

115TH CONGRESS
2D SESSION

H. R. 7339

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 19, 2018

Ms. DELAURO (for herself and Ms. SCHAKOWSKY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, Education and the Workforce, Natural Resources, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare for America Act of 2018”.

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

Sec. 1. Short title; table of contents.

TITLE I—TRANSITIONING TO AND ESTABLISHING MEDICARE FOR AMERICA

Subtitle A—Transitional Public Health Option

- Sec. 101. Establishment.
- Sec. 102. Eligibility.
- Sec. 103. Benefits.
- Sec. 104. Premiums.
- Sec. 105. Providers and reimbursement rates.
- Sec. 106. Account; funding.

Subtitle B—Medicare for America

- Sec. 111. Establishment and administration of Medicare for America.
- Sec. 112. Modifications to and coordination with existing Federal health programs.

Subtitle C—Targeted Reforms

- Sec. 121. Limitation on removal of Medicare Advantage providers by MA organizations.
- Sec. 122. Network adequacy.
- Sec. 123. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
- Sec. 124. Employer health plan options.
- Sec. 125. Prohibition on step therapy and prior authorization under group health plans.
- Sec. 126. Medicare outpatient observation services.
- Sec. 127. Abortion coverage.

TITLE II—TAX PROVISIONS

- Sec. 201. Sunset of Public Law 115–97.
- Sec. 202. Surtax.
- Sec. 203. Basis of property acquired from a decedent.
- Sec. 204. Medicare payroll tax.
- Sec. 205. Net investment income tax.
- Sec. 206. Termination of health savings accounts.
- Sec. 207. Termination of flexible spending arrangements.
- Sec. 208. Increase in excise tax on small cigars and cigarettes and other tobacco products.
- Sec. 209. Excise tax on alcohol.
- Sec. 210. Tax on sugared drinks.

TITLE III—DRUG-RELATED PROVISIONS

- Sec. 301. Establishment of the prescription drug and medical device review board.
- Sec. 302. Membership; staff.
- Sec. 303. Reporting requirements.
- Sec. 304. Prohibition against excessive price.
- Sec. 305. Enforcement provisions.
- Sec. 306. Authority.
- Sec. 307. Regulations.
- Sec. 308. Report to Federal agencies.
- Sec. 309. Definitions.

Sec. 310. Moratorium on direct-to-consumer drug advertising.

Sec. 311. Reporting on justification for drug price increases.

1 **TITLE I—TRANSITIONING TO**
 2 **AND ESTABLISHING MEDI-**
 3 **CARE FOR AMERICA**
 4 **Subtitle A—Transitional Public**
 5 **Health Option**

6 **SEC. 101. ESTABLISHMENT.**

7 The Secretary of Health and Human Services (in this
 8 subtitle referred to as the “Secretary”) shall establish a
 9 public health plan option that is offered in the individual
 10 market through the Federal and State Exchanges under
 11 title I of the Patient Protection and Affordable Care Act
 12 to eligible individuals for plan years 2020 and 2021 in
 13 accordance with this subtitle.

14 **SEC. 102. ELIGIBILITY.**

15 (a) **IN GENERAL.**—Subject to subsection (b), an indi-
 16 vidual is eligible to enroll in such public health plan option
 17 if the individual is otherwise eligible to purchase individual
 18 health insurance coverage through an Exchange and the
 19 individual resides in a rating area in which the Secretary
 20 makes the public health plan option available.

21 (b) **PRIORITY.**—In determining in which rating areas
 22 the Secretary initially will make the public health plan op-
 23 tion available, the Secretary shall give priority to rating
 24 areas in which—

1 (1) not more than 1 health insurance issuer of-
2 fers plans on the applicable State or Federal Amer-
3 ican Health Benefit Exchange; or

4 (2) there is a shortage of health providers or
5 lack of competition that results in a high cost of
6 health care services, including health professional
7 shortage areas and rural areas.

8 **SEC. 103. BENEFITS.**

9 (a) IN GENERAL.—The public health plan option
10 shall be a qualified health plan within the meaning of sec-
11 tion 1301(a) of the Patient Protection and Affordable
12 Care Act (42 U.S.C. 18021(a)) that—

13 (1) meets all requirements applicable to quali-
14 fied health plans under subtitle D of title I of the
15 Patient Protection and Affordable Care Act (other
16 than the requirement under section
17 1301(a)(1)(C)(ii) of such Act (42 U.S.C.
18 18021(a)(1)(C)(ii))) and title XXVII of the Public
19 Health Service Act;

20 (2) provides coverage of the essential health
21 benefits described in section 1302(b) of the Patient
22 Protection and Affordable Care Act (42 U.S.C.
23 18022(b));

24 (3) provides silver and gold-level coverage de-
25 scribed in section 1302(d)(1)(C) of the Patient Pro-

1 tection and Affordable Care Act (42 U.S.C.
2 18022(d)(1)(C)); and

3 (4) provides coverage of abortions and all other
4 reproductive health services.

5 (b) PREEMPTION.—Notwithstanding section
6 1303(a)(1) of the Patient Protection and Affordable Care
7 Act (42 U.S.C. 18023(a)(1))—

8 (1) a State may not prohibit the public health
9 plan option from offering the coverage described in
10 subsection (a)(4); and

11 (2) no State law that would prohibit such a
12 plan from offering such coverage shall apply to such
13 plan.

14 **SEC. 104. PREMIUMS.**

15 The Secretary shall establish premium rates for the
16 public health plan option that—

17 (1) are adjusted based on the applicable rating
18 area;

19 (2) are at a level sufficient to fully finance—

20 (A) the costs of health benefits provided by
21 such plans; and

22 (B) administrative costs related to oper-
23 ating the plans; and

1 (3) comply with the requirements under section
2 2701 of the Public Health Service Act (42 U.S.C.
3 300gg).

4 **SEC. 105. PROVIDERS AND REIMBURSEMENT RATES.**

5 (a) IN GENERAL.—The Secretary shall establish a
6 rate schedule for reimbursing types of health care pro-
7 viders furnishing items and services under the public
8 health insurance plan option at rates based on rates ap-
9 plied for such items and services under title XVIII of the
10 Social Security Act, as of the date of the enactment of
11 this Act, that are necessary to maintain network ade-
12 quacy. The Secretary shall establish a rate schedule for
13 items and services not currently covered under title XVIII
14 of the Social Security Act at a level to ensure adequate
15 access to providers.

16 (b) PARTICIPATING PROVIDERS.—

17 (1) IN GENERAL.—A health care provider that
18 is a participating provider of services or supplier
19 under the Medicare program under title XVIII of
20 the Social Security Act or under the Medicaid pro-
21 gram under title XIX of such Act on the date of en-
22 actment of this title shall be a participating provider
23 for public health insurance plan option.

24 (2) ADDITIONAL PROVIDERS.—The Secretary
25 shall establish a process to allow health care pro-

1 viders not described in paragraph (1) to become par-
2 ticipating providers for the public health insurance
3 plan option.

4 (c) **PRESCRIPTION DRUGS.**—The Secretary shall
5 apply the provisions of section 1860D–11(i) of the Social
6 Security Act (42 U.S.C. 1395w–111(i)) to prescription
7 drugs under the public health plan option in the same
8 manner as such provisions apply with respect to applicable
9 covered part D drugs under such section.

10 **SEC. 106. ACCOUNT; FUNDING.**

11 (a) **ESTABLISHMENT.**—There is established in the
12 Treasury of the United States an account for the receipts
13 and disbursements attributable to the operation of the
14 public health plan option.

15 (b) **APPROPRIATION.**—There is appropriated to the
16 account established under subsection (a), out of any funds
17 in the Treasury not otherwise obligated, such sums as may
18 be necessary to be used by the Secretary for purposes of
19 carrying out this part.

20 (c) **PROHIBITION OF STATE IMPOSITION OF**
21 **TAXES.**—Section 1854(g) of the Social Security Act (42
22 U.S.C. 1395w–24(g)) shall apply to receipts and disburse-
23 ments described in subsection (a) in the same manner as
24 such section applies to payments or premiums described
25 in such section.

1 (d) CLARIFICATION.—Any provision of law restricting
2 the use of Federal funds with respect to any reproductive
3 health service shall not apply to funds appropriated under
4 subsection (b) or with respect to the account under sub-
5 section (a).

6 **Subtitle B—Medicare for America**

7 **SEC. 111. ESTABLISHMENT AND ADMINISTRATION OF MEDI-** 8 **CARE FOR AMERICA.**

9 The Social Security Act is amended by adding at the
10 end the following new title:

11 **“TITLE XXII—MEDICARE FOR** 12 **AMERICA**

13 **“PART A—COMPREHENSIVE HEALTH COVERAGE**

14 **“SEC. 2201. ESTABLISHMENT.**

15 “The Secretary shall establish a public health insur-
16 ance program, to be known as ‘Medicare for America’,
17 which shall for calendar year 2022 and each subsequent
18 calendar year provide comprehensive health benefits in ac-
19 cordance with this part to individuals enrolled for coverage
20 under this title.

21 **“SEC. 2202. ELIGIBILITY; AUTOMATIC ENROLLMENT.**

22 “(a) ELIGIBLE INDIVIDUALS.—For purposes of this
23 title, every individual who is a resident of the United
24 States is entitled to benefits for health care services under
25 this title. The Secretary shall promulgate a rule that pro-

1 vides criteria for determining residency for eligibility pur-
2 poses under this title.

3 “(b) ENROLLMENTS.—Subject to subsection (c):

4 “(1) IN GENERAL.—Beginning in 2022, the
5 Secretary shall provide a mechanism for the enroll-
6 ment of individuals entitled to benefits under this
7 title and, in conjunction with such enrollment, the
8 issuance of a Medicare card which may be used for
9 purposes of identification and processing of claims
10 for benefits under this title. As a condition of par-
11 ticipation in the program, participating providers
12 shall facilitate enrollment as specified by the Sec-
13 retary.

14 “(2) AUTOMATIC ENROLLMENTS.—The mecha-
15 nism provided under paragraph (1) shall, subject to
16 paragraph (4), provide, for plan years beginning
17 with plan year 2022, for the following automatic en-
18 rollments under Medicare for America:

19 “(A) ENROLLMENT AT BIRTH.—For plan
20 years (beginning with plan year 2022), a proc-
21 ess, established by the Secretary in consultation
22 with the Commissioner of Social Security, for
23 the automatic enrollment of eligible individuals
24 born during such plan year.

1 “(B) CURRENT MEDICARE BENE-
2 FICIARIES.—

3 “(i) CURRENT MEDICARE BENE-
4 FICIARIES.—For plan years (beginning
5 with plan year 2022), a process established
6 by the Secretary for the automatic enroll-
7 ment of all individuals who are enrolled for
8 benefits under part A or B of title XVIII
9 (other than individuals who are enrolled
10 for such benefits and receiving benefits
11 under title XIX).

12 “(ii) CONTINUING POPULATION.—For
13 plan years (beginning with plan year
14 2022), a process established by the Sec-
15 retary for the automatic enrollment of eli-
16 gible individuals who attain the age of 65
17 during such plan year.

18 “(iii) DUALS.—For plan years (begin-
19 ning with plan year 2024), a process estab-
20 lished by the Secretary for the automatic
21 enrollment of eligible individuals who are
22 enrolled for benefits under part A or B of
23 title XVIII and receiving benefits under
24 title XIX.

1 “(C) OTHER INDIVIDUALS WITHOUT
2 QUALIFIED HEALTH COVERAGE.—For plan
3 years (beginning with plan year 2022), a proc-
4 ess established by the Secretary for the auto-
5 matic enrollment of eligible individuals who are
6 not enrolled in other qualified health coverage
7 (as defined in paragraph (4)(B)) for such plan
8 year.

9 “(3) OTHER ENROLLMENTS.—The mechanism
10 provided under paragraph (1) shall provide for the
11 following:

12 “(A) IN GENERAL.—Enrollment periods
13 and processes for each plan year (beginning
14 with plan year 2022) for enrollment under
15 Medicare for America of any eligible individual
16 not otherwise described in paragraph (2).

17 “(B) SMALL EMPLOYERS.—For plan years
18 (beginning with plan year 2022), a process and
19 methodology under which a small employer, as
20 defined in section 124(d)(3) of the Medicare for
21 America Act, may provide for the enrollment of
22 the employees of such employer under Medicare
23 for America. For purposes of the previous sen-
24 tence, the term ‘small employer’ means any em-
25 ployer for any calendar year if the annual pay-

1 roll of such employer for the preceding calendar
2 year does not exceed \$2,000,000 or has fewer
3 than 100 employees.

4 “(C) LARGE EMPLOYERS.—For plan years
5 (beginning with plan year 2026), the Secretary
6 shall provide for a process and methodology
7 under which a large employer may provide for
8 the enrollment of the employees of such em-
9 ployer under Medicare for America. For pur-
10 poses of the preceding sentence, the term ‘large
11 employer’ means an employer with at least 100
12 employees.

13 “(4) OPT OUT FOR INDIVIDUALS ENROLLED
14 UNDER QUALIFIED HEALTH COVERAGE.—

15 “(A) IN GENERAL.—The mechanism pro-
16 vided under paragraph (1) shall provide, with
17 respect to a plan year, for a process that en-
18 ables individuals who are enrolled in qualified
19 health coverage for such plan year to opt out of
20 coverage under Medicare for America for such
21 year.

22 “(B) QUALIFIED HEALTH COVERAGE DE-
23 FINED.—For purposes of this section, the term
24 ‘qualified health coverage’ means coverage
25 under any of the following:

1 “(i) For plan years 2022 and 2023:

2 “(I) Qualified employer coverage,
3 as defined in section 124 of the Medi-
4 care for America Act.

5 “(II) Medical coverage under
6 chapter 55 of title 10, United States
7 Code, including coverage under the
8 TRICARE program.

9 “(III) A health care program
10 under chapter 17 or 18 of title 38,
11 United States Code, as determined by
12 the Secretary of Veterans Affairs, in
13 coordination with the Secretary of
14 Health and Human Services and the
15 Secretary.

16 “(IV) The health benefit program
17 under chapter 89 of title 5, United
18 States Code.

19 “(V) Medical benefits and serv-
20 ices provided by or through the Indian
21 Health Service.

22 “(VI) The Medicaid program
23 under title XIX of the Social Security
24 Act.

1 “(VII) The CHIP program under
2 title XXI of the Social Security Act.

3 “(ii) For plan years 2024 and 2025:

4 “(I) Coverage described in sub-
5 clause (I), (II), (III), (IV), or (V) of
6 clause (i).

7 “(II) Coverage described in sub-
8 clause (VI) of clause (i), but only with
9 respect to coverage that is not for in-
10 dividuals described in subclause (VIII)
11 of section 1902(a)(10)(A)(i) or who
12 are also enrolled for benefits under
13 title XVIII.

14 “(iii) For each subsequent plan year,
15 coverage described in subclause (I), (II),
16 (III), (IV), or (V) of clause (i).

17 “(c) WAIVER.—The Secretary shall establish a proc-
18 ess under which the Secretary may grant waivers to States
19 for additional time before populations described in a pre-
20 vious subsection of this section of such State are automati-
21 cally enrolled under Medicare for America.

