which includes all or any part of the area in which the population for which the application is submitted resides, and

"(B) if there is a part of such area within a health service area for which no health systems agency has been designated, the State health planning and development agency of the State (designated under section 1521) in which such part is located.

an opportunity to review the application and submit its comments to the Secretary respecting the need for and proposed use of the Corps personnel requested in the application. In considering such an application, the Secretary shall take into consideration the need of the population for which the application was submitted for the health services which may be provided under this subpart; the willingness of the population and the appropriate governmental agencies or health entities serving it to assist and cooperate with the Corps in providing effective health services to the population; and recommendations from medical, osteopathic, dental, or other health societies or from medical personnel serving the population.

"(3) If with respect to any proposed assignment of Corps personnel for a medically underserved population the requirements of subparagraphs (A) and (B) of paragraph (1) are met except for the certification required by subparagraph (B) (ii) of such paragraph and if the Secretary

finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, the Secretary may, after consultation with appropriate medical, osteopathic, dental, or other health societies, waive the application of the certification requirement to such proposed assignment.

"(b) (1) The Secretary shall require as a condition to the approval of an application under subsection (a) that the entity which submitted the application enter into an appropriate arrangement with the Secretary under which—

"(A) the entity shall be responsible for charging in accordance with paragraph (3) for health services provided by the Corps personnel to be assigned;

"(B) the entity shall take such action as may be reasonable for the collection of payments for such health services, including if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps personnel under this subpart, the collection, on a fee-for-service or other basis, from such agency or third party the portion of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health

services provided by Corps personnel shall be considered as being provided by private practitioners) ; and

"(C) the entity shall pay to the United States as prescribed by the Secretary for each calendar quarter (or other period as may be specified in the arrangement) during which any Corps personnel are assigned to such entity the sum of—

"(i) the pay (including amounts paid in accordance with 329(c)) and allowances of such Corps personnel for the portion of such quarter (or other period) during which assigned to the entity;

"(ii) if such entity received a grant under section 332 for the assistance period (as defined in subsection (c)) for which such personnel are assigned, an amount which bears the same ratio to the amount of such grant as the number of days in such quarter (or other period) during which any Corps personnel were assigned to the entity bears to the number of days in the assistance period after such entity received such grant; and

"(iii) if during such quarter (or other period) any member of the Corps assigned to such entity is providing obligated service pursuant to an agreement under the Public Health and National Health

Service Corps Scholarship Training Program, for each such member an amount which bears the same ratio to the amount paid under such Program to or on the behalf of such member as the number of days of obligated service provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such Program.

The Secretary may waive in whole or in part the application of the requirement of subparagraph (C) to an entity if he determines that the entity is financially unable to meet such requirement or if he determines that compliance with such requirement would unduly limit the ability of the entity to maintain the quality of the services it provides.

"(2) The excess (if any) of the amount collected by an entity in accordance with paragraph (1)(B) over the amount paid to the United States in accordance with paragraph (1)(C) shall be used by the entity to expand or improve the provision of health services to the population for which the entity submitted an application under subsection (a) or to recruit and retain health manpower to provide health services for such population.

"(3) Any person who receives health services provided by Corps personnel under this subpart shall be charged for such services on a fee-for-service or other basis at a rate

approved by the Secretary, pursuant to regulations, to recover the value of such services; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate or without charge.

"(4) Funds received by the Secretary under an arrangement entered into under paragraph (1) shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amounts of appropriations to be requested under section 335 and the amounts to be made available from appropriations made under such section to carry out this subpart.

"(c) Upon approval of an application submitted under subsection (a) for the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may approve the assignment of Corps personnel for such population during a period (hereinafter in this subpart referred to as the 'assistance period') which may not exceed four years from the date of the first assignment of Corps personnel for such population after the date of the approval of the application. No assignment of individual Corps personnel may be made for a period ending after the expiration of the applicable approved assistance period.

"(d) Upon expiration of an approved assistance period for a medically underserved population, no new assignment

of Corps personnel may be made for such population unless an application is submitted in accordance with subsection (a) for such new assignment. The Secretary may not approve such an application unless—

"(1) the application and certification requirements of subsection (a) are met;

"(2) the Secretary has conducted an evaluation of the continued need for health manpower of the population for which the application is submitted, of the utilization of the manpower by such population, of the growth of the health care practice of the Corps personnel assigned for such population, and of community support for the assignment; and

"(3) the Secretary has determined that such population has made continued efforts to secure its own health manpower, that there has been sound fiscal management of the health care practice of the Corps personnel assigned for such population, including efficient collection of fee-for-service, third-party, and other funds available to such population, and that there has been appropriate and efficient utilization of such Corps personnel.

"(e) Corps personnel shall be assigned to provide health services for a medically underserved population on the

basis of the extent of the population's need for health services and without regard to the ability of the members of the population to pay for health services.

"(f) In making an assignment of Corps personnel the Secretary shall seek to match characteristics of the assignee (and his spouse (if any)) and of the population to which such assignee may be assigned in order to increase the likelihood of the assignee remaining to serve the population upon completion of his assignment period. The Secretary shall, before the ~~expiration~~ *beginning* of the last nine months of the assignment period of a member of the Corps, review such member's assignment and the situation in the area to which he was assigned for the purpose of determining the advisability of extending the period of such member's assignment.

"(g) (1) The Secretary shall (A) provide assistance to persons seeking assignment of Corps personnel under this section, and (B) conduct such information programs in areas in which such populations reside as may be necessary to inform the public and private health entities serving those areas of the assistance available to such populations by virtue of their designation under section 330 as medically underserved.

"(2) The Secretary shall provide technical assistance to all medically underserved populations to which are not assigned Corps personnel to assist in the recruitment of

health manpower for such populations. The Secretary shall also give such populations current information respecting public and private programs under which they may receive assistance in securing health manpower for them.

"PROVISION OF HEALTH SERVICES BY CORPS PERSONNEL

"SEC. 332. (a) In providing health services for a medically underserved population under this subpart, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area in which the population resides and shall, to the maximum extent feasible, provide such services (1) to all members of the population regardless of their ability to pay for the services, and (2) in connection with (A) direct health services programs carried out by the Service; (B) any other direct health services program carried out in whole or in part with Federal financial assistance; or (C) any other health services activity which is in furtherance of the purposes of this subpart.

"(b) (1) Notwithstanding any other provision of law, the Secretary (A) may, to the extent feasible, make such arrangements as he determines necessary to enable Corps personnel in providing health services for a medically underserved population to utilize the health facilities of the area in which the population resides and if there are no health facilities in or serving such area, the Secretary may arrange to have Corps personnel provide health services in the near-

est health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the provision of health services, (B) may make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of other equipment and supplies, and (C) may secure the temporary services of ~~nurses~~ *physicians, nurses,* and allied health professionals.

"(2) If such an area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make under paragraph (1), arrange for the utilization of such hospital or facility by Corps personnel in providing health services for the population, but only to the extent that such utilization will not impair the delivery of health services and treatment through such hospital or facility to persons who are entitled to health services and treatment through such hospital or facility.

"(c) The Secretary may make one grant to any applicant with an approved application under section 331 to assist it in meeting the costs of establishing medical practice management systems for Corps personnel, acquiring equipment for their use in providing health services, and establishing appropriate continuing education programs and

opportunities for them. No grant may be made under this subsection unless an application therefor is submitted to, and approved by, the Secretary. The amount of any grant shall be determined by the Secretary, except that no grant may ~~be made for~~ *exceed* more than $25,000.

"(d) Upon the expiration of the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may (notwithstanding any other provision of law) sell to the entity which submitted the last application approved under section 331 for the assignment of Corps personnel for such population equipment of the United States utilized by such personnel in providing health services. Sales made under this subsection shall be made for the fair market value of the equipment sold (as determined by the Secretary).

"REPORTS

"SEC. 333. The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number and identity of all medically underserved populations in each of the States in the calendar year preceding the year in which the report is made and the number of medically underserved populations which the Secretary estimates will be designated under section 330 in the calendar year in which the report is made;

"(2) the number of applications filed under section 331 in such preceding calendar year for assignment of Corps personnel and the action taken on each such application;

"(3) the number and types of Corps personnel assigned in such preceding year to provide health services for medically underserved populations, the number and types of additional Corps personnel which the Secretary estimates will be assigned to provide such services in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps;

"(4) the recruitment efforts engaged in for the Corps in such preceding year, including the programs carried out under section 329 (b) (1), and the number of qualified persons who applied for service in the Corps in each professional category;

"(5) the total number of patients seen and patient visits recorded during such preceding year in each area where Corps personnel were assigned;

"(6) the number of health personnel electing to remain, after termination of their service in the Corps, to provide health services to medically underserved populations, the number of such personnel who do not make

such election, and their reasons for not making such election;

"(7) the results of evaluations made under section 331 (d) (2), and determinations made under section 331 (d) (3), during such preceding year; and

"(8) the *total* amount (A) charged during such preceding year for health services by Corps personnel, (B) collected in such year by entities in accordance with arrangements under section 331 (b), and (C) paid to the Secretary in such year under such arrangements.

"NATIONAL ADVISORY COUNCIL

"SEC. 334. (a) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the 'Council'). The Council shall be composed of fifteen members appointed by the Secretary as follows:

"(1) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be members of a medically underserved population for which Corps personnel are providing health services under this subpart.

"(2) Three members shall be appointed from the medical, dental, and other health professions and health teaching professions.

"(3) One member shall be appointed from a State health planning and development agency designated under section 1521, one member shall be appointed from a Statewide Health Coordinating Council under section 1524, and one member shall be appointed from a health systems agency designated under section 1515.

"(4) Three members shall be appointed from the Service, at least two of whom shall be members of the Corps directly engaged in the provision of health services for a medically underserved population.

"(5) Two members shall be appointed from the National Council on Health Planning and Development (established under section 1503).

The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this subpart, and shall review and comment upon regulations promulgated by the Secretary under this section subpart.

"(b) (1) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

"(2) Members of the Council (other than members who are officers or employees of the United States), while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive

for each day (including traveltime) in which they are so serving the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule; and while so serving away from their homes or regular places of business all members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b) of title 5 of the United States Code for persons in the Government Service employed intermittently.

"AUTHORIZATION OF APPROPRIATION

"SEC. 335. To carry out the purposes of this subpart, there is authorized to be appropriated $30,000,000 for fiscal year 1976.".

(c) (1) The amendments made by subsections (a) and (b) of this section shall take effect July 1, 1975.

(2) (A) Any area for which a designation under section 329 (b) of the Public Health Service Act (as in effect on June 30, 1975) was in effect on such date and in which National Health Service Corps personnel were, on such date, providing, under an assignment made under such section (as so in effect), health care and services for persons residing in such area shall, effective July 1, 1975, bbee deemed under subpart II of part C of title III of such Act (as added by subsection (b) of this section) to (i) be an area in which is locataed a medically underserved population (as defined by section 330 of such Act (as so added)), and (ii) be

qualified under section 331 of such Act (as so added) for the assignment of Corps personnel unless, as determined under subparagraph (B) of this paragraph, the assistance period applicable to such area (within the meaning of such section 331) has expired.

(B) The assistance period (within the meaning of such section 331) applicable to an area described in subparagraph (A) of this paragraph shall be deemed to have begun on the date Corps personnel were first assigned to such area under section 329 of such Act (as in effect on June 30, 1975).

(C) In the case of any physician or dentist member of the Corps who was providing health care and services on June 30, 1975, under an assignment made under section 329(b) of such Act (as in effect on June 30, 1975), the number of the months during which such member provided such care and services before July 1, 1975, shall be counted in determining the application of the additional pay provisions of section 329(c) of such Act (as added by section (b) of this section) to such member.

(3) The amendment made by subsection (b) which changed the name of the Advisory Council established under section 329 of the Public Health Service Act (and placed the authority for the Advisory Council in section 334 of such Act) shall not be construed as requiring the establishment of a new Advisory Council under such section 334;

and the amendment made by such subsection with respect to the composition of such Advisory Council shall apply with respect to appointments made to the Advisory Council after July 1, 1975, and the Secretary of Health, Education, and Welfare shall make appointments to the Advisory Council after such date in a manner which will bring about, at the earliest feasible time, the Advisory Council composition prescribed by the amendment.

REPORT AND STUDIES

SEC. 3. (a) The Secretary of Health, Education, and Welfare shall report to Congress (1) not later than October 1, 1975, the criteria used by him in designating medically underserved populations under section 330 of the Public Health Service Act, and (2) not later than January 1, 1976, the identity and number of medically underserved populations in each State meeting such criteria.

(b) The Secretary of Health, Education, and Welfare shall conduct or contract for studies of methods of assigning under section 331 of the Public Health Service Act (as added by section 2(b) of this Act) National Health Service Corps personnel to medically underserved populations and of providing health care to such populations. Such studies shall be for the purpose of identifying (1) the characteristics of health manpower who are more likely to remain in practice in areas in which medically underserved populations

are located, (2) the characteristics of areas which have been able to retain health manpower, ~~(3)~~ *personnel, and (3)* the appropriate conditions for assignment of nurse practitioners, physician's assistants, and expanded function dental auxiliaries in areas in which medically underserved populations are located~~, and (4) the effect that primary care residency training in such areas has on the health care provided in such areas and on the decisions of physicians who received such training respecting the areas in which to locate their practice~~.

CONFORMING AMENDMENT

SEC. 4. (a) Section 741 (f) (1) (C) of the Public Health Service Act is amended by striking out all that follows after "in a State" and inserting in lieu thereof "in which is located a medically underserved population designated under section 330;".

(b) The amendment made by subsection (a) shall apply with respect to agreements entered into under section 741 (f) of the Public Health Service Act after June 30, 1975.

Union Calendar No. 53

94TH CONGRESS
1ST SESSION

H. R. 4114

[Report No. 94–137]

A BILL

To amend the Public Health Service Act to revise and extend the National Health Service Corps program.

By Mr. ROGERS, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. WIRTH, Mr. CARTER, Mr. BROYHILL, Mr. HASTINGS, and Mr. HEINZ

MARCH 4, 1975

Referred to the Committee on Interstate and Foreign Commerce

APRIL 10, 1975

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

Union Calendar No. 59

94TH CONGRESS
1ST SESSION

H. R. 4115

[Report No. 94–143]

IN THE HOUSE OF REPRESENTATIVES

MARCH 4, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. WIRTH, Mr. CARTER, Mr. HASTINGS, and Mr HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

APRIL 10, 1975

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To amend title VIII of the Public Health Service Act to revise and extend the programs of assistance under that title for nurse training.

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

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Nurse Training Act of 1975".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to

be made to a section or other provision of the Public Health Service Act.

TITLE I—ONE-YEAR EXTENSION

EXTENSION OF EXISTING AUTHORITIES THROUGH FISCAL YEAR 1975

SEC. 101. (a) Section 801 (relating to construction grants) is amended by striking out "for the fiscal year ending June 30, 1974" and inserting in lieu thereof "each for the fiscal years ending June 30, 1974, and June 30, 1975".

(b) Section 806(i) (relating to capitation grants) is amended by striking out "for the fiscal year ending June 30, 1974" and inserting in lieu thereof "each for the fiscal years ending June 30, 1974, and June 30, 1975".

(c) Section 808 (relating to special project grants and contracts and financial distress grants) is amended by striking out "for the fiscal year ending June 30, 1974" each place it occurs and inserting in lieu thereof "each for the fiscal years ending June 30, 1974, and June 30, 1975".

(d) Section 809 (relating to loan guarantees and interest subsidies) is amended—

(1) by striking out "1974" in subsections (a) and (b) and inserting in lieu thereof "1975", and

(2) by striking out "in the fiscal year ending June 30, 1974" in subsection (e) and inserting in lieu

thereof "in the fiscal year ending June 30, 1974, or in the next fiscal year".

(e) Section 810(d) (relating to start-up grants) is amended by striking out "for the fiscal year ending June 30, 1974" and inserting in lieu thereof "each for the fiscal years ending June 30, 1974, and June 30, 1975".

(f) Section 860 (relating to scholarships) is amended—

(1) by striking out "next two fiscal year" in subsection (b) and inserting in lieu thereof "next three fiscal years",

(2) by striking out "1975" in that subsection and inserting in lieu thereof "1976",

(3) by striking out "1974" in that subsection and inserting in lieu thereof "1975",

(4) by striking out "the next two fiscal years" in subsection (c) (1) (A) and and inserting in lieu thereof "the next three fiscal years",

(5) by striking out "1974" in subsection (c) (1) (B) and inserting in lieu thereof "1975", and

(6) by striking out "1975" in that subsection and inserting in lieu thereof "1976".

(g) Section 868(b) (relating to recruitment programs) is amended by striking out "for the fiscal year ending June 30, 1974" and inserting in lieu thereof "each for the fiscal years ending June 30, 1974, and June 30, 1975".

TITLE II—REVISION AND EXTENSION OF PROGRAMS THROUGH FISCAL YEAR 1978

PART A—EFFECTIVE DATE

EFFECTIVE DATE

SEC. 201. Except as may otherwise be specifically provided, the amendments made by this title shall take effect July 1, 1975. The amendments made by this title to provisions of title VIII of the Public Health Service Act (hereinafter in this title referred to as the "Act") are made to such provisions as amended by title I of this Act.

PART B—CONSTRUCTION ASSISTANCE

EXTENSION OF GRANTS AND LOAN GUARANTEES AND INTEREST SUBSIDIES

SEC. 202. (a) (1) Section 801 is amended by striking out "and" after "1973,"; and by inserting before the period a comma and the following: "$20,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, and $20,000,000 for fiscal year 1978".

(2) Effective with respect to grants for construction projects under part A of title VIII of the Act made from appropriations under section 801 of the Act, section ~~801~~ *802* (c) (1) (A) is amended (A) by inserting "(i)" after "proposed facilities", and (B) by inserting before the semicolon ", or (ii) in expanding the capacity of the school to provide graduate training".

(b) (1) (A) Subsections (a) and (b) of section 809 are each amended by striking out "June 30, 1975" and inserting in lieu thereof "September 30, 1978".

(B) (i) The last sentence of subsection (a) of section 809 is amended (I) by striking out "(1)" and (II) by striking out all after "the project" and inserting in lieu thereof a period.

(ii) The amendment made by clause (i) shall apply with respect to loans guaranteed under subpart I of part A of title VIII of the Act after the date of the enactment of this Act.

(2) The second sentence of subsection (e) of such section is amended (A) by striking out "and" after "1973,", (B) by inserting after "the next fiscal year" a comma and the following: "$1,000,000 in fiscal year 1976, $1,000,000 in fiscal year 1977, and $1,000,000 in fiscal year 1978", and (C) by inserting a period after "Treasury" the second time it appears in the fourth sentence and by striking out the remainder of that sentence.

(c) (1) Subsection (a) of section 809 is amended by inserting "or the Federal Financing Bank" and "non-Federal lenders".

(2) Subsection (b) of section 809 is amended by inserting "or the Federal Financing Bank" after "non-Federal lender".

