The original documents are located in Box 22, folder "1975/01/04 S2994 National Health Planning and Resources Development Act (1)" of the White House Records Office: Legislation Case Files at the Gerald R. Ford Presidential Library.

APPROVED
JAN 4 - 1975

Posted 1/4/75
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THE WHITE HOUSE
WASHINGTON

ACTION

Last Day: January 4

January 2, 1975

MEMORANDUM FOR: THE PRESIDENT

FROM: KEN COLE

SUBJECT: Enrolled Bill S. 2994 National Health Planning and Resources Development Act

BACKGROUND

Since 1967 the Federal Government has been supporting state and local comprehensive health planning through a series of formula grants to state agencies and through project grants to local agencies, both Governmental and non-profit. This legislation would create new health planning machinery in every state and local health service area to replace existing activities. The bill also authorizes a continuation, with amendments, of the Hill-Burton medical facilities construction program.

CURRENT SITUATION

Earlier this year, the executive branch proposed legislation to improve health planning activities. While this bill incorporates elements of the Administration's approach toward local health planning, it goes beyond the Administration's proposals by specifying coordination, administrative and procedural requirements in extensive detail. In addition, it would require more direct Federal involvement in the development and administration of health planning agencies - particularly at the State level - then currently exists.

The bill authorizes spending of over $1 billion for fiscal years 1975, 1976 and 1977. Your revised 1975 and 1976 budget decisions and the OMB projection for 1977 contemplates spending of approximately $500 million over the same time period. Hill-Burton construction grants account for $390 million of the total.

Additional information is provided in Roy Ash's enrolled bill report (Tab A).

There is a great deal of interest in this bill. In the health establishment, the AMA has urged you to veto the bill. The National Blue Cross Association, the American Nursing Home Association, and the Health Insurance Association

of America, recommend that you approve the bill. Mel Laird and Elliot Richardson have called asking that they be recorded as recommending approval. Jim Hastings has asked that you be informed that he has spent 2 years working on this bill. He thinks it is a good bill and urges you to sign it.

The National Governors' Conference has not taken a formal position on the enrolled bill. The Conference staff reports that they "got 80% of what the Governors' wanted in the bill." Governor Cal Rampton, currently Chairman of the Governors Conference, urges approval. On the other hand, Governor Reagan has sent you a telegram urging disapproval of the bill. The National Association of Counties will support approval or a veto. They are concerned about how HEW would administer the program.

The original bills passed the Senate by a vote of 65 to 18 and the House of Representatives by a vote of 236 to 79. The Conference Report was adopted by voice vote in both houses.

OPTIONS

1. Sign the bill

   Pro: Would consolidate and improve Federal health planning authorities, phase out the poorly conceived regional medical programs and refocus the Hill-Burton programs on areas of recognized need.

   Con: Excessive statutory requirements at the state and local levels which, when coupled with Federal approval of such detailed matters as staff size and qualifications, internal operating procedures of the state, etc., have the appearance of a virtual federalization of the health planning apparatus at the state and local levels.

2. Pocket veto the bill

   Pro: The high authorization levels - $1 billion over 3 years compared to $500 million contemplated by OMB - would create strong pressures for greater spending. Would also require an additional 200-350 Federal employees to administer.

   Con: Even if fully funded, federal spending under these programs would amount to only .3 percent of the U.S. health care dollar - a small investment compared to the potential benefit of correcting serious defects in a major sector of the economy.

RECOMMENDATIONS

Areeda -	Sign the bill. OMB not persuasive - Federalism argument not strong. Funding authorization is too high, but President could cover this with a signing statement.
Weinberger -	Approve - it is example of effective legislative cooperation between the Administration and the Congress - product of bipartisan effort - bill will consolidate and improve health planning efforts and help reduce rapidly rising cost of medical care. The Secretary would like to talk to you if you are considering a veto.
Cole -	I recommend approval.
Friedersdorf - (Vern Loen)	Pocket veto
Ash -	Pocket veto - bill incorporates many Administration provisions but we have reservations about the extensive Federal role and costs.

DECISION: S. 2994

Sign (Tab C) MC9

Pocket Veto _____
(Sign memorandum of disapproval at Tab B)

THE WHITE HOUSE

WASHINGTON

ACTION

January 3, 1974

MEMORANDUM FOR: THE PRESIDENT

FROM: KEN COLE

SUBJECT: Secretary Weinberger's views on three pending enrolled bills

Secretary Weinberger called this morning to strongly urge that his personal views about the following three bills be brought to your attention. The Secretary's views will be transmitted to you in the enrolled bill memorandum.

1. H.R. 17045 - Social Services Amendments of 1974

   The Secretary strongly recommends that you sign this bill.

2. S. 2994 - National Health Planning and Resources Development Act of 1974

   Here again the Secretary strongly recommends your approval of this bill.

3. H.R. 14449 - Extension and Modification of the Economic Opportunity Act

   On this bill the Secretary feels strongly that you veto this bill and issue a memorandum of disapproval.

I call these three bills to your attention separately because of the Secretary's strong recommendations. You may want to telephone him prior to acting on these bills.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DEC 31 1974

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 2994 - National Health Planning and Resources Development Act of 1974
Sponsor - Sen. Kennedy (D) Mass.

Last Day for Action

January 4, 1975 - Saturday

Purpose

Authorizes the establishment of a new Federal program to assist State and local health planning; continues and amends the Hill-Burton medical facilities construction program.

Agency Recommendations

Office of Management and Budget	Disapproval (Memorandum of Disapproval attached)
Department of Health, Education, and Welfare	Approval
Department of the Treasury	Would concur in disapproval recommendation
Department of Housing and Urban Development	Defer to HEW (Informally)
Veterans Administration	Defer to HEW

Discussion

S. 2994 would require the creation of new health planning machinery in every State and local health service area to replace current health planning activities of existing State and areawide comprehensive health planning (CHP) agencies and planning activities undertaken in the past by some Regional Medical Program (RMP) entities. S. 2994 would also continue and amend the Hill-Burton medical facility construction program.

Current health planning at the Federal, State and local levels is largely fragmented, uncoordinated and ineffective. Earlier this year the Administration proposed legislation to improve planning activities primarily at the local level. While S. 2994 incorporates elements of the Administration's approach toward local health planning, it goes far beyond the Administration's proposals by specifying organization, administrative and procedural requirements in extensive detail. Moreover, it would require substantially more direct Federal involvement in the development and administration of health planning agencies--particularly at the State level--than currently exists or was proposed by the Administration.

The following sections of this memorandum--on health planning, health resources development, and budgetary impact--compare the major provisions of S. 2994 with the Administration's proposal.

Health Planning

S. 2994 contains three major provisions authorizing the establishment of new national health planning machinery. It would require the development of (1) national guidelines for health planning, (2) a nation-wide system of regional health systems agencies (HSAs), and (3) two types of State health planning bodies--the State health planning agency and the State Health Coordinating Council (SHCC).

