I

103D CONGRESS
1ST SESSION

H. R. 2624

To provide for comprehensive health care and health care cost containment.

IN THE HOUSE OF REPRESENTATIVES

JULY 13, 1993

Mr. PETERSON of Minnesota introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, Armed Services, and Post Office and Civil Service

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A BILL

To provide for comprehensive health care and health care cost containment.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Health Care and Cost Containment Act of 1993''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS AND PROGRAM GOALS.

(a) FINDINGS.—Congress finds the following:

(1) RISING COSTS OF HEALTH CARE.—(A) Health care spending in the United States has grown at a rate that substantially exceeds the rise in the gross national product.

(B) Between 1965 and 1989, national health care spending doubled, increasing from 5.9 percent to 11.6 percent of the gross national product.

(C) National spending on health care has been increasing at a greater rate than the general cost-of-living index and the growth in the gross national product for a number of years.

(D) In 1989, spending on health care was $604 billion, an amount which exceeds the proportion of

the gross national product spent on health care by every other industrialized nation.

(E) The high relative expenditure of the United States on health care diminishes American incomes, productivity, and competitiveness in global trade.

(F) Administrative, marketing, and liability costs are among those components of health care costs that have grown the fastest.

(G) Cost-shifting, the rising cost of insurance premiums, and declining coverage are leaving Americans without access (or without adequate access) to important health services.

(2) LIMITED ACCESS TO HEALTH CARE.—(A) A growing number of Americans are uninsured or inadequately insured to meet their health care needs.

(B) All Americans have a right to at least a basic level of health care services that are continuously available and determined to be cost-effective.

(C) At least 33 million Americans currently lack access to basic health services at any point in time.

(D) It is estimated that during any 2-year period, approximately 25 percent of the non-elderly population of the United States has neither health insurance nor public health care coverage for some

period of time, and that an additional 13 percent of the population are underinsured for health care.

(3) NATIONAL PROBLEM.—(A) The growing costs of health care, coupled with declining access to services, represent a growing national problem.

(B) Despite growing expenditures on health care, health status indicators in the United States lag well behind those of other industrialized nations.

(C) Studies indicate that person who are uninsured or underinsured are less likely to receive adequate health care services.

(D) Studies also find that insufficient access to health care services has a negative impact on health status and also increased health care expenditures in the longer term.

(E) The current system of financing health care in the United States is complex, confusing, and frustrating to many Americans, including physicians and other providers of health care.

(F) National expenditures on health care cannot continue to expand faster than inflation and the rate of national economic growth without endangering the domestic standard of living and international economic competitiveness.

(b) PROGRAM GOALS.—The goals of the program of comprehensive health care and cost containment contained in this Act are as follows:

(1) To provide universal access to health care services for all Americans regardless of their financial and medical conditions.

(2) To establish the institutional and political capacity to control the escalating health care costs in the United States and to eliminate administrative waste.

(3) To ensure the portability of health care coverage to all regions of the United States.

(4) To build on the strengths of the Federal system, with the Federal Government contributing progressive financing while State government and units of local government supply additional funding and administer the program with the flexibility to address the specific concerns of each region.

(5) To utilize community care networks and local control to maximize our ability to expand access while containing costs.

(6) To maintain the proven advantages of the American health care delivery system, including private practice, the freedom to choose among practitioners, and superiority in biomedical technology.

(7) To encourage the effective use of preventive and primary care.

(8) To enhance the autonomy of practitioners by limiting the intrusiveness of government intervention in the actual delivery of care.

(9) To promote the role of competition and collaboration among practitioners and insurers to encourage innovation that results in higher quality and more efficient care.

(10) To reduce the incentives providers face to perform medically unnecessary or inappropriate services.

(11) To reinforce the public accountability of the health care system, permitting explicit and open deliberation about the allocation of resources to health care.

(12) To provide that all Americans share in the responsibility of maintaining an efficient health care system.

SEC. 3. DEFINITIONS.

In this Act:

(1) The term ''approved health insurance policy'' means a health insurance policy which has been approved by the Federal Health Board under section 201(a).

(2) The term ''covered district health care services'' means the following services:

(A) Ambulance services.

(B) Dialysis.

(C) Hospice care.

(D) Inpatient and outpatient hospital services (including such services provided for treatment of mental illness), including—

(i) accommodation and meals at the standard level (and preferred accommodation if medically required),

(ii) nursing services,

(iii) laboratory, radiological, and other diagnostic procedures (together with necessary interpretations),

(iv) drugs, biologicals, and related preparations when administered in the hospital,

(v) use of operating room, case room, and anesthetic facilities, including necessary equipment and supplies,

(vi) medical and surgical equipment and supplies,

(vii) emergency room services,

(viii) use of radiotherapy facilities,

(ix) use of physiotherapy facilities,

(x) services of hospital-based health care practitioners (such as anesthesiologists, certified registered nurse anesthetists, pathologists, and radiologists), as specified by the Federal Health Board, and

(xi) services provided by other persons who receive remuneration therefore from the hospital;

but excluding health care practitioner services furnished on an outpatient basis and for which remuneration is not paid by the hospital.

(E) Inhalation services.

(F) Partial hospitalization or day treatment services for treatment of mental illness, excluding health care practitioner services furnished on an outpatient basis and for which remuneration is not paid by the hospital.

(G) Nuclear medicine.

(H) Nursing care in an individual's place of residence.

(I) Inpatient, outpatient, and residential substance abuse treatment services.

(J) Home care services (other than health care practitioner services)—

(i) for treatment of a diagnosed medical condition or rehabilitation,

(ii) for treatment of a long-term disability, or

(iii) for frail individuals at risk of institutionalization in the absence of such services.

(K) Nursing facility services, including long-term residential care.

(L) Respite care.

(3) The term ''district board'' refers to a Health Care District Board appointed under section 202.

(4) The term ''Federal Health Board'' refers to the Federal Health Board established under section 101.

(5) The term ''Federal Health Education Commission'' refers to the Federal Health Education Commission established under section 102.

(6) The term ''global budget'' means, with respect to a district for a 12-month period, a comprehensive annual budget established by the district board for the district and setting forth, in advance of the period—

(A) aggregate receipts anticipated by the board from the Federal and State governments for the provision of health care services in the year, and

(B) aggregate expenditures for the provision of such services in the period, broken down by (i) capital expenditures, and (ii) other expenditures.

(7) The term ''health care practitioner'' means an individual lawfully entitled under the law of the State to provide health services in the place in which the services are provided by the individual.