TECHNICAL AMENDMENTS

SEC. 203. (a) (1) Title VIII is amended by inserting after the heading for part A the following:

"Subpart I—Construction Assistance"

(2) The heading for part A is amended by striking out "GRANTS" and inserting in lieu thereof "ASSISTANCE".

(b) Section 809 is inserted after section 804 and is redesignated as section 805.

PART C—CAPITATION GRANTS

EXTENSION AND REVISION OF CAPITATION GRANTS

SEC. 205. (a) Section 806 (a) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

"(1) Each collegiate school of nursing shall receive $400 for each undergraduate full-time student enrolled in each of the last two years of such school in such year.

"(2) Each associate degree school of nursing shall receive (A) the product of $275 and one-half of the number of full-time students enrolled in the first year of such school in such year, and (B) for each full-time student enrolled in the last year of such school in such year.

"(3) Each diploma school of nursing shall receive

$250 for each full-time student enrolled in such school in such year.".

(b) Subsections (c), (d), (e), and (f) of section 806 are repealed and the following new subsection is inserted after subsection (b):

"(c) (1) REQUIREMENTS FOR GRANTS.—The Secretary shall not make a grant under subsection (a) to any school of nursing in a fiscal year beginning after June 30, 1975, unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that—

"(A) the first-year enrollment of full-time students in the school in the school year beginning after the fiscal year in which the grant applied for is to be made will not be less than the first-year enrollment of such students in the school in the preceding school year; and

"(B) that the school will expend in carrying out its function as a school of nursing, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the average amount of funds expended by such applicant for such purposes (excluding expenditures of a nonrecurring nature) in the three fiscal years

immediately preceding the fiscal year for which such grant is sought.

The requirement of subparagraph (A) shall be in addition to the requirements of section 802(b)(2)(D), where applicable.

"(2) The Secretary shall not make a grant under subsection (a) to any school of nursing in a fiscal year beginning after June 30, 1975, unless one of the following requirements is met:

"(A) The application for such grant shall contain or be supported by reasonable assurances satisfactory to the Secretary that for the school year beginning after the close of the fiscal year in which such grant is to be made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-time students in such school will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1975—

"(i) by 10 per centum of such number if such number was not more than one hundred, or

"(ii) by 5 per centum of such number, *or ten students, whichever is greater,* if such number was more than one hundred.

"(B) The school has provided reasonable assurances satisfactory to the Secretary that it will carry out, in

accordance with a plan submitted by the school to the Secretary and approved by him, one of the following programs in the school year beginning after the close of the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made:

"(i) In the case of collegiate schools of nursing, a program for the training of nurse practitioners (as defined in section 822).

"(ii) A program under which students enrolled in a school of nursing will receive a significant portion of their clinical training in community health centers, long-term care facilities, and ambulatory care facilities geographically remote from the main site of the teaching facilities of the school.

"(iii) A program for the continuing education of nurses which meets needs identified by appropriate State, regional, or local health or educational entities (including health systems agencies).

"(iv) A program to identify, recruit, enroll, retain, and graduate individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary) under which program at least 10 per centum of each year's enter-

ing class (or ten students, whichever is greater) is comprised of such individuals.".

(c) (1) Section 806(i)(1) is amended by striking out "and" after "1973," and by inserting before "for grants" the following: "$50,000,000 for fiscal year 1976, $55,000,000 for fiscal year 1977, and $60,000,000 for fiscal year 1978".

(d) For fiscal year 1976, and for each of the next two fiscal years, there are authorized to be appropriated such sums as may be necessary to continue to make annual grants to schools of nursing under section 806(a) of the Act (as in effect on June 30, 1975) based on the number of enrollment bonus students (determined in accordance with subsections (c) and (d) of section 806 of the Act (as so in effect)) enrolled in such schools who were first-year students in such schools for school years beginning before June 30, 1975.

TECHNICAL AMENDMENTS

SEC. 206. (a) Subsections (g), (h), and (i) of section 806 are redesignated as subsections (d), (e), and (f), respectively.

(b) Subsection (b) of such section is amended by striking out "subsection (i)" and inserting in lieu thereof "subsection (f)".

(c) Title VIII is amended by inserting after section

805 (as so redesignated by section 102(b) of this Act) the following:

"Subpart II—Capitation Grants".

EFFECTIVE DATE

SEC. 207. The amendments made by this part shall take effect with respect to grants made under section 806 (redesignated as section 810 by title III of this Act) of the Act from appropriations under such section for fiscal years beginning after June 30, 1975.

PART D—FINANCIAL DISTRESS GRANTS

EXTENSION OF FINANCIAL DISTRESS GRANT PROGRAM

SEC. 209. Title VIII is amended by inserting after section 807 the following:

"Subpart III—Financial Distress Grants

"FINANCIAL DISTRESS GRANTS

"SEC. 815. (a) The Secretary may make grants to assist public or nonprofit private schools of nursing which are in serious financial straits to meet operational costs required to maintain quality educational programs or which have special need for financial assistance to meet accreditation requirements. Any such grant may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree (1) to disclose any financial information or data deemed by the Secretary to be necessary to determine

the sources or causes of that school's financial distress, (2) to conduct a comprehensive cost analysis study in cooperation with the Secretary, and (3) to carry out appropriate operational and financial reforms on the basis of information obtained in the course of the comprehensive cost analysis study or on the basis of other relevant information.

"(b) (1) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Nurse Training.

"(2) An application for a grant under subsection (a) must contain or be supported by assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of nursing, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the average amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the three fiscal years immediately preceding the fiscal year for which such grant is sought. The Secretary may, after consultation with the National Advisory Council on Nurse Training, waive the requirement of the preceding sentence with respect to any school if he determines that

the application of such requirement to such school would be inconsistent with the purposes of subsection (a).

"(c) For payments under grants under this section there are authorized to be appropriated $5,000,000 for fiscal year 1976, $5,000,000 for fiscal year 1977, and $5,000,000 for fiscal year 1978.".

TECHNICAL AMENDMENT

SEC. 210. Sections 805 and 808 (as in effect on June 30, 1975) are repealed.

PART E—SPECIAL PROJECT ASSISTANCE

SPECIAL PROJECT GRANTS AND CONTRACTS

SEC. 215. (a) Title VIII is amended by inserting after subpart III of part A (as added by section 209 of this Act) the following:

"Subpart IV—Special Projects

"SPECIAL PROJECT GRANTS AND CONTRACTS

"SEC. 820. (a) The Secretary may make grants to public and nonprofit private schools of nursing and other public or nonprofit private entities, and enter into contracts with any public or private entity, to meet the costs of special projects to—

"(1) assist in—

"(A) mergers between hospital training programs or between hospital training programs and academic institutions, or

"(B) other cooperative arrangements among hospitals and academic institutions,

leading to the establishment of nurse training programs;

"(2) (A) plan, develop, or establish new nurse training programs or programs of research in nursing education, or

"(B) significantly improve curricula of schools of nursing (including curriculums of pediatric nursing and geriatric nursing) or modify existing programs of nursing education;

"(3) increase nursing education opportunities for individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, by—

"(A) identifying, recruiting, and selecting such individuals,

"(B) facilitating the entry of such individuals into schools of nursing,

"(C) providing counseling or other services designed to assist such individuals to complete successfully their nursing education.

"(D) providing, for a period prior to the entry of such individuals into the regular course of education at a school of nursing, preliminary education

designed to assist them to complete successfully such regular course of education,

"(E) paying such stipends (including allowances for travel and dependents) as the Secretary may determine for such individuals for any period of nursing education, and

"(F) publicizing, especially to licensed vocational or practical nurses, existing sources of financial aid available to persons enrolled in schools of nursing or who are undertaking training necessary to qualify them to enroll in such schools;

"(4) provide continuing education for nurses;

"(5) provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession;

"(6) help to increase the supply or improve the distribution by geographic area or by specialty group of adequately trained nursing personnel (including nursing personnel who are bilingual) needed to meet the health needs of the Nation, including the need to increase the availabilty of personal health services and the need to promote preventive health care; or

"(7) provide training and education to upgrade the skills of licensed vocational or practical nurses,

nursing assistants, and other paraprofessional nursing personnel.

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(b) The Secretary may, with the advice of the National Advisory Council on Nurse Training, provide assistance to the heads of other departments and agencies of the Government to encourage and assist in the utilization of medical facilities under their jurisdiction for nurse training programs.

"(c) No grant or contract may be made under this section unless an application therefor has been submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Nurse Training. Such an application shall provide for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this section.

"(d) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $15,000,000 for fiscal year 1977, and $15,000,000 for fiscal year 1978. Not less than 10 per

centum of the funds appropriated under this subsection for any fiscal year shall be used for payments under grants and contracts to meet the costs of the special projects described in subsection (a) (3).

"ADVANCED NURSE TRAINING PROGRAMS

"SEC. 821. (a) (1) The Secretary may make grants to and enter into contracts with public and nonprofit private collegiate schools of nursing to meet the costs of projects to—

"(A) plan, develop, and operate,

"(B) significantly expand, or

"(C) maintain existing,

programs for the advanced training of professional nurses to teach in the various fields of nurse training, to serve in administrative or supervisory capacities, or to serve in other professional nursing specialties (including service as nurse clinicians) determined by the Secretary to require advanced training.

"(b) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, and $25,000,000 for fiscal year 1978.

"NURSE PRACTITIONER PROGRAMS

"SEC. 822. (a) (1) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of nursing, medicine, and public health, public or

nonprofit private hospitals, and other public or nonprofit private entities to meet the cost of projects to—

"(A) plan, develop, and operate,

"(B) significantly expand, or

"(C) maintain existing,

programs for the training of nurse practitioners.

"(2) (A) For purposes of this section, the term 'programs for the training of nurse practitioners' means educational programs *for registered nurses (irrespective of the type of school of nursing in which the nurses received their training)* which meet guidelines prescribed by the Secretary in accordance with subparagraph (B) and which have as their objective the education of nurses (including pediatric and geriatric nurses) who will, upon completion of their studies in such programs, be qualified to effectively provide primary health care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions.

~~"(B) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for programs for nurse practitioners. Such guidelines shall, as a minimum, require—~~

~~"(i) a program of at least one academic year consisting of (I) supervised clinical practice and (II)~~

~~at least four months (in the aggregate) classroom instruction, and that the program be directed toward preparing nurses to deliver primary health care; and~~

~~"(ii) a minimum level of enrollment in each year of not less than eight students.~~

"(B) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for programs for the training of nurse practitioners. Such guidelines shall, as a minimum, require that such a program—

"(i) extend for at least one academic year and consist of—

"(I) supervised clinical practice, and

"(II) at least four months (in the aggregate) of classroom instruction,

directed toward preparing nurses to deliver primary health care; and

"(ii) have an enrollment of not less than eight students.

"(b) No grant may be made or contract entered into *for a project* to plan, develop, and operate a program for the training of nurse practitioners unless the application for the grant or contract contains assurances satisfactory to the Secretary that the program will upon its development meet the guidelines which are in effect under subsection (a) (2)

(B); and no grant may be made or contract entered into *for a project* to expand or maintain such a program unless the application for the grant or contract contains assurances satisfactory to the Secretary that the program meets the guidelines which are in effect under such subsection.

"(c) The costs for which a grant or contract under this section may be made may include costs of preparation of faculty members in order to conform to the guidelines established under subsection (a) (2) (B).

"(d) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, and $25,000,000 for fiscal year 1978.".

(b) Sections 810 and 868 are repealed.

GUIDELINES FOR NURSE PRACTITIONER TRAINING PROGRAMS

SEC. 216. The Secretary of Health, Education, and Welfare shall within ninety days of the date of the enactment of this Act prescribe the guidelines for nurse practitioner programs specified in section 822(a) of the Act (as added by section 215 of this Act).

PART F—ASSISTANCE TO NURSING STUDENTS

EXTENSION OF TRAINEESHIPS

SEC. 221. (a) Subsection (a) of section 821 (as in effect on June 30, 1975) is amended to read as follows:

"(a) There are authorized to be appropriated $15,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, and $25,000,000 for fiscal year 1978, to cover the costs of traineeships for the training of professional nurses—

"(1) to teach in the various fields of nurse training (including practical nurse training),

"(2) to serve in administrative or supervisory capacities,

"(3) to serve as nurse practitioners, or

"(4) to serve in other professional nursing specialties determined by the Secretary to require advanced training.".

(b) Effective with respect to grants under section 821 of the Act from appropriations under such section for fiscal years beginning after June 30, 1975, subsection (b) of section 821 (as so in effect) is amended by adding at the end thereof the following: "In making grants for traineeships under this section, the Secretary shall give special consideration to applications for traineeship programs which conform to guidelines established by the Secretary under section 822(a) (2) (B).".

EXTENSION OF STUDENT LOAN PROGRAM

SEC. 222. (a) Section 822(b) (4) (as in effect on June 30, 1975) is amended by striking out "July 1, 1975" and inserting in lieu thereof "October 1, 1978".

(b) Effective with respect to periods of training to be a nurse anesthetist undertaken on or after the date of the enactment of this Act, section 823 (b) (2) (B) is amended by inserting "(or training to be a nurse anesthetist)" after "professional training in nursing".

(c) Section 824 is amended to read as follows:

"AUTHORIZATION OF APPROPRIATIONS FOR STUDENT LOAN FUNDS

"SEC. 824. There are authorized to be appropriated for allotments under section 825 to schools of nursing for Federal capital contributions to their student loan funds established under section 822, $25,000,000 for fiscal year 1976, $30,000,000 for fiscal year 1977, and $35,000,000 for fiscal year 1978. For fiscal year 1979, and for each of the next two succeeding fiscal years there are authorized to be appropriated such sums as may be necessary to enable students who have received a loan for any academic year ending before October 1, 1978, to continue or complete their education.".

(d) Section 826 is amended (1) by striking out "June 30, 1977" each place it occurs and inserting in lieu thereof "September 30, 1980", and (2) by striking out "September 30, 1977" *in subsection (b)* and inserting in lieu thereof "December 31, 1980".

(e) (1) Section 827 is repealed.

(2) The nurse training fund created within the Treasury

by section 827 (d) (1) of the Act shall remain available to the Secretary of Health, Education, and Welfare for the purpose of meeting his responsibilities respecting participations in obligations acquired under section 827 of the Act. The Secretary shall continue to deposit in such fund all amounts received by him as interest payments or repayments of principal on loans under such section 827. If at any time the Secretary determines the moneys in the funds exceed the present and any reasonable prospective further requirements of such fund, such excess may be transferred to the general fund of the Treasury.

(3) There are authorized to be appropriated without fiscal year limitation such sums as may be necessary to enable the Secretary to make payments under agreements entered into under section 827 (b) of the Act before the date of the enactment of this Act.

EXTENSION OF SCHOLARSHIP PROGRAM

SEC. 223. Section 860 is amended—

(1) by striking out "1972 ~~and~~, *and for each of* the next three fiscal years" in subsection (b) and in subsection (c) (1) (A) inserting in lieu thereof "1976 ~~and~~, *and for each of* the next two fiscal years";

(2) by striking out "June 30, 1976" in the second sentence of subsection (b) and in subsection (c) (1)

(B) and inserting in lieu thereof "September 30, 1979"; and

(3) by striking out "July 1, 1975" in the second sentence of subsection (b) and in subsection (c) (1) (B) and inserting in lieu thereof "October 1, 1978".

TITLE III—TECHNICAL AND CONFORMING AMENDMENTS

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 301. (a) (1) Section 802 is amended—

(A) by striking out "this part" each place it occurs and inserting in lieu thereof "this subpart";

(B) by striking out "subsection 806 (e) of this Act" in subsection (b) (2) and inserting in lieu thereof "section 810 (c)";

(C) by striking out paragraph (5) of subsection (b) and inserting in lieu thereof the following:

"(5) the application contains or is supported by adequate assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).";

(D) by striking out "section 841 (hereinafter in this part referred to as the 'Council')" in the first sentence following paragraph (5) of subsection (b) and inserting in lieu thereof "section 851";

(E) by striking out the second sentence following such paragraph; and

(F) by striking out "above in paragraph (A)" in subsection (c) (1) (B) and inserting in lieu thereof "in subparagraph (A)".

(b) (1) Subsection (a) of section 803 is amended to read as follows:

"(a) The amount of any grant for a construction project under this subpart shall be such amount as the Secretary determines to be appropriate after obtaining the advice of the National Advisory Council on Nurse Training; except that—

"(1) in the case of a grant—

"(A) for a project for a new school,

"(B) for a project for new facilities for an existing school in cases where such facilities are of particular importance in providing a major expan-

sion of training capacity, as determined in accordance with regulations, or

"(C) for a project for major remodeling or renovation of an existing facility where such project is required to meet an increase in student enrollment,

the amount of such grant may not exceed 75 per centum of the necessary cost of construction, as determined by the Secretary, of such project; and

"(2) in the case of a grant for any other project, the amount of such grant may not, except where the Secretary determines that unusual circumstances make a larger percentage (which may in no case exceed 75 per centum) necessary in order to effectuate the purposes of this subpart, exceed 67 per centum of the necessary cost of construction, as so determined, of the project with respect to which the grant is made.".

(2) Subsections (b) and (c) of section 803 are each amended by striking out "this part" and inserting in lieu thereof "this subpart".

(c) Section 804 is amended (1) by striking out "this part" and inserting in lieu thereof "this subpart", and (2) by redesignating paragraphs (a), (b), and (c) as paragraphs (1), (2), and (3), respectively.

(d) Section 805 (as redesignated by section 203(b)) is amended by striking out "this part" each place it occurs and inserting in lieu thereof "this subpart".

(e) Section 806 is redesignated as section 810.

(f) Section 807 is redesignated as section 811 and is amended—

(1) by striking out "section 805, 806, or 810" in subsections (a) and (c) and inserting in lieu thereof "this subpart";

(2) by striking out "part" in subsection (b) and inserting in lieu thereof "subpart";

(3) by amending paragraph (1) of subsection (c) to read as follows:

"(1) is from a public or nonprofit private school of nursing;"; and

(4) by striking out "those sections" each place it occurs in paragraphs (2) and (3) of such subsection *and inserting in lieu thereof "this subpart"*.

(g) (1) Title VIII is amended by inserting after the heading for part B the following:

"Subpart I—Traineeships".

(2) Section 821 (as so designated on the day before the date of the enactment of this Act) is redesignated as section 830.

(3) Title VIII is amended by inserting after section 830 (as so redesignated) the following:

"Subpart II—Student Loans".

(h) Sections 822, 823, 825, 826, 828, and 830 (as so designated on the day before the date of the enactment of this Act) are amended as follows:

(1) Sections 822 (a), 823, 825, 826, and 828 are each amended by striking out "this part" *each place it occurs* and inserting in lieu thereof "this subpart".

(2) Sections 822 (a), 823 (b), 823 (c), 825 (b) (2), and 826 (a) (1) are each amended by striking out "of Health, Education, and Welfare".

(3) Section 822 (b) (2) (A) is amended by striking out "under this part" and inserting in lieu thereof "from allotments under section 838".