National guidelines. S. 2994 would require the HEW Secretary to issue within 18 months "guidelines concerning national health planning policy, " including " standards for the appropriate supply, distribution and organization of health resources, " and a statement in "quantitative terms"--to the maximum extent practicable--of "national health planning goals."

The bill also would establish a National Council on Health Planning and Development in HEW. This 15-member advisory council would include representation from VA, DOD, HEW, Health Systems Agencies, State Health Coordinating Councils and the public.

The Administration bill did not propose national health policy planning guidelines. Moreover, it specifically proposed the termination of the existing Advisory Council on Comprehensive Health Planning on the grounds that such a council was unnecessary.

Health Systems Agencies. The provisions in S. 2994 for the designation of health service areas and the HSA membership requirements conform closely to those contained in the Administration's proposal. The Administration proposal did not, however, contain the entitlement-type formula grant provision, the Fund for development grants, or requirements for staff size and structure as detailed as those in the enrolled bill. Moreover, it would have restricted HSAs to private non-profit entities.

A major provision of S. 2994 would require establishment of health service areas throughout the United States and the creation of Health Systems Agencies (HSAs) for each area. The HEW Secretary would be required to designate HSAs within 18 months from the date of enactment, giving priority to applications from existing areawide comprehensive health planning agencies established under section 314(b) of the Public Health Service Act, or from RMPs. The boundaries of the health service areas for which HSAs would be designated, would, however, be designated by the Governor of each State and would be subject to revision by the HEW Secretary if the area failed to meet the criteria in S. 2994, including in most instances a population requirement of between 1/2 to 3 million. The Secretary would designate health services areas if a Governor failed to submit areas for the Secretary's approval. It is anticipated that approximately 200 HSAs would ultimately be designated throughout the country.

HSAs could be private non-profit corporations, regional planning bodies (under certain conditions) or single units of general local government. The bill would require consumers to constitute a majority, but not more than 60%, of the HSA governing body membership. The remainder of the governing body would have to include "providers" of health care, local government officials, representation from non-metropolitan residents, the Veterans Administration, and health maintenance organizations (HMOs). S. 2994 would specify in detail the types of staff expertise HSAs must have and would set minimum staff sizes for HSAs (based on population). The bill would require an absolute minimum HSA staff of 5, with a minimum of 25 for areas with larger populations.

HSAs would be required to establish and update annually a health system plan and an annual implementation plan. These plans would consist of a detailed statement of HSA goals for developing and improving health services and the

specific actions proposed to achieve those goals. HSAs would implement their plans by providing technical assistance to individuals and public and private entities through project grants and contracts funded through the Area Health Services Development Funds, also required by S. 2994.

HSAs would have the authority to review and approve or disapprove the proposed use of virtually all HEW funds provided for services or construction in the HSA area. The Secretary could, however, make grants for such disapproved projects, after notifying the HSA of his reasons for doing so.

S. 2994 would require HEW to award minimum annual "planning grants" to each HSA for its operating costs in an amount equivalent to 50¢ multiplied by the population of the area or $3.8 million whichever is less; the minimum grant to any HSA, however, would be $175,000. HSAs receiving certain non-Federal funds would be eligible for additional Federal bonus monies.

In addition to operating support, S. 2994 would require HEW to make annual development grants to each HSA of not more than $1 multiplied by the population of the health service area to enable the agency to establish and maintain an Area Health Service Development Fund. Development grants would be used for the "planning and development of projects and programs...necessary for the advancement of the health system" described in the health system plan but could not be used for the construction or financing of health services. The Fund would be, for all practical purposes, a bank account into which the annual HEW development grant would be deposited.

State planning. The Administration bill would have left health planning at the State level generally up to the States. In contrast, S. 2994 would require State health planning and development agencies to be established, would authorize operating grants to be made to the State agencies, and would specify in extensive detail the functions and procedures to be followed by the agencies--all of which HEW would be required to approve.

Under S. 2994, states would be required to establish State agencies within 4 years or face a cut-off of all HEW health service and resource development funds. In addition, the Governors would be required to appoint State Health Coordinating Councils (SHCCs) to prepare the final State health plans based upon the HSAs proposals, and to coordinate the health

systems plans and annual implementation plans of the HSAs. Federal operating grants to State agencies would be limited to 75 percent of costs; these funds could not be used to reduce the amount States spent on health planning activities.

The enrolled bill would mandate State agencies to prepare "State Administrative Programs" which Governors would be required to publish for public comment and to submit to HEW annually for approval. S. 2994 enumerates extensive requirements for the State planning agency which the HEW Secretary would have to stipulate and approve in areas such as staff size and qualifications, operating procedures, health information statistical gathering, evaluation methods and procedures, fiscal controls, and appeal procedures in those situations where the State and an HSA may disagree. In addition, State planning agencies would be required to review at least every 5 years and to make public their findings with respect to the appropriateness of all institutional health services being offered in the State. S. 2994 would also authorize grants to up to six State agencies for the demonstration of health care rate regulation functions.

While the provisions in S. 2994 relating to State Health Coordinating Councils and rate regulation grants are similar to those contained in the Administration proposal, the Administration opposed Federal designation of State planning agencies, the extensive, detailed requirements for functions to be performed by State planning agencies and State Health Coordinating Councils, and the regulatory and approval relationship between those State bodies and HEW.

Other provisions. In addition to the activities described above, S. 2994 contains the following planning requirements, none of which were in the Administration proposal:

-- creation of a national health planning information center

-- development, within one year, of a Federal classification system for health services institutions and uniform systems for calculating (a) individual institutional costs and volume of service, (b) aggregate health care operating costs and volume of service and (c) rates to be charged to health insurers by health service institutions

-- funding for at least five centers for multidisciplinary health planning development and assistance, to be in

operation by June 1976 "to the extent practicable"

-- review by HEW of the budget of each HSA and State agency annually and an evaluation of their performance and operations at least every three years

-- preparation of a report within one year to the Congress containing recommendations with respect to the termination of (a) advisory committees established by the PHS, mental health and alcoholism Acts, and (b) agency reports required under such Acts. S. 2994 would prohibit the termination of these advisory committees except by an Act of Congress.

Health Resources Development (Hill-Burton)

The other major section of S. 2994 would revise the authorities for making grants and loans under the Hill-Burton hospital construction program.

The Administration bill proposed limited project grant Federal assistance for modernization or replacement of public or other nonprofit hospitals and the construction of outpatient facilities. Priority would have been given to hospitals (not less than 100 beds) in medically underserved areas whose facilities are decrepit and whose acute-care bed occupancy rate has been 80 percent for at least two years.

The Administration proposed terminating HEW approval of State facility plans and allocation of funds by State formula. The Administration proposal also would have terminated direct Federal loans and loan guarantees, relying exclusively on project grants.

