Madam Speaker, over 500,000 independent restaurants with 11 million employees are going to face catastrophic consequences this year. In April alone, one-half of the unemployed, 5.5 million people, were from the independent restaurants area. Without special, tailored Federal help, we are going to see 85 percent of them disappear for good.

Madam Speaker, I am pleased to have introduced, on a bipartisan basis, the RESTAURANTS Act, H.R. 7197, which would establish a $120 billion fund tailored to provide assistance for independent restaurants.

I strongly urge my colleagues to talk to their independent restaurants, the cornerstone of a vital community. If we act now, we can save them yet this year, a vital element in each and every one of our communities.

Madam Speaker, the H.R. 7197, the RESTAURANTS Act, will provide massive support at a time when it is needed.

MEMORIALIZING MAYOR LEONARD SCARCELLA

(Mr. OLSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. OLSON. Madam Speaker, the city of Stafford, Fort Bend County, the State of Texas, and all of America lost a great man Sunday: Mayor Leonard Scarcella.

He was a true Texas force of nature. He listened to all, regardless of what country you came from or where you worshipped. His life was about making all human life better.

Madam Speaker, for 51 years as mayor, he did just that. He helped bring Texas Instruments to Stafford in 1967, opening the door to Fort Bend to attract corporate America.

Not happy with the public education in Stafford, he fought for the only city-run school board in Texas.

Tired of people going to the big city of Houston for concerts and conventions, Leonard opened the Stafford Centre in 2004.

He proudly governed without one penny of property tax.

It was Leonard who brought the stunning 30,000-piece BAPS Hindu Temple to Stafford in 2004.

Madam Speaker, to close, nearly 1 million Texans in Fort Bend County are mourning now. I join them. God bless Mayor Leonard Scarcella.

STRENGTHEN THE ACA

(Mr. VEASEY asked and was given permission to address the House for 1 minute.)

Mr. VEASEY. Madam Speaker, I rise today to ask my colleagues to pass the Patient Protection and Affordable Care Enhancement Act.

Because we are in the middle of a global pandemic that has killed almost 130,000 Americans and is ravaging my home State of Texas and has left our hospitals overwhelmed right now, it is now more important that we do everything that we can to strengthen the ACA. This important legislation has already given access to millions of people that now have lifesaving healthcare, many who could not previously access it.

Madam Speaker, this legislation that I am working on now pushes critical provisions, like lowering healthcare costs, strengthening protections for people with preexisting conditions, negotiating for lower prescription drug prices, and expanding healthcare by pressing for Medicaid expansion.

Madam Speaker, let me tell you something: You don't want to get sick in Texas right now. You don't want to get sick in Texas right now. Our hospitals are overwhelmed because of the inaction of our Governor. It is shameful.

Anything that we can do here to help the crisis that we have back in our State, which is also about to grip other States in this Nation, we need to act on it now.

Time cannot wait.

STATE HEALTH CARE PREMIUM REDUCTION ACT

Mr. PALLONE. Madam Speaker, pursuant to House Resolution 1017, I call up the bill (H.R. 1425) 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, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 1017, in lieu of the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce printed in the bill, an amendment in the nature of a substitute consisting of the text of the Rules Committee Print 116–56, modified by the amendment printed in part B of House Report 116–436, is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 1425

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''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—LOWERING HEALTH CARE COSTS AND PROTECTING PEOPLE WITH PREEXISTING 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
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 eligibility 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 individuals 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 beneficiary 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 reenrollment of, or prepopulated applications for, individuals 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 waiver 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 restrictive 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 described 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 assistance 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 supervised 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 administered 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 respect 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 recent 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 subparagraph (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 subparagraph (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 described 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 application 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 initial 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 described 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 provision 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 offering 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 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.''.

(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 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 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 chapter 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 organization, 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 NONCOMPLIANCE.

(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 paragraph (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.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 3 hours equally divided among and controlled by the respective chairs and ranking minority members of the Committee on Education and Labor, the Committee on Energy and Commerce, and the Committee on Ways and Means.

The gentleman from Virginia (Mr. SCOTT), the gentlewoman from North Carolina (Ms. FOXX), the gentleman from New Jersey (Mr. PALLONE), the gentleman from Oregon (Mr. WALDEN), the gentleman from Massachusetts (Mr. NEAL), and the gentleman from Texas (Mr. BRADY) each will control 30 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. PALLONE).

GENERAL LEAVE

Mr. PALLONE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and add extraneous material on H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, as Americans continue to face the COVID–19 pandemic and a severe economic downturn, they are justifiably concerned about their health and their financial future.

Today, we are here to provide more relief to the American people, and I rise in strong support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, legislation that will make healthcare and prescription drugs more affordable and will expand access to health coverage.

Madam Speaker, this legislation strengthens the Affordable Care Act for the future, which is critical at a time when the Trump administration and Republicans continue to support a lawsuit before the Supreme Court that would strike down the entire ACA.

These actions could result in 23 million Americans losing their health coverage and the elimination of critical consumer protections for more than 130 million people with preexisting conditions during the middle of a pandemic. Sadly, this is nothing new.

Madam Speaker, over the last 4 years, much of the ACA's progress has been halted and, in some cases, reversed by the Trump administration's sabotage campaign.

Thanks to the ACA, the uninsured rate fell to a historic low. However, the Trump administration's actions have driven up the uninsured rate. Today, millions more Americans are uninsured and afraid they will not be able to afford the cost of care if they become sick.

□ 1015

The Patient Protection and Affordable Care Enhancement Act will reverse these trends. This legislation is a commonsense, fiscally responsible one-two punch that uses the Federal Government's savings from lowering prescription drug costs to lower health insurance costs for Americans.

The bill does this by empowering the Secretary of Health and Human Services to negotiate a fair price for prescription drugs. This legislation stops the gouging at the pharmacy counter and ensures that Americans no longer pay 4 or 5 or 10 times the amount people in other countries pay for the exact same drug. This negotiation not only levels the playing field, but it also saves hundreds of billions of dollars.

H.R. 1425 will then reinvest these savings to lower healthcare costs for consumers and to expand access to affordable care. More middle-class Americans would receive financial assistance with monthly premiums. A family of four, for example, with an annual income of $60,000 would save $2,000 annually, and a family of four with an annual income of $100,000, who previously did not qualify for subsidies, would save $8,000 every year.

Now, this is in addition to the savings that they also had under the underlying ACA. This is, under this bill, in addition to what they normally saved—and that is real savings to hard-working families.

This legislation also lowers Americans' healthcare costs by reversing some of the worst sabotage from the Trump administration. It reverses the administration's expansion of junk insurance plans that leave patients saddled with thousands of dollars in medical debt. It restores critical outreach in enrollment funding that was gutted by the Trump administration, and it reduces racial and ethnic healthcare disparities.

H.R. 1425 also builds on the ACA's Medicaid expansion and further strengthens this important program and provides for additional incentives to States that stubbornly refuse to expand their programs. And for political reasons, many of the red States have done that; they just refuse to expand Medicaid. But these holdout States, if they expand Medicaid, 4.8 million people would gain Medicaid coverage overnight, including 2.3 million uninsured Americans.

This bill also takes an important step to address the country's maternal mortality crisis by extending Medicaid postpartum coverage from 60 days to 1 year. Simply put, this policy will save lives.

Madam Speaker, the Patient Protection and Affordable Care Enhancement Act lowers healthcare and prescription drug costs, expands coverage for millions of Americans, and reverses the Trump administration's years-long effort to undermine Americans' access to quality and affordable healthcare.

Madam Speaker, I strongly urge my colleagues to support this bill, and I reserve the balance of my time.

Mr. WALDEN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, our constituents are looking for us to put aside partisan politics. They want us not to play political games, and they want us to find common ground to address the unprecedented deadly challenges caused by COVID–19.

We need to work together to lower prescription drug prices. We need to work together to aid States in stabilizing health markets damaged by the ACA. We need to work together to lower out-of-pocket costs for patients, including capping seniors' drug costs under Medicare, encourage participation of private health insurance, and we really need to fund our community health centers. We need to increase the options available through the market and end surprise medical billing. We could do all of that. We could do it together, and it could become law.

Unfortunately, instead, here we are wasting time on a partisan bill that has zero chance of becoming law. This is no way to govern at any time, but especially in a pandemic.

At a time when we are asking our Nation's innovators to find new cures and treatments to address COVID–19 at record speed and with record investment, Democrats want to enact a socialist drug pricing scheme that could devastate this country's innovation in the middle of a global pandemic. Frankly, it is unconscionable.

This legislation before us today provides $100 billion in bailouts for insurance companies at a time when insurers are not paying for elective procedures due to COVID. Now, we all want to make premiums more affordable, but all signs are insurers do not need a bailout right now.

Wouldn't that money be better spent, Madam Speaker, on funding our Nation's community health centers, giving them certainty, rather than letting their funding run out in just a matter of months? They are on the front lines of this fight in our communities. They are on the front lines of the fight on testing and treating patients in rural and underserved communities. Shouldn't we fund them, give them stability and certainty?

And speaking of monies poorly spent, today Democrats are proposing we spend $400 million to prop up ObamaCare's enrollment. This includes $100 million for the failed and discredited Navigator Program; $100 million for outreach and marketing, only for ACA-compliant plans, not any of the more affordable alternatives; and $200 million for States to boost enrollment, with no strings attached—no transparency, no accountability.

This law has been on the books for 10 years, and we must spend nearly half a billion dollars to make it look like it is working?

In this bill, Democrats want to force States to expand Medicaid, allowing expansion States to get 100 percent of

Federal Medicaid payments, while punishing, in the middle of a pandemic, taking money away from, nonexpansion States, taking it away from their Medicaid. That is what this bill does. If they don't expand, the Federal Government's heavy hand comes in and takes money back out of Medicaid. It is vindictive, and it is probably unconstitutional.

You know, the Supreme Court, Madam Speaker, said expansion is the States' decision. This legislation violates that. We need to work together with the States as partners, not treat them like subordinates.

Now, in the last Congress, I advocated for multiple policies that would help States stabilize health markets damaged by the ACA. But, unfortunately, House Democrats repeatedly blocked our ideas.

We all want patients to have access to high-quality and affordable health coverage, but this measure doubles down on policies that have already failed.

One thing is clear: We need to make our healthcare system work better for all Americans. That is why our goal should be to advance solutions to protect patients, to stabilize healthcare markets, to encourage greater flexibility for States, and to promote policies to help Americans get and keep coverage.

Madam Speaker, I have great respect for the chairman. We have worked together on a number of different issues in the Congress with great success at the Energy and Commerce Committee. Unfortunately, our bipartisan work to lower drug prices was derailed by the Speaker in December when she decided to force politics over real progress.

I recently read an article about a man suffering from ALS who has dedicated his life to finding a cure. And like Americans with ALS, there are millions of Americans suffering from other life-threatening or debilitating diseases, like cancer or sickle cell anemia. They are hoping, and their families are hoping, that one day there will be a cure.

Now, it is not debatable the bill before us today will reduce the number of new treatments in the future, new medicines, new lifesaving medicines, perhaps. The Council of Economic Advisers found there could be more than 100 fewer treatments, fewer medicines, that would never be invented, never be discovered, if this legislation we are going to vote on becomes law—100 fewer.

We can lower drug prices while preserving the hope those praying for a cure have. There is common ground to be had here, and I have offered many times to work on bipartisan legislation to lower drug costs without limiting—perhaps, even ending—innovation.

H.R. 19 is a bill comprised entirely of bipartisan policies. That is our Republican alternative. But it is not just a Republican alternative. Everything in there is bipartisan. And already, seven of the provisions we put in months ago have been signed into law, proving that it is, indeed, a bipartisan package.

Instead of pursuing proven bipartisan solutions, unfortunately, Democrats again are forcing partisan politics on this House and this country, fewer options for patients at a time when we need more treatments and more cures than most.

This bill is a perfect illustration why Americans are so cynical about Washington. The American people deserve better.

Madam Speaker, I urge a ''no'' vote, and I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO), a longtime champion of the ACA.

Ms. ESHOO. Madam Speaker, I rise in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

Today, we deliver on our promise to the American people to undo the Trump administration's total sabotage of the Affordable Care Act and make healthcare affordable for every American.

Since the ACA was signed into law, 23 million Americans have been insured, every person with a preexisting condition was protected, and children could stay on their parents' health insurance policy until they turned 26.

Now, in the middle of a pandemic and a recession, the Trump administration and congressional Republicans are supporting a lawsuit before the Supreme Court—imagine this—to strike down the entirety of the ACA. I think that there is one word for this: cruel.

H.R. 1425 does the opposite. It strengthens the ACA and makes healthcare affordable by lowering premiums and reducing drug prices.

The bill ensures that no American will pay more than 8.5 percent of their income for insurance premiums, benefiting approximately 20 million Americans.

The bill allows Medicare to directly negotiate the price of the costliest drugs, and the lower prices will be available to every American, including those who receive their health insurance through their employer.

H.R. 1425 extends coverage to nearly 5 million Americans by pushing the holdout States to finally expand Medicaid. This would be such a blessing to people in those States whose Governors denied them health insurance coverage.

It also mandates 12 months of Medicaid coverage for eligible postpartum mothers.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. PALLONE. Madam Speaker, I yield an additional 1 minute to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Madam Speaker, it mandates 12 months of Medicaid coverage for eligible postpartum mothers and ensures that, once a person is enrolled in Medicaid, regardless of their income changes, they will be covered for a full year.

The bill ends the Trump administration's expansion of junk insurance plans, which exclude coverage of routine care—imagine that; what kind of policy doesn't cover routine care?—and has left patients on the hook for thousands of dollars in medical bills, and it reinstates critical funding for outreach, marketing, and enrollment so more Americans can easily sign up for insurance.

I am very proud that many parts of this bill originated in the Health Subcommittee, which I chair, where my first hearings as chair examined how to strengthen the ACA.

This is good for the American people, especially during this crisis of a pandemic and a recession.

Mr. WALDEN. Madam Speaker, I yield 3 minutes to the gentleman from Texas (Mr. BURGESS), the ranking member and former chairman of the Health Subcommittee on the Energy and Commerce Committee.

Mr. BURGESS. Madam Speaker, the Affordable Care Act, for the last 10 years, really has been anything but affordable. Prices have gone up every year in spite of what we were promised. It has only been the last 2 years that premiums have actually begun to reduce, and that is because of some of the policies enacted by the current administration expanding the usability of limited duration plans, expanding association health plans.

So when we talk about this bill to expand the Affordable Care Act, what we are really doing is increasing the unaffordability of healthcare in this country.

Now, H.R. 1425 establishes a new reinsurance program, and it is going to cost $10 billion per year forever. There is no end date.

This reinsurance program does not include some of the longstanding protections that ensure that Federal funding cannot be used to pay for abortions.