(8) The term ''health care practitioner services'' means medical, chiropractic, dental, mental health, and vision services provided by a health care practitioner, other than services described in paragraph (2)(D)(x) (except for such services furnished on an outpatient basis and for which remuneration is not paid by a hospital).

(9) The term ''State Health Board'' refers to a State Health Board established under section 111.

(10) The term ''State-chartered practitioners association'' means an organization of health care practitioners that is chartered by the State in accordance with section 211.

TITLE I—FEDERAL AND STATE ADMINISTRATION

Subtitle A—Federal Administration

SEC. 101. FEDERAL HEALTH BOARD.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services a Federal Health Board.

(2) MEMBERSHIP; APPOINTMENT.—The Board shall consist of 5 individuals, appointed by the President by and with the advice and consent of the Senate.

(3) TERMS.—Members of the Board shall serve for terms of 5 years, except that the terms of the members initially appointed shall be for terms of 1, 2, 3, 4, and 5 years, as specified by the President at the time of appointment.

(4) COMPENSATION.—Members of the Board are entitled, subject to amounts provided in advance in appropriations Acts, to compensation at the rate provided for level V of the Executive Schedule.

(b) DUTIES.—The Board is responsible for the following:

(1) DETERMINATION OF NATIONAL PER CAPITA SPENDING RATES.—

(A) COVERED DISTRICT HEALTH CARE SERVICES.—The Board shall determine, in accordance with section 221(a), national per capita spending rates for covered district health care services. In determining such rates, the Board shall use data provided by the State.

(B) PRACTITIONER SERVICES.—The Board shall determine national per capita spending rates for health care practitioner services. In determining such rates, the Board shall use data provided by the insurance companies.

(2) ESTABLISHMENT OF SINGLE NATIONAL INSURANCE PREMIUMS.—The Board shall establish a single national insurance premium for each of the following categories of enrollment:

(A) Individuals.

(B) Married couples without children and an unmarried individual with a child.

(C) Married couples with one child and an unmarried individual with two children.

(D) Married couples with two children and an unmarried individual with three or more children.

(E) Married couples with three or more children.

(3) PAYMENT.—The Board shall make Federal payments to States and insurers under this Act.

(4) CERTIFICATION.—The Board shall determine whether States comply with the goals and guidelines for implementing provisions under this Act.

(5) RECIPROCITY.—The Board shall enter into reciprocity agreements with foreign countries which agree to provide health care services to United States citizens in a manner similar to the provision of services under this Act.

(6) REVIEW OF DUPLICATIVE PROGRAMS.—Within 1 year after the date of the enactment of this Act, the Board shall submit to Congress a report that identifies Federal health care programs (other than provided in this Act) which duplicate the services provided in this Act. The Board may include in the report such recommendations for the revision or elimination of such programs as may be appropriate.

(7) ANNUAL REPORT.—The Board shall submit to Congress an annual report on the status of the health care system in the United States.

SEC. 102. FEDERAL HEALTH EDUCATION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established within the Department of Education a Federal Health Education Commission.

(2) MEMBERSHIP; APPOINTMENT.—The Commission shall consist of 5 individuals, appointed by the President by and with the advise and consent of the Senate.

(3) TERMS.—Members of the Board shall serve for terms of 5 years, except that the terms of the members initially appointed shall be for terms of 1, 2, 3, 4, and 5 years, as specified by the President at the time of appointment.

(4) COMPENSATION.—Members of the Board are entitled, subject to amounts provided in advance in appropriations Acts, to compensation at the rate provided for level V of the Executive Schedule.

(b) DUTIES.—The Commission is responsible for the following:

(1) CONSUMER EDUCATION GRANTS.—The Commission shall manage the program of Federal grants to States for consumer education programs, under section 113 and title V.

(2) PRIMARY CARE PRACTITIONER TRAINING GRANTS.—The Commission shall manage the pro-

gram of Federal grants to States for primary care practitioner training, under section 113 and title V.

(3) ANNUAL REPORT.—The Commission shall submit to Congress an annual report on its activities under this Act.

Subtitle B—State Administration

SEC. 111. STATE HEALTH BOARDS.

(a) ESTABLISHMENT.—Each State shall provide for the establishment of a State Health Board that meets the requirements of this section.

(b) MEMBERSHIP.—

(1) IN GENERAL.—Each State Health Board shall—

(A) include representatives of the organizations described in paragraph (2),

(B) include representatives of the interests described in paragraph (3), and

(C) assure that at least 60 percent of the membership represents the interests described in paragraph (3).

(2) HEALTH PROVIDER ORGANIZATIONS.—The organizations described in this paragraph are as follows:

(A) The State-chartered medical association.

(B) The State-chartered nurses association.

(C) The State-chartered chiropractic physicians association.

(D) The State-chartered mental health providers association.

(E) The State hospital association.

(F) The State nursing home association.

(3) NON-PROVIDER INTERESTS.—The interests described in this paragraph are the interests of—

(A) consumers,

(B) the State legislature, and

(C) the insurance industry.

(c) DUTIES.—Each State Health Board shall have responsibility for the following:

(1) To establish health districts in the State and to appoint a district health care board for each such district, in accordance with section 112.

(2) To set the global budget (as defined in section 3(6)) for each health care district in the State.

(3) To establish fee schedules for each practitioner group in the State.

(4) To develop a long-range plan for future health care infrastructure in the State.

(d) SUBMISSION OF PROGRAMS.—Not later than October 1, 1995, each State shall submit to the Board the State program in the State.

(e) REVIEW AND APPROVAL OF PROGRAMS.—The Board shall review programs submitted under subsection (d) and determine whether such programs meet the requirements for approval, not later than October 1, 1996. The Board shall not approve such a program unless it finds that the program provides, consistent with the provisions of this Act, for—

(1) adequate financing of covered district health care services, including the annual submission of the State program budget to the Board,

(2) adequate administration and sufficient provisions to ensure against fraud and abuse,

(3) an organized grievance procedure available to consumers through which complaints about the organization and administration of the State program may be filed, heard, and resolved, and

(4) the modification of State law as it relates to medical malpractice, consistent with title III.

(f) OPERATIONAL STATUS.—A State program in a State shall not be considered operational unless it is approved and remains approved under subsection (e).

(g) FAILURE TO COMPLY WITH THIS ACT.—Whenever the Board, after reasonable notice and opportunity for hearing to the designated State agency finds that in the administration of the State program there is a failure to comply with any provision of this Act, the Board may—

(1) withhold further payments to the State under this Act, or

(2) place the State program, or specific portions of such program, in receivership under the jurisdiction of the Board,

until such failure has been corrected.