S. 2994 would amend the Hill-Burton program to provide Federal grants and loans to public and non-profit private agencies, and loan guarantees and interest subsidies to non-profit private agencies, for the following:

-- modernization of existing medical facilities

-- construction of new outpatient facilities

-- construction of new inpatient facilities in areas which have experienced recent rapid population growth, and

-- conversion of existing medical facilities to provide new health services.

The bill would also authorize HEW to provide direct assistance through project grants for up to 75 percent of the costs (100 percent in poverty areas) for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance with State or voluntary licensure or accreditation standards.

S. 2994 would continue the requirement that States prepare and maintain State medical facilities plans for approval by the Secretary of HEW. Responsibility for determining medical facility construction priorities would be vested in the new State agencies that S. 2994 would require. The Secretary of HEW would issue regulations under which each State agency would be required to give "special consideration" in determining priorities to rural communities, rural or urban poverty areas, areas with small financial resources, and densely populated areas. Like the old Hill-Burton program, individual applications for Federal medical facility development would generally originate at the HSA level and be forwarded to the State agency and SHCC for approval. HEW would approve every individual proposal after review at the HSA, State agency and SHCC levels.

S. 2994 would authorize HEW to make an annual allotment to each State of not less than $1 million based on population, financial need and the need for medical facilities projects. HEW also would be authorized to make direct loans for medical facility construction and modernization from a loan revolving fund to be established in the Treasury. In addition, HEW would be authorized to guarantee loans made to private nonprofit entities by private lenders or the Federal Financing Bank, and to pay a 3 percent interest subsidy on such loans.

S. 2994 would remove the current statutory limit of $1.5 billion on the amount of outstanding loan principal which may be guaranteed or made directly by HEW. In addition, unlike current law, S. 2994 contains no provision which would make taxable the interest on any loans made to public bodies and sold and guaranteed by HEW.

Administration proposals not incorporated in S. 2994, in addition to those already mentioned, included a lower Federal share (12.5 percent v. the 66 to 100 percent generally in S. 2994), mandatory State matching funds, a finding that applicants are unable to obtain other assistance, and a requirement that applicants establish a sinking fund to cover future modernization needs.

Budgetary Impact

S. 2994 would authorize spending of over $1 billion for fiscal years 1975 through 1977, as detailed in the attached table. In contrast, the revised 1975 and 1976 Budget decisions, and the current projection for 1977 contemplate spending of approximately $500 million over the same 3-year period. The higher authorizations contained in S. 2994 would likely generate strong pressures for high funding levels.

Arguments in favor of approval

1. HEW contends that the enrolled bill marks "a major Administration triumph" because it would:

-- phase out RMP, "a significant achievement in an era when Congress has resisted vigorously attempts to eliminate health programs,"

-- "combine scattered, sometimes inconsistent and uncoordinated planning authorities into a single, carefully structured program,"

-- "take a giant step toward converting Hill-Burton from a rigid formula grant program to a flexible project grant program," and

-- "encourage State regulation of the rates at which health services are provided," e.g., physician fees and hospital charges.

2. Even if fully funded, the total Federal spending for these programs authorized in S. 2994 would amount to only about .3 percent of total national health spending--a relatively small investment compared to the potential benefits of correcting serious defects in a major sector of the economy.

3. A viable network of improved planning entities could make a potentially important contribution to the successful implementation of national health insurance. HEW suggests that the development of such a planning network is an "essential base for any national health insurance financing system."

4. The formula-type mechanisms for allocating funds would reduce controversy by providing a uniform and relatively objective means of funding hundreds of potential

grantees. It also would reduce the size of the HEW administrative apparatus potentially needed to run a project grant program properly.

5. S. 2994 would achieve a measure of reform in the medical facilities (Hill-Burton) construction program by significantly reducing the authorization levels, limiting the different kinds of construction for which Federal assistance would be available, and requiring that special consideration be given to rural and urban poverty areas and densely populated areas.

6. Disapproval could result in a protracted period of wasteful funding of the nearly defunct RMP and Hill-Burton programs, at levels considerably higher than the proposed 1975 authorizations in S. 2994.

7. Many of the provisions contained in S. 2994 are desirable and would probably be detailed in HEW implementing regulations in any event. Moreover, the CHP and RMP programs suffered from too little statutory specificity, making their objectives vague and transitory.

8. There is no reason to expect that the 94th Congress would produce legislation in this area any closer to the Administration bill than S. 2994. On the other hand, it is difficult to envision a more detailed bill than S. 2994.

Arguments against approval

1. S. 2994 would stipulate excessively detailed Federal requirements for the organization, operation and administration of local and State health planning agencies. The extensive involvement of the Federal Government required by S. 2994 would mean that State and local health planning agencies would effectively lose much flexibility and initiative to develop various solutions tailored to their particular situations.

2. The patterns of Federal/State relationships in S. 2994 constitute an undesirable precedent for other areas where the Federal government supports planning programs, e.g., community development, manpower, social services. For example, three of the most undesirable requirements are that HEW (1) annually approve the budgets of some 250 State and local planning and development agencies, (2) conduct evaluations

of State and local planning agency performance every three years, and (3) establish minimum staff sizes for State and local planning agencies.

3. The high authorization levels contained in S. 2994--$1 billion over 3 years compared to approximately $500 million contemplated by the Administration--would create strong pressures for greater spending. Moreover, HEW has informally indicated that the current HEW staff for health planning and resources development activities of 300 would have to be increased by 200. We believe this is an understatement--given the Federal responsibilities under S. 2994--and that as many as 300 to 450 more persons ultimately could be required.

4. The formula-type appropriations authorizations would encourage long-term Federal financial support, making it increasingly difficult to terminate this type of Federal grant assistance. It would also reduce HEW's ability to target limited resources on higher priority areas.

5. S. 2994 would undesirably give priority to existing CHPs (314(b)) and RMPs in being designated as HSAs. Many of the existing agencies have been poor performers. A principal objective of the Administration's proposal was to make these agencies compete for the designation as the new planning body in order to achieve the most efficient and effective performance.

6. S. 2994 fails to adopt the Administration's recommendations for limiting Federal construction assistance strictly to modernization of existing hospitals serving shortage areas and construction of outpatient facilities and for imposing cost-sharing and managerial reforms on participating institutions. It also undesirably retains the formula grant mechanism of the Hill-Burton program for allocating as much as 78 percent of the construction grant funds.

7. Although S. 2994 formally phases out RMP, the authority for HSAs to make "development" awards represents a defacto continuation of many of the activities supported by RMPs in the past. The potential growth in budgetary requirements for such funds is indicated by the authorization levels in S. 2994--$25 million, $75 million, and $120 million for 1975, 1976, and 1977--and by the fact that the $1/population formula could be cited to justify annual spending of over $215 million.