If we want to pass a bipartisan reinsurance policy, Energy and Commerce Republicans have a bill, H.R. 1510, which includes reinsurance coupled with structural reform of the Affordable Care Act and gives States more choice on how to repair their markets that have been damaged by the Affordable Care Act, and it is offset by stopping bad actors from gaming the system. Importantly, it does include the Hyde protections and, therefore, protects life.

H.R. 1425 also punishes States that choose not to expand Medicaid by cutting their Federal share of Medicaid funding.

So let's be very clear about this. A State such as mine that did not expand Medicaid reevaluates year by year, but if they choose not to expand, if they say they can't afford what this expansion would bring to the State, now this bill proposes to reduce the funding, the

Federal match, for the traditional Medicaid populations. And who are they? Blind, aged, disabled, medically fragile, children, women.

□ 1030

Why would we want to do that? Now, look, remember the reason that we have some States expanding Medicaid and some not is because of a Supreme Court case, National Federation of Independent Business v. Sebelius, which ruled that threatening States' Medicaid funding for not expanding is unconstitutional. Sections 204 and 205 of this bill would violate those very same principles and coerce States rather than incentivize them to expand Medicaid. This will be struck down by the Supreme Court as well.

Lastly, this bill uses offsets that would actively harm our Nation's coronavirus response by using offsets from H.R. 3 that would require the government to set prices and confiscate dollars from pharmacologic developers. The Congressional Budget Office analysis found that such policies would lead to substantially fewer new drugs coming to market. We really can't afford a world without the next remdesivir.

Mr. WALDEN. Madam Speaker, I would just point out that as we sit here today, Oklahoma, under a Republican Governor, has chosen to expand Medicaid coverage. That is how it should work, not a penalizing system.

Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. SCHRADER), a member of the Energy and Commerce Committee.

Mr. SCHRADER. Madam Speaker, I rise today to speak in favor of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

The bill before us today has a variety of provisions that I have been a longtime supporter of, and now, given the current healthcare crisis with COVID–19, many of these provisions are more important than ever before. Negotiating drug prices to save people money, we do it in all aspects of our life, we need to do it here.

I am also proud to colead an effort with Representative HARDER, included in today's bill, to ensure that folks who are losing their employer-sponsored healthcare coverage are aware that options to maintain that healthcare include both COBRA and the marketplace. It also maintains State flexibility and has a mechanism to ensure resources get to the individuals that need the help the most.

My home State of Oregon has a State innovation waiver reinsurance program under Section 1332 of the ACA, and within the first year it already started saving money for families by preventing a 10 to 15 percent premium increase.

These reinsurance provisions in H.R. 1425, widely bipartisan, will bolster and augment efforts States like mine who are already doing it, and provide other States additional opportunity to afford this type of program.

While the impact of the marketplace may not be seen immediately, we know that the uncertainty around COVID–19 will likely drive rates up and may consolidate the options available in the marketplace that we have worked so hard to build robust, quality options for coverage.

Since the ACA went into effect, we have seen positive trends in coverage and utilization. We must continue to build on the parts we know that are working, and in no small part, it is the Medicaid expansion that is helping so many. All of our States are facing budget crises right now, and more folks are shifting over to Medicaid as they lose their jobs. While providing healthcare is an investment upfront, it pays dividends on the back end by driving preventative care and reducing costly treatments.

Madam Speaker, I encourage my colleagues on both sides of the aisle to consider supporting the comprehensive bill before us today.

Mr. WALDEN. Madam Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. BUCSHON), a member of the Energy and Commerce Committee.

Mr. BUCSHON. Madam Speaker, first of all, I want to echo all the points made by Mr. WALDEN in his opening statement.

A decade ago, ObamaCare became the law of the land. This massive, near government takeover of our Nation's healthcare system came full of empty promises.

President Obama and Congressional Democrats famously promised Americans that if you liked your doctor, you can keep your doctor. That turned out not to be true. Millions of Americans lost access to their doctors as insurances have resorted to narrowing networks.

And instead of seeing premiums decrease by $2,500, as President Obama promised, American families have seen premiums and deductibles skyrocket. Americans deserve an accessible and affordable healthcare system that promotes quality care and peace of mind, not a system that is a downpayment on socialized, one-size-fits-all single-payer healthcare system that would put the government in charge of one of the most personal decisions families will ever make.

Rather than working to find bipartisan solutions for patients, Democrats are choosing to double-down on ObamaCare's biggest flaws. I will focus on drug pricing.

They are planning to give Washington the power to set drug prices. Well, we know that nonpartisan analysis has determined that this would result in fewer medicines being developed and fewer cures.

As a physician, I have had to share bad news with families. I know all too well that by eliminating just one new drug, how devastating that would be. What if that new drug was a cure for Alzheimer's, sickle cell anemia, cancer, ALS, or maybe even a vaccine for COVID–19?

If Democrats want to get serious about addressing our Nation's healthcare problems and lowering prescription drug prices, a good place to start would be H.R. 19, bipartisan legislation that would lower out-of-pocket spending, protect access to new and innovative cures, and increase transparency.

We can turn America's healthcare system around with common sense, patient-centered solutions. Sadly, H.R. 1425 puts the Federal Government at the center, not the patient.

Madam Speaker, I urge my colleagues to vote ''no.''

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. KENNEDY), a member of the Energy and Commerce Committee.

Mr. KENNEDY. Madam Speaker, yesterday afternoon I spent a few moments on the porch of a woman named Therese in Lowell, Massachusetts. Through an oxygen tube and a mask, and surrounded by four generations of her family, she told me the challenges of living with COPD, even though she never smoked a cigarette.

Her mother and her brother both passed away in that home. She was adamant that she would, too. She was hoping to make it for just a few more months, but that survival, Madam Speaker, was contingent on having access to healthcare. Access that our President, in court just this last week, was still trying to take away.

Madam Speaker, how is our country made stronger by taking away Therese's healthcare? What kind of person, let alone administration, looks to the wreckage of nearly over 120,000 lives lost, 2½ million infected by a pandemic, and decides that the best response is to take away healthcare from millions more?

What is great about an administration that idly watches 40 million Americans lose their jobs, and then tries to take away their healthcare, too? How morally bankrupt that we can lavish praise on essential workers, and then thank them by trying to strip away their access to medicine? All so that the rich can become richer, the powerful more powerful, backed up by a massive tax cut and aggregation of corporate power.

Madam Speaker, this moment has proved, like many other moments of truth in our Nation, that our fates are linked. That our future is shared and uncertain. We have a choice to advance together or to scramble for our own. Four generations of Therese's family know the answer. We know that answer. Today is our chance to prove it.

Mr. WALDEN. Madam Speaker, one of the greatest tragedies for Therese's family, and that of all other families in

America, is what the Congressional Budget Office tells us this bill will do, and that is, 38 fewer cures. 38. What if one of those was a cure for COPD?

Madam Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER), our pharmacist on the committee.

Mr. CARTER of Georgia. Madam Speaker, I rise today in opposition to this ObamaCare wish list legislation.

I want to start off by saying, Madam Speaker, how disappointed I am. How disappointed I am that this comes—this partisan healthcare legislation is being moved at such a serious time in our Nation's response to the pandemic.

This bill was developed and written without Republican input, which seems to be the thing to do these days. I was up here last week talking about the policing bill, same thing, no Republican input. Now we are talking about the healthcare bill. No Republican input. Partisan legislation, at a time when our country needs bipartisan solutions.

You know, when a bill is developed and written without Republican input, that is usually a good sign that there is no real intention of moving this legislation; and there is not. The other side, Madam Speaker, knows that this is not going to move.

Unfortunately, Americans are suffering right now, they are suffering from COVID–19. We should be working together, Republicans and Democrats, to create solutions that benefit every American. Unfortunately, this bill has many issues, it is a big government-controlled healthcare agenda.

Once again, Democrats are trying to mandate the price of drugs, or tax manufacturers out of the U.S. market if they don't comply, at a time when we need to be bringing back manufacturing to the United States. Now we are doing just the opposite with this partisan legislation.

My colleagues across the aisle want fewer cures during the pandemic. Fewer cures during the pandemic. Are you kidding me? That is the last thing America needs right now.

This legislation also expands ObamaCare subsidies, allowing some of the wealthiest Americans to get subsidies for insurance paid for by the hard-earned taxpayers' dollars.

This is not the time to be partisan, Madam Speaker, this is a time for us to work together. I hope my colleagues across the aisle can set aside these efforts and work with us to pass meaningful, bipartisan legislation.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Michigan (Mrs. DINGELL), another member of the committee.

Mrs. DINGELL. Madam Speaker, I rise in support of the Patient Protection and Affordable Care Enhancement Act.

And, yes, I agree with my colleagues, this is not the time for partisan politics. It has been over 10 years since the passage of the historic Patient Protection and Affordable Care Act, which expanded healthcare to 20 million Americans. And now this administration is at the Supreme Court trying to repeal it, and it has been 4 years since our colleagues, who say they will protect people, have done anything. They have not given us anything else. All they do is take knocks.

Many forget that when that bill passed the reforms ended lifetime limits. People could not get health insurance if they couldn't afford it, if they had pre-existing conditions. It allowed States to expand Medicaid and provide access to both quality, affordable healthcare and protection from crippling medical bills.

In my home State, the bipartisan expansion under Governor Rick Snyder, a Republican Governor, Healthy Michigan, currently covers 650,000 Michiganders, and supports rural hospitals in Michigan that would otherwise face a significant financial hardship. The reforms in today's bill, the Patient Protection and Affordable Care Enhancement Act, build on these successes.

The legislation would reduce healthcare premiums for Americans by expanding existing subsidies under the Affordable Care Act to those that need the help. It would also support outreach and enrollment efforts and roll back the current administration's plans to promote junk insurance plans that lack the coverage of basic benefits.

Finally, it would save Americans billions of dollars annually by allowing the Secretary of Health and Human Services, a Republican right now, to negotiate drug prices. The Congressional Budget Office also estimates that the drugs subject to negotiation would reduce prices by 55 percent.

Madam Speaker, I urge my colleagues to support this bill.

Mr. WALDEN. Madam Speaker, may I inquire as to how much time each side has remaining?

The SPEAKER pro tempore. The gentleman from Oregon has 16½ minutes remaining. The gentleman from New Jersey has 17 minutes remaining.

Mr. WALDEN. Madam Speaker, I yield 4 minutes to the gentleman from Arkansas (Mr. WESTERMAN).

□ 1045

Mr. WESTERMAN. Madam Speaker, I am grateful that we are finally having a discussion on the important issue of healthcare. More than a decade of healthcare conflict has squandered trillions of dollars, driven up our national debt, done relatively little to improve healthcare, and destroyed the public's confidence in either party's ability to fix the system. We can do better, yet we don't.

As an engineer, I learned that the first step to solving a problem is identifying and defining the problem. Our problem is not that we lack creative solutions to the issues that plague the healthcare system. Our problem is not that the electorate doesn't care about healthcare. They do. The need for healthcare is nonpartisan.

There are no Republican, Democrat, or Independent strains of cancer, forms of dementia, types of diabetes, or hospitals that check your political party registration when you arrive at the emergency room.

Our primary problem with fixing healthcare for America is that we have pushed and continue to push partisan solutions for a nonpartisan issue.

Have we in both parties not learned that this will not work? We both paid the price for our failures on healthcare, but the folks who have lost the most are our constituents, the American citizens that sent us here.

Let's be honest, face our past, learn from it, and craft a better healthcare future. The record is clear.

In 2008, the Democratic Party controlled the House, the Senate, and the White House. You passed the Affordable Care Act on straight party lines. If it were the correct solution to America's healthcare problems, we wouldn't be here today with your bill to fix it.

Fast forward to 2017. My Republican Party had majorities in the House, the Senate, and controlled the Presidency. We failed to even get the American Healthcare Act on the President's desk.

Both of these attempts at solving healthcare failed, just like any other partisan attempt to solve healthcare will fail.

The issue is so partisan that both parties had to ultimately resort to the parliamentary gymnastics of budget reconciliation to have a prayer of getting a bill on President Obama's or President Trump's desk.

We know that budget reconciliation creates too many limits to implement the best solutions for healthcare policy. We know that you can pass whatever healthcare legislation you dream up with a simple majority here in the House.

We also know that partisan bill from the House will not get past the 60-vote cloture threshold in the Senate, much less get signed into law by the President of the opposing party.

Must we continue learning our lessons in Congress at the expense of the American citizenry? Let's work on healthcare legislation that can get a veto-proof vote in the House and 60 votes in the Senate, regardless of which party controls each Chamber.

Let's pass a healthcare bill that is too good for a President of either party not to sign into law.

After the Republican failure to pass the American Health Care Act in 2017, I called my staff together and told them, ''Even though we failed to pass a bill and moved on to the next issue, the problems with healthcare did not go away and we are not going to stop working on the issue.''

We decided to reverse engineer legislation with the final goal being something that everyone could agree upon,

a bipartisan bill that covered preexisting conditions, insured more people, lowered cost, and gave Americans a fair shot at healthcare.

After 1½ years of hard work, the result was the Fair Care Act of 2019. After another year of work, scrutiny, and more good ideas, we are close to filing the Fair Care Act of 2020 with both a House and Senate version.

It has more than 50 bipartisan bills from the House and Senate in the language, and a few of the bipartisan bills from the 2019 bill have already been signed into law. We should follow this pattern.

Hopefully, you will be pleased to know that several of the provisions of your Affordable Care Enhancement Act can be found in the Fair Care Act. However, no one reached out to me for input on your bill.

I am reaching across the aisle and asking you to consider working with us in cosponsoring the Fair Care Act or other bills with bipartisan policy.

The American citizenry and I am tired of partisan healthcare in action. Will you please join us to change that?

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. KELLY), who is a member of the committee and chairs the CBC Brain Trust.

Ms. KELLY of Illinois. Madam Speaker, I rise today in support of H.R. 1425.

Since enactment of the ACA, millions of Americans have gained health coverage, but too many families have been left behind by GOP Governors and legislatures more interested in playing politics than helping families.

Today, we build on that success.

Each year, more than 700 American women die from pregnancy complications, and more than half of these deaths are entirely preventable.

Tragically, Black moms die at three to four times the rate of White moms, but passing this bill will help address that by allowing new moms to remain on Medicaid for the entire postpartum period. And this piece of legislation left the Committee on Energy and Commerce with many Republican votes.

This portion is just one example of the good in this bill and the lives it will save. We cannot allow preventable deaths to continue in this country. We must do more. It was safer for me to have my daughter than it is for my daughter now to have a baby.

I hope my colleagues will join me in supporting this lifesaving legislation.

There is a lot of talk about how we should care about the health of the American citizens, and one thing that we all can do is wear a mask.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker I yield 2 minutes to the gentlewoman from Minnesota (Ms. CRAIG).

