116TH CONGRESS
2D SESSION

H. R. 1425

AN ACT

To amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patient Protection and Affordable Care Enhancement Act''.

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TITLE I—LOWERING HEALTH CARE COSTS AND PROTECTING PEOPLE WITH PRE-EXISTING CONDITIONS

SEC. 101. IMPROVING AFFORDABILITY BY EXPANDING PREMIUM ASSISTANCE FOR CONSUMERS.

(a) IN GENERAL.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended to read as follows:

"(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150.0 percent	0.0	0.0

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
150.0 percent up to 200.0 percent	0.0	3.0
200.0 percent up to 250.0 percent	3.0	4.0
250.0 percent up to 300.0 percent	4.0	6.0
300.0 percent up to 400.0 percent	6.0	8.5
400.0 percent and higher	8.5	8.5".

(b) CONFORMING AMENDMENT.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking "but does not exceed 400 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 102. IMPROVING AFFORDABILITY BY REDUCING OUT-OF-POCKET AND PREMIUM COSTS FOR CONSUMERS.

Section 1302(c)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(c)(4)) is amended by striking "calendar year)" and inserting "calendar year, based on estimates and projections for the applicable calendar year of the percentage (if any) by which the average per enrollee premium for eligible employer-sponsored health plans (as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986) exceeds such average per enrollee premium for the preceding calendar year, as published in the National Health Expenditure Accounts)".

SEC. 103. EXPANDING AFFORDABILITY FOR WORKING FAMILIES TO FIX THE FAMILY GLITCH.

(a) IN GENERAL.—Clause (i) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended to read as follows:

"(i) COVERAGE MUST BE AFFORDABLE.—

"(I) EMPLOYEES.—An employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the employee's household income.

"(II) FAMILY MEMBERS.—An individual who is eligible to enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) by reason of a relationship the individual bears to the employee shall not be treated as eligible for minimum essential coverage by reason of such eligi-

bility to enroll if the employee's required contribution (within the meaning of section 5000A(e)(1)(B), determined by substituting 'family' for 'self-only') with respect to the plan exceeds 9.5 percent of the employee's household income.''.

(b) CONFORMING AMENDMENTS.—

(1) Clause (ii) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by striking ''Except as provided in clause (iii), an employee'' and inserting ''An individual''.

(2) Clause (iii) of section 36B(c)(2)(C) of such Code is amended by striking ''the last sentence of clause (i)'' and inserting ''clause (i)(II)''.

(3) Clause (iv) of section 36B(c)(2)(C) of such Code is amended by striking ''the 9.5 percent under clause (i)(II)'' and inserting ''the 9.5 percent under clauses (i)(I) and (i)(II)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2021.

SEC. 104. TAX CREDIT RECONCILIATION PROTECTIONS FOR INDIVIDUALS RECEIVING SOCIAL SECURITY LUMP-SUM PAYMENTS.

(a) IN GENERAL.—Section 36B(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(C) EXCLUSION OF PORTION OF LUMP-SUM SOCIAL SECURITY BENEFITS.—

"(i) IN GENERAL.—The term 'modified adjusted gross income' shall not include so much of any lump-sum social security benefit payment as is attributable to months ending before the beginning of the taxable year.

"(ii) LUMP-SUM SOCIAL SECURITY BENEFIT PAYMENT.—For purposes of this subparagraph, the term 'lump-sum social security benefit payment' means any payment of social security benefits (as defined in section 86(d)(1)) which constitutes more than 1 month of such benefits.

"(iii) ELECTION TO INCLUDE EXCLUDABLE AMOUNT.—A taxpayer may elect (at such time and in such manner as the Secretary may provide) to have this

subparagraph not apply for any taxable year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2019.

SEC. 105. PRESERVING STATE OPTION TO IMPLEMENT HEALTH CARE MARKETPLACES.

(a) IN GENERAL.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended—

(1) in subsection (a)—

(A) in paragraph (4)(B), by striking ''under this subsection'' and inserting ''under this paragraph or paragraph (1)''; and

(B) by adding at the end the following new paragraph:

''(6) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—

''(A) IN GENERAL.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $200 million to award grants to eligible States for the uses described in paragraph (3).

''(B) DURATION AND RENEWABILITY.—A grant awarded under subparagraph (A) shall be for a period of 2 years and may not be renewed.

''(C) LIMITATION.—A grant may not be awarded under subparagraph (A) after December 31, 2023.

''(D) ELIGIBLE STATE DEFINED.—For purposes of this paragraph, the term 'eligible State' means a State that, as of the date of the enactment of this paragraph, is not operating an Exchange (other than an Exchange described in section 155.200(f) of title 45, Code of Federal Regulations).''; and

(2) in subsection (d)(5)(A)—

(A) by striking ''OPERATIONS.—In establishing an Exchange under this section'' and inserting ''OPERATIONS.—

''(i) IN GENERAL.—In establishing an Exchange under this section (other than in establishing an Exchange pursuant to a grant awarded under subsection (a)(6))''; and

(B) by adding at the end the following:

''(ii) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—In establishing

an Exchange pursuant to a grant awarded under subsection (a)(6), the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2025, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.''.

(b) CLARIFICATION REGARDING FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) is amended—

(1) in paragraph (1), by striking ''If'' and inserting ''Subject to paragraph (3), if''; and

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

''(3) CLARIFICATION.—This subsection shall not apply in the case of a State that elects to apply the requirements described in subsection (a) and satisfies the requirement described in subsection (b) on or after January 1, 2014.''.

SEC. 106. ESTABLISHING A HEALTH INSURANCE AFFORDABILITY FUND.

Subtitle D of title I of the Patient Protection and Affordable Care Act is amended by inserting after part 5 (42 U.S.C. 18061 et seq.) the following new part:

"PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

"SEC. 1351. ESTABLISHMENT OF PROGRAM.

''There is hereby established the 'Improve Health Insurance Affordability Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this part, to the 50 States and the District of Columbia (each referred to in this section as a 'State') beginning on January 1, 2022, for the purposes described in section 1352.

"SEC. 1352. USE OF FUNDS.

''(a) IN GENERAL.—A State shall use the funds allocated to the State under this part for one of the following purposes:

''(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

''(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

''(b) EXCLUSION OF CERTAIN GRANDFATHERED AND TRANSITIONAL PLANS.—For purposes of subsection (a), a plan described in this subsection is the following:

''(1) A grandfathered health plan (as defined in section 1251).

''(2) A plan (commonly referred to as a 'transitional 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 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, February 13, 2017, April 9, 2018, March 25, 2019, and January 31, 2020, or under any subsequent extensions thereof.

''(3) Student health insurance coverage (as defined in section 147.145 of title 45, Code of Federal Regulations).

"SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

''(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

''(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2022), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2022, not later than 90 days after the date of the enactment of this part and, in the case of allocations for a subsequent year, not later than March 1 of the previous year) and in such form and manner as specified by the Administrator containing—

''(A) a description of how the funds will be used; and

''(B) such other information as the Administrator may require.

''(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of

such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

''(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

''(4) REVOCATION OF APPROVAL.—The approval of an application of a State, with respect to a purpose described in section 1352, may be revoked if the State fails to use funds provided to the State under this section for such purpose or otherwise fails to comply with the requirements of this section.

''(b) DEFAULT FEDERAL SAFEGUARD.—

''(1) 2022.—For 2022, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

''(2) 2023 AND SUBSEQUENT YEARS.—For 2023 or a subsequent year, in the case of a State that does not have in effect an approved application under this section for such year, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

''(3) SPECIFIED USE.—The amount described in paragraph (4), with respect to 2022 or a subsequent year, shall be used to carry out the purpose described in section 1352(a)(1) in each State described in paragraph (1) or (2) for such year, as applicable, by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2)), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to, subject to paragraph (5), the percentage (specified for such year by the Secretary under such subparagraph) of the amount of such claims.

''(4) AMOUNT DESCRIBED.—The amount described in this paragraph, with respect to 2022 or a subsequent year, is the amount equal to the total

sum of amounts that the Secretary would otherwise estimate under section 1354(b)(2)(A)(i) for such year for each State described in paragraph (1) or (2) for such year, as applicable, if each such State were not so described for such year.

''(5) ADJUSTMENT.—For purposes of this subsection, the Secretary may apply a percentage under paragraph (3) with respect to a year that is less than the percentage otherwise specified in section 1354(b)(2)(B) for such year, if the cost of paying the total eligible attachment range claims for States described in this subsection for such year at such percentage otherwise specified would exceed the amount calculated under paragraph (4) for such year.

''SEC. 1354. ALLOCATIONS.

''(a) APPROPRIATION.—For the purpose of providing allocations for States under subsection (b) and payments under section 1353(b) there is appropriated, out of any money in the Treasury not otherwise appropriated, $10,000,000,000 for 2022 and each subsequent year.

''(b) ALLOCATIONS.—

''(1) PAYMENT.—

''(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the

Secretary shall, with respect to a State not described in section 1353(b) for such year and not later than the date specified under subparagraph (B) for such year, allocate for such State the amount determined for such State and year under paragraph (2).

''(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

''(i) for 2022, the date that is 45 days after the date of the enactment of this part; and

''(ii) for 2023 or a subsequent year, January 1 of the respective year.

''(C) NOTIFICATIONS OF ALLOCATION AMOUNTS.—For 2023 and each subsequent year, the Secretary shall notify each State of the amount determined for such State under paragraph (2) for such year by not later than January 1 of the previous year.

''(2) ALLOCATION AMOUNT DETERMINATIONS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State described in

paragraph (1)(A) for such year is the amount equal to—

"(i) the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if such State used such funds only for the purpose described in paragraph (1) of section 1352(a) at the dollar amounts and percentage specified under subparagraph (B) for such year; minus

"(ii) the amount, if any, by which the Secretary determines—

"(I) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year without application of this part; exceeds

"(II) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for

such year if such State were a State described in section 1353(b) for such year.

For purposes of the previous sentence and section 1353(b)(3), the term 'attachment range claims' means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount specified by the Secretary for such year, under subparagraph (B).

''(B) SPECIFICATIONS.—For purposes of subparagraph (A) and section 1353(b)(3), the Secretary shall determine the dollar amounts and the percentage to be specified under this subparagraph for a year in a manner to ensure that the total amount of expenditures under this part for such year is estimated to equal the total amount appropriated for such year under subsection (a) if such expenditures were used solely for the purpose described in paragraph (1) of section 1352(a) for attachment range claims at the dollar amounts and percentage so specified for such year.

''(3) AVAILABILITY.—Funds allocated to a State under this subsection for a year shall remain available through the end of the subsequent year.''.

SEC. 107. RESCINDING THE SHORT-TERM LIMITED DURATION INSURANCE REGULATION.

(a) FINDINGS.—Congress finds the following:

(1) On August 3, 2018, the Administration issued a final rule entitled ''Short-Term, Limited-Duration Insurance'' (83 Fed. Reg. 38212).

(2) The final rule dramatically expands the sale and marketing of insurance that—

(A) may discriminate against individuals living with preexisting health conditions, including children with complex medical needs and disabilities and their families;

(B) lacks important financial protections provided by the Patient Protection and Affordable Care Act (Public Law 111–148), including the prohibition of annual and lifetime coverage limits and annual out-of-pocket limits, that may increase the cost of treatment and cause financial hardship to those requiring medical care, including children with complex medical needs and disabilities and their families; and

(C) excludes coverage of essential health benefits including hospitalization, prescription drugs, and other lifesaving care.

(3) The implementation and enforcement of the final rule weakens critical protections for up to 130 million Americans living with preexisting health conditions and may place a large financial burden on those who enroll in short-term limited-duration insurance, which jeopardizes Americans' access to quality, affordable health insurance.

(b) PROHIBITION.—The Secretary of Health and Human Services, the Secretary of the Treasury, and the Secretary of Labor—

(1) may not take any action to implement, enforce, or otherwise give effect to the rule entitled ''Short-Term, Limited Duration Insurance'' (83 Fed. Reg. 38212 (August 3, 2018));

(2) shall apply any regulation revised by such rule as if such rule had not been issued; and

(3) may not promulgate any substantially similar rule.

SEC. 108. REVOKING SECTION 1332 GUIDANCE.

(a) FINDINGS.—Congress finds the following:

(1) On October 24, 2018, the administration published new guidance to carry out section 1332 of

the Patient Protection and Affordable Care Act (42 U.S.C. 18052) entitled ''State Relief and Empowerment Waivers'' (83 Fed. Reg. 53575).

(2) The new guidance encourages States to provide health insurance coverage through insurance plans that may discriminate against individuals with preexisting health conditions, including the one in four Americans living with a disability.

(3) The implementation and enforcement of the new guidance weakens protections for the millions of Americans living with preexisting health conditions and jeopardizes Americans' access to quality, affordable health insurance coverage.

(b) PROVIDING THAT CERTAIN GUIDANCE RELATED TO WAIVERS FOR STATE INNOVATION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT SHALL HAVE NO FORCE OR EFFECT.—Beginning July 1, 2020, the Secretary of Health and Human Services and the Secretary of the Treasury may not take any action to implement, enforce, or otherwise give effect to the guidance entitled ''State Relief and Empowerment Waivers'' (83 Fed. Reg. 53575 (October 24, 2018)), including any such action that would result in individuals losing health insurance coverage that includes the essential health benefits package (as defined in subsection (a) of section 1302 of

the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) without regard to any waiver of any provision of such package under a waiver under such section 1332), including the maternity and newborn care essential health benefit described in subsection (b)(1)(D) of such section, including any such action that would result in a decrease in the number of such individuals enrolled in coverage that is at least as comprehensive as the coverage defined in section 1302(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) compared to the number of such individuals who would have been so enrolled in such coverage had such action not been taken, including any such action that would, with respect to individuals with substance use disorders, including opioid use disorders, reduce the availability or affordability of coverage that is at least as comprehensive as the coverage defined in section 1302(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) compared to the availability or affordability, respectively, of such coverage had such action not been taken, including any such action that would result, with respect to vulnerable populations (including low-income individuals, elderly individuals, and individuals with serious health issues or who have a greater risk of developing serious health issues), in a decrease in the availability of coverage that is at least

as comprehensive as the coverage defined in section 1302(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) with coverage and cost sharing protections required under section 1332(b)(1)(B) of such Act (42 U.S.C. 18052(b)(1)(B)), including any such action that would, with respect to individuals with preexisting conditions, reduce the affordability of coverage that is at least as comprehensive as the coverage defined in section 1302(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) compared to the affordability of such coverage had such action not been taken, including any such action that would result in higher health insurance premiums for individuals enrolled in health insurance coverage that is at least as comprehensive as the coverage defined in section 1302(b) of such Act (42 U.S.C. 18022(b)), and the Secretaries may not promulgate any substantially similar guidance or rule. Nothing in the previous sentence shall be construed to affect the approval of waivers under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) that establish reinsurance programs that are consistent with the requirements under subsection (b)(1) of such section (42 U.S.C. 18052(b)(1)), lower health insurance premiums, and protect health insurance coverage for people with preexisting conditions.

