II

115TH CONGRESS
1ST SESSION

S. 1511

To bring stability to the individual insurance market, make insurance coverage more affordable, lower prescription drug prices, and improve Medicaid.

IN THE SENATE OF THE UNITED STATES

JUNE 29, 2017

Mr. CARDIN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To bring stability to the individual insurance market, make insurance coverage more affordable, lower prescription drug prices, and improve Medicaid.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Keeping Health Insurance Affordable Act of 2017''.

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

TITLE I—MARKETPLACE STABILITY AND SECURITY

SEC. 101. INDIVIDUAL MARKET REINSURANCE FUND.

(a) ESTABLISHMENT OF FUND.—

(1) IN GENERAL.—There is established the ''Individual Market Reinsurance Fund'' to be administered by the Secretary to provide funding for an individual market stabilization reinsurance program in each State that complies with the requirements of this section.

(2) FUNDING.—There is appropriated to the Fund, out of any moneys in the Treasury not otherwise appropriated, such sums as are necessary to carry out this section (other than subsection (c)) for each calendar year beginning with 2018. Amounts appropriated to the Fund shall remain available without fiscal or calendar year limitation to carry out this section.

(b) INDIVIDUAL MARKET REINSURANCE PROGRAM.—

(1) USE OF FUNDS.—The Secretary shall use amounts in the Fund to establish a reinsurance program under which the Secretary shall make reinsurance payments to health insurance issuers with respect to high-cost individuals enrolled in qualified health plans offered by such issuers that are not grandfathered health plans or transitional health plans for any plan year beginning with the 2018 plan year. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide payments from the Fund in accordance with this subsection.

(2) AMOUNT OF PAYMENT.—The payment made to a health insurance issuer under subsection (a) with respect to each high-cost individual enrolled in a qualified health plan issued by the issuer that is not a grandfathered health plan or a transitional health plan shall equal 80 percent of the lesser of—

(A) the amount (if any) by which the individual's claims incurred during the plan year exceeds—

(i) in the case of the 2018, 2019, or 2020 plan year, $50,000; and

(ii) in the case of any other plan year, $100,000; or

(B) for plan years described in—

(i) subparagraph (A)(i), $450,000; and

(ii) subparagraph (A)(ii), $400,000.

(3) INDEXING.—In the case of plan years beginning after 2018, the dollar amounts that appear in subparagraphs (A) and (B) of paragraph (2) shall each be increased by an amount equal to—

(A) such amount; multiplied by

(B) the premium adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting ''2018'' for ''2013''.

(4) PAYMENT METHODS.—

(A) IN GENERAL.—Payments under this subsection shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this subsection are made during a plan year based on the Sec-

retary's best estimate of amounts that will be payable after obtaining all of the information.

(B) REQUIREMENT FOR PROVISION OF INFORMATION.—

(i) REQUIREMENT.—Payments under this subsection to a health insurance issuer are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this subsection.

(ii) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to clause (i) is subject to the HIPAA privacy and security law, as defined in section 3009(a) of the Public Health Service Act (42 U.S.C. 300jj–19(a)).

(5) SECRETARY FLEXIBILITY FOR BUDGET NEUTRAL REVISIONS TO REINSURANCE PAYMENT SPECIFICATIONS.—If the Secretary determines appropriate, the Secretary may substitute higher dollar amounts for the dollar amounts specified under subparagraphs (A) and (B) of paragraph (2) (and adjusted under paragraph (3), if applicable) if the Sec-

retary certifies that such substitutions, considered together, neither increase nor decease the total projected payments under this subsection.

(c) OUTREACH AND ENROLLMENT.—

(1) IN GENERAL.—During the period that begins on January 1, 2018, and ends on December 31, 2020, the Secretary shall award grants to eligible entities for the following purposes:

(A) OUTREACH AND ENROLLMENT.—To carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage enrollment in, qualified health plans.

(B) ASSISTING INDIVIDUALS TRANSITION TO QUALIFIED HEALTH PLANS.—To provide assistance to individuals who are enrolled in health insurance coverage that is not a qualified health plan enroll in a qualified health plan.

(C) ASSISTING ENROLLMENT IN PUBLIC HEALTH PROGRAMS.—To facilitate the enrollment of eligible individuals in the Medicare program or in a State Medicaid program, as appropriate.

(D) RAISING AWARENESS OF PREMIUM ASSISTANCE AND COST-SHARING REDUCTIONS.—

To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

(2) ELIGIBLE ENTITIES DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''eligible entity'' means—

(i) a State; or

(ii) a nonprofit community-based organization.