Ms. CRAIG. Madam Speaker, I thank the gentleman for yielding.

I ask you: What good is a cure if you can't access it because you can't afford it?

The Patient Protection and Affordable Care Act is immensely personal to me. See, I grew up for a portion of my childhood without health insurance. I also spent more than 20 years working in two healthcare manufacturing companies and was responsible for providing healthcare to 18,000 Americans at a U.S. company.

These experiences and the stories I have heard across my district are why I am here today working to reduce out-of-pocket costs and the price of prescription drugs.

Today, Les and his family, they farm in my district. They pay over $20,000 a year in premiums with a $12,000 deductible.

Another family farms by flashlight and works another job during the day, just for the family health insurance.

These examples show the heart of the problem: If healthcare isn't affordable, it is not accessible.

I am proud that the base of this bill is my bipartisan bill, H.R. 1425, the State Health Care Premium Reduction Act, the first healthcare legislation that I authored as a Member of Congress. This bill will allow States to lower the cost of premiums in the individual marketplace and to expand access to healthcare to more Americans. I am also pleased that this package includes the transformational drug price negotiation mechanism from the Elijah E. Cummings Lower Drug Costs Now Act, which finally takes on the high cost of prescription drugs.

For the 51 percent of nonelderly with preexisting conditions in my congressional district, the ACA was a lifeline. This is a moment that requires us to come together as Americans to strengthen the ACA and reduce the cost and increase the access to healthcare.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I neglected to mention that Ms. CRAIG is actually the prime sponsor of this legislation.

I yield 2 minutes to the gentleman from California (Mr. RUIZ), who is a member of the Energy and Commerce Committee and has long worked on the ACA enhancement.

Mr. RUIZ. Madam Speaker, I rise in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

We are in the middle of a global pandemic that has infected millions of Americans, left millions more unemployed and struggling to pay their bills, and underscored the American people's need for quality, affordable healthcare.

It is precisely during this time; it is precisely in our moment of history, during American families' hardships and agony; it is precisely now that we must act for the people and fight to make healthcare more affordable and accessible.

As an emergency physician, I have seen the faces of failed healthcare policies, the anguish from severe illness and death that could have been prevented if only the patient had routine care and health insurance.

That is why today, for the patients who need to see a doctor and get treatment, for the recently laid-off workers who just lost their health insurance, for the families struggling economically, I ask you to join me in voting for H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

This bill would lower healthcare premiums for middle-class families; encourage States to expand Medicaid; lower the cost of prescription drugs; and strengthen protections for preexisting conditions, the same ones that render a person more likely to die from COVID–19.

The American people need our help in this moment, and they need this bill.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BUSTOS).

Mrs. BUSTOS. Madam Speaker, I thank the gentleman for yielding.

I rise today to support the Patient Protection and Affordable Care Enhancement Act.

So many in our Nation are facing extreme financial insecurity and extreme worry surrounding this global pandemic. And the Trump administration is trying to eliminate protections for people and families with preexisting conditions and leave millions of Americans without care. This includes more than 730,000 Illinoisans.

A man from the congressional district I serve named Robert wrote to me about his family's rising healthcare costs. Robert and his wife have both worked hard almost their entire lives. Robert's first job went back to the age of 17. His wife started working when she was 16.

Today, they are in their early sixties and they are facing skyrocketing premiums and astronomical deductibles. Robert currently pays more than $2,500 each and every month for just his premiums. That, along with his deductibles, cost his family about a quarter of all they earn every month. He has even been told that because of his age and his wife's age they are lucky to get coverage at all.

Working your whole life and having to struggle so much just to afford a necessity like healthcare, that is not what the American Dream is all about.

Robert said to me, ''I am hoping more than lip service will happen in Washington, D.C.'' For Robert and his wife and so many other Americans, we must pass this bill to lower the cost of healthcare and the cost of prescription drugs, and also to protect people with preexisting conditions.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. MALINOWSKI).

Mr. MALINOWSKI. Madam Speaker, 40 million Americans have lost their

jobs in the biggest global pandemic in modern history. Not long ago, most of them would have lost their health insurance, too. I bet that in the last 3 months every single one of us, Republican and Democrat, in private or public moments with our constituents has reassured them that at least the Affordable Care Act is there for you, you do not have to lose your health insurance in the middle of this crisis.

So how can it be that at this very moment when the value of the ACA is so plainly obvious to tens of millions of Americans, the administration is in court trying to strike it down? The President has told us repeatedly he wants to protect people with preexisting conditions, but right there in his brief to the Supreme Court, it explicitly says that should be struck down, too.

And when we ask him, What will you do to replace the ACA if it is struck down? He says, I won't tell you until after the election. Come on.

Now, today we are going to pass the Patient Protection Act, which means, unlike the President, we are willing to tell the American people, now, exactly how we plan to improve healthcare in America.

We believe that the ACA should be improved, not taken away. The Congressional Budget Office says that this plan for doing so will lower premiums Americans pay by 10 percent.

We want what President Trump said he wanted in the 2016 election, to let Medicare negotiate the price of prescription drugs which will save Americans money and save the government over $500 billion.

And we want to eliminate the junk insurance plans that the administration wants all those folks who are losing their jobs to take, even though they don't cover essential services like prescription drugs and maternity care.

I hope everyone will vote for this bill. If there are Members who disagree, so be it. I would just ask, Madam Speaker, that they please be honest. Don't say you want to protect people with preexisting conditions if you won't vote to do so or put forward a plan to do so. Don't advise your constituents to take advantage of the ACA if you are not going to do anything while the President tries to strike it down.

□ 1100

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentleman from California (Mr. COX).

Mr. COX of California. Madam Speaker, I am honored to be here today to speak about the Patient Protection and Affordable Care Enhancement Act.

As the COVID–19 pandemic and the related recession causes massive suffering across the country, we have a duty to act. Government has a duty to act so as to minimize human suffering, not to exacerbate it.

We must strengthen and enhance the Affordable Care Act rather than do what the Trump administration wants us to do and rip away health coverage for millions of Americans.

A constituent of mine put it best. He said to me: ''You know, Donald Trump is bad for my health.''

I am sure all of us here came to Congress to make a positive difference in the lives of our constituents.

In my district, there are 325,000 people enrolled in Medicare, Medicaid, and CHIP. Almost 27,000 individuals, hardworking individuals, got their health insurance through the ACA, through ObamaCare. But what this administration and congressional Republicans want to do and what they are telling me is that these citizens and 23 million other Americans don't deserve healthcare.

My Democratic colleagues and I feel differently. We are standing up to the Trump administration's attempts to kill the Affordable Care Act. We are not going to let this happen, not today, not on our watch.

That is why I am glad the House Democrats have reintroduced this legislative package that will make healthcare and prescription drugs more affordable for American families.

This is commonsense legislation that is a win for all Americans.

This bill lowers health insurance premiums and makes prescription drugs more affordable by empowering Medicare to negotiate for lower prices, which is something we all know we should do. It is way past time to stop letting drug companies rip off Americans by allowing them to charge us more than other countries for the same drugs.

This bill also strengthens the critical outreach and enrollment funding that has been gutted by the Trump administration.

This is a personal passion of mine. Last year, I offered an amendment to H.R. 987 that would ensure that communities with high unemployment were prioritized in outreach, education, and enrollment assistance to Americans shopping for healthcare. And let me tell you, it works. In California, we are enrolling more people, who pay less, because of widespread enrollment.

We all deserve healthcare. That is our right as Americans.

Madam Speaker, I urge my colleagues to support this bill.

Mr. WALDEN. Madam Speaker, may I inquire as to the amount of time remaining and if my friend has any other speakers. We do not, on our side.

The SPEAKER pro tempore. The gentleman from Oregon has 12½ minutes remaining. The gentleman from New Jersey has 6 minutes remaining.

Mr. WALDEN. Madam Speaker, I believe the gentleman has other speakers, so I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. MUCARSEL-POWELL).

Ms. MUCARSEL-POWELL. Madam Speaker, I stand here today as a Member of Congress because, 3 years ago, I watched as this body took a vote to repeal the Affordable Care Act, which would have ripped healthcare away from tens of thousands of constituents in my district and over 2 million Floridians in my home State.

This was an unconscionable move that would have taken away protections for millions with preexisting conditions, like my constituent Michelle Garcia, who still suffers after a faulty medical device left broken pieces in her that, to this day, cause her chronic pain that requires persistent treatment.

It is because of the ACA that her coverage is protected.

It is because of the ACA that disparities in coverage for Latino communities and African-American communities have narrowed.

It is because of the ACA that insurance plans can't deny or make healthcare more expensive because of someone's gender.

It is because I watched my colleagues across the aisle try to take the ACA away that I ran for Congress and am here fighting to protect their care.

Today's vote is very important to me. While the President continues his efforts to take away much-needed healthcare, especially during a pandemic, we are making quality care more affordable and accessible while removing junk plans. We are lowering health insurance premiums and prescription drug prices. We are also putting in incentives for States like Florida so that they can expand Medicaid and bring care to millions who need it.

It is simple. We shouldn't be taking care away from anyone right now, not ever. We shouldn't be making quality care more expensive.

We need to make it more accessible. We need to make it more affordable.

That is why I am proud to vote ''yes'' on today's legislation, and, Madam Speaker, I urge my colleagues to do the same.

Mr. WALDEN. Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. Madam Speaker, I thank the chairman of the Energy and Commerce Committee for his dynamic leadership.

Let me indicate that I stand here today in the midst of a catastrophic pandemic of COVID–19 in the State of Texas and in my congressional district in Houston and Harris County. Over the last couple of days, we have had upwards of 900 cases.

There are 2.5 million cases over the Nation and growing, with 126,000 who have died. In the last 3 days of last week, there were 45,000 new cases. Most of them were in Texas, California, and Arizona.

That is why I am absolutely baffled and saddened by the fact that this administration would go to the Supreme Court to cut off, deny, extinguish, put

in harm's way Americans who need health insurance and who have pre-existing conditions.

This is legislation that is a lifeline. We are saving lives.

A family of four earning $40,000 would save nearly $1,600. They may have a COVID patient in their family. A 60-year-old earning $57,000 would save $8,000.

It takes into account people who are unemployed by replacing insurance that they have lost.

It takes into account the great need for drug price negotiation under the Elijah E. Cummings Lower Drug Costs Now Act, something that we have all been fighting for, for a very long time. Why can't we negotiate drug prices just like they do in Medicare?

I am pleased that this legislation protects vulnerable populations from losing health coverage by ensuring that Medicaid and CHIP beneficiaries receive a full 12 months of coverage once enrolled, protecting them from interruption due to fluctuations in their income throughout the year. That has happened to a lot of hard-working parents.

In addition, it improves Medicaid beneficiaries' access to primary care. And, yes, for those States that did not do the right thing, it encourages Medicaid expansion. It gets rid of junk policies.

Madam Speaker, let us vote for this bill because it stops the devastation.

Madam Speaker, as a senior member of this body and an original cosponsor of the legislation, I rise in strong and enthusiastic support of H.R. 1425, the ''Patient Protection and Affordable Care Enhancement Act,'' which expands tax credits to lower Americans' Marketplace health insurance premiums and allow more middle-class individuals and families to qualify for subsidies and know the peace of mind that comes with access to affordable, high quality health care.

This legislation is especially needed in these dark and troubling times when the COVID–19 pandemic has already claimed the lives of more than 128,000 Americans and over 40 million have lost their jobs because of the Administration's catastrophic response to the crisis.

Specifically, Madam Speaker, I support H.R. 1425 because under this legislation:

1. A family of four earning $40,000 would save nearly $1,600 in premiums each year.

2. A 64-year-old earning $57,420 would save more than $8,700 in premiums each year.

3. A single adult with income of $31,900 would see premiums cut in half.

4. An adult earning $19,140 would see premiums cut to zero, saving $800 dollars a year.

Additionally, the legislation ensures that families who do not have an offer of affordable family coverage from an employer can qualify for subsidies in the Marketplaces and it provides funding for reinsurance initiatives to further lower premiums, deductibles, and other out-of-pocket costs.

Importantly, included in the legislation is the drug price negotiation mechanism from H.R. 3, the transformational Elijah E. Cummings Lower Drug Costs Now Act, (H.R. 3), which delivers immense savings to taxpayers, employers, workers and patients by preventing Americans from having to pay so much more for our medicines than pharmaceutical companies charge for the same drugs overseas.

Madam Speaker, this legislation strongly encourages Medicaid expansion to hold-out states like my home state of Texas to reconsider by renewing the ACA's original expanded federal matching for states that adopt the Medicaid expansion and progressively reducing administrative FMAP for those who continue to refuse.

Currently, nearly 5 million Americans have been cruelly excluded from coverage because states have refused to expand Medicaid.

Madam Speaker, this legislation provides necessary funding for critical federal and state efforts to increase health coverage enrollment, educate consumers of their health care rights, and help individuals navigate the health insurance system.

And it delivers funding for states who want to establish their own statebased Marketplaces.

Madam Speaker, the COVID–19 pandemic has laid bare the racial and ethnic inequalities and disparities in our health care delivery system.

That is why I am pleased that the legislation before us protects vulnerable populations from losing health coverage by ensuring that Medicaid and CHIP beneficiaries receive a full 12 months of coverage once enrolled, protecting them from interruptions due to fluctuations in their income throughout the year.

And it improves Medicaid beneficiaries' access to primary care physicians, by reauthorizing the ACA's increased payments to primary care physicians who treat Medicaid recipients.

Also, very important is that the legislation addresses the maternal mortality epidemic by requiring states to extend Medicaid or CHIP coverage to new mothers for 1-year post-partum.

Finally, Madam Speaker, H.R. 1425 cracks down on junk plans & strengthens protections for people with pre-existing conditions and reverses the Trump Administration's expansion of junk health insurance plans that do not provide coverage for essential medical treatments and drugs, and that are allowed to discriminate against people with preexisting medical conditions.

And it curtails the Trump Administration's pernicious practice of giving states waivers to undermine protections for people with pre-existing conditions and weaken standards for essential health benefits.

Madam Speaker, to stroll down memory lane for those of us who remember how things were before the enactment of the Affordable Care Act, dozens of our committees, including the Judiciary Committee, heard the pain of people whose family members had died because they had no access to healthcare and/or they had junk policies.

Access to affordable, high quality health insurance because of the ACA was a game changer or persons with preexisting conditions like Sickle Cell anemia, triple negative breast cancer, and diabetes which plague communities like the ones I represent.

As a member of Congress who voted against each of the dozens of Republican efforts to repeal the Affordable Care Act, I know first-hand how important and critical access to affordable, high quality, accessible health care available to everyone, including those with pre-existing conditions, to the well-being of American families.