(c) GAO REPORT ON AFFECT OF STATE INNOVATION WAIVERS ON COVERAGE OF INDIVIDUALS AND ON MENTAL HEALTH HEALTH CARE TREATMENT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the number of individuals expected to lose access to health insurance coverage (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) if subsection (b) were not enacted and waivers under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) were approved under the guidance described in such subsection (b). Such report shall include an analysis of the expected effect such waivers approved under such guidance would have on mental health care treatment.

SEC. 109. REQUIRING MARKETPLACE OUTREACH, EDUCATIONAL ACTIVITIES, AND ANNUAL ENROLLMENT TARGETS.

(a) IN GENERAL.—Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)), as amended by section 105(b), is further amended by adding at the end the following new paragraphs:

"(4) OUTREACH AND EDUCATIONAL ACTIVITIES.—

"(A) IN GENERAL.—In the case of an Exchange established or operated by the Secretary within a State pursuant to this subsection, the Secretary shall carry out outreach and educational activities for purposes of informing individuals about qualified health plans offered through the Exchange, including by informing such individuals of the availability of coverage under such plans and financial assistance for coverage under such plans. Such outreach and educational activities shall be provided in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the Exchange (including hard-to-reach populations, such as racial and sexual minorities, limited English proficient populations, individuals in rural areas, veterans, and young adults) and shall be provided to populations residing in high health disparity areas (as defined in subparagraph (E)) served by the Exchange, in addition to other populations served by the Exchange.

"(B) LIMITATION ON USE OF FUNDS.—No funds appropriated under this paragraph shall

be used for expenditures for promoting non-ACA compliant health insurance coverage.

"(C) NON-ACA COMPLIANT HEALTH INSURANCE COVERAGE.—For purposes of subparagraph (B):

"(i) The term 'non-ACA compliant health insurance coverage' means health insurance coverage, or a group health plan, that is not a qualified health plan.

"(ii) Such term includes the following:

"(I) An association health plan.

"(II) Short-term limited duration insurance.

"(D) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are hereby appropriated for fiscal year 2022 and each subsequent fiscal year, $100,000,000 to carry out this paragraph. Funds appropriated under this subparagraph shall remain available until expended.

"(E) HIGH HEALTH DISPARITY AREA DEFINED.—For purposes of subparagraph (A), the term 'high health disparity area' means a contiguous geographic area that—

"(i) is located in one census tract or ZIP code;

"(ii) has measurable and documented racial, ethnic, or geographic health disparities;

"(iii) has a low-income population, as demonstrated by—

"(I) average income below 138 percent of the Federal poverty line; or

"(II) a rate of participation in the special supplemental nutrition program under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) that is higher than the national average rate of participation in such program;

"(iv) has poor health outcomes, as demonstrated by—

"(I) lower life expectancy than the national average; or

"(II) a higher percentage of instances of low birth weight than the national average; and

''(v) is part of a Metropolitan Statistical Area identified by the Office of Management and Budget.

''(5) ANNUAL ENROLLMENT TARGETS.—For plan year 2021 and each subsequent plan year, in the case of an Exchange established or operated by the Secretary within a State pursuant to this subsection, the Secretary shall establish annual enrollment targets for such Exchange for such year.''.

(b) STUDY AND REPORT.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall release to Congress all aggregated documents relating to studies and data sets that were created on or after January 1, 2014, and related to marketing and outreach with respect to qualified health plans offered through Exchanges under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.).

SEC. 110. REPORT ON EFFECTS OF WEBSITE MAINTENANCE DURING OPEN ENROLLMENT.

Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report examining whether the Department of Health and Human Services has been conducting maintenance on the website commonly referred to

as ''Healthcare.gov'' during annual open enrollment periods (as described in section 1311(c)(6)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)(B)) in such a manner so as to minimize any disruption to the use of such website resulting from such maintenance.

SEC. 111. PROMOTING CONSUMER OUTREACH AND EDUCATION.

(a) IN GENERAL.—Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(C) SELECTION OF RECIPIENTS.—In the case of an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), in awarding grants under paragraph (1), the Exchange shall—

''(i) select entities to receive such grants based on an entity's demonstrated capacity to carry out each of the duties specified in paragraph (3);

''(ii) not take into account whether or not the entity has demonstrated how the entity will provide information to individ-

uals relating to group health plans offered by a group or association of employers described in section 2510.3–5(b) of title 29, Code of Federal Regulations (or any successor regulation), or short-term limited duration insurance (as defined by the Secretary for purposes of section 2791(b)(5) of the Public Health Service Act); and

''(iii) ensure that, each year, the Exchange awards such a grant to—

''(I) at least one entity described in this paragraph that is a community and consumer-focused nonprofit group; and

''(II) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group in addition to any such group awarded a grant pursuant to subclause (I).

In awarding such grants, an Exchange may consider an entity's record with respect to waste, fraud, and abuse for purposes of maintaining the integrity of such Exchange.'';

(2) in paragraph (3)—

(A) by amending subparagraph (C) to read as follows:

''(C) facilitate enrollment, including with respect to individuals with limited English proficiency and individuals with chronic illnesses, in qualified health plans, State medicaid plans under title XIX of the Social Security Act, and State child health plans under title XXI of such Act;'';

(B) in subparagraph (D), by striking ''and'' at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and'';

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) provide referrals to community-based organizations that address social needs related to health outcomes.''; and

(E) by adding at the end the following flush left sentence:

''The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.'';

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking ''not'';

(B) in clause (i)—

(i) by inserting ''not'' before ''be''; and

(ii) by striking ''; or'' and inserting a semicolon;

(C) in clause (ii)—

(i) by inserting ''not'' before ''receive''; and

(ii) by striking the period and inserting a semicolon; and

(D) by adding at the end the following new clauses:

''(iii) maintain physical presence in the State of the Exchange so as to allow in-person assistance to consumers; and

''(iv) receive opioid specific education and training that ensures the navigator can best educate individuals on qualified health plans offered through an Exchange, specifically coverage under such plans for opioid health care treatment.''; and

(4) in paragraph (6)—

(A) by striking ''FUNDING.—Grants under'' and inserting ''FUNDING.—

''(A) STATE EXCHANGES.—Grants under''; and

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

''(B) FEDERAL EXCHANGES.—For purposes of carrying out this subsection, with respect to an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), the Secretary shall obligate $100,000,000 out of amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations), for fiscal year 2022 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2021.

SEC. 112. IMPROVING TRANSPARENCY AND ACCOUNTABILITY IN THE MARKETPLACE.

(a) OPEN ENROLLMENT REPORTS.—For plan year 2021 and each subsequent year, the Secretary of Health

and Human Services (referred to in this section as the ''Secretary''), in coordination with the Secretary of the Treasury and the Secretary of Labor, shall issue biweekly public reports during the annual open enrollment period on the performance of the federally facilitated Exchange operated pursuant to section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)). Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the number of unique website visits;

(2) the number of individuals who create an account;

(3) the number of calls to the call center;

(4) the average wait time for callers contacting the call center;

(5) the number of individuals who enroll in a qualified health plan; and

(6) the percentage of individuals who enroll in a qualified health plan through each of—

(A) the website;

(B) the call center;

(C) navigators;

(D) agents and brokers;

(E) the enrollment assistant program;

(F) directly from issuers or web brokers; and

(G) other means.

(b) OPEN ENROLLMENT AFTER ACTION REPORT.—For plan year 2021 and each subsequent year, the Secretary, in coordination with the Secretary of the Treasury and the Secretary of Labor, shall publish an after action report not later than 3 months after the completion of the annual open enrollment period regarding the performance of the Exchange described in subsection (a) for the applicable plan year. Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the open enrollment data reported under subsection (a) for the entirety of the enrollment period; and

(2) activities related to patient navigators described in section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)), including—

(A) the performance objectives established by the Secretary for such patient navigators;

(B) the number of consumers enrolled by such a patient navigator;

(C) an assessment of how such patient navigators have met established performance metrics, including a detailed list of all patient navigators, funding received by patient navigators, and whether established performance objectives of patient navigators were met; and

(D) with respect to the performance objectives described in subparagraph (A)—

(i) whether such objectives assess the full scope of patient navigator responsibilities, including general education, plan selection, and determination of eligibility for tax credits, cost-sharing reductions, or other coverage;

(ii) how the Secretary worked with patient navigators to establish such objectives; and

(iii) how the Secretary adjusted such objectives for case complexity and other contextual factors.

(c) REPORT ON ADVERTISING AND CONSUMER OUTREACH.—Not later than 3 months after the completion of the annual open enrollment period for plan year 2021, the Secretary shall issue a report on advertising and outreach

to consumers for the open enrollment period for plan year 2021. Such report shall include a description of—

(1) the division of spending on individual advertising platforms, including television and radio advertisements and digital media, to raise consumer awareness of open enrollment;

(2) the division of spending on individual outreach platforms, including email and text messages, to raise consumer awareness of open enrollment; and

(3) whether the Secretary conducted targeted outreach to specific demographic groups and geographic areas.

(b) PROMOTING TRANSPARENCY AND ACCOUNTABILITY IN THE ADMINISTRATION'S EXPENDITURES OF EXCHANGE USER FEES.—For plan year 2021 and each subsequent plan year, not later than the date that is 3 months after the end of such plan year, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress and make available to the public an annual report on the expenditures by the Department of Health and Human Services of user fees collected pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations). Each such report for a plan year shall include a detailed accounting of the amount of such user fees collected during such plan

year and of the amount of such expenditures used during such plan year for the federally facilitated Exchange operated pursuant to section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) on outreach and enrollment activities, navigators, maintenance of Healthcare.gov, and operation of call centers.

SEC. 113. IMPROVING AWARENESS OF HEALTH COVERAGE OPTIONS.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall update, and make publicly available in a prominent location on the website of the Department of Labor, the model Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to in this section as ''COBRA'') continuation coverage general notice and the model COBRA continuation coverage election notice developed by the Secretary of Labor for purposes of facilitating compliance of group health plans with the notification requirements under section 606 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166). In updating each such notice, the Secretary of Labor shall include information regarding any Exchange established under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) through which a qualified bene-

ficiary may be eligible to enroll in a qualified health plan, including—

(1) the publicly accessible Internet website address for such Exchange;

(2) the publicly accessible Internet website address for the Find Local Help directory maintained by the Department of Health and Human Services on the healthcare.gov Internet website (or a successor website);

(3) a clear explanation that—

(A) an individual who is eligible for continuation coverage may also be eligible to enroll, with financial assistance, in a qualified health plan offered through such Exchange, but, in the case that such individual elects to enroll in such continuation coverage and subsequently elects to terminate such continuation coverage before the period of such continuation coverage expires, such individual will not be eligible to enroll in a qualified health plan offered through such Exchange during a special enrollment period; and

(B) an individual who elects to enroll in continuation coverage will remain eligible to enroll in a qualified health plan offered through

such Exchange during an open enrollment period and may be eligible for financial assistance with respect to enrolling in such a qualified health plan;

(4) information on consumer protections with respect to enrolling in a qualified health plan offered through such Exchange, including the requirement for such a qualified health plan to provide coverage for essential health benefits (as defined in section 1302(b) of such Act (42 U.S.C. 18022(b)) and the requirements applicable to such a qualified health plan under part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.); and

(5) information on the availability of financial assistance with respect to enrolling in a qualified health plan, including the maximum income limit for eligibility for a premium tax credit under section 36B of the Internal Revenue Code of 1986.

(b) NAME OF NOTICES.—In addition to updating the model COBRA continuation coverage general notice and the model COBRA continuation coverage election notice under paragraph (1), the Secretary of Labor shall rename each such notice as the ''model COBRA continuation coverage and Affordable Care Act coverage general notice''

and the ''model COBRA continuation coverage and Affordable Care Act coverage election notice'', respectively.

(c) CONSUMER TESTING.—Prior to making publicly available the model COBRA continuation coverage general notice and the model COBRA continuation coverage election notice updated under paragraph (1), the Secretary of Labor shall provide an opportunity for consumer testing of each such notice, as so updated, to ensure that each such notice is clear and understandable to the average participant or beneficiary of a group health plan.

(d) DEFINITIONS.—In this subsection:

(1) CONTINUATION COVERAGE.—The term ''continuation coverage'', with respect to a group health plan, has the meaning given such term in section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162).

(2) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 607 of such Act (29 U.S.C. 1167).

(3) QUALIFIED BENEFICIARY.—The term ''qualified beneficiary'' has the meaning given such term in such section 607.

(4) QUALIFIED HEALTH PLAN.—The term ''qualified health plan'' has the meaning given such

term in section 1301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18021).

SEC. 114. PROMOTING STATE INNOVATIONS TO EXPAND COVERAGE.

(a) IN GENERAL.—Subject to subsection (d), the Secretary of Health and Human Services shall award grants to eligible State agencies to enable such States to explore innovative solutions to promote greater enrollment in health insurance coverage in the individual and small group markets, including activities described in subsection (c).

(b) ELIGIBILITY.—For purposes of subsection (a), eligible State agencies are Exchanges established by a State under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) and State agencies with primary responsibility over health and human services for the State involved.

(c) USE OF FUNDS.—For purposes of subsection (a), the activities described in this subsection are the following:

(1) State efforts to streamline health insurance enrollment procedures in order to reduce burdens on consumers and facilitate greater enrollment in health insurance coverage in the individual and small group markets, including automatic enrollment and re-enrollment of, or pre-populated applications for, in-

dividuals without health insurance who are eligible for tax credits under section 36B of the Internal Revenue Code of 1986, with the ability to opt out of such enrollment.

(2) State investment in technology to improve data sharing and collection for the purposes of facilitating greater enrollment in health insurance coverage in such markets.

(3) Implementation of a State version of an individual mandate to be enrolled in health insurance coverage.

(4) Feasibility studies to develop comprehensive and coherent State plan for increasing enrollment in the individual and small group market.

(d) FUNDING.—For purposes of carrying out this section, there is hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $200,000,000 for each of the fiscal years 2022 through 2024. Such amount shall remain available until expended.

SEC. 115. STRENGTHENING NETWORK ADEQUACY.