22 **“SEC. 2203. BENEFITS.**

23 “(a) IN GENERAL.—Medicare for America shall, in
24 accordance with this section, provide coverage for all the
25 benefits, as determined to be medically necessary and rea-

1 sonable, as covered and defined under parts A and B of
2 title XVIII and title XIX as of the date of the enactment
3 of this title, including the following:

4 “(1) Ambulatory patient services.

5 “(2) Emergency care and urgent care services.

6 “(3) Hospitalization.

7 “(4) Maternity and newborn care.

8 “(5) Behavioral health, mental health and sub-
9 stance use disorder services, including the following:

10 “(A) Home-based services.

11 “(B) Acute services for mental health cri-
12 ses, including crisis stabilization services such
13 as mobile crisis services, including emergency
14 mobile psychiatric services.

15 “(C) 23-hour observation.

16 “(D) Outpatient services provided by hos-
17 pitals, freestanding clinics, and behavioral
18 health providers in independent practice.

19 “(E) Smoking and tobacco cessation.

20 “(F) Case management.

21 “(G) Peer support services.

22 “(H) Counseling.

23 “(I) Other intensive outpatient community-
24 based services, such as Assertive Community

1 Treatment and supported employment, provided
2 through the LTSS benefit.

3 “(J) Other intensive community-based
4 services provided through the Early and Peri-
5 odic Screening, Diagnostic, and Treatment
6 (EPSDT) benefit (as defined in subpart B of
7 part 441 of title 42 of the Code of Federal Reg-
8 ulations).

9 “(K) Medication assisted treatment and
10 maintenance services.

11 “(L) Inpatient detoxification.

12 “(M) Ambulatory detoxification.

13 “(N) Psychological testing.

14 “(O) Home health agency services.

15 “(6) Prescription drugs.

16 “(7) Rehabilitative and habilitative services and
17 devices, including the following:

18 “(A) Physical therapy.

19 “(B) Speech therapy.

20 “(C) Occupational therapy.

21 “(8) Laboratory services.

22 “(9) Preventive and wellness services and
23 chronic disease management.

24 “(10) Pediatric services, including oral and vi-
25 sion care and all services that would otherwise be

1 covered under Early and Periodic Screening, Diag-
2 nostic, and Treatment under the Medicaid program
3 under title XIX.

4 “(11) Dental.

5 “(12) Hearing health services including aids
6 and exams.

7 “(13) Home and community-based long-term
8 supports and services.

9 “(14) Chiropractic services.

10 “(15) Durable medical equipment, including the
11 following:

12 “(A) Wheelchairs and accessories.

13 “(B) Walking aides such as walkers, canes,
14 and crutches.

15 “(C) Bathroom equipment such as com-
16 modes and safety equipment.

17 “(D) Inhalation therapy equipment such as
18 nebulizers.

19 “(E) Hospital beds and accessories.

20 “(F) Other devices such as continuous
21 positive airway pressure (CPAP) machines,
22 apnea monitors, and ventilators.

23 “(G) Insulin pumps and glucometers.

24 “(H) Breast pumps.

1 “(I) Lymphedema compression treatment
2 items.

3 “(J) Wigs.

4 “(K) Augmentative and alternative com-
5 munication devices, including dual-use devices.

6 “(16) Family planning, including the following:

7 “(A) Reproductive health exams.

8 “(B) Patient counseling and education re-
9 lated to family planning.

10 “(C) Abortion.

11 “(D) Screening, testing, treatment, and
12 pre- and post-test counseling for sexually trans-
13 mitted diseases and HIV.

14 “(E) Contraceptives including pill, patch,
15 medication, condom, implant, or other devices
16 used to prevent pregnancy.

17 “(F) Sterilization for beneficiaries over the
18 age of 21.

19 “(G) Infertility treatment.

20 “(17) Gender-confirming medical procedures
21 and treatment.

22 “(18) Dietary and nutrition counseling.

23 “(19) Medically necessary food and vitamins for
24 digestive and inherited metabolic disorders.

25 “(20) Nursing facilities.

1 “(21) Orthotic and prosthetics devices.

2 “(22) Oxygen.

3 “(23) Acupuncture.

4 “(24) Telehealth.

5 “(25) Services otherwise included under the
6 maternal, infant, and early childhood home visiting
7 program under section 511 of the Social Security
8 Act, as of the date of the enactment of this title.

9 “(26) Any additional benefit or service not in-
10 cluded in this section that is covered by any State
11 plan (or waiver of such State plan) under title XIX
12 on the date of the enactment of this title.

13 “(b) UPDATES.—Benefits covered under Medicare for
14 America shall be updated in accordance with the National
15 Coverage Determination process that had, as of the date
16 before the date of the enactment of this title, applied with
17 respect to benefits covered under title XVIII.

18 “(c) PROHIBITION AGAINST DUPLICATING COV-
19 ERAGE.—

20 “(1) IN GENERAL.—It is unlawful for a private
21 health insurer (other than an insurer with respect to
22 a Medicare Advantage for America plan under part
23 C of this title or qualified employer-based coverage)
24 to sell health insurance coverage that duplicates the

1 benefits provided under Medicare for America under
2 this part.

3 “(2) CONSTRUCTION.—Nothing in paragraph
4 (1) shall be construed as prohibiting the sale of
5 health insurance coverage for any additional benefits
6 not covered by this part, insofar as the coverage sat-
7 isfies the conditions of paragraph (3).

8 “(3) APPLICATION OF PROTECTIONS.—For pur-
9 poses of paragraph (2), health insurance coverage
10 for any additional benefits must satisfy the following
11 conditions:

12 “(A) The provisions of section 2718 of the
13 Public Health Service Act, relating to a medical
14 loss ratio.

15 “(B) The provisions of section 2702 of the
16 Public Health Service Act, relating to guaran-
17 teed issue.

18 “(C) The provisions of section 2701 of the
19 Public Health Service Act, relating to commu-
20 nity rating.

21 “(D) The provisions of section 2704 of the
22 Public Health Service Act, relating to the ban
23 on pre-existing conditions exclusions.

24 “(d) STATES MAY PROVIDE ADDITIONAL BENE-
25 FITS.—Individual States may provide additional benefits

1 for the residents of such States at the expense of the
2 State.

3 “(e) PROHIBITION AGAINST STEP THERAPY AND
4 PRIOR AUTHORIZATION.—Items and services covered
5 under Medicare for America shall be covered without any
6 need for any prior authorization determination and with-
7 out any limitation applied through the use of step therapy
8 protocols.

9 **“SEC. 2204. PREMIUMS.**

10 “(a) IN GENERAL.—(1) Subject to paragraph (2),
11 each individual enrolled for benefits under this title for
12 a year shall pay monthly community-rated premiums for
13 such year in an amount determined by the Secretary in
14 accordance with subsection (b).

15 “(2) GRANDFATHERED MEDICARE BENE-
16 FICIARIES.—In the case of an individual enrolled under
17 part B of title XVIII as of the date of the enactment of
18 this part, the premium applied under this section for such
19 individual for benefits under this title shall be the lesser
20 of—

21 “(A) the premium otherwise applicable to such
22 individual under such title XVIII if this title had not
23 been enacted; or

1 “(B) the premium that would be applied to
2 such individual under this title without the applica-
3 tion of this paragraph.

4 “(b) PREMIUM CONTRIBUTION BASED ON INCOME.—

5 The amount of a monthly premium, with respect to a plan
6 year (beginning with 2022), under this section shall be
7 established by the Secretary in accordance with the fol-
8 lowing:

9 “(1) Such premium shall be determined such
10 that the collective premiums for the plan year are
11 with respect to the costs of health benefits provided
12 under this title for such year and related administra-
13 tive costs.

14 “(2) Premiums shall vary by family composition
15 only.

16 “(3) Federal subsidies shall be provided to en-
17 sure that the premium shall be—

18 “(A) zero in the case of an individual
19 whose annual household income is below 200
20 percent of the poverty line;

21 “(B) determined by a linear sliding scale,
22 in the case of an individual whose household in-
23 come is at least 200 percent of the poverty line,
24 but not more than 600 percent of the poverty
25 line, with the premiums ranging between the

1 amount determined for individuals described in
2 clause (i) and for individuals described in clause
3 (iii); and

4 “(C) no individual or household will pay
5 more than 9.69 percent of monthly income to-
6 ward such monthly premium.

7 “(4) For an individual whose employer will be
8 making a firm-wide contribution under this title in
9 lieu of offering employer sponsored insurance (as
10 specified in section 124(b)(1)(B) of the Medicare for
11 America Act), such individual shall pay a premium
12 in accordance with this subsection.

13 “(5) For an individual who has opted out of
14 their employer sponsored insurance in order to enroll
15 in Medicare for America as specified in section
16 124(c) of such Act, the individual shall pay the pre-
17 mium described in this subsection.

18 “(c) DEPOSITS.—Amounts paid under this section for
19 coverage under this title shall be deposited in the Treasury
20 to the credit of the Trust Fund established under section
21 2206.

22 “(d) APPEALS FOR CERTAIN MEDICARE GRAND-
23 FATHERED POPULATION.—In calculating premiums for
24 purposes of subsection (a)(2):

1 “(1) Any individual that was subject to a late
2 enrollment penalty under part B of title XVIII shall
3 have the right to appeal the assessment of the pen-
4 alty for good faith enrollment mistakes.

5 “(2) In any case in which the Secretary finds
6 that an individual’s enrollment or nonenrollment in
7 the insurance program established by this part or
8 part A of title XVIII pursuant to section 1818 is un-
9 intentional, inadvertent, or erroneous, whether the
10 result of the error, misrepresentation, or inaction of
11 an officer, employee, or agent of the Federal Govern-
12 ment or its instrumentalities, an employer, a rep-
13 resentative of a group health plan, a State, or for
14 any other good faith reason on the part of such indi-
15 vidual, the Secretary shall take such action (includ-
16 ing the designation for such individual of a special
17 initial or subsequent enrollment period, including
18 retroactive enrollment, with a coverage period deter-
19 mined on the basis thereof and with appropriate ad-
20 justments of premiums) as may be necessary to cor-
21 rect or eliminate the effects of such error, misrepre-
22 sentation, or inaction. The failure of an individual to
23 enroll in the insurance program established by this
24 part or part A pursuant to section 1818 due to en-
25 rollment under a group health plan; coverage pursu-

1 ant to title XXII of the Public Health Service Act,
2 section 4980B of the Internal Revenue Code of
3 1986, title VI of the Employee Retirement Income
4 Security Act of 1974, or title XIX; or enrollment
5 under a qualified health plan offered through an Ex-
6 change established under title I of the Patient Pro-
7 tection and Affordable Care Act shall under this
8 subsection absent exceptional circumstances, as de-
9 termined by the Secretary.

10 “(3) The Secretary, in consultation with the
11 Commissioner of Social Security, shall develop and
12 publish a formal application for requesting an action
13 of the Secretary under paragraph (1) to correct or
14 eliminate the effects of an error, misrepresentation,
15 or inaction described in such paragraph and deter-
16 mine and publish specific timelines for timely resolu-
17 tion of such a request.

18 “(4) The Secretary shall also require that all
19 such determinations with respect to such requests
20 shall be reached within 15 business days of the sub-
21 mission of such application. All determinations shall
22 be in writing through a standard decision notice
23 which shall include an explanation of the reasons for
24 the determination.

1 “(5) The Commissioner of Social Security shall
2 enter into contracts with independent review organi-
3 zations in accordance with this subsection for the
4 purpose of reviewing and determining individual ap-
5 peals of determinations under paragraph (3) with re-
6 spect to an application submitted pursuant to para-
7 graph (2) relating to enrollment under part A or
8 part B.

9 “(6) An individual who receives an adverse de-
10 termination under paragraph (3) with respect to an
11 application submitted pursuant to paragraph (2)
12 may appeal to an independent review organization
13 designated by the Commission. Any such appeal
14 must be sent to the independent review organization
15 within 90 days of the date the individual received
16 the determination to be eligible for review. The inde-
17 pendent review organization shall review and reach
18 a determination of the review in writing within 45
19 days of the receipt of any such appeal.

20 “(7) The Secretary of the Treasury may not
21 enter into a contract under paragraph (5) with an
22 independent review organization—

23 “(A) unless the organization has staff that
24 has the appropriate knowledge of, and experi-
25 ence with, the eligibility and coordination of

1 benefits rules and regulations under this title;
2 and

3 “(B) to the extent the organization is a fis-
4 cal intermediary under section 1816, a carrier
5 under section 1842, or a Medicare administra-
6 tive contractor under section 1874A.

7 “(8) The Secretary of Health and Human Serv-
8 ices shall provide for access by independent review
9 organizations conducting appeal determinations
10 under this subsection, to the database of the Coordi-
11 nation of Benefits Contractor of the Centers for
12 Medicare & Medicaid Services as necessary in order
13 to conduct the duties of such organizations to deter-
14 mine appeals pursuant to this subsection.

15 **“SEC. 2205. PAYMENT OF BENEFITS; COST-SHARING; OUT-
16 OF-POCKET LIMITS.**

17 “(a) PAYMENT OF BENEFITS; COST-SHARING.—
18 There shall be paid, in the case of each individual who
19 is enrolled under Medicare for America and incurs ex-
20 penses for items and services with respect to which bene-
21 fits are payable under this part, after application of sub-
22 section (b) and subject to subsection (c), 80 percent of
23 the reimbursement rates established pursuant to section
24 2206 for such items and services, except that with respect
25 to USPTF recommended preventive and chronic disease

1 services, and generic drugs, the amounts paid under this
2 section shall be equal to 100 percent of the reimbursement
3 rates established pursuant to section 2206 for such items
4 and services.

5 “(b) DEDUCTIBLE.—

6 “(1) IN GENERAL.—There shall be a deductible
7 applied under this part for each plan year that shall
8 be determined on a linear sliding scale for household
9 income that is at least 200 percent of the poverty
10 line, but not more than 600 percent of the poverty
11 line, and shall not exceed, subject to paragraphs (2)
12 and (3)—

13 “(A) \$350 for an individual; or

14 “(B) \$500 total for all members of a
15 household.

16 “(2) INDEXING.—In the case of plan years be-
17 ginning after 2021, the dollar amounts described in
18 paragraph (1) shall be increased by the percentage
19 increase over the previous year in the medical care
20 expenditure category of the Consumer Price Index
21 for All Urban Consumers (United States city aver-
22 age), published by the Bureau of Labor Statistics.

23 “(3) EXCEPTION.—There shall be no deductible
24 applied under this part for months in a plan year for

1 individuals and households with annual income below
2 200 percent of the federal poverty line.

3 “(c) MAXIMUM OUT-OF-POCKET LIMIT.—

4 “(1) IN GENERAL.—The coverage under Medi-
5 care shall provide benefits, after the eligible indi-
6 vidual has incurred out-of-pocket expenses for items
7 and services with respect to which benefits are pay-
8 able under this part in a year equal to the annual
9 out-of-pocket threshold specified in paragraph (2),
10 with cost-sharing that is equal to \$0.

11 “(2) ANNUAL OUT-OF-POCKET THRESHOLD.—

12 “(A) IN GENERAL.—For purposes of para-
13 graph (1), subject to subparagraphs (B) and
14 (C), the annual out-of-pocket threshold speci-
15 fied in this paragraph is a threshold that shall
16 be determined on a linear sliding scale for
17 household income that is at least 200 percent of
18 the poverty line, but not more than 600 percent
19 of the poverty line, and that shall not exceed—

20 “(i) with respect to an individual,
21 \$3,500; or

22 “(ii) with respect to a household,
23 \$5,000.