Because of the passage of the Affordable Care Act, the national uninsured rate has been slashed from 14.8 in 2012 to 8.8 percent in 2018.

Texas has long led the nation in rate of uninsured so the comparable rates are 24.6 and 15 percent, respectively.

Madam Speaker, I distinctly recall a candidate for the highest public office in the land saying ''Obamacare is a disaster'' and appealing for voters to support him with this question: ''What have you got to lose?''

The question deserves a response so I hope that person, who occupies the Oval Office, is listening to my answer.

The Affordable Care Act, or ''Obamacare,'' has been an unmitigated success to the more than 20 million Americans who for the first time now have the security and peace of mind that comes with affordable, accessible, high quality health care.

Madam Speaker, Tip O'Neill used to say that ''all politics is local'' so let me share with you how Obamacare has dramatically changed lives for the better for the people in my home state of Texas.

1.874 million Texans gained coverage since the ACA was implemented but could lose their coverage if the ACA is entirely or partially repealed or invalidated.

508,000 kids in Texas who have gained coverage since the ACA was implemented are also at risk of having their coverage rolled back.

205,000 young adult Texans who were able to stay on a parent's health insurance plan thanks to the ACA now stand to lose coverage if the ACA is struck down, eliminating the requirement that insurers allow children to stay on their parents' plans until age 26.

646,415 Texans who received cost-sharing reductions to lower out-of-pocket costs such as deductibles, co-pays, and coinsurance but are now at risk of having healthcare become unaffordable if the Trump Administration has its way in the Supreme Court.

10.28 million Texans who now have private health insurance that covers preventive services without any co-pays, coinsurance, or deductibles stand to lose this access if the provisions in the ACA requiring health insurers to cover important preventive services without cost-sharing is stricken.

913,177 individuals Texans who received financial assistance to purchase Marketplace coverage in 2016, averaging $271 per individual, are at risk of having coverage become unaffordable if the ACA is not protected.

Madam Speaker, millions more Texans could have insurance if all states adopted the ACA's Medicaid expansion.

Women in Texas who can now purchase insurance for the same price as men are at risk of being charged more for insurance if the ACA's ban on gender rating in the individual and small group markets is invalidated.

Before the ACA, women paid up to 56 percent more than men for their health insurance.

Roughly 4.5 million Texans who have pre-existing health conditions are at risk of having their coverage rescinded, being denied coverage, or being charged significantly more for coverage if the ACA's ban on preexisting conditions is struck down.

346,750 Texas seniors who have saved an average of $1,057 each as a result of closing the Medicare prescription drug ''donut hole'' gap in coverage stand to lose this critical help going forward.

1.75 million Texas seniors who have received free preventive care services thanks to ACA provisions requiring coverage of annual wellness visits and eliminating cost-sharing for many recommended preventive services covered by Medicare Part B, such as cancer screenings, are at risk of losing access to these services if the ACA is not protected.

The Affordable Care Act works and has made a life-affirming difference in the lives of millions of Americans, in Texas and across the country.

This is what happens when a visionary president cares enough to work with a committed and empathetic Congress to address the real issues facing the American people. The Republicans have NO vision whether it is for Obamacare (ACA) or Medicare for all—they are denying health coverage to the most vulnerable American families and Americans with pre-existing conditions. Vote for this bill.

You want to know why the American people have Obamacare?

It is because Obama cared.

The same cannot be said about this Republican president and congressional Republicans who have made careers of attacking and undermining the Affordable Care Act's protections and benefits for the American people.

I urge all Members to vote for H.R. 1425 and send a powerful message to the President and the American people that this House will not stand idly by as this Administration tries to take away health care from more than 130 million persons.

Mr. WALDEN. Madam Speaker, I believe neither of us has any more speakers. I yield myself such time as I may consume to close.

Madam Speaker, we have had a good debate here on the floor. Unfortunately, it is not a debate over a bipartisan piece of legislation. It is a debate over a partisan bill that will never become law. The President's office has issued a recommendation that he would veto this bill, should it ever get out of the Senate and to his desk.

Beyond that, let's talk about what impact this will have in this pandemic.

We have heard a lot about drugs. We know from the Congressional Budget Office that this legislation will reverse the gains and innovation made in the bipartisan 21st Century Cures Act, that it would result in fewer new drug products developed and coming to market. In fact, the Congressional Budget Office estimates that up to 38 fewer medicines would be developed to cure diseases.

My friend from Massachusetts talked about Therese on the doorstep in Lowell, Massachusetts, with COPD. What a tragedy it would be if one of those 38 medicines under development happened to cure COPD.

Maybe it is a cure for COVID–19. Maybe it is a cure for ALS or Alzheimer's or some form of cancer, like the ovarian cancer that claimed my mother.

What we do know is it puts a dagger in the heart of innovation. In fact, those scientists we are all turning to right now, Madam Speaker, these brilliant young men and women in laboratories all across America, especially those out in California at California Life Sciences Association, said this legislation, H.R. 3, part of which is incorporated in this bill, could lead to as much as a 58 percent reduction in revenue, which would significantly reduce investment in partnerships, licensing agreements, and emerging companies, and, therefore, lead to an 88 percent reduction in new medicines developed by small U.S. biotech companies. That number was an 88 percent reduction.

Further, they expect it to eliminate 80,000 high-paying biotech and R&D jobs nationwide. Why would you do that now? Why would you knowingly enact a provision in legislation that would cut 80,000 American high-tech and R&D jobs in the healthcare field, where we are pleading for a cure. We are, dare I say, praying for a cure or a treatment not only for COVID but for these other diseases. The legislation before us today would do that.

We have heard a lot about international price controls this legislation would put in place, government price setting. Now, let's talk about what that means.

For example, when looking at a sample of 270 new medicines launched in the United States from 2011 to 2018, of those available in the United States under our formula, 67 percent are available in Germany, 64 percent in the U.K., 48 percent in Japan, 53 percent in France, about 52 percent in Canada, 41 percent in Australia.

Even in countries where treatment may have been launched, patients often have to wait months, sometimes years, before they get access to that treatment. Compared to the United States, in Australia, it takes an average of 19 months longer for medicines to become available to patients.

By the way, this is the scheme that this legislation wants to put into the United States.

Compared to the U.S., in Canada, it takes an average of 14 months longer for medicines to become available to patients.

More than a year is a long time to wait if you know there is a medicine that could help you with some disease and that medicine has just been developed, and you can get it in America tomorrow and wait 14 months in Canada. In the U.K., it could be 11 months longer.

It doesn't have to be that way. We have H.R. 19. We introduced it at the beginning of this debate some time ago. I think there were seven different provisions that have already become law. Everything in that legislation is bipartisan.

Look, there are going to be differences of opinion among really good people that I work with on a regular basis, and we just disagree on policy. But wouldn't it make more sense to take the things upon which we do agree on policy and move those forward into law while we debate the things where we have a disagreement and work to try and find common ground? But that is not what is happening today.

The navigator program, the bill dumps $100 million more into the exchange user fee program, into the failed navigator program. Let's talk about that a minute.

Navigators enroll less than 1 percent of total enrollees, according to one report. In fact, one awardee of the navigator program had an enrollment goal of 2,000. It kind of missed their goal, Madam Speaker. They enrolled one person.

□ 1115

They eventually enrolled a total of 67 for $2,300 per enrollee. And in the private sector, they do that for about $2.40, not $2,300.

The top 10 navigators signed up just 317 people in 2017. We are going to pump far more money into that. This legislation would do that. We have heard about some of that.

The subsidies in here for some of the wealthiest Americans—kind of ironic that the Democrats would be doing this in their legislation, but they removed the subsidy cap that diverts taxpayer dollars for some of the highest earners in the country.

There is a blank check for insurance companies. I have talked about the loss of cures, up to 38 in the next 20 years. Remember, the 10- and 20-year pipelines here, there are some estimates that there could be hundreds of new drugs.

When I think about the farmer in Minnesota we heard about with $20,000 in premiums per year and $12,000 copayments, that is what America got from the ''Affordable Care Act.'' That is what ObamaCare delivered. It didn't do anything to go after the costs of healthcare.

The Trump administration, conversely, has done a lot to go after the cost of healthcare. I have been with the President when he announced initiatives to make hospitals disclose their costs so Americans could shop and we could get competition. We had no more left the Roosevelt Room and returned to the Oval Office when the Secretary of Health and Human Services announced the American Hospital Association already filed suit to stop that transparency in disclosure.

By the way, the administration just won a judgment in court that they can proceed to get that disclosure so consumers can know what things cost and make informed decisions.

We worked together across the aisle when I was chairman of the Energy and Commerce Committee on really powerful legislation to address the opioid crisis in America. We put enormous amounts of money into our community health centers. We fully funded, for a decade, the Children's Health Insurance Program, and we did all of that in a very, very bipartisan way.

We, in the last few years, under the Republican majorities, rewrote America's mental health laws. We all know there is more to be done to get mental health services into our communities, but we have put an unprecedented amount of support into mental health services.

Meanwhile, our community health centers, under the Democrats, continue to get an every-couple-of-month infusion of money, which is enormously frustrating for them. I know when I was chairman, it made national headlines that there were some levels of delay in fully funding our community health centers, and we ended up getting them a 2-year, fully funded, at the highest level ever, funding guarantee.

Their money runs out in November. Why are we doing that? Why aren't we taking that up?

The President led the effort on surprise medical billing so that, even if you have insurance and you end up like a woman in Colorado who, a few years back, gave birth to her second son. That child, born in a hospital, covered by her insurance, doctors covered by her insurance, had a medical issue after birth and had to go to the neonatal intensive care unit—just down the hall, by the way. It turned out that that hospital had contracted out that neonatal intensive care unit, and it turns out it wasn't in her insurance at all. Now, how in the heck does a consumer know that?

We have bipartisan surprise billing legislation. It passed out of the Energy and Commerce Committee a year ago and has yet to come to the floor of the House under the Democrats. So, meanwhile, consumers are getting stuck with surprise bills when they are playing by the rules. It continues and it shouldn't. Hopefully, we can get that legislation to the President's desk. He is ready to sign it.

Meanwhile, we have made record investments at NIH, and we reauthorized the user fee agreement so that FDA, the Food and Drug Administration, our innovators, can bring their drugs and new medical devices to market faster than any time and still safe. We did that under Republican legislation and signed by President Trump.

President Trump invoked the Defense Production Act when we didn't have enough ventilators or masks or gowns to order companies to make swabs, to make ventilators and move forward and continued that investment.

And that was in a bipartisan way, by the way, with the CARES Act. We can do bipartisan work. We are just not doing it today.

The choice to do partisan or bipartisan work is always made by the majority. When I was chairman I could move anything I wanted, generally speaking, at any time, but I chose to try and make the bulk of our work—nearly all of our work—bipartisan because I actually wanted it to become law.

The drug bill Democrats passed earlier this year that takes away access to new medicines and put 88,000 jobs in the high-tech world of innovation in medicine, that bill is going nowhere. This bill is going nowhere. The police reform bill is going nowhere.

What a tragedy. What a lot of opportunity. Because there are many, many of us on this side of the aisle, as the Speaker knows, who stand ready to work in a bipartisan way to get good policy and to solve problems for the American people.

Madam Speaker, it is unfortunate we find ourselves here today when Americans expect so much more out of this institution. I hope people will show up and we can actually do our work and actually do it in a way that will bring a positive view on this House and on our ability to solve these enormous problems that the American people are facing, whether they are suffering from COPD or simply higher insurance premiums and deductibles.

What good is your insurance plan if you can't afford to use it, or when you think you followed all of the rules to use it and then find out they contracted out the emergency room and nobody covers the costs there?

So let's defeat this now. Let's go to a room where we can work these things out, we can find common ground here that won't put a dagger in the heart of innovative jobs in America, that won't slow innovation in medicine and medical devices, lifesaving medicines, but that will bring better healthcare for Americans.

Finally, on the issue of preexisting conditions, the President has been very clear he supports protecting people with preexisting conditions, as do I, going back to when I was in the State legislature in Oregon. We made efforts to do that.

I have had legislation since the opening day of this Congress to make sure, regardless of how the lawsuit comes out, that we protect people with preexisting conditions. The Democrats won't let us bring this bill to the floor.

So, Madam Speaker, I urge a ''no'' vote on this legislation, and I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, I respect, greatly, my colleague, the ranking member, but I have to say, the tragedy that we face is the President, President Trump, who has totally neglected the situation here.

The tragedy is not this Congress. This Congress passed the HEROES Act, but we have a President who simply ignores the COVID crisis, who doesn't want to take the bull by the horns and actually do something nationally to deal with testing, to deal with medical supplies, to deal with what needs to be done, and continues to suggest that somehow the pandemic has gone away.

This Congress took action with the HEROES Act. The tragedy is a President who continues to seek repeal of the Affordable Care Act.

The Affordable Care Act, Madam Speaker, had led to over 90 percent of Americans having health insurance when President Obama left office. That number is going down. Last week, the Trump administration filed a brief again to repeal the Affordable Care Act.

The tragedy is what he has done, what President Trump has done to encourage junk plans, which basically don't allow people with preexisting conditions to even get health insurance. This is the tragedy. And we in this Congress are doing things to reverse this sabotage of the Trump administration, beginning today, again, with this enhancement act.

Now, I just want to say that one of the things that we are doing here that is so important is reversing the Trump administration's pushing of these junk plans. The Energy and Commerce Committee did a report investigation of it last year, and what we found was that these junk plans discriminate against people with preexisting conditions. They rescind coverage if they have to pay out too much. They limit coverage.

Remember, the Affordable Care Act provided an essential benefit package, robust coverage, that you would have mental health coverage, that you would have hospitalization, that you would have the things that people expect to have in their insurance policy; but instead, the Trump administration is pushing out to millions of people—and the numbers keep growing every year—these junk plans that discriminate and do the opposite.

And we are going to bring down prescription drugs.

Madam Speaker, I urge support of this bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The time for the Committee on Energy and Commerce has expired.

The gentleman from Massachusetts (Mr. NEAL) and the gentleman from Texas (Mr. BRADY) each will control 30 minutes.

The Chair recognizes the gentleman from Massachusetts.

Mr. NEAL. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I am really pleased today to join with the Speaker and other committee chairs to have successfully introduced the Patient Protection and Affordable Care Enhancement Act and welcome the measure's consideration in this House today.

Hearing the former chairman of the Energy and Commerce Committee a few minutes ago, a decent guy, he said that there was room for bipartisanship in the healthcare debate. I mean, I have been here for a long time. Where was the bipartisanship—and I am going to submit something. Republicans, in all the years I have been in this House, they have not agreed amongst themselves on healthcare, never mind agreeing with Democrats on healthcare.

So, for years, we have worked to expand access. That is what this argument is about today. We want to make sure that affordable healthcare exists

for the American family and to build upon the coverage gains of the Affordable Care Act.