Recommendations

In his letter recommending approval of S. 2994, the HEW Secretary concludes:

> "While the enrolled bill does not include all the provisions we advocated, I believe it can stand as an example of effective legislative cooperation between the Administration and the Congress. Moreover, the bill is the product of an intensive bipartisan effort on the part of the pertinent congressional committees, and is heavily supported by the Congress as a whole. Of particular significance to me is that this bill will consolidate and improve our health planning authorities, phase out the poorly conceived regional medical programs and refocus the Hill-Burton program on areas of recognized need. Further, by requiring all States to enact a certificate-of-need law it can substantially aid in our efforts to reduce the very sizeable excess of hospital beds and other expensive facilities that now contribute to the rapidly rising costs of medical care."

Treasury states that it "would concur in a recommendation that the enrolled enactment not be approved." In its letter, Treasury notes that S. 2994 contains no provision "which would make taxable the interest on any loans made to public bodies and sold and guaranteed by the Secretary of HEW." Treasury also notes that HEW previously opposed certain objectionable features of S. 2994, including the loan and interest subsidy provisions, the excessive authorizations, the formula grant mechanisms and the nature and size of the development fund proposals.

* * * * * * * *

We believe S. 2994 should be disapproved. The bill contains many far-reaching provisions opposed by the Administration. These include excessive statutory requirements at the State and local levels which--when coupled with Federal approval of such detailed matters as staff size and qualification, internal operating procedures of the State, etc.,--result, in effect, in a virtual Federalization of the health planning apparatus at the State and local levels. In addition, the excessive appropriation authorizations could lead to strong pressures for spending at higher levels than are necessary.

Although S. 2994 incorporates provisions sought by the Administration, our reservations over the extensive Federal role and costs lead us to recommend against restructuring the nation's health planning machinery along the lines of S. 2994. Accordingly, we recommend disapproval of S. 2994. A proposed memorandum of disapproval is attached for your consideration.

Director

Enclosures

Attachment

S. 2994, "National Health Planning and Resources Development Act of 1974
Comparison of Authorization and Funding Levels

($ in Millions)

	1974 Actual	1975 S. 2994 Authorization	1975 Budget Request	1976 S. 2994 Authorization	1976 Presidential Decisions	1977 S. 2994 Authorizatior
Expired Programs (RMP, CHP, and Hill-Burton)	307	--	--	--	--	--
Planning:						
° Planning grants to Health Systems Agencies	--	60	50	90	75	125
° State Planning Agency grants	--	25	--	30	--	35
° Rate regulation demonstration grants	--	4	--	5	--	6
° Centers for Health Planning	--	5	--	8	--	10
° Development grants to HSAs	--	25	--	75	--	120
Construction:						
° Construction grants	--	125	100	130	100	135
° Loan Fund	--	"such sums"	--	"such sums"	--	"such sums"
Totals	307	244	150	338	175	421

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

DEC 3 1 1974

Honorable Roy L. Ash
Director, Office of Management
and Budget
Washington, D. C. 20503

Dear Mr. Ash:

This is in response to Mr. Rommel's request for a report on S. 2994, an enrolled bill "To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes." The bill, when approved, will be cited as the "National Health Planning and Resources Development Act of 1974".

Broadly speaking, the bill would accomplish two objectives. First, in place of Federal assistance now provided under the Public Health Service Act for the State or areawide planning components of five programs--comprehensive health planning under sections 314(a) and 314(b), the Hill-Burton program under title VI, the regional medical programs under title IX, the program supporting area health education activities funded through the regional medical programs, and the program assisting experimental health services delivery systems under section 304--the bill would assist in the establishment of a single network of health planning organizations, known as "health systems agencies", to plan for the provision of adequate health services throughout the United States.

Second, the bill would refocus the Hill-Burton program to emphasize assistance for modernizing the existing health facilities without increasing bed capacity, and assisting health facilities to come into compliance, or avoid noncompliance, with Federal, State, or local safety codes and State or voluntary licensure or accreditation standards.

The bill would phase out regional medical programs under title IX.

Overview

The new health planning structure will primarily employ three types of agencies: the previously mentioned health systems agency (HSA), which will formulate health goals and the means for their implementation within the geographic areas to which they are designated; the State health planning and development agency (the State Agency), a public agency which will function as the arm of the State for the administration of the Hill-Burton program, and for implementing a State health plan and the plans of the HSA's relating to the State; and a Statewide Health Coordinating Council for each State (SHCC), which will be responsible for welding the individual plans of the State's HSA's into a coordinated State health plan and for advising the State Agency.

These agencies will operate within a framework of the Secretary's national guidelines for health planning, which will reflect national health goals and priorities. Apart from financial assistance, discussed below, the Secretary will provide HSA's and State Agencies with technical assistance and establish a national health planning information center to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology. The bill would also encourage the Secretary to support the development and operation of at least five centers for multidisciplinary health planning development and assistance, in order to make available to the Secretary, to HSA's, and to State Agencies technical and consulting assistance.

The bill establishes formulas under which HSA's will receive annual planning grants and State Agencies will receive up to 75 percent of their costs of operation. A formula is also established under which the Secretary will contribute to an Area Health Services Development Fund maintained by each HSA. The funds are intended to support grants (not to exceed $100,000 each except in extraordinary circumstances) by HSA's for planning and development necessary for the achievement of planned health systems.

Within 18 months of the bill's enactment, the Secretary would be required to issue the previously mentioned guidelines on

national health planning policy, which would give special consideration to ten goals, of which the most significant is the provision of primary care services for medically underserved populations, especially those located in rural or economically depressed areas. In the development of these guidelines, the implementation and administration of the bill, and in the evaluation of the implications of new medical technology for the organization, delivery, and equitable distribution of health care services, the Secretary would be assisted by a newly-established National Council on Health Planning and Development. (The current National Advisory Council on Comprehensive Health Planning Programs would be abolished, and the Federal Hospital Council would be allowed to terminate under the provisions of the Federal Advisory Committee Act.)

The bill would establish a procedure under which the Governor of each State would take the initiative, subject to the Secretary's final approval, in establishing geographical areas, to be known as "health service areas", within which there will be available a comprehensive range of health services, and which will encompass a region appropriate for the effective planning and development of health services. The procedure looks to the setting of most area boundaries within 210 days after the bill's enactment, and completion of the process within one year of that enactment. Generally speaking, population of the areas would range in size between one-half to three million. Existing regional planning areas, developed under section 314(b), would be designated as health service areas if they otherwise meet the requirements for designation.

Health Service Agency

To each of these health service areas there would be designated an HSA, which would be a nonprofit private corporation, a public regional planning body, or a single unit of general local government. In any case, the HSA would be required to comply with very detailed organizational requirements. Most significantly, it or its governing body must consist of a majority (but not more than 60 percent) of health care consumers, with the balance of the membership consisting of representatives of health professionals, allied health

professions, health care institutions, health care insurers, and health professional schools. Public officials would be included, either as consumer or provider members. Membership would be balanced to assure representation of individuals living in nonmetropolitan areas, of Veterans Administration facilities, and of HMO's, located within the HSA's health service area.