(a) IN GENERAL.—Section 1311(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(d)) is amended by adding at the end the following new paragraph:

''(8) NETWORK ADEQUACY STANDARDS.—

"(A) CERTAIN EXCHANGES.—In the case of an Exchange operated by the Secretary pursuant section 1321(c)(1) or an Exchange described in section 155.200(f) of title 42, Code of Federal Regulations (or a successor regulation), the Exchange shall require each qualified health plan offered through such Exchange to meet such quantitative network adequacy standards as the Secretary may prescribe for purposes of this subparagraph.

"(B) STATE EXCHANGES.—In the case of an Exchange not described in subparagraph (A), the Exchange shall establish quantitative network adequacy standards with respect to qualified health plans offered through such Exchange and require such plans to meet such standards.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 116. PROTECTING CONSUMERS FROM UNREASONABLE RATE HIKES.

(a) PROTECTION FROM EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—The first section 2794 of the Public Health Service Act (42 U.S.C.

300gg–94), as added by section 1003 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by adding at the end the following new subsection:

''(e) PROTECTION FROM EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—

''(1) AUTHORITY OF STATES.—Nothing in this section shall be construed to prohibit a State from imposing requirements (including requirements relating to rate review standards and procedures and information reporting) on health insurance issuers with respect to rates that are in addition to the requirements of this section and are more protective of consumers than such requirements.

''(2) CONSULTATION IN RATE REVIEW PROCESS.—In carrying out this section, the Secretary shall consult with the National Association of Insurance Commissioners and consumer groups.

''(3) DETERMINATION OF WHO CONDUCTS REVIEWS FOR EACH STATE.—The Secretary shall determine, after the date of enactment of this section and periodically thereafter, the following:

''(A) In which markets in each State the State insurance commissioner or relevant State regulator shall undertake the corrective actions

under paragraph (4), based on the Secretary's determination that the State regulator is adequately undertaking and utilizing such actions in that market.

"(B) In which markets in each State the Secretary shall undertake the corrective actions under paragraph (4), in cooperation with the relevant State insurance commissioner or State regulator, based on the Secretary's determination that the State is not adequately undertaking and utilizing such actions in that market.

"(4) CORRECTIVE ACTION FOR EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—In accordance with the process established under this section, the Secretary or the relevant State insurance commissioner or State regulator shall take corrective actions to ensure that any excessive, unjustified, or unfairly discriminatory rates are corrected prior to implementation, or as soon as possible thereafter, through mechanisms such as—

"(A) denying rates;

"(B) modifying rates; or

"(C) requiring rebates to consumers.

''(5) NONCOMPLIANCE.—Failure to comply with any corrective action taken by the Secretary under this subsection may result in the application of civil monetary penalties under section 2723 and, if the Secretary determines appropriate, make the plan involved ineligible for classification as a qualified health plan.''.

(b) CLARIFICATION OF REGULATORY AUTHORITY.—Such section is further amended—

(1) in subsection (a)—

(A) in the heading, by striking ''PREMIUM'' and inserting ''RATE'';

(B) in paragraph (1), by striking ''unreasonable increases in premiums'' and inserting ''potentially excessive, unjustified, or unfairly discriminatory rates, including premiums,''; and

(C) in paragraph (2)—

(i) by striking ''an unreasonable premium increase'' and inserting ''a potentially excessive, unjustified, or unfairly discriminatory rate'';

(ii) by striking ''the increase'' and inserting ''the rate''; and

(iii) by striking ''such increases'' and inserting ''such rates''; and

(2) in subsection (b)—

(A) by striking ''premium increases'' each place it appears and inserting ''rates''; and

(B) in paragraph (2)(B), by striking ''premium'' and inserting ''rate''.

(c) CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in section 2723 (42 U.S.C. 300gg–22), as redesignated by the Patient Protection and Affordable Care Act—

(A) in subsection (a)—

(i) in paragraph (1), by inserting ''and section 2794'' after ''this part''; and

(ii) in paragraph (2), by inserting ''or section 2794'' after ''this part''; and

(B) in subsection (b)—

(i) in paragraph (1), by inserting ''and section 2794'' after ''this part''; and

(ii) in paragraph (2)—

(I) in subparagraph (A), by inserting ''or section 2794 that is'' after ''this part''; and

(II) in subparagraph (C)(ii), by inserting ''or section 2794'' after ''this part''; and

(2) in section 2761 (42 U.S.C. 300gg–61)—

(A) in subsection (a)—

(i) in paragraph (1), by inserting ''and section 2794'' after ''this part''; and

(ii) in paragraph (2)—

(I) by inserting ''or section 2794'' after ''set forth in this part''; and

(II) by inserting ''and section 2794'' after ''the requirements of this part''; and

(B) in subsection (b)—

(i) by inserting ''and section 2794'' after ''this part''; and

(ii) by inserting ''and section 2794'' after ''part A''.

(d) APPLICABILITY TO GRANDFATHERED PLANS.—Section 1251(a)(4)(A) of the Patient Protection and Affordable Care Act (Public Law 111–148), as added by section 2301 of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), is amended by adding at the end the following:

''(v) Section 2794 (relating to reasonableness of rates with respect to health insurance coverage).''.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this Act such sums as may be necessary.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall be implemented with respect to health plans beginning not later than January 1, 2022.

SEC. 117. ELIGIBILITY OF DACA RECIPIENTS FOR QUALIFIED HEALTH PLANS OFFERED THROUGH EXCHANGES.

(a) IN GENERAL.—Section 1312(f)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)(3)) is amended—

(1) by striking ''or an alien lawfully present in the United States'' and inserting '', an alien lawfully present in the United States, or a DACA recipient''; and

(2) by adding at the end the following: ''For purposes of the previous sentence, the term 'DACA recipient' means an individual who was granted deferred action pursuant to the Deferred Action for Childhood Arrivals Program announced in the

memorandum of the Secretary of Homeland Security dated June 15, 2012, and for whom such grant remains valid.''.

(b) APPLICATION OF REDUCED COST-SHARING.—Section 1402(e)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(e)(2)) is amended by adding at the end the following: ''A DACA recipient (as defined in section 1312(f)(3)) shall be treated as lawfully present for purposes of this section.''.

(c) ELIGIBILITY FOR ADVANCE PAYMENTS.—Section 1412(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(d)) is amended by adding at the end the following: ''For purposes of the previous sentence, a DACA recipient (as defined in section 1312(f)(3)) shall be treated as lawfully present in the United States.''.

(d) VERIFICATION OF ELIGIBILITY.—Section 1411(c)(2)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(c)(2)(B)) is amended—

(1) in clause (i)(I), by inserting ''or a DACA recipient (as defined in section 1312(f)(3))'' after ''an alien lawfully present in the United States''; and

(2) in clause (ii), by inserting ''or a DACA recipient (as defined in section 1312(f)(3))'' after ''an alien lawfully present in the United States''.

(e) APPLICATION OF TAX CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.—Section 36B(e)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''A DACA recipient (as defined in section 1312(f)(3) of the Patient Protection and Affordable Care Act) shall be treated as lawfully present for purposes of this section.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2021.

TITLE II—ENCOURAGING MEDICAID EXPANSION AND STRENGTHENING THE MEDICAID PROGRAM

SEC. 201. INCENTIVIZING MEDICAID EXPANSION.

(a) IN GENERAL.—Section 1905(y)(1) of the Social Security Act (42 U.S.C. 1396d(y)(1)) is amended—

(1) in subparagraph (A), by striking ''2014, 2015, and 2016'' and inserting ''each of the first 3 consecutive 12-month periods in which the State provides medical assistance to newly eligible individuals'';

(2) in subparagraph (B), by striking ''2017'' and inserting ''the fourth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals'';

(3) in subparagraph (C), by striking ''2018'' and inserting ''the fifth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals'';

(4) in subparagraph (D), by striking ''2019'' and inserting ''the sixth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals''; and

(5) in subparagraph (E), by striking ''2020 and each year thereafter'' and inserting ''the seventh consecutive 12-month period in which the State provides medical assistance to newly eligible individuals and each such period thereafter''.

(b) EFFECTIVE DATE.—Beginning on January 1, 2022, the amendments made by subsection (a) shall take effect as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148).

SEC. 202. PROVIDING 12-MONTHS OF CONTINUOUS ELIGIBILITY FOR MEDICAID AND CHIP.

(a) REQUIREMENT OF 12-MONTH CONTINUOUS ENROLLMENT UNDER MEDICAID.—Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended to read as follows:

''(12) 12-MONTH CONTINUOUS ENROLLMENT.—Notwithstanding any other provision of this title, a

State plan approved under this title (or under any waiver of such plan approved pursuant to section 1115 or section 1915), shall provide that an individual who is determined to be eligible for benefits under such plan (or waiver) shall remain eligible and enrolled for such benefits through the end of the month in which the 12-month period (beginning on the date of determination of eligibility) ends.''.

(b) REQUIREMENT OF 12-MONTH CONTINUOUS ENROLLMENT UNDER CHIP.—

(1) IN GENERAL.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended by adding at the end the following new paragraph:

''(6) REQUIREMENT FOR 12-MONTH CONTINUOUS ENROLLMENT.—Notwithstanding any other provision of this title, a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), shall provide that an individual who is determined to be eligible for benefits under such plan shall remain eligible and enrolled for such benefits through the end of the month in which the 12-month period (beginning on the date of determination of eligibility) ends.''.

(2) CONFORMING AMENDMENT.—Section 2105(a)(4)(A) of the Social Security Act (42 U.S.C. 1397ee(a)(4)(A)) is amended—

(A) by striking ''has elected the option of'' and inserting ''is in compliance with the requirement for''; and

(B) by striking ''applying such policy under its State child health plan under this title'' and inserting ''in compliance with section 2102(b)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2) or (3), the amendments made by subsections (a) and (b) shall apply to determinations (and redeterminations) of eligibility made on or after the date that is 12 months after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)).

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX or State child health plan under title XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.) which the Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the respective plan to meet the additional requirement imposed by the amendment made by subsection (a) or (b), respectively, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such applicable additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

(3) OPTION TO IMPLEMENT 12-MONTH CONTINUOUS ELIGIBILITY PRIOR TO EFFECTIVE DATE.—A State may elect through a State plan amendment under title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.) to apply the amendment made by subsection (a) or (b), respectively, on any date prior to the date specified in paragraph (1), but not sooner than the date of the enactment of this Act.

SEC. 203. MANDATORY 12-MONTHS OF POSTPARTUM MEDICAID ELIGIBILITY.

(a) EXTENDING CONTINUOUS MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(1) MEDICAID.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) in section 1902(l)(1)(A), by striking ''60-day period'' and inserting ''365-day period'';

(B) in section 1902(e)(6), by striking ''60-day period'' and inserting ''365-day period'';

(C) in section 1903(v)(4)(A)(i), by striking ''60-day period'' and inserting ''365-day period''; and

(D) in section 1905(a), in the 4th sentence in the matter following paragraph (30), by striking ''60-day period'' and inserting ''365-day period''.

(2) CHIP.—Section 2112 of the Social Security Act (42 U.S.C. 1397ll) is amended by striking ''60-day period'' each place it appears and inserting ''365-day period''.

(b) REQUIRING FULL BENEFITS FOR PREGNANT AND POSTPARTUM WOMEN.—

(1) MEDICAID.—

(A) IN GENERAL.—Paragraph (5) of section 1902(e) of the Social Security Act (24 U.S.C. 1396a(e)) is amended to read as follows:

''(5) Any woman who is eligible for medical assistance under the State plan or a waiver of such plan and who is, or who while so eligible becomes, pregnant, shall continue to be eligible under the plan or waiver for medical assistance through the end of the month in which the 365-day period (beginning on the last day of her pregnancy) ends, regardless of the basis for the woman's eligibility for medical assistance, including if the woman's eligibility for medical assistance is on the basis of being pregnant.''.

(B) CONFORMING AMENDMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G) by striking ''(VII) the medical assistance'' and all that follows through ''complicate pregnancy,''.

(2) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (H) through (S) as subparagraphs (I) through (T), respectively; and

(B) by inserting after subparagraph (G), the following:

''(H) Section 1902(e)(5) (requiring 365-day continuous coverage for pregnant and postpartum women).''.

(c) MAINTENANCE OF EFFORT.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in paragraph (74), by striking ''subsection (gg); and'' and inserting ''subsections (gg) and (qq);''; and

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

''(qq) MAINTENANCE OF EFFORT RELATED TO LOW-INCOME PREGNANT WOMEN.—For calendar quarters beginning on or after the effective date described in section 203(d) of the Patient Protection and Affordable Care Enhancement Act, and before January 1, 2023, no Federal payment shall be made to a State under section 1903(a) for amounts expended under a State plan under this title or a waiver of such plan if the State—

''(1) has in effect under such plan eligibility standards, methodologies, or procedures for individuals described in subsection (l)(1) who are eligible for medical assistance under the State plan or waiv-

er under subsection (a)(10)(A)(ii)(IX) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, for such individuals under such plan or waiver that are in effect on the date of the enactment of this subsection; or

''(2) provides medical assistance to individuals described in subsection (l)(1) who are eligible for medical assistance under such plan or waiver under subsection (a)(10)(A)(ii)(IX) at a level that is less than the level at which the State provides such assistance to such individuals under such plan or waiver on the date of the enactment of this subsection.''.

(2) CHIP.—Section 2112 of the Social Security Act (42 U.S.C. 1397ll), as amended by subsection (b), is further amended by adding at the end the following subsection:

''(g) MAINTENANCE OF EFFORT.—For calendar quarters beginning on or after the effective date described in section 203(d) of the Patient Protection and Affordable Care Enhancement Act, and before January 1, 2023, no payment may be made under section 2105(a) with respect to a State child health plan if the State—

''(1) has in effect under such plan eligibility standards, methodologies, or procedures for targeted low-income pregnant women that are more restric-

tive than the eligibility standards, methodologies, or procedures, respectively, under such plan that are in effect on the date of the enactment of this subsection; or

''(2) provides pregnancy-related assistance to targeted low-income pregnant women under such plan at a level that is less than the level at which the State provides such assistance to such women under such plan on the date of the enactment of this subsection.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided under paragraph (2), the amendments made by subsections (a) and (b) shall take effect on (and the effective date described in this subsection shall be) the first day of the calendar quarter during which the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)) occurs.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX or State child health plan under title XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.) which the Secretary of Health and Human Services

determines requires State legislation (other than legislation appropriating funds) in order for the respective plan to meet the additional requirement imposed by the amendments made by subsection (a) or (b), respectively, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such applicable additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 204. REDUCING THE ADMINISTRATIVE FMAP FOR NONEXPANSION STATES.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by inserting ''subsection (bb) and'' before ''section 1919(g)(3)(B)''; and

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

''(bb) REDUCTION OF FEDERAL PAYMENTS FOR CERTAIN ADMINISTRATIVE COSTS OF NONEXPANSION STATES.—

''(1) IN GENERAL.—In the case of a State that does not provide under the State plan of such State (or waiver of such plan) for making medical assistance available in accordance with section 1902(k)(1) to all individuals described in section 1902(a)(10)(i)(VIII) for a calendar quarter beginning on or after October 1, 2022, the Secretary may reduce the percentage specified in subsection (a)(7) for amounts described in such subsection expended during such quarter by such State by the number of percentage points specified in paragraph (2) for such quarter.