The COVID–19 crisis only adds urgency to an already pressing problem for millions of American families, a problem that has been consistently exacerbated by the Trump administration's relentless crusade to dismantle the American healthcare system.

Recall on the campaign trail when President Trump was asked by reporters what he intended to replace ObamaCare with, and he said: Don't worry, pal, you are going to love it.

That was the answer.

Just last week, under the cover of night and while many Americans were likely sleeping, the Trump administration took another step toward invalidating our healthcare laws. They filed a brief with the Supreme Court in support of undoing the ACA and ending protections for nearly 130 million Americans with preexisting conditions.

I helped to write this law. I am really proud of it.

They staked out this position during a pandemic, when millions of Americans need healthcare more than ever.

Our new Patient Protection and Affordable Care Enhancement Act is utilized to expand tax credits for lower premium costs for the American consumer. For the first time in the history of the ACA, no one will pay more than 8.5 percent of their income on a silver plan through the marketplace.

□ 1130

I will quickly share the other scenarios that people will witness savings through:

A family of four earning $40,000 would save nearly $1,600 in premiums each year.

An adult earning about $19,000 would see premiums cut to zero, saving $800 a year.

And a 64-year-old earning $57,000 a year would save more than $8,700 in premiums each year.

These are significant savings that would make a big difference for Americans particularly during the current health and economic crisis that we find ourselves in.

I want to thank Representative UNDERWOOD for her tireless work on these provisions and advocating for the millions of Americans who will see their premium costs go down, recalling that when the ACA was offered and embraced 20 million Americans received health insurance.

I want to thank Representative WILD for leading the effort to remove a longstanding barrier for families with an offer of affordable family coverage, as well as Representative NEGUSE for his work on behalf of Social Security beneficiaries who were at risk of losing premium tax credits for the time they were covered by the ACA marketplace.

These tax credits aren't the only benefits consumers can expect under this very important legislation. We also slashed prescription drug costs, we reduced consumers' deductibles, encouraged more States to expand Medicaid and establish their own ACA marketplace, and to put an end to the expansion of junk insurance plans.

Notably, this legislation reduces the number of uninsured Americans by more than 4 million people. These are issues that matter to everyday Americans perhaps now in this COVID crisis more than ever. Ensuring all Americans can access quality healthcare without risking their family's financial security really shouldn't be a partisan issue.

After almost 70 votes on Republican bills to repeal or undermine the ACA, I am really happy to stand on this floor today in support of this legislation that will continue to build on the gains of the ACA, for legislation that increases access to affordable, quality healthcare, and for legislation that is for the American people.

Madam Speaker, I urge my colleagues to vote in favor of this timely legislation, and I reserve the balance of my time.

Mr. BRADY. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, as a Republican in Congress, I am proud of our Republican congressional efforts creating the Medicare part D prescription drug program for seniors which then-Leader NANCY PELOSI and Democrats tried to kill. You may remember that Speaker PELOSI famously predicted that creating the crucial part D prescription plan for the elderly ''would end Medicare as we know it.''

Can you imagine how many seniors' lives would have been lost if she had succeeded in stopping the affordable Medicare drug program 43 million seniors have come to depend on today?

We are in the middle of an unprecedented national pandemic. Americans are worried about their health and their jobs. Yet here we go again in the Democratic House, another partisan bill with no input from Republicans but lots of input from campaign operatives and special interest groups. The American people are sick and tired of this partisanship.

To my Democratic colleagues and friends, I say: Stop playing political games with healthcare.

Madam Speaker, this bill is dangerous to your health in three key ways: It stops lifesaving cures from getting to the patients who need them most. It blocks Americans from buying affordable, short-term health plans that cover them in between jobs. And it threatens to slash State support for Medicaid for the most vulnerable and poor. As if that isn't enough, it doubles down on the most unpopular healthcare plan in modern history: the Affordable Care Act.

Madam Speaker, you remember that disaster. It broke every promise Democrats made to the American public.

Do you remember: If you like your healthcare plan you can keep it? False.

If you like your doctors, you can keep them? False.

Your healthcare costs will go down by $2,500 a year? Big false.

No American making less than $250,000 a year will see a tax increase? False.

ObamaCare won't add a dime to the Federal deficit? False.

By the way, it will add over $1.5 trillion in debt this decade.

Here we are battling the coronavirus and hoping against hope as companies partnering with the government are racing heroically to bring new treatments and medicines that will save our lives and prevent Americans from being infected.

Yet today, House Democrats are unbelievably advancing a bill with provisions that the Congressional Budget Office and the Council of Economic Advisers predicts will stop as many as 100 lifesaving cures from ever getting to the patients who need them most.

The California Life Sciences Association says that the Pelosi plan for government setting medicine prices would mean nearly nine of ten new drugs would never be made available—never—from their researchers in small biotech companies. These are the medicines that could be the answer to some of the most heartbreaking and devastating diseases—including COVID–19—that our children, seniors, and families are facing.

As this pandemic makes urgently clear, we need more cures, not fewer. Fewer cures means more lives cut short. Yet leading Democrats shrugged off these research experts and say: We are fine with that.

Although the Affordable Care Act has improved under President Trump—no sabotage—prices went down in most States, insurance companies have stabilized, and many families see more choices today. But it remains fatally flawed.

Here is proof: two out of three Americans eligible for ObamaCare are turning it down—two out of three. They say that it is healthcare they don't want, they can't afford, and it doesn't work for them.

Unbelievably, Democrats are so hellbent on forcing Americans on to the ACA, today they are threatening to slash State support for Medicaid unless States buckle to expand ObamaCare.

Holding the poor hostage, threatening to defund the operations of Medicaid at the State level? That is immoral. Maybe they don't remember that the Supreme Court quickly struck down their last scheme to extort States.

Finally, despite the claims they are expanding healthcare choice, this misguided bill blocks Americans from buying legal, affordable, short-term plans often used by small business workers and Americans who are out of work or in between jobs. Yes, these health plans aren't for everyone. But to the 3 million Americans with these lifesaving plans, Democrats say: Tough. If you don't like your plan, or even if you do, you can't keep it.

There is a better way than this dangerous, partisan waste of time. Real people are hurting. We should work together in Congress to make affordable, patient-centered healthcare a reality for Americans.

Last year Republicans proposed legislation that brought together ideas and bills from Members of Congress from both parties to lower drug prices and accelerate new cures. Healthcare policy fails when it is partisan. We must work together now to make drugs more affordable, to expand access to quality care, and, yes, to lower costs. This bill doesn't achieve any of those goals. It is partisan business as usual during a time when our Nation calls out for so much more.

I reserve the balance of my time, Madam Speaker.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Madam Speaker, I rise in strong support of H.R. 1425, legislation expanding and enhancing the Affordable Care Act and lowering healthcare costs for all Americans.

In the past 6 months over 120,000 Americans have died due to COVID–19. Millions have lost their jobs and, in many cases, their health insurance. That is why it is so critical that we strengthen and build upon the foundation of the Affordable Care Act, which is exactly what this bill does.

This legislation reduces the price of expensive pharmaceuticals—including insulin—saving taxpayers billions of dollars while driving down drug costs for all Americans.

The bill uses those savings to lower insurance premiums and expand tax credits, helping more Americans afford the coverage that they need.

This bill bolsters State Medicaid programs, funds COVID–19 vaccine research, and cuts the number of uninsured Americans by nearly 4 million.

The President and my Republican colleagues are actively trying to gut protections for preexisting conditions and take healthcare away from millions of Americans.

By contrast, this legislation reduces healthcare costs for millions of Americans at this critical time. It is vital that we give our constituents the help they need.

I heard so many of my friends on the other side talk about how they want to protect people who have preexisting conditions, every one of which is in support of the lawsuit to repeal the Affordable Care Act, the very bill and the very law that protects people who have preexisting conditions.

Madam Speaker, you cannot be for protecting preexisting conditions and for repealing the law that provides that protection.

Madam Speaker, I urge my colleagues to vote ''yes'' on this bill.

Mr. BRADY. Madam Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLY), who is a key member of the Ways and Means Committee.

Mr. KELLY of Pennsylvania. Madam Speaker, the objective of this bill is to prop up the Affordable Care Act, so we want to pump money into Medicaid the program and then impose price controls on prescription drugs.

H.R. 1425 lifted the provision in Speaker PELOSI's drug bill, H.R. 3, that gives the Secretary of HHS the power to set Medicare drug price controls for pharmaceutical manufacturers and use it as a pay-for. The savings from this price-setting power is meant for the expansion of the Affordable Care Act.

Now, the facts are clear. Private investment in drug research and development fuels the innovation ecosystem for the new medicines. It is just that simple.

Madam Speaker, the Congressional Budget Office has already determined that H.R. 3's negotiation provision would result in fewer cures. You have to be especially tone deaf to introduce legislation that punishes the very pharmaceutical companies that are going to innovate and mass-produce the vaccine the entire world is counting on to counter the spread of COVID–19.

Last year, we were 80 percent of the way there on a bipartisan measure before we got sidelined by H.R. 3 and legislation just like this. Let's get back to the people's work and work together on solutions that make sense, like H.R. 19, drug legislation that would actually make it to the President's desk.

Now, with all that in mind, let's talk about who it is that we are really talking for today, who it is that we represent on the people's floor, and who it is that we are looking out for because too often this becomes about November 3, 2020, and not about everyday lives back in the Districts and the folks whom we represent.

I want to read a letter that I have read before because I think it really deserves to be repeated. This was sent to me in October of 2019.

''Dear Congressman KELLY: My name is Sara Stewart, and I'm from St. Petersburg, Pennsylvania. It is my understanding that the House Ways and Means Committee is having a public hearing on H.R. 3—the Lower Drug Costs Now Act of 2019.''

This is the very H.R. 3, by the way, that is being included in H.R. 1425.

''It appears this legislation does not have bipartisan support and needs to take a more balanced approach. The balance is needed for patients like my 10-year-old daughter Maddie.

''Maddie suffers from a rare mitochondrial deletion condition called Pearson's syndrome, which is a disorder that occurs as the result of mutated genes in the body. These genes impact the mitochondria of her cells and prevent them from producing enough energy for the body to function properly. Pearson's syndrome is difficult to diagnose because it affects each individual differently. Maddie's symptoms through the years have included being blood transfusion dependent for several years, the inability to heal after sun exposure damage, becoming type 1 diabetic, progressively losing her hearing and her vision, kidney failure, and several other daily complications including developmental delays when having a body that runs on limited energy. It has been truly heartbreaking to see her endure this disease, but she continues to defy the odds.''

This child is a 10-year-old.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BRADY. Madam Speaker, I yield the gentleman an additional 30 seconds.

Mr. KELLY of Pennsylvania. ''My simple message to you, Mr. Kelly, and the rest of the committee''—and the rest of Congress—''is: There is no cure or treatments for Pearson's syndrome. Each day is a struggle to keep Maddie balanced so her body is able to better cope with symptoms of this terrible disorder. All we have, as well as many other families across the world, is hope. Please, don't let partisan bickering impact the ability of researchers to discover and innovate new therapies that could save Maddie's life one day. The clock is ticking, and Maddie is waiting.''

Madam Speaker, it simply comes down to this: if you want to develop new drugs, then don't penalize the people who develop them. Don't hold them as the bad guys when we require them. Please come up with something to address COVID–19.

□ 1145

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Madam Speaker, approaching July Fourth, we should be celebrating the greatness of our country. Instead, we are mired in a pandemic when we have more people infected and more deaths from this pandemic than any country in the entire world—with President Trump floundering and whining.

His approach to this pandemic—denial, delay, and ongoing deception—has been exposed for the fraud that it is. And because of his multiple failures, now is a time when more Americans desperately need the opportunity to enroll in health insurance, not the junk insurance that he has been promoting. Instead, he seeks to eliminate—as do our Republican colleagues—the Affordable Care Act and the coverage that it has today for millions of our citizens.

Madam Speaker, today's bill offers a reaffirmation that the Affordable Care Act should be strengthened, not destroyed. Strengthening that would have been occurring long ago but for the fanatic decade of our Republican colleagues in trying to destroy the Affordable Care Act. Next year, however, we have to do much more for healthcare than simply to return where it should have been. Millions of Americans, particularly in a State like

Texas, which has more uninsured children than any State in America, they are still likely to be excluded because of obstructionist Republican State leaders. And even those who have insurance, are still often the victims of prescription price gouging.

Madam Speaker, the exceedingly modest pharmaceutical provision in today's bill excludes the uninsured and falls well short of what is needed to prevent monopoly prices for drugs developed at taxpayer expense. This bill pours more billions into pharmaceutical development with no assurance that the prices or the resulting cures will be affordable. We see only today with the pricing of remdesivir, a drug that would have been left in the scrap heap of failures but for taxpayer funding, that the same taxpayers that developed the drugs will be charged billions to get them.

Let's look forward to a day when we have a competent and committed President to bring healthcare for all.

Mr. BRADY. Madam Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. SMITH), a leader in rural healthcare reform.

Mr. SMITH of Nebraska. Madam Speaker, I rise today in opposition to H.R. 1425.

I stand here somewhat surprised that there is celebration of the successes of the so-called Affordable Care Act. Many of my constituents are offended by the mere name of the bill, the Affordable Care Act, because they don't find it affordable. They found it quite unaffordable.

I would argue that is why we are here today, with a fairly clever scheme of taking money from here and putting it there, which likely will still drive up the cost of healthcare. It is just a few different people paying for it.

Madam Speaker, if we want true healthcare reform, we should do that, but we haven't done that. Let's look for the bipartisan opportunities on drug costs, as mentioned earlier. Those had been advancing, but those were all pushed aside for H.R. 3.

H.R. 3 passed the House knowing that it wasn't going to go anywhere. I would argue that some people probably even voted ''yes'' on H.R. 3 because they knew the Senate would not take it up and because they also know that it has major problems.

But here we are today, again, with this scheme that I think will fail the American people, just like so much of the so-called Affordable Care Act has failed the American people in its mere cost, not to mention other things.

Yes, I remember those comments of, ''If you like your healthcare plan, you can keep it.'' We know that didn't happen. So many other promises were made that were not kept.

And the American people want us to work together, especially now. Probably more than in the history of our country, the people want us to work together on bipartisan solutions.

Madam Speaker, we need to do that. We can do that. There is even evidence that there is productive work already done in a bipartisan fashion.

So let's not do this bill, H.R. 1425, today. Let's go about it in a bipartisan way where we know the American people will benefit more and our system can support that.

Mr. NEAL. Madam Speaker, I would point out that 100 percent of the children in Massachusetts have healthcare today and 97 percent of the adults.

Madam Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Madam Speaker, I listened to my colleagues cry out for a bipartisan cooperation and progress. I listened to them talk about somehow having promises not kept.