Each HSA would establish for its area, and keep current, a health systems plan (the HSP), which would be a statement of its goals for assuring the availability of quality health services for all residents of its area at reasonable cost, and an annual implementation plan (the AIP), which would describe, and establish the priorities among, objectives that will achieve the HSP goals. Among the functions performed by the HSA to implement its HSP and AIP would be that of making grants or providing contract assistance from the previously mentioned Area Health Services Development Fund. These development funds could not be used for services and would be for no more than one year, with no more than two years of such assistance to any recipient. The committee of conference also expresses its expectation that such grant or contract will rarely exceed $100,000. (H. Rep. No. 93-1640, p. 71.) In this regard, each fund would be supported by an annual grant to the HSA of an amount not in excess of $1.00 multiplied by the population of the area it serves. Appropriations for the fund would be authorized at $25 million, $75 million, and $120 million for fiscal years 1975, 1976, and 1977, respectively.

Also in aid of its HSP and AIP, an HSA would, within certain limitations, review and advise on (but is not empowered to veto) the use of funds within its area appropriated under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, or funds made available in its area by the State in which the area is located, if from assistance under those Acts, for the development, expansion, or support of health resources.

Other provisions ensure HSA review of institutional health services offered within the area, and coordination of HSA activities with Professional Standards Review Organizations designated under the Social Security Act and with other regional planning or administrative agencies.

In the case of HSA's that are conditionally designated, i.e., that are not yet able to assume all of the specified HSA functions, the Secretary shall make planning grants in amounts he deems appropriate. No HSA may enjoy conditional designation for more than two years. To an HSA finally designated as such, the Secretary shall make an annual grant, subject to a $3.75 million ceiling, equal to $0.50 multiplied by the population of the area served by the HSA, and an additional amount equal to the lesser of the non-Federal funds employed by the agency during the grant period or $0.25 multiplied by the area's population. No grant to an HSA under the formula would be less than $175,000. A pro rata reduction provision would prevent an HSA from claiming an entitlement to these amounts in the absence of a supporting appropriation. (Note that this provision marshals the appropriation to preserve the $175,000 floor per HSA to the extent of the appropriation.)

Appropriations for the planning grants would be authorized at $60 million, $90 million, and $125 million for fiscal years 1975, 1976, and 1977, respectively.

State Health Planning and Development Agency

The Secretary would also enter into an agreement with the Governor for the designation of a State health planning and development agency, mentioned previously, to carry out the State health planning and development functions. If, after four fiscal years after the expiration of the calendar year of the bill's enactment, this agreement has not yet been entered into by a State, no assistance under the Public Health Service Act, the CMHC Act, or the Alcohol Act for development, expansion, or support of health resources within the State would be available until the agreement were entered into.

Except in certain situations in which designation of a different agency is permitted, the State agency would be required to administer a State certificate-of-need program, conduct the review of capital expenditures required by section 1122 of the Social Security Act (in the case of a State that has entered into an agreement with the Secretary under that section), prepare a preliminary State health plan (made up principally of the HSA HSP's) for submission to the SHCC, review (with HSA recommendations) the need for new health services within the State, and assist in the review of a medical facilities plan contemplated by the bill's restructured Hill-Burton program. The State Agency must in all cases serve, also, as the agency for Hill-Burton administration.

The Secretary shall make grants to a State Agency in an amount not to exceed 75 percent of its costs of operations during the period for which the grant is available for obligation. For this purpose, the bill authorizes the appropriation of $25 million, $30 million, and $35 million, for the fiscal years 1975, 1976, and 1977, respectively.

State Health Coordinating Council

The State Agency would be advised by the SHCC. This consists of representatives of the State's HSA's appointed by the Governor, and other members also appointed by the Governor. A majority of SHCC members would be representative of consumers of health care.

The SHCC reviews and coordinates the HSP's and AIP's of the State's HSA's. (!?) After receipt from the State Agency of the previously mentioned preliminary State plan, it prepares the final State plan. It is limited, however, essentially to melding the HSP's and AIP's into an integrated plan of Statewide application, and may not undertake fundamental changes. The SHCC revisions are ultimately fed back to the HSA's for incorporation into their individual HSP's and AIP's. The SHCC also reviews HSA budgets and reports to the Secretary on them; reviews HSA applications for planning grants, and reviews HSA applications for contributions to its AHSD Fund. It also advises the Secretary

on PHS Act, CMHC Act, and Alcohol Act State formula grants, with an apparent new power in the Secretary to deny a formula grant if the SHCC disapproves of it.

Multidisciplinary centers

To fund the previously mentioned multidisciplinary centers, which will assist the Secretary in the provision of technical assistance to HSA's and State Agencies, the bill authorizes the appropriation of $5 million, $8 million, and $10 million for fiscal years 1975, 1976, and 1977, respectively. There would also be authorized for those years $4 million, $5 million, and $6 million, respectively, for a demonstration program, involving no more than six State Agencies, of grants to assist those agencies in the regulation of the rates for the provision of health care within their States, where such regulation is authorized under State law.

Assistance for health resources

Having completed this rather general description of the bill's health planning aspects, we turn briefly toward its health resources portion. In substance, this portion is an updated, significantly pruned Hill-Burton program, which provides grants and subsidized loans to public and nonprofit private agencies, and loan guarantees and interest subsidies for loans to nonprofit private agencies, for (1) modernization of medical facilities, (2) construction of new outpatient facilities; (3) construction of new inpatient facilities in areas of population explosion, (4) conversion of existing medical facilities for new health services; and grants for construction and modernization to eliminate or prevent imminent safety hazards or to avoid noncompliance with State or voluntary licensure or accreditation standards (referred to below as "section 1625 aid").

Allotments of grant assistance would be made among the States on the basis of population, financial need, and the need for medical facilities projects. Assistance under the allotments would be provided under a medical facilities plan administered by the State Agency which, among other things, would require that the assistance (other than section 1625 aid) be approved by a State SHCC as consistent with the previously described State plan developed by it under the planning portion of the bill.

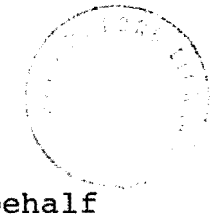
An allotment would be available to pay the Federal share of a project. This share, in the case of certain small modernization projects, could not exceed 100 percent of the first $6000 of cost and 66-2/3 percent of the next $21,000 of cost to a total ceiling of $20,000 of Federal assistance. In the case of other projects assisted under the allotment (except projects involving section 1625 aid, discussed below), the Federal share could not exceed 66-2/3 percent of cost, except for projects in urban or rural poverty areas, where 100 percent of the cost may be paid.

No more than 20 percent of a State's allotment in any fiscal year may be used for construction of new inpatient facilities, and at least 25 percent of it must be used for outpatient facilities (of which portion at least one-half must go to rural facilities). For grants under the allotment the bill authorizes $125 million for fiscal year 1975 and $130 million for each of the next two fiscal years.