''(2) AMOUNT OF REDUCTION.—For purposes of paragraph (1), the number of percentage points specified in this paragraph for a calendar quarter is the following:

''(A) For the calendar quarter beginning on October 1, 2022, 0.5.

''(B) For a calendar quarter beginning on or after January 1, 2023, and ending before July 1, 2027, the number of percentage points

specified under this paragraph for the previous quarter, plus 0.5.

''(C) For a calendar quarter beginning on or after July 1, 2027, 10.

''(3) DEFINITION.—For purposes of this subsection, the term 'State' means a State that is one of the 50 States or the District of Columbia.''.

SEC. 205. ENHANCED REPORTING REQUIREMENTS FOR NONEXPANSION STATES.

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 204, is further amended—

(1) in subsection (a)(7), by striking ''subsection (bb)'' and inserting ''subsections (bb) and (cc)''; and

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

''(cc) REDUCTION OF FEDERAL PAYMENTS FOR CERTAIN ADMINISTRATIVE COSTS OF NONEXPANSION STATES THAT DO NOT SATISFY REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—

''(A) REDUCTION.—In the case of a nonexpansion State, with respect to a fiscal year (beginning with fiscal year 2023) that does not satisfy the reporting requirement under paragraph (2) for such fiscal year, the percentage specified in subsection (a)(7) for amounts de-

scribed in such subsection expended by such State during a calendar quarter described in paragraph (4) with respect to such fiscal year, subject to subparagraph (B), shall be reduced by the number of percentage points specified in paragraph (4) for the respective calendar quarter.

''(B) EXCEPTION.—In the case of a nonexpansion State that is subject to a reduction under subparagraph (A) for the calendar quarter described in paragraph (4)(A) with respect to a fiscal year, if the State satisfies the criteria described in subparagraphs (A), (B), and (C) of paragraph (2) (without regard to the dates specified in such subparagraph (A) and (C)) before the beginning of a subsequent calendar quarter described in paragraph (4) with respect to such fiscal year, then such State shall not be subject to a reduction under subparagraph (A) for such subsequent calendar quarter.

''(2) REPORTING REQUIREMENT.—For purposes of paragraph (1), a nonexpansion State satisfies the reporting requirement under this paragraph for a fiscal year, if the nonexpansion State—

"(A) by not later than January 1 of such year, posts on the public website of the State agency administering the State plan, the information described in paragraph (3) with respect to such State for the previous year;

"(B) provides for at least a 30-day period for notice and comment on such information; and

"(C) by not later than March 1 of such year, submits to the Secretary a complete report including such information, comments submitted pursuant to subparagraph (B), and a response by the State to each such comment.

"(3) INFORMATION DESCRIBED.—The information described in this paragraph, with respect to a State and year, is the following:

"(A) The the estimated number of individuals who were uninsured for at least 6 months, shown by age-groups of 0 to 18 years of age and of 19 years of age to 64 years of age, as well as a detailed description of the basis for the estimates.

"(B) The estimated number of the individuals estimated under subparagraph (A) in the State who would be eligible for medical assist-

ance under the State plan if the State were to make medical assistance under the State plan available in accordance with section 1902(k)(1) to all individuals described in section 1902(a)(10)(i)(VIII), and a detailed description of the basis for the estimates.

''(C) A comprehensive listing of State income eligibility criteria for all mandatory and optional Medicaid eligibility groups for which the State plan provides medical assistance (other than with respect to individuals described in clause (i)(II), (ii)(VI), or (ii)(XXII) of section 1902(a)(10)(A)).

''(D) The total amount of hospital uncompensated-care costs and a breakdown of the source of such costs, as well as a breakdown for rural and non-rural hospitals.

''(4) PERCENTAGE DESCRIBED.—For purposes of paragraph (1), a calendar quarter described in this paragraph, with respect to a fiscal year, and the percentage points described in this paragraph for such quarter, with respect to a State, are—

''(A) for the calendar quarter beginning on the April 1 occurring during such fiscal year, 0.5 percentage points;

"(B) for the calendar quarter beginning on the July 1 occurring during such fiscal year, 1.0 percentage point; and

"(C) for the calendar quarter beginning on the October 1 occurring during the subsequent fiscal year, 1.5 percentage points.

"(5) PAYMENT IN CASE OF REPORTING STATE.—The expenses incurred by a non-expansion State, with respect to any calendar quarter with respect to a fiscal year (beginning with 2021), for carrying out subparagraphs (A) through (C) of paragraph (2) shall, for purposes of section 1903(a)(7), be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

"(6) NONEXPANION STATE DEFINED.—For purposes of this subsection, the term 'nonexpansion State' means, with respect to a fiscal year, a State that as of the first quarter of such fiscal year does not provide under the State plan of such State (or waiver of such plan) for making medical assistance available in accordance with section 1902(k)(1) to all individuals described in section 1902(a)(10)(i)(VIII).".

SEC. 206. PRIMARY CARE PAY INCREASE.

(a) RENEWAL OF PAYMENT FLOOR; ADDITIONAL PROVIDERS.—

(1) IN GENERAL.—Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended by striking subparagraph (C) and inserting the following:

"(C) payment for primary care services (as defined in subsection (jj)) at a rate that is not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009), and that is not less than the rate that would otherwise apply to such services under this title if the rate were determined without regard to this subparagraph, and that are—

"(i) furnished during 2013 and 2014, by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine; or

"(ii) furnished during the period that begins on the first day of the first month

that begins one year after the date of enactment of the Patient Protection and Affordable Care Enhancement Act and ends September 30, 2024—

"(I) by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, but only if the physician self-attests that the physician is Board certified in family medicine, general internal medicine, or pediatric medicine;

"(II) by a physician with a primary specialty designation of obstetrics and gynecology, but only if the physician self-attests that the physician is Board certified in obstetrics and gynecology;

"(III) by an advanced practice clinician, as defined by the Secretary, that works under the supervision of—

"(aa) a physician that satisfies the criteria specified in subclause (I) or (II); or

"(bb) a nurse practitioner or a physician assistant (as such terms are defined in section 1861(aa)(5)(A)) who is working in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) who is working in accordance with State law;

"(IV) by a rural health clinic, Federally-qualified health center, or other health clinic that receives reimbursement on a fee schedule applicable to a physician, a nurse practitioner or a physician assistant (as such terms are defined in section 1861(aa)(5)(A)) who is working in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) who is working in accordance with State law, for services furnished by a physician, nurse practitioner, physician assistant, or certified nurse-midwife, or services furnished by an advanced practice clinician su-

pervised by a physician described in subclause (I)(aa) or (II)(aa), another advanced practice clinician, or a certified nurse-midwife; or

''(V) by a nurse practitioner or a physician assistant (as such terms are defined in section 1861(aa)(5)(A)) who is working in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) who is working in accordance with State law, in accordance with procedures that ensure that the portion of the payment for such services that the nurse practitioner, physician assistant, or certified nurse-midwife is paid is not less than the amount that the nurse practitioner, physician assistant, or certified nurse-midwife would be paid if the services were provided under part B of title XVIII;''.

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

(A) by striking ''Notwithstanding'' and inserting the following:

''(1) IN GENERAL.—Notwithstanding'';

(B) by inserting ''or furnished during the additional period specified in paragraph (2),'' after ''2015,''; and

(C) by adding at the end the following:

''(2) ADDITIONAL PERIOD.—For purposes of paragraph (1), the additional period specified in this paragraph is the period that begins on the first day of the first month that begins one year after the date of enactment of the Patient Protection and Affordable Care Enhancement Act.''.

(b) IMPROVED TARGETING OF PRIMARY CARE.—Section 1902(jj) of the Social Security Act (42 U.S.C. 1396a(jj)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively and realigning the left margins accordingly;

(2) by striking ''For purposes of'' and inserting the following:

''(1) IN GENERAL.—For purposes of''; and

(3) by adding at the end the following:

''(2) EXCLUSIONS.—Such term does not include any services described in subparagraph (A) or (B) of

paragraph (1) if such services are provided in an emergency department of a hospital.''.

(c) ENSURING PAYMENT BY MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xii), by striking ''and'' after the semicolon;

(B) by realigning the left margin of clause (xiii) so as to align with the left margin of clause (xii) and by striking the period at the end of clause (xiii) and inserting ''; and''; and

(C) by inserting after clause (xiii) the following:

''(xiv) such contract provides that (I) payments to providers specified in section 1902(a)(13)(C) for primary care services defined in section 1902(jj) that are furnished during a year or period specified in section 1902(a)(13)(C) and section 1905(dd) are at least equal to the amounts set forth and required by the Secretary by regulation, (II) the entity shall, upon request, provide documentation to the State, sufficient to enable the State and the Secretary to ensure compliance with subclause (I), and (III) the

Secretary shall approve payments described in subclause (I) that are furnished through an agreed upon capitation, partial capitation, or other value-based payment arrangement if the capitation, partial capitation, or other value-based payment arrangement is based on a reasonable methodology and the entity provides documentation to the State sufficient to enable the State and the Secretary to ensure compliance with subclause (I).''.

(2) CONFORMING AMENDMENT.—Section 1932(f) of the Social Security Act (42 U.S.C. 1396u–2(f)) is amended by inserting ''and clause (xiv) of section 1903(m)(2)(A)'' before the period.

SEC. 207. PERMANENT FUNDING FOR CHIP.

(a) IN GENERAL.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (26), by inserting at the end ''and'';

(2) by amending paragraph (27) to read as follows:

''(27) for each fiscal year beginning with fiscal year 2024, such sums as are necessary to fund allotments to States under subsections (c) and (m).''; and

(3) by striking paragraph (28).

(b) IN GENERAL.—Section 2104(a)(28) of the Social Security Act (42 U.S.C. 1397dd(a)(28)) is amended to read as follows:

''(28) for fiscal year 2027 and each subsequent year, such sums as are necessary to fund allotments to States under subsections (c) and (m).''.

(c) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(A) in paragraph (2)(B)(i), by striking '',, 2023, and 2027'' and inserting ''and 2023'';

(B) in paragraph (7)—

(i) in subparagraph (A), by striking ''and ending with fiscal year 2027,''; and

(ii) in the flush left matter at the end, by striking ''or fiscal year 2026'' and inserting ''fiscal year 2026, or a subsequent even-numbered fiscal year'';

(C) in paragraph (9)—

(i) by striking ''(10), or (11)'' and inserting ''or (10)''; and

(ii) by striking ''2023, or 2027,'' and inserting ''or 2023''; and

(D) by striking paragraph (11).

(2) CONFORMING AMENDMENT.—Section 50101(b)(2) of the Bipartisan Budget Act of 2018 (Public Law 115–123) is repealed.

SEC. 208. PERMANENT EXTENSION OF CHIP ENROLLMENT AND QUALITY MEASURES.

(a) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i)(1) of the Social Security Act (42 U.S.C. 1320b–9a(i)(1)) is amended—

(1) in subparagraph (C), by striking at the end ''and'';

(2) in subparagraph (D), by striking the period at the end and insert a semicolon; and

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

''(E) for fiscal year 2028, $15,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)); and

''(F) for a subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over such previous fiscal year, for the purpose of carrying out this section (other than subsections (e), (f), and (g)).''.

(b) EXPRESS LANE ELIGIBILITY OPTION.—Section 1902(e)(13) of the Social Security Act (42 U.S.C. 1396a(e)(13)) is amended by striking subparagraph (I).

(c) ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—

(1) IN GENERAL.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—

(A) in the paragraph heading, by striking ''THROUGH SEPTEMBER 30, 2027''; and

(B) in subparagraph (A), in the matter preceding clause (i)—

(i) by striking ''During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2027'' and inserting ''Beginning on the date of the enactment of the Patient Protection and Affordable Care Act'';

(ii) by striking ''During the period that begins on October 1, 2019, and ends on September 30, 2027'' and inserting ''Beginning on October 1, 2019''; and

(iii) by striking ''The preceding sentences shall not be construed as preventing

a State during any such periods from'' and inserting ''The preceding sentences shall not be construed as preventing a State from''.

(2) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—

(A) in the paragraph heading, by striking ''THROUGH SEPTEMBER 30, 2027''; and

(B) by striking ''through September 30'' and all that follows through ''ends on September 30, 2027'' and inserting ''(but beginning on October 1, 2019,''.

(d) QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—

(1) in the paragraph heading, by striking ''FOR FISCAL YEARS 2009 THROUGH 2027'' and inserting ''AFTER FISCAL YEAR 2008''; and

(2) in subparagraph (A), by striking ''for any of fiscal years 2009 through 2027'' and inserting ''for any fiscal year after fiscal year 2008''.

(e) OUTREACH AND ENROLLMENT PROGRAM.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''during the period of fiscal years 2009 through 2027'' and inserting '', beginning with fiscal year 2009,'';

(B) in paragraph (2)—

(i) by striking ''10 percent of such amounts'' and inserting ''10 percent of such amounts for the period or the fiscal year for which such amounts are appropriated''; and

(ii) by striking ''during such period'' and inserting '', during such period or such fiscal year,''; and

(C) in paragraph (3), by striking ''For the period of fiscal years 2024 through 2027, an amount equal to 10 percent of such amounts'' and inserting ''Beginning with fiscal year 2024, an amount equal to 10 percent of such amounts for the period or the fiscal year for which such amounts are appropriated''; and

(2) in subsection (g)—

(A) by striking ''2017,,'' and inserting ''2017,'';

(B) by striking ''and $48,000,000'' and inserting ''$48,000,000''; and

(C) by inserting after ''through 2027'' the following: '', $12,000,000 for fiscal year 2028, and, for each fiscal year after fiscal year 2028, the amount appropriated under this subsection for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over such previous fiscal year''.

(f) CHILD ENROLLMENT CONTINGENCY FUND.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)(ii)—

(i) by striking ''and 2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(ii) by striking ''2023, and 2027'' and inserting '', and 2023''; and

(B) in subparagraph (B)—

(i) by striking ''2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(ii) by striking ''2023, and 2027'' and inserting '', and 2023''; and

(2) in paragraph (3)(A)—

(A) by striking ''fiscal years 2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(B) by striking ''2023, or 2027'' and inserting '', or 2023''.