24 “(B) INDEXING.—In the case of plan years
25 beginning after 2021, the threshold described in

1 subparagraph (A) (as in effect for the preceding
2 plan year after application of this subpara-
3 graph) shall be increased by the percentage in-
4 crease over the previous year in the medical
5 care expenditure category of the Consumer
6 Price Index for All Urban Consumers (United
7 States city average), published by the Bureau
8 of Labor Statistics.

9 “(C) EXCEPTION.—For purposes of para-
10 graph (1), the annual out-of-pocket threshold
11 for individuals and households with annual in-
12 come below 200 percent of the federal poverty
13 line is \$0.

14 “(d) NO BALANCE BILLING.—No provider may im-
15 pose a charge to an enrolled individual for covered services
16 for which benefits are provided under this part in an
17 amount higher than the reimbursement rate for such serv-
18 ices under section 2206 and may not impose a charge to
19 such individual for such service other than with respect
20 to the deductible or other cost-sharing described in this
21 section.

22 **“SEC. 2206. PROVIDERS NETWORK AND REIMBURSEMENT**
23 **RATES.**

24 “(a) IN GENERAL.—The Secretary shall establish a
25 rate schedule for reimbursing types of health care pro-

1 viders furnishing items and services under Medicare for
2 America at rates that are consistent with subsection (b)
3 and are necessary to maintain network adequacy.

4 “(b) RATES.—

5 “(1) IN GENERAL.—Except as provided in para-
6 graphs (2) and (3), the Secretary shall provide for
7 rates to be provided to health care providers and
8 suppliers furnishing items and services under Medi-
9 care for America based on rates that would be ap-
10 plied (including as computed, updated, and adjusted)
11 under title XVIII for such type of health care pro-
12 viders and suppliers and item and service if such
13 title remained in effect and, in the case of a type of
14 provider and supplier or item or service covered
15 under Medicare for America but not otherwise cov-
16 ered under title XVIII, shall provide for rates that
17 ensure adequate access to care.

18 “(2) EXCEPTIONS.—For purposes of this sec-
19 tion, in applying paragraph (1) the Secretary shall
20 ensure that rates to hospitals for inpatient services
21 or outpatient services furnished under Medicare for
22 America are at least 110 percent of such rates on
23 average or in the aggregate for furnishing such inpa-
24 tient or outpatient services otherwise applied under
25 title XVIII, except that for hospitals serving under-

1 served areas as specified by the Secretary, such
2 rates are increased as necessary to ensure adequate
3 access to care.

4 “(3) APPLICATION.—In applying rates under
5 title XVIII for purposes of this part, the following
6 shall apply:

7 “(A) The Secretary shall provide for site-
8 neutral payments for items and services fur-
9 nished in an outpatient hospital and physician
10 office, the rate of payment for such service shall
11 be the same.

12 “(B) The Secretary shall increase the aver-
13 age relative value of primary care and other
14 mental and behavioral health and cognitive
15 services by not less than 20 percent in order to
16 ensure adequate access to inpatient and out-
17 patient care.

18 “(C) As a condition of participation in the
19 program, participating providers shall accept
20 Medicare for America rates paid by employer-
21 sponsored insurance plans and Medicare Advan-
22 tage plans.

23 “(c) PARTICIPATING PROVIDERS.—

24 “(1) IN GENERAL.—A health care provider that
25 is a participating provider of services or supplier

1 under the Medicare program under title XVIII on
2 the date of enactment of this title shall remain a
3 participating provider for Medicare for America.

4 “(2) ADDITIONAL PROVIDERS.—The Secretary
5 shall establish a process to allow health care pro-
6 viders not described in paragraph (1) to become par-
7 ticipating providers for Medicare for America.

8 “(d) PRESCRIPTION DRUGS.—

9 “(1) IN GENERAL.—Any payment rate under
10 this part for a prescription drug shall be at a rate
11 negotiated by the Secretary based on value assess-
12 ments by one or more independent nonprofit organi-
13 zations certified by the National Academy of Medi-
14 cine and MedPAC. If the Secretary is unable to
15 reach a negotiated agreement on such a reimburse-
16 ment rate, the Secretary shall apply prices paid by
17 the Department of Veterans Affairs for such drugs
18 or the average price of such drugs in nations which
19 are members of the Organization for Economic Co-
20 operation and Development, whichever is lower.

21 “(2) FAILURE TO NEGOTIATE.—If a drug man-
22 ufacturer refuses to negotiate with the Secretary,
23 then Medicare for America will not cover any of the
24 manufacturer’s products. There shall be an excep-
25 tions process for drugs that are otherwise unavail-

1 able for people with chronic conditions. Individuals
2 shall continue to have access to drugs during the ap-
3 peals process. The Secretary shall modify such rates
4 in order to accommodate payments for drugs that
5 are not otherwise covered under the original Medi-
6 care fee-for-service program under title XVIII.

7 “(3) VALUE OR COST-EFFECTIVENESS ASSESS-
8 MENTS.—The use of Quality-Adjusted Life Years,
9 Disability-Adjusted Life Years, or other similar
10 mechanisms is prohibited for use in value or cost-ef-
11 fectiveness assessments for purposes of this sub-
12 section.

13 **“SEC. 2207. TRUST FUND; FUNDING.**

14 “(a) TRUST FUND.—There shall be established a uni-
15 fied Medicare Trust Fund in which funds provided under
16 this title are deposited and from which expenditures under
17 this title are made. The Trust Fund shall consist of such
18 gifts and bequests as may be made and such amounts as
19 may be deposited in, or appropriated to, such Trust Fund
20 as provided in this Act.

21 “(b) FUNDING.—

22 “(1) TAXES.—There are hereby appropriated to
23 the Trust Fund for each fiscal year beginning with
24 fiscal year 2022, out of any moneys in the Treasury
25 not otherwise appropriated, amounts equivalent to

1 100 percent of the net increase in revenues to the
2 Treasury which is attributable to the amendments
3 made by title II of the Medicare for America Act
4 and premiums collected under this title. The
5 amounts appropriated by the preceding sentence
6 shall be transferred from time to time (but not less
7 frequently than monthly) from the general fund in
8 the Treasury to the Trust Fund, such amounts to be
9 determined on the basis of estimates by the Sec-
10 retary of the Treasury of the taxes paid to or depos-
11 ited into the Treasury; and proper adjustments shall
12 be made in amounts subsequently transferred to the
13 extent prior estimates were in excess of or were less
14 than the amounts that should have been so trans-
15 ferred.

16 “(2) CURRENT PROGRAM RECEIPTS.—Notwith-
17 standing any other provision of law, there are hereby
18 appropriated to the Trust Fund for each fiscal year,
19 beginning with fiscal year 2022, the amounts that
20 would otherwise have been appropriated to carry out
21 the following programs:

22 “(A) The Medicare program under title
23 XVIII.

24 “(B) The Medicaid program under title
25 XIX, beginning as of 2026.

1 “(3) ADDITIONAL APPROPRIATIONS.—Addi-
2 tional sums are authorized to be appropriated annu-
3 ally as needed to maintain maximum quality, effi-
4 ciency, and access under this part.

5 “(4) MEDICAID MAINTENANCE OF EFFORT PAY-
6 MENTS.—There shall be transferred to the Trust
7 Fund the maintenance of effort payments made
8 under section 2209.

9 “(c) RESTRICTIONS SHALL NOT APPLY.—Any other
10 provision of law in effect on the date of enactment of this
11 title restricting the use of Federal funds for any reproduc-
12 tive health service, including abortion, shall not apply to
13 monies in the Trust Fund.

14 “(d) INCORPORATION OF PROVISIONS.—The provi-
15 sions of subsections (b) through (i) of section 1817 shall
16 apply to the Trust Fund under this section in the same
17 manner as such provisions applied to the Federal Hospital
18 Insurance Trust Fund under such section 1817, except
19 that, for purposes of applying such subsections to this sec-
20 tion, the ‘Board of Trustees of the Trust Fund’ shall mean
21 the ‘Secretary’.

22 “(e) TRANSFER OF FUNDS.—Any amounts remain-
23 ing in the Federal Hospital Insurance Trust Fund under
24 section 1817 or the Federal Supplementary Medical Insur-
25 ance Trust Fund under section 1841 after the payment

1 of claims for items and services furnished under title
2 XVIII have been completed, shall be transferred into the
3 Trust Fund under this section.

4 **“SEC. 2208. ADMINISTRATIVE PROVISIONS.**

5 “(a) CENTER FOR MEDICARE.—Beginning 2022, the
6 Centers for Medicare & Medicaid Services shall be re-
7 named the Center for Medicare and all references in law
8 and regulation to such Centers shall be deemed a reference
9 to such Center. All powers, duties, and responsibilities of
10 the Centers for Medicare & Medicaid Services shall be
11 transferred to the Center for Medicare.

12 “(b) AUTHORITY.—The Secretary shall have the au-
13 thority to issue interim final rules with respect to any pro-
14 vision in this part.

15 “(c) ADMINISTRATIVE LAW JUDGES.—

16 “(1) IN GENERAL.—The Center for Medicare is
17 not authorized to appoint administrative law judges,
18 in accordance with pages 11420 through 499 of title
19 70 of the Federal Register (March 8, 2005).

20 “(2) TIMING.—Under this title, administrative
21 law judges must issue a decision within 90 days of
22 receipt of a hearing request, as specified in sub-
23 sections (a) and (c) of section 405.1016 of title 2,
24 Code of Federal Regulations.

25 “(d) COVERAGE DETERMINATIONS APPEALS.—

1 “(1) Individuals may appeal a coverage deter-
2 mination under this title before the individual ob-
3 tains the service or item that is the subject of the
4 appeal.

5 “(2) The Secretary shall eliminate the redeter-
6 mination by a Medicare administrative contractor
7 from the appeals process under the Medicare pro-
8 gram for beneficiaries.

9 “(e) PRIVATE RIGHT OF ACTION.—

10 “(1) IN GENERAL.—An applicant or recipient
11 aggrieved by any law, regulation, policy or practice
12 in violation of a provision of this title may bring a
13 civil action seeking any remedy available in law or
14 equity to remedy that violation. In addition to any
15 cause of action that may be available in a State
16 court, the district courts of the United States shall
17 have concurrent jurisdiction in the matters under
18 the provisions of this title.

19 “(2) REASONABLE ATTORNEY FEES.—In any
20 action or proceeding to enforce this title, the court
21 may award reasonable attorneys’ fees and litigation
22 costs (including expert fees) reasonably incurred
23 against the defendant or defendants.

24 “(3) APPEAL.—Any civil action brought under
25 this section shall be subject to appeal as provided in

1 sections 1291 and 1292 of title 28 of the United
2 States Code.

3 **“SEC. 2209. MAINTENANCE OF EFFORT REQUIREMENT.**

4 “(a) IN GENERAL.—A State is not eligible for pay-
5 ment under any program specified in subsection (d) for
6 a calendar quarter in a plan year beginning after 2026
7 unless the State makes to the Secretary for transfer to
8 the unified Medicare Trust Fund under section 2207 the
9 maintenance of effort payment applicable to such State
10 and plan year under subsection (b). The Secretary shall
11 extend such a waiver (including the availability of Federal
12 financial participation under such waiver) for such period
13 as may be required for a State to meet the requirement
14 of the previous sentence.

15 “(b) MAINTENANCE OF EFFORT PAYMENTS.—For
16 purposes of this section, a maintenance of effort payment
17 with respect to a State and plan year is—

18 “(1) for plan year 2027 and a State, a payment
19 in an amount equal to the total amount of expendi-
20 tures of the State for medical assistance under title
21 XIX and child health assistance under title XXI in-
22 cluding administrative costs for the plan year before
23 the date of the enactment of this title;

24 “(2) for plan year 2028 and each subsequent
25 plan year before plan year 2032—

1 “(A) in the case of a State that is a
2 PPACA expansion State, the payment amount
3 applied under this subsection for the previous
4 plan year, increased by growth in GDP per cap-
5 ita plus 0.4 percent; and

6 “(B) in the case of a State that is not a
7 PPACA expansion State, the payment amount
8 applied under this subsection for the previous
9 plan year, increased by growth in GDP per cap-
10 ita plus 0.7 percent; and

11 “(3) beginning in 2032, for each subsequent
12 plan year, with respect to any State, the payment
13 amount applied under this subsection for the pre-
14 vious year, increased by growth in GDP per capita
15 plus 0.7 percent.

16 “(c) PROGRAMS SPECIFIED.—For purposes of this
17 section, the programs specified in this subsection are each
18 of the following:

19 “(1) Block grants for community mental health
20 services under subpart I of part B of title XIX of
21 the Public Health Service Act.

22 “(2) Block grants and programs for social serv-
23 ices and elder justice under title XX of the Social
24 Security Act.

1 “(3) Maternal and child health services block
2 grants under title V of the Social Security Act.

3 “(4) Block grants for prevention and treatment
4 of substance abuse under subpart II of part B of
5 title XIX of the Public Health Service Act.

6 “(5) State Targeted Response to Opioid Crisis
7 Grant Community Services Block Grant.

8 “(6) Grants under section 330 of the Public
9 Health Service Act.

10 “(7) Ryan White HIV/AIDS Program grants
11 under title XXVI of the Public Health Service Act.

12 **“SEC. 2210. APPLICATION OF TITLE XVIII PROVISIONS.**

13 “Except as specified otherwise in this title, in imple-
14 menting Medicare for America, the Secretary shall to the
15 greatest extent practicable apply the following provisions
16 of title XVIII to the program under this title, benefits cov-
17 ered under this title, individuals entitled to benefits under
18 this title, and providers of services and suppliers partici-
19 pating under the program under this title in a similar
20 manner as such provisions applied to the program under
21 title XVIII, benefits covered under such title, individuals
22 entitled to benefits or enrolled under such title, and pro-
23 viders of services and suppliers participating under the
24 program under such title:

25 “(1) Section 1801.

- 1 “(2) Section 1805.
- 2 “(3) Section 1806.
- 3 “(4) Section 1807.
- 4 “(5) Section 1809.
- 5 “(6) Section 1812.
- 6 “(7) Section 1814.
- 7 “(8) Section 1815.
- 8 “(9) Section 1816.
- 9 “(10) Section 1818.
- 10 “(11) Section 1818A.
- 11 “(12) Section 1819.
- 12 “(13) Section 1820.
- 13 “(14) Section 1832.
- 14 “(15) Section 1834.
- 15 “(16) Section 1834A.
- 16 “(17) Section 1835.
- 17 “(18) Section 1843.
- 18 “(19) Section 1846.
- 19 “(20) Section 1847.
- 20 “(21) Section 1851.
- 21 “(22) Section 1852.
- 22 “(23) Section 1855.
- 23 “(24) Section 1856.
- 24 “(25) Section 1857.
- 25 “(26) Section 1858.

1 “(27) Section 1861.

2 “(28) Section 1863.

3 “(29) Section 1864.

4 “(30) Section 1866B.

5 “(31) Section 1866C.

6 “(32) Section 1866E.

7 “(33) Section 1867.

8 “(34) Section 1868.

9 “(35) Section 1869.

10 “(36) Section 1871.

11 “(37) Section 1874A.

12 “(38) Section 1880.

13 “(39) Section 1881.