(h) JUDICIAL REVIEW.—

(1) IN GENERAL.—If any State is dissatisfied with the Board's action in denying approval of such State's program or finding a failure under subsection (g) with respect to such program, such State may, within 60 days after notice of such action, file with the United States court of appeals for the circuit in which such State is located a petition for review of that action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Board. The Board thereupon shall file in the court the record of the proceedings upon which the Board's action was based, as provided in section 2112 of title 28, United States Code.

(2) FINDINGS OF FACT.—The findings of fact by the Board, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Board to take further evidence, and the Board may thereupon make new or modified findings of fact and may modify the Board's previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(3) JURISDICTION OF COURT.—Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Board or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

SEC. 112. HEALTH CARE DISTRICTS AND BOARDS.

(a) ESTABLISHMENT OF DISTRICTS.—

(1) IN GENERAL.—Subject to paragraph (3), each State Health Board shall establish health care districts in the State of such number and size as such Board deems appropriate area for the effective planning, development, and delivery of covered district health care services in the State under this Act.

(2) STATEWIDE DISTRICT.—A State Health Board may treat the entire State as a single district in the case of a State with a population under 1,000,000.

(3) TREATMENT OF INDIAN RESERVATIONS.—Each State Health Board shall provide the designation of each Indian reservation as a separate district.

(b) APPOINTMENT OF BOARDS.—

(1) IN GENERAL.—Each State Health Board shall provide for the appointment of a Health Care District Board for each district established under subsection (a). Subject to paragraphs (2) and (3), each such board shall consist of 7 members appointed by the State Board, of whom at least 3 shall represent providers of covered district health care services.

(2) STATEWIDE DISTRICTS.—If the State has elected to treat the entire State as a single district under subsection (a)(2), the State Health Board shall serve as the Health Care District Board for the entire State.

(3) INDIAN RESERVATIONS.—The Health Care District Board for an Indian reservation designated under subsection (a)(3) shall consist of 7 members

appointed by the Chairman of the reservation, at least 3 of whom shall represent providers of covered district health care services in the area of the reservation.

(c) RESPONSIBILITIES OF DISTRICT BOARDS.—Each Health Care District Board is responsible—

(1) through contracts with health care facilities and service providers, for ensuring that covered district health care services are provided to residents of the district; and

(2) for developing, and submitting to the State Board, a global budget for the district.

SEC. 113. STATE HEALTH CARE EDUCATION COMMISSIONS.

(a) IN GENERAL.—Each State Health Board shall establish a State Health Care Education Commission.

(b) COMPOSITION AND APPOINTMENT.—The Commission shall consist of 5 members, appointed by the State Health Board, of whom 2 shall be professional educators.

(c) DUTIES.—Each State Health Care Education Commission shall be responsible for the following activities:

(1) Receipt of transfers from the Health Education Trust Fund.

(2) Providing grants to local school districts to conduct health education and preventive care pro-

grams, in accordance with guidelines developed by the National Health Care Education Commission.

(3) Providing grants to other organizations to promote health education, in accordance with guidelines developed by the National Health Care Education Commission.

(4) Providing grants to individuals for training as primary care practitioners, in accordance with guidelines developed by the National Health Care Education Commission.

TITLE II—HEALTH CARE SERVICES

Subtitle A—National Health Insurance Program

SEC. 201. NATIONAL STANDARDS FOR HEALTH INSURANCE; REQUIREMENT OF ENROLLMENT.

(a) IN GENERAL.—No health insurance policy which provides for coverage of either covered district health care services or health care practitioner services may be in effect on or after January 1, 1995, unless the Federal Health Board has determined that the policy meets the requirements of sections 202 through 205.

(b) ENROLLMENT REQUIREMENT.—

(1) IN GENERAL.—Each legal resident of the United States shall be enrolled in an approved insurance policy.

(2) ASSIGNMENT OF UNENROLLED INDIVIDUALS.—If a State determines that an individual who is a resident of the State is not enrolled in an approved health insurance policy in accordance with paragraph (1), the State shall provide for the enrollment of the individual in such a policy. In providing for such enrollment, the State shall assign such individuals to such a policy in an appropriate random manner.

SEC. 202. COVERAGE OF ALL NECESSARY AND APPROPRIATE HEALTH CARE PRACTITIONER SERVICES.

(a) IN GENERAL.—Each approved health insurance policy shall cover all health care practitioner services that are necessary and appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following, injury, disability, or disease, if furnished anywhere in the United States (or in any country with which the Federal Health Board has a reciprocity agreement under section 101(b)(5)).

(b) LIMITATION ON SERVICES COVERED.—

(1) IN GENERAL.—An approved health insurance policy shall not cover services other than services described in paragraph (1).

(2) REFERENCE TO ADDITIONAL INSURANCE.—For provision permitting separate insurance coverage for certain other health care services, see section 701.

SEC. 203. PREMIUMS; REDUCTION IN PREMIUMS FOR LOW INCOME INDIVIDUALS.

(a) IN GENERAL.—The premium rates that may be charged by an approved health insurance policy shall be such rates as are approved by the Federal Health Board.

(b) PREMIUM ASSISTANCE.—

(1) IN GENERAL.—In the case of an individual or family who is a legal resident of the United States who is enrolled under an approved health insurance policy and who is determined by the issuer of the policy (in accordance with guidelines specified by the Federal Health Board) to have total adjusted gross income (as determined for purposes of the Internal Revenue Code of 1986 for the individual and all members of the family) below maximum income level specified under paragraph (3)—

(A) the individual or family is entitled to a percentage reduction specified under para-

graph (2) in the premium rates charged under subsection (a), and

(B) the issuer of the policy is entitled to payment by the Federal Health Board of an amount equal to the amount of such reduction.

(2) PERCENTAGE REDUCTION.—In the case of an individual or family the total adjusted gross income of whose members—

(A) does not exceed the Federal poverty line (applicable to a family of the size involved), the percentage reduction is 100 percent, or

(B) exceeds such line, the percentage reduction is 100 percent less 10 percent for each dollar unit (specified in paragraph (4)) by which such total adjusted gross income exceeds the applicable Federal poverty line.

(3) MAXIMUM INCOME LEVEL.—The maximum income level specified in this subparagraph for a family is the sum of—

(A) the Federal poverty line, and

(B) 10 times the dollar unit specified in paragraph (4),

applicable to a family of the size involved.