SEC. 209. STATE OPTION TO INCREASE CHILDREN'S ELIGIBILITY FOR MEDICAID AND CHIP.

Section 2110(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1397jj(b)(1)(B)(ii)) is amended—

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

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

(3) by inserting after subclause (III) the following new subclause:

''(IV) at the option of the State, whose family income exceeds the maximum income level otherwise established for children under the State child health plan as of the date of the enactment of this subclause; and''.

SEC. 210. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following new subparagraph:

"(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the designated Federal program defined in paragraph (3)(C) (relating to the Medicaid program), section 401(a) and paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.".

(b) EXCEPTION TO 5–YEAR LIMITED ELIGIBILITY.—Section 403(d) of such Act (8 U.S.C. 1613(d)) is amended—

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

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

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

''(3) an individual described in section 402(b)(2)(G), but only with respect to the designated Federal program defined in section 402(b)(3)(C).''.

(c) DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting a comma;

(2) in paragraph (7), by striking the period at the end and inserting '', or''; and

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

''(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G), but only with respect to the designated Federal program

defined in section 402(b)(3)(C) (relating to the Medicaid program).''.

(d) APPLICATION TO STATE PLANS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended by inserting after subclause (IX) the following:

''(X) who are described in section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and eligible for benefits under this title by reason of application of such section;''.

(e) CONFORMING AMENDMENTS.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), in the matter preceding paragraph (1), by striking ''subsections (g) and (h) and section 1935(e)(1)(B)'' and inserting ''subsections (g), (h), and (i) and section 1935(e)(1)(B)''; and

(2) by adding at the end the following:

''(i) EXCLUSION OF MEDICAL ASSISTANCE EXPENDITURES FOR CITIZENS OF FREELY ASSOCIATED STATES.—Expenditures for medical assistance provided to an individual described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of

1996 (8 U.S.C. 1641(b)(8)) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits for items and services furnished on or after the date of the enactment of this Act.

SEC. 211. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO INDIAN HEALTH CARE PROVIDERS.

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

(1) in subsection (a), by amending paragraph (9) to read as follows:

''(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including—

''(A) such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address; and

''(B) such services provided outside the clinic on the basis of a referral from a clinic ad-

ministered by an Indian Health Program (as defined in paragraph (12) of section 4 of the Indian Health Care Improvement Act, or an Urban Indian Organization as defined in paragraph (29) of section 4 of such Act that has a grant or contract with the Indian Health Service under title V of such Act;''.

(2) in subsection (b), by inserting after ''(as defined in section 4 of the Indian Health Care Improvement Act)'' the following: ''; the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) that has a grant or contract with the Indian Health Service under title V of such Act''.

(b) EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO SERVICES FURNISHED BY NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—

(1) IN GENERAL.—Beginning on the date of enactment of this Act—

(A) for purposes of section 1905(a)(9) of the Social Security Act (42 U.S.C. 1396d(a)(9)), services described in subsection

(b) that are furnished in any location shall be deemed to be clinic services; and

(B) notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage with respect to amounts expended as medical assistance for such services shall be 100 percent.

(2) SERVICES DESCRIBED.—The services described in this subsection are services for which payment is available under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of Hawaii (or any waiver of such plan) that—

(A) are furnished on or after the date of enactment of this Act;

(B) are furnished to an individual who—

(i) is a Native Hawaiian; and

(ii) is eligible for medical assistance under such plan; and

(C) are furnished by an Indian health care provider (as such term is defined in section 1932(h)(4)(A) of the Social Security Act (42 U.S.C. 1396u–2(h)(4)(A)) or a Native Hawaiian health care system (without regard to whether such services are furnished through an Indian Health Service facility).

TITLE III—LOWERING PRICES THROUGH FAIR DRUG PRICE NEGOTIATION

SEC. 301. ESTABLISHING A FAIR DRUG PRICING PROGRAM.

(a) PROGRAM TO LOWER PRICES FOR CERTAIN HIGH-PRICED SINGLE SOURCE DRUGS.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

"PART E—FAIR PRICE NEGOTIATION PROGRAM TO LOWER PRICES FOR CERTAIN HIGH-PRICED SINGLE SOURCE DRUGS

"SEC. 1191. ESTABLISHMENT OF PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish a Fair Price Negotiation Program (in this part referred to as the 'program'). Under the program, with respect to each price applicability period, the Secretary shall—

''(1) publish a list of selected drugs in accordance with section 1192;

''(2) enter into agreements with manufacturers of selected drugs with respect to such period, in accordance with section 1193;

''(3) negotiate and, if applicable, renegotiate maximum fair prices for such selected drugs, in accordance with section 1194; and

''(4) carry out the administrative duties described in section 1196.

''(b) DEFINITIONS RELATING TO TIMING.—For purposes of this part:

''(1) INITIAL PRICE APPLICABILITY YEAR.—The term 'initial price applicability year' means a plan year (beginning with plan year 2023) or, if agreed to in an agreement under section 1193 by the Secretary and manufacturer involved, a period of more than one plan year (beginning on or after January 1, 2023).

''(2) PRICE APPLICABILITY PERIOD.—The term 'price applicability period' means, with respect to a drug, the period beginning with the initial price applicability year with respect to which such drug is a selected drug and ending with the last plan year during which the drug is a selected drug.

''(3) SELECTED DRUG PUBLICATION DATE.—The term 'selected drug publication date' means, with respect to each initial price applicability year, April 15 of the plan year that begins 2 years prior to such year.

''(4) VOLUNTARY NEGOTIATION PERIOD.—The term 'voluntary negotiation period' means, with re-

spect to an initial price applicability year with respect to a selected drug, the period—

"(A) beginning on the sooner of—

"(i) the date on which the manufacturer of the drug and the Secretary enter into an agreement under section 1193 with respect to such drug; or

"(ii) June 15 following the selected drug publication date with respect to such selected drug; and

"(B) ending on March 31 of the year that begins one year prior to the initial price applicability year.

"(c) OTHER DEFINITIONS.—For purposes of this part:

"(1) FAIR PRICE ELIGIBLE INDIVIDUAL.—The term 'fair price eligible individual' means, with respect to a selected drug—

"(A) in the case such drug is furnished or dispensed to the individual at a pharmacy or by a mail order service—

"(i) an individual who is enrolled under a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title if coverage is provided

under such plan for such selected drug; and

''(ii) an individual who is enrolled under a group health plan or health insurance coverage offered in the group or individual market (as such terms are defined in section 2791 of the Public Health Service Act) with respect to which there is in effect an agreement with the Secretary under section 1197 with respect to such selected drug as so furnished or dispensed; and

''(B) in the case such drug is furnished or administered to the individual by a hospital, physician, or other provider of services or supplier—

''(i) an individual who is entitled to benefits under part A of title XVIII or enrolled under part B of such title if such selected drug is covered under the respective part; and

''(ii) an individual who is enrolled under a group health plan or health insurance coverage offered in the group or individual market (as such terms are defined

in section 2791 of the Public Health Service Act) with respect to which there is in effect an agreement with the Secretary under section 1197 with respect to such selected drug as so furnished or administered.

''(2) MAXIMUM FAIR PRICE.—The term 'maximum fair price' means, with respect to a plan year during a price applicability period and with respect to a selected drug (as defined in section 1192(c)) with respect to such period, the price published pursuant to section 1195 in the Federal Register for such drug and year.

''(3) AVERAGE INTERNATIONAL MARKET PRICE DEFINED.—

''(A) IN GENERAL.—The terms 'average international market price' and 'AIM price' mean, with respect to a drug, the average price (which shall be the net average price, if practicable, and volume-weighted, if practicable) for a unit (as defined in paragraph (4)) of the drug for sales of such drug (calculated across different dosage forms and strengths of the drug and not based on the specific formulation or package size or package type), as computed (as

of the date of publication of such drug as a selected drug under section 1192(a)) in all countries described in clause (ii) of subparagraph (B) that are applicable countries (as described in clause (i) of such subparagraph) with respect to such drug.

''(B) APPLICABLE COUNTRIES.—

''(i) IN GENERAL.—For purposes of subparagraph (A), a country described in clause (ii) is an applicable country described in this clause with respect to a drug if there is available an average price for any unit for the drug for sales of such drug in such country.

''(ii) COUNTRIES DESCRIBED.—For purposes of this paragraph, the following are countries described in this clause:

''(I) Australia.

''(II) Canada.

''(III) France.

''(IV) Germany.

''(V) Japan.

''(VI) The United Kingdom.

''(4) UNIT.—The term 'unit' means, with respect to a drug, the lowest identifiable quantity

(such as a capsule or tablet, milligram of molecules, or grams) of the drug that is dispensed.

"SEC. 1192. SELECTION OF NEGOTIATION-ELIGIBLE DRUGS AS SELECTED DRUGS.

"(a) IN GENERAL.—Not later than the selected drug publication date with respect to an initial price applicability year, subject to subsection (h), the Secretary shall select and publish in the Federal Register a list of—

"(1)(A) with respect to an initial price applicability year during 2023, at least 25 negotiation-eligible drugs described in subparagraphs (A) and (B), but not subparagraph (C), of subsection (d)(1) (or, with respect to an initial price applicability year during such period beginning after 2023, the maximum number (if such number is less than 25) of such negotiation-eligible drugs for the year) with respect to such year; and

"(B) with respect to an initial price applicability year during 2024 or a subsequent year, at least 50 negotiation-eligible drugs described in subparagraphs (A) and (B), but not subparagraph (C), of subsection (d)(1) (or, with respect to an initial price applicability year during such period, the maximum number (if such number is less than 50) of

such negotiation-eligible drugs for the year) with respect to such year;

"(2) all negotiation-eligible drugs described in subparagraph (C) of such subsection with respect to such year; and

"(3) all new-entrant negotiation-eligible drugs (as defined in subsection (g)(1)) with respect to such year.

Each drug published on the list pursuant to the previous sentence shall be subject to the negotiation process under section 1194 for the voluntary negotiation period with respect to such initial price applicability year (and the renegotiation process under such section as applicable for any subsequent year during the applicable price applicability period). In applying this subsection, any negotiation-eligible drug that is selected under this subsection for an initial price applicability year shall not count toward the required minimum amount of drugs to be selected under paragraph (1) for any subsequent year, including such a drug so selected that is subject to renegotiation under section 1194.

"(b) SELECTION OF DRUGS.—In carrying out subsection (a)(1) the Secretary shall select for inclusion on the published list described in subsection (a) with respect to a price applicability period, the negotiation-eligible

drugs that the Secretary projects will result in the greatest savings to the Federal Government or fair price eligible individuals during the price applicability period. In making this projection of savings for drugs for which there is an AIM price for a price applicability period, the savings shall be projected across different dosage forms and strengths of the drugs and not based on the specific formulation or package size or package type of the drugs, taking into consideration both the volume of drugs for which payment is made, to the extent such data is available, and the amount by which the net price for the drugs exceeds the AIM price for the drugs.

''(c) SELECTED DRUG.—For purposes of this part, each drug included on the list published under subsection (a) with respect to an initial price applicability year shall be referred to as a 'selected drug' with respect to such year and each subsequent plan year beginning before the first plan year beginning after the date on which the Secretary determines two or more drug products—

''(1) are approved or licensed (as applicable)—

''(A) under section 505(j) of the Federal Food, Drug, and Cosmetic Act using such drug as the listed drug; or

"(B) under section 351(k) of the Public Health Service Act using such drug as the reference product; and

"(2) continue to be marketed.

"(d) NEGOTIATION-ELIGIBLE DRUG.—

"(1) IN GENERAL.—For purposes of this part, the term 'negotiation-eligible drug' means, with respect to the selected drug publication date with respect to an initial price applicability year, a qualifying single source drug, as defined in subsection (e), that meets any of the following criteria:

"(A) COVERED PART D DRUGS.—The drug is among the 125 covered part D drugs (as defined in section 1860D–2(e)) for which there was an estimated greatest net spending under parts C and D of title XVIII, as determined by the Secretary, during the most recent plan year prior to such drug publication date for which data are available.

"(B) OTHER DRUGS.—The drug is among the 125 drugs for which there was an estimated greatest net spending in the United States (including the 50 States, the District of Columbia, and the territories of the United States), as determined by the Secretary, during the most re-

cent plan year prior to such drug publication date for which data are available.

"(C) INSULIN.—The drug is a qualifying single source drug described in subsection (e)(3).

"(2) CLARIFICATION.—In determining whether a qualifying single source drug satisfies any of the criteria described in paragraph (1), the Secretary shall, to the extent practicable, use data that is aggregated across dosage forms and strengths of the drug and not based on the specific formulation or package size or package type of the drug.

"(3) PUBLICATION.—Not later than the selected drug publication date with respect to an initial price applicability year, the Secretary shall publish in the Federal Register a list of negotiation-eligible drugs with respect to such selected drug publication date.

"(e) QUALIFYING SINGLE SOURCE DRUG.—For purposes of this part, the term 'qualifying single source drug' means any of the following:

"(1) DRUG PRODUCTS.—A drug that—

"(A) is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act and

continues to be marketed pursuant to such approval; and

''(B) is not the listed drug for any drug that is approved and continues to be marketed under section 505(j) of such Act.

''(2) BIOLOGICAL PRODUCTS.—A biological product that—

''(A) is licensed under section 351(a) of the Public Health Service Act, including any product that has been deemed to be licensed under section 351 of such Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009, and continues to be marketed under section 351 of such Act; and

''(B) is not the reference product for any biological product that is licensed and continues to be marketed under section 351(k) of such Act.

''(3) INSULIN PRODUCT.—Notwithstanding paragraphs (1) and (2), any insulin product that is approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under subsection (a) or (k) of section 351 of the Public Health Service Act and continues to be

marketed under such section 505 or 351, including any insulin product that has been deemed to be licensed under section 351(a) of the Public Health Service Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 and continues to be marketed pursuant to such licensure.

For purposes of applying paragraphs (1) and (2), a drug or biological product that is marketed by the same sponsor or manufacturer (or an affiliate thereof or a cross-licensed producer or distributor) as the listed drug or reference product described in such respective paragraph shall not be taken into consideration.

''(f) INFORMATION ON INTERNATIONAL DRUG PRICES.—For purposes of determining which negotiation-eligible drugs to select under subsection (a) and, in the case of such drugs that are selected drugs, to determine the maximum fair price for such a drug and whether such maximum fair price should be renegotiated under section 1194, the Secretary shall use data relating to the AIM price with respect to such drug as available or provided to the Secretary and shall on an ongoing basis request from manufacturers of selected drugs information on the AIM price of such a drug.