The bill also authorizes the Secretary to make direct loans, from a revolving loan fund that the bill establishes, to pay the Federal share of the previously described projects. The Secretary may also guarantee to non-Federal lenders for their loans to nonprofit private entities for these projects, and to the Federal Financing Bank for its loans to nonprofit private entities for such projects, the payment of principal and interest on those loans. Loans and loan guarantees would be allotted among the States on the basis of population, financial need, and need for the facilities. The Secretary would pay to the holder of a loan to a nonprofit private entity guaranteed by him an interest subsidy sufficient to reduce the interest rate otherwise payable by 3 percent. Similarly, direct loans would bear an interest rate comparable to those of guaranteed loans, minus 3 percent. To revolve the loan fund, the Secretary would be authorized to sell guaranteed paper (including guarantees of his own loans) and deposit the proceeds in the fund. The availability of the fund and the maximum outstanding principal of loans and loan guarantees would be governed by appropriation Acts. The Federal share for which loans and loan guarantees under

this portion of the bill would be available may not exceed 90 percent of facility cost (when added to any other Hill-Burton assistance), except with respect to facilities in rural or urban poverty areas, where the share may rise to 100 percent.

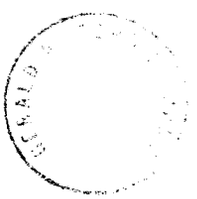
In the case of section 1625 aid, grants may not exceed 75 percent of cost, again with the exception for rural and urban poverty areas. Note that 22 percent of the appropriation for the previously described grant allotment is reserved for this section 1625 aid.



Comments

On March 11, 1974, we submitted to the Congress on behalf of the Administration a draft bill entitled "the Health Resources Planning Act". The health planning portions of the enrolled bill establish a mechanism that, except as explained below, is similar to that which we proposed. Like the enrolled bill, the Administration bill, introduced as S. 3166 in the Senate, would have established a procedure under which State governors would take the initiative in establishing health service areas within which there would be available a comprehensive range of health services, and which--with populations, like the enrolled bill, between 1/2 and 3 million--would be rational areas for the effective planning and development of health services. The Secretary would certify to those areas private nonprofit organizations (the enrolled bill adds certain public entities as well) as HSA's. Like the enrolled bill's HSA's, the HSA's of S. 3166 would direct their efforts at aiding the major sectors of the health care market within their areas--consumers, health care providers, health care insurers, health educational institutions, and government--to develop for the area adequate, equitably distributed health services of high quality at reasonable cost. The HSA, like that of the enrolled bill, would supply this aid by preparing and keeping current a comprehensive health plan for services, facilities, and manpower; by reviewing and advising the Secretary with respect to applications to the Secretary for financial assistance for the construction of health facilities, the development of health services, or the training of health manpower; by advising State and local governments in regard to actions those governments may propose relating to health

services, facilities, or manpower; and by providing technical assistance, including grants and contracts not in excess of $25,000 each (compared to the enrolled bill's $100,000 each) for projects and activities that would contribute to implementing the comprehensive health plan. Like the enrolled bill, the Administration proposal would support these activities through grants (although, unlike the enrolled bill, the grants would not have been based upon a formula), technical assistance, and amounts (again, not by formula) to fund the HSA's own assistance grants and contracts. A system of SHCC's would also have been established under S. 3166 to perform functions similar to those performed by SHCC's under the enrolled bill.



The Administration proposal would also have established a program of State formula grants, based upon a State's population and the cost of the services for which the grant is supplied, to aid each State in paying its costs of regulating capital expenditures for health care and the payment or reimbursement for health care services. This compares with the enrolled bill's demonstration program to assist a limited number of States to implement a program of rate regulation, and its requirement for State certificate-of-need legislation.

Like the enrolled bill, the Administration proposal would have replaced the State or areawide planning components of programs now scattered throughout the Public Health Service Act and which will be replaced by the enrolled bill.

The major point of difference between the two planning proposals is the enrolled bill's reliance upon a State Agency to prepare a preliminary State plan for the State and exercise the State's planning responsibilities in other respects. Although the Administration bill would not have interfered with the State's establishment of such an agency, it would not have had the SHCC rely upon it for assistance in preparation of the State plan. Although under the enrolled bill membership of HSA's and SHCC's is more clearly consumer oriented than under the Administration bill and, in the case of the SHCC's, in large part determined by the State's chief executive officer, these differences do not touch

significantly on HSA and SHCC functions, or their capacity to perform those functions, and therefore seem largely to be differences of detail.

On August 12, 1974, the Department submitted a proposal, consistent with the Administration's objectives, to provide for assistance for the modernization and replacement of hospitals. The proposal, a replacement for the Hill-Burton program, envisioned direct project grants targeted on the modernization or replacement of aged public and other nonprofit hospitals, including their outpatient departments. The Federal contribution would have been subject to a ceiling of 12-1/2 percent of cost and would have required matching non-Federal public funds for the project. Applicants would have had to establish a sinking fund, as a condition of receiving a grant, to provide for future modernization or replacement. The enrolled bill's Hill-Burton substitute, more nearly than the Department's proposal, resembles the current Hill-Burton program.

Notwithstanding several reservations to it discussed below, the enrolled bill marks a major Administration triumph. First, the bill would phase out the RMP program, for which $684 million was authorized during the four preceding fiscal years and for which $409 million was appropriated. This is a significant achievement in an era when Congress has resisted vigorously attempts to eliminate health programs.

Second, as the Administration proposed, the enrolled bill would combine scattered, sometimes inconsistent and uncoordinated, planning authorities into a single, carefully structured program, thereby greatly contributing to rationalizing the process of planning the provision of health services and resources throughout the United States. A system to provide this planning is an essential base for any national health insurance financing system.

Third, the enrolled bill would take a giant step toward converting Hill-Burton from a rigid formula grant program to a flexible project grant program. Moreover, it would refocus the program so as to emphasize the modernization of

facilities and the provision of facilities for ambulatory care. These objectives are essentially the ones sought by the Department's own Hill-Burton proposal.

Fourth, although in a less ambitious fashion than the Administration proposal, the enrolled bill would encourage State regulation of the rates at which health services are provided. It would also, for all practical purposes, mandate the States to administer certificate-of-need programs and would also facilitate their execution of section 1122 agreements.

We are concerned, of course, with the bill's authorization ceilings which, if viewed as appropriations targets, would be excessive. In our view the amounts provided in the Department's budget for health planning and health systems development, a total of $325 million for fiscal years 1975 and 1976 (exclusive of certain mandated interest payments on existing obligations), is sufficient, if appropriately reallocated among the enrolled bill's programs, to fund an effective health planning and resources development effort over those years.