(4) DOLLAR UNIT.—The dollar unit specified in this paragraph is—

(A) for a family of four, $1,000, and

(B) for a family of other size (including a family consisting only of an individual), such amount as bears the same ratio to the amount specified in subparagraph (A) as the ratio of the Federal poverty line applicable to a family of the size involves bears to the Federal poverty line applicable to a family of four.

The amounts determined under subparagraph (B) may be rounded by the Federal Health Board to an appropriate multiple of $10.

(5) FEDERAL POVERTY LINE.—In this subsection, the term ''Federal poverty line'' means the official poverty line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(c) EMPLOYER CONTRIBUTIONS.—Nothing in this section shall be construed as preventing an employer of an individual from paying some or all of the premiums for coverage of employees and family members under health insurance policies.

(d) SPECIAL PROVISIONS RELATING TO NATIVE AMERICANS.—In the case of an individual who is a Native American and who is an enrolled member of a Federally-

recognized Indian tribe or otherwise qualifies under regulations promulgated by the Federal Health Board (in consultation with the Secretary of the Interior)—

(1) the individual is entitled to a 100 percent reduction in the premium rates charged under subsection (a), and

(2) the issuer of the policy is entitled to payment by the Federal Health Board of an amount equal to the amount of such reduction.

A reduction and payment under this subsection for such an individual shall be instead of any reduction or payment otherwise provided under subsection (b).

(e) EXPANSION OF TAX DEDUCTIBILITY OF PREMIUMS.—For provision making payment of premiums under this section fully tax deductible, see title VI of this Act.

SEC. 204. USE OF STANDARDIZED FORMS.

Each approved health insurance policy shall provide for the use of such standardized claims forms as the Federal Health Board specifies, after consultation with State Health Boards and other interested parties.

SEC. 205. PAYMENTS TO PRACTITIONERS.

(a) IN GENERAL.—Each approved health insurance policy shall provide for payment for health care practi-

tioner services based on the fee schedules established under part 1 of subtitle B.

(b) MANDATORY ASSIGNMENT.—Payment for health care practitioner services may only be made to the practitioner furnishing the services and only if the practitioner agrees to accept payment of such fee schedule amounts as payment in full for the services.

Subtitle B—Payment Amounts for Health Care Practitioner Services and for Covered District Health Care Services

PART 1—HEALTH CARE PRACTITIONER SERVICES

SEC. 211. STATE-CHARTERED PRACTITIONERS ASSOCIATIONS.

Each State shall provide for the chartering of practitioner associations—

(1) to represent licensed members of the discipline in the establishment of fee schedules in the State under this part, and

(2) to provide medical malpractice insurance under section 302.

SEC. 212. ESTABLISHMENT OF FEE SCHEDULES.

(a) IN GENERAL.—Each State Health Board, in conjunction with State-chartered practitioners associations provided for under section 211, shall develop fee schedules

of amounts that may be paid for health care practitioner services by approved health insurance policies under subtitle A. The Board shall provide for the review and revision (if appropriate) of the structure of such schedules not less often than once every 10 years.

(b) BASIS.—Such schedules may take into consideration regional cost variations, practitioner expertise, outcome-based measures, and any other factors deemed relevant by the Board.

(c) NEGOTIATIONS.—Each State Health Board shall provide for annual negotiations with State-chartered practitioners associations regarding the changes in the amounts specified in fee schedules developed under this section. Such negotiations shall consider changes in the cost of living, the cost of supplies, and other elements which affect the costs of delivering health care services by the practitioners.

(d) SPECIAL NONPHYSICIAN PRACTITIONER PROVISIONS.—In the establishment of fee schedule amounts for nonphysician practitioners, in the case of health care practitioner services which may be provided by nonphysician practitioners and physicians, basic reimbursement rates for those same services shall be the same regardless of the type of practitioner providing such services.

PART 2—PAYMENTS FOR COVERED DISTRICT HEALTH CARE SERVICES

SEC. 221. ESTABLISHMENT OF ANNUAL PER CAPITA RATES.

(a) IN GENERAL.—The Federal Health Board, using data from State Health Boards and Health Care District Boards, shall determine an annual per capita rate for costs of covered district health care services provided by such Boards.

(b) DIVISION OF RATE.—The Federal Health Board shall specify the portion of the annual per capita rate under subsection (a) that is attributable to nursing facility services and the portion not attributable to such services. Such portions shall reflect the average of approved State budgets under section 222 which are attributable to the different services.

SEC. 222. STATE BUDGETS FOR COVERED DISTRICT HEALTH CARE SERVICES.

(a) DEVELOPMENT.—

(1) IN GENERAL.—Each State Health Board shall develop and approve a State budget for covered district health care services for all districts in the State. Such budget shall be the sum of the district budgets submitted to and approved by the Board under section 223.

(2) DEVELOPMENT OF SEPARATE OPERATING AND CAPITAL BUDGETS.—The State budget under this subsection may consist of separate components for operating and capital expenditures under guidelines established by the Federal Health Board.

(b) PAYMENTS TO DISTRICT BOARDS.—

(1) IN GENERAL.—Each State Health Board shall establish procedures for payment of each district board of amounts under its approved budget in a manner that provides for an adequate cash flow to allow the timely payment of obligations for the provision of covered district health care services.

(2) TREATMENT OF NATIVE AMERICANS.—Under guidelines established by the Federal Health Board, State Health Boards shall establish such procedures as assure full payment of amounts due to Native American districts established under section 112(a)(4).

SEC. 223. DISTRICT BUDGETS FOR COVERED DISTRICT HEALTH CARE SERVICES.

(a) DEVELOPMENT AND SUBMISSION.—

(1) GLOBAL BUDGETS.—Each health care district board shall develop and submit to the State Health Board, in a manner and at a time consistent with guidelines developed by the appropriate State

Health Board, a global budget for the district that reflects the funding levels necessary to provide for adequate covered district health care services in the district for a fiscal year.

(2) TREATMENT OF CAPITAL.—Such a budget shall provide for separate components for operating and capital expenditures if the State has elected to provide for such separate components under its State budget under section 222.

(b) NEGOTIATIONS.—After the receipts of all district budgets submitted under subsection (a), each State Health Board shall provide an opportunity for district boards to negotiate over the final district budgets to be approved by the State Health Board and submitted by such Board to the Federal Health Board.

(c) LIMITATION ON PAYMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), each district board shall not make total payments for covered district health care services in a fiscal year that exceed the amount of the district budget approved under subsection (b).