"(g) NEW-ENTRANT NEGOTIATION-ELIGIBLE DRUGS.—

"(1) IN GENERAL.—For purposes of this part, the term 'new-entrant negotiation-eligible drug' means, with respect to the selected drug publication date with respect to an initial price applicability year, a qualifying single source drug—

"(A) that is first approved or licensed, as described in paragraph (1), (2), or (3) of subsection (e), as applicable, during the year preceding such selected drug publication date; and

"(B) that the Secretary determines under paragraph (2) is likely to be included as a negotiation-eligible drug with respect to the subsequent selected drug publication date.

"(2) DETERMINATION.—In the case of a qualifying single source drug that meets the criteria described in subparagraph (A) of paragraph (1), with respect to an initial price applicability year, if the wholesale acquisition cost at which such drug is first marketed in the United States is equal to or greater than the median household income (as determined according to the most recent data collected by the United States Census Bureau), the Secretary shall determine before the selected drug publication date

with respect to the initial price applicability year, if the drug is likely to be included as a negotiation-eligible drug with respect to the subsequent selected drug publication date, based on the projected spending under title XVIII or in the United States on such drug. For purposes of this paragraph the term 'United States' includes the 50 States, the District of Columbia, and the territories of the United States.

''(h) CONFLICT OF INTEREST.—

''(1) IN GENERAL.—In the case the Inspector General of the Department of Health and Human Services determines the Secretary has a conflict, with respect to a matter described in paragraph (2), the individual described in paragraph (3) shall carry out the duties of the Secretary under this part, with respect to a negotiation-eligible drug, that would otherwise be such a conflict.

''(2) MATTER DESCRIBED.—A matter described in this paragraph is—

''(A) a financial interest (as described in section 2635.402 of title 5, Code of Federal Regulations (except for an interest described in subsection (b)(2)(iv) of such section)) on the date of the selected drug publication date, with

respect the price applicability year (as applicable);

"(B) a personal or business relationship (as described in section 2635.502 of such title) on the date of the selected drug publication date, with respect the price applicability year;

"(C) employment by a manufacturer of a negotiation-eligible drug during the preceding 10-year period beginning on the date of the selected drug publication date, with respect to each price applicability year; and

"(D) any other matter the General Counsel determines appropriate.

"(3) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is—

"(A) the highest-ranking officer or employee of the Department of Health and Human Services (as determined by the organizational chart of the Department) that does not have a conflict under this subsection; and

"(B) is nominated by the President and confirmed by the Senate with respect to the position.

"SEC. 1193. MANUFACTURER AGREEMENTS.

"(a) IN GENERAL.—For purposes of section 1191(a)(2), the Secretary shall enter into agreements with manufacturers of selected drugs with respect to a price applicability period, by not later than June 15 following the selected drug publication date with respect to such selected drug, under which—

"(1) during the voluntary negotiation period for the initial price applicability year for the selected drug, the Secretary and manufacturer, in accordance with section 1194, negotiate to determine (and, by not later than the last date of such period and in accordance with subsection (c), agree to) a maximum fair price for such selected drug of the manufacturer in order to provide access to such price—

"(A) to fair price eligible individuals who with respect to such drug are described in subparagraph (A) of section 1191(c)(1) and are furnished or dispensed such drug during, subject to subparagraph (2), the price applicability period; and

"(B) to hospitals, physicians, and other providers of services and suppliers with respect to fair price eligible individuals who with respect to such drug are described in subparagraph (B) of such section and are furnished or

administered such drug during, subject to subparagraph (2), the price applicability period;

''(2) the Secretary and the manufacturer shall, in accordance with a process and during a period specified by the Secretary pursuant to rulemaking, renegotiate (and, by not later than the last date of such period and in accordance with subsection (c), agree to) the maximum fair price for such drug if the Secretary determines that there is a material change in any of the factors described in section 1194(d) relating to the drug, including changes in the AIM price for such drug, in order to provide access to such maximum fair price (as so renegotiated)—

''(A) to fair price eligible individuals who with respect to such drug are described in subparagraph (A) of section 1191(c)(1) and are furnished or dispensed such drug during any year during the price applicability period (beginning after such renegotiation) with respect to such selected drug; and

''(B) to hospitals, physicians, and other providers of services and suppliers with respect to fair price eligible individuals who with respect to such drug are described in subpara-

graph (B) of such section and are furnished or administered such drug during any year described in subparagraph (A);

''(3) the maximum fair price (including as renegotiated pursuant to paragraph (2)), with respect to such a selected drug, shall be provided to fair price eligible individuals, who with respect to such drug are described in subparagraph (A) of section 1191(c)(1), at the pharmacy or by a mail order service at the point-of-sale of such drug;

''(4) the manufacturer, subject to subsection (d), submits to the Secretary, in a form and manner specified by the Secretary—

''(A) for the voluntary negotiation period for the price applicability period (and, if applicable, before any period of renegotiation specified pursuant to paragraph (2)) with respect to such drug all information that the Secretary requires to carry out the negotiation (or renegotiation process) under this part, including information described in section 1192(f) and section 1194(d)(1); and

''(B) on an ongoing basis, information on changes in prices for such drug that would affect the AIM price for such drug or otherwise

provide a basis for renegotiation of the maximum fair price for such drug pursuant to paragraph (2);

''(5) the manufacturer agrees that in the case the selected drug of a manufacturer is a drug described in subsection (c), the manufacturer will, in accordance with such subsection, make any payment required under such subsection with respect to such drug; and

''(6) the manufacturer complies with requirements imposed by the Secretary for purposes of administering the program, including with respect to the duties described in section 1196.

''(b) AGREEMENT IN EFFECT UNTIL DRUG IS NO LONGER A SELECTED DRUG.—An agreement entered into under this section shall be effective, with respect to a drug, until such drug is no longer considered a selected drug under section 1192(c).

''(c) SPECIAL RULE FOR CERTAIN SELECTED DRUGS WITHOUT AIM PRICE.—

''(1) IN GENERAL.—In the case of a selected drug for which there is no AIM price available with respect to the initial price applicability year for such drug and for which an AIM price becomes available beginning with respect to a subsequent plan year

during the price applicability period for such drug, if the Secretary determines that the amount described in paragraph (2)(A) for a unit of such drug is greater than the amount described in paragraph (2)(B) for a unit of such drug, then by not later than one year after the date of such determination, the manufacturer of such selected drug shall pay to the Treasury an amount equal to the product of—

"(A) the difference between such amount described in paragraph (2)(A) for a unit of such drug and such amount described in paragraph (2)(B) for a unit of such drug; and

"(B) the number of units of such drug sold in the United States, including the 50 States, the District of Columbia, and the territories of the United States, during the period described in paragraph (2)(B).

"(2) AMOUNTS DESCRIBED.—

"(A) WEIGHTED AVERAGE PRICE BEFORE AIM PRICE AVAILABLE.—For purposes of paragraph (1), the amount described in this subparagraph for a selected drug described in such paragraph, is the amount equal to the weighted average manufacturer price (as defined in section 1927(k)(1)) for such dosage strength and

form for the drug during the period beginning with the first plan year for which the drug is included on the list of negotiation-eligible drugs published under section 1192(d) and ending with the last plan year during the price applicability period for such drug with respect to which there is no AIM price available for such drug.

''(B) AMOUNT MULTIPLIER AFTER AIM PRICE AVAILABLE.—For purposes of paragraph (1), the amount described in this subparagraph for a selected drug described in such paragraph, is the amount equal to 200 percent of the AIM price for such drug with respect to the first plan year during the price applicability period for such drug with respect to which there is an AIM price available for such drug.

''(d) CONFIDENTIALITY OF INFORMATION.—Information submitted to the Secretary under this part by a manufacturer of a selected drug that is proprietary information of such manufacturer (as determined by the Secretary) may be used only by the Secretary or disclosed to and used by the Comptroller General of the United States or the Medicare Payment Advisory Commission for purposes of carrying out this part.

''(e) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall, pursuant to rulemaking, specify, in accordance with paragraph (2), the information that must be submitted under subsection (a)(4).

''(2) INFORMATION SPECIFIED.—Information described in paragraph (1), with respect to a selected drug, shall include information on sales of the drug (by the manufacturer of the drug or by another entity under license or other agreement with the manufacturer, with respect to the sales of such drug, regardless of the name under which the drug is sold) in any foreign country that is part of the AIM price. The Secretary shall verify, to the extent practicable, such sales from appropriate officials of the government of the foreign country involved.

''(f) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under section 1196(c)(1), as applicable, for purposes of administering the program.

''SEC. 1194. NEGOTIATION AND RENEGOTIATION PROCESS.

''(a) IN GENERAL.—For purposes of this part, under an agreement under section 1193 between the Secretary and a manufacturer of a selected drug, with respect to

the period for which such agreement is in effect and in accordance with subsections (b) and (c), the Secretary and the manufacturer—

''(1) shall during the voluntary negotiation period with respect to the initial price applicability year for such drug, in accordance with this section, negotiate a maximum fair price for such drug for the purpose described in section 1193(a)(1); and

''(2) as applicable pursuant to section 1193(a)(2) and in accordance with the process specified pursuant to such section, renegotiate such maximum fair price for such drug for the purpose described in such section.

''(b) NEGOTIATING METHODOLOGY AND OBJECTIVE.—

''(1) IN GENERAL.—The Secretary shall develop and use a consistent methodology for negotiations under subsection (a) that, in accordance with paragraph (2) and subject to paragraph (3), achieves the lowest maximum fair price for each selected drug while appropriately rewarding innovation.

''(2) PRIORITIZING FACTORS.—In considering the factors described in subsection (d) in negotiating (and, as applicable, renegotiating) the maximum fair price for a selected drug, the Secretary shall, to the

extent practicable, consider all of the available factors listed but shall prioritize the following factors:

"(A) RESEARCH AND DEVELOPMENT COSTS.—The factor described in paragraph (1)(A) of subsection (d).

"(B) MARKET DATA.—The factor described in paragraph (1)(B) of such subsection.

"(C) UNIT COSTS OF PRODUCTION AND DISTRIBUTION.—The factor described in paragraph (1)(C) of such subsection.

"(D) COMPARISON TO EXISTING THERAPEUTIC ALTERNATIVES.—The factor described in paragraph (2)(A) of such subsection.

"(3) REQUIREMENT.—

"(A) IN GENERAL.—In negotiating the maximum fair price of a selected drug, with respect to an initial price applicability year for the selected drug, and, as applicable, in renegotiating the maximum fair price for such drug, with respect to a subsequent year during the price applicability period for such drug, in the case that the manufacturer of the selected drug offers under the negotiation or renegotiation, as applicable, a price for such drug that is not more than the target price described in sub-

paragraph (B) for such drug for the respective year, the Secretary shall agree under such negotiation or renegotiation, respectively, to such offered price as the maximum fair price.

''(B) TARGET PRICE.—

''(i) IN GENERAL.—Subject to clause (ii), the target price described in this subparagraph for a selected drug with respect to a year, is the average price (which shall be the net average price, if practicable, and volume-weighted, if practicable) for a unit of such drug for sales of such drug, as computed (across different dosage forms and strengths of the drug and not based on the specific formulation or package size or package type of the drug) in the applicable country described in section 1191(c)(3)(B) with respect to such drug that, with respect to such year, has the lowest average price for such drug as compared to the average prices (as so computed) of such drug with respect to such year in the other applicable countries described in such section with respect to such drug.

"(ii) SELECTED DRUGS WITHOUT AIM PRICE.—In applying this paragraph in the case of negotiating the maximum fair price of a selected drug for which there is no AIM price available with respect to the initial price applicability year for such drug, or, as applicable, renegotiating the maximum fair price for such drug with respect to a subsequent year during the price applicability period for such drug before the first plan year for which there is an AIM price available for such drug, the target price described in this subparagraph for such drug and respective year is the amount that is 80 percent of the average manufacturer price (as defined in section 1927(k)(1)) for such drug and year.

"(4) ANNUAL REPORT.—After the completion of each voluntary negotiation period, the Secretary shall submit to Congress a report on the maximum fair prices negotiated (or, as applicable, renegotiated) for such period. Such report shall include information on how such prices so negotiated (or renegotiated) meet the requirements of this part, including the requirements of this subsection.

''(c) LIMITATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the maximum fair price negotiated (including as renegotiated) under this section for a selected drug, with respect to each plan year during a price applicability period for such drug, shall not exceed 120 percent of the AIM price applicable to such drug with respect to such year.

''(2) SELECTED DRUGS WITHOUT AIM PRICE.—In the case of a selected drug for which there is no AIM price available with respect to the initial price applicability year for such drug, for each plan year during the price applicability period before the first plan year for which there is an AIM price available for such drug, the maximum fair price negotiated (including as renegotiated) under this section for the selected drug shall not exceed the amount equal to 85 percent of the average manufacturer price for the drug with respect to such year.

''(d) CONSIDERATIONS.—For purposes of negotiating and, as applicable, renegotiating (including for purposes of determining whether to renegotiate) the maximum fair price of a selected drug under this part with the manufacturer of the drug, the Secretary, consistent with subsection (b)(2), shall take into consideration the factors de-

scribed in paragraphs (1), (2), (3), and (5), and may take into consideration the factor described in paragraph (4):

"(1) MANUFACTURER-SPECIFIC INFORMATION.—The following information, including as submitted by the manufacturer:

"(A) Research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs.

"(B) Market data for the drug, including the distribution of sales across different programs and purchasers and projected future revenues for the drug.

"(C) Unit costs of production and distribution of the drug.

"(D) Prior Federal financial support for novel therapeutic discovery and development with respect to the drug.

"(E) Data on patents and on existing and pending exclusivity for the drug.

"(F) National sales data for the drug.

"(G) Information on clinical trials for the drug in the United States or in applicable countries described in section 1191(c)(3)(B).

''(2) INFORMATION ON ALTERNATIVE PRODUCTS.—The following information:

''(A) The extent to which the drug represents a therapeutic advance as compared to existing therapeutic alternatives and, to the extent such information is available, the costs of such existing therapeutic alternatives.

''(B) Information on approval by the Food and Drug Administration of alternative drug products.

''(C) Information on comparative effectiveness analysis for such products, taking into consideration the effects of such products on specific populations, such as individuals with disabilities, the elderly, terminally ill, children, and other patient populations.

In considering information described in subparagraph (C), the Secretary shall not use evidence or findings from comparative clinical effectiveness research in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill. Nothing in the previous sentence shall affect the ap-

plication or consideration of an AIM price for a selected drug.

''(3) FOREIGN SALES INFORMATION.—To the extent available on a timely basis, including as provided by a manufacturer of the selected drug or otherwise, information on sales of the selected drug in each of the countries described in section 1191(c)(3)(B).