(4) (A) Section 825 is amended—

(i) by striking out "(whether as Federal capital contributions or as loans to schools under section 827)" in subsection (a); and

(ii) by striking out ", and for loans pursuant to section 827," in subsection (b) (1).

(B) Section 826 (b) is amended by striking out "(other than so much of such fund as relates to payments from the revolving fund established by section 827 (d))".

(C) Section 828 is amended by striking out "or loans."

(5) Section 830 is—

(A) transferred to section 823 and inserted after subsection (i) of such section; and

(B) is amended by striking out "Sec. 830. (a)" and inserting in lieu thereof "(j)".

(i) (1) Sections 822, 823, 824, 825, 826, 828, and 829 (as so designated on the day before the date of the enactment of this Act) are redesignated as sections 835, 836, 837, 838, 839, 840, and 841, respectively.

(2) Section 835 (as so redesignated) is amended (A) by striking out "829" each place it occurs and inserting in lieu thereof "841", and (B) by striking out "823" and inserting in lieu thereof "836".

(3) Section 837 (as so redesignated) is amended (A) by striking out "825" and inserting in lieu thereof "838", and (B) by striking out "822" and inserting in lieu thereof "835".

(4) Section 838 (as so redesignated) is amended by striking out "824" each place it occurs and inserting in lieu thereof "837".

(5) Section 839 (as so redesignated) is amended by striking out "822" each place it occurs and inserting in lieu thereof "835".

(6) Section 841 (as so redesignated) is amended (A) by striking out "822" and inserting in lieu thereof "835",

and (B) by striking out "part D" and inserting in lieu thereof "subpart III of this part".

(j) (1) Part D of title VIII is inserted after subpart II of part B of such title; sections 860 and 861 are redesignated as sections 845 and 846, respectively; and the heading for such part is amended to read as follows:

"Subpart III—Scholarship Grants to Schools of Nursing".

(2) Section 845 (a) (as so redesignated) is amended by striking out "this part" and inserting in lieu thereof "this section".

(3) Section 846 (as so redesignated) is amended (A) by striking out "this part" the first time it occurs and inserting in lieu thereof "section 845", and (B) by striking out "to the sums available to the school under this part for (and to be regarded as) Federal capital contributions, to be used for the same purpose as such sums" and inserting in lieu thereof "to the student loan fund of the school established under an agreement under section 835. Funds transferred under this section to such a student loan fund shall be considered as part of the Federal capital contributions to such fund".

(4) Section 869 is repealed.

(k) (1) Sections 841, 842, 843, 844, and 845 (as so designated on the day before the date of the enactment of

this Act) are redesignated as sections 851, 852, 853, 854, and 855, respectively.

(2) Section 851 (as so redesignated) is amended (A) by striking out "part A of applications under section 805" in subsection (a) (2) and inserting in lieu thereof "subpart I of part A, of applications under section 805, and of applications under subpart III of part A"; (B) by striking out subsection (b); (C) by striking out "(a) (1)" and inserting in lieu thereof "(a)"; and (D) by striking out "(2)" and inserting in lieu thereof "(b)".

(3) Section 853 (as so redesignated) is amended—

(A) by striking out "part A" in paragraph (f) and inserting in lieu thereof "subpart I of part A";

(B) by striking out "806" in paragraph (f) and inserting in lieu thereof "810";

(C) by striking out "part B" each place it occurs in paragraph (f) and inserting in lieu thereof "section 835";

(D) by striking out "825" in paragraph ~~(i)~~ *(f)* and inserting in lieu thereof "838";

(E) by redesignating paragraphs (a) through (j) as paragraphs (1) through (10) respectively;

(F) by redesignating clauses (1), (2), and (3)

of paragraph (6) (as so redesignated) as clauses (A), (B), and (C), respectively.

(G) by redesignating subclauses (A) and (B) of such paragraph (6) as subclauses (i) and (ii), respectively; and

(H) by redesignating clauses (1) and (2) of paragraph (9) (as so redesignated) as clauses (A) and (B), respectively.

(4) Part C is amended by adding at the end thereof the following:

"DELEGATION

"SEC. 856. The Secretary may delegate the authority to administer any program authorized by this title to the administrator of a central or regional office or offices in the Department of Health, Education, and Welfare, except that the authority—

"(1) to review, and prepare comments on the merit of, any application for a grant or contract under any program authorized by this title for purposes of presenting such application to the National Advisory Council on Nurse Training, or

"(2) to make such a grant or enter into such a contract,

shall not be further delegated to any administrator of, or officer in, any regional office or offices in the Department.".

EFFECTIVE DATE

SEC. 302. The amendments made by section 301 shall take effect July 1, 1975. Except as otherwise specifically provided, the amendments made by section 301 to provisions of title VIII of the Act are made to such provisions as in effect July 1, 1975, and as amended by title II of this Act.

TITLE IV—MISCELLANEOUS

INFORMATION RESPECTING THE SUPPLY AND DISTRIBUTION OF AND REQUIREMENTS FOR NURSES

SEC. 401. (a) (1) Using procedures developed in accordance with paragraph (3), the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") shall determine on a continuing basis—

(A) the supply (both current and projected and within the United States and within each State) of registered nurses, licensed practical and vocational nurses, nurse's aides, registered nurses with advanced training or graduate degrees, and nurse practitioners;

(B) the distribution, within the United States and within each State, of such nurses so as to determine (i) those areas of the United States which are oversupplied or undersupplied, or which have an adequate supply of such nurses in relation to the population of the area, and (ii) the demand for the services which such nurses provide; and

(C) the current and future requirements for such nurses, nationally and within each State.

(2) The Secretary shall survey and gather data, on a continuing basis, on—

(A) the number and distribution of nurses, by type of employment and location of practice;

(B) the number of nurses who are practicing full time and those who are employed part time, within the United States and within each State;

(C) the average rates of compensation for nurses, by type of practice and location of practice;

(D) the activity status of the total number of registered nurses within the United States and within each State;

(E) the number of nurses with advanced training or graduate degrees in nursing, by specialty, including nurse practitioners, nurse clinicians, nurse researchers, nurse educators, and nurse supervisors and administrators; and

(F) the number of registered nurses entering the United States annually from other nations, by country of nurse training and by immigrant status.

(3) Within six months of the date of the enactment of this Act, the Secretary shall develop procedures for determining (on both a current and projected basis) the supply and distribution of and requirements for nurses within the United States and within each State.

(b) Not later than February 1, 1977, and February 1 of each succeeding year, the Secretary shall report to the Congress—

(1) his determinations under subsection (a) (1) and the data gathered under subsection (a) (2);

(2) an analysis of such determination and data; and

(3) recommendations for such legislation as the Secretary determines, based on such determinations and data, will achieve (A) an equitable distribution of nurses within the United States and within each State, and (B) adequate supplies of nurses within the United States and within each State.

(c) The Office of Management and Budget may review the Secretary's report under subsection (b) before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report.

Union Calendar No. 59

94TH CONGRESS
1ST SESSION

H. R. 4115

[Report No. 94–143]

A BILL

To amend title VIII of the Public Health Service Act to revise and extend the programs of assistance under that title for nurse training.

By Mr. ROGERS, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. WIRTH, Mr. CARTER, Mr. HASTINGS, and Mr. HEINZ

MARCH 4, 1975

Referred to the Committee on Interstate and Foreign Commerce

APRIL 10, 1975

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

DOLLARS INVOLVED IN S. 66, NURSES TRAINING, HEALTH SERVICES, ET. AL.

1976

Authorization in President's Budget:	$481 million
Conference Report:	$1.049 billion
Over Budget:	$568 million

In addition, the Conference Report authorizes $1.082 billion for FY '77. The President has not even begun to consider an FY '77 budget request.

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THE WHITE HOUSE

WASHINGTON

November 20, 1974

MEMORANDUM FOR: WILLIAM E. TIMMONS

THRU: MAX L. FRIEDERSDORF M.L.F.

FROM: VERN LOEN VL

SUBJECT: National Health Insurance Meeting

Secretary Weinberger chaired a meeting of about fifteen representatives of the health services industry, including the AMA, dentists and insurance carriers.

The following conclusions were reached:

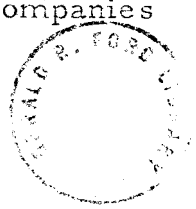
(1) It is probably hopeless to expect any action on the Administration's comprehensive health insurance program (CHIP) until next year, so the Administration and the industry must present a united front to a liberal Congress.

(2) The Long-Ribicoff bill limited to catastrophic insurance is far more costly than the Administration's. Long has indicated that this is all he will accept and threatens to bring it out of his committee in the rump session in order to position himself for next year.

(3) A suggestion that we back a five-year experimental program of national health insurance was rejected as politically unachieveable and unnecessary, since we already have the experience of Medicaid and Medicare.

(4) Each element of the health services industry represented at the meeting is to hand deliver a set of principles to Secretary Weinberger to see if they can reach an agreement before the group reconvenes at 2 p.m. next Tuesday, November 26. Updated cost estimates will be made available at that time.

(5) There seems to be a broad general agreement that there must be cost-sharing and deductions to avoid over-utilization and must rely on the private system of medicine with competition among the insurance companies to keep costs down.



THE WHITE HOUSE

WASHINGTON

January 21, 1975

MEMORANDUM FOR: MAX L. FRIEDERSDORF

THRU: VERN LOEN VL

FROM: DOUG BENNETT DFB

SUBJECT: National Health Insurance

In connection with the President's decision to veto any new spending programs approved by Congress during 1975 to include National Health Insurance, this is intended to point out some problems we may face.

(1) With the ranks of the unemployed increasing, there is growing concern particularly on the part of organized labor that participation in the various employer/employee health insurance plans will lapse and coverage terminated. Although some states provide by law for coverage of such persons under medicaid or unemployment compensation, many do not. I understand the AFL-CIO is drafting legislation to include all such unemployed under medicaid (Federally funded) with a substantial price tag. HEW is aware of this. In sum, the President may be forced into a program such as this for temporary reasons but with a permanent result.

(2) In consideration of the above, the Health Subcommittee of Ways and Means chaired by Jim Corman may, behind the scenes, put together a package which would be brought out at the first opportunity of subcommittee hearings. Corman has already approached Jerry Pettis, ranking on the subcommittee about this. In this connection it seems to me that the Administration must get some input into this if it begins to develop, otherwise, we may be precluded.

(3) So the President is not further criticized for abandoning the health insurance concept he advocated last year, he should consider stating that he has not abandoned such a program, but merely deferring

it for a year for fiscal reasons. He must be careful that he doesn't get boxed in <u>against</u> a health insurance program but can buy some time to work out a proposal that meets the needs of this complex and difficult subject.

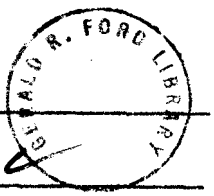
cc: Kendall, O'Donnell, Wolthuis, Leppert

THE WHITE HOUSE
WASHINGTON

Date 3-10-75

TO: Doug B.

FROM: VERN C. LOEN VL



Please Handle _____

For Your Information ✓

Per Our Conversation _____

Other: ~~Interstate~~ + F. C.,
Health S. C. re hearing hrgs
on HR 4003 (same subject)
March 10, 11 + 12

THE WHITE HOUSE

WASHINGTON

March 10, 1975

MEMORANDUM FOR: JAMES J. CANNON

THRU: MAX L. FRIEDERSDORF
VERN LOEN VL

FROM: DOUGLAS P. BENNETT DPB

SUBJECT: Health Insurance for the Unemployed

The Health Subcommittee of the Ways and Means will begin in the next few days markup of a bill to provide health insurance for the unemployed. This concept was primarily advanced by the AFL-CIO and has picked up remarkable steam. Senator Kennedy has embraced a concept which would directly subsidize employers so that they would continue to pay benefits for their former employees. Congressman Corman is advancing a concept to use the Medicare system for such individuals. The Republicans are about to advance a plan which relies upon the tax system as a means of disbursing payments to the employers of "temporarily" unemployed individuals.

The Kennedy and Corman concepts are already in bill form (which I believe you already have) and attached is a description of the Republican concept.

It seems to me that this is the type of legislation that would be very hard to vote against and similarly would present difficulty in justifying a veto. It is my understanding that to date the Administration has not taken a position on any concept.

Attachment

cc: J. Marsh, J. Cavanaugh, P. O'Neill, C. Leppert

Specifications for legislation providing for the continuation of an insured unemployed's health insurance benefits.

1. The bill should provide a mechanism under which the Internal Revenue Service would disburse funds (from general revenues) to employers who carry unemployed persons previously covered under their group health plan. The employers would have to cover the former employees for a period of one year after the date of enactment or as long as the unemployed former employee is an "insured unemployed" under either a federal or state unemployment insurance program.

2. In order to insure that the employers participate in this program, an amendment to Sec 162 of the Internal Revenue Code would be added which would deny the employer the deduction for contributions to insurance plans for his current employees (for tax year 1975) unless he agreed to participate in this program.

3. In order to insure the temporary nature of the disbursement program, Sec 162 should be further amended to provide that for tax years after 1975, a deduction for contributions to an employee's health insurance plan would not be allowed unless the employer's plan provided for continuation of coverage under it for a period of six months or one year after the employee left the employment of the company involved or became insured under another employer plan or self-employed plan, whichever occurred sooner.

   Under this latter change in Sec 162, transition rules would have to be included to exempt from this requirement health plans negotiated pursuant to a bona fide collective bargaining agreement completed on or before the date of enactment but in no case past December 31, 1975 (perhaps July 1, 1976). Similar transition rules were included in Sections 211 and 308 of P.L. 93-406, the "Employee Retirement Income Security Act of 1974." (ERISA)

4. The bill should provide that eligibility for coverage will be determined by the certification of the state unemployment insurance offices that the individual is an "insured unemployed" and eligible for either state or federal UI benefits.

5. It is contemplated that the insured unemployed would obtain certification of his unemployed status from the state UI office, go to the IRS and fill out a short form indicating his name, address, number of dependents to be covered, the name and addr of his former employer and swearing that neither he nor his dependents are eligible for coverage under any other employer-sponsored health insurance plan. Falsification of this information would subject the unemployed person to the fraud penalties of the Internal Revenue Code. Therefore, such a provision should be included.

6. The employed person would send this form with the Certification attached to the Internal Revenue Service. Upon receipt, the IRS would contact the former employer regarding the premium cost and the Service would pay the employer. The employer would then reinstate the employee in his health plan and issue a card to the employee.

94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 94-137

NATIONAL HEALTH SERVICE CORPS AMENDMENTS OF 1975

APRIL 10, 1975.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 4114]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4114) to amend the Public Health Service Act to revise and extend the National Health Service Corps Program, having considered the same, reports favorably thereon with amendments and recommends that the bill do pass.

The amendments are as follows:

Page 3, strike out lines 12 through 15 and insert in lieu thereof the following:

> for medically underserved populations shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

Page 3, strike out "shall" in line 16 and insert in lieu thereof "may".

Page 4, beginning in line 1, strike out "competitive with" and all that follows down through and including line 3 and insert in lieu thereof the following:

> competitive with the average monthly income from a practice of an individual who is a member of the profession of the Corps member, who has equivalent training, and who has been in practice for a period equivalent to the period during which the Corps member has been in practice.

Page 4, beginning in line 21, strike out "the provisions of paragraph (1) shall apply to such member" and insert in lieu thereof "the adjustment in pay authorized by paragraph (1) may be made for such a member only".

Page 5, line 7, strike out "have to".

Page 5, line 16, strike out "designating" and insert in lieu thereof "determining whether to designate a population as".

38-006—75——1

Page 5, line 22, insert "the" after "which".
Page 6, line 22, insert "only" after "population".
Page 13, line 24, strike out "expiration" and insert in lieu thereof "beginning".
Page 15, line 21, strike out "nurses" and insert in lieu thereof "physicians, nurses,".
Page 16, line 19, strike out "be made for" and insert in lieu thereof "exceed".
Page 18, line 21, insert "total" after "the".
Page 23, line 15, strike out ", (3)" and insert in lieu thereof "personnel, and (3)"; and strike out ", and" in line 18 and all that follows through line 22 and insert in lieu thereof a period.

Summary of Legislation

H.R. 4114, as reported, provides a one year simple extension through fiscal 1975 of the National Health Service Corps Program with an authorization of $16 million. The authorizations for the Program expired on June 30, 1974, and the Program is presently being funded under continuing resolution for fiscal 1975. It also provides for a one year substantive revision of the Program for fiscal 1976 with an authorization of $30 million. H.R. 4114 does not affect the provisions of the scholarship training program which authorize the award of scholarships to health professions students who agree to join the National Health Service Corps in return for scholarship assistance.

The major substantive revisions made in the Program for fiscal 1976 by H.R. 4114 are as follows:

1. It authorizes the award of bonuses of up to $1,000 per month to members of the National Health Service Corps in order that the monthly income of the NHSC member may be competitive with the average monthly income of a member of the applicable profession with equivalent training and time in practice.

2. It provides for the designation of medically underserved populations by the Secretary of HEW in lieu of the provisions of existing law, which authorize designation of medically underserved areas. Populations are eligible to receive health services from NHSC personnel for periods of up to four years, with provision for extension of this period.

3. It provides that an entity to which NHSC personnel are assigned must repay the Federal government, from collections it receives as a result of service provided by such personnel, amounts equal to the pay of the NHSC members assigned to it, the amount of any grant the entity has received, and the amount of scholarship assistance received by a NHSC assignee. A waiver of this provision is authorized in instances in which an entity is financially unable to comply or if compliance would unduly limit quality of services.

4. It authorizes grants of up to $25,000 to communities or other entities with approved applications for assignment of NHSC personnel in order to establish medical practice management systems, acquire equipment and provide continuing education for NHSC personnel.

5. It continues, with revisions, the National Advisory Council on the National Health Service Corps.

Background

The Emergency Health Personnel Act of 1970 (Public Law 91–623) constituted the first substantial effort by this Committee to legislate solutions to the problems of geographic maldistribution of health manpower personnel. The Act provided for the establishment of a program whereby members of the Public Health Service and other personnel may volunteer to practice their professions in areas of the United States where health personnel and services are inadequate, thereby contributing to the improvement of the accessibility of persons living in these areas to health services.

In 1972, the Emergency Health Personnel Act Amendments of 1972 (Public Law 92–585) was enacted. This Act officially established the National Health Service Corps and charged the Corps with the responsibility for implementation of the Emergency Health Personnel Act. The 1972 Act also established a scholarship program authorizing the award of scholarships to health professions students who agree to serve at least one year in the Corps following their training for each year of scholarship assistance.

The legislative authority for the National Health Service Corps Program expired on June 30, 1974. The scholarship authority was extended for fiscal year 1975 at an authorization level of $40 million under Public Law 93–585.