Other aspects of the bill, although troublesome, are of less concern. We do not consider the formula allocations to HSA's a desirable means of financing their planning activities or their planning and development grants. Nevertheless, the size of these grants is controllable through the appropriations process. */

We would oppose the use of loans, loan guarantees, and interest subsidies as a means of providing Hill-Burton assistance. Here, again, through the budget process we would seek to focus the program on grant assistance for the purposes intended to be supported under the Department's proposal. In this regard, the enrolled bill's reservation of 22 percent of the Hill-Burton grant allotment for projects to eliminate or prevent imminent safety hazards or avoid

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*/ It should be noted that the total of the appropriations authorized by the bill for the current fiscal year for the planning and resources development programs are below both the total appropriations authorized and the total amounts appropriated for CHP and Hill-Burton programs for this year or for the preceding fiscal year.

noncompliance with State or voluntary licensure or accreditation standards will greatly aid in this focusing. We are also pleased to note that the Hill-Burton authorization levels are well below those provided in previous years.

While the enrolled bill does not include all the provisions we advocated, I believe it can stand as an example of effective legislative cooperation between the Administration and the Congress. Moreover, the bill is the product of an intensive bipartisan effort on the part of the pertinent congressional committees, and is heavily supported by the Congress as a whole. Of particular significance to me is that this bill will consolidate and improve our health planning authorities, phase out the poorly conceived regional medical programs and refocus the Hill-Burton program on areas of recognized need. Further, by requiring all States to enact a certificate-of-need law it can substantially aid in our efforts to reduce the very sizeable excess of hospital beds and other expensive facilities that now contribute to the rapidly rising costs of medical care.

We recommend that the enrolled bill be approved.

Sincerely,

Secretary

THE UNDER SECRETARY OF THE TREASURY

WASHINGTON, D.C. 20220

DEC 27 1974

Director, Office of Management and Budget
Executive Office of the President
Washington, D.C. 20530

Attention: Assistant Director for Legislative Reference

Sir:

Reference is made to your request for the views of this Department on the enrolled enactment of S. 2994, "To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes."

Section 4 of the enrolled enactment would add a new title XVI to the Public Health Service Act under which the Secretary of Health, Education, and Welfare would be authorized to make and guarantee loans and to provide interest subsidies to assist the construction and modernization of certain medical facilities. In a letter of October 2, 1974 to Senate Committee on Labor and Public Welfare on S. 2994, the Secretary of Health, Education, and Welfare objected to the loan and interest subsidies features of the bill because of their high expense and limited usefulness to those entities which most need financial assistance. The Secretary also opposed the excessive authorizations, the formula grant mechanisms, and the nature and size of the development fund proposals in the bill.

The credit program provisions of title XVI appear to be patterned after the credit provisions of the Hill-Burton loan and guarantee program contained in title VI of the Public Health Service Act. Yet, unlike the provisions of title VI, there is no provision in proposed title XVI which would make taxable the interest on any loans made to public bodies and sold and guaranteed by the Secretary of HEW.

In view of the foregoing, the Department would concur in a recommendation that the enrolled enactment not be approved by the President. If, however, the enrolled enactment is approved, in order to assure that the loan program is not financed in the tax-exempt bond market, the Department recommends that the Secretary of Health, Education, and Welfare be instructed that no loans to public bodies shall be sold except to the Federal Financing Bank.

Sincerely yours,

Edward C. Schmults

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

DECEMBER 27 1974

The Honorable
Roy L. Ash
Director, Office of
Management and Budget
Washington, D. C. 20503

Dear Mr. Ash:

This will respond to the request of the Assistant Director for Legislative Reference for the views of the Veterans Administration on the enrolled enactment of S. 2994, 93d Congress, an act "To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes."

On December 13, 1974, we submitted a report to your office on S. 2994, 93d Congress, directed to the Chairman, Subcommittee on Health and Hospitals, Senate Committee on Veterans' Affairs. We favored the sections of the bill as they applied to the Veterans Administration, with certain technical changes, which were made. Section 1503(b) of the act requires the Chief Medical Director of the Veterans Administration to serve as a nonvoting ex officio member of a National Council on Health Planning and Development. Section 1512(b)(3)(C) provides that a representative of the Chief Medical Director would serve as an ex officio member of the governing body, and executive committee of any health planning agency serving an area in which there is located one or more hospitals or other health care facilities of the Veterans Administration. Section 1524(b)(1)(D) provides that a representative of the Chief Medical Director of the Veterans Administration would serve as an ex officio member of the statewide health coordinating council where there are two or more VA hospitals in a State.

As we mentioned in our December 13th letter, we favor VA participation as outlined in the act. However, we defer to the Department of Health, Education, and Welfare regarding recommendations as to Presidential action on S. 2994, since it would be ultimately responsible for implementation.

Sincerely,

Odell W. Vaught

Deputy Administrator - in the absence of
RICHARD L. ROUDEBUSH
Administrator

THE WHITE HOUSE

WASHINGTON

1/2/75

MEMORANDUM FOR: WARREN HENDRIKS

FROM: MAX L. FRIEDERSDORF

SUBJECT: Action Memorandum - Log No. Enrolled Bill S. 2994 National Health Planning and Resources Development Act of 1974

The Office of Legislative Affairs concurs with the Agencies that the enrolled bill should be VETOED.

Attachments

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: December 31, 1974 Time: 7:00 p.m.

FOR ACTION: Jim Cavanaugh
Max Friedersdorf
Phil Areeda
Paul Theis

cc (for information): Warren Hendriks
Jerry Jones
Jack Marsh

FROM THE STAFF SECRETARY

DUE: Date: Thursday, January 2 Time: noon

SUBJECT:

Enrolled Bill S. 2994 - National Health Planning and Resources Development Act of 1974

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

____ For Your Comments ____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

Sign the bill. OMB not persuasive: federalism argument not strong. Funding authorization is too high, but President could issue signing statement saying that he will use only responsible (i.e., reduced) appropriation.

P. Areeda

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

Warren K. Hendriks
For the President

MEMORANDUM OF DISAPPROVAL

I have withheld my signature from S. 2994, the "National Health Planning Resources Development Act of 1974."

S. 2994 would require the creation of new health planning machinery in every State and in over 200 local health service areas throughout the country. The bill would attempt to improve State and local health planning efforts. It would, however, impose Federal conditions and approval requirements that sharply limit their initiative and flexibility in meeting particular State and local problems.

Among other things, S. 2994 would require advance Federal approval of the budget of every State and local health planning agency on an annual basis. It would also require a detailed Federal evaluation of each agency's performance every three years against such criteria as the competence of staff, improvements in the health status of area residents, quality improvements in health services, and the extent to which health care costs have been restrained. States would be required to establish State planning agencies and detailed State administrative programs and procedures for health planning that the Federal Government would have to approve. Also, minimum staff sizes for State and local planning agencies would be established. Such extensive Federal intrusion in State and local management responsibilities is unacceptable.