(2) EMERGENCIES.—Under guidelines established by the Federal Health Board or the State Health Board, a district board may provide in the case of unforeseen emergencies for payment of

amounts in excess of the amounts provided under the approved budget.

SEC. 224. PAYMENTS FROM FEDERAL GOVERNMENT TO STATES FOR COVERED DISTRICT HEALTH CARE SERVICES.

(a) IN GENERAL.—The Federal Health Board shall provide for payment each fiscal year to each State Health Board of an amount, on an annualized basis, equal to the sum of the following:

(1) 25 percent of the product of (A) the portion of the national per capita health care facilities rate not attributable to nursing facility services (determined under section 221) and (B) the total number of eligible State residents (other than native Americans) in the State.

(2) 10 percent of the product of (A) the portion of the national per capita health care facilities rate attributable to nursing facility services (as determined under section 221) and (B) the total number of eligible State residents (other than native Americans) in the State.

(3) Subject to subsection (b), 100 percent of the product of (A) the national per capita health care facilities rate (as determined under section 221)

and (B) the total number of native Americans who are eligible State residents in the State.

(b) TREATMENT OF NATIVE AMERICANS.—Instead of the payment amounts provided under subsection (a)(3), the Federal Health Board may pay to a State such amounts as may be required in order to provide for full payment of the amounts of the global budgets for district boards established pursuant to section 112(b)(3).

(c) PERIODIC PAYMENTS.—Payments under this section shall be made on a periodic base (not less often than monthly).

(d) PAYMENTS FOR HEALTH EDUCATION AND PRIMARY HEALTH CARE PRACTITIONER TRAINING.—For provisions relating to payments to State Health Education Commissions for grants for health education and training of primary health care practitioners, see section 501 of this Act.

(e) ADDITIONAL EXPENDITURES.—Nothing in this section shall be construed as preventing a district board from providing for payments for health care services in addition to the amounts provided under this section.

SEC. 225. STATE PROGRAM BUDGETS.

(a) IN GENERAL.—Each State program shall establish an annual fiscal year State program budget which provides for—

(1) the total expenditures to be made under the State program in such fiscal year for covered district health care services (including administrative and associated costs), and

(2) the revenues to meet such expenditures.

(b) STATE SHARE.—

(1) IN GENERAL.—Each State program shall cover the State share of program costs through the use of tax revenues and other financing methods.

(2) ADDITIONS TO STATE SHARE.—Each State shall raise the revenues necessary to cover at least the State share of the State health budget established by the State Health Board.

(c) ESTABLISHMENT OF ANNUAL BUDGETS UNDER STATE PLANS.—

(1) SUBMISSION OF ESTIMATED PLAN EXPENDITURES.—Not later than 3 months before the beginning of each calendar year, each district board in each State shall submit to the State Health Care Board the estimated plan expenditures for the district for that year.

(2) STATE PLAN BUDGET.—

(A) IN GENERAL.—The State plan budget for a year shall be equal to the sum of the estimated negotiated expenditures for all district

boards in the State submitted under paragraph (1).

(B) PERMITTING RETROACTIVE ADJUSTMENT.—The State Health Care Board may make a retroactive adjustment to the State plan budget for a year under subparagraph (A) to take into account differences between the budget and total amount of expenditures under the State plan during the year.

TITLE III—MALPRACTICE INSURANCE REFORM

SEC. 301. ELIGIBILITY REQUIREMENTS FOR FEDERAL PAYMENTS FOR STATE PLANS.

For purposes of section 111(e)(4), a State has enacted and is enforcing laws, rules, or regulations relating to physician medical malpractice liability that meet the requirements of this title if State law meets the requirements of sections 302 through 304.

SEC. 302. STATE-CHARTERED PRACTITIONERS ASSOCIATION ASSUMPTION OF RESPONSIBILITY FOR MALPRACTICE INSURANCE COVERAGE AND PAYMENT OF DAMAGES.

(a) STATE-CHARTERED PRACTITIONERS ASSOCIATION RESPONSIBLE FOR OBTAINING INSURANCE.—With respect to each class of health care practitioners in a

State, the State-chartered practitioners association in the State shall provide (either directly or through contracts with insurance companies) medical malpractice insurance for each practitioner member of the association.

(b) STATE-CHARTERED PRACTITIONERS ASSOCIATION RESPONSIBLE FOR PAYING DAMAGES ARISING FROM MEDICAL MALPRACTICE CLAIMS.—Any damages assessed with respect to any medical malpractice claim filed in the State against a health care practitioner who is a member of a State-chartered practitioners association shall be assessed against the association or other entity providing the medical malpractice insurance under subsection (a), and the individual or entity to whom the damages are awarded may not collect the damages from the practitioner.

SEC. 303. PROHIBITION AGAINST PUNITIVE DAMAGES.

No punitive damages may be assessed with respect to any medical malpractice claim filed in the State against any provider of health care services.

SEC. 304. MEDICAL MALPRACTICE CLAIM DEFINED.

(a) IN GENERAL.—In this title, the term ''medical malpractice claim'' means (subject to subsection (b)) any claim relating to the provision of (or the failure to provide) health care services without regard to the theory of liability asserted.

(b) MEDICAL PRODUCT LIABILITY CLAIMS NOT INCLUDED.—The term ''medical malpractice claim'' does not include any claim in which the claimant alleges an injury arising from or relating to the use of a device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) or a drug (as defined in section 201(g)(1) of such Act) that is filed against any entity that is the designer, manufacturer, producer, or seller of the device or drug.

TITLE IV—PROVISIONS RELATING TO ERISA AND FEDERAL AND STATE ANTITRUST LAWS

SEC. 401. RELATION TO ERISA.

The provisions of the Employee Retirement Income Security Act are superseded to the extent inconsistent with the requirements of this Act.

SEC. 402. RELATION TO FEDERAL AND STATE ANTITRUST LAWS.

(a) IN GENERAL.—The Antitrust laws, or any State law similar to the Antitrust laws, shall not apply to any hospital, nursing home, long-term care facility, or other entity with the potential to deliver health services provided under this Act, entering or attempting to enter into contracts with any State, unit of local government or Board

or entity established by a State or unit of local government under this Act.

(b) ANTITRUST LAWS DEFINED.—The term ''antitrust laws'' has the meaning given such term in section 1(a) of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45), to the extent that such section applies to unfair methods of competition.

TITLE V—HEALTH CARE EDUCATION TRUST FUND

SEC. 501. HEALTH CARE EDUCATION TRUST FUND.