The substantive provisions of this bill are virtually identical to the National Health Service Corps Program and National Health Service Corps scholarship training program provisions of H.R. 17084, the Health Manpower Act of 1974, in the 93rd Congress. Hearings on H.R. 17084 were conducted on May 20, 21, 22, 23, 28, 29, 30, and June 27, 1974. The Subcommittee on Public Health and Environment reported H.R. 17084 to the Committee on Interstate and Foreign Commerce on October 3, 1974, after extensive markup sessions. It was ordered reported from the Committee on Interstate and Foreign Commerce with amendments by unanimous voice vote on November 19, 1974, and passed the House on December 12, 1974. Similar legislation, S. 3585, had already passed the Senate, and one House-Senate conference meeting convened but failed to resolve the differences between the two versions before the 93rd Congress adjourned sine die.

Because of the critical need to extend the authorities for the NHSC Program and the probability of lengthy deliberations on many of the other provisions of the health manpower legislation, the provisions of H.R. 17084 which affect the NHSC Program and the NHSC scholarship training program were introduced by Mr. Rogers, Chairman of the Subcommittee on Health and the Environment, and others, as a separate bill, H.R. 2958.

Hearings on H.R. 2958, and bills which would revise and extend the health manpower and nurse training authorities of the Public Health Service Act were held on February 20, and 21, 1975, by the Subcommittee on Health and the Environment. On March 4, 1975, following executive sessions, the Subcommittee ordered reported a clean bill, H.R. 4114. H.R. 4114 was subsequently considered and ordered reported with amendments by voice vote of the Committee on Interstate and Foreign Commerce on March 26, 1975.

Cost of Legislation

As reported by the Committee, H.R. 4114 provides for authorizations of appropriations for two fiscal years for the National Health Service Corps Program as shown in the following table. (As noted above, this bill does not affect the scholarship training program.)

TABLE 1.—NEW OBLIGATIONAL AUTHORITY FOR FISCAL YEARS 1975-76 UNDER H.R. 4114

National Health Service Corps program:	*Millions*
Fiscal year 1975	$16
Fiscal year 1976	30
Total	46

These authorizations may be compared with a 1973 authorization of $30 million and a 1974 authorization of $25 million.

Complete budgetary history of the National Health Service Corps Program is shown in the following table:

TABLE 2.—NATIONAL HEALTH SERVICE CORPS BUDGET HISTORY[1]

[In millions of dollars]

	Authorization	Budget request	Appropriation	Obligation
Fiscal year—				
1971	10	0	3	0
1972	20	10	12.574	8.58
1973	30	14.803	[2] 11	10.701
1974	25	11	13	12.574
1975		12.383	[3] 15.180	[3] 15.180

[1] Includes expenses of program management and field costs.
[2] Continuing resolution.
[3] HEW projection.

Need for Legislation

The geographic maldistribution of health manpower represents one of the most serious barriers to access to quality health care in this Nation today. Increases in the supply of health professionals have not led to a more equitable distribution of health manpower. In fact, despite significant increases in total supply, the geographic maldistribution of health manpower has worsened in the past decade.

Dr. Malcolm Todd, the current president of the American Medical Association recently summarized the situation with respect to geographic maldistribution by saying: "to say we're eliminating the shortage of physicians is playing with words. It won't make any difference if we do have 440,000 physicians in 1980 because they won't be where we need them. Unless we can come up with acceptable incentives for rural practice and inner city practice, we're going to have the same [distribution] problem in 1980 that we do now."

As access to physicians is of the most critical concern in terms of assuring access to quality health care to all Americans, this discussion concerns itself primarily with the geographic maldistribution of physicians. Similar problems exist within most other health professions.

The national ratio of physicians to population is 156 physicians for every 100,000 people, or one physician for every 641 people. Although many experts believe that this ratio would be sufficient to meet the medical needs of this country, the distribution of physicians significantly hampers access to medical care for large segments of the population. Health manpower is maldistributed by region and by demographic units within regions. The New England and Pacific regions of the nation now have much larger per capita supplies of health manpower than do the Midwestern and Southern regions, yet even within the manpower rich Northeastern and Western regions, the rural and inner city urban areas have significantly smaller per capita supplies of health manpower than do the suburban and smaller urban areas.

Testimony presented before the Committee during 1974 health manpower hearings indicates that the New England and Pacific regions of the nation now have, on a per capita basis, over 50% more physicians as do the Midwestern and Southeastern regions. Table 3 indicates that the physician: population ratios in the various regions of the United States range from a low of 67 percent of the national average a high of 126 percent.

TABLE 3.—PHYSICIAN POPULATION RATIO BY REGION AND REGIONAL RATIOS AS A PERCENTAGE OF THE NATIONAL AVERAGE RATIO

	Number of active physicians per 100,000 population (M.D.'s and D.O.'s Dec. 31, 1970)	Physicians per 100,000 as percentage of national average
United States	156	100
New England	190	122
Middle Atlantic	196	126
South Atlantic	149	96
East south-central	105	67
West south-central	132	85
East north-central	135	87
West north-central	135	87
Mountain	150	96
Pacific	183	117

Source: Health Resources Statistics, 1971, NCHS, DHEW publication No. 72-1509, 1971 ed.

Table 4 indicates that the physician: population ratios vary even more widely by State.

TABLE 4.—PHYSICIAN POPULATION RATIO BY STATE AND STATE RATIOS AS A PERCENTAGE OF THE NATIONAL AVERAGE RATIO

	Number of active physicians per 100,000 population (M.D.'s and D.O.'s Dec. 31, 1970)	Physicians per 100,000 as percentage of national average
United States	156	100
Northeast	195	125
New England	190	122
Connecticut	189	121
Maine	125	80
Massachusetts	213	137
New Hampshire	139	89
Rhode Island	169	108
Vermont	184	118
Middle Atlantic	196	126
New Jersey	152	97
New York	236	151
Pennsylvania	163	104
South	133	85
South Atlantic	149	96
Delaware	141	90
District of Columbia	525	337
Florida	146	94
Georgia	117	75
Maryland	232	149
North Carolina	114	73
South Carolina	97	62
Virginia	134	86
West Virginia	111	71
East South Central	105	67
Alabama	93	60
Kentucky	107	69
Mississippi	89	57
Tennessee	123	79
West South Central	132	58
Arkansas	95	61
Louisiana	126	81
Oklahoma	122	78
Texas	134	86
North Central	135	87
East North Central	135	87
Illinois	142	91
Indiana	103	66
Michigan	144	92
Ohio	141	90
Wisconsin	123	79
West North Central	135	87
Iowa	115	74
Kansas	129	83
Minnesota	153	98
Missouri	150	96
Nebraska	118	76
North Dakota	102	65
South Dakota	95	61
West	176	113
Mountain	150	96
Arizona	160	103
Colorado	197	126
Idaho	97	62
Montana	111	71
Nevada	116	74
New Mexico	139	98
Utah	141	90
Wyoming	103	66
Pacific	183	117
Alaska	106	68
California	194	124
Hawaii	151	98
Oregon	148	95
Washington	158	101

Source: "Health Resources Statistics, 1971," NCHS, DHEW publication No. 72-1509, 1971 ed.

The maldistribution of physicians by regions has worsened appreciably in the past decade. As Table 5 indicates, the regions which were relatively physician-rich in 1959 experienced a greater increase in physician:population ratios than did the physician-poor regions.

TABLE 5.—CHANGE IN PHYSICIAN POPULATION RATIO BY REGION: 1959-70

	Number of active physicians per 100,000 (MD's and DO's)		Increase in ratio as percentage of 1959 nationa average
	1959	1970	
United States	132	156	18
New England	164	190	20
Middle Atlantic	165	190	23
South Atlantic	112	149	28
East south-central	88	105	13
West south-central	106	132	20
East north-central	122	135	10
West north-central	124	135	8
Mountain	119	150	23
Pacific	161	183	17

Source: Health Resources Statistics, 1971, NCHS, DHEW, publication No. 72-1509, 1971 ed. and Health Manpowe Sourcebook, sec. 10. PHS publication 263-10, 1960.

Complicating the maldistribution by region is the lack of balance within regions; the suburban and smaller urban areas generally have many more physicians, on a per capita basis, than do the rural and inner city areas. Nationally, the physician : population ratio in urban areas is 170 physicians per 100,000 population, more than twice the nonurban ratio of 80:100,000.

In 35 States, rural areas now have less than one-half of the per-capita physician supply of urban areas. In 14 States, rural areas have less than one-third the urban supply. Further, a recent HEW report indicates that the discrepancy in physician: population ratios between rural and urban counties worsened in 43 states between 1960 and 1970.

Commenting on this situation Donald Madison, M.D. of the University of North Carolina stated during Committee hearings:

> The first conclusion is that the rural deficit of physician distribution has been a recognized fact and a focus of concern for at least five decades. Yet it has shown no improvement at anytime in the last 50 years, even in places where specific programs have been directed toward the problem. In fact, the urban rural differential has been widening.

The situation with respect to the physician supply in inner city areas is in many ways similar to the problem in rural areas: a relative shortage of physicians and a worsening of that situation.

The best study of the supply of physicians in specific neighborhoods within an urban area is an analysis of the Chicago metropolitan area. This study indicates that the inner suburban area of Chicago in 1970 had 123 physicians per 100,000 population while the inner city area, not including the Loop, had 75 physicians per 100,000 population. Studies in other cities confirm that this suburban inner city discrepancy is a pattern in many urban areas.

Moreover, this discrepancy has increased over the past two decades. The Chicago study compared the physician : population ratio in the various neighborhoods of the Chicago metropolitan area in 1950, 1960 and 1970. This portion of the study indicated that while the physician : population ratio increased in the inner suburban areas, in the inner city areas the ratio fell from 111 physicians per 100,000 population in 1950 to 80 in 1960 to 75 in 1970. Similar studies in Boston, New York and Baltimore indicate that the physician supply in inner-city areas of these cities has also decreased over the past ten years.

There are many reasons for the present geographic maldistribution of physicians and other health professionals. The three most important are the high level of financial remuneration for medical services, the life-style preference of middle-class Americans, and the nature and location of medical training.

Physicians can earn a high income in virtually any area of any region in this country. This stems from the apparent unlimited demand for, and ability to pay for, health services by affluent groups in our society. The Committee on Goals and Priorities of the National Board of Medical Examiners reported in 1973:

> The commercial market place operates on the premise that overproduction of a product leads to lower prices, curtailment of supply, and the automatic introduction of the

product into undersupplied areas. There is no evidence that such a process operates within the health care system. The suburbs of this country appear to have an unlimited capacity to absorb physicians.

The net effect of this situation on the national level is that it is impossible, in any practical sense, to train so many physicians that areas become "oversaturated" and physicians are induced, for economic reasons, to seek practice elsewhere. Boston now has 321 physicians per 100,000 population, more than twice the national average, yet there are still large areas of inner city Boston and rural Vermont and New Hampshire which lack adequate physican services. Dr. John A. D. Cooper, president of the Association of American Medical Colleges has said: "Over production of physicans has never, in any country, corrected geographical distribution". The financial factor, therefore, is a passive one, in that physicians can earn an attractive income regardless of where they practice.

If the first factor is passive, the second is active. Given a choice unencumbered by economic considerations, many Americans choose to live on the east or west coasts. Furthermore, within any region, most middle-class Americans choose to live in suburban and smaller urban areas with good housing and schools, easy access to shopping areas, and cultural attractions. A study prepared by the American Medical Association reported that the quality of life in a community is the most important influence on physician location decisions.

The third factor important to the maldistribution of physicians is the nature and location of medical training. Most medical training, both undergraduate and postgraduate, is now provided in large academic medical centers. These centers specialize in providing very complex, subspecialty care. As a result of the presentation of this type of practice as an occupational model, many medical students come to believe that subspecialty care and modern medicine are synonymous and that modern medicine can only be practiced in association with a large urban hospital.

In addition, virtually all medical schools are located in large metropolitan areas. In the rural states of Nebraska, Kansas, and Oklahoma, where the state universities are located in the relatively small urban communities of Lincoln, Lawrence, and Norman, the medical schools are located in the cities of Omaha, Kansas City, and Oklahoma City. As a result of the urban location of medical schools, medical students and their spouses, whatever their origin, become accustomed; over a seven year period or more, to an urban lifestyle. Medical education, therefore, actively contributes to the aggregation of physicians in urban areas.

Legislation establishing the National Health Service Corps Program was developed by this Committee as a result of the well-documented need to correct the geographical imbalance of physicians and other health professionals. It is the view of this Committee that the continuation of the National Health Service Corps Program, and its substantial expansion as contemplated by H.R. 4114, holds the promise of having a significant impact upon this acute national problem.

History of the National Health Service Corps

The National Health Service Corps began operations in 1972. Since that time, a substantial number of physicians, dentists, nurses and other health professionals have joined the Corps and have received assignments to practice their professions in critical health manpower shortage areas in the United States designated by HEW. These areas are identified to the Corps by State and local planning agencies and must, under HEW regulations, have a primary care physician-to-population ratio of less than 1:4000 and a dentist-to-population ratio of less than 1:5000. (By comparison the national primary care physician-to-population ratio is approximately 1:2000.) As of February, 1975, 981 counties and areas were designated as critical health manpower shortage areas.

Communities located within designated critical health manpower shortage areas may apply for assignment of Corps personnel. Applicant organizations are usually organized citizen groups concerned with the shortage of health manpower in their area. Applicants must submit recommendations from their State or local medical or dental societies and from the local government for their area respecting the need for personnel. Each community which applies must document its service needs and lack of medical manpower to meet those needs, and demonstrate an ability to provide supportive services and facilities necessary for the establishment of a medical or dental practice.

Typically, a community to which Corps members are assigned has a potential patient population large enough to maintain some degree of financial viability for a private medical or dental practice.

The Corps assigns from one to five health professionals to communities with approved applications to deliver needed health services, and helps establish, in conjunction with the sponsoring community, an ongoing system of health care delivery. The type and number of assigned personnel and the settings in which they practice vary considerably, based on the needs and location of the community. Support staff for NHSC assignees are hired by the community and supported from patient receipts.

Fee collection regulations require that patients be charged for services provided by a National Health Services Corps assignee, although services may be provided at reduced rates or without charge for persons unable to afford health services. These requirements serve to provide the practice with economic viability in order to retain or attract physicians on a permanent basis to the community; they also enable the community to reimburse the Federal government for costs incurred by the Corps to support its assigned health professionals.

The Corps has developed an effective recruitment program for health personnel, especially physicians. Through an organized campaign of visits to over 100 medical schools and 250 medical residency training programs, and special mailings to 52,000 medical residents, the Corps has increased its recruitment of physicians and dentists from 14 in 1971 to over 300 in 1975.

Through use of a data bank, the Corps has developed a means of matching NHSC assignees to communities. Each applicant is matched with at least four sites in two regions which most closely resemble his or her preferences; this process is repeated, if necessary, until satisfaction with the choices is expressed. Based on both applicant and com-

munity needs and preferences, the most acceptable match is made, thus minimizing the possibility of future dissatisfaction of either party.

The Corps has approved 443 sites for Corps assistance and has placed 405 physicians, dentists, nurses and other health professionals in 196 communities in 40 States. In addition, over 800 non-Federal support personnel have been employed to assist assignees in their practices and are being supported from the patient receipts generated by the NHSC professionals. Approximately 85 percent of the practices are in rural areas with the remainder in urban inner city areas.

Of the approved sites, 49 are located in rural Appalachia, 31 are migrant health projects, 62 have black populations of at least 25 percent, 19 have Indian populations of at least 15 percent, 35 have Spanish speaking populations of at least 10 percent, and 234 have elderly populations of at least 10 percent. The Corps has approved 26 sites which are located in counties that previously had no physicians.

The NHSC has experimented successfully with utilizing physician extenders (nurse practitioners and physicians' assistants) to provide health services; over 70 physician extenders will be employed in shortage areas by July, 1975. The presence of Corps personnel is also drawing other health professionals to underserved areas.

A major undertaking of the Corps has been to assist community groups in establishing programs that link NHSC assignees to other providers of health services. These programs, which foster improved systems of care and develop professional and personal relationships, greatly improve the possibility of assignees remaining in the community. The Corps' retention rate for 1975, to date, was 30 percent compared to 25 percent in 1974 and 3 percent for 1973. Because of improved matching techniques and community assistance activities, this rate is expected to increase in 1976.

Committee Proposal

It is the view of this Committee that the National Health Service Corps Program, coupled with the scholarship program, represents the most effective legislative mechanism ever developed by the Congress in attempts to solve the growing problem of geographic maldistribution of health professionals in the United States. As noted above, the Program has already attracted 405 health professionals into rural and inner city areas experiencing acute health manpower shortages, and the percentage of personnel remaining in these areas after completing their assignments has been remarkable. The potential of the Program is such that, if adequate funding for the Program continues, it will serve to attract several thousand health professionals to provide much needed care to medically served populations in the foreseeable future.

Thus, the Committee has chosen to extend the Program at levels reflecting its potential. For fiscal year 1975, the bill authorizes $16 million for the operation of Program. If the authorization is fully funded, the Corps will be able to increase the number of assigned personnel to 551 by June, 1975. If the fiscal year 1976 authorization of $30 million is fully funded, this number can increase to 826 by June, 1976.

Effective in fiscal year 1976, the bill would substantially revise existing provisions of the National Health Service Corps Program to make the Program more attractive to medically underserved populations and potential National Health Service Corps participants, and

to encourage Corps personnel to remain in areas with medically underserved populations following their service commitments.

First, the bill authorizes the Secretary to enter into agreements with non-Federal health professionals to serve medically underserved populations. This provision makes it clear that health professionals who cannot enter the Public Health Service because of physical or age limitations can nevertheless participate in the Program.

Second, in order to make the Program more attractive to potential participants, the reported bill authorizes reimbursement of applicants for travel expenses incurred for the purpose of evaluating areas to which they may be assigned. More importantly, it authorizes bonus payments of up to $1,000 per month to participants the first three years of practice. (In the case of scholarship recipients, this provision applies for the three years following the termination of service obligations incurred as a result of scholarship assistance. This provision is designed to provide assignees with monthly incomes competitive with those of private practitioners of the individual's profession with equivalent training and time in practice. The bonus would be authorized to continue beyond the three-year period only to the extent that it would be necessary to render total monthly income equal to the income received in the final month of the three year period. Thus, as salaries and other benefits increase due to promotion or longevity, bonus payments would decrease. This payment method will, in the Committee's view, serve to make initial service beyond the period of obligated service not financially unattractive to the health professional and also will provide an incentive to enter private practice in the community due to a leveling off of income following the first three years of bonus payments.

Third, in order to render the Program available to greater segments of the country which experience inaccessibility to health personnel, the bill dispenses with existing legislative rigidities that require defining medically undeserved areas by specific geographic boundaries or political subdivisions and instead authorizes designation of medically undeserved populations as targets of assistance. This provision will allow the Secretary to designate, as undeserved, pockets of populations that may reside within political subdivisions that do not fall within the criteria necessary for designation as underserved areas, but nevertheless do not enjoy geographical access to health care.