Think for a moment. My colleagues—the promise of Donald Trump and the Republicans to replace and enhance the Affordable Care Act. They are going to eliminate it, and they are going to replace it with something better.

No, they could not do it.

They have been assaulting the Affordable Care Act since the moment it was passed and they got their hands on part of the political control.

They fought to protect Big Pharma so that we have this corrupt bargain where Americans have to pay the highest prescription drug prices in the world in order to bribe pharmaceutical companies to continue research. And they wouldn't unless Americans pay more than anybody else in the world—including, in many instances, people who can't afford their prescription drugs. That corrupt bargain needs to be rejected.

Madam Speaker, now we are hearing, I think, starkly, the difference between Republicans and Democrats—night and day—that active sabotage of the Affordable Care Act, today with the Republican attorneys general and the full weight of the Trump administration to try again to repeal it in its entirety.

Madam Speaker, our legislation would increase coverage for 4 million people. You know, it is interesting watching people fight against the efforts of the Trump administration and the Republicans to deny them coverage. Almost one-half million people figured out a way to apply, demonstrating the need in the time of coronavirus.

Madam Speaker, my Republican friends have nothing to offer. They have no plan. The Trump administration only wants to destroy the Affordable Care Act at a time when it is more important than ever.

Madam Speaker, I strongly urge approval of this package.

Mr. BRADY. Madam Speaker, I yield 1 minute to the gentleman from New York (Mr. REED), a key leader of the Committee on Ways and Means on healthcare reform.

Mr. REED. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, I rise today in opposition to the bill before us.

The debate, America, is very simple. I am a proud Republican, and I stand with the private market. I stand with you, as the people.

My Democratic colleagues, they offer you a vision of healthcare defined and controlled by the government. If you believe the government can do a better job with your healthcare, then so be it, vote with the Democratic colleagues. But if you believe in entrepreneurs, if you believe in innovators, then vote with the Republican ideas that lead to more innovation.

The bill before us today, we had a conversation with the Health and Human Services Secretary in the Committee on Ways and Means and with the Congressional Budget Office independently confirming that there will be dozens fewer innovations when it comes to treatments and cures for Americans with the passage of this bill.

That is what you are doing—eyes wide open—and we are not going to let you get away with it.

Madam Speaker, when you vote for this bill, you are dooming millions of Americans to not have a cure for the disease. Vote for the bipartisan bill, H.R. 19, Lower Costs, More Cures. That is the bill that will get through the system.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentlewoman from Washington State (Ms. DELBENE).

Ms. DELBENE. Madam Speaker, I rise today in support of the Patient Protection and Affordable Care Enhancement Act.

The high price of prescription drugs is one of the top issues I hear about from my constituents. In 2019, I received nearly four times as many comments about prescription drug costs as the year before. Now, with the COVID–19 pandemic and resulting economic crisis, addressing the issue of drug pricing is more urgent than ever.

The patient stories are numerous and never-ending. I would like to share just one with my colleagues and the American people to remind us why this legislation is so necessary.

A constituent of mine, Dana, from Kenmore, Washington, has lived with type 1 diabetes for 14 years. When Dana was first diagnosed with diabetes, insulin cost her $50 each month. Today, that same insulin costs over $600 per month.

That is an 1,100 percent increase for the exact same product, and there have been virtually no changes to insulin since Dana's diagnosis, so the price spike is inexplicable.

Madam Speaker, Dana is not only a diabetes patient but also a nurse practitioner and diabetes educator. She has told me about her patients who go to Canada, where they can get insulin for just $40 a month. But with the border closed because of the pandemic, for many, that option is shut off to them.

Dana has also shared stories of her own patients who can't afford their medications and ration their insulin, which we know can lead to poor health, vision loss, kidney failure, and even death.

Madam Speaker, I strongly support the Patient Protection and Affordable Care Enhancement Act, which will strengthen and improve upon the ACA and finally give the Health and Human Services Secretary the power to negotiate a fair price for insulin, which will dramatically help patients, like Dana, and all the patients that Dana serves in my district.

Madam Speaker, I urge my colleagues to support this legislation.

Mr. BRADY. Madam Speaker, I include in the RECORD a veto threat from President Trump that states the administration strongly opposes H.R. 1425, further demonstrating this bill has no chance of becoming law.

STATEMENT OF ADMINISTRATION POLICY

H.R. 1425—PATIENT PROTECTION AND AFFORDABLE CARE ENHANCEMENT ACT—REP. CRAIG, D–MN, AND 61 COSPONSORS

The Administration strongly opposes House passage of H.R. 1425. This bill attempts to exploit the coronavirus pandemic to resuscitate tired, partisan proposals that would send hundreds of billions of dollars to insurance companies in order to paper over serious flaws in Obamacare. Furthermore, H.R. 1425 would pay for this bailout by imposing price controls that undermine the American innovation the entire globe is depending on to deliver the vaccines and therapeutics needed to respond to the coronavirus.

Since the beginning of this crisis, the Administration has taken a whole-of-America approach to fight the corona virus. This includes a productive partnership with both houses of Congress to respond to the healthcare needs of our citizens. The Administration has delivered millions of pieces of personal protective equipment to frontline healthcare responders, surged hospital capacity, and dramatically scaled up diagnostic and surveillance testing capabilities. The Administration also launched Operation Warp Speed to collaborate with the private sector to develop a coronavirus vaccine, therapeutics, and diagnostics. Additionally, the Administration is working to reimburse providers for corona virus testing and treatment of uninsured Americans so they do not have to worry about the financial implications of obtaining these services.

All this was done while putting the country in the strongest possible position to rebound from the most significant economic challenge since the Great Depression. Working with Congress, the Administration has delivered financial relief directly to over 160 million Americans, over 4.5 million businesses and their employees, and over one million healthcare providers.

Instead of building on these vital, bipartisan efforts, H.R. 1425 reads as if the corona virus never emerged. It repurposes failed proposals from years past that would literally pay insurance companies more to hide the true cost of Obamacare from consumers. Even the additional billions of taxpayer funding is not enough to prop up Obamacare on its own, thus H.R. 1425 goes out of its way to systematically eliminate any competition by prohibiting more affordable coverage options and the consideration of alternative approaches by States. At the same time, the bill lacks any provision to ensure the Federal Government adheres to the long-held consensus to not fund abortion services or abortion coverage.

To create a façade of ''paying'' for the revival of last decade's most partisan project, Obamacare, H.R. 1425 invokes another partisan misadventure reflected in provisions of H.R. 3. In its Statement of Administration Policy on H.R. 3, the Administration explained that these provisions would impose price controls under the guise of ''negotiation'' that would ultimately ''harm seniors and all who need lifesaving medicines.'' In perhaps an indication of the intentions of H.R. 1425, it does not even attempt to include those provisions of H.R. 3 that had previously garnered bipartisan support, such as establishing a cap on out-of-pocket expenses for all beneficiaries in Medicare Part D and other improvements to that program for seniors.

While any time is an inopportune time to dramatically undermine the development of innovative medicines, H.R. 1425 is even more imprudent given the current focus on developing vaccines and therapeutics rapidly to help America and the world combat the coronavirus. To take such an action simply to double down on the same expensive, inefficient, and bureaucratic approach to health coverage that the American people endured for the past decade makes it even more misguided and counter to the most urgent needs of the country.

If H.R. 1425 were resented to the President his advisors would recommend that he veto the bill.

Mr. BRADY. Madam Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. HOLDING), a leading healthcare expert in the Committee on Ways and Means.

Mr. HOLDING. Madam Speaker, I thank the chairman for yielding.

Madam Speaker, one thing that I think has become abundantly clear during this pandemic is how important it is to incentivize biopharmaceutical innovation. Over the past few months, Federal officials worked tirelessly with drug companies to identify and develop treatments that can help mitigate the effects of the coronavirus—indeed, save thousands of lives.

In my district, the town of Wilson, North Carolina, is home to one of the three manufacturing sites that produce over 40 percent of the world's supply of dexamethasone, which has been identified as one of the first lifesaving drugs for coronavirus patients. This site in Wilson is preparing to ramp up production and meet global demands.

Madam Speaker, to effectively fight this pandemic, policymakers must continue working with healthcare stakeholders to spur innovation and ensure a steady supply of vital drugs to treat the coronavirus.

Madam Speaker, unfortunately, we are wasting time today talking about government price controls that would do the exact opposite. Rather than incentivize the development of a vaccine and new and innovative treatments, these price-setting proposals will discourage companies from investing in new drugs, and the tax penalty for noncompliance threatens to force companies and certain drugs out of the United States entirely.

That not only means that thousands of Americans could lose access to the drugs they desperately need, but thousands of folks in towns like Wilson could lose their jobs as companies leave the United States.

Madam Speaker, under no circumstances—no circumstances—can we adopt a policy that will curtail patient access to vital drugs and discourage the development of new, innovative treatments. Even the development of one less drug as a result of this policy is too many in the middle of a pandemic.

Madam Speaker, I urge my colleagues to vote ''no'' on this misguided bill.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. SCHNEIDER).

Mr. SCHNEIDER. Madam Speaker, I am proud to rise in strong support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

Our country is in the midst of an unprecedented pandemic requiring unprecedented actions, like the HEROES Act the House sent to the Senate more than 6 weeks ago. Beating back this virus will test us in unimaginable ways, and we cannot afford to allow petty politics to push us backward.

Sadly, inconceivably, that is exactly what the Trump administration asked from the Supreme Court last week when they argued to fully overturn the Affordable Care Act.

With more than 2.5 million infections, and more than 125,000 lives tragically lost, we need to expand access to affordable healthcare; lower the cost of prescription drugs; and improve outcomes for those hardest hit, especially in communities of color and rural communities.

Madam Speaker, the end of the Affordable Care Act and other actions previously announced by this administration, with no plan of their own, will instead leave millions of Americans at risk of losing their insurance. It will result in higher premiums for millions of individuals and small businesses.

Remember this: The 130,000 of us with preexisting conditions, including those who have been infected with COVID–19, will pay the heaviest price.

Madam Speaker, the Affordable Care Act is essential to ensuring Americans have access to affordable and quality healthcare. It is still under attack by our President and his allies.

Today, I and my colleagues demonstrate our commitment to protecting it. The Patient Protection and Affordable Care Enhancement Act will strengthen the ACA by strengthening protections for those with preexisting conditions. It will ensure that no one pays more than 8.5 percent of their income for quality coverage. It will allow negotiations for lower drug costs. It will help address the inequalities in healthcare faced by so many in our country, especially communities of color.

Madam Speaker, this is the kind of bill that should receive bipartisan support in the middle of a historic pandemic, and I urge my colleagues to vote for it.

□ 1200

Mr. BRADY. Madam Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. SCHWEIKERT), a key member

of the Ways and Means Committee and a technology leader.

Mr. SCHWEIKERT. Madam Speaker, 2 minutes is almost impossible to actually have an honest and detailed debate/discussion in here.

But do understand—and I believe this is a sin of both sides—we are playing this game where we are moving around who pays. We are doing almost nothing to actually reduce the underlying cost of healthcare. Your bill is doing it; ours has done it.

But this bill actually has a very cynical mechanism in it. This board is being recycled from H.R. 3. We are all familiar with the mechanism of reference pricing. We have debated it around here for years.

So, if you are in Great Britain and there is a new drug that gives you a year of healthy life and it costs more than $37,000, it is not purchased. That pricing, that scarcity mechanism, is what the Democrats' bill is importing. So its savings are actually very cynical, because it is going to take away pharmaceuticals that make people healthy.

How could we be doing this, even allow this mechanism, in a time of a pandemic?

You are about to crush all of the little biopharma companies that we are hoping desperately produce miracle cures, and, in a perverse way, for large pharma. You have just given them the market, because you have taken away those who are nipping at their heels.

I beg of you, think about what you are actually doing, because this type of financing mechanism will kill people. It will end lives, because it will create a dearth, a shortage, of the next generation of cures.

Let's not engage in that cruelty. There are better ways to get there. And we have proposed many of them. It would just be nice to get heard, because there are solutions, and this is a really dark one.

Mr. NEAL. Madam Speaker, I yield 1½ minutes to the gentlewoman from Alabama (Ms. SEWELL).

Ms. SEWELL of Alabama. Madam Speaker, I am proud to support the Patient Protection and Affordable Care Enhancement Act today because it is high time that we reduce prescription drug costs for all Americans.

Likewise, this bill includes provisions to expand access to Medicaid and quality healthcare insurance with expanded tax credits and premium subsidies.

This bill includes a provision in the bill—that is, the bill that I have been advocating with my colleagues JOHN LEWIS and MARK VEASEY for some time now—to ensure that all States that expand Medicaid coverage receive an equal Federal match for expansion, regardless of when they expanded. That means that the 14 States—like Alabama, that I represent—could expand Medicaid and get equal Federal coverage in their match.

This provision incentivizes Medicaid expansion because it would help 113 million Americans living in nonexpansion States. In my State alone, over 300,000 more Alabamians would qualify for coverage from Medicaid if we had this bill passed.

The writing is on the wall and the facts are clear: Premiums and healthcare costs are higher in States that haven't expanded Medicaid, and over 70 percent of the rural hospital closures are in States that have not expanded Medicaid.

The public health emergency and economic crisis that we are currently facing means that more uninsured and more unemployed constituents are more vulnerable.

Let's pass this legislation. It will not only expand Medicaid and give Medicaid expansion opportunities with equal Federal match in States like Alabama, but it would also decrease prescription drug costs and protect the preexisting conditions that are so important for all Americans.

This is an important tool, providing our States with enhanced Federal matching funds to ensure Medicaid is one of the best tools that we have to help the communities we represent now and into the future. I urge my colleagues to support this important bill.

Mr. BRADY. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. NUNES), the ranking member of the Health Subcommittee.

Mr. NUNES. Madam Speaker, I rise today in opposition to H.R. 1425.

Per usual, this is a partisan bill that will go nowhere in the Senate and the President will not sign into law.

Among the various problems in this bill is the Democrats' insistence on including provisions which will prevent scientists from finding new cures—at a time when our Nation is working to overcome the coronavirus.

According to the California Life Sciences Association, if this bill passes, 88 percent of new drugs in the pipeline will be discontinued. That is hundreds of diseases that will not be cured and countless lives that will be lost. That is not something that I can support.

Rather than engineer a government takeover of the prescription drug industry, we can work together to provide lower prices for families, and we can do it without reducing cures. But this bill we have before us today is not the answer.

I urge all of my colleagues to vote ''no'' on H.R. 1425.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from California (Mr. PANETTA).

Mr. PANETTA. Madam Speaker, I rise today in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

This comprehensive legislation will do what I have always said needs to be done to the ACA: It won't get rid of it, but it does fix it. This bill does that by lowering healthcare costs and raising access to quality healthcare, especially for those who need it the most.