14 “(40) Section 1881A.

15 “(41) Section 1891.

16 “(42) Section 1894.

17 “(43) Section 1895.

18 “(44) Section 1896.

19 **“PART B—LONG-TERM SERVICES AND SUPPORTS**

20 **“SEC. 2221. LONG-TERM SERVICES AND SUPPORTS BEN-**

21 **EFIT.**

22 “All individuals enrolled under Medicare for America
23 under this title shall have coverage for long-term services
24 and supports benefits.

1 **“SEC. 2222. ELIGIBILITY.**

2 “(a) **ELIGIBLE INDIVIDUALS.**—An individual who is
3 eligible for long-term care benefits under this part is an
4 individual who satisfies each of the following:

5 “(1) The individual is eligible for Medicare for
6 America.

7 “(2) The individual is determined to have a
8 condition, as certified by a licensed health care prac-
9 titioner, that results in substantially reduced func-
10 tional capacity in one or more of the following areas:

11 “(A) Communication.

12 “(B) Social interaction.

13 “(C) Learning.

14 “(D) Mobility.

15 “(E) Self-care.

16 “(F) Self-management.

17 “(G) Impairments that affect the person’s
18 capacity for social or economic participation.

19 “(b) **CLARIFICATION.**—Under this part, in the case
20 of an individual described in subsection (a) who, due to
21 the nature of the condition of the individual, experience
22 periods in which their functional capacity changes or im-
23 proves, such individual shall continue to have access to
24 benefits under this part as needed. If such an individual’s
25 functional capacity improves to a point in which the indi-
26 vidual no longer requires long term supports and services,

1 or requires fewer services, the individual shall be able to
2 immediately and seamlessly resume receiving all needed
3 services if and when their functional needs recur. Eligi-
4 bility for services shall be maintained if, without the serv-
5 ices, the individual would have reduced functional capac-
6 ity. The presence of supports and services or other miti-
7 gating measures shall not be taken into account when
8 looking at functional impairment.

9 “(c) BENEFITS.—

10 “(1) DEFINITION.—For purposes of this title,
11 the term ‘long-term services and supports benefit’
12 means the daily living supports needed by eligible in-
13 dividuals and includes all long-term services and
14 supports covered, as of the date of the enactment of
15 this title, under any State plan under title XIX, in-
16 cluding—

17 “(A) home and community-based services;
18 and

19 “(B) any additional services and supports
20 developed to help people with disabilities live,
21 work, and participate in their communities, in-
22 cluding—

23 “(i) home health aides and home-
24 makers;

1 “(ii) direct support professionals and
2 personal attendant care services;

3 “(iii) hospice;

4 “(iv) nursing care;

5 “(v) medical social services;

6 “(vi) case management, fiscal inter-
7 mediary, and support brokerage services;

8 “(vii) short-term inpatient care, in-
9 cluding respite care and care for pain con-
10 trol;

11 “(viii) behavioral health long-term
12 services and supports, including assertive
13 community treatment, peer support serv-
14 ices, intensive case management, supported
15 employment, and supported housing wrap-
16 around; and

17 “(ix) all additional services coverable
18 in Medicaid under state plan services, sec-
19 tions 1115, 1915(c), 1915(k), 1915(i), and
20 1915(j), for people with disabilities.

21 “(2) SELF-DIRECTED MODEL.—All eligible indi-
22 viduals shall be defaulted into a self-directed care
23 option (as defined by the Secretary).

24 “(3) COMMUNITY FIRST.—The benefit under
25 this part shall be provided with a community-first

1 presumption and eligible individuals should be ini-
2 tially provided home and community-based services,
3 as defined for purposes of section 1915(i). Before an
4 eligible individual is admitted into a long term care
5 institution, the State mental health or developmental
6 disability authority or State agency that administers
7 the State plan under title XIX shall conduct a man-
8 datory assessment to determine whether their needs
9 could be met through home and community-based
10 services and if so, the services would have to be ar-
11 ranged for by the State and the coverage would not
12 be provided for the individual with respect to such
13 an admission. This assessment shall be conducted at
14 least annually or upon a change in condition for all
15 individual already admitted to an institution.

16 “(d) COORDINATION WITH OTHER FEDERAL BENE-
17 FITS.—

18 “(1) RULE OF CONSTRUCTION.—Nothing in
19 this part shall be construed as prohibiting benefits
20 paid under this part from being used to compensate
21 a caregiver who provides community living assistance
22 services and supports to a dependent relative not
23 less than 80 hours a month for providing community
24 living assistance services and supports to an eligible
25 individual under this part.

1 “(2) DEPENDENT RELATIVE DEFINED.—The
2 term ‘dependent relative’ means—

3 “(A) a child, grandchild, niece, or nephew
4 (of such caregiver or such caregiver’s spouse or
5 domestic partner);

6 “(B) a child to which the caregiver or the
7 caregiver’s spouse or domestic partner is stand-
8 ing in loco parentis;

9 “(C) a parent, grandparent, sibling, aunt,
10 or uncle (of such caregiver or his or her spouse
11 or domestic partner); or

12 “(D) such caregiver’s spouse or domestic
13 partner, if such child, grandchild, niece, neph-
14 ew, parent, grandparent, sibling, aunt, uncle,
15 spouse, or domestic partner is an eligible indi-
16 vidual.

17 “(3) SUPPLEMENT NOT SUPPLANT.—Benefits
18 received under this part by a caregiver shall supple-
19 ment, but not supplant, other benefits for which the
20 individual is eligible under any other Federally fund-
21 ed program that provides benefits or assistance.

22 “(4) DISREGARD.—Benefits paid to a caregiver
23 under this part shall be disregarded for purposes of
24 determining or continuing the eligibility of the indi-
25 vidual or the spouse of the individual for receipt of

1 benefits under any other Federal, State, or locally
2 funded assistance program, including benefits paid
3 under titles II or XVI under the laws administered
4 by the Secretary of Veterans Affairs, under low-in-
5 come housing assistance programs, under the sup-
6 plemental nutrition assistance program established
7 under the Food and Nutrition Act of 2008, or under
8 programs administered by State vocational rehabili-
9 tation agencies.

10 **“PART C—MEDICARE ADVANTAGE FOR AMERICA**

11 **“SEC. 2231. ALL PRIVATE PLANS.**

12 “(a) IN GENERAL.—For plan years beginning with
13 plan year 2026, a health insurance issuer may offer health
14 insurance coverage in the individual market only if such
15 issuer has entered into a contract with the Secretary
16 under subsection (b) to offer such coverage.

17 “(b) AGREEMENTS.—The Secretary shall enter into
18 an agreement with an MA for America sponsor to offer
19 MA for America plans under this part for the coverage
20 of individuals enrolled under Medicare for America who
21 elect to receive benefits under part A through such a plan.

22 “(c) MA FOR AMERICA PLAN; MA FOR AMERICA
23 SPONSOR.—For purposes of this part—

24 “(1) MA FOR AMERICA PLAN.—An MA for
25 America plan is a Medicare Advantage plan under

1 part C of title XVIII, except such plan shall provide
2 coverage for individuals enrolled under Medicare for
3 America under part A of this title, with respect to
4 at least the benefits covered under such part A.

5 “(2) MA FOR AMERICA SPONSOR.—An MA for
6 America sponsor is a sponsor of an MA for America
7 plan.

8 **“SEC. 2232. APPLICATION OF MEDICARE ADVANTAGE PRO-**
9 **VISIONS.**

10 “For purposes of applying this part, except as other-
11 wise specified under this part, the provisions of part C
12 of title XVIII, as in effect as of the date of the enactment
13 of this title shall apply with respect to an MA for America
14 sponsor, MA for America plan, individuals eligible for cov-
15 erage under this part, individuals enrolled under such
16 plan, and benefits covered under part A in a similar man-
17 ner and to a similar extent as such provisions applied to
18 an MA organization, MA plan, individuals eligible for
19 under part C of such title, individuals enrolled under an
20 MA plan, and benefits covered under fee-for-service Medi-
21 care as of such date.

22 **“SEC. 2233. INCREASED PREMIUM FOR MEDICARE ADVAN-**
23 **TAGE FOR AMERICA PLANS.**

24 “Nothing in this part shall preclude an individual
25 from choosing a Medicare Advantage for America plan

1 which requires the individual to pay an additional amount
2 because of supplemental benefits or because it is a more
3 expensive plan. In such case the individual enrolled under
4 such plan would be responsible for the increased monthly
5 premium.

6 **“SEC. 2234. REFERENCES.**

7 “Beginning in 2022, all references in law and regula-
8 tion to Medicare Advantage shall be deemed a reference
9 to Medicare Advantage for America.”.

10 **SEC. 112. MODIFICATIONS TO AND COORDINATION WITH**
11 **EXISTING FEDERAL HEALTH PROGRAMS.**

12 (a) **MEDICARE, MEDICAID, AND STATE CHILDREN’S**
13 **HEALTH INSURANCE PROGRAM (SCHIP).—**

14 (1) **IN GENERAL.**—Notwithstanding any other
15 provision of law, subject to paragraphs (2) and (3)
16 and section 2202(c) of the Social Security Act, as
17 added by section 111—

18 (A) no benefits shall be available under
19 title XVIII of the Social Security Act for any
20 item or service furnished—

21 (i) beginning on or after January 1,
22 2022 (except in the case of an individual
23 enrolled under such title and title XIX of
24 such Act); and

1 (ii) beginning on or after January 1,
2 2024, with respect to all individuals, in-
3 cluding individuals enrolled under such
4 title and title XIX of such Act;

5 (B) no individual is entitled to medical as-
6 sistance under a State plan approved under
7 title XIX of such Act—

8 (i) for any item or service furnished
9 on or after January 1, 2024, in the case
10 of an individual enrolled under such title
11 and title XVIII of the Social Security Act
12 or an individual described in subclause
13 (VIII) of section 1902(a)(10)(A)(i); and

14 (ii) for any item or service furnished
15 on or after January 1, 2026;

16 (C) no individual is entitled to medical as-
17 sistance under a State child health plan under
18 title XXI of such Act for any item or service
19 furnished on or after January 1, 2024; and

20 (D) no payment shall be made to a State
21 under section 1903(a) or 2105(a) of such Act
22 with respect to medical assistance or child
23 health assistance—

24 (i) for any item or service furnished
25 on or after January 1, 2024, in the case

1 of an individual enrolled under such title
2 and title XVIII of the Social Security Act
3 or an individual described in subclause
4 (VIII) of section 1902(a)(10)(A)(i); and
5 (ii) for any item or service furnished
6 on or after January 1, 2026.

7 (2) TRANSITION.—In the case of inpatient hos-
8 pital services and extended care services during a
9 continuous period of stay which began before Janu-
10 ary 1, 2024 for Medicare and 2026 for Medicaid or
11 CHIP, and which had not ended as of such date, for
12 which benefits are provided under title XVIII of the
13 Social Security Act, under a State plan under title
14 XIX of such Act, or under a State child health plan
15 under title XXI such Act, the Secretary of Health
16 and Human Services shall provide for continuation
17 of benefits under such title or plan until the end of
18 the period of stay.

19 (b) OTHER FEDERAL HEALTH PROGRAMS.—

20 (1) FEDERAL EMPLOYEES HEALTH BENEFITS
21 PROGRAM.—Nothing in this Act, or the amendments
22 made by this Act, shall affect benefits made avail-
23 able under chapter 89 of title 5, United States Code.

24 (2) TRICARE.—Nothing in this Act, or the
25 amendments made by this Act, shall affect benefits

1 made available under sections 1079 and 1086 of
2 title 10, United States Code.

3 (3) TREATMENT OF BENEFITS FOR VETERANS
4 AND NATIVE AMERICANS.—

5 (A) IN GENERAL.—Nothing in this Act, or
6 the amendments made by this Act, shall affect
7 the eligibility of veterans for the medical bene-
8 fits and services provided under title 38, United
9 States Code, or of Indians for the medical bene-
10 fits and services provided by or through the In-
11 dian Health Service.

12 (B) REEVALUATION.—No reevaluation of
13 the Indian Health Service shall be undertaken
14 without consultation with tribal leaders and
15 stakeholders.

16 (c) SUNSET OF PROVISIONS RELATED TO THE STATE
17 EXCHANGES.—Effective January 1, 2022, the Federal
18 and State Exchanges established pursuant to title I of the
19 Patient Protection and Affordable Care Act (Public Law
20 111–148) shall terminate, and any other provision of law
21 that relies upon participation in or enrollment through
22 such an Exchange, including such provisions of the Inter-
23 nal Revenue Code of 1986, shall cease to have force or
24 effect.

1 (d) SEVERABILITY.—Every provision in this Act and
2 every application of the provisions in this Act are severable
3 from each other as a matter of Federal law. If any applica-
4 tion of any provision in this Act to any person or group
5 of persons or circumstances is found by a court to be in-
6 valid, the remainder of this Act and the application of the
7 Act’s provisions to all other persons and circumstances
8 may not be affected.

9 **Subtitle C—Targeted Reforms**

10 **SEC. 121. LIMITATION ON REMOVAL OF MEDICARE ADVAN-** 11 **TAGE PROVIDERS BY MA ORGANIZATIONS.**

12 (a) LIMITATION.—Section 1852(d) of the Social Se-
13 curity Act (42 U.S.C. 1395w–22(d)) is amended by adding
14 at the end the following:

15 “(7) LIMITATION ON REMOVAL OF PROVIDERS
16 FROM MA PLANS BY MA ORGANIZATIONS.—

17 “(A) REMOVAL OF PROVIDERS WITH
18 CAUSE.—Beginning with plan year 2019, except
19 as provided in subparagraph (C), an MA orga-
20 nization offering an MA plan may only remove
21 a provider of services or a supplier from a net-
22 work of such plan if the organization has cause
23 to remove such provider or supplier.

24 “(B) CAUSE TO REMOVE PROVIDERS.—

1 “(i) IN GENERAL.—An MA organiza-
2 tion offering an MA plan has cause to re-
3 move a provider of services or a supplier
4 from a network of such plan if the Sec-
5 retary determines that the provider or sup-
6 plier is—

7 “(I) medically negligent;

8 “(II) in violation of any legal or
9 contractual requirement applicable to
10 the provider or supplier acting within
11 the lawful scope of practice, including
12 any participation or other requirement
13 applicable to such provider or supplier
14 under this title or under any contrac-
15 tual term for such plan; or

16 “(III) otherwise unfit to furnish
17 items and services in accordance with
18 requirements of this title.

19 “(ii) CONSIDERATION OF COST TO MA
20 ORGANIZATIONS.—For purposes of sub-
21 paragraph (A), cost to an MA organization
22 offering an MA plan due to the participa-
23 tion of a provider of services or supplier in
24 a network of such plan does not constitute
25 cause for the MA organization to remove

1 such provider or supplier from the network
2 mid-year, and such cost may not be consid-
3 ered as a factor in favor of a determination
4 that such organization has cause to remove
5 the provider.

6 “(C) EXCEPTION.—With respect to each
7 upcoming plan year, beginning with plan year
8 2019, an MA organization offering an MA plan
9 may only remove a provider of services or sup-
10 plier from a network of such plan for reasons
11 not specified in subparagraph (B)(i) before the
12 date that is 60 days before the first day of the
13 annual coordinated election period for such plan
14 year under section 1851(e)(3).