(a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Health Care Education Trust Fund'' (in this section referred to as the ''Fund''). The Fund shall consist of such gifts and bequests as are hereby authorized to be received and such amounts as may be deposited in, or appropriated to, such Fund as provided in this section.

(b) OPERATION.—The Federal Health Care Education Commission shall administer the Fund and shall provide for grants under subsection (c) from the amounts in the Fund.

(c) USE OF FUNDS.—

(1) STATE HEALTH CARE EDUCATION.—

(A) IN GENERAL.—The Federal Health Care Education Commission shall make annual grants to State Health Care Education Commissions to provide for health care consumer education and health care education in a manner consistent with guidelines issued by the Commission.

(B) PER CAPITA FORMULA.—The amounts of the grants made to the States under this paragraph shall be in proportion to the population of each of the States.

(2) PRIMARY CARE HEALTH CARE PRACTITIONER TRAINING.—The Federal Health Care Education Commission shall provide for grants to States to provide for payment for primary health care practitioner training.

(3) LIMITATION.—In no case shall the total amount of grants made under this subsection in any fiscal year exceed the amount available in the Fund to make such grants in such year.

(d) APPROPRIATION.—There are hereby appropriated to the Fund for each fiscal year, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the increase in taxes resulting from the amendments made by section 502. The amounts ap-

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

SEC. 502. INCREASE IN TAXES ON CIGARETTES AND DISTILLED SPIRITS.

(a) INCREASE IN TAX ON CIGARETTES.—

(1) RATE OF TAX.—Subsection (b) of section 5701 of the Internal Revenue Code of 1986 (relating to rate of tax on cigarettes) is amended—

(A) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$30.50 per thousand''; and

(B) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$64.05 per thousand''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to articles removed after December 31, 1994.

(3) FLOOR STOCKS.—

(A) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before January 1, 1995, and held on such date for sale by any person, there shall be imposed the following taxes:

(i) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, $20.50 per thousand;

(ii) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, $43.05 per thousand; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.

(B) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(i) LIABILITY FOR TAX.—A person holding cigarettes on January 1, 1995, to which any tax imposed by subparagraph (A) applies shall be liable for such tax.

(ii) METHOD OF PAYMENT.—The tax imposed by subparagraph (A) shall be treated as a tax imposed under section 5701 of the Internal Revenue Code of 1986 and shall be due and payable on February 15, 1995, in the same manner as the tax imposed under such section is payable with respect to cigarettes removed on January 1, 1995.

(C) CIGARETTE.—For purposes of this paragraph, the term ''cigarette'' shall have the meaning given to such term by subsection (b) of section 5702 of the Internal Revenue Code of 1986.

(D) EXCEPTION FOR RETAIL STOCKS.—The taxes imposed by subparagraph (A) shall not apply to cigarettes in retail stocks held on January 1, 1995, at the place where intended to be sold at retail.

(E) FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (19 U.S.C. 81a et seq.) or any other provision of law—

(i) cigarettes—

(I) on which taxes imposed by Federal law are determined, or customs duties are liquidated, by a customs officer pursuant to a request made under the first proviso of section 3(a) of the Act of June 18, 1934 (19 U.S.C. 81c(a)) before January 1, 1995, and

(II) which are entered into the customs territory of the United States on or after January 1, 1995, from a foreign trade zone, and

(ii) cigarettes which—

(I) are placed under the supervision of a customs officer pursuant to the provisions of the second proviso of section 3(a) of the Act of June 18, 1934 (19 U.S.C. 81c(a)) before January 1, 1995, and

(II) are entered into the customs territory of the United States on or

after January 1, 1995, from a foreign trade zone,

shall be subject to the tax imposed by subparagraph (A) and such cigarettes shall, for purposes of subparagraph (A), be treated as being held on January 1, 1995, for sale.

(b) INCREASE IN TAX ON DISTILLED SPIRITS.—

(1) IN GENERAL.—Section 5001(a) of the Internal Revenue Code of 1986 (relating to rate of tax on distilled spirits) is amended by striking ''$13.50'' each place it appears in paragraphs (1) and (3) and inserting ''$50.00''.

(2) TECHNICAL AMENDMENT.—Section 5010 of such Code (relating to credit for wine and flavors content) is amended by striking ''$13.50'' each place it appears in paragraphs (1)(A) and (2) and inserting ''$50.00''.

(3) FLOOR STOCKS.—

(A) IMPOSITION OF TAX.—On any item subject to tax under section 5001 of the Internal Revenue Code of 1986 that is removed before January 1, 1995, and held after such date for sale by any person, there shall be imposed a tax equal to $36.50.

(B) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(i) LIABILITY FOR TAX.—A person holding an item to which any tax imposed by subparagraph (A) applies shall be liable for such tax.

(ii) METHOD OF PAYMENT.—The tax imposed on any item by subparagraph (A) shall be treated as a tax imposed under section 5001 of the Internal Revenue Code of 1986 and shall be due and payable on February 13, 1995, in the same manner as the tax imposed under such section is payable with respect to such items removed on January 1, 1995.

(C) EXCEPTION FOR RETAILERS.—To the extent provided in regulations prescribed by the Secretary of the Treasury or the Secretary's delegate, the tax imposed by subparagraph (A) shall not apply to items in retail stocks held after December 31, 1994, on the premises of a retail establishment where alcoholic beverages are sold for consumption on the premises only.

(D) TREATMENT OF ITEMS IN FOREIGN TRADE ZONES.—Notwithstanding the Act of

June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a), or any other provision of law, any item which is located in a foreign trade zone on January 1, 1995, shall be subject to the tax imposed by subparagraph (A) and shall be treated for purposes of this paragraph as held on such date for sale if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such item before such date pursuant to a request made under the first proviso of section 3(a) of such Act, or

(ii) such item is held on such date under the supervision of a customs officer pursuant to the second proviso of such section 3(a).

Under regulations prescribed by the Secretary of the Treasury or the Secretary's delegate, provisions similar to sections 5062 and 5064 of such Code shall apply to any item with respect to which tax is imposed by subparagraph (A) by reason of this subparagraph.

(E) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the excise taxes imposed under sec-

tion 5001 of the Internal Revenue Code of 1986 shall, insofar as applicable and not inconsistent with the provisions of this paragraph, apply in respect of the taxes imposed by subparagraph (A).

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items removed after December 31, 1994.