''(4) VA DRUG PRICING INFORMATION.—Information disclosed to the Secretary pursuant to subsection (f).

''(5) ADDITIONAL INFORMATION.—Information submitted to the Secretary, in accordance with a process specified by the Secretary, by other parties that are affected by the establishment of a maximum fair price for the selected drug.

''(e) REQUEST FOR INFORMATION.—For purposes of negotiating and, as applicable, renegotiating (including for purposes of determining whether to renegotiate) the maximum fair price of a selected drug under this part with the manufacturer of the drug, with respect to a price applicability period, and other relevant data for purposes of this section—

''(1) the Secretary shall, not later than the selected drug publication date with respect to the ini-

tial price applicability year of such period, request drug pricing information from the manufacturer of such selected drug, including information described in subsection (d)(1); and

''(2) by not later than October 1 following the selected drug publication date, the manufacturer of such selected drug shall submit to the Secretary such requested information in such form and manner as the Secretary may require.

The Secretary shall request, from the manufacturer or others, such additional information as may be needed to carry out the negotiation and renegotiation process under this section.

''(f) DISCLOSURE OF INFORMATION.—For purposes of this part, the Secretary of Veterans Affairs may disclose to the Secretary of Health and Human Services the price of any negotiation-eligible drug that is purchased pursuant to section 8126 of title 38, United States Code.

''SEC. 1195. PUBLICATION OF MAXIMUM FAIR PRICES.

''(a) IN GENERAL.—With respect to an initial price applicability year and selected drug with respect to such year, not later than April 1 of the plan year prior to such initial price applicability year, the Secretary shall publish in the Federal Register the maximum fair price for such

drug negotiated under this part with the manufacturer of such drug.

"(b) UPDATES.—

"(1) SUBSEQUENT YEAR MAXIMUM FAIR PRICES.—For a selected drug, for each plan year subsequent to the initial price applicability year for such drug with respect to which an agreement for such drug is in effect under section 1193, the Secretary shall publish in the Federal Register—

"(A) subject to subparagraph (B), the amount equal to the maximum fair price published for such drug for the previous year, increased by the annual percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) as of September of such previous year; or

"(B) in the case the maximum fair price for such drug was renegotiated, for the first year for which such price as so renegotiated applies, such renegotiated maximum fair price.

"(2) PRICES NEGOTIATED AFTER DEADLINE.—In the case of a selected drug with respect to an initial price applicability year for which the maximum fair price is determined under this part after the date of publication under this section, the Secretary

shall publish such maximum fair price in the Federal Register by not later than 30 days after the date such maximum price is so determined.

"SEC. 1196. ADMINISTRATIVE DUTIES; COORDINATION PROVISIONS.

"(a) ADMINISTRATIVE DUTIES.—

"(1) IN GENERAL.—For purposes of section 1191, the administrative duties described in this section are the following:

"(A) The establishment of procedures (including through agreements with manufacturers under this part, contracts with prescription drug plans under part D of title XVIII and MA–PD plans under part C of such title, and agreements under section 1197 with group health plans and health insurance issuers of health insurance coverage offered in the individual or group market) under which the maximum fair price for a selected drug is provided to fair price eligible individuals, who with respect to such drug are described in subparagraph (A) of section 1191(c)(1), at pharmacies or by mail order service at the point-of-sale of the drug for the applicable price period for such drug and providing that such maximum fair

price is used for determining cost-sharing under such plans or coverage for the selected drug.

''(B) The establishment of procedures (including through agreements with manufacturers under this part and contracts with hospitals, physicians, and other providers of services and suppliers and agreements under section 1197 with group health plans and health insurance issuers of health insurance coverage offered in the individual or group market) under which, in the case of a selected drug furnished or administered by such a hospital, physician, or other provider of services or supplier to fair price eligible individuals (who with respect to such drug are described in subparagraph (B) of section 1191(c)(1)), the maximum fair price for the selected drug is provided to such hospitals, physicians, and other providers of services and suppliers (as applicable) with respect to such individuals and providing that such maximum fair price is used for determining cost-sharing under the respective part, plan, or coverage for the selected drug.

''(C) The establishment of procedures (including through agreements and contracts de-

scribed in subparagraphs (A) and (B)) to ensure that, not later than 90 days after the dispensing of a selected drug to a fair price eligible individual by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

''(i) the lesser of—

''(I) the wholesale acquisition cost of the drug;

''(II) the national average drug acquisition cost of the drug; and

''(III) any other similar determination of pharmacy acquisition costs of the drug, as determined by the Secretary; and

''(ii) the maximum fair price for the drug.

''(D) The establishment of procedures to ensure that the maximum fair price for a selected drug is applied before—

''(i) any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provi-

sion of prescription drug coverage on behalf of fair price eligible individuals as the Secretary may specify; and

''(ii) any other discounts.

''(E) The establishment of procedures to enter into appropriate agreements and protocols for the ongoing computation of AIM prices for selected drugs, including, to the extent possible, to compute the AIM price for selected drugs and including by providing that the manufacturer of such a selected drug should provide information for such computation not later than 3 months after the first date of the voluntary negotiation period for such selected drug.

''(F) The establishment of procedures to compute and apply the maximum fair price across different strengths and dosage forms of a selected drug and not based on the specific formulation or package size or package type of the drug.

''(G) The establishment of procedures to negotiate and apply the maximum fair price in a manner that does not include any dispensing or similar fee.

''(H) The establishment of procedures to carry out the provisions of this part, as applicable, with respect to—

''(i) fair price eligible individuals who are enrolled under a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title;

''(ii) fair price eligible individuals who are enrolled under a group health plan or health insurance coverage offered by a health insurance issuer in the individual or group market with respect to which there is an agreement in effect under section 1197; and

''(iii) fair price eligible individuals who are entitled to benefits under part A of title XVIII or enrolled under part B of such title.

''(I) The establishment of a negotiation process and renegotiation process in accordance with section 1194, including a process for acquiring information described in subsection (d) of such section and determining amounts described in subsection (b) of such section.

''(J) The provision of a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, fair price eligible individuals, and the third party with a contract under subsection (c)(1).

''(2) MONITORING COMPLIANCE.—

''(A) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under section 1193, including by establishing a mechanism through which violations of such terms may be reported.

''(B) NOTIFICATION.—If a third party with a contract under subsection (c)(1) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under section 4192 of the Internal Revenue Code of 1986 or section 1198, as applicable.

''(b) COLLECTION OF DATA.—

''(1) FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans under part D of title XVIII and MA–PD plans under part C of such title in a timeframe that allows for maximum

fair prices to be provided under this part for selected drugs.

''(2) FROM HEALTH PLANS.—The Secretary may collect appropriate data from group health plans or health insurance issuers offering group or individual health insurance coverage in a timeframe that allows for maximum fair prices to be provided under this part for selected drugs.

''(3) COORDINATION OF DATA COLLECTION.—To the extent feasible, as determined by the Secretary, the Secretary shall ensure that data collected pursuant to this subsection is coordinated with, and not duplicative of, other Federal data collection efforts.

''(c) CONTRACT WITH THIRD PARTIES.—

''(1) IN GENERAL.—The Secretary may enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this part. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

''(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

''(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this part;

''(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this part, as necessary for the manufacturer to fulfill its obligations under this part; and

''(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

''(2) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (1) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this part.

''SEC. 1197. VOLUNTARY PARTICIPATION BY OTHER HEALTH PLANS.

''(a) AGREEMENT TO PARTICIPATE UNDER PROGRAM.—

"(1) IN GENERAL.—Subject to paragraph (2), under the program under this part the Secretary shall be treated as having in effect an agreement with a group health plan or health insurance issuer offering group or individual health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), with respect to a price applicability period and a selected drug with respect to such period—

"(A) with respect to such selected drug furnished or dispensed at a pharmacy or by mail order service if coverage is provided under such plan or coverage during such period for such selected drug as so furnished or dispensed; and

"(B) with respect to such selected drug furnished or administered by a hospital, physician, or other provider of services or supplier if coverage is provided under such plan or coverage during such period for such selected drug as so furnished or administered.

"(2) OPTING OUT OF AGREEMENT.—The Secretary shall not be treated as having in effect an agreement under the program under this part with a group health plan or health insurance issuer offer-

ing group or individual health insurance coverage with respect to a price applicability period and a selected drug with respect to such period if such a plan or issuer affirmatively elects, through a process specified by the Secretary, not to participate under the program with respect to such period and drug.

''(b) PUBLICATION OF ELECTION.—With respect to each price applicability period and each selected drug with respect to such period, the Secretary and the Secretary of Labor and the Secretary of the Treasury, as applicable, shall make public a list of each group health plan and each health insurance issuer offering group or individual health insurance coverage, with respect to which coverage is provided under such plan or coverage for such drug, that has elected under subsection (a) not to participate under the program with respect to such period and drug.

''SEC. 1198. CIVIL MONETARY PENALTY.

''(a) VIOLATIONS RELATING TO OFFERING OF MAXIMUM FAIR PRICE.—Any manufacturer of a selected drug that has entered into an agreement under section 1193, with respect to a plan year during the price applicability period for such drug, that does not provide access to a price that is not more than the maximum fair price (or a lesser price) for such drug for such year—

"(1) to a fair price eligible individual who with respect to such drug is described in subparagraph (A) of section 1191(c)(1) and who is furnished or dispensed such drug during such year; or

"(2) to a hospital, physician, or other provider of services or supplier with respect to fair price eligible individuals who with respect to such drug is described in subparagraph (B) of such section and is furnished or administered such drug by such hospital, physician, or provider or supplier during such year;

shall be subject to a civil monetary penalty equal to ten times the amount equal to the difference between the price for such drug made available for such year by such manufacturer with respect to such individual or hospital, physician, provider, or supplier and the maximum fair price for such drug for such year.

"(b) VIOLATIONS OF CERTAIN TERMS OF AGREEMENT.—Any manufacturer of a selected drug that has entered into an agreement under section 1193, with respect to a plan year during the price applicability period for such drug, that is in violation of a requirement imposed pursuant to section 1193(a)(6) shall be subject to a civil monetary penalty of not more than $1,000,000 for each such violation.

''(c) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''SEC. 1199. MISCELLANEOUS PROVISIONS.

''(a) PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to data collected under this part.

''(b) NATIONAL ACADEMY OF MEDICINE STUDY.—Not later than December 31, 2025, the National Academy of Medicine shall conduct a study, and submit to Congress a report, on recommendations for improvements to the program under this part, including the determination of the limits applied under section 1194(c).

''(c) MEDPAC STUDY.—Not later than December 31, 2025, the Medicare Payment Advisory Commission shall conduct a study, and submit to Congress a report, on the program under this part with respect to the Medicare program under title XVIII, including with respect to the effect of the program on individuals entitled to benefits or enrolled under such title.

''(d) LIMITATION ON JUDICIAL REVIEW.—The following shall not be subject to judicial review:

''(1) The selection of drugs for publication under section 1192(a).

''(2) The determination of whether a drug is a negotiation-eligible drug under section 1192(d).

''(3) The determination of the maximum fair price of a selected drug under section 1194.

''(4) The determination of units of a drug for purposes of section 1191(c)(3).

''(e) COORDINATION.—In carrying out this part with respect to group health plans or health insurance coverage offered in the group market that are subject to oversight by the Secretary of Labor or the Secretary of the Treasury, the Secretary of Health and Human Services shall coordinate with such respective Secretary.

''(f) DATA SHARING.—The Secretary shall share with the Secretary of the Treasury such information as is necessary to determine the tax imposed by section 4192 of the Internal Revenue Code of 1986.

''(g) GAO STUDY.—Not later than December 31, 2025, the Comptroller General of the United States shall conduct a study of, and submit to Congress a report on, the implementation of the Fair Price Negotiation Program under this part.''.

(b) APPLICATION OF MAXIMUM FAIR PRICES AND CONFORMING AMENDMENTS.—

(1) UNDER MEDICARE.—

(A) APPLICATION TO PAYMENTS UNDER PART B.—Section 1847A(b)(1)(B) of the Social Security Act (42 U.S.C. 1395w–3a(b)(1)(B)) is amended by inserting ''or in the case of such a drug or biological that is a selected drug (as defined in section 1192(c)), with respect to a price applicability period (as defined in section 1191(b)(2)), 106 percent of the maximum fair price (as defined in section 1191(c)(2) applicable for such drug and a plan year during such period'' after ''paragraph (4)''.

(B) EXCEPTION TO PART D NON-INTERFERENCE.—Section 1860D–11(i) of the Social Security Act (42 U.S.C. 1395w–111(i)) is amended by inserting '', except as provided under part E of title XI'' after ''the Secretary''.

(C) APPLICATION AS NEGOTIATED PRICE UNDER PART D.—Section 1860D–2(d)(1) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)) is amended—

(i) in subparagraph (B), by inserting '', subject to subparagraph (D),'' after ''negotiated prices''; and

(ii) by adding at the end the following new subparagraph:

"(D) APPLICATION OF MAXIMUM FAIR PRICE FOR SELECTED DRUGS.—In applying this section, in the case of a covered part D drug that is a selected drug (as defined in section 1192(c)), with respect to a price applicability period (as defined in section 1191(b)(2)), the negotiated prices used for payment (as described in this subsection) shall be the maximum fair price (as defined in section 1191(c)(2)) for such drug and for each plan year during such period.".

(D) INFORMATION FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS REQUIRED.—

(i) PRESCRIPTION DRUG PLANS.—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:

"(8) PROVISION OF INFORMATION RELATED TO MAXIMUM FAIR PRICES.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall require the sponsor to provide information to

the Secretary as requested by the Secretary in accordance with section 1196(b).''.

(ii) MA–PD PLANS.—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 new subparagraph:

''(E) PROVISION OF INFORMATION RELATED TO MAXIMUM FAIR PRICES.—Section 1860D–12(b)(8).''.