15 “(D) NOTICE AND APPEAL PROCESS.—

16 “(i) IN GENERAL.—Any removal of a
17 provider of services or supplier from a net-
18 work of an MA plan may occur only after
19 the completion of a fair notice and appeal
20 process that the Secretary shall establish
21 by regulation. Such process shall require
22 the MA organization to provide to such
23 provider or supplier and to the Secretary
24 an explanation of the reason or reasons for
25 the removal.

1 “(ii) APPLICATION.—

2 “(I) APPLICATION OF NEW PROC-
3 ESS.—In the case of a removal of a
4 provider of services or supplier from a
5 network of an MA plan occurring on
6 or after the effective date published in
7 a final rule for such fair notice and
8 appeal process, such process shall
9 apply in lieu of the process for the
10 termination or suspension of a pro-
11 vider contract under section
12 422.202(a) of title 42, Code of Fed-
13 eral Regulations.

14 “(II) CONTINUATION OF OLD
15 PROCESS.—In the case of a removal of
16 a provider of services or supplier from
17 a network of an MA plan occurring
18 before such effective date, the process
19 for the termination or suspension of a
20 provider contract under section
21 422.202(a) of title 42, Code of Fed-
22 eral Regulations, shall apply.

23 “(E) PARTICIPANT NOTICE AND PROTEC-
24 TION.—

1 “(i) NOTICE TO PARTICIPANTS OF
2 PROVIDER REMOVAL.—Not less than 60
3 days before the date on which a provider
4 of services or supplier is removed from a
5 network of an MA plan, the MA organiza-
6 tion offering such plan shall provide writ-
7 ten notification of the removal to each in-
8 dividual enrolled in such plan receiving
9 items or services from the provider or sup-
10 plier during the plan year in effect on the
11 date of removal or during the previous
12 plan year. Such notification shall include
13 at the minimum—

14 “(I) the names and telephone
15 numbers of available in-network pro-
16 viders of services and suppliers offer-
17 ing items and services that are the
18 same or similar to the items and serv-
19 ices offered by the removed provider
20 or supplier;

21 “(II) information regarding the
22 options available to an individual en-
23 rolled in such plan to request the con-
24 tinuation of medical treatment or

1 therapy with the removed provider or
2 supplier; and

3 “(III) one or more customer serv-
4 ice telephone numbers that an indi-
5 vidual enrolled in such plan may ac-
6 cess to obtain information regarding
7 changes to the network of the plan.

8 “(ii) ANNUAL NOTICE OF CHANGE.—

9 In addition to providing the notification of
10 removal as required under clause (i), the
11 MA organization offering such MA plan
12 shall include such notification in the an-
13 nual notice of change for the MA plan for
14 the upcoming plan year.

15 “(iii) CONTINUITY OF CARE.—In any

16 case in which a provider of services or sup-
17 plier is removed from a network of an MA
18 plan, such plan shall ensure that the re-
19 moval satisfies the continuity of care re-
20 quirements under paragraph (1)(A) with
21 respect to each individual enrolled in such
22 plan receiving items or services from the
23 provider or supplier during the plan year
24 in effect on the date of removal or during
25 the previous plan year.

1 “(F) RULE OF CONSTRUCTION.—Nothing
2 in this paragraph shall be construed as affect-
3 ing the ability of a provider of services or sup-
4 plier to decline to participate in a network of an
5 MA plan.

6 “(8) TRANSPARENCY IN MEASURES USED BY
7 MA ORGANIZATIONS TO ESTABLISH OR MODIFY PRO-
8 VIDER NETWORKS.—

9 “(A) IN GENERAL.—Beginning with plan
10 year 2019, an MA organization offering an MA
11 plan shall include the information described in
12 subparagraph (B)—

13 “(i) in the annual bid information
14 submitted by the MA organization with re-
15 spect to the MA plan under section 1854;
16 and

17 “(ii) on the Internet Web Site for the
18 MA plan.

19 “(B) INFORMATION DESCRIBED.—The in-
20 formation described in this subparagraph is the
21 following:

22 “(i) Information regarding the meas-
23 ures used by the MA organization to estab-
24 lish or modify the provider network of the
25 MA plan, including measures of the quality

1 and efficiency of providers. Such informa-
2 tion shall include the specifications, meth-
3 odology, and sample size of such measures.

4 “(ii) Other information related to the
5 establishment or modification of such pro-
6 vider network that the Secretary deter-
7 mines appropriate.

8 “(C) LIMITATION.—The information de-
9 scribed in subparagraph (B) shall not include
10 any individually identifiable information of any
11 provider or supplier of services.”.

12 (b) ENFORCEMENT.—

13 (1) SANCTIONS FOR NONCOMPLIANCE.—Section
14 1857(g)(1) of the Social Security Act (42 U.S.C.
15 1395w–27(g)(1)) is amended—

16 (A) in subparagraph (J), by striking “or”;

17 (B) by redesignating subparagraph (K) as
18 subparagraph (L);

19 (C) by inserting after subparagraph (J)
20 the following new subparagraph:

21 “(K) fails to comply with section
22 1852(d)(7) or 1852(d)(8); or”; and

23 (D) in subparagraph (L) (as so redesi-
24 gnated), by striking “through (J)” and inserting
25 “through (K)”.

1 (2) SANCTIONS NOT APPLICABLE TO PART D.—
2 Title XVIII of the Social Security Act is amended—

3 (A) in section 1860D–12(b)(3)(E) (42
4 U.S.C. 1395w–112(b)(3)(E)), by striking
5 “paragraph (1)(F)” and inserting “paragraphs
6 (1)(F) and (1)(K)”; and

7 (B) in section 1894(e)(6)(B) (42 U.S.C.
8 1395eee(e)(6)(B)), by inserting “(other than
9 paragraph (1)(K) of such section)” after
10 “1857(g)(1)”.

11 (c) MEDICARE ADVANTAGE PLAN COMPARE TOOL.—
12 Not later than one year after the date of enactment of
13 this Act, the Secretary of Health and Human Services
14 shall take such measures as are necessary to ensure that
15 the Medicare Advantage Compare Tool takes into account
16 the preferences and utilization needs of such individuals.

17 **SEC. 122. NETWORK ADEQUACY.**

18 (a) IN GENERAL.—Section 1852(d) of the Social Se-
19 curity Act (42 U.S.C. 1395w–22(d)) is amended by adding
20 at the end the following:

21 “(9) NETWORK ADEQUACY REQUIREMENTS.—
22 Beginning in plan year 2019, notwithstanding any
23 other provision of law, the following shall apply:

24 “(A) PROVIDER AVAILABILITY.—When es-
25 tablishing a plan network, a Medicare Advan-

1 tage organization offering an MA plan shall,
2 among other factors determined by the Sec-
3 retary, consider the following:

4 “(i) The anticipated enrollment in the
5 plan.

6 “(ii) The expected types of services
7 provided and utilization of services by en-
8 rollees under the plan.

9 “(iii) The number and types of pro-
10 viders needed to provide such services.

11 “(iv) The number of network pro-
12 viders who are not accepting new patients.

13 “(v) The location of providers and en-
14 rollees.

15 “(vi) The full-time equivalent avail-
16 ability of a provider to provide such serv-
17 ices.

18 “(B) PROVISION OF CARE IN A TIMELY
19 MANNER.—A Medicare Advantage organization
20 offering an MA plan shall ensure that providers
21 are able to provide services in a timely manner,
22 as defined by the Secretary, under the plan.

23 “(C) APPLICATION OF NETWORK ACCESS
24 ADEQUACY STANDARDS.—In applying the net-
25 work access adequacy standards pursuant to

1 paragraph (1), the Secretary shall seek input
2 from patient advocacy groups, providers of serv-
3 ices and suppliers, and MA plans under this
4 part.

5 “(D) CERTIFICATION.—Each plan year, a
6 Medicare Advantage organization shall certify
7 to the Secretary, with respect to each MA plan
8 offered by the organization, that the providers,
9 including specialists and subspecialists, in the
10 plan network are able to provide the services re-
11 quired under the organization’s contract with
12 the Secretary under section 1857 with respect
13 to the offering of such plan and to meet the
14 needs of the enrollees within the plan service
15 area during the year.

16 “(E) ANNUAL REPORTING.—Each plan
17 year, a Medicare Advantage organization shall
18 report to the Secretary the following with re-
19 spect to each MA plan offered by the organiza-
20 tion:

21 “(i) AVERAGE WAIT TIME.—The aver-
22 age wait time for primary and specialty
23 care for enrollees under the plan.

1 “(ii) UTILIZATION OF OUT-OF-NET-
2 WORK PROVIDERS.—The utilization of out-
3 of-network providers under the plan.

4 “(iii) AVERAGE COST PER PATIENT.—
5 The average annual spending per patient
6 for primary and specialty care for enrollees
7 under the plan.

8 “(F) CERTIFICATION.—In advance of the
9 annual, coordinated election period under sec-
10 tion 1851(e)(3), a Medicare Advantage organi-
11 zation shall certify to the Secretary the accu-
12 racy of provider directories for each plan of-
13 fered by the organization.

14 “(G) NETWORK REVIEW.—The Secretary
15 shall ensure that the network of each MA plan
16 offered by a Medicare Advantage organization
17 meets the network adequacy guidelines estab-
18 lished under this paragraph and under section
19 422.112(a)(4) of title 42, Code of Federal Reg-
20 ulations (or any successor regulation to such
21 section), at least once every 3 years or when a
22 material change in network occurs.”.

23 (b) ENFORCEMENT.—Section 1857(g)(1)(K) of the
24 Social Security Act (42 U.S.C. 1395w-27(g)(1)(K)), as

1 added by section 2(b), is amended by striking “or
2 1852(d)(8)” and inserting “, 1852(d)(8), or 1852(d)(9)”.

3 **SEC. 123. ELIMINATING THE 24-MONTH WAITING PERIOD**
4 **FOR MEDICARE COVERAGE FOR INDIVID-**
5 **UALS WITH DISABILITIES.**

6 (a) IN GENERAL.—Section 226(b) of the Social Secu-
7 rity Act (42 U.S.C. 426(b)) is amended—

8 (1) in paragraph (2)(A), by striking “, and has
9 for 24 calendar months been entitled to,”;

10 (2) in paragraph (2)(B), by striking “, and has
11 been for not less than 24 months,”;

12 (3) in paragraph (2)(C)(ii), by striking “, in-
13 cluding the requirement that he has been entitled to
14 the specified benefits for 24 months,”;

15 (4) in the first sentence, by striking “for each
16 month beginning with the later of (I) July 1973 or
17 (II) the twenty-fifth month of his entitlement or sta-
18 tus as a qualified railroad retirement beneficiary de-
19 scribed in paragraph (2), and” and inserting “for
20 each month for which the individual meets the re-
21 quirements of paragraph (2), beginning with the
22 month following the month in which the individual
23 meets the requirements of such paragraph, and”;
24 and

1 (5) in the second sentence, by striking “the
2 ‘twenty-fifth month of his entitlement’” and all that
3 follows through “paragraph (2)(C) and”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) SECTION 226.—Section 226 of the Social
6 Security Act (42 U.S.C. 426) is amended by—

7 (A) striking subsections (e)(1)(B), (f), and

8 (h); and

9 (B) redesignating subsections (g) and (i)

10 as subsections (f) and (g), respectively.

11 (2) MEDICARE DESCRIPTION.—Section 1811(2)
12 of the Social Security Act (42 U.S.C. 1395e(2)) is
13 amended by striking “have been entitled for not less
14 than 24 months” and inserting “are entitled”.

15 (3) MEDICARE COVERAGE.—Section 1837(g)(1)
16 of the Social Security Act (42 U.S.C. 1395p(g)(1))
17 is amended by striking “25th month of” and insert-
18 ing “month following the first month of”.

19 (4) RAILROAD RETIREMENT SYSTEM.—Section
20 7(d)(2)(ii) of the Railroad Retirement Act of 1974
21 (45 U.S.C. 231f(d)(2)(ii)) is amended—

22 (A) by striking “has been entitled to an
23 annuity” and inserting “is entitled to an annu-
24 ity”;

1 (B) by striking “, for not less than 24
2 months”; and

3 (C) by striking “could have been entitled
4 for 24 calendar months, and”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to insurance benefits under title
7 XVIII of the Social Security Act with respect to items and
8 services furnished in months beginning after the date of
9 enactment of this Act.

10 **SEC. 124. EMPLOYER HEALTH PLAN OPTIONS.**

11 (a) DEFINITION.—A qualifying employer sponsored
12 plan is—

13 (1) a governmental plan (within the meaning of
14 section 2791(d)(8) of the Public Health Service
15 Act); or

16 (2) any other plan or coverage that meets the
17 benefits criteria of title XXII of the Social Security
18 Act, as added by section 111, and the criteria under
19 subsection (b),

20 that provides health coverage that is equivalent to an actu-
21 arial value of at least 80 percent and makes a premium
22 contribution of at least 70 percent.

23 (b) OBLIGATION.—Large employers shall, with re-
24 spect to any full-time employee of such employer—

1 (1) offer a qualifying employer sponsored plan
2 to such employee, in accordance with subsection (c);
3 or

4 (2) make a contribution of 8 percent of their
5 annual payroll to the Medicare Trust Fund under
6 title XXII of the Social Security Act.

7 (c) EMPLOYEE CHOICE.—An employee may opt out
8 of a qualifying employer sponsored plan as satisfied by
9 subsection (b)(1) in order to enroll in Medicare for Amer-
10 ica. The employer shall be exempt from the contribution
11 specified in subsection (b)(2). The Secretary of Health
12 and Human Services shall have authority to set standards
13 for determining whether employers or insurers are under-
14 taking any actions to affect the risk pool within Medicare
15 for America by inducing individuals to decline coverage
16 under a qualifying employer sponsored plan and instead
17 to enroll in Medicare for America. An employer violating
18 such standards shall be treated as not meeting the require-
19 ments of subsection (a).

20 (d) SPECIAL RULES.—

21 (1) ANNUAL PAYROLL.—For purposes of this
22 paragraph, the term “annual payroll” means, with
23 respect to any employer for any calendar year, the
24 aggregate wages paid by the employer during such
25 calendar year.

1 (2) AGGREGATION RULES.—Related employers
2 and predecessors shall be treated as a single em-
3 ployer for purposes of this subsection.

4 (3) REDUCTION FOR PART-TIME EMPLOYEES.—
5 In the case of a part-time employee, the employer
6 contribution requirements of paragraph (1) shall be
7 treated as satisfied if the employer contribution with
8 respect to such employee is not less than the part-
9 time employment ratio of the contribution required
10 under paragraph (1).

11 (4) RULES RELATED TO PART-TIME EMPLOY-
12 MENT.—For purposes of this subsection—

13 (A) PART-TIME EMPLOYEE.—The term
14 “part-time employee” means, with respect to
15 any month, an employee who works on average
16 fewer than 30 hours per week.

17 (B) PART-TIME EMPLOYMENT RATIO.—
18 The term “part-time employment ratio” means,
19 with respect to a part-time employee of an em-
20 ployer in a month, a fraction—

21 (i) the numerator of which is the
22 number of hours in the employee’s normal
23 work week, and

24 (ii) the denominator of which is 30
25 hours.