(B) ENROLLMENT AGENTS.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State or nonprofit community-based organization to enroll eligible individuals in qualified health plans.

(C) EXCLUSIONS.—Such term does not include an entity that—

(i) is a health insurance issuer; or

(ii) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to awarding grants to States or eligible entities in States that have geographic rating areas at risk of having no qualified health plans in the individual market.

(4) FUNDING.—Out of any moneys in the Treasury not otherwise appropriated, $500,000,000 is appropriated to the Secretary for each of calendar years 2018 through 2020, to carry out this subsection.

(d) REPORTS TO CONGRESS.—

(1) ANNUAL REPORT.—The Secretary shall submit a report to Congress, not later than January 21, 2019, and each year thereafter, that contains the following information for the most recently ended year:

(A) The number and types of plans in each State's individual market, specifying the num-

ber that are qualified health plans, grandfathered health plans, or health insurance coverage that is not a qualified health plan.

(B) The impact of the reinsurance payments provided under this section on the availability of coverage, cost of coverage, and coverage options in each State.

(C) The amount of premiums paid by individuals in each State by age, family size, geographic area in the State's individual market, and category of health plan (as described in subparagraph (A)).

(D) The process used to award funds for outreach and enrollment activities awarded to eligible entities under subsection (c), the amount of such funds awarded, and the activities carried out with such funds.

(E) Such other information as the Secretary deems relevant.

(2) EVALUATION REPORT.—Not later than January 31, 2022, the Secretary shall submit to Congress a report that—

(A) analyzes the impact of the funds provided under this section on premiums and en-

rollment in the individual market in all States; and

(B) contains a State-by-State comparison of the design of the programs carried out by States with funds provided under this section.

(e) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

(2) FUND.—The term ''Fund'' means the Individual Market Reinsurance Fund established under subsection (a).

(3) GRANDFATHERED HEALTH PLAN.—The term ''grandfathered health plan'' has the meaning given that term in section 1251(e) of the Patient Protection and Affordable Care Act.

(4) HIGH-COST INDIVIDUAL.—The term ''high-cost individual'' means an individual enrolled in a qualified health plan (other than a grandfathered health plan or a transitional health plan) who incurs claims in excess of $50,000 during a plan year.

(5) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(6) TRANSITIONAL HEALTH PLAN.—The term ''transitional health plan'' means a plan continued

under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 of the Patient Protection and Affordable Care Act does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, and February 13, 2017.

SEC. 102. PUBLIC HEALTH INSURANCE OPTION.

(a) IN GENERAL.—Part 3 of subtitle D of title I of the Patient Protection and Affordable Care Act (Public Law 111–148) is amended by adding at the end the following new section:

"SEC. 1325. PUBLIC HEALTH INSURANCE OPTION.

''(a) ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION.—

''(1) ESTABLISHMENT.—For years beginning with 2018, the Secretary of Health and Human Services (in this subtitle referred to as the 'Secretary') shall provide for the offering through Exchanges established under this title of a health benefits plan (in this Act referred to as the 'public health

insurance option') that ensures choice, competition, and stability of affordable, high-quality coverage throughout the United States in accordance with this section. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without compromising quality or access to care.

"(2) OFFERING THROUGH EXCHANGES.—

"(A) EXCLUSIVE TO EXCHANGES.—The public health insurance option shall only be made available through Exchanges established under this title.

"(B) ENSURING A LEVEL PLAYING FIELD.—Consistent with this section, the public health insurance option shall comply with requirements that are applicable under this title to health benefits plans offered through such Exchanges, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

"(C) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

"(i) shall offer bronze, silver, and gold plans; and

"(ii) may offer platinum plans.

''(3) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

''(4) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act. In addition, such office shall work with States to ensure that information and notice is provided that the public health insurance option is one of the health plans available through an Exchange.

''(5) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this section, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care.

''(6) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

''(b) PREMIUMS AND FINANCING.—

''(1) ESTABLISHMENT OF PREMIUMS.—

''(A) IN GENERAL.—The Secretary shall establish geographically adjusted premium rates for the public health insurance option—

''(i) in a manner that complies with the premium rules under paragraph (3); and

"(ii) at a level sufficient to fully finance the costs of—

"(I) health benefits provided by the public health insurance option; and

"(II) administrative costs related to operating the public health insurance option.