I support improvement in planning for health activities at the State and local levels. Earlier this year the Administration submitted health planning legislation and some of those features are incorporated in S. 2994. The Administration bill, however, would not have imposed on the States and local governments the excessively detailed administrative, procedural and structural requirements of

S. 2994. Even if all of the requirements of S. 2994 were workable -- which is seriously questionable -- they inappropriately mandate Federal responsibilities far beyond a reasonable oversight of State and local planning activities.

S. 2994 is also objectionable because it would continue the Hill-Burton program with only minimal changes. This program provided needed hospitals in rural areas following the post-World War II period. Over the longer term, it resulted in a surplus of hospital beds nationally and the construction of hospitals in areas other than those of the greatest need. The program largely ignores the priority needs of our older cities and urban areas.

The Administration proposed to reorient the Hill-Burton program so that scarce Federal resources would be targeted on modernization and replacement in areas suffering a shortage of hospital beds. S. 2994 fails to accomplish that purpose. Instead, it would continue a formula-grant funding program to all States, whether or not a shortage of beds and facilities existed. It would also continue the requirement for annual Federal approval of State medical facility plans and would provide excessive Federal matching for construction projects.

The appropriation authorizations in S. 2994 for fiscal years 1975, 1976 and 1977 are half a billion dollars more than the levels I consider adequate. Approval of excessive authorizations would create pressures for spending which are inconsistent with my strong commitment to the American taxpayers to hold Federal spending to essential levels.

Improvements need to be made in health planning at the State and local levels. Unfortunately, S. 2994 does not represent the best way to accomplish this objective.

Extensive Federal monitoring of State and local staffing, organization, and administration of planning activities can stifle the initiative we want to promote.

I will propose legislation to the 94th Congress to provide an appropriate Federal role in supporting health planning improvements at the State and local levels.

THE WHITE HOUSE,

To: M. Hendricks
12-31-74
6:30 p.m.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DEC 31 1974

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 2994 - National Health Planning and Resources Development Act of 1974
Sponsor - Sen. Kennedy (D) Mass.

Last Day for Action

January 4, 1975 - Saturday

Purpose

Authorizes the establishment of a new Federal program to assist State and local health planning; continues and amends the Hill-Burton medical facilities construction program.

Agency Recommendations

Office of Management and Budget	Disapproval (Memorandum of Disapproval attached)
Department of Health, Education, and Welfare	Approval
Department of the Treasury	Would concur in disapproval recommendation
Department of Housing and Urban Development	Defer to HEW (Informally)
Veterans Administration	Defer to HEW

Discussion

S. 2994 would require the creation of new health planning machinery in every State and local health service area to replace current health planning activities of existing State and areawide comprehensive health planning (CHP) agencies and planning activities undertaken in the past by some Regional Medical Program (RMP) entities. S. 2994 would also continue and amend the Hill-Burton medical facility construction program.

OK LD

MEMORANDUM OF DISAPPROVAL

I have withheld my signature from S. 2994, the "National Health Planning Resources Development Act of 1974."

S. 2994 would require the creation of new health planning machinery in every State and in over 200 local health service areas throughout the country. The bill would attempt to improve State and local health planning efforts. It would, however, impose Federal conditions and approval requirements that sharply limit their initiative and flexibility in meeting particular State and local problems.

Among other things, S. 2994 would require advance Federal approval of the budget of every State and local health planning agency on an annual basis. It would also require ~~the conduct of~~ a detailed Federal ~~program~~ evaluation of each agency's performance every three years against such criteria ~~such~~ as the competence of staff, improvements in the health status of area residents, quality improvements in health services, and the extent to which health care costs have been restrained. States would be required to establish State planning agencies and detailed State administrative programs and procedures for health planning that the Federal Government would have to approve. Also, minimum staff sizes for State and local planning agencies would be established. Such extensive Federal intrusion in State and local management responsibilities is unacceptable.

I support improvement in planning for health activities at the State and local levels. Earlier this year the Administration submitted health planning legislation, and some of those features are incorporated in S. 2994. The Administration bill, however, would not have imposed on the States and local governments the excessively detailed administrative, procedural and

structural requirements ~~that~~ of S. 2994 ~~would impose~~. Even if all of the requirements of S. 2994 were workable -- which is seriously questionable -- they inappropriately mandate Federal responsibilities far beyond a reasonable oversight of State and local planning activities.

S. 2994 is also objectionable because it would continue the Hill-Burton program with only minimal changes. This program provided needed hospitals in rural areas following the post-World War II period. Over the longer term, it resulted in a surplus of hospital beds nationally and the construction of hospitals in areas other than those of the greatest need. The program ~~has not been targeted on~~ largely ignores the priority needs of our older cities and urban areas.

The Administration proposed to reorient the Hill-Burton program so that scarce Federal resources would be targeted on modernization and replacement in areas suffering a shortage of hospital beds. S. 2994 fails to accomplish that purpose. Instead, it would continue a formula-grant funding program to all States, whether or not a shortage of beds and facilities existed. It would also continue the requirement for annual Federal approval of State medical facility plans and would provide excessive Federal matching for construction projects.

The appropriations authorizations in S. 2994 for fiscal years 1975, 1976 and 1977 are half a billion dollars more than the levels I ~~believe are appropriate~~ consider adequate. Approval of excessive authorizations would create pressures for spending which are inconsistent with my strong commitment to the American taxpayers to hold Federal spending to essential levels.

Improvements need to be made in health planning at the State and local levels. Unfortunately, ~~I believe that~~ S. 2994 does not represent the best way to accomplish this objective. Extensive Federal monitoring of State and local staffing, organization, and administration of planning activities can stifle the initiative we want to promote.

I will propose ~~a bill~~ legislation to the 94th Congress ~~shortly~~ to provide an appropriate Federal role in supporting health planning improvements at the State and local levels.

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: December 31, 1974 Time: 7:00 p.m.

FOR ACTION: Jim Cavanaugh
Max Friedersdorf
Phil Areeda
Paul Theis

cc (for information): Warren Hendriks
Jerry Jones
Jack Marsh

FROM THE STAFF SECRETARY

DUE: Date: Thursday, January 2 Time: noon

SUBJECT:

Enrolled Bill S. 2994 - National Health Planning and Resources Development Act of 1974

ACTION REQUESTED:

____ For Necessary Action ____ For Your Recommendations

____ Prepare Agenda and Brief ____ Draft Reply

____ For Your Comments ____ Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

1974 DEC 2 AM 8 28

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: December 31, 1974 Time: 7:00 p.m.

FOR ACTION: Jim Cavanaugh
Max Friedersdorf *veto*
Phil Areeda *sign*
Paul Theis

cc (for information): Warren Hendriks
Jerry Jones
Jack Marsh

FROM THE STAFF SECRETARY

DUE: Date: Thursday, January 2 Time: noon

SUBJECT:

Enrolled Bill S. 2994 - National Health Planning and Resources Development Act of 1974

ACTION REQUESTED:

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REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

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If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

K. R. COLE, JR.
For the President