1 (C) SPECIAL RULES.—Under rules pre-
2 scribed by the Secretary of Health and Human
3 Services, in consultation with the Secretary of
4 the Treasury, in the case of an employee for an
5 employer whose defined work week for full-time
6 employees is less than 30 hours, any reference
7 in this subsection to 30 hours is deemed a ref-
8 erence to the number of hours in the work week
9 so defined.

10 (D) CONVERSION TO HOURS OF EMPLOY-
11 MENT.—The Secretary of Health and Human
12 Services, in consultation with the Secretary of
13 the Treasury, shall establish rules for the con-
14 version of compensation to hours of employ-
15 ment, for purposes of this subsection in the
16 case of employees that receive compensation on
17 a salaried basis, or on the basis of a commis-
18 sion, or other contingent or bonus basis, rather
19 than based on an hourly wage.

20 (e) TIMING AND MANNER.—Each employer that
21 makes a financial contribution under subsection (b)(2)
22 under this section (other than with respect to coverage
23 under a group health plan) shall pay such contribution in
24 a form and manner, specified by the Secretary of the
25 Treasury, based upon the form and manner in which em-

1 ployer excise taxes are required to be paid under section
2 3111 of the Internal Revenue Code of 1986.

3 (f) NON-DISCRIMINATION.—

4 (1) IN GENERAL.—Except as otherwise pro-
5 vided for in this title (or an amendment made by
6 this title), an individual shall not, on the ground
7 prohibited under title VI of the Civil Rights Act of
8 1964 (42 U.S.C. 2000d et seq.), title IX of the Edu-
9 cation Amendments of 1972 (20 U.S.C. 1681 et
10 seq.), the Age Discrimination Act of 1975 (42
11 U.S.C. 6101 et seq.), or section 504 of the Rehabili-
12 tation Act of 1973 (29 U.S.C. 794), be excluded
13 from participation in, be denied the benefits of, or
14 be subjected to discrimination under, any health pro-
15 gram or activity, any part of which is receiving Fed-
16 eral financial assistance, including credits, subsidies,
17 or contracts of insurance, or under any program or
18 activity that is administered by an Executive Agency
19 or any entity established under this title (or amend-
20 ments) or any employer-sponsored insurance.

21 (2) CONTINUED APPLICATION OF LAWS.—Noth-
22 ing in this title (or an amendment made by this
23 title) shall be construed to invalidate or limit the
24 rights, remedies, procedures, or legal standards
25 available to individuals aggrieved under title VI of

1 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
2 seq.), title VII of the Civil Rights Act of 1964 (42
3 U.S.C. 2000e et seq.), title IX of the Education
4 Amendments of 1972 (20 U.S.C. 1681 et seq.), sec-
5 tion 504 of the Rehabilitation Act of 1973 (29
6 U.S.C. 794), or the Age Discrimination Act of 1975
7 (42 U.S.C. 611 et seq.), or to supersede State laws
8 that provide additional protections against discrimi-
9 nation on any basis described in paragraph (1).

10 (3) REGULATIONS.—The Secretary of Health
11 and Human Services may promulgate regulations to
12 implement this subsection.

13 **SEC. 125. PROHIBITION ON STEP THERAPY AND PRIOR AU-**
14 **THORIZATION UNDER GROUP HEALTH**
15 **PLANS.**

16 Section 2719A of the Public Health Service Act (42
17 U.S.C. 300gg–19a) is amended by adding at the end the
18 following new subsection:

19 “(e) PROHIBITION AGAINST STEP THERAPY AND
20 PRIOR AUTHORIZATION.—Beginning with the first plan
21 year following the date of the enactment of this subsection,
22 a group health plan may not require a prior authorization
23 determination for coverage of any benefit under such plan
24 and may not apply treatment limitations through the use
25 of step therapy protocols.”.

1 **SEC. 126. MEDICARE OUTPATIENT OBSERVATION SERV-**
2 **ICES.**

3 Section 1861(i) of the Social Security Act (42 U.S.C.
4 1395x(i)) is amended by adding at the end the following:
5 “For purposes of this subsection, an individual receiving
6 outpatient observation services shall be deemed to be an
7 inpatient during such period, and the date such individual
8 ceases receiving such services shall be deemed the hospital
9 discharge date (unless such individual is admitted as a
10 hospital inpatient at the end of such period).”.

11 **SEC. 127. ABORTION COVERAGE.**

12 Notwithstanding any other provision of law, Federal
13 funds may be used to provide for abortion services under
14 any health program under any of the following:

15 (1) Indian Health Service.

16 (2) Benefits provided to women veterans.

17 (3) Benefits provided through the United States
18 Immigration and Customs Enforcement to women in
19 detention centers under the jurisdiction of such
20 agency.

21 **TITLE II—TAX PROVISIONS**

22 **SEC. 201. SUNSET OF PUBLIC LAW 115–97.**

23 (a) IN GENERAL.—All provisions of, and amend-
24 ments made by, Public Law 115–97 shall not apply to cal-
25 endar, taxable, plan, or limitation years beginning after
26 December 22, 2017.

1 (b) APPLICATION OF CERTAIN LAWS.—The Internal
2 Revenue Code of 1986 shall be applied and administered
3 to years described in subsection (a) as if the provisions
4 and amendments described in subsection (a) had never
5 been enacted.

6 **SEC. 202. SURTAX.**

7 There is hereby imposed a tax of 5 percent on the
8 adjusted gross income of each taxpayer to the extent such
9 income exceeds \$500,000.

10 **SEC. 203. BASIS OF PROPERTY ACQUIRED FROM A DECE-**
11 **DENT.**

12 (a) IN GENERAL.—Section 1014 of the Internal Rev-
13 enue Code of 1986 is amended by striking “person, be”
14 and all that follows through the period at the end and
15 inserting the following: “person, be the basis in the hands
16 of the decedent.”.

17 (b) EFFECTIVE DATE.—The amendments made by
18 this section to property acquired or passed after the date
19 of enactment of this Act.

20 **SEC. 204. MEDICARE PAYROLL TAX.**

21 (a) IN GENERAL.—Section 3101(b)(2) of the Internal
22 Revenue Code of 1986 is amended by striking “0.9 per-
23 cent” and inserting “4 percent”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply with respect to taxable years begin-
3 ning after the date of the enactment of this Act.

4 **SEC. 205. NET INVESTMENT INCOME TAX.**

5 (a) IN GENERAL.—Section 1411(a) of the Internal
6 Revenue Code of 1986 is amended by striking “3.8 per-
7 cent” each place such term appears and inserting “6.9
8 percent”.

9 (b) EFFECTIVE DATE.—The amendments made by
10 this section shall apply with respect to taxable years begin-
11 ning after the date of the enactment of this Act.

12 **SEC. 206. TERMINATION OF HEALTH SAVINGS ACCOUNTS.**

13 Section 223(a) of the Internal Revenue Code of 1986
14 is amended by inserting after “during such taxable year”
15 the following: “and before December 31, 2019”.

16 **SEC. 207. TERMINATION OF FLEXIBLE SPENDING AR-**
17 **RANGEMENTS.**

18 Section 125(i)(1) of the Internal Revenue Code of
19 1986 is amended by striking “may not elect for any tax-
20 able year to have salary reduction contributions in excess
21 of \$2,500 made to such arrangement” and inserting the
22 following: “may not elect to have salary reduction con-
23 tributions made to such arrangement—

24 “(A) for taxable years beginning before
25 January 1, 2020, in excess of \$2,500, and

1 “(B) for taxable years beginning after De-
2 cember 31, 2019, in excess of \$0.”.

3 **SEC. 208. INCREASE IN EXCISE TAX ON SMALL CIGARS AND**
4 **CIGARETTES AND OTHER TOBACCO PROD-**
5 **UCTS.**

6 (a) **SMALL CIGARS.**—Section 5701(a)(1) of the Inter-
7 nal Revenue Code of 1986 is amended by striking
8 “\$50.33” and inserting “\$100.66”.

9 (b) **CIGARETTES.**—Section 5701(b) of such Code is
10 amended—

11 (1) by striking “\$50.33” in paragraph (1) and
12 inserting “\$100.66”, and

13 (2) by striking “\$105.69” in paragraph (2) and
14 inserting “\$211.38”.

15 (c) **PIPE TOBACCO.**—Section 5701(f) of the Internal
16 Revenue Code of 1986 is amended by striking “\$2.8311
17 cents” and inserting “\$50.00”.

18 (d) **ROLL-YOUR-OWN TOBACCO.**—Section 5701(g) of
19 such Code is amended by striking “\$24.78” and inserting
20 “\$49.56”.

21 (e) **LARGE CIGARS.**—Paragraph (2) of section
22 5701(a) of the Internal Revenue Code of 1986 is amended
23 by striking “52.75 percent” and all that follows through
24 the period and inserting “\$24.78 per pound (and a propor-

1 tionate tax at the like rate on all fractional parts of a
2 pound) but not less than 5.033 cents per cigar.”.

3 (f) SMOKELESS TOBACCO.—

4 (1) IN GENERAL.—Section 5701(e) of the Inter-
5 nal Revenue Code of 1986 is amended—

6 (A) in paragraph (1), by striking “\$1.51”
7 and inserting “\$28.04”,

8 (B) in paragraph (2), by striking “50.33
9 cents” and inserting “\$12.42”, and

10 (C) by adding at the end the following:

11 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
12 SINGLE-USE UNITS.—On discrete single-use units,
13 \$107.65 per each 1,000 single-use units.”.

14 (2) DISCRETE SINGLE-USE UNIT.—Section
15 5702(m) of such Code is amended—

16 (A) in paragraph (1), by striking “or chew-
17 ing tobacco” and inserting “chewing tobacco,
18 discrete single-use unit”;

19 (B) in paragraphs (2) and (3), by inserting
20 “that is not a discrete single-use unit” before
21 the period in each such paragraph; and

22 (C) by adding at the end the following:

23 “(4) DISCRETE SINGLE-USE UNIT.—The term
24 ‘discrete single-use unit’ means any product con-
25 taining tobacco that—

1 “(A) is not intended to be smoked, and

2 “(B) is in the form of a lozenge, tablet,
3 pill, pouch, dissolvable strip, or other discrete
4 single-use or single-dose unit.”.

5 **SEC. 209. EXCISE TAX ON ALCOHOL.**

6 (a) **DISTILLED SPIRITS.**—Section 5001(a)(1) of the
7 Internal Revenue Code of 1986 is amended by striking
8 “\$13.50” and inserting “\$16.00”.

9 (b) **WINE.**—

10 (1) Section 5041(b)(1) of the Internal Revenue
11 Code of 1986 is amended by striking “\$1.07 per
12 wine gallon” and inserting “\$16.00 per proof gal-
13 lon”.

14 (2) Section 5041(b)(2) of the Internal Revenue
15 Code of 1986 is amended by striking “\$1.57 per
16 wine gallon” and inserting “\$16.00 per proof gal-
17 lon”.

18 (3) Section 5041(b)(3) of the Internal Revenue
19 Code of 1986 is amended by striking “\$3.15 per
20 wine gallon” and inserting “\$16.00 per proof gal-
21 lon”.

22 (4) Section 5041(b)(4) of the Internal Revenue
23 Code of 1986 is amended by striking “\$3.40 per
24 wine gallon” and inserting “\$16.00 per proof gal-
25 lon”.

1 (5) Section 5041(b)(5) of the Internal Revenue
2 Code of 1986 is amended by striking “\$3.30 per
3 wine gallon” and inserting “\$16.00 per proof gal-
4 lon”.

5 (6) Section 5041(b)(3) of the Internal Revenue
6 Code of 1986 is amended by striking “\$22.6 cents
7 per wine gallon” and inserting “\$16.00 per proof
8 gallon”.

9 (c) BEER.—Section 5051(B) of the Internal Revenue
10 Code of 1986 is amended by striking “\$18 for per barrel”
11 and inserting “\$16 per proof gallon”.

12 **SEC. 210. TAX ON SUGARED DRINKS.**

13 (a) IN GENERAL.—Subchapter D of chapter 32 of the
14 Internal Revenue Code of 1986 is amended by inserting
15 after part I the following new part:

16 **“PART II—SUGAR-SWEETENED BEVERAGES**

 “Sec. 4171. Imposition of tax.

 “Sec. 4172. Definitions.

 “Sec. 4173. Special rules.

17 **“SEC. 4171. IMPOSITION OF TAX.**

18 “(a) IN GENERAL.—There is hereby imposed a tax
19 on the sale or transfer of any specified sugar-sweetened
20 beverage product by the manufacturer, producer, or im-
21 porter thereof.

22 “(b) RATE OF TAX.—The rate of tax imposed under
23 subsection (a) shall be equal to one cent per 4.2 grams

1 of caloric sweetener contained in such specified sugar-
2 sweetened beverage product.

3 “(c) PERSONS LIABLE FOR TAX.—The manufac-
4 turer, producer, or importer referred to in subsection (a)
5 shall be liable for the tax imposed by such subsection.

6 **“SEC. 4172. DEFINITIONS.**

7 “(a) SPECIFIED SUGAR-SWEETENED BEVERAGE
8 PRODUCT.—For purposes of this part—

9 “(1) IN GENERAL.—For purposes of this part,
10 the term ‘specified sugar-sweetened beverage prod-
11 uct’ means—

12 “(A) any liquid intended for human con-
13 sumption which contains a caloric sweetener,
14 and

15 “(B) any liquid, or solid mixture of ingre-
16 dients, which—

17 “(i) contains a caloric sweetener, and

18 “(ii) is intended for use as an ingre-
19 dient in a liquid described in subparagraph
20 (A).

21 “(2) EXCEPTIONS.—The following shall not be
22 treated as liquids described in paragraph (1)(A):

23 “(A) Any liquid the primary ingredients of
24 which are milk or soy, rice, or similar plant-
25 based milk substitute.

1 “(B) Any liquid composed entirely of one
2 or more of the following:

3 “(i) The original liquid resulting from
4 the pressing of fruit or vegetables.

5 “(ii) The liquid resulting from the re-
6 constitution of fruit or vegetable juice con-
7 centrate.

8 “(iii) The liquid resulting from the
9 restoration of water to dehydrated fruit or
10 vegetable juice.

11 “(C) Infant formula.

12 “(D) Any liquid products manufactured for
13 use as—

14 “(i) an oral nutritional therapy for
15 persons who cannot absorb or metabolize
16 dietary nutrients from food or beverages,

17 “(ii) a source of necessary nutrition
18 used due to a medical condition, or

19 “(iii) an oral electrolyte solution for
20 infants and children formulated to prevent
21 dehydration due to illness.

22 “(E) Any liquid with respect to which tax
23 is imposed under chapter 51 (relating to dis-
24 tilled spirits, wines, and beer) or under section
25 7652 by reason of the tax imposed under chap-

1 ter 51 being imposed on like articles of domes-
2 tic manufacture.

3 “(b) CALORIC SWEETENER.—For purposes of this
4 part, the term ‘caloric sweetener’ means monosaccharides,
5 disaccharides, and high-fructose corn syrup.

6 **“SEC. 4173. SPECIAL RULES.**

7 “(a) SWEETENER TAXED ONLY ONCE.—In the case
8 of any specified sugar-sweetened beverage product which
9 is manufactured or produced by including one or more
10 other specified sugar-sweetened beverage products, no tax
11 shall be imposed under this section on any caloric sweet-
12 ener contained in the resulting specified sugar-sweetened
13 beverage product if tax was previously imposed under this
14 section on such caloric sweetener when contained in the
15 specified sugar-sweetened beverage product so included.