"(B) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

"(2) ACCOUNT.—

"(A) ESTABLISHMENT.—There is established in the Treasury of the United States an account for the receipts and disbursements attributable to the operation of the public health insurance option, including the start-up funding under subparagraph (B). Section 1854(g) of the Social Security Act shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

"(B) START-UP FUNDING.—

"(i) IN GENERAL.—In order to provide for the establishment of the public health insurance option there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

"(ii) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under clause (i) to the Treasury in an amortized manner over the 10-year period beginning with 2018.

"(iii) LIMITATION ON FUNDING.—Nothing in this subsection shall be construed as authorizing any additional appropriations to the account, other than such amounts as are otherwise provided with re-

spect to other health benefits plans participating under the Exchange involved.

''(3) INSURANCE RATING RULES.—The premium rate charged for the public health insurance option may not vary except as provided under section 2701 of the Public Health Service Act.

''(c) PAYMENT RATES FOR ITEMS AND SERVICES.—

''(1) RATES ESTABLISHED BY SECRETARY.—

''(A) IN GENERAL.—The Secretary shall establish payment rates for the public health insurance option for services and health care providers consistent with this subsection and may change such payment rates in accordance with subsection (d).

''(B) INITIAL PAYMENT RULES.—

''(i) IN GENERAL.—During 2018, 2019, and 2020, the Secretary shall set the payment rates under this subsection for services and providers described in subparagraph (A) equal to the payment rates for equivalent services and providers under parts A and B of Medicare, subject to clause (ii), paragraph (4), and subsection (d).

"(ii) EXCEPTIONS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare for graduate medical education and disproportionate share hospitals shall apply under this section.

"(C) FOR NEW SERVICES.—The Secretary shall modify payment rates described in subparagraph (B) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

"(D) PRESCRIPTION DRUGS.—Payment rates under this subsection for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

"(2) SUBSEQUENT PERIODS; PROVIDER NETWORK.—

"(A) SUBSEQUENT PERIODS.—Beginning with 2021 and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote af-

fordability and the efficient delivery of medical care consistent with subsection (a)(1). Such rates shall not be set at levels expected to increase average medical costs per enrollee covered under the public health insurance option beyond what would be expected if the process under paragraph (1)(B) were continued, as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services.

''(B) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary.

''(3) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code, shall apply to the process for the initial establishment of payment rates under this subsection but not to the specific methodology for establishing such rates or the calculation of such rates.

''(4) CONSTRUCTION.—Nothing in this section shall be construed as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the provisions of sub-

section (a)(1) and any appropriate adjustments based on the demographic characteristics of enrollees covered under the public health insurance option, but in no case shall the correction of payments under this paragraph result in a level of expenditures per enrollee that exceeds the level of expenditures that would have occurred under paragraph (1)(B), as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services.

''(5) CONSTRUCTION.—Nothing in this section shall be construed as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services, such as the initiatives provided for under subsection (d).

''(6) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this subsection or under subsection (d).

''(d) MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.—

''(1) IN GENERAL.—For plan years beginning with 2018, the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health

insurance option. The payment mechanisms and policies under this subsection may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. Payment rates under such payment mechanisms and policies shall not be set at levels expected to increase average medical costs per enrollee covered under the public health insurance option beyond what would be expected if the process under subsection (c)(1)(B) were continued, as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services.

''(2) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—The Secretary shall design and implement the payment mechanisms and policies under this subsection in a manner that—

''(A) seeks to—

''(i) improve health outcomes;

''(ii) reduce health disparities (including racial, ethnic, and other disparities);

''(iii) provide efficient and affordable care;

"(iv) address geographic variation in the provision of health services; or

"(v) prevent or manage chronic illness; and

"(B) promotes care that is integrated, patient-centered, high-quality, and efficient.

"(3) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all health benefits plans participating under the Exchange involved, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

"(4) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

"(e) PROVIDER PARTICIPATION.—

"(1) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

"(2) LICENSURE OR CERTIFICATION.—The Secretary shall not allow a health care provider to par-

ticipate in the public health insurance option unless such provider is appropriately licensed or certified under State law.

''(3) PAYMENT TERMS FOR PROVIDERS.—

''(A) PHYSICIANS.—The Secretary shall provide for the annual participation of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

''(i) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment rate established under this section (without regard to cost-sharing) as the payment in full.

''(ii) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment rate described in subsection (c) for such physicians) that exceed the ratio permitted under section 1848(g)(2)(C) of the Social Security Act.

''(B) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians)

under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment rate established under subsection (c) (without regard to cost-sharing) as the payment in full.