TITLE VI—TAX TREATMENT OF HEALTH INSURANCE PREMIUMS

SEC. 601. DEDUCTION FOR HEALTH INSURANCE PREMIUMS.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended to read as follows:

''(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise—

''(1) the amount by which the amount of the expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152) exceeds 7.5 percent of adjusted gross income, and

''(2) the amount of the expenses paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.''

(b) DEDUCTION FOR INSURANCE ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code (defining adjusted gross income) is amended by adding at the end thereof the following new paragraph:

''(14) EXPENSES FOR HEALTH INSURANCE.—The deduction allowed by section 213(a)(2).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

TITLE VII—PRIVATE OPTIONS

SEC. 701. ADDITIONAL INSURANCE.

Nothing in this Act shall be construed as preventing individuals from obtaining insurance for services that are not covered by health care services.

TITLE VIII—PRESCRIPTION DRUG REVIEW BOARD

SEC. 801. ESTABLISHMENT OF BOARD.

(a) ESTABLISHMENT.—There is established in the executive branch the Prescription Drug Price Review Board (in this title referred to as the ''Board'').

(b) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Board shall be composed of 5 members appointed by the President, by and with the advice and consent of the Senate, from among individuals—

(A) who are recognized experts in the fields of consumer advocacy, medicine, pharmacology, pharmacy, and prescription drug reimbursement; and

(B) who have not worked in the pharmaceutical manufacturing industry during the 3-year period ending on the date of appointment.

(2) INITIAL APPOINTMENTS.—Initial appointments under paragraph (1) shall be made not later than 90 days after the date of the enactment of this Act.

(3) TERMS.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), each member shall be appointed for a term of 5 years.

(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

(i) 1 member shall be appointed for a term of 1 year;

(ii) 1 member shall be appointed for a term of 2 years;

(iii) 1 member shall be appointed for a term of 3 years;

(iv) 1 member shall be appointed for a term of 4 years; and

(v) 1 member shall be appointed for a term of 5 years.

(C) VACANCIES.—A vacancy in the Board shall be filled in the manner in which the original appointment was made. Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of the member's term until a successor has taken office.

(4) INITIAL MEETING.—The initial meeting of the Board shall be held not later than 90 days after the date on which the first appointments of the members have been completed.

(5) CHAIRPERSON.—The President shall designate 1 member of the Board to serve as the chairperson.

(6) BASIC PAY.—

(A) IN GENERAL.—Members shall be paid at a rate not to exceed the daily equivalent of the maximum annual rate of basic pay payable under section 5376 of title 5, United States Code, for each day during which the members are engaged in the actual performance of the duties of the Board.

(B) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(c) DIRECTOR AND STAFF.—

(1) DIRECTOR.—The Board shall have a director who shall be appointed by the chairperson, subject to rules prescribed by the Board.

(2) STAFF.—The chairperson may appoint and fix the pay of such additional personnel as the chairperson considers appropriate, subject to rules prescribed by the Board.

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The director and staff of the Board shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the requirements of chapter 51 and subchapter III of

chapter 53 of such title relating to classification and General Schedule pay rates; except that an individual so appointed may not receive pay in excess of the maximum annual rate of basic pay payable for grade GS–15 of the General Schedule.

SEC. 802. POWERS OF BOARD.

(a) OBTAINING OFFICIAL DATA.—The chairperson of the Board may secure directly from any Federal agency information necessary to enable the Board to carry out its duties. Upon request of the chairperson, the head of the agency shall furnish such information to the Board to the extent such information is not prohibited from disclosure by law.

(b) MAILS.—The Board may use the United States mails in the same manner and under the same conditions as other Federal agencies.

(c) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the chairperson, the Administrator of General Services shall provide to the Board on a reimbursable basis the administrative support services necessary for the Board to carry out its duties.

(d) CONTRACT AUTHORITY.—The chairperson may contract with and compensate government and private agencies or persons for the purpose of conducting re-

search, surveys, and other services necessary to enable the Board to carry out its duties.

(e) INVESTIGATIONS.—The Board may make such investigations as it considers necessary to determine whether there is or may be a violation of any regulation promulgated under this title and may require or permit any person to file with it a statement in writing, under oath or otherwise as the Board shall determine, as to all the facts and circumstances concerning the matter to be investigated.

(f) SUBPOENA POWER.—

(1) IN GENERAL.—The Board may issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence relating to any matter under investigation by the Board. The attendance of witnesses and the production of evidence may be required from any place within the United States at any designated place of hearing within the United States.

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the Board may apply to a United States district court for an order requiring that person to appear before the Board to give testimony, produce evidence, or both, relating to the matter under inves-

tigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(3) SERVICE OF SUBPOENAS.—The subpoenas of the Board shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) SERVICE OF PROCESS.—All process of any court to which application is made under paragraph (2) may be served in the judicial district in which the person required to be served resides or may be found.

SEC. 803. FUNCTIONS OF THE BOARD.

(a) GUIDELINES.—The Board shall—

(1) develop and publish within 9 months of the date of the establishment of the Board the initial guidelines that the Board will use in determining whether an existing price or an increase in the price of any prescription drug is excessive,

(2) develop and publish within 12 months of the date of the establishment of the Board the initial guidelines that the Board will use in determining

whether the initial price at which a prescription drug is first sold is excessive, and

(3) periodically review the guidelines developed under paragraphs (1) and (2) and make appropriate revisions.

(b) DETERMINATIONS AND REVIEWS.—The Board shall—

(1) within 24 months of the date of the establishment of the Board, make an initial determination of whether the price of each prescription drug approved for sale on the date of the enactment of this Act is excessive,

(2) promptly make an initial determination of whether the price of each prescription drug first approved for sale after the date of the enactment of this Act is excessive,

(3) review, on an ongoing basis, each increase in the price of a drug reviewed under paragraphs (1) and (2) to determine if the price increase is excessive, and

(4) consider whether determinations and reviews similar to the ones carried out under paragraphs (1), (2), and (3) should be made for non-prescription drugs and make such determinations and reviews if appropriate.

(c) FACTORS.—In making determinations under subsection (b) as to whether the price of a prescription drug is excessive, the Board shall take into consideration—

(1) changes in the producer price index (published by the Bureau of Labor Statistics of the Department of Labor),

(2) changes in the prescription drug component of such producer price index,

(3) the price at which such drug was sold to wholesalers in the United States during the preceding 10 years,

(4) the price at which such drug was sold to wholesalers in other countries during the preceding 10 years,

(5) the price at which other drugs in the same therapeutic class were sold to wholesalers in the United States during the preceding 10 years,

(6) the therapeutic potential rating of such drug by the Food and Drug Administration,

(7) the percentage of such drug's research and development costs paid by the United States,

(8) the cost of manufacturing and marketing such drug, and

(9) such other factors as the Board considers relevant.