We must do this now, more than ever, with COVID–19 numbers spiking and an administration that is trying to overturn the ACA and reduce healthcare access rather than expand it.

In my district on the central coast of California, the numbers of COVID–19 are growing, but impacting certain communities more than others. Nearly 80 percent of all COVID cases in Monterey County have been found to be in the Latinx community.

Across the Nation, Latinos make up 34 percent of the cases of COVID–19, despite only representing 18 percent of the total U.S. population, while, nationally, Latinos have the highest uninsured rate. H.R. 1425 would fix that by eliminating barriers to affordable healthcare for Latinos and expanding coverage for DACA recipients.

This bill would improve healthcare for all Americans by increasing protections for people with preexisting conditions, strengthening the State marketplaces, expanded premium tax credits, and helping low-income postpartum women and children.

So I call on my colleagues to come together and vote for this bill because now, more than ever, it is time for us to do our job: Improve the Affordable Care Act so that we can provide the necessary healthcare to those who need it the most and everybody in our Nation.

Mr. BRADY. Madam Speaker, I yield 2 minutes to the gentlewoman from West Virginia (Mrs. MILLER).

Mrs. MILLER. Madam Speaker, I rise in opposition to H.R. 1425, which should be called the expanding government and killing cures act.

With this legislation, my colleagues across the aisle are bending American healthcare to the will of Washington bureaucrats.

Any way you look at this, House Democrats took a bipartisan issue, improving healthcare and lowering prices, and botched it. We are now left with bad policy that will stifle innovation for new treatments and therapeutics and do what government does worst: pick winners and losers in the private sector.

This absolutely will not fix ObamaCare's failed policies. This bill gives billions in taxpayer-funded bailouts and subsidies, while doing nothing to streamline services, lower costs, or cut taxes.

Today, House Democrats are wasting everyone's time pushing a bill with price controls, punitive taxes, blank checks, bailouts, and more red tape and bureaucracy.

I want a bill that protects preexisting conditions, lowers drug pricing, incentivizes innovation, fixes our healthcare system, cuts taxes, and actually lets you keep your own doctor—but this is not it.

For these reasons, I urge my colleagues to oppose this legislation so we can get to work and actually pass a bill that improves the lives of our citizens.

Mr. NEAL. Madam Speaker, I am pleased to yield 1½ minutes to the gentlewoman from Florida (Mrs. MURPHY).

Mrs. MURPHY of Florida. Madam Speaker, every American should have affordable access to doctor care, hospital care, and prescription drugs. This is important in normal times and vital during a pandemic.

Before COVID, Florida had one of the worst uninsured rates in the country. That is because State leaders refused to expand Medicaid, placing politics over public health. It is also because many Floridians chose not to buy a marketplace plan because they couldn't find an affordable option.

COVID has made a bad situation worse. In Florida, cases, hospitalizations, and deaths are rising sharply. Millions of workers have lost their jobs and their employer-sponsored health coverage.

Passage of this bill would make an immediate difference in the lives of my constituents who are really struggling. The bill would encourage Florida and other holdout States to expand Medicaid by having the Federal Government pay nearly the full cost. It would make exchange coverage more affordable, reducing premiums and deductibles. It would lower the cost of prescription drugs, which are far too high.

Finally, it would guarantee that no American can be denied coverage because of a preexisting condition. This protection is even more important than ever since there is a risk that insurers could classify a COVID–19 diagnosis as a preexisting condition.

I strongly support this bill and urge its passage.

Mr. BRADY. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. ARRINGTON), a member of the Ways and Means Committee.

Mr. ARRINGTON. Madam Speaker, at a time when our Nation is reeling from an unprecedented public health crisis and our fellow Americans are struggling just to survive, the Democrat leadership is wasting precious time on yet another partisan messaging bill.

This legislation is going nowhere, and my friends on the other side of the aisle know it. The name Patient Protection and Affordable Care Enhancement Act is no such thing. It is the protecting ObamaCare act. It is the pretend we are legislating under the guise of partisan messaging act. It is the perpetuate the broken promises of ObamaCare act. It is empty; it is devoid; it is going nowhere. We are wasting time in this national crisis.

If it did pass, it would take flexibility and responsibility from States. It would coerce States to expand Medicaid—a flawed Medicaid system, I might add—and it would allow for these monies to be used on abortion, which is a nonstarter. We know it is not serious when that is in there. That is a poison pill.

Madam Speaker, I encourage my colleagues to stop wasting the American people's time, and let's get back to governing this great Nation.

Mr. NEAL. Madam Speaker, I yield 2 minutes to gentlewoman from California (Ms. JUDY CHU).

Ms. JUDY CHU of California. Madam Speaker, last week, as COVID–19 cases continued to spread, even reaching historic highs, and as the number of Americans killed by this virus rose well above 100,000, Donald Trump asked the Supreme Court to strike down the entire Affordable Care Act. If Trump and Republicans got their way, millions of Americans would immediately lose their health insurance in the middle of a pandemic, with no alternative available.

Ending the ACA is life-threatening, especially as we battle COVID–19. That is why I am proud to support the Affordable Care Enhancement Act. This bill would build on the success of the ACA by expanding tax credits to ensure more Americans have access to health insurance, not fewer. And it expands eligibility for these credits so that Dreamers can access affordable healthcare as well, something we know will benefit entire communities.

The coronavirus does not discriminate, and neither should we.

Critically, this bill undoes the Trump administration's expansion of junk insurance plans, which offer minimal coverage and leave patients with massive bills when they do get sick; because, while access to healthcare is essential, it must be affordable.

That is why it is so important that this bill also includes language from H.R. 3, the Elijah Cummings Lower Drug Costs Now Act. This will lower prescription drug prices by allowing the government to negotiate for those prices, bringing our prescription drug prices in line with what they cost overseas.

This bill puts the health of the American people first when we need it most. I am proud to support this legislation, and I urge my colleagues to vote ''yes.''

Mr. BRADY. Madam Speaker, I yield 3 minutes to the to gentleman from Louisiana (Mr. SCALISE), the Republican whip.

□ 1215

Mr. SCALISE. Madam Speaker, I think we all remember: If you like what you have, you can keep it. Remember that phrase? Probably the most broken promise in political history.

Millions of people lost the good healthcare that they liked because Washington bureaucrats came in and said not ''if you like what you have, you can keep it,'' but ''if Washington likes what you have, you can keep it.'' And they took it away.

After that, you still see, years later, they are trying to pull more people out of the private insurance market who actually like what they have, and say, ''Get back on this.''

If it works so well, by the way, Madam Speaker, wouldn't people be going in droves to it? In fact, it works so poorly that, under this bill, they have to bribe you with over $400 billion more in taxpayer money.

That is how much this costs, more than $400 billion to take you off the private health insurance that you like. This is free market. If you don't like it, you can go somewhere else. But most people like their private health insurance, so they are going to push them onto this at the expense of over $400 billion.

If that isn't bad enough, Madam Speaker, what else do they do? They pay for it—get this—by limiting the amount of drugs that will come to market. Yes. The Council of Economic Advisers has advised ''as many as 100 fewer drugs entering the United States market over the next decade, or about one-third of the total number of drugs expected to enter the market.''

Can you believe this? In the middle of a global pandemic, when we are trying and rushing to find a cure and a vaccine for COVID–19, they are going to bring a bill to the floor to stop drugs from coming to the market, over 100 of them.

Let's read more. This ''would reduce Americans' average life expectancy by about 4 months.'' My God, what are we doing, bringing a bill to the floor right now when we are trying to find a cure that will make it harder to find a cure? All to push more people, including wealthy people who would be eligible under the bill that already have private insurance, onto a heavily taxpayer-subsidized program that has been failing under its own weight, failing so much they need to add $400 billion to try to entice you to take it and, in the process, limit the ability to bring lifesaving drugs, like a cure for COVID–19, to the market.

This is absurd. This is psychotic that we are even debating this right now. We should be focusing on helping expedite a cure, not making it harder to bring that very cure for COVID–19 to the market.

Madam Speaker, I would strongly urge a ''no.''

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from California (Mr. GOMEZ).

Mr. GOMEZ. Madam Speaker, first, I want to remind my colleagues from the other side of the aisle that this President has attempted to get rid of, to eliminate, the Affordable Care Act, ObamaCare, over and over and over again. So when you pretend to care about expanding healthcare or taking care of people who don't have healthcare, it seems a little hollow to me.

That is why I am proud to stand up here to support the Patient Protection and Affordable Care Enhancement Act because it would invest in working families by expanding affordability, strengthening consumer protections, and increasing coverage. And there is a lot to like in this bill.

For the first time ever, under this legislation, doctor recipients would be

eligible for help with their premiums for plans they purchased under Covered California or HealthCare.gov.

For DACA recipients, home is here. Many of them have been working as first responders and frontline health providers during the pandemic, and they should have affordable healthcare like any other American.

Madam Speaker, I would like to thank Chairman NEAL for working with me on this important provision.

Second, this bill makes changes so that Medicaid more effectively serves its patients.

For instance, under the legislation, Medicaid enrollees would have better access to primary care physicians, and they won't lose their healthcare coverage just because of small fluctuations in their income over the course of a year.

Forty-seven percent of my congressional district is enrolled in Medicaid or Medi-Cal, so these provisions are crucial.

Last, this bill makes healthcare more affordable by increasing subsidies for working families on the marketplace. This provision is similar to the Healthcare Affordability Act of 2019 that I introduced with Congresswoman LAUREN UNDERWOOD. This is a historic step.

The Affordable Care Act was a big step, but it is not done. We are going to keep pushing, and we are not going to negotiate with the other side of the aisle that keeps trying to eliminate and roll back protections and affordable healthcare for millions of Americans.

Mr. BRADY. Madam Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. WENSTRUP), a leader on the Ways and Means Committee.

Mr. WENSTRUP. Madam Speaker, I thank the gentleman from Texas for yielding and for his leadership.

Madam Speaker, I rise today in opposition to this bill.

I grew up watching a show called ''Medical Center'' as a kid. It led me to wanting to become a doctor because I wanted to help people.

After I graduated and completed my surgical residency, I owned a small practice with two employees. Eventually, I merged with a larger provider group, in part because the administrative burdens of complying with new laws and regulations were just too costly for my solo practice.

That wasn't the end, though. Costs continued to rise, and my physician-owned surgery center was ultimately sold to a local hospital. Medicare reimbursement rates nearly doubled overnight, including an increase in patient co-pays.

When I got to Congress, I joined the GOP Doctors Caucus, and I am now proud to serve as the vice chair. Most of us in the Doctors Caucus agree that one of the reasons we came to Congress is because of the mountains of red tape, red tape involved in practicing medicine that has killed much of the joy of providing care to patients.

Now, the bill we are debating today is another perfect example of an attempt to expand Big Government, making it harder on the medical community. In this case, it is patients who rely on prescription drugs who stand to lose the most.

In the midst of the COVID–19 outbreak and responses, we rush toward finding treatments and a vaccine. My colleagues on the other side of the aisle want to pass a bill that will result in fewer cures for Americans in need.

That is right. The CBO analysis concluded that this bill would result in fewer cures coming to market to help the American people. Drug manufacturers that may feel government isn't willing to pay a reasonable price for their product would have their revenue taxed at astronomical rates, essentially coercing the drugmaker into submission or cease to exist.

The reason America leads the world in producing new medicines is because we allow competition, competition to drive innovation.

Right now, Congress needs to be fostering innovation through competition, not imposing one-size-fits-all Washington mandates that accomplish just the opposite.

We have already proven that we can do some work together. Last year, the Ways and Means Committee marked up a bipartisan drug-pricing legislation bill only to have it die because of partisan leadership. I know the Energy and Commerce and Judiciary Committees have done the same. Let's debate and find compromise on that legislation, which actually stand a chance of becoming law.

I urge my friends on the other side of the aisle to work with us on bipartisan legislation that would result in finding more cures for the American people because cures save money and save lives. I oppose this legislation.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from Nevada (Mr. HORSFORD).

Mr. HORSFORD. Madam Speaker, I rise today in support of the Patient Protection and Affordable Care Enhancement Act.

In the middle of the historic health and financial security crisis of the coronavirus pandemic, especially in my home State of Nevada that has suffered the most debilitating economic impact, affordable healthcare is now more important than ever.

Last week, in the middle of this COVID–19 crisis, President Trump petitioned the Supreme Court to strike down every last protection and benefit of the Affordable Care Act. On Friday, I learned that such a ruling would cost 23 million Americans, including 309,000 Nevadans, to lose their health insurance.

There is no excuse for this cruelty ever. But it is truly unconscionable at a time when over 100,000 Americans have lost their lives to a virus that we have yet to curb completely. When access to quality healthcare could be the difference between life and death, we should be building on the Affordable Care Act to lower health costs, not ripping away every last benefit.

With all due respect to my colleagues on the other side who keep saying this bill has no chance in the Senate, who do you work for: MITCH MCCONNELL or the American people? My constituents elected me to do my job, and that is to fight for their healthcare.

Madam Speaker, I fully support the Patient Protection and Affordable Care Enhancement Act because we need to do more to provide affordable healthcare and bring down the rising costs of prescription drugs.

This bill does that, and I urge my colleagues to join us. Do your job today.

Mr. BRADY. Madam Speaker, I yield myself such time as I may consume.

I have here a host of letters in opposition to this dangerous legislation, one signed by more than 40 State and regional life science organizations and another signed by over 130 small biotech companies, many of whom are currently working to develop COVID–19 therapies and vaccines. In these letters, they emphasize that this bill will deter badly needed investment that will harm their ability to manufacture and produce therapies and cures for American families.

Madam Speaker, in the midst of a pandemic, we just heard a question: Why do we oppose this bill? In the midst of a pandemic where countless lives will depend upon the development of these new cures, this cannot happen on our watch. We will not stand idly by.

Madam Speaker, I include in the RECORD the letters, and I reserve the balance of my time.

OCTOBER 16, 2019.

Hon. MITCH MCCONNELL,
Majority Leader, U.S. Senate,
Washington, DC.
Hon. CHARLES SCHUMER,
Democratic Leader, U.S. Senate,
Washington, DC.
Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.
Hon. KEVIN MCCARTHY,
Republican Leader, House of Representatives,
Washington, DC.

DEAR SENATE MAJORITY LEADER MCCONNELL, SENATE DEMOCRATIC LEADER SCHUMER, HOUSE SPEAKER PELOSI, AND HOUSE REPUBLICAN LEADER MCCARTHY: As state and regional life sciences organizations across the country, all dedicated to supporting the development and delivery of innovative life-enhancing and life-saving products, we write to express our strong concerns about recent legislative proposals that seek to introduce international reference pricing and foreign price controls as a strategy to reduce prescription drug costs. We are gravely concerned that such polices will consequentially threaten patient access and choice and cede America's global leadership in biomedical innovation.