Fourth, the reported bill requires that entities to which Corps personnel are assigned must repay to the Federal government, from collections received from services provided by NHSC assignees, the amount of pay and allowances of personnel assigned to the entity, the amount of any grants received by the entity to prepare for the arrival of Corps members, and the amount of National Health Service Corps scholarship support that assignees received. Fees collected by entities in excess of the amount required to be returned to the Federal government must be used to expand or improve the provision of health services or to recruit permanent health personnel. A waiver of the payback provision is authorized in instances in which the entity is financially unable to meet the requirement or if compliance would unduly limit the quality of services provided. This waiver provision will allow for flexibility during initial periods of assignment of Corps members when utilization and billings are low, and the community is assuming the major proportion of costs.

Fifth, the bill authorizes assignment of Corps personnel to medically underserved populations for periods of up to four years and requires evaluation of the continued need of the population for health manpower and determination of efficient operation of the practice of Corps personnel before eligibility for Corps personnel may be extended. Thus, a medically underserved population is in effect placed on notice that it should make every reasonable effort to secure health services from non-Federal sources after four years of Corps assistance. Populations would not be deprived of service beyond an initial assignment period if significant efforts had been made to secure alternative sources of health manpower but circumstances rendered provision of health services from other sources impossible.

Finally, the proposed bill authorizes the award of one-time grants of up to $25,000 for the purpose of meeting the costs of establishing a medical practice, acquiring equipment and establishing continuing education programs for assignees to entities which have approved applications. These grants will enable communities to prepare for the arrival of the National Health Service Corps assignees through establishment of appropriate billing systems, acquisition of equipment, renovation or acquisition of facilities, and other needed planning prior to the commencement of National Health Service Corps services.

Section-by-Section Analysis

Section 1 of the bill authorizes appropriations of $16 million for fiscal year 1975 for the National Health Service Corps (NHSC) Program under existing sec. 329(h) of the Public Health Service Act.

Section 2(a) of the bill makes technical amendments.

Section 2(b) of the bill would, effective with respect to appropriations made for fiscal years beginning after June 30, 1975, amend Part C of Title III of the Public Health Service Act pertaining to the National Health Service Corps as follows:

New section 329(a).—Amends existing language establishing the NHSC so that the Corps will be utilized to improve the delivery of health services to medically underserved populations. Members of the NHSC may be regular or reserve members of the Public Health Service Corps, Federal employees or other personnel as designated by the Secretary of Health, Education, and Welfare (the Secretary).

New section 329(b)(1).—Requires the Secretary to conduct, at medical and nursing schools and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps, including dissemination of written information on the NHSC and, as feasible, visits to such schools by personnel of the Corps.

New section 329(b)(2).—Authorizes the Secretary to reimburse NHSC applicants for travel expenses for one round trip between their residences and areas in which they may be assigned for the purpose of evaluating such areas.

New section 329(b)(3).—Provides that commissioned officers and other personnel of the NHSC assigned to provide services for underserved populations shall not be included in determining whether any limitation on the number of personnel which may be employed by the Department of Health, Education and Welfare has been exceeded.

New section 329(c).—Authorizes the Secretary, under regulations, to adjust the monthly pay of each NHSC physician and dentist engaged directly in the delivery of health services to a medically underserved

population following termination of his service obligation (if any) incurred as a result of receipt of scholarship assistance up to an amount not to exceed $1000 so that such pay will be competitive with that of members of the same profession with equivalent training and time in practice. Upon the expiration of the thirty-six month period, such bonus support would continue only to the extent necessary to make the NHSC member's monthly pay equal to the income he received for the last month of the thirty-six month period.

New section 330(a)(1).—Requires the Secretary to designate medically underserved populations in States. A "medically underserved population" is defined as the population of an urban or rural area (which need not conform to the geographical boundaries of a political subdivision and which should be a rational area for the delivery of health services) determined by the Secretary to have a critical health manpower shortage or population group which has such a shortage.

New section 330(b)(1).—Requires the Secretary, in designating medically undeserved populations, to take into account the recommendations of health systems agencies for areas in which populations under consideration reside, or in the case of areas for which no health systems agency has been designated, the recommendations of the appropriate State health planning and development agency; ratios of available health manpower; the population's access to health services; the health status of the population; and the population's need and demand for health services.

New section 330(b)(2).—Authorizes any person to apply for the designation of a population as medically underserved.

New section 331(a)(1).—Authorizes the assignment of NHSC personnel to provide health services to medically underserved populations, upon application to the Secretary by State or local health agencies or other health entities serving such populations, and upon certification by the appropriate local government and medical, osteopathic or dental societies that the assignment is needed.

New section 331(a)(2).—Provides that the Secretary may not approve an application for assignment unless the applicant agrees to arrangements in accordance with subsection (b) and has afforded either the appropriate health systems agency or, in the case of areas for which no health systems agency has been designated, the State health planning and development agency an opportunity to review the application and submit its comments. Further requires that, in considering an application, the Secretary take into consideration the population's need for health services; the willingness of the population and the agencies or entities serving it to assist and cooperate in providing effective health services; and recommendations from medical, osteopathic, dental, and other societies or from medical personnel serving the population.

New section 331(a)(3).—Provides that if all requirements are met in an application for assignment of NHSC personnel except for the certification by a State and district medical, osteopathic or dental society or other appropriate health society and if the Secretary finds that such certification has been arbitrarily and capriciously withheld, then he may, after consultation with appropriate medical, osteopathic, dental or other appropriate health societies, waive the requirement for such certification.

New section 331(b)(1).—Requires entities receiving assignment of NHSC personnel to enter into arrangements with the Secretary under which entities will charge patients for health services received; make reasonable efforts to collect the amounts of such charges; and pay quarterly to the United States the sum of pay and allowances of NHSC personnel assigned to the entity, proportionate amounts of any grants received by the entity under sec. 332, and proportionate amounts of any National Health Service Corps scholarship that assignees have received. Authorizes the Secretary to waive in whole or in part these requirements if he determines that the entity is financially unable to meet them or that compliance would unduly limit the ability of the entity to maintain the quality of the services it provides.

New section 331(b)(2).—Provides that entitles must use excess collections to expand or improve the provision of health services to the population served by the entity or to recruit and retain health personnel to provide health services.

New section 331(b)(3).—Requires that any person receiving health services provided by NHSC personnel be charged for such services on a fee-for-service or other basis at a rate approved by the Secretary; except that if it is determined under regulations that the person is unable to pay such charge, the Secretary shall provide that these services be furnished at a reduced rate or without charge.

New section 331(b)(4)—Requires that funds received by the Secretary from entities be deposited in the United States Treasury as miscellaneous receipts and disregarded in determining appropriations for the National Health Service Corps Program.

New section 331(c).—Authorizes the Secretary to approve applications for assignment of NHSC personnel for periods of up to four years.

New section 331(d).—Requires reapplication for assignment of NHSC personnel after the expiration of the period of assistance authorized under subsection (c). Requires the Secretary in considering applications for continued assistance for a population to apply the criteria necessary for the original approval of an application and, in addition, to evaluate the population's continued need for NHSC personnel, the use of the manpower assigned to date, the growth of the practice of the assigned personnel, the community support for the assignment, and to determine that the population has made continued efforts to secure its own manpower and that there has been sound fiscal management of the NHSC practice.

New section 331(e).—Provides that NHSC personnel be assigned on the basis of the extent of a medically underserved population's need and without regard to the ability of the members of the population to pay for health services.

New section 331(f).—Requires that the Secretary, in assigning Corps personnel to communities, seek to match the characteristics of the personnel (and their spouses) and the communities to which they may be assigned in order to increase the likelihood that the personnel will remain in the community after the completion of their assignment. Further requires the Secretary to review the assignment of each Corps assignee and the situation in the community to which he is assigned before the beginning of the last nine months of the assignment period for the purpose of determining the appropriateness of extending the assignment.

New section 331(g)(1).—Requires the Secretary to provide assistance to persons seeking the assignment of NHSC personnel and conduct information programs as are necessary to inform health entities within areas in which underserved populations reside of available assistance.

New section 331(g)(2).—Requires the Secretary to provide technical assistance to all medically underserved populations which are not assigned NHSC personnel to assist them in the recruitment of health manpower and to provide such populations current information respecting programs which may assist them in securing health manpower.

New section 332(a).—Requires Corps personnel, in providing health services, to utilize techniques, facilities, and organizational forms appropriate for the area and, to the maximum extent feasible, provide such services to all members of the population regardless of ability to pay, and in connection with direct health services programs carried out by the Service, direct health services programs carried out with Federal financial assistance, or other health services activities which further the purposes of the NHSC Program.

New section 332(b)(1).—Authorizes the Secretary to make necessary arrangements to enable NHSC personnel to utilize health facilities of the areas in which the medically underserved population resides, and make necessary arrangements for use of equipment and supplies of the Public Health Service and for lease or acquisition of other equipment and supplies, and secure temporary services of physicians, nurses and allied health professionals.

New section 332(b)(2).—Requires that, if the area is being served by a hospital or other facility of the Public Health Service, the Secretary make arrangements for the use of such hospital or facility by NHSC personnel in providing health services, but only to the extent that such use will not impair the delivery of services through the facility to persons entitled to such services.

New section 332(c).—Authorizes the Secretary to make one-time grants, not in excess of $25,000, to medically underserved populations to be used for the purpose of establishing medical practice management systems, acquiring equipment and establishing continuing education programs for NHSC personnel.

New section 332(d).—Authorizes the Secretary, following the expiration of assignment of NHSC personnel, to sell to the last approved applicant for assistance, at fair market value, any equipment in his ownership which has been used by NHSC personnel in providing health services. Such sales of equipment may be carried out by the Secretary without regard to provision of other Federal laws.

New section 333.—Requires the Secretary to report to Congress no later than May 15 of each year the number of medically underserved populations designated in the preceding calendar year and expected to be designated in the calendar year in which the report is submitted, the number of applicants to receive NHSC personnel in the preceding calendar year, the number of personnel assigned in the preceding year and estimates for the year in which the report is submitted, recruitment efforts, the number of patient visits recorded in the previous year by the NHSC, information on retention rates, the results of evaluations conducted by the NHSC, and the amounts charged, collected, and paid to the Federal government by NHSC communities.

New section 334.—Establishes the National Advisory Council on the NHSC and requires membership on the Council as follows: four members to represent consumers of health care, at least two of whom must come from populations served by NHSC members; three members from the medical, dental, and other health professions and teaching professions; one member from a State health planning and development agency, one member from a Statewide Health Coordinating Council and one member from a health systems agency; three members from the Public Health Service, at least two of whom are assigned NHSC personnel; and two members from the National Council on Health Planning and Development. Requires the Council to advise the Secretary with respect to his responsibilities under the Program and review and comment on Program regulations.

New section 335.—Authorizes appropriations of $30 million for fiscal year 1976 for operation of the NHSC.

Section 2(c) of the bill includes transitional provisions respecting changes in designation of areas eligible for assignment, assistance periods, bonus pay provisions, and the advisory council.

Section 3 of the bill requires the Secretary to conduct or contract for studies of methods of assigning personnel in the NHSC with the purpose of identifying the characteristics of health manpower who are likely to remain in practice in medically underserved populations, the characteristics of areas which have been able to retain health manpower, the appropriate conditions for the assignment of nurse practitioners, physicians assistants, and dental auxiliaries in medically underserved populations, including studies of State laws which may restrict the use of such personnel, and the effect of primary care postgraduate physician training in such populations on the health care provided and the decisions of the residents respecting areas in which to locate their practice.

Section 4 of the bill makes technical and conforming changes to section 741 of the Public Health Service Act.

Agency Reports

Agency reports were requested on H.R. 2958, a similar predecessor to H.R. 4114, but reports on that bill have not been received.

Inflation Impact Statement

The Committee is unaware of any inflationary impact on the economy that would result from passage of the proposed legislation. The authorization for fiscal year 1975 is $16 million, which compares favorably with amounts already provided under continuing resolution. The proposed authorizations represent .005 percent of the proposed outlays of the President's budget for fiscal year 1975 and .009 percent of the 1976 budget. They represent .06 percent of the amount budgeted for health programs for fiscal 1975 and .11 percent of the amount budgeted for health programs for fiscal 1976.

Moreover, the National Health Service Corps Program is cost effective. The reported bill requires (sec. 331(b)) that entities to which Corps personnel are assigned must repay to the Federal Government, from collections received from services provided by NHSC personnel, the pay and allowances of personnel assigned to the entity, the amount of any grants received by the entity to prepare for the arrival of Corps members, and the amount of National Health Service Corps scholarship support that assignees have received. Thus, unlike most Federal grant programs, the majority of funds appropriated for the National Health Service Corps Program will be repaid to the Federal Government.

Program Oversight

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authority. Oversight hearings on the Program and several other Federal health programs were conducted by the Subcommittee in January of 1973, and legislative hearings were held in May of 1974, and again, in February of 1975. The Subcommittee's findings are discussed in the report under Need for Legislation and History of the National Health Service Corps as the proposed legislation is designed to respond to the Subcommittee's findings.

The Committee has not received oversight reports from either its own Subcommittee on Investigations and Oversight or the Committee on Government Operations.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Public Health Service Act

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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Part C—Hospitals, Medical Examinations, and Medical Care

Subpart I—General Provisions

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[Effective on Date of Enactment]

ASSIGNMENT OF MEDICAL AND OTHER HEALTH PERSONNEL TO CRITICAL NEED AREAS

SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the "Corps") which shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate and which shall be utilized by the Secretary to improve the delivery of health care and services to persons residing in areas which have critical health manpower shortages.

* * * * * * *

(h) To carry out the purposes of this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $20,000,000 for the fiscal year ending June 30, 1972; $30,000,000 for the fiscal year ending June 30, 1973; [and] $25,000,000 for the fiscal year ending June 30, 1974, *and $16,000,000 for the fiscal year ending June 30, 1975.*

[EFFECTIVE JULY 1, 1975]

[ASSIGNMENT OF MEDICAL AND OTHER HEALTH PERSONNEL TO CRITICAL NEED AREAS

[SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the "Corps") which shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate and which shall be utilized by the Secretary to improve the delivery of health care and services to persons residing in areas which have critical health manpower shortages.

[(b)(1) The Secretary shall (A) designate those areas which he determines have critical health manpower shortages, (B) provide assistance to persons seeking assignment of Corps personnel to such designated areas to provide under this section health care and services for persons residing in such areas, and (C) conduct such information programs in such designated areas as may be necessary to inform the public and private health entities serving those areas of the assistance available under this section.

[(2)(A) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health care and services for persons residing in an area designated by the Secretary under paragraph (1) if—

[(i) the State health agency of each State in which such area is located or the local public health agency or any other public or nonprofit private health entity in such area requests such assignment, and

[(ii) the (I) local government of such area, and (II) the State and district medical, dental, or other appropriate health societies (as the case may be), certify to the Secretary that such assignment of Corps personnel is needed for such area.

If with respect to any proposed assignment of Corps personnel to an area the requirements of clauses (i) and (ii) of the preceding sentence are met except for the certification by the State and district medical, dental, or other appropriate health societies required by clause (ii) and if the Secretary finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, the Secretary may, after consultation with appropriate medical, dental, or other health societies, assign such personnel to such area. Corps personnel shall be assigned under this section on the basis of the extent of an area's need for health care and services and without regard to the ability of the residents of an area to pay for health care and services.

[(B) In providing health care and services under this section, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area and shall, to the maximum extent feasible, provide such care and services (i) to all persons in such area

regardless of the ability of such persons to pay for the care and services, and (ii) in connection with (I) direct health care programs carried out by the Service; (II) any direct health care program carried out in whole or in part with Federal financial assistance; or (III) any other health care activity which is in futherance of the purpose of this section.

[(C) Any person who receives health care or services provided under this section shall be charged for such care or service on a fee-for-service or other basis at a rate established by the Secretary, pursuant to regulations, to recover the reasonable cost of providing such care or service; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such care or service at a reduced rate or without charge. If a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of the care or service provided under this section if such care or service had not been provided under this section, the Secretary shall collect, on a fee-for-service or other basis, from such agency or third party the portion of such cost for which it would be so responsible. Any funds collected by the Secretary under this subparagraph shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining (i) the amounts of appropriations to be requested under subsection (h), and (ii) the amounts to be made available from appropriations made under such subsection to carry out this section.

[(c) Commissioned officers and other personnel of the Corps assigned to areas designated under subsection (b) shall not be included in determining whether any limitation on the number of personnel which may be employed by the Department of Health, Education, and Welfare has been exceeded. The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling to and from their place of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

[(d)(1) Notwithstanding any other provision of law, the Secretary, to the extent feasible, may make such arrangements as he determines necessary to enable officers and other personnel of the Corps in providing care and services under subsection (b) to utilize the health facilities of the area to be served, except that if such area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make to insure the availability in such area of care and services by Corps personnel, arrange for the utilization of such hospital or facility by Corps personnel in providing care and services in such area but only to the extent that such utilization will not impair the delivery of care and treatment through such hospital or facility to persons who are entitled to care and treatment through such hospital or facility. If there are no health facilities in or serving such area, the Secretary may arrange to have such care and services provided in the nearest health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the provision of such care and services. In providing such care and services, the Secretary may (A) make such arrangements as he determines are necessary for the use of equipment and supplies

of the Service and for the lease or acquisition of other equipment and supplies, and (B) secure the temporary services of nurses and allied health professionals.

[(2) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and training centers for the allied health professions, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps.

[(e)(1) There is established a council to be known as the National Advisory Council on Health Manpower Shortage Areas (hereinafter in this section referred to as the "Council"). The Council shall be composed of fifteen members appointed by the Secretary as follows:

[(A) Four members shall be appointed from the general public, representing the consumers of health care.

[(B) Three members shall be appointed from the medical, dental, and other health professions and health teaching professions.

[(C) Three members shall be appointed from State health or health planning agencies.

[(D) Three members shall be appointed from the Service, at least two of whom shall be commissioned officers of the Service.

[(E) One member shall be appointed from the National Advisory Council on Comprehensive Health Planning.

[(F) One member shall be appointed from the National Advisory Council on Regional Medical Programs.

The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this section.

[(2) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

[(3) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5 of the United States Code for persons in the Government service employed intermittently.

[(f) It shall be the function of the Secretary—

[(1) to establish guidelines with respect to how the Corps shall be utilized in areas designated under this section;

[(2) to select personnel of the Corps for assignment to the areas designated under this section; and

[(3) to determine which communities or areas may receive assistance under this section taking into consideration—

[(A) the need of the community or area for health services provided under this section;

[(B) the willingness of the community or area and the appropriate governmental agencies therein to assist and cooperate with the Corps in providing effective health services to residents of the community or area;

[(C) the recommendations of any agency or organization which may be responsible for the development, under section 314(b), of a comprehensive plan covering all or any part of the area or community involved; and

[(D) recommendations from the State medical, dental, and other health associations and from other medical personnel of the community or area considered for assistance under this section.

[(g) The Secretary shall report to Congress no later than May 15 of each year—

[(1) the number of areas designated under subsection (b) in the calendar year preceding the year in which the report is made as having critical health manpower shortages and the number of areas which the Secretary estimates will be so designated in the calendar year in which the report is made;

[(2) the number and types of Corps personnel assigned in such preceding calendar year to areas designated under subsection (b), the number and types of additional Corps personnel which the Secretary estimates will be assigned to such areas in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps; and

[(3) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application.