(d) REPORTING.—The Board shall—

(1) promptly provide to consumers and health care providers the results of the Board's determinations under subsection (b) and the method used in each such determination,

(2) provide information to consumers and health care providers regarding prescription drug pricing and price increases by therapeutic class and manufacturer,

(3) provide to consumers and health care providers information regarding the Food and Drug Administration therapeutic potential rating of each prescription drug and the percentage of the research and development of each such drug paid by the United States,

(4) provide to consumers such other information as the Board determines will assist consumers in reducing their expenses for prescription drugs,

(5) publish an easy to understand consumer's guide to prescription drug prices, including the information described in paragraphs (1), (2), (3), and (4), within 24 months of the date of the establishment of the Board and update and publish such guide annually thereafter, and

(6) provide to the President and the Congress a report of its determinations under subsection (b) within 24 months of the date of the establishment of the Board and update and report such determinations annually thereafter.

SEC. 804. SANCTIONS AND REMEDIES.

(a) HEARINGS.—After making a determination under section 803(b) that the price of a prescription drug or an increase in the price of such a drug is excessive, the Board shall—

(1) notify, in writing, the manufacturer of such drug of such determination,

(2) fix a date on which a public hearing before the Board respecting such determination shall be held and hold such hearing,

(3) request from such manufacturer such additional information as the Board deems necessary for such public hearing, and

(4) notify such manufacturer of the Board's recommendation as to the pricing of the drug at a rate which is not excessive.

(b) SETTLEMENT.—If, after a public hearing under subsection (a), the Board finds that the price or an increase in the price of a prescription drug is not excessive, the Board shall—

(1) notify the manufacturer of such drug of the Board's finding, and

(2) remove from all publications and reports of the Board after the date of such finding any statement that the price or increase in the price of such drug is excessive.

(c) PATENT REVOCATION.—If, after a public hearing under subsection (a), the Board finds that the price or an increase in the price of a prescription drug is excessive, the Board shall—

(1) notify the manufacturer of such drug of the Board's finding,

(2) notify the manufacturer of such drug of the Board's intent to revoke the patent for such drug if the drug is patented or to revoke the patent of another drug of such manufacturer if such drug is not patented, and

(3) take such action as may be necessary to revoke a drug patent under paragraph (2) if the manufacturer of such drug does not reduce the price of the drug to a level that is not excessive.

SEC. 805. MANUFACTURERS.

Each manufacturer of a prescription drug subject to review under section 803 shall—

(1) provide to the Board such information as the Board may require to make the determinations under section 803, including—

(A) information identifying such drug,

(B) the price at which such drug is being sold or has been sold in any market,

(C) the cost of manufacturing and marketing such drug, and

(D) such other information as the Board considers necessary to be provided in such form and manner and at such time as the Board prescribes by regulation, and

(2) notify the Board immediately of any increase in the wholesale price of any prescription drug marketed by the manufacturer.

SEC. 806. STUDY.

The Board shall engage the Institute of Medicine of the National Academy of Sciences to conduct a study of prescription drug research and development and pricing practices, the difficulties many Americans have in affording prescription drugs, and options for making prescription drugs available to all that need them. Such study shall—

(1) examine Federal incentives for research and development and determine which incentives are

most effective and what changes would better encourage the development of low cost, effective drugs,

(2) examine the Federal regulatory process and identify ways it might be streamlined without jeopardizing consumer safety,

(3) consider whether the authority of the Food and Drug Administration should be enhanced and whether the funding for such agency should be increased to improve Federal regulation of drugs,

(4) consider steps the United States might take (including possible trade sanctions) to protect manufacturers of drugs in the United States from product pirating and other unfair trade practices by foreign competitors,

(5) consider changes in the patent laws (including delaying the start of a product's 17 years patent protection until after the product has been approved under the Federal Food, Drug, and Cosmetic Act) to allow manufacturers to charge lower prices and still recoup their research and development costs,

(6) consider whether a Board review of non-prescription drug prices would have a positive effect on consumer costs of such drugs,

(7) consider mechanisms to assist consumers with the high cost of prescription drugs (including

providing reimbursement under title XVIII of the Social Security Act for prescription drugs at lower prices negotiated with manufacturers of drugs),

(8) examine Federal policies regarding the licensing of drugs discovered and developed by federally funded researchers and recommend actions that would allow the United States to recoup its costs or to influence the pricing of such drugs, and

(9) examine the effects on retail pharmacies of disparities in drug prices wherein the drug manufacturers charge hospitals, mail order pharmacies, and health maintenance organizations significantly lower prices than those charged wholesalers for such drugs.

TITLE IX—TERMINATION OF PROGRAMS

SEC. 901. TERMINATION OF CERTAIN FEDERAL HEALTH CARE PROGRAMS.

(a) MEDICARE AND MEDICAID.—Titles XVIII and XIX of the Social Security Act are repealed.

(b) REPEAL OF CHAMPUS PROVISIONS.—

(1) AMENDMENTS TO CHAPTER 55 OF TITLE 10.—Sections 1079 through 1083, 1086, and 1097 through 1100 of title 10, United States Code, are repealed.

(2) TABLE OF SECTIONS.—The table of sections at the beginning of chapter 55 of title 10, United States Code, is amended by striking out the items relating to the sections referred to in paragraph (1).

(3) CONFORMING AMENDMENTS.—Chapter 55 of title 10, United States Code, is amended as follows:

(A) DEFINITION.—Section 1072 is amended by striking out paragraph (4).

(B) REIMBURSEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS.—Section 1104(b) is amended—

(i) in the subsection heading, by striking out ''**FROM CHAMPUS FUNDS**''; and

(ii) by striking out ''from funds'' and all that follows and inserting in lieu thereof ''for medical care provided by the Department of Veterans Affairs pursuant to such agreement.''.

(c) REPEAL OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—Chapter 89 of title 5, United States Code, is repealed.

(d) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect on October 1, 1998.

SEC. 902. TRANSITION.

(a) IN GENERAL.—The Federal Health Board shall issue such regulations as are necessary to provide for a transition to this Act from the programs repealed under section 901.

(b) RELATION TO OTHER PROGRAMS.—The Federal Health Board shall recommend to the Congress appropriate legislative proposals for the amendment or repeal of any other Federal program inconsistent with, or duplicative of, the principles of this Act.

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