''(4) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from participation under the public health insurance option a health care provider that is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act).

''(f) APPLICATION OF FRAUD AND ABUSE PROVISIONS.—Provisions of law (other than criminal law provisions) identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as the False Claims Act (31 U.S.C. 3729 et seq.), shall also apply to the public health insurance option.

''(g) MEDICARE DEFINED.—For purposes of this section, the term 'Medicare' means the health insurance programs under title XVIII of the Social Security Act.''.

(b) CONFORMING AMENDMENTS.—

(1) TREATMENT AS QUALIFIED HEALTH PLAN.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act is amended—

(A) in the heading, by inserting ", THE PUBLIC HEALTH INSURANCE OPTION," before "AND"; and

(B) by inserting "the public health insurance option under section 1325," before "and a multi-State plan".

(2) LEVEL PLAYING FIELD.—Section 1324(a) of such Act is amended by inserting "the public health insurance option under section 1325," before "or a multi-State qualified health plan".

TITLE II—HEALTH CARE FINANCIAL ASSISTANCE

SEC. 201. INCREASE IN ELIGIBILITY FOR PREMIUM ASSISTANCE TAX CREDITS.

(a) IN GENERAL.—Subparagraph (A) of section 36B(c)(1) of the Internal Revenue Code of 1986 is amended by striking "400 percent" and inserting "600 percent".

(b) CONFORMING AMENDMENT.—The table contained in clause (i) of section 36B(b)(3)(A)(i) of the Internal Revenue Code of 1986 is amended by striking "400%" and inserting "600%".

(c) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—Clause (i) of section 36B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''In the case of'' and all that follows through ''the amount of'' and inserting ''The amount of''; and

(2) by striking ''but less than 400%'' in the table.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 202. ENHANCEMENTS FOR REDUCED COST SHARING.

(a) MODIFICATION OF AMOUNT.—

(1) IN GENERAL.—Section 1402(c)(2) of the Patient Protection and Affordable Care Act is amended to read as follows:

''(2) ADDITIONAL REDUCTION.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

''(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, in-

crease the plan's share of the total allowed costs of benefits provided under the plan to 95 percent of such costs;

"(B) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

"(C) in the case of an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs.".

(2) CONFORMING AMENDMENT.—Clause (i) of section 1402(c)(1)(B) of such Act is amended to read as follows:

"(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

''(I) 95 percent in the case of an eligible insured described in paragraph (2)(A);

''(II) 90 percent in the case of an eligible insured described in paragraph (2)(B); and

''(III) 85 percent in the case of an eligible insured described in paragraph (2)(C).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2017.

(b) FUNDING.—Section 1402 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

''(g) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary such sums as may be necessary for payments under this section.''.

TITLE III—DRUG PRICING

SEC. 301. REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR DRUGS DISPENSED TO LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(1) in subsection (e)(1), in the matter preceding subparagraph (A), by inserting ''and subsection (f)'' after ''this subsection''; and

(2) by adding at the end the following new subsection:

''(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR REBATE ELIGIBLE INDIVIDUALS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2019, in this part, the term 'covered part D drug' does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

''(B) 2018 PLAN YEAR REQUIREMENT.—Any drug or biological product manufactured by a manufacturer that declines to enter into a rebate agreement described in paragraph (2) for the period beginning on January 1, 2018, and ending on December 31, 2018, shall not be included as a 'covered part D drug' for the subsequent plan year.

''(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manu-

facturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2017, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2017, to any rebate eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor or MA organization under this part for such period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3), or 30 days after the receipt of information under subparagraph (D) of paragraph (3), as determined by the Secretary. Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement relating to compliance, penalties, and program evaluations, investigations, and audits that are similar to the terms and conditions for rebate agreements under paragraphs (3) and (4) of section 1927(b).

''(3) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer and dispensed to a rebate eligible individual, shall be equal to the product of—

''(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor or an MA organization under this part for the rebate period, including payments passed through the low-income and reinsurance subsidies under sections 1860D–14 and 1860D–15(b), respectively; and

''(ii) the amount (if any) by which—

''(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

''(II) the average Medicare drug program rebate eligible rebate amount

(as defined in subparagraph (C)) for such form, strength, and period.