16 “(b) INFLATION ADJUSTMENT.—In the case of any
17 sale after December 31, 2015, the one cent amount in sec-
18 tion 4171(b) shall be increased by an amount equal to—

19 “(1) such amount, multiplied by

20 “(2) the cost-of-living adjustment determined
21 under section 1(f)(3) for the calendar year in which
22 such sale occurs, determined by substituting ‘cal-
23 endar year 2014’ for ‘calendar year 1992’ in sub-
24 paragraph (B) thereof.

1 Any increase determined under this subsection shall be
2 rounded to the nearest multiple of one-tenth of a cent.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 4221(a) is amended by adding at
5 the end the following: “Paragraphs (1), (4), (5), and
6 (6) shall not apply to the tax imposed under section
7 4171.”.

8 (2) The table of parts for subchapter D of
9 chapter 32 of such Code is amended by inserting
10 after the item relating to part I the following new
11 item:

“PART II—SUGAR-SWEETENED BEVERAGES”.

12 (c) REVENUES USED FOR PREVENTION, TREAT-
13 MENT, AND RESEARCH OF DIET-RELATED HEALTH CON-
14 DITIONS IN PRIORITY POPULATIONS.—

15 (1) TRANSFER TO PREVENTION AND PUBLIC
16 HEALTH FUND.—There are hereby appropriated to
17 the Prevention and Public Health Fund created
18 under section 4002 of the Patient Protection and
19 Affordable Care Act (in addition to any other
20 amounts appropriated to such Fund) amounts equiv-
21 alent to taxes received in the Treasury under part
22 II of subchapter D of chapter 32. Rules similar to
23 the rules of section 9601 of the Internal Revenue
24 Code of 1986 shall apply with respect to amounts
25 appropriated under this paragraph.

1 (2) RESTRICTION ON USE OF FUNDS.—Not-
2 withstanding subsections (c) and (d) of section 4002
3 of the Patient Protection and Affordable Care Act,
4 amounts appropriated to the Prevention and Public
5 Health Fund under paragraph (1) may be trans-
6 ferred to accounts in the Department of Health and
7 Human Services only for the purpose of making ex-
8 penditures for programs and research designed to
9 reduce the human and economic costs of diabetes,
10 obesity, dental caries, and other diet-related health
11 conditions in priority populations (within the mean-
12 ing of section 901(c) of the Public Health Service
13 Act).

14 (d) EFFECTIVE DATE.—

15 (1) IN GENERAL.—Except as provided in para-
16 graph (2), the amendments made by this section
17 shall take effect on the date of the enactment of this
18 Act.

19 (2) EXCISE TAX.—The amendments made by
20 subsections (a) and (b) shall apply to sales after the
21 date of the enactment of this Act.

1 **TITLE III—DRUG-RELATED**
2 **PROVISIONS**

3 **SEC. 301. ESTABLISHMENT OF THE PRESCRIPTION DRUG**
4 **AND MEDICAL DEVICE REVIEW BOARD.**

5 There is established in the Department of Health and
6 Human Services a board to be known as the Prescription
7 Drug and Medical Device Price Review Board (in this Act
8 referred to as the “Board”).

9 **SEC. 302. MEMBERSHIP; STAFF.**

10 (a) MEMBERS.—The Board shall be composed of the
11 members as follows:

12 (1) The Assistant Secretary for Planning and
13 Evaluation of the Department of Health and Human
14 Services (or the Assistant Secretary’s designee).

15 (2) The Administrator of the Centers for Medi-
16 care & Medicaid Services or, beginning with 2022,
17 the Administrator of the Center for Medicare (or the
18 Administrator’s designee).

19 (3) The Assistant Director for the Health Serv-
20 ices Division of the Federal Bureau of Prisons (or
21 the Assistant Director’s designee).

22 (4) The Secretary of Defense (or the Sec-
23 retary’s designee).

24 (5) The Secretary of Veterans Affairs (or the
25 Secretary’s designee).

1 (6) The Commissioner of Food and Drugs (or
2 the Commissioner's designee).

3 (7) The Director of the National Institutes of
4 Health.

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

7 (c) DIRECTOR AND STAFF.—

8 (1) DIRECTOR.—The Board shall have a direc-
9 tor who shall be appointed by the chairperson of the
10 Board, subject to rules prescribed by the Board.

11 (2) STAFF.—The director may appoint and fix
12 the pay of such additional personnel as the chair-
13 person considers appropriate, subject to rules pre-
14 scribed by the Board.

15 (3) APPLICABILITY OF CERTAIN CIVIL SERVICE
16 LAWS.—The director and staff of the Board shall be
17 appointed subject to the provisions of title 5, United
18 States Code, governing appointments in the competi-
19 tive service, and shall be paid in accordance with the
20 requirements of chapter 51 and subchapter III of
21 chapter 53 of such title relating to classification and
22 General Schedule pay rates; except that an indi-
23 vidual so appointed may not receive pay in excess of
24 the maximum annual rate of basic pay payable for
25 grade GS-15 of the General Schedule.

1 (d) ASSISTANCE FOR THE BOARD.—Subject to sec-
2 tion 306(g), in carrying out this title, the Board—

3 (1) may seek assistance from outside experts in
4 the fields of consumer advocacy, medicine, pharma-
5 cology, pharmacy, and prescription drug reimburse-
6 ment; and

7 (2) shall establish and maintain an advisory
8 group and a stakeholder group for purposes of seek-
9 ing such assistance.

10 (e) INITIAL MEETING.—The Board shall hold its ini-
11 tial meeting not later than 90 days after the date of the
12 enactment of this Act.

13 **SEC. 303. REPORTING REQUIREMENTS.**

14 (a) REPORTING BY MANUFACTURERS.—The Board
15 shall require each manufacturer of a prescription drug or
16 medical device that is sold in the United States to submit
17 to the Board on a periodic basis, at a level of specificity
18 determined by the Board to be necessary to make a deter-
19 mination under section 304, the following information
20 with respect to the reporting period:

21 (1) Each type of prescription drug and medical
22 device that is sold by the manufacturer or an affil-
23 iate of the manufacturer—

24 (A) in the United States; or

1 (B) in a country that is a member of the
2 Organization for Economic Co-operation and
3 Development.

4 (2) The price charged by the manufacturer and
5 the affiliate for the prescription drug or medical de-
6 vice in the United States and in any such country,
7 as applicable.

8 (3) The costs of the manufacturer and the affil-
9 iate to produce and market the prescription drug or
10 medical device for sale in the United States and in
11 any such country, as applicable.

12 (b) REPORTING BY CBO.—The Director of the Con-
13 gressional Budget Office shall submit an annual report to
14 the Board on trends in the prices charged for prescription
15 drugs and medical devices.

16 **SEC. 304. PROHIBITION AGAINST EXCESSIVE PRICE.**

17 (a) PROHIBITION.—Beginning on the effective date
18 of the regulation required by subsection (b), the manufac-
19 turer of a prescription drug or medical device shall not
20 charge an excessive price, as determined pursuant to such
21 regulation, for such drug or device.

22 (b) FORMULA.—The Board shall by regulation pre-
23 scribe a formula for determining whether the average
24 manufacturer price of such drug or device over an annual
25 quarter is an excessive price.

1 (c) DETERMINATION OF EXCESSIVE PRICE.—If the
2 Board determines, on its own initiative or in response to
3 a petition submitted under subsection (d), that the manu-
4 facturer of a prescription drug or medical device charges
5 an excessive price for such drug or device in violation of
6 subsection (a)—

7 (1) the Board shall give the manufacturer—

8 (A) notice of such violation; and

9 (B) subject to subsection (d), a period to
10 correct such violation; and

11 (2) if the manufacturer fails to correct the vio-
12 lation by the end of such period, the manufacturer
13 shall be subject to section 305, section
14 1927(e)(2)(E) of the Social Security Act (as added
15 by subsection (c) of section 305), and section 4192
16 of the Internal Revenue Code of 1986, as added by
17 subsection (d) of section 305.

18 (d) PETITIONS.—Any person may petition the Board
19 to make a determination under subsection (c) regarding
20 the pricing of a prescription drug or medical device. Not
21 later than 90 days after the date of receipt of such a peti-
22 tion, the Board shall—

23 (1) make a determination under subsection (c)
24 regarding such pricing; or

25 (2) decline to make such a determination.

1 (e) CONTINUING VIOLATION.—The Board shall not
2 be required to give a manufacturer an opportunity to cor-
3 rect a violation, as described in subsection (c)(1)(B), be-
4 fore the manufacturer becomes subject to the provisions
5 described in subsection (c)(2) for such violation, if—

6 (1) the Board has already provided such an op-
7 portunity to correct to the manufacturer; and

8 (2) the Board finds that the violation of sub-
9 section (a) is a continuation of an earlier violation
10 with respect to which such an opportunity was pro-
11 vided.

12 (f) CONSIDERATIONS.—The formula required by sub-
13 section (a) shall at a minimum take into consideration—

14 (1) the average manufacturer price of the pre-
15 scription drug or medical device over the respective
16 annual quarter or quarters;

17 (2) the average manufacturer price of other
18 prescription drugs or medical devices in the same
19 therapeutic class over the same quarter or quarters;

20 (3) the average price at which the prescription
21 drug or medical device and other prescription drugs
22 and medical devices in the same therapeutic class
23 have been sold by manufacturers in countries other
24 than the United States;

1 (4) the costs associated with producing and
2 marketing the prescription drug or medical device,
3 the value of the drug or device to patients where suf-
4 ficient data is available to determine such value, the
5 total Federal investment in the development of the
6 drug or device, the size of the patient population re-
7 ceiving the drug or device, and other factors deter-
8 minative as to the true cost of production; and

9 (5) whether the price of the prescription drug
10 or medical device increased during any annual quar-
11 ter by a percentage that is more than 2 percent
12 greater than the CPI increase percentage (as defined
13 in section 215(i) of the Social Security Act (42
14 U.S.C. 415)) for the respective annual quarter.

15 **SEC. 305. ENFORCEMENT PROVISIONS.**

16 (a) **REDUCED PATENT TERM.**—If the Board finds
17 that the manufacturer of a prescription drug or medical
18 device, who is also an owner of a patent for such drug
19 or device, charged an excessive price for such drug or de-
20 vice in violation of section 304(a), the Board may—

21 (1) reduce the term, by not more than 5 years,
22 of any patent issued under title 35, United States
23 Code, relating to such drug or device; or

24 (2) if the term of each patent for such drug or
25 device has expired, reduce the term, by not more

1 than 5 years, of another patent owned by the patent
2 owner relating to a prescription drug or medical de-
3 vice.

4 (b) CIVIL PENALTIES.—If the Board determines
5 under section 304(c) that a manufacturer of a prescription
6 drug or medical device charged an excessive price for a
7 prescription drug or medical device in violation of section
8 304(a), the Board may impose a civil penalty on the man-
9 ufacturer of not more than 10 percent of the manufactur-
10 er’s gross sales of the drug or device during the period
11 beginning on the date on which an excessive price is first
12 charged and ending on the date on which the manufac-
13 turer ceases to charge an excessive price.

14 (c) ENFORCEMENT THROUGH INCREASED MEDICAID
15 REBATES.—

16 (1) IN GENERAL.—Section 1927(c)(2) of the
17 Social Security Act (42 U.S.C. 1396r–8(c)(2)) is
18 amended—

19 (A) in subparagraph (A), by inserting “,
20 subject to subparagraph (E),” after “increased
21 by”; and

22 (B) by adding at the end the following new
23 subparagraph:

24 “(E) DISCOURAGING EXCESSIVE PRICES.—

1 “(i) IN GENERAL.—In the case of a
2 manufacturer of a single source drug or an
3 innovator multiple source drug with a re-
4 bate agreement under this section, if the
5 Prescription Drug and Medical Device
6 Price Review Board established under sec-
7 tion 301 of the Medicare for America Act
8 determines under section 304(a) of such
9 Act that such manufacturer charged, with
10 respect to a 30-day period, an excessive
11 price for such drug, and the Board deter-
12 mines under clause (ii) to apply an in-
13 creased amount described in such clause
14 with respect to such manufacturer and
15 drug, the amount of the rebate determined
16 under subparagraph (A) for such manufac-
17 turer and drug shall be, subject to sub-
18 paragraph (D), increased by such amount
19 for the 4 rebate periods following such 30-
20 day period.

21 “(ii) INCREASED AMOUNT DETER-
22 MINATION.—For purposes of clause (i), if
23 the Board described in such clause makes
24 such a determination under such section
25 304(a), with respect to a manufacturer

1 and drug described in such clause, the
2 Board may determine an increased amount
3 to apply with respect to such manufacturer
4 and drug and rebate period described in
5 such clause. Such increased amount may
6 not exceed the rebate amount that would
7 otherwise be applied to such manufacturer
8 and drug under this section for such rebate
9 period, without regard to this subpara-
10 graph.”.

11 (2) EFFECTIVE DATE.—This subsection and the
12 amendments made by this subsection shall apply
13 with respect to rebate agreements entered into after
14 the date that is 60 days after the date of the enact-
15 ment of this Act.

16 (d) TAX ON EXCESS PRESCRIPTION DRUG AND MED-
17 ICAL DEVICE PROFITS.—

18 (1) DETERMINATION OF AMOUNT.—If the
19 Board determines under section 304(a) that a man-
20 ufacturer, producer, or importer of a prescription
21 drug or medical device charged an excessive price for
22 such prescription drug or medical device during a
23 taxable year, the Board may determine under this
24 paragraph a reasonable price for such drug or device
25 for such taxable year.

1 (2) IMPOSITION OF TAX.—

2 (A) IN GENERAL.—The Internal Revenue
3 Code of 1986 is amended by inserting after sec-
4 tion 4191 the following new section:

5 **“SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL**
6 **DEVICE PRICE.**

7 “(a) IN GENERAL.—There is hereby imposed on the
8 sale of any prescription drug or medical device by the
9 manufacturer, producer, or importer a tax equal to the
10 difference between the price at which such drug or device
11 is so sold and the reasonable price determined by the Pre-
12 scription Drug and Medical Device Price Review Board
13 under section 305(d)(1) of the Medicare for America Act
14 for such drug or device for the taxable year for sales after
15 the determination.

16 “(b) PRESCRIPTION DRUG OR MEDICAL DEVICE.—
17 For purposes of this section, the term ‘prescription drug
18 or medical device’ means any prescription drug (as defined
19 in section 9008 of the Patient Protection and Affordable
20 Care Act) or device (as defined in section 201(h) of the
21 Federal Food, Drug, and Cosmetic Act) intended for hu-
22 mans.”.

23 (B) CLERICAL AMENDMENT.—The table of
24 parts for chapter 32 of such Code is amended—

1 (i) in the item relating to subchapter
2 E, by striking “Medical” and inserting
3 “Drugs and medical”, and

4 (ii) by inserting after the item relating
5 to section 4191 the following new item:

6 **“SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL**
7 **DEVICE PRICE.”.**

8 (3) EFFECTIVE DATE.—This subsection and the
9 amendments made by this subsection shall apply
10 with respect to sales after December 31, 2018.