(2) UNDER GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE.—

(A) PHSA.—Part A of title XXVII of the Public Health Service Act is amended by inserting after section 2729 the following new section:

''SEC. 2729A. FAIR PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

''(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that is treated under section 1197 of the Social Security Act as having in effect an agreement with the Secretary under the Fair Price Negotiation Program under part E of title XI of such Act, with respect to a price applicability period (as defined in

section 1191(b) of such Act) and a selected drug (as defined in section 1192(c) of such Act) with respect to such period with respect to which coverage is provided under such plan or coverage—

''(1) the provisions of such part shall apply—

''(A) if coverage of such selected drug is provided under such plan or coverage if the drug is furnished or dispensed at a pharmacy or by a mail order service, to the plans or coverage offered by such plan or issuer, and to the individuals enrolled under such plans or coverage, during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to individuals enrolled under such prescription drug plans and MA–PD plans during such period; and

''(B) if coverage of such selected drug is provided under such plan or coverage if the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to the plans or coverage offered by such plan or issuers, to the individuals enrolled under such plans or coverage, and to hospitals, physicians, and other providers of services and

suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary, to individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

''(2) the plan or issuer shall apply any cost-sharing responsibilities under such plan or coverage, with respect to such selected drug, by substituting an amount not more than the maximum fair price negotiated under such part E of title XI for such drug in lieu of the drug price upon which the cost-sharing would have otherwise applied, and such cost-sharing responsibilities with respect to such selected drug may not exceed such maximum fair price; and

''(3) the Secretary shall apply the provisions of such part E to such plan, issuer, and coverage, such individuals so enrolled in such plans and coverage, and such hospitals, physicians, and other providers and suppliers participating in such plans and coverage.

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN FAIR PRICE NEGOTIATION PROGRAM.—A group health

plan or a health insurance issuer offering group or individual health insurance coverage shall publicly disclose in a manner and in accordance with a process specified by the Secretary any election made under section 1197 of the Social Security Act by the plan or issuer to not participate in the Fair Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan or coverage before the beginning of the plan year for which such election was made.''.

(B) ERISA.—

(i) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended by adding at the end the following new section:

''SEC. 716. FAIR PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

''(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group health insurance coverage that is treated under section 1197 of the Social Security Act as having in effect an agreement with the Secretary under the Fair Price Negotiation Program under part E of title XI of such Act, with respect to a

price applicability period (as defined in section 1191(b) of such Act) and a selected drug (as defined in section 1192(c) of such Act) with respect to such period with respect to which coverage is provided under such plan or coverage—

''(1) the provisions of such part shall apply, as applicable—

''(A) if coverage of such selected drug is provided under such plan or coverage if the drug is furnished or dispensed at a pharmacy or by a mail order service, to the plans or coverage offered by such plan or issuer, and to the individuals enrolled under such plans or coverage, during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to individuals enrolled under such prescription drug plans and MA–PD plans during such period; and

''(B) if coverage of such selected drug is provided under such plan or coverage if the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to the plans or coverage offered by such plan or issuers, to the individuals enrolled

under such plans or coverage, and to hospitals, physicians, and other providers of services and suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary, to individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

''(2) the plan or issuer shall apply any cost-sharing responsibilities under such plan or coverage, with respect to such selected drug, by substituting an amount not more than the maximum fair price negotiated under such part E of title XI for such drug in lieu of the drug price upon which the cost-sharing would have otherwise applied, and such cost-sharing responsibilities with respect to such selected drug may not exceed such maximum fair price; and

''(3) the Secretary shall apply the provisions of such part E to such plan, issuer, and coverage, and such individuals so enrolled in such plans.

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN FAIR PRICE NEGOTIATION PROGRAM.—A group health plan or a health insurance issuer offering group health in-

surance coverage shall publicly disclose in a manner and in accordance with a process specified by the Secretary any election made under section 1197 of the Social Security Act by the plan or issuer to not participate in the Fair Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan or coverage before the beginning of the plan year for which such election was made.''.

(ii) APPLICATION TO RETIREE AND CERTAIN SMALL GROUP HEALTH PLANS.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(iii) CLERICAL AMENDMENT.—The table of sections for subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

''Sec. 716. Fair Price Negotiation Program and application of maximum fair prices.''.

(C) IRC.—

(i) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9816. FAIR PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

"(a) IN GENERAL.—In the case of a group health plan that is treated under section 1197 of the Social Security Act as having in effect an agreement with the Secretary under the Fair Price Negotiation Program under part E of title XI of such Act, with respect to a price applicability period (as defined in section 1191(b) of such Act) and a selected drug (as defined in section 1192(c) of such Act) with respect to such period with respect to which coverage is provided under such plan—

"(1) the provisions of such part shall apply, as applicable—

"(A) if coverage of such selected drug is provided under such plan if the drug is furnished or dispensed at a pharmacy or by a mail order service, to the plan, and to the individuals enrolled under such plan during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to individ-

uals enrolled under such prescription drug plans and MA–PD plans during such period; and

"(B) if coverage of such selected drug is provided under such plan if the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to the plan, to the individuals enrolled under such plan, and to hospitals, physicians, and other providers of services and suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary, to individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

"(2) the plan shall apply any cost-sharing responsibilities under such plan, with respect to such selected drug, by substituting an amount not more than the maximum fair price negotiated under such part E of title XI for such drug in lieu of the drug price upon which the cost-sharing would have otherwise applied, and such cost-sharing responsibilities

with respect to such selected drug may not exceed such maximum fair price; and

''(3) the Secretary shall apply the provisions of such part E to such plan and such individuals so enrolled in such plan.

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN FAIR PRICE NEGOTIATION PROGRAM.—A group health plan shall publicly disclose in a manner and in accordance with a process specified by the Secretary any election made under section 1197 of the Social Security Act by the plan to not participate in the Fair Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan before the beginning of the plan year for which such election was made.''.

(ii) APPLICATION TO RETIREE AND CERTAIN SMALL GROUP HEALTH PLANS.—Section 9831(a)(2) of the Internal Revenue Code of 1986 is amended by inserting ''other than with respect to section 9816,'' before ''any group health plan''.

(iii) CLERICAL AMENDMENT.—The table of sections for subchapter B of chap-

ter 100 of such Code is amended by adding at the end the following new item:

''Sec. 9816. Fair Price Negotiation Program and application of maximum fair prices.''.

(3) FAIR PRICE NEGOTIATION PROGRAM PRICES INCLUDED IN BEST PRICE AND AMP.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(A) in subsection (c)(1)(C)(ii)—

(i) in subclause (III), by striking at the end ''; and'';

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

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

''(V) in the case of a rebate period and a covered outpatient drug that is a selected drug (as defined in section 1192(c)) during such rebate period, shall be inclusive of the price for such drug made available from the manufacturer during the rebate period by reason of application of part E of title XI to any wholesaler, retailer, provider, health maintenance organi-

zation, nonprofit entity, or governmental entity within the United States.''; and

(B) in subsection (k)(1)(B), by adding at the end the following new clause:

''(iii) CLARIFICATION.—Notwithstanding clause (i), in the case of a rebate period and a covered outpatient drug that is a selected drug (as defined in section 1192(c)) during such rebate period, any reduction in price paid during the rebate period to the manufacturer for the drug by a wholesaler or retail community pharmacy described in subparagraph (A) by reason of application of part E of title XI shall be included in the average manufacturer price for the covered outpatient drug.''.

(4) FEHBP.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p) A contract may not be made or a plan approved under this chapter with any carrier that has affirmatively elected, pursuant to section 1197 of the Social Security Act, not to participate in the Fair Price Negotiation Program established under section 1191 of such Act for any

selected drug (as that term is defined in section 1192(c) of such Act).''.

(5) OPTION OF SECRETARY OF VETERANS AFFAIRS TO PURCHASE COVERED DRUGS AT MAXIMUM FAIR PRICES.—Section 8126 of title 38, United States Code, is amended—

(A) in subsection (a)(2), by inserting '', subject to subsection (j),'' after ''may not exceed'';

(B) in subsection (d), in the matter preceding paragraph (1), by inserting '', subject to subsection (j)'' after ''for the procurement of the drug''; and

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

''(j)(1) In the case of a covered drug that is a selected drug, for any year during the price applicability period for such drug, if the Secretary determines that the maximum fair price of such drug for such year is less than the price for such drug otherwise in effect pursuant to this section (including after application of any reduction under subsection (a)(2) and any discount under subsection (c)), at the option of the Secretary, in lieu of the maximum price (determined after application of the reduction under subsection (a)(2) and any discount under subsection (c), as

applicable) that would be permitted to be charged during such year for such drug pursuant to this section without application of this subsection, the maximum price permitted to be charged during such year for such drug pursuant to this section shall be such maximum fair price for such drug and year.

''(2) For purposes of this subsection:

''(A) The term 'maximum fair price' means, with respect to a selected drug and year during the price applicability period for such drug, the maximum fair price (as defined in section 1191(c)(2) of the Social Security Act) for such drug and year.

''(B) The term 'negotiation eligible drug' has the meaning given such term in section 1192(d)(1) of the Social Security Act.

''(C) The term 'price applicability period' has, with respect to a selected drug, the meaning given such term in section 1191(b)(2) of such Act.

''(D) The term 'selected drug' means, with respect to a year, a drug that is a selected drug under section 1192(c) of such Act for such year.''.

SEC. 302. DRUG MANUFACTURER EXCISE TAX FOR NON-COMPLIANCE.

(a) IN GENERAL.—Subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4192. SELECTED DRUGS DURING NONCOMPLIANCE PERIODS.

''(a) IN GENERAL.—There is hereby imposed on the sale by the manufacturer, producer, or importer of any selected drug during a day described in subsection (b) a tax in an amount such that the applicable percentage is equal to the ratio of—

''(1) such tax, divided by

''(2) the sum of such tax and the price for which so sold.

''(b) NONCOMPLIANCE PERIODS.—A day is described in this subsection with respect to a selected drug if it is a day during one of the following periods:

''(1) The period beginning on the June 16th immediately following the selected drug publication date and ending on the first date during which the manufacturer of the drug has in place an agreement described in subsection (a) of section 1193 of the Social Security Act with respect to such drug.

''(2) The period beginning on the April 1st immediately following the June 16th described in para-

graph (1) and ending on the first date during which the manufacturer of the drug has agreed to a maximum fair price under such agreement.

''(3) In the case of a selected drug with respect to which the Secretary of Health and Human Services has specified a renegotiation period under such agreement, the period beginning on the first date after the last date of such renegotiation period and ending on the first date during which the manufacturer of the drug has agreed to a renegotiated maximum fair price under such agreement.

''(4) With respect to information that is required to be submitted to the Secretary of Health and Human Services under such agreement, the period beginning on the date on which such Secretary certifies that such information is overdue and ending on the date that such information is so submitted.

''(5) In the case of a selected drug with respect to which a payment is due under subsection (c) of such section 1193, the period beginning on the date on which the Secretary of Health and Human Services certifies that such payment is overdue and ending on the date that such payment is made in full.

''(c) APPLICABLE PERCENTAGE.—For purposes of this section, the term 'applicable percentage' means—

''(1) in the case of sales of a selected drug during the first 90 days described in subsection (b) with respect to such drug, 65 percent,

''(2) in the case of sales of such drug during the 91st day through the 180th day described in subsection (b) with respect to such drug, 75 percent,

''(3) in the case of sales of such drug during the 181st day through the 270th day described in subsection (b) with respect to such drug, 85 percent, and

''(4) in the case of sales of such drug during any subsequent day, 95 percent.

''(d) SELECTED DRUG.—For purposes of this section—

''(1) IN GENERAL.—The term 'selected drug' means any selected drug (within the meaning of section 1192 of the Social Security Act) which is manufactured or produced in the United States or entered into the United States for consumption, use, or warehousing.

''(2) UNITED STATES.—The term 'United States' has the meaning given such term by section 4612(a)(4).

''(3) COORDINATION WITH RULES FOR POSSESSIONS OF THE UNITED STATES.—Rules similar to

the rules of paragraphs (2) and (4) of section 4132(c) shall apply for purposes of this section.

''(e) OTHER DEFINITIONS.—For purposes of this section, the terms 'selected drug publication date' and 'maximum fair price' have the meaning given such terms in section 1191 of the Social Security Act.

''(f) ANTI-ABUSE RULE.—In the case of a sale which was timed for the purpose of avoiding the tax imposed by this section, the Secretary may treat such sale as occurring during a day described in subsection (b).''.

(b) NO DEDUCTION FOR EXCISE TAX PAYMENTS.—Section 275 of the Internal Revenue Code of 1986 is amended by adding ''or by section 4192'' before the period at the end of subsection (a)(6).

(c) CONFORMING AMENDMENTS.—

(1) Section 4221(a) of the Internal Revenue Code of 1986 is amended by inserting ''or 4192'' after ''section 4191''.

(2) Section 6416(b)(2) of such Code is amended by inserting ''or 4192'' after ''section 4191''.

(d) CLERICAL AMENDMENTS.—

(1) The heading of subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by striking ''**Medical Devices**'' and inserting ''**Other Medical Products**''.

(2) The table of subchapters for chapter 32 of such Code is amended by striking the item relating to subchapter E and inserting the following new item:

''SUBCHAPTER E. OTHER MEDICAL PRODUCTS''.

(3) The table of sections for subchapter E of chapter 32 of such Code is amended by adding at the end the following new item:

''Sec. 4192. Selected drugs during noncompliance periods.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to sales after the date of the enactment of this Act.

SEC. 303. FAIR PRICE NEGOTIATION IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established a Fair Price Negotiation Implementation Fund (referred to in this section as the ''Fund''). The Secretary of Health and Human Services may obligate and expend amounts in the Fund to carry out this title (and the amendments made by such title).

(b) FUNDING.—There is authorized to be appropriated, and there is hereby appropriated, out of any monies in the Treasury not otherwise appropriated, to the Fund $3,000,000,000, to remain available until expended, of which—

(1) $600,000,000 shall become available on the date of the enactment of this Act;

(2) $600,000,000 shall become available on October 1, 2020;

(3) $600,000,000 shall become available on October 1, 2021;

(4) $600,000,000 shall become available on October 1, 2022; and

(5) $600,000,000 shall become available on October 1, 2023.

(c) SUPPLEMENT NOT SUPPLANT.—Any amounts appropriated pursuant to this section shall be in addition to any other amounts otherwise appropriated pursuant to any other provision of law.

TITLE IV—PUBLIC HEALTH INVESTMENTS

SEC. 401. SUPPORTING INCREASED INNOVATION.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall continue to support and to expand, as applicable, biomedical research carried out through the National Institutes of Health innovation projects described in section 1001(b)(4) of the 21st Century Cures Act (Public Law 114–255). The Secretary shall ensure that any such research (and related activities)

is conducted in compliance with section 492B of the Public Health Service Act (42 U.S.C. 289a–2) (relating to the inclusion of women and members of minority groups in research).

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, in addition to funds made available under paragraph (2) of section 1001(b) of the 21st Century Cures Act (Public Law 114–255), there is authorized to be appropriated, and there is appropriated to the NIH Innovation Account established under such section 1001(b), out of any moneys in the Treasury not otherwise obligated, $2,000,000,000 for fiscal year 2021, to remain available until expended.

Passed the House of Representatives June 29, 2020.

Attest:

Clerk.

116TH CONGRESS
2D SESSION

H. R. 1425

AN ACT

To amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.