[(h) To carry out the purposes of this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $20,000,000 for the fiscal year ending June 30, 1972; $30,000,000 for the fiscal year ending June 30, 1973; and $25,000,000 for the fiscal year ending June 30, 1974.

[(i) For purposes of this section, the term "State" includes Guam, American Samoa, and the Trust Territory of the Pacific Islands.]

Subpart II—National Health Service Corps Program

NATIONAL HEALTH SERVICE CORPS

SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this subpart referred to as the "Corps") which (1) shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate, and (2) shall be utilized by the Secretary under this subpart to improve the delivery of health services to medically underserved populations.

(b)(1) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools and entities by personnel of the Corps.

(2) The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling to and from their places of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

(3) Commissioned officers and other personnel of the Corps assigned under section 331 to provide health services for medically underserved populations shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

(c)(1) The Secretary may, under regulations prescribed by him, adjust the monthly pay of each physician and dentist member of the Corps who is directly engaged in the delivery of health services to a medically underserved population as follows:

(A) During the first thirty-six months in which such a member is so engaged in the delivery of health services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowance will provide a monthly income competitive with the average monthly income from a practice of an individual who is a member of the profession of the Corps member, who has equivalent training, and who has been in practice for a period equivalent to the period during which the Corps member has been in practice.

(B) During the period beginning upon the expiration of the thirty-six months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances is equal to or exceeds the monthly income he received for the last of such thirty-six months, the member shall receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

For purposes of subparagraphs (A) and (B), the term 'monthly pay' includes special pay recieved under chapter 5 of title 37 of the United States Code.

(2) In the case of a member of the Corps who is directly engaged in the provision of health services to a medically underserved population in accordance with a service obligation incurred under the Public Health Service and National Health Service Corps Scholarship Training Program, the adjustment in pay authorized by paragraph (1) may be made for such a member only upon satisfactory completion of such service obligation and the first thirty-six months of his being so engaged in the delivery of health care shall, for purposes of paragraph (1)(A), be deemed to begin upon such satisfactory completion.

DESIGNATION OF MEDICALLY UNDERSERVED POPULATIONS

SEC. 330. (a) For purposes of this subpart—

(1) the term "medically underserved population" means (A) the population of an urban or rural area (which need not conform to the geographical boundaries of a political subdivision and which should be a rational area for the delivery of health services) which the Secretary determines has a critical health manpower shortage, or (B) a population group determined by the Secretary to have such a shortage; and

(2) the term "State" includes Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(b)(1) The Secretary shall designate the medically underserved populations in the States. In determining whether to designate a population as a medically underserved population, the Secretary shall take into account the following:

(A) The recommendations of each health systems agency designated under section 1515 for a health service area which includes all or any part of the area in which the population under consideration for designation resides.

(B) If such area is within a health service area (or areas) for which no health systems agency has been designated, the recommendations of the State health planning and development agency designated under section 1521 for the State (or States) in which such area is located.

(C) Ratios of available health manpower to the population under consideration for designation.

(D) Indicators of the population's access to health services.

(E) Indicators of the health status of the population.

(F) Indicators of such population's need and demand for health services.

(2) Any person may apply to the Secretary (in such manner as he may prescribe) for the designation (in accordance with the second sentence of paragraph (1)) of a population as a medically underserved population.

ASSIGNMENT OF CORPS PERSONNEL

SEC. 331. (a)(1) The Secretary may assigh personnel of the Corps to provide, under regulations prescribed by the Secretary, health services for a medically underserved population only if—

(A) the State health agency of each State in which such population is located or the local public health agency or any other public or nonprofit private health entity serving such population makes application to the Secretary for such assignment, and

(B)(i) the local government of the area in which such population resides certifies to the Secretary that such assignment of Corps personnel is needed for such population, and

(ii) any State and district medical, osteopathic, or dental society for such area, or any other appropriate health society (as the case may be) for such area, makes such a certification to the Secretary.

(2) The Secretary may not approve an application under paragraph (1)(A) for an assignment unless the applicant agrees to enter into an arrangement with the Secretary in accordance with subsection (b) and has afforded—

(A) each health systems agency designated under section 1515 for a health service area which includes all or any part of the area in which the population for which the application is submitted resides, and

(B) if there is a part of such area within a health service area for which no health systems agency has been designated, the State health planning and development agency of the State (designated under section 1521) in which such part is located,

an opportunity to review the application and submit its comments to the Secretary respecting the need for and proposed use of the Corps personnel requested in the application. In considering such an application, the Secretary shall take into consideration the need of the population for which the application was submitted for the health services which may be provided under this subpart, the willingness of the population and the appropriate governmental agencies or health entities serving it to assist and cooperate with the Corps in providing effective health services to the population, and recommendations from medical, osteopathic, dental, or other health societies or from medical personnel serving the population.

(3) If with respect to any proposed assignment of Corps personnel for a medically underserved population the requirements of subparagraphs (A) and (B) of paragraph (1) are met except for the certification required

by subparagraph (B)(ii) of such paragraph and if the Secretary finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, the Secretary may, after consultation with appropriate medical, osteopathic, dental, or other health societies, waive the application of the certification requirement to such proposed assignment.

(b)(1) The Secretary shall require as a condition to the approval of an application under subsection (a) that the entity which submitted the application enter into an appropriate arrangement with the Secretary under which—

(A) the entity shall be responsible for charging in accordance with paragraph (3) for health services provided by the Corps personnel to be assigned;

(B) the entity shall take such action as may be reasonable for the collection of payments for such health services, including if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps personnel under this subpart, the collection, on a fee-for-service or other basis, from such agency or third party the portion of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health services provided by Corps personnel shall be considered as being provided by private practioners); and

(C) the entity shall pay to the United States as prescribed by the Secretary for each calendar quarter (or other period as may be specified in the arrangement) during which any Corps personnel are assigned to such entity the sum of—

(i) the pay (including amounts paid in accordance with 329 (c)) and allowances of such Corps personnel for the portion of such quarter (or other period) during which assigned to the entity;

(ii) if such entity received a grant under section 332 for the assistance period (as defined in subsection (c)) for which such personnel are assigned, an amount which bears the same ratio to the amount of such grant as the number of days in such quarter (or other period) during which any Corps personnel were assigned to the entity bears to the number of days in the assistance period after such entity received such grant; and

(iii) if during such quarter (or other period) any member of the Corps assigned to such entity is providing obligated service pursuant to an agreement under the Public Health and National Health Service Corps Scholarship Training Program, for each such member an amount which bears the same ratio to the amount paid under such Program to or on the behalf of such member as the number of days of obligated service provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such Program.

The Secretary may waive in whole or in part the application of the requirement of subparagraph (C) to an entity if he determines that the entity is financially unable to meet such requirement or if he determines that compliance with such requirement would unduly limit the ability the tntity to maintain the quality of the services it provides.

(2) The excess (if any) of the amount collected by an entity in accordance with paragraph (1)(B) over the amount paid to the United States in accordance with paragraph (1)(C) shall be used by the entity to expand or improve the provision of health services to the population for which the entity submitted an application under subsection (a) or to recruit and retain health manpower to provide health services for such population.

(3) Any person who receives health services provided by Corps personnel under this subpart shall be charged for such services on a fee-for-service or other basis at a rate approved by the Secretary, pursuant to regulations, to recover the value of such services; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate or without charge.

(4) Funds received by the Secretary under an arrangement entered into under paragraph (1) shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amounts of appropriations to be requested under section 335 and the amounts to be made available from appropriations made under such section to carry out this subpart.

(c) Upon approval of an application submitted under subsection (a) for the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may approve the assignment of Corps personnel for such population during a period (hereinafter in this subpart referred to as the "assistance period") which may not exceed four years from the date of the first assignment of Corps personnel for such population after the date of the approval of the application. No assignment of individual Corps personnel may be made for a period ending after the expiration of the applicable approved assistance period.

(d) Upon expiration of an approved assistance period for a medically underserved population, no new assignment of Corps personnel may be made for such population unless an application is submitted in accordance with subsection (a) for such new assignment. The Secretary may not approve such an application unless—

(1) the application and certification requirements of subsection (a) are met;

(2) the Secretary has conducted an evaluation of the continued need for health manpower of the population for which the application is submitted, of the utilization of the manpower by such population, of the growth of the health care practice of the Corps personnel assigned for such population, and of community support for the assignment; and

(3) the Secretary has determined that such population has made continued efforts to secure its own health manpower, that there has been sound fiscal management of the health care practice of the Corps personnel assigned for such population, including efficient collection of fee-for-service, third party, and other funds available to such population, and that there has been appropriate and efficient utilization of such Corps personnel.

(e) Corps personnel shall be assigned to provide health services for a medically underserved population on the basis of the extent of the population's need for health services and without regard to the ability of the members of the population to pay for health services.

(f) In making an assignment of Corps personnel the Secretary shall seek to match characteristics of the assignee (and his spouse (if any)) and of the population to which such assignee may be assigned in order to increase the likelihood of the assignee remaining to serve the population upon completion of his assignment period. The Secretary shall, before the beginning of the last nine months of the assignment period of a member of the Corps, review such member's assignment and the situation in the area to which he was assigned for the purpose of determining the advisability of extending the period of such member's assignment.

(g)(1) The Secretary shall (A) provide assistance to persons seeking assignment of Corps personnel under this section, and (B) conduct such information programs in areas in which such populations reside as may be necessary to inform the public and private health entities serving those areas of the assistance available to such populations by virtue of their designation under section 330 as medically underserved.

(2) The Secretary shall provide technical assistance to all medically underserved populations to which are not assigned Corps personnel to assist in the recruitment of health manpower for such populations. The Secretary shall also give such populations current information respecting public and private programs under which they may receive assitance in securing health manpower for them.

PROVISION OF HEALTH SERVICES BY CORPS PERSONNEL

SEC. 332. (a) In providing health services for a medically underserved population under this subpart, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area in which the population resides and shall, to the maximum extent feasible, provide such services (1) to all members of the population regardless of their ability to pay for the services, and (2) in connection with (A) direct health services programs carried out by the Service; (B) any other direct health services program carried out in whole or in part with Federal financial assistance, or (C) any other health services activity which is in furtherance of the purposes of this subpart.

(b)(1) Notwithstanding any other provision of law, the Secretary (A) may, to the extent feasible, make such arrangements as he determines necessary to enable Corps personnel in providing health services for a medically underserved population to utilize the health facilities of the area in which the population resides and if there are no health facilities in or serving such area, the Secretary may arrange to have Corps personnel provide health services in the nearest health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the provision if health services, (B) may make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of other equipment and supplies, and (C) may secure the temporary services of physicians, nurses, and allied health professionals.

(2) If such an area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make under paragraph (1), arrange for the utilization of such hospital or facility by Corps personnel in providing health services for the population, but only to the extent that such utilization will not

impair the delivery of health services and treatment through such hospital or facility to persons who are entitled to health services and treatment through such hospital or facility.

(c) The Secretary may make one grant to any applicant with an approved application under section 331 to assist it in meeting the costs of establishing medical practice management systems for Corps personnel, acquiring equipment for their use in providing health services, and establishing appropriate continuing education programs and opportunities for them. No grant may be made under this subsection unless an application therefor is submitted to, and approved by, the Secretary. The amount of any grant shall be determined by the Secretary, except that no grant may exceed more than $25,000.

(d) Upon the expiration of the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may (notwithstanding any other provision of law) sell to the entity which submitted the last application approved under section 331 for the assignment of Corps personnel for such population equipment of the United States utilized by such personnel in providing health services. Sales made under this subsection shall be made for the fair market value of the equipment sold (as determined by the Secretary).

REPORTS

SEC. 333. The Secretary shall report to Congress no later than May 15 of each year—

(1) the number and identity of all medically underserved populations in each of the States in the calendar year preceding the year in which the report is made and the number of medically underserved populations which the Secretary estimates will be designated under section 330 in the calendar year in which the report is made;

(2) the number of applications filed under section 331 in such preceding calendar year for assignment of Corps personnel and the action taken on each such application;

(3) the number and types of Corps personnel assigned in such preceding year to provide health services for medically underserved populations, the number and types of additional Corps personnel which the Secretary estimates will be assigned to provide such services in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps;

(4) the recruitment efforts engaged in for the Corps in such preceding year, including the programs carried out under section 329(b)(1), and the number of qualified persons who applied for service in the Corps in each professional category;

(5) the total number of patients seen and patient visits recorded during such preceding year in each area where Corps personnel were assigned;

(6) the number of health personnel electing to remain, after termination of their service in the Corps, to provide health services to medically underserved populations, the number of such personnel who do not make such election, and their reasons for not making such election;

(7) the results of evaluations made under section 331(d)(2), and determinations made under section 331(d)(3), during such preceding year; and

(8) the total amount (A) charged during such preceding year for health services by Corps personnel, (B) collected in such year by entities in accordance with arrangements under section 331(b), and (C) paid to the Secretary in such year under such arrangements.

NATIONAL ADVISORY COUNCIL

SEC. 334. (a) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the "Council"). The Council shall be composed of fifteen members appointed by the Secretary as follows:

(1) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be members of a medically underserved population for which Corps personnel are providing health services under this subpart.

(2) Three members shall be appointed from the medical, dental, and other health professions and health teaching professions.

(3) One member shall be appointed from a State health planning and development agency designated under section 1521, one member shall be appointed from a Statewide Health Coordinating Council under section 1524, and one member shall be appointed from a health systems agency designated under section 1515.

(4) Three members shall be appointed from the Service, at least two of whom shall be members of the Corps directly engaged in the provision of health services for a medically underserved population.

(5) Two members shall be appointed from the National Council on Health Planning and Development (established under section 1503).

The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this subpart, and shall review and comment upon regulations promulgated by the Secretary under this section subpart.

(b)(1) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

(2) Members of the Council (other than members who are officers or employees of the United States), while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive for each day (including traveltime) in which they are so serving the daily equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule; and while so serving away from their homes or regular places of business all members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5 of the United States Code for persons in the Government Service employed intermittently.

AUTHORIZATION OF APPROPRIATION

SEC. 335. To carry out the purposes of this subpart, there is authorized to be appropriated $30,000,000 for fiscal year 1976.

PART D—LEPERS

RECEIPT OF LEPERS

SEC. [331] *338*. The Service shall, in accordance with regulations, receive into any hospital of the Service suitable for his accommodation any person afflicted with leprosy who presents himself for care,

detention, or treatment, or who may be apprehended under section 332 or 361 of this Act, and any person afflicted with leprosy duly consigned to the care of the Service by the proper health authority of any State. The Surgeon General is authorized, upon the request of any health authority to send for any person within the jurisdiction of such authority who is afflicted with leprosy and to convey such person to the appropriate hospital for detention and treatment. When the transportation of any such person is undertaken for the protection of the public health the expense of such removal shall be met from funds available for the maintenance of hospitals of the Service. Such funds shall also be available, subject to regulations, for transportation of recovered indigent leper patients to their homes, including subsistence allowance while traveling. When so provided in appropriations available for any fiscal year for the maintenance of hospitals of the Service, the Surgeon General is authorized and directed to make payments to the Board of Health of Hawaii for the care and treatment in its facilities of persons afflicted with leprosy at a per diem rate, determined from time to time by the Surgeon General, which shall, subject to the availability of appropriations, be approximately equal to the per diem operating cost per patient of such facilities, except that such per diem rate shall not be greater than the comparable per diem operating cost per patient at the National Leprosarium, Carville, Louisiana.

APPREHENSION, DETENTION, TREATMENT, AND RELEASE

SEC. [332] *339*. The Surgeon General may provide by regulation for the apprehension, detention, treatment, and release of persons being treated by the Service for leprosy.

TITLE VII—HEALTH RESEARCH AND TEACHING FACILITIES AND TRAINING OF PROFESSIONAL HEALTH PERSONNEL

PART C—STUDENT LOANS

Subpart I—Loans to Students Studying in the United States

LOAN PROVISIONS

SEC. 741. (a) Loans from a loan fund established under this subpart may not exceed $3,500 for any student for any academic year or its equivalent.

(b) Any such loans shall be made on such terms and conditions as the school may determine, but may be made only to a student in need of the amount thereof to pursue a full-time course of study at the school leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree, doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, or doctor of veterinary medicine or an equivalent degree.

(c) Such loans shall be repayable in equal or graduated periodic installments (with the right of the borrower to accelerate repayment) over the 10-year period which begins 1 year after the student ceases to pursue a full-time course of study at a school of medicine, osteopathy, dentistry, pharmacy, podiatry, optometry, or veterinary

medicine, excluding from such 10-year period all periods (up to 3 years) of (1) active duty performed by the borrower as a member of a uniformed service, or (2) service as a volunteer under the Peace Corps Act; and periods of advanced professional training including internships and residences.

(d) The liability to repay the unpaid balance of such a loan and accrued interest thereon shall be canceled upon the death of the borrower, or if the Secretary determines that he has become permanently, and totally disabled.

(e) Such loans shall bear interest, on the unpaid balance of the loan, computed only for periods for which the loan is repayable, at the rate of 3 per centum per year.

(f)(1) In the case of any individual—

(A) who has received a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, doctor of optometry or an equivalent degree, bachelor of science in pharmacy or an equivalent degree, or doctor of podiatry or an equivalent degree:

(B) who obtained (i) one or more loans from a loan fund established under this part, or (ii) any other educational loan for his costs at a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, or podiatry; and

(C) who enters into an agreement with the Secretary to practice his profession (as a member of the National Health Service Corps or otherwise) for a period of at least two years in an area in a State [designated under section 329(b) or otherwise determined by the Secretary, after consultation with the appropriate State health authority (as determined by the Secretary by regulations), to have a shortage of and need for persons trained in his profession;] *in which is located a medically underserved population designated under section 330;*

the Secretary shall make payments in accordance with paragraph (2), for and on behalf of that individual, on the principal of and interest on any loan of his described in subparagraph (B) of this paragraph which is outstanding on the date he begins the practice specified in the agreement described in subparagraph (C) of this paragraph.

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FOR IMMEDIATE RELEASE July 26, 1975

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE SENATE OF THE UNITED STATES:

I am today returning, without my approval, S. 66, a bill to amend the Public Health Service Act to provide support for health services, nurse training, and the National Health Service Corps program.

This bill is very similar to two separate bills which I disapproved during the last session of the 93rd Congress, H.R. 14214 and H.R. 17085. In my memorandums of disapproval, dated December 23, 1974, and January 3, 1975, respectively, I cited a number of reasons why I could not approve those bills. Those objections remain valid for the measure before me today.

As in last year's bills, S. 66 would authorize excessive appropriation levels. I realize that in considering the bill this year, the 94th Congress made some reductions in the total cost of the measure. However, the levels authorized are still far in excess of the amounts we can afford for these programs. The bill would authorize almost $550 million above my fiscal year 1976 budget request for the programs involved, and it exceeds fiscal year 1977 levels by approximately the same amount resulting in a total increase of $1.1 billion. At a time when the overall Federal deficit is estimated at $60 billion, proposed authorization levels such as these cannot be tolerated.