11 **SEC. 306. AUTHORITY.**

12 (a) OBTAINING OFFICIAL DATA.—The chairperson of
13 the Board may secure directly from any Federal agency
14 information necessary to enable the Board to carry out
15 its duties. Upon request of the chairperson, the head of
16 the agency shall furnish such information to the Board
17 to the extent such information is not prohibited from dis-
18 closure by law.

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

22 (c) ADMINISTRATIVE SUPPORT SERVICES.—Upon the
23 request of the chairperson of the Board, the Administrator
24 of General Services shall provide to the Board, on a reim-

1 bursable basis, the administrative support services nec-
2 essary for the Board to carry out its duties.

3 (d) CONTRACT AUTHORITY.—The Board may con-
4 tract with and compensate government and private agen-
5 cies or persons for the purpose of conducting research,
6 surveys, and other services necessary to enable the Board
7 to carry out its duties.

8 (e) INVESTIGATIONS.—The Board may make such in-
9 vestigations as it considers necessary to determine whether
10 there is or may be a violation of any regulation promul-
11 gated under this Act and may require or permit any per-
12 son to file with it a statement in writing, under oath or
13 otherwise as the Board shall determine, as to all the facts
14 and circumstances concerning the matter to be inves-
15 tigated.

16 (f) SUBPOENA POWER.—

17 (1) IN GENERAL.—The Board may issue sub-
18 poenas requiring the attendance and testimony of
19 witnesses and the production of any evidence relat-
20 ing to any matter under investigation by the Board.
21 The attendance of witnesses and the production of
22 evidence may be required from any place within the
23 United States at any designated place of hearing
24 within the United States.

1 (2) FAILURE TO OBEY A SUBPOENA.—If a per-
2 son refuses to obey a subpoena issued under para-
3 graph (1), the Board may apply to a United States
4 district court for an order requiring that person to
5 appear before the Board to give testimony, produce
6 evidence, or both, relating to the matter under inves-
7 tigation. The application may be made within the ju-
8 dicial district where the hearing is conducted or
9 where that person is found, resides, or transacts
10 business. Any failure to obey the order of the court
11 may be punished by the court as civil contempt.

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

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

22 (5) NOTICE.—Upon issuing any subpoena
23 under this subsection, the Board shall give notice of
24 such issuance to the appropriate committees of Con-
25 gress, including the Committee on Appropriations of

1 the House of Representatives and the Committee on
2 Appropriations of the Senate.

3 (g) CONFIDENTIALITY.—Nothing in this title shall be
4 construed as authorizing the Board to disclose any infor-
5 mation that is a trade secret or confidential information
6 subject to section 552(b)(4) of title 5, United States Code,
7 or section 1905 of title 18, United States Code.

8 **SEC. 307. REGULATIONS.**

9 (a) IN GENERAL.—Not later than 1 year after the
10 date of the initial meeting held under section 302(e), the
11 Board shall issue final regulations to carry out this Act.

12 (b) NOTICE AND COMMENT REQUIREMENT.—The
13 regulations developed under subsection (a) shall be issued
14 in accordance with the notice and comment procedures es-
15 tablished under section 553 of title 5, United States Code.

16 **SEC. 308. REPORT TO FEDERAL AGENCIES.**

17 Not later than 1 year after the effective date of the
18 regulations under section 307 and annually thereafter, the
19 Board shall submit to each Federal agency that dispenses
20 or makes payments for the dispensing of prescription
21 drugs or medical devices a report containing—

22 (1) a list of each prescription drug and medical
23 device for which an excessive price was charged dur-
24 ing the preceding calendar year, as determined by
25 the Board under section 304;

1 (2) recommendations to the Federal agency
2 against dispensing or making payments for the dis-
3 pensing of the prescription drug or medical device;
4 and

5 (3) recommendations to the Federal agency to
6 substitute, in place of any drug or device listed pur-
7 suant to paragraph (1), a similar prescription drug
8 or medical device that is not sold at an excessive
9 price.

10 **SEC. 309. DEFINITIONS.**

11 In this title:

12 (1) The term “affiliate” means, with respect to
13 a manufacturer, any entity that controls, is con-
14 trolled by, or is under common control with such
15 manufacturer.

16 (2) The term “average manufacturer price”
17 means the average price charged by the manufac-
18 turer of a prescription drug or medical device, as ap-
19 plicable, for sales of the drug or device by the manu-
20 facturer in the United States over the respective an-
21 nual quarter.

22 (3) The term “medical device” means a device
23 (as defined in section 201 of the Federal Food,
24 Drug, and Cosmetic Act (21 U.S.C. 321)).

1 (4) The term “prescription drug” means a drug
 2 (as defined in section 201 of the Federal Food,
 3 Drug, and Cosmetic Act (21 U.S.C. 321)) that is
 4 subject to section 503(b)(1) of such Act (21 U.S.C.
 5 353(b)(1)).

6 **SEC. 310. MORATORIUM ON DIRECT-TO-CONSUMER DRUG**
 7 **ADVERTISING.**

8 The Federal Food, Drug, and Cosmetic Act (21
 9 U.S.C. 301 et seq.) is amended—

10 (1) in section 301 (21 U.S.C. 331), by adding
 11 at the end the following:

12 “(eee) The conduct of direct-to-consumer advertising
 13 of a drug in violation of section 506J.”; and

14 (2) in chapter V, by inserting after section 506I
 15 (21 U.S.C. 356f) the following:

16 **“SEC. 506J. DIRECT-TO-CONSUMER DRUG ADVERTISING.**

17 “(a) PROHIBITIONS.—

18 “(1) FIRST THREE YEARS.—

19 “(A) IN GENERAL.—Subject to subpara-
 20 graph (B), no person shall conduct direct-to-
 21 consumer advertising of a drug for which an
 22 application is submitted under section 505(b)
 23 before the end of the 3-year period beginning
 24 on the date of the approval of such application.

1 “(B) WAIVER.—The Secretary may waive
2 the application of subparagraph (A) to a drug
3 during the third year of the 3-year period de-
4 scribed in such subparagraph if—

5 “(i) the sponsor of the drug submits
6 an application to the Secretary pursuant to
7 subparagraph (C); and

8 “(ii) the Secretary, after considering
9 the application and any accompanying ma-
10 terials, determines that direct-to-consumer
11 advertising of the drug would have an af-
12 firmative value to public health.

13 “(C) APPLICATION FOR WAIVER.—To seek
14 a waiver under subparagraph (B), the sponsor
15 of a drug shall submit an application to the
16 Secretary at such time, in such manner, and
17 containing such information as the Secretary
18 may require.

19 “(2) SUBSEQUENT YEARS.—The Secretary may
20 prohibit direct-to-consumer advertising of a drug
21 during the period beginning at the end of the 3-year
22 period described in paragraph (1)(A) if the Sec-
23 retary determines that the drug has significant ad-
24 verse health effects based on post-approval studies,
25 risk-benefit analyses, adverse event reports, the sci-

1 entific literature, any clinical or observational stud-
2 ies, or any other appropriate resource.

3 “(b) REGULATIONS.—Not later than 1 year after the
4 date of the enactment of this section, the Secretary shall
5 revise the regulations promulgated under this Act gov-
6 erning drug advertisements to the extent necessary to im-
7 plement this section.

8 “(c) RULE OF CONSTRUCTION.—This section shall
9 not be construed to diminish the authority of the Secretary
10 to prohibit or regulate direct-to-consumer advertising of
11 drugs under other provisions of law.”.

12 **SEC. 311. REPORTING ON JUSTIFICATION FOR DRUG PRICE**
13 **INCREASES.**

14 Title III of the Public Health Service Act (42 U.S.C.
15 241 et seq.) is amended by adding at the end the fol-
16 lowing:

17 **“PART W—DRUG PRICE REPORTING; DRUG**
18 **VALUE FUND**

19 **“SEC. 3990O. REPORTING ON JUSTIFICATION FOR DRUG**
20 **PRICE INCREASES.**

21 “(a) DEFINITIONS.—In this section:

22 “(1) MANUFACTURER.—The term ‘manufac-
23 turer’ means the person—

24 “(A) that holds the application for a drug
25 approved under section 505 of the Federal

1 Food, Drug, and Cosmetic Act or the license
2 issued under section 351 of the Public Health
3 Service Act; or

4 “(B) who is responsible for setting the
5 price for the drug.

6 “(2) QUALIFYING DRUG.—The term ‘qualifying
7 drug’ means any drug that is approved under sub-
8 section (c) or (j) of section 505 of the Federal Food,
9 Drug, and Cosmetic Act or licensed under subsection
10 (a) or (k) of section 351 of this Act—

11 “(A) that has a wholesale acquisition cost
12 of \$100 or more per month supply or per a
13 course of treatment that lasts less than a
14 month and is—

15 “(i)(I) subject to section 503(b)(1) of
16 the Federal Food, Drug, and Cosmetic
17 Act; or

18 “(II) commonly administered by hos-
19 pitals (as determined by the Secretary);

20 “(ii) not designated as a drug for a
21 rare disease or condition under section 526
22 of the Federal Food, Drug, and Cosmetic
23 Act; and

24 “(iii) not designated by the Secretary
25 as a vaccine; and

1 “(B) for which, during the previous cal-
2 endar year, at least 1 dollar of the total amount
3 of sales were for individuals enrolled under the
4 Medicare program under title XVIII of the So-
5 cial Security Act (42 U.S.C. 1395 et seq.) or
6 under a State Medicaid plan under title XIX of
7 such Act (42 U.S.C. 1396 et seq.) or under a
8 waiver of such plan.

9 “(3) WHOLESALE ACQUISITION COST.—The
10 term ‘wholesale acquisition cost’ has the meaning
11 given that term in section 1847A(c)(6)(B) of the So-
12 cial Security Act (42 U.S.C. 1395w-3a(c)(6)(B)).

13 “(b) REPORT.—

14 “(1) REPORT REQUIRED.—The manufacturer of
15 a qualifying drug shall submit a report to the Sec-
16 retary for each price increase of a qualifying drug
17 that will result in an increase in the wholesale acqui-
18 sition cost of that drug that is equal to—

19 “(A) 10 percent or more over a 12-month
20 period; or

21 “(B) 25 percent or more over a 36-month
22 period.

23 “(2) REPORT DEADLINE.—Each report de-
24 scribed in paragraph (1) shall be submitted to the

1 Secretary not later than 30 days prior to the
2 planned effective date of such price increase.

3 “(c) CONTENTS.—A report under subsection (b)
4 shall, at a minimum, include—

5 “(1) with respect to the qualifying drug—

6 “(A) the percentage by which the manufac-
7 turer will raise the wholesale acquisition cost of
8 the drug on the planned effective date of such
9 price increase;

10 “(B) a justification for, and description of,
11 each manufacturer’s price increase that oc-
12 curred during the 12-month period described in
13 subsection (b)(1)(A) or the 36-month period de-
14 scribed in subsection (b)(1)(B), as applicable;

15 “(C) the identity of the initial developer of
16 the drug;

17 “(D) a description of the history of the
18 manufacturer’s price increases for the drug
19 since the approval of the application for the
20 drug under section 505 of the Federal Food,
21 Drug, and Cosmetic Act or the issuance of the
22 license for the drug under section 351, or since
23 the manufacturer acquired such approved appli-
24 cation or license;

25 “(E) the current list price of the drug;

1 “(F) the total expenditures of the manu-
2 facturer on—

3 “(i) materials and manufacturing for
4 such drug; and

5 “(ii) acquiring patents and licensing
6 for such drug;

7 “(G) the percentage of total expenditures
8 of the manufacturer on research and develop-
9 ment for such drug that was derived from Fed-
10 eral funds;

11 “(H) the total expenditures of the manu-
12 facturer on research and development for such
13 drug that is used for—

14 “(i) basic and preclinical research;

15 “(ii) clinical research;

16 “(iii) new drug development;

17 “(iv) pursuing new or expanded indi-
18 cations for such drug through supple-
19 mental applications under section 505 of
20 the Federal Food, Drug, and Cosmetic
21 Act; and

22 “(v) carrying out postmarket require-
23 ments related to such drug, including those
24 under section 505(o)(3) of such Act;

1 “(I) the total revenue and the net profit
2 generated from the qualifying drug for each cal-
3 endar year since the approval of the application
4 for the drug under section 505 of the Federal
5 Food, Drug, and Cosmetic Act or the issuance
6 of the license for the drug under section 351,
7 or since the manufacturer acquired such ap-
8 proved application or license; and

9 “(J) the total costs associated with mar-
10 keting and advertising for the qualifying drug;
11 “(2) with respect to the manufacturer—

12 “(A) the total revenue and the net profit
13 of the manufacturer for the 12-month period
14 described in subsection (b)(1)(A) or the 36-
15 month period described in subsection (b)(1)(B),
16 as applicable;

17 “(B) all stock-based performance metrics
18 used by the manufacturer to determine execu-
19 tive compensation for the 12-month period de-
20 scribed in subsection (b)(1)(A) or the 36-month
21 period described in subsection (b)(1)(B), as ap-
22 plicable; and

23 “(C) any additional information the manu-
24 facturer chooses to provide related to drug pric-
25 ing decisions, such as total expenditures on—

1 “(i) drug research and development;

2 or

3 “(ii) clinical trials on drugs that failed
4 to receive approval by the Food and Drug
5 Administration; and

6 “(3) such other related information as the Sec-
7 retary considers appropriate.

8 “(d) CIVIL PENALTY.—Any manufacturer of a quali-
9 fying drug that fails to submit a report for the drug as
10 required by this section shall be subject to a civil penalty
11 of \$100,000 for each day on which the violation continues.

12 “(e) PUBLIC POSTING.—

13 “(1) IN GENERAL.—Subject to paragraph (3),
14 not later than 30 days after the submission of a re-
15 port under subsection (b), the Secretary shall post
16 the report on the public website of the Department
17 of Health and Human Services.

18 “(2) FORMAT.—In developing the format of
19 such report for public posting, the Secretary shall
20 consult stakeholders, including beneficiary groups,
21 and shall seek feedback on the content and format
22 from consumer advocates and readability experts to
23 ensure such public reports are user-friendly to the
24 public and are written in plain language that con-
25 sumers can readily understand.

1 “(3) TRADE SECRETS AND CONFIDENTIAL IN-
2 FORMATION.—In carrying out this section, the Sec-
3 retary shall enforce applicable law concerning the
4 protection of confidential commercial information
5 and trade secrets.

6 **“SEC. 39900-1. USE OF CIVIL PENALTY AMOUNTS.**

7 “The Secretary shall collect the civil penalties under
8 section 39900, in addition to any other amounts avail-
9 able, and without further appropriation, and shall use
10 such funds to carry out activities described in this part
11 and to improve consumer and provider information about
12 drug value and drug price transparency.

13 **“SEC. 39900-2. ANNUAL REPORT TO CONGRESS.**

14 “(a) IN GENERAL.—Subject to subsection (b), the
15 Secretary shall submit to Congress, and post on the public
16 website of the Department of Health and Human Services
17 in a way that is easy to use and understand, an annual
18 report—

19 “(1) summarizing the information reported pur-
20 suant to section 39900; and

21 “(2) including copies of the reports and sup-
22 porting detailed economic analyses submitted pursu-
23 ant to such section.

24 “(b) TRADE SECRETS AND CONFIDENTIAL INFORMA-
25 TION.—In carrying out this section, the Secretary shall

- 1 enforce applicable law concerning the protection of con-
- 2 fidential commercial information and trade secrets.”.

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