"(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period—

"(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii)(II) or (2)(C) of section 1927(c) plus the amount, if any, specified in subparagraph (A)(ii) of paragraph (2) of such section, for such form, strength, and period; or

"(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

"(C) AVERAGE MEDICARE DRUG PROGRAM REBATE ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program rebate eligible rebate amount' means, with respect to each dosage

form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering an MA–PD plan under part C, of—

"(i) the product, for each such sponsor or organization, of—

"(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) or any discounts under the program under section 1860D–14A) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to rebate eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not rebate eligible individuals; and

"(II) the number of the units of such dosage and strength of the drug

dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA organization; divided by

''(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA organizations.

''(D) USE OF ESTIMATES.—The Secretary may establish a methodology for estimating the average Medicare drug program rebate eligible rebate amounts for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates under this section. If the Secretary elects to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall establish a reconciliation process for adjusting manufacturer rebate payments not later than 3 months after

the date that manufacturers receive the information collected under section 1860D–12(b)(7)(B).

''(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

''(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

''(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

''(A) REBATE ELIGIBLE INDIVIDUAL.—The term 'rebate eligible individual' means—

''(i) a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A));

''(ii) a Medicaid beneficiary treated as a subsidy eligible individual under clause (v) of section 1860D–14(a)(3)(B); and

''(iii) any part D eligible individual not described in clause (i) or (ii) who is de-

termined for purposes of the State plan under title XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E).

''(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).''.

(b) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(1) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2019, each contract entered into with a PDP sponsor under this part with respect to a prescription

drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

''(B) REPORT FORM AND CONTENTS.—Not later than a date specified by the Secretary, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

''(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to rebate eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

''(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

''(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to rebate eligible Medicare drug plan enrollees and PDP enrollees who are not rebate eligible Medicare drug plan enrollees; and

"(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program rebate eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

"(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

"(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

"(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

"(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

"(iii) clause (iv) of such subparagraph shall not apply.

"(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

"(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

"(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of

$10,000 for each day in which such information has not been provided; or

''(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

''(D) REPORTING REQUIREMENT RELATED TO REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).''.

(c) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of the

Social Security Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

''(6) REBATE FOR REBATE ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account.''.

(d) EXCLUSION FROM DETERMINATION OF BEST PRICE AND AVERAGE MANUFACTURER PRICE UNDER MEDICAID.—

(1) EXCLUSION FROM BEST PRICE DETERMINATION.—Section 1927(c)(1)(C)(ii)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(ii)(I)) is amended by inserting ''and amounts paid under a rebate agreement under section 1860D–2(f)'' after ''this section''.

(2) EXCLUSION FROM AVERAGE MANUFACTURER PRICE DETERMINATION.—Section 1927(k)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)(B)(i)) is amended—

(A) in subclause (IV), by striking ''and'' after the semicolon;

(B) in subclause (V), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(VI) amounts paid under a rebate agreement under section 1860D–2(f).''.

SEC. 302. NEGOTIATION OF PRICES FOR MEDICARE PRESCRIPTION DRUGS.

Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and inserting the following:

''(i) NEGOTIATION; NO NATIONAL FORMULARY OR PRICE STRUCTURE.—

''(1) NEGOTIATION OF PRICES WITH MANUFACTURERS.—In order to ensure that beneficiaries enrolled under prescription drug plans and MA–PD plans pay the lowest possible price, the Secretary shall have and exercise authority similar to that of other Federal entities that purchase prescription drugs in bulk to negotiate contracts with manufacturers of covered part D drugs, consistent with the requirements and in furtherance of the goals of providing quality care and containing costs under this part.

''(2) NO NATIONAL FORMULARY OR PRICE STRUCTURE.—In order to promote competition under this part and in carrying out this part, the Secretary may not require a particular formulary or

institute a price structure for the reimbursement of covered part D drugs.''.

SEC. 303. GUARANTEED PRESCRIPTION DRUG BENEFITS.

(a) IN GENERAL.—Section 1860D–3 of the Social Security Act (42 U.S.C. 1395w–103) is amended to read as follows:

''ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE

''SEC. 1860D–3. (a) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

''(1) CHOICE OF AT LEAST THREE PLANS IN EACH AREA.—Beginning on January 1, 2019, the Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in—

''(A) a nationwide prescription drug plan offered by the Secretary in accordance with subsection (b); and

''(B) at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan.

''(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1)(B) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

"(3) QUALIFYING PLAN DEFINED.—For purposes of this section, the term 'qualifying plan' means—

"(A) a prescription drug plan;

"(B) an MA–PD plan described in section 1851(a)(2)(A)(i) that provides—

"(i) basic prescription drug coverage; or

"(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C); or

"(C) a nationwide prescription drug plan offered by the Secretary in accordance with subsection (b).