When I signed the Tax Reduction Act of 1975, I pledged to do everything in my power to keep this year's deficit from exceeding $60 billion and to restrain the longer-run growth in Federal spending. I stated that I would resist every attempt by the Congress to add to that deficit. Bills currently being considered by the Congress would add $25 billion to the fiscal year 1976 deficit and $45 billion to next year's deficit. If they were to become law, they would lock us into a permanent policy of excessive spending and make the Federal budget a primary cause of inflation for years to come. To avoid this, I have no choice but to veto these bills if the Congress insists upon sending them to me.

Apart from its excessive authorization levels, S. 66 is unsound from a program standpoint. In the area of health services, for example, the bill proposes extension and expansion of Community Mental Health Centers projects which have been adequately demonstrated and should now be absorbed by the regular health services delivery system. S. 66 also would continue and expand such separate categorical programs as Community Health Centers and Migrant Health Centers. In addition, it would authorize several new narrow categorical, and potentially costly programs which duplicate existing authorities, including $30 million for the treatment of hypertension, $17 million for rape prevention and control, $10 million for home health service demonstration agencies, and $16 million for hemophilia treatment and blood separation centers. Three new national commissions on specific diseases

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also would be established. The expansion of the Federal role in health services delivery through such narrow categorical programs is not consistent with development of an integrated, flexible health service delivery system.

The Administration repeatedly and vigorously has opposed measures such as S. 66 and urged passage of a more effective and more equitable approach to Federal assistance for health services. H.R. 4819 and S. 1203, which reflect our proposals, would consolidate various separate programs into the flexible project grant authority of the Public Health Service Act to allow funding of a wide variety of health services projects based on State and local needs. Moreover, such programs would be for demonstration purposes. Once a new service model has been adequately tested, its adoption into the delivery of services can -- and should -- be the primary responsibility of the private sector and State and local governments.

The Federal roles in overcoming barriers to needed health care should emphasize health care financing programs -- such as Medicare and Medicaid for which spending is estimated at $22 billion this year. These programs establish specified eligibility and benefits standards and provide assistance generally available to those most in need, such as the poor and the aged. S. 66, on the other hand, would have the Federal Government select individual communities and groups for special funding assistance. In my view, this is clearly an inequitable approach to health problems and an unwise attempt to substitute judgments made in Washington for those of responsible persons in State and local governments and the private sector.

In extending the registered nurse training authorities, S. 66 inappropriately proposes continuation of large amounts of capitation and construction support. These support mechanisms have outlived their usefulness. They were introduced to stimulate nursing schools to educate more general-duty nurses because of an overall shortage. The schools responded, with enrollements in baccalaureate and associate degree programs rising by more than 90 percent during the period 1970-74. As a result, with no further Federal stimulation, we can expect the supply of active registered nurses to increase by more than 50 percent during this decade.

With these increases, the employment market for general duty nurses already is tightening in some areas. As early as January, 1973, the American Nurses' Association stated that "...it appears that the shortage of staff nurses is disappearing." Our failure to limit growth now could result in our training an excess number of nurses, creating the same kind of oversupply that has left thousands of elementary and secondary school teachers disillusioned with the lack of teaching opportunities.

The general nursing student assistance provisions contained in this bill are largely duplicative of existing undergraduate student aid programs offered by the Office of Education, and represent just one more unnecessary categorical program.

The bill also fails to shift emphasis in any meaningful way from problems of aggregate supply shortages to the problem of geographic maldistribution, which is reflected in very substantial intra- and inter-State differentials in nurse-to-population ratios.

S. 66 continues to treat nurse training separately from the other health professions. The Congress is now considering various measures for Federal support for education in other health professions. Nurse training

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should be considered as part of that debate to interrelate health manpower education programs rather than to perpetuate a fragmented Federal health professions policy.

Finally, S. 66 provides for a one-year extension of the National Health Service Corps. I support this fine program, and the Administration has submitted legislation to the Congress for its extension. I believe, however, that the authorization level proposed in S. 66 of $30 million for fiscal year 1976 is excessive.

Good health care and the availability of health personnel to administer that care are obviously of great importance. I share with the Congress the desire to improve the Nation's health care. I am convinced that legislation can be devised to accomplish our common objectives which does not adversely affect our efforts to restrain the budget or inappropriately structure our health care system. I urge the Congress to pass such legislation, using the bills I have endorsed as the starting point in such deliberations.

GERALD R. FORD

THE WHITE HOUSE,

July 26, 1975.

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FILE

August 18, 1975

MEMORANDUM FOR: VERN LOEN
TOM LOEFFLER

FROM: CHARLES LEPPERT, JR.

SUBJECT: John Meagher

John Meagher wants to meet with Administration people, namely Jack Veneman, Paul O'Neill, and Jim Cavanaugh on national health insurance legislation.

Meagher wants to relate the Committee's feelings onthe subject and wants to get the President and the Administration people committed to a graduated program. He feels some Committee Democrats also favor a graduated approach.

Suggest we let Tom Loeffler set this up.

(typed but not read)

EMBARGOED UNTIL 3:00 P.M. (EST) February 25, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

The health of our people is one of our Nation's most vital resources.

Significant progress has been made in improving the health of the Nation's people during the last 25 years, as can be seen in the reductions in the infant mortality rate, increases in life expectancy, and the conquering of some communicable diseases. This progress has come under a largely private health care system with the support of public funds.

In the past 10 year period (1965-1975) Federal spending for health has increased from $5 billion to $37 billion. With greater Federal funding has come a multitude of Federal programs, regulations and restrictions -- all motivated by the best of intentions but each adding to the confusion and overlap and inequity that now characterizes our efforts at the national level.

Today I am proposing to the Congress legislation that addresses these problems. I am asking Congress to enact the Financial Assistance for Health Care Act which will consolidate Medicaid and 15 categorical Federal health programs into a $10 billion block grant to the States. I am proposing that future Federal funding for this new program be increased annually in increments of $500 million plus the amounts needed after 1980 to ensure that no State will in the future receive less under this proposal than it received in fiscal year 1976.

The Financial Assistance for Health Care proposal is being submitted after extensive consultation with organizations representing the publicly elected officials who will be responsible for administering the program. I believe this proposal represents a major step toward overcoming some of the most serious defects in our present system of Federal financing of health care.

My proposal is designed to achieve a more equitable distribution of Federal health dollars among States and to increase State control over health spending. My proposal also recognizes the appropriate Federal role in providing financial assistance to State and local governments to improve the quality and distribution of health services.

The enactment of this legislation will achieve a more equitable distribution of Federal health dollars by providing funds according to a formula giving primary weight to a State's low-income population. The formula also takes into account the relative "tax effort" made by a State and the per capita income of that State.

Let me emphasize that every State will receive more Federal funds in fiscal years 1977, 1978 and 1979 under the block grant than it received in fiscal year 1976. My proposal

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also allows for a gradual phase-in of the distribution formula in future years to ensure a systematic, orderly transition that will permit States to adjust to the new program.

To assure accountability and responsiveness to the public, my proposal requires each State to develop an annual health care plan as a condition to receiving Federal funds. This plan will be developed through a Statewide public review and comment process which will assure participation by all concerned parties. Thus, increased State responsibility will be coupled with expanded public participation, and accountability in the development of State health policies.

This proposed consolidation of health programs is essential to continue our national progress in the field of health. It is designed to permit States greater flexibility in providing for delivery of health care services to those with low income. It eliminates the requirements for State matching. And it recognizes the need for a cooperative relationship among governments at all levels. My proposal would reduce Federal red tape, increase local control over health spending, and expand public participation in health planning.

While I am proposing to increase State control over health spending, we will continue to concentrate our efforts in areas of appropriate Federal responsibility. For example, my budget proposals for 1977 include the following:

-- In food and drug safety, I have asked for $226 million in 1977, an increase of $17 million, to enable further progress in priority areas;

-- In the area of drug abuse prevention, I propose almost $500 million for prevention and treatment to expand national drug abuse treatment capacity to meet the current need;

-- My budget requests more than $3 billion for health research, including continued support of major national efforts in cancer and heart disease research and support for new scientific opportunities in the fields of environmental health, aging, and immunology;

-- In our effort to improve the training and utilization of doctors and other health professionals, I have requested new legislation and funding of $319 million, designed to concentrate on the problems of geographic and specialty maldistribution of health professionals;

-- To assist local communities to attract physicians, dentists and other health professionals to underserved areas, I am proposing to expand the National Health Service Corps demonstration program 38% from $18 million to $25 million.

-- To assist the development of a strong health maintenance alternative, I have directed HEW to move rapidly in administering the dual option provisions of the HMO Act. And, to complete the 5-year effort to demonstrate and test the

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health maintenance organization concept, I have requested an additional year's authorization for new commitments. As of last June, there were 10 health maintenance organizations certified through the dual option provisions;

--- To provide improved health services to American Indians and Alaska Natives, I am asking for $355 million. Spending by the Indian Health Service alone in 1977 will result in over $685 per beneficiary, or over $2,740 per Indian family of four;

--- In the area of veterans' health care, I have requested $4.5 billion to assure continued quality care by providing for increases in medical staff and research related to VA health care delivery.

A realistic assessment of the present health care programs and the responsibilities of Federal, State, and local governments fully demonstrates that the reforms I am proposing in Federal health care are needed now. The Medicare Improvements of 1976 that I recommended to the Congress on February 11 also represents a balanced response to needed program reforms. This proposal is designed to improve catastrophic health cost protection for our aged and disabled, restrain cost increases in the Medicare program and provide training for the hospital insurance trust fund.

I request that the Congress give both these measures the earliest possible consideration.

GERALD R. FORD

THE WHITE HOUSE,

February 25, 1976.

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EMBARGOED FOR RELEASE
UNTIL 3:00 P.M. (EST)

FEBRUARY 25, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

FINANCIAL ASSISTANCE FOR HEALTH CARE ACT

FACT SHEET

The President is proposing to improve the efficiency and equity of health services to the poor by consolidating 16 Federal health programs, including Medicaid, into one $10 billion block grant to the States. Every State will receive more in FY 1977, 1978 and 1979 than it received in FY 1976. And, no State will ever receive less than it did in FY 1976.

BACKGROUND

The existing array of Federal categorical health programs includes varying eligibility requirements. This results in expensive and cumbersome program administration as well as gaps in coverage for those who are needy but categorically ineligible, such as two-parent families, childless couples and single individuals.

To receive Medicaid funds, States are currently required to provide matching funds. Under the existing structure of health programs, some States with high per capita income receive more than four times as much Federal money per low-income recipient as do States with low per capita income.

Also, the current system involves programs administered at the Federal level by six different HEW agencies requiring over 2300 employees and close to 3000 grants and contracts to run. Under the President's proposal, one HEW health agency with 100 employees would be responsible.

DESCRIPTION OF PROGRAM

The objectives of the Financial Assistance for Health Care Act are to:

-- improve access to quality health care at reasonable costs;

-- achieve over time a more equitable distribution of Federal health dollars among States in relationship to those persons most in need;

-- increase State and local control over health spending to:

   a. allow each State to set its own priorities for health programs based on the particular needs of its low-income population and its resources;

   b. allow each State to integrate its programs into a cohesive total; and

   c. increase the States' motivation to control rising health care costs;

-- restrain the growth of Federal spending and the Federal bureaucracy and reduce Federal red tape.

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The proposal includes a requirement for the development by the States of a State Health Care Plan. Public participation in the development of the plan is required to ensure that increased State responsibility is coupled with expanded public involvement in the formation of State health policies.

A. Programs Included

The President's proposal would consolidate 16 Federal health programs into one $10 billion block grant to the States, to be effective October 1, 1976. The programs, which fall into four major categories are:

(1) Medicaid;

(2) Public Health Service (PHS) preventive and community health programs:

-- Community Mental Health Centers

-- Alcohol Project and State Formula Grants

-- Venereal Disease

-- Immunization

-- Rat Control

-- Lead Paint Poisoning Prevention

-- Community Health Centers

-- State Health Grants

-- Maternal and Child Health

-- Family Planning

-- Migrant Health

-- Emergency Medical Services;

(3) Health planning, construction and resources development programs; and

(4) Developmental disabilities.

A chart is attached to the Supplemental Fact Sheet (Appendix A) which compares the flow of Federal health service dollars under current laws to the flow of funds under the President's proposed consolidation and illustrates the proposed simplification.

B. Funding

The FY 1977 Budget requests $10 billion for the State block grant with $500 million annual increments in Federal funds in future years, plus the amounts needed after 1980 to ensure that no State will in the future receive less under this proposal than it received in Fiscal Year 1976. An additional $1.5 million in budget authority is requested for program administration costs for an estimated 100 positions.

# # # #

EMBARGOED FOR RELEASE
UNTIL 3:00 P.M. (EST)

FEBRUARY 25, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

FINANCIAL ASSISTANCE FOR HEALTH CARE ACT

SUPPLEMENTAL FACT SHEET

TABLE OF CONTENTS

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I. Distribution Formula

After an initial period of transition, funds will be distributed according to a formula giving primary weight to a State's low-income population. The formula gives weight also to the relative "tax effort" made by a State and to a State's per capita income.

II. Phase-in of Formula

The distribution formula will be gradually phased-in, to allow States to make program adjustments. At no time will a State receive less than it did in FY 1976. For the first three years of the program, beginning October 1, 1976, the maximum annual increase for any State will not exceed 10 percent.

In subsequent years States will continue to move toward the amount allocated by the formula; increases in subsequent years are limited to a maximum of 20 percent over the previous year. The distribution of block grant funds is shown in Appendix B.

III. Protection for Direct Federal Grantees

To avoid disruptions in health services delivery and to insure an orderly, gradual transition to the block grant program, direct Federal grantees (such as community mental health centers, neighborhood health centers, and alcoholism programs) will be protected from large budgetary reductions during the first three years of the program. Grantees will be guaranteed at least 80 percent of their FY 1976 grant level in the first year, 50 percent in the second year, and 25 percent in the third year.

IV. State Financial Participation

No State match is required under the block grant program. States and localities spent $16 billion of their own funds for health purposes in 1975. At least this level of spending is expected to continue.

V. Reimbursement and Cost-Sharing

States will have broad latitude on reimbursement levels and methodologies and may impose any level of premiums or cost-sharing they deem appropriate on services. States may not permit providers to "extra-bill" patients above the level of payment authorized by States.

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VI. Covered Services

A. Personal Health Care. At least 90 percent of Federal funds must be spent on personal health care services. These include a broad range of physical and mental health activities including all services now covered by Medicaid, as well as other personal health services deemed appropriate by States (for example, living arrangements that could substitute for institutional care).

B. Community and Environmental Health Activities. At least 5 percent of Federal funds must be spent for (1) community health protection (e.g., disease control, environmental health, health education); (2) community-based mental health services, including alcoholism and drug abuse treatment, and (3) developmental disabilities programs.

C. Other Health Activities. The remaining 5 percent may be spent on other State-selected health activities including State and sub-State planning, rate regulation, data acquisition and analysis, and resources development. They may also be spent for activities in categories A and B described above.

Services currently provided under Medicaid and the PHS grants are listed in Appendix C.

VII. Target Population and Eligibility

States will have broad discretion in setting income and other standards for defining the eligible population, except that funds must be used to assure that personal health care services are provided to low income persons. States are not required to use Federal categorical restrictions in determining eligibility (e.g., childless couples, single persons between ages 21 and 65, and intact families may qualify for assistance). And States may deduct out-of-pocket medical expenses in counting income.

States may not impose duration of residence requirements as a condition of participation, nor illegally discriminate against service applicants or recipients. Changes in eligibility from existing State standards must be presented for public review and comment as part of the State Plan.

Services financed with the 5 percent community health protection, mental health, and disabilities monies may be offered to all individuals without regard to income.

VIII. State Plan Requirements

A. A State Health Care Plan must be developed annually as a condition of receiving Federal funds. It will have two major components: A general requirements part will cover the entire State population and both publicly and privately financed health services. A second part will concentrate on the population and services covered by the Financial Assistance for Health Care Act.

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The State Health Care Plan must provide assurance that the funds for services included in the Plan will be passed by the State to those units of government which are responsible under the law for providing those services.

The State Health Care Plan should be directed at achieving State-defined goals consistent with the following objectives of the Act:

-- Assuring all citizens of the State, and particularly low-income persons, access to needed health services of acceptable quality;

-- Development and utilization of preventive health services;

-- Prevention or reduction of inappropriate institutional care;

-- Encouraging the use of ambulatory care in lieu of inpatient services;

-- Provision of primary care services especially for those located in rural or medically underserved areas;

-- Assurance of the most appropriate, effective, and efficient utilization of existing health care facilities and services;

-- Promotion of community health.

The Plan must describe the relationship of its provisions to the achievement of these goals, with particular reference to its effect on children, the elderly, migrants, the mentally ill, the developmentally disabled, the handicapped, alcoholics and drug abusers.

B. General Requirements

This portion of the State Health Care Plan must include at least the following information:

-- Analysis of the supply and distribution of State health care facilities and services (e.g., inpatient, ambulatory, long-term care);

-- Assessment of the supply of health manpower and manpower training programs;

-- Analysis of the sources of health financing available to State residents (e.g., private insurance, public subsidies);

-- Assessment of the health needs of the population and the availability of needed services, especially in medically underserved areas (e.g., rural areas).

C. Requirements Concerning State-Supported Health Services

This portion of the State Health Care Plan must include at least the following:

-- Definition of the eligible population, including the numbers and categories of individuals to be served (e.g., aged, children). States must provide a rationale for differences in coverage from the plan of the previous year or, from current eligibility standards.

more

-- **Definition of covered services** -- including amount, duration and scope -- and a rationale for any change from current State programs. (See Appendix C).

-- Estimates of individuals to be served and of the expenditures for each service to be provided and each category of individuals to whom services are provided.

-- Identification of categories of service providers, specification of the standards for each group of providers, explanation of the process for enforcing these standards, and identification of the State agency (agencies) responsible for enforcement. States must provide a rationale for differences in provider standards over existing standards.

-- Description of the methods used to reimburse each category of providers and the levels of reimbursement proposed to be offered.

-- Explanation of the mechanisms for program coordination between the State's personal health services program and other human service programs (e.g., Medicare, SSI, Title XX).

-- Description of a system under which service applicants and recipients may file complaints and receive a fair hearing.

-- Provisions regarding the safeguarding of information on applicants and beneficiaries.

-- Definition of the organizational structure responsible for administration of funds provided under the Financial Assistance for Health Care Act.

-- Description of quality assurance system(s) to be used for each type of provider. States must have quality of care systems including peer review of services provided based on objective normal criteria and standards.

-- Description of the State planning, reporting, and other activities in the field of health.

D. Planning Process

An open and public planning process, including designation of substate planning bodies, wherever practical, composed of elected officials of local general purpose government, providers, consumers, insurors and health education institutions is required. Where local funds are used to help finance services under the Plan, elected officials of local governments must be consulted regarding State Plan priorities.

Both parts of the State Health Care Plan must be published and made available for public review and comment. State Plan publication, review, and amendment procedures will be monitored by HEW.

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IX. Certificate-of-Need

To assure efficient development and distribution of costly institutional health services, States must administer a certificate-of-need program that includes a review and approval or disapproval of new institutional health care services proposed to be offered in the State.

X. Reports

States must submit a report to HEW at the end of each program year which accounts for the use of Federal funds in accordance with the State Plan and explains major variances.

XI. Enforcement, Audit, Compliance, Penalties

States must have a mechanism for citizens to file complaints and receive a hearing. In addition, aggrieved citizens may bring civil suit. States must also have procedures for auditing block grant expenditures and evaluating State compliance with the State Health Care Plan. HEW will approve these State procedures and require certifications from States that they are complying with their State Plans.

HEW may hold compliance hearings and terminate all Federal funds when there is both a finding of noncompliance and State refusal to come into compliance or alternatively, reduce Federal payments by up to three (3) percent for each requirement for which a State is not in compliance.

XII. Federal Health Planning Activities

1. National Council for Health Planning and Policy

A National Health Planning and Policy Council will continue to serve as a forum for addressing issues of nationwide concern affecting health care in the U.S. The Council will be composed of representatives of major health interests, including consumers, State and local government providers, insurors, and educational institutions. The Council will address such concerns as (1) health costs; (2) manpower; (3) resources allocation/planning and regulation by States, and (4) the impact of new medical technology on the costs and quality of health care.

2. Federal Technical Assistance and Research for Health Planning

The Department will continue to develop technical assistance materials, including data, analyses, and comparative studies to assist States in their health planning and regulatory activities. The Department will also continue to conduct research on the impact of health planning and regulatory decisions.

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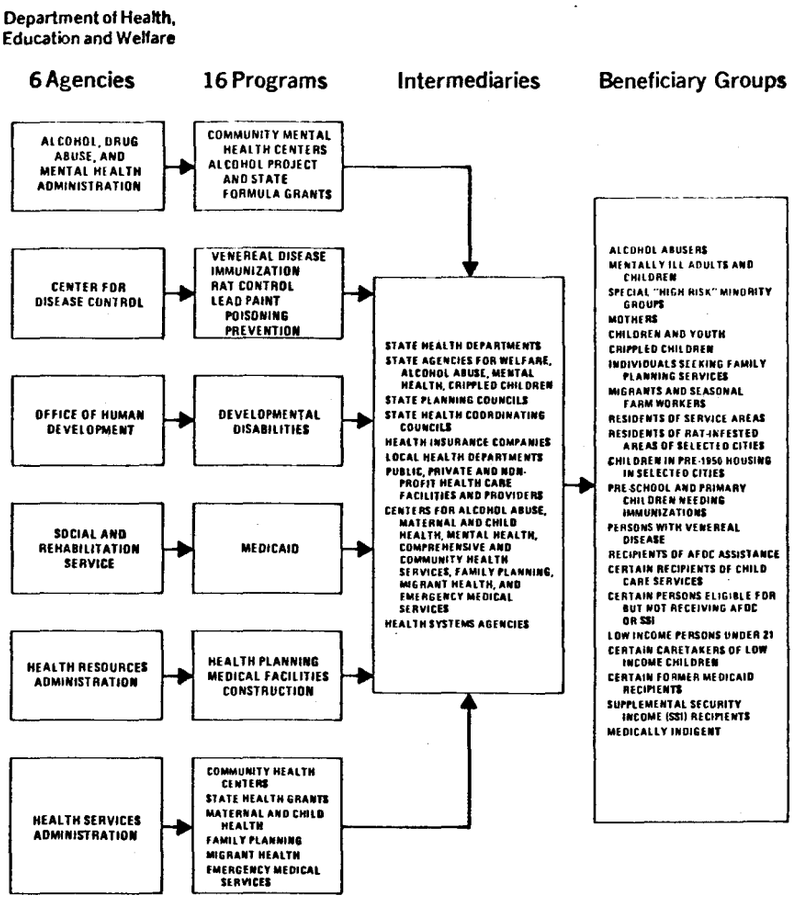
APPENDIX A

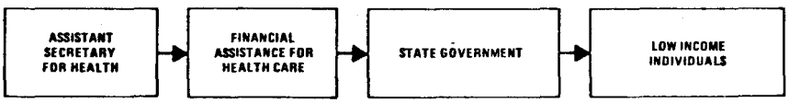
Flow of Federal Health Services Dollars

Before Consolidation



After Consolidation

($10 Billion in Budget Authority in 1977)



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APPENDIX B

DISTRIBUTION OF FUNDS BY STATE

FISCAL YEARS 1976 THROUGH 1986

($ MILLIONS)

STATE	FY1976	FY1977	FY1978	FY1979	FY1980	FY1981	FY1982	FY1983	FY1984	FY1985	FY1986
ALABAMA	156.0	171.5	188.7	207.6	249.1	298.9	358.7	375.3	389.7	404.1	418.6
ALASKA	11.5	11.8	12.0	12.3	11.6	11.5	11.5	11.5	11.5	11.6	11.6
ARIZONA	12.5	13.8	15.2	16.7	20.0	24.0	28.8	34.2	41.1	49.3	59.1
ARKANSAS	111.1	122.2	134.4	147.9	177.5	213.0	225.7	234.7	243.8	252.8	261.8
CALIFORNIA	1124.8	1155.2	1173.0	1198.8	1133.5	1127.5	1126.4	1124.8	1135.3	1177.3	1219.4
COLORADO	92.1	94.5	96.0	98.1	110.4	115.2	120.0	124.8	129.6	134.4	139.2
CONNECTICUT	110.5	113.5	115.2	117.8	111.3	110.8	110.7	110.5	110.6	111.1	111.0
DELAWARE	12.9	14.2	15.7	17.2	20.7	21.7	22.6	23.5	24.4	25.3	26.2
DISTRICT OF COLUMBIA	74.2	76.3	77.4	79.1	74.8	74.4	74.4	74.2	74.3	74.7	74.6
FLORIDA	164.5	181.0	199.1	219.0	262.8	315.4	378.5	449.4	485.4	503.4	521.4
GEORGIA	235.7	259.3	285.2	313.7	359.8	375.5	391.1	406.8	422.4	438.1	453.7
HAWAII	29.3	30.1	30.6	31.2	31.8	33.2	34.5	35.9	37.3	38.7	40.1
IDAHO	31.1	34.2	37.6	41.3	43.6	45.5	47.4	49.3	51.2	53.1	55.0
ILLINOIS	458.1	470.5	477.7	488.3	461.7	459.2	458.8	458.1	458.7	462.9	479.4
INDIANA	157.8	173.6	176.3	180.1	202.2	211.0	219.8	228.6	237.4	246.2	255.0
IOWA	86.8	95.5	105.0	115.5	138.6	154.2	160.6	167.0	173.4	179.9	186.3
KANSAS	70.9	78.0	85.8	94.4	113.2	118.1	123.0	127.9	132.9	137.8	142.7
KENTUCKY	152.4	167.7	184.4	202.9	243.5	292.2	320.2	333.0	345.8	358.6	371.4
LOUISIANA	160.5	176.6	194.2	213.6	256.4	307.6	369.2	438.3	504.1	522.8	541.5
MAINE	64.4	70.9	71.9	79.1	84.5	88.2	91.9	95.6	99.2	102.9	106.6
MARYLAND	169.7	174.3	177.0	180.9	171.0	170.1	170.0	169.7	174.9	181.3	187.8
MASSACHUSETTS	354.1	363.6	369.2	377.3	356.8	354.9	354.6	354.1	354.5	356.1	355.8
MICHIGAN	461.4	473.9	481.2	491.8	465.0	462.5	462.1	461.4	462.0	464.2	463.8
MINNESOTA	193.3	198.6	201.6	206.1	215.3	224.6	234.0	243.4	252.7	262.1	271.4
MISSISSIPPI	116.4	128.0	140.8	154.9	185.9	223.1	267.7	317.9	381.4	433.4	448.8
MISSOURI	104.7	115.2	126.7	139.3	167.2	200.7	240.8	285.9	316.1	327.8	339.5
MONTANA	25.8	28.4	31.2	34.3	41.2	49.4	51.4	53.5	55.6	57.6	59.7
NEBRASKA	40.6	44.7	49.1	54.0	64.8	77.8	88.3	91.8	95.3	98.9	102.4
NEVADA	15.7	17.3	19.0	21.0	22.1	23.0	24.0	24.9	25.9	26.8	27.8
NEW HAMPSHIRE	25.7	26.4	26.8	29.5	30.8	32.2	33.5	34.8	36.2	37.5	38.9
NEW JERSEY	244.4	251.0	254.9	260.5	246.3	245.0	244.7	244.4	244.7	245.8	250.4
NEW MEXICO	34.6	38.0	41.9	46.0	55.2	66.3	79.5	94.5	113.3	136.0	151.5
NEW YORK	1666.4	1711.4	1737.8	1776.0	1679.2	1670.4	1668.8	1666.4	1668.6	1676.2	1674.8
NORTH CAROLINA	174.2	191.6	210.8	231.8	278.2	333.8	400.6	449.2	466.5	483.8	501.1
NORTH DAKOTA	21.1	23.2	25.6	28.1	33.7	38.3	39.9	41.5	43.1	44.7	46.3
OHIO	302.3	310.4	341.5	349.0	377.5	393.9	410.3	426.7	443.1	459.5	476.0
OKLAHOMA	134.6	148.1	162.9	166.5	185.4	193.4	201.5	209.6	217.6	225.7	233.7
OREGON	78.3	86.1	94.7	96.8	105.4	110.0	114.6	119.1	123.7	128.3	132.9
PENNSYLVANIA	451.9	464.1	510.5	521.8	566.8	591.5	616.1	640.7	665.4	690.0	714.7
RHODE ISLAND	60.6	62.2	63.2	64.6	61.0	60.7	60.7	60.6	60.7	60.9	60.9

more

RUN 1 MAX GAIN 0.20

STATE	FY1976	FY1977	FY1978	FY1979	FY1980	FY1981	FY1982	FY1983	FY1984	FY1985	FY1986
				NET GRANT ($ MILLIONS)							
SOUTH CAROLINA	103.6	113.9	125.3	137.8	165.4	198.5	238.2	282.8	299.0	310.1	321.1
SOUTH DAKOTA	23.2	25.5	28.1	30.9	37.0	44.5	53.4	63.3	72.3	75.0	77.7
TENNESSEE	160.9	177.0	194.7	214.2	257.0	308.4	353.9	368.1	382.2	396.4	410.6
TEXAS	503.8	554.2	609.6	670.5	739.0	771.1	803.3	835.4	867.5	899.7	931.8
UTAH	38.6	42.5	46.7	51.4	61.7	72.8	75.8	78.9	81.9	84.9	88.0
VERMONT	32.0	32.9	36.1	36.9	40.0	41.7	43.4	45.2	46.9	48.7	50.4
VIRGINIA	140.0	154.0	169.4	186.3	223.6	265.0	276.1	287.1	298.2	309.2	320.2
WASHINGTON	137.5	141.2	143.4	146.6	138.6	138.4	144.1	149.9	155.7	161.4	167.2
WEST VIRGINIA	49.6	54.6	60.0	66.0	79.2	95.1	114.1	135.5	162.5	195.1	218.6
WISCONSIN	276.1	283.5	287.9	294.2	278.2	276.7	276.5	281.3	292.1	302.9	313.7
WYOMING	8.0	8.8	9.6	10.6	12.7	15.3	18.3	20.5	21.3	22.1	22.9
Other*		45.0	47.3	49.5	51.7	54.0	56.3	58.5	60.8	63.0	65.3
TOTALS	9466.32										
		10,000	10,500	11,000	11,500	12,200	12,900	13,500	14,050	14,550	15,000

* Puerto Rico, Virgin Islands, Guam, Am. Samoa, Trust Territories

more

APPENDIX C

Services Now Covered Under Medicaid and PHS Grants

Medicaid Services

Required

Hospital services (inpatient and outpatient)
Physician services
Labs and X-ray services
Skilled nursing facility services for persons over 21
Screening, diagnosis, and treatment of children (includes outreach and referral services)
Family planning
Medically-related Home Health Care services
Transportation to necessary medical care

Optional

Private nursing services
Clinic services
Dental services
Physical therapy
Drugs
Intermediate care facility services
Mental hospital services for persons over 65
Prosthetic devices, eyeglasses, and hearing aids
Inpatient psychiatric hospital services for persons under 21
Other diagnostic, screening, preventive, and rehabilitative services
Skilled nursing facility services for persons under 21
Services of other practitioners licensed under State law

PHS Grantee Services

Community Mental Health Centers
Alcoholism Services
Rat Control
Lead-based paint
Immunizations
Venereal disease
Comprehensive Health Centers
Family Planning
Maternal and Child Health
Emergency Medical Services
Migrant Health Services
Health Planning, Construction, and Resources Development

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FOR IMMEDIATE RELEASE FEBRUARY 25, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY

THE WHITE HOUSE

REMARKS OF THE PRESIDENT
UPON SIGNING
THE FINANCIAL ASSISTANCE FOR
HEALTH CARE ACT

THE CABINET ROOM

1:53 P.M. EST

Secretary Mathews, and your associates in the Department of Health, Education and Welfare:

As you well know, I am asking the Congress today to enact the Financial Assistance for Health Care Act, which will consolidate Medicaid in 15 categorical Federal health programs into the $10 billion block grant to our various States.

I am proposing that future Federal funding for this new program be increased in increments of $500 million annually. My proposal is designed to distribute Federal health care dollars more equitably and to increase State control over health spending.

My proposal also recognizes what I consider to be a more appropriate Federal role in providing financial assistance to State and local Governments to improve the quality and the distribution of health services.

Let me emphasize that no State will receive less Federal money in the future under my block grant proposal than it received in fiscal year 1976 under the programs being consolidated.

My consolidation proposal will allow the States far greater flexibility in providing for the delivery of health care services to those with low incomes. It eliminates the requirement for State matching funds.

My proposal is designed to reduce Federal red tape, increase local control over health spending and expand public participation in health planning. It is essential to continuing our national progress in the field of health.

MORE

I strongly urge the Congress to take affirmative action quickly and positively on this important proposal.

Mr. Secretary, I am signing the message to the Congress so that they can move quickly and, as I said, positively on this very important proposal.

Thank you very much.

END (AT 1:56 P.M. EST)

FOR IMMEDIATE RELEASE FEBRUARY 25, 1976

OFFICE OF THE WHITE HOUSE PRESS SECRETARY

THE WHITE HOUSE

PRESS CONFERENCE
OF
FORREST DAVID MATHEWS
SECRETARY
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
AND
WILLIAM A. MORRILL
ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION
OF THE
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

THE BRIEFING ROOM

2:06 P.M. EST

MR. CARLSON: As many of you just saw, the President has signed the Financial Assistance for Health Care Act, and here to summarize the legislation and take your questions is Secretary Mathews and other officials from the Department of Health, Education and Welfare.

Secretary Mathews.

SECRETARY MATHEWS: I think it might serve your purposes best if I answered your questions. The President made the essential statement and I would be pleased to respond to any questions that you have.

Sarah says we will have a statement shortly.

Q What are the 100 new positions? This is supposed to cut out red tapes and Federal bureaucracy.

SECRETARY MATHEWS: If this block grant is accepted by the Congress and if Congress accepts our recommendations on the public health service hospitals, we will be able to make some reductions in personnel. There are points in the total departmental budget, however, where we have special responsibilities.

For example, we are making a major increase in the Office of Civil Rights, the addition of 150 people. We are making a major addition in the Social Security Administration to deal with the problems of the SSI program. So even though the total department budget stays relatively level -- as a matter of fact, it comes down a bit -- there are points in the budget where we will have increases to contend with specific problems.

Q Mr. Secretary, my question goes to the second paragraph on page 2 of the President's statement, in which he says his proposal eliminates the requirements for State matching. Now I presume he is saying that for all 16 of the programs.

My question is: Is State matching required in all of those programs and, if it is not, which ones is it not required in?

SECRETARY MATHEWS: As you know, there is a general requirement for State matching across all of the three block grant proposals. As to the specific proposals, the programs here where we have matching -- Bill Morrill, where are you? Bill is just about to make a statement on that.

MR. MORRILL: I was just checking with the health people. I think on almost all of the programs there is matching. I was just double-checking as to whether immunization -- perhaps not immunization but essentially the rest.

Q And the matching now under Medicaid, as I understand it, is about 55-45 Federal-State on a national average.

MR. MORRILL: On a national average. It varies among the States.

Q What is the current Medicaid cost total?

SECRETARY MATHEWS: Point two is what we are spending in fiscal 1976 -- $8.262 billion, just to throw out a number.

Q That $10 billion figure, then, is really a decrease.

SECRETARY MATHEWS: Depending on where you start. It is an increase certainly over the President's recommendations for 1976 and I believe the $10 billion may be an increase over -- certainly the Medicaid program is an increase of a billion dollars.

As for the particular line item, since Congress has now enacted a new appropriation level, there are discrepancies and I think the total discrepancies, the difference is around $500 million.

Q A half a billion decrease, then, in programs other than Medicaid?

SECRETARY MATHEWS: From Congress' recent budget, yes.

Q From the appropriation by Congress?

SECRETARY MATHEWS: That is right.

Q So you are actually cutting the spending capability in these programs?

SECRETARY MATHEWS: The President has a difference with Congress over what the total Federal budget should be. His policy decision in this field was to make a major increase in Medicaid and to follow the same policy that he followed in the past in which he proposed level funding compared to what he had proposed for the past year.

So in terms of the President's policy, he has made no policy decision to de-emphasize any of these programs. He does have a difference with Congress on the appropriate level of Federal spending which is reflected in any and all of the programs.

Q But actual spending to his proposal, there is a decrease of half a billion dollars in programs other than Medicaid?

SECRETARY MATHEWS: Not in actual spending, Bill says.

MR. MORRILL: It is about$9.5 billion in 1976; that is actual funding. It is proposed at $10 billion in 1977. If the programs were left unconstrained, as they now stand, in 1977, they would run out to more than $10 billion -- about $10.3 billion.

Q So that is really $800 million rather than $500 million?

SECRETARY MATHEWS: If you assume the programs would run out without any restraints to the $10.3 billion.

MR. MORRILL: $10.3 billion versus $10 billion budgeted.

Q Okay.

SECRETARY MATHEWS: In regard to the State participation, often there is some concern that by removing the requirement for State matching that States would participate less and any assertion that they would not is usually regarded as a matter of conjecture.

MORE

I think it is, though, instructive to remember that before we had matching requirements, the States were supplying about $13 out of every $100 in these fields. After 10 years of requiring matching, the States are now furnishing about $13 out of every $100.

Are there any other questions?

THE PRESS: Thank you.

END (AT 2:13 P.M. EST)