"(b) HHS AS PDP SPONSOR FOR A NATIONWIDE PRESCRIPTION DRUG PLAN.—

"(1) IN GENERAL.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall take such steps as may be necessary to qualify and serve as a PDP

sponsor and to offer a prescription drug plan that offers basic prescription drug coverage throughout the United States. Such a plan shall be in addition to, and not in lieu of, other prescription drug plans offered under this part.

''(2) PREMIUM; SOLVENCY; AUTHORITIES.—In carrying out paragraph (1), the Secretary—

''(A) shall establish a premium in the amount of $37 for months in 2019 and, for months in subsequent years, in the amount specified in this paragraph for months in the previous year increased by the annual percentage increase described in section 1860D–2(b)(6) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved;

''(B) is deemed to have met any applicable solvency and capital adequacy standards; and

''(C) shall exercise such authorities (including the use of regional or other pharmaceutical benefit managers) as the Secretary determines necessary to offer the prescription drug plan in the same or a comparable manner as is the case for prescription drug plans offered by private PDP sponsors.

''(c) FLEXIBILITY IN RISK ASSUMED.—In order to ensure access pursuant to subsection (a) in an area the Secretary may approve limited risk plans under section 1860D–11(f) for the area.''.

(b) CONFORMING AMENDMENT.—Section 1860D–11(g) of the Social Security Act (42 U.S.C. 1395w–111(g)) is amended by adding at the end the following new paragraph:

''(8) APPLICATION.—This subsection shall not apply on or after January 1, 2019.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2019.

SEC. 304. FULL REIMBURSEMENT FOR QUALIFIED RETIREE PRESCRIPTION DRUG PLANS.

(a) ELIMINATION OF TRUE OUT-OF-POCKET LIMITATION.—Section 1860D–2(b)(4)(C)(iii) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)(iii)) is amended—

(1) in subclause (III), by striking ''or'' at the end;

(2) in subclause (IV), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new subclause:

"(V) under a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2))."

(b) EQUALIZATION OF SUBSIDIES.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall provide for such increase in the special subsidy payment amounts under section 1860D–22(a)(3) of the Social Security Act (42 U.S.C. 1395w–132(a)(3)) as may be appropriate to provide for payments in the aggregate equivalent to the payments that would have been made under section 1860D–15 of such Act (42 U.S.C. 1395w–115) if the individuals were not enrolled in a qualified retiree prescription drug plan. In making such computation, the Secretary shall not take into account the application of the amendments made by section 1202 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2480).

(c) EFFECTIVE DATE.—This section, and the amendments made by this section, shall take effect on January 1, 2019.

TITLE IV—MEDICAID COLLABORATIVE CARE MODELS

SEC. 401. ENHANCED FMAP FOR MEDICAL ASSISTANCE PROVIDED THROUGH A COLLABORATIVE CARE MODEL.

Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking ", and (5)" and inserting ", (5)"; and

(B) by inserting ", and (6) beginning January 1, 2018, the Federal medical assistance percentage shall be 100 percent with respect to medical assistance provided by a State for items and services delivered through a collaborative care model (as defined in subsection (ee)) or an evidence-based model (which may be a collaborative care model) that integrates behavioral health services into primary care treatment" before the period; and

(2) by adding at the end the following new subsection:

"(ee) COLLABORATIVE CARE MODELS.—

"(1) IN GENERAL.—The term 'collaborative care model' means a model for providing health care

to individuals which adheres to the core services described in paragraph (2) and under which each individual receiving care through the model receives care from a collaborative team of providers described in paragraph (3).

''(2) CORE SERVICES.—The services described in this paragraph are:

''(A) Comprehensive care management.

''(B) Care coordination and health promotion.

''(C) Comprehensive transitional care from inpatient settings to other settings, including appropriate follow up.

''(D) Individual and family support, which shall include authorized representatives.

''(E) Referral to community and social support services, as appropriate.

''(F) The use of health information technology to link services, as feasible and appropriate.

''(3) COLLABORATIVE HEALTH TEAM.—A team described in this paragraph includes the following providers:

"(A) A primary care provider such as a primary care physician, an internist, a nurse practitioner, or a physician's assistant.

"(B) Care management staff which shall include a member who is a registered professional nurse, a clinical social worker, or a psychologist, and who specializes in primary care management and is trained to provide evidence based care coordination, brief behavioral interventions, and to support treatments (including medications) initiated by a primary care physician.

"(C) A psychiatric consultant who shall advise the primary care provider as necessary (either in person or remotely).".

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