At the outset, we underscore our appreciation for the bipartisan and bicameral efforts underway to provide relief to patients from unaffordable out-of-pocket costs for prescription drugs. This is a critical challenge for our nation, and we are committed to being

part of the solution to address it, while also ensuring that incentives still exist to spawn future innovation. However, we are deeply concerned by proposals by some in Congress to introduce price controls, particularly foreign reference pricing, into government and private healthcare programs. These proposals are concerning for states and regions of the country with established life sciences communities, as well as for emerging biomedical innovation ecosystems working to attract capital investment and support entrepreneurship to build the companies and therapies of the future. Most importantly, they would be devastating for those patients hoping for medicines to treat serious, life-threatening diseases.

For example, 96 percent of new cancer drugs are available in the U.S., at an average delay of 3 months. By comparison, Japanese patients have access to 50% of new medicines and wait on average 23 months. German and Canadian patients wait four times longer, French patients wait six times longer. None of these countries even approach the access to new therapies that our patients have. Should the U.S. implement foreign price controls, patient choice and access to the full range of life-saving therapies would undoubtedly be threatened.

Proposals to implement foreign price controls also put at risk the U.S.'s world-leading innovative biopharmaceutical sector that has created nearly one million jobs across all 50 states and represents a large portion of our nation's Gross Domestic Product (GDP)—generating an economic output of approximately $1.3 trillion annually. As a sector that already takes on extraordinary risks and significant investments with the hope that a few will eventually become the next life-saving treatment for patients, the looming potential of foreign price controls brings a threat that risks the support of future investment.

It is also important to remember that the overwhelming majority—over 80 percent—of biopharmaceutical innovators in the US are small, start-up, pre-revenue companies without a single product yet on the market. A recent report by IQVIA showed that emerging biopharmaceutical (EBP) companies account for over 70 percent of the total late-stage R&D pipeline and were responsible for almost two-thirds of the patents for new drugs launched in 2018. These mostly pre-revenue companies without a product on the market are the ones to be most affected by fluctuations in investment caused by the political and public policy environment.

The recent actions taken by the Administration and Congress on drug pricing are seen as extremely threatening by the life sciences sector, and we are therefore concerned that the proposed foreign price controls policies will scare investment away from life sciences investment, and towards other industry sectors that pose far less risk. If price controls as proposed are implemented it may reduce drug pricing in the short term, but it will certainly result in significantly reduced innovation and severely restricted access to life-saving medicines.

On behalf of the US's innovative life sciences community, we urge you to reject any efforts to undermine America's global leadership in biomedical innovation through international reference pricing or other price controls. Patients deserve access to and choice of the lifesaving therapies of today and tomorrow. As you move forward, we stand ready to work with you to consider alternative proposals that will propel American innovation forward and deliver affordable, accessible and innovative therapies for patients who need them.

Sincerely,

Alabama: BIO Alabama.

Arizona: Arizona Bioindustry Association, Inc. (AZBio).

California: California Life Sciences Association—CLSA, BIOCOM, SoCalBio.

Colorado: Colorado BioScience Association.

Connecticut: BioCT.

Delaware: Delaware Bioscience Association (Delaware BIO).

Florida: BioFlorida.

Georgia: Georgia BIO.

Illinois: Illinois Biotechnology Innovation Organization (iBIO).

Indiana: Indiana Health Industry Forum (IHIF).

Iowa: Iowa Biotechnology Association (IowaBio).

Kansas: Bio Kansas.

Kentucky: Kentucky Life Sciences Council.

Louisiana: Louisiana BIO.

Maryland: Maryland Technology Council.

Massachusetts: MassBio.

Maine: Bioscience Association of Maine (BioME).

Michigan: Michigan Biosciences Industry Association (MichBio).

Minnesota: Medical Alley Association.

Missouri: Missouri Biotechnology Association (MOBIO).

Montana: Montana Bioscience Association.

Nebraska: Bio Nebraska.

Nevada: The Nevada Biotechnology and Life Science Association.

New Jersey: BioNJ, HealthCare Institute of New Jersey (HINJ).

New Mexico: NMBio.

New York: New York BIO.

North Carolina: North Carolina Biosciences Organization (NCBIO).

North Dakota: BioScience Association of North Dakota.

Ohio: BioOhio.

Oregon: Oregon Bioscience Association (Oregon BIO).

Pennsylvania: Life Sciences Pennsylvania (LSPA).

South Carolina: SCBIO.

South Dakota: South Dakota Biotech.

Tennessee: Life Science Tennessee.

Texas: Texas Healthcare and Biosciences Institute (THBI).

Utah: BioUtah.

Virginia: VirginiaBio.

Washington: Life Science Washington.

West Virginia: Biosciences Association of West Virginia.

Wisconsin: BioForward Wisconsin.

Puerto Rico: Industry-University (INDUNIV) Research Center Inc/Bio Alliance Puerto Rico.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from New York (Mr. SUOZZI).

Mr. SUOZZI. Madam Speaker, I rise today in strong support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

Madam Speaker, the Democrats have been debating internally over the past couple of years: What is the best way to reduce healthcare costs? What is the best way to provide more access to people? What should we be doing?

Some people push for Medicare for All. People like myself say: Let's build upon the Affordable Care Act. Let's try and figure out how we can provide more access and reduce drug costs. That is what we are doing here today.

Meanwhile, our Republican colleagues are continuing to hurtle down a dark and misguided path to take away coverage from almost 20 million Americans in the middle of the worst economic and health crisis we have had in almost a century.

I am mystified by the strategy of my colleagues on the other side. What are they thinking?

Now, they say that they want to protect people with preexisting conditions. In fact, the President tweeted over the weekend, saying he will always protect people with preexisting conditions. And I have heard colleagues of mine in the Ways and Means Committee say: We are convinced. We know now that we have to protect people with preexisting conditions.

Yet, what do they do? Not what they say, what do they do? Their policies don't match their rhetoric.

In 2017, they tried to repeal the ACA altogether, which would take away people's preexisting conditions protections. Now, in the midst of a pandemic that has already killed 130,000 Americans, this administration and the Republicans are pursuing a lawsuit to actually undo the Affordable Care Act. That will get rid of preexisting conditions protections. It doesn't make any sense.

Prescription drugs, the President said during his campaign and thereafter, when talking about Big Pharma, he said that these guys are getting away with murder. We should be negotiating prescription drug prices. Yet, we have passed the bill before. We are doing it again today, to actually negotiate prescription drug prices, and they are opposing it once again, and they are not doing anything to try to negotiate prescription drug prices.

Today, Democrats are, once again, taking steps to reduce premiums, lower drug prices, and expand coverage.

Madam Speaker, I urge my colleagues on both sides of the aisle to support this bill.

Mr. BRADY. Madam Speaker, I yield myself 30 seconds.

Madam Speaker, just a quick fact check, because you know the Republican Congress in 1996 enacted the first comprehensive protections for preexisting conditions, which cover, today, 275 million Americans who are not affected by the lawsuit. There is simply too much fear-mongering and bad information in this debate.

Madam Speaker, I reserve the balance of my time.

Mr. NEAL. Madam Speaker, I yield 1 minute to the gentlewoman from Chicago (Ms. SCHAKOWSKY).

□ 1230

Ms. SCHAKOWSKY. Madam Speaker, I thank the chairman for yielding to me.

I would think that my colleagues on the other side of the aisle, the Republicans, would get tired of trying to take healthcare away from Americans, particularly right now.

The Patient Protection and Affordable Care Enhancement Act would actually make such incredible improvements and make healthcare more affordable, but, no.

The bill includes the No More Narrow Networks Act that I actually introduced that would ensure that consumers can access more comprehensive, equitable, and timely healthcare within their own insurance network now. It also includes the Protecting Consumers from Unreasonable Rates Act and allows the Federal Government to help lower prices when those rates, those premiums are too high.

This is a great bill. You should be for this.

Mr. BRADY. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, Republicans support children, seniors, and patients with preexisting conditions. A Republican Congress created the popular Children's Health Insurance Program that millions of families rely on today.

A Republican Congress created the prescription drug program and Medicare to help seniors get the medicine they need, and every Democrat and Speaker PELOSI tried to kill that bill.

A Republican Congress created the Medicare Advantage program that serves 20 million seniors in America.

And a Republican Congress created the first law that established protections for patients with preexisting conditions that covered 275 million Americans today regardless of this ACA lawsuit.

We want people to have access to quality, affordable healthcare that fits their needs, not Speaker PELOSI's. We also support cures now for serious and life-threatening diseases that plague so many families and our loved ones. Eliminating the hope for those cures is why this bill is just so dangerous.

Let me also be clear about what isn't in this bill, Madam Speaker. We have heard a lot today from my friends on the other side of the aisle bemoaning the Trump administration's effort to root out unconstitutional laws while committing to protect people with preexisting conditions.

The Democrats could end this uncertainty now. They are in charge of the House. Bring to the floor a measure Republicans support that sever the individual mandate from the rest of the ACA. Bring to the floor a legislative fix for your unconstitutional law. Bring to the floor certainty for all Americans, especially those with preexisting health conditions.

But House Democrats won't do that. No, they find the political fearmongering to be too potent an election-year weapon. So we continue this charade.

Let me state it all again for all to hear: Republicans support protections for those with preexisting conditions. We wrote the law that protects 275 million Americans today. And we warned Democrats about this unconstitutional law, and we knew it would get struck down in court.

But we cannot have a healthy society, we cannot protect all Americans, if we don't have access to lifesaving cures. As we continue to fight COVID–19, what are you thinking? Why are we destroying the incentives for new medicine and cures? We ought to be doing all we can to accelerate medical innovation, not destroy it in this bill.

Democrats would force patients to choose between affordable medicines and lifesaving cures for Alzheimer's ALS, Parkinson's, diabetes, or cancer. That is a false choice. And we are not talking about just a few cures for some very rare diseases, we are talking about up to 100 cures, dozens lost.

Our country is in a time of uncertainty. Millions are unemployed. States still have deep restrictions in place. For folks who are relying on short-term limited plans for this period of uncertainty, why do Democrats propose to make their lives harder?

I oppose this dangerous bill and urge everyone to oppose it.

Madam Speaker, I yield back the balance of my time.

Mr. NEAL. Mr. Speaker, I yield myself the balance of my time.

Madam Speaker, this is very sensible legislation. It builds upon the Affordable Care Act. It keeps the protections of preexisting conditions. It makes the children's healthcare initiative permanent. But most importantly, it expands the opportunity.

I am going to reiterate something I said earlier about the experience we have had in Massachusetts with the Affordable Care Act. 100 percent of the children in Massachusetts have health insurance. Ninety-seven percent of the adults in Massachusetts have health insurance, and it polls in the high seventies in terms of consumer satisfaction. It was the experiment that worked.

We should be expanding healthcare opportunities for members of the American family, not trying to deny them. We shouldn't be filing a lawsuit in front of the Supreme Court suggesting that we should do away with the Affordable Care Act.

Last point, and I mean this very sincerely, as long as I have been in this House, Republicans have never agreed amongst themselves on health insurance, never mind trying to find an agreement with us. They have always disagreed sharply about the role of government in health insurance. So before they give us a lecture on how this ought to proceed, perhaps they could offer a competing plan that has never happened in my time in Congress.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. LURIA). All time for the Committee on Ways and Means has expired.

The gentleman from Virginia (Mr. SCOTT) and the gentlewoman from North Carolina (Ms. FOXX) each will control 30 minutes.

The gentleman from Virginia is recognized.

Mr. SCOTT of Virginia. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, I rise in support of the Patient Protection and Affordable Care Enhancement Act.

As we continue to confront the worst public health emergency in recent history, our first priority must be to protect the health and safety of the American people. But during this pandemic, millions of people have lost their jobs and, regrettably, in America when you lose your job you frequently lose your health insurance.

Based on the job losses in March and April alone, experts estimate that over 26 million people across the country have lost their job-based health insurance.

With so many workers looking to turn to the Affordable Care Act marketplaces for healthcare, we must be building on the progress we have made to expand access to affordable coverage. This is exactly what this bill does.

For example, as my colleagues have noted, under this proposal, no person would pay more than 8.5 percent of income on benchmark silver plans through the marketplace. Moreover, we fix the so-called family glitch, a technical problem that prohibits families from getting affordable coverage, and we make that affordable coverage available for millions of working families.

The legislation will also provide incentives to expand Medicaid so that low-income families across the country will have coverage regardless of where they live.

It builds on existing patient protections by reversing the Trump administration's expansion of short-term so-called junk health plans, which discriminate against patients with preexisting conditions and are not required to cover essential health benefits.

These plans raise costs for everybody not in a plan and then abandon the patients when they get sick and actually need coverage.

Finally, the Patient Protection and Affordable Care Enhancement Act would save money for workers and employees by cutting the cost of prescription drugs and bringing them in line with the cost people in other countries pay.

And when they talk about the loss in investments and research, listen very carefully because they are saying that reducing the cost of prescription drugs is a bad thing. And second, they are talking about a previous version of the bill.

In this version of the bill we have an amendment in here that puts more money into research and NIH, so that those investments will continue to get made.

In contrast, the Trump administration has continued to aggressively pursue the Texas v. United States lawsuit. Just last week, the Department of Justice filed briefs urging that the Supreme Court overturn the Affordable Care Act.

If that suit is successful, all of the benefits of the ACA will be lost. Tens

of millions of people will lose insurance. People with preexisting conditions will lose their protections. Affordability credits will evaporate. Consumer protections will be lost. This will happen in the middle of a public health emergency.

And for all those on the other side that say that the Affordable Care Act has problems, and they have a replacement, remember what the CBO said.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. SCOTT of Virginia. Madam Speaker, I yield myself an additional 1 minute.

Remember what the CBO said about the bill that the Republicans passed when they had the majority a few years ago. They said the costs would go up 20 percent the first year, 20 something million fewer people would have insurance, people with preexisting conditions would lose their insurance, and the insurance you get is worse than what you got.

We can't afford to take this major step backwards in our efforts to put quality insurance within the reach of all Americans, and this is why I urge all of my colleagues to support the Patient Protection and Affordable Care Enhancement Act so that we can strengthen the ACA and ensure millions of Americans will have access to better health insurance than they have now and certainly better than they would have if this lawsuit is successful.

Madam Speaker, I reserve the balance of my time.

Ms. FOXX of North Carolina. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise today in opposition to H.R. 1425, the so-called Patient Protection and Affordable Care Enhancement Act, the latest in a series of attempts by House Democrats to score cheap political points at the expense of hardworking taxpayers.

And speaking of scoring cheap political points, I think most of my colleagues and I are tired of having words put in our mouths that aren't there. We do not oppose reducing the cost of drugs. We want that. We don't believe it is a bad thing.

At a time when Congress should be united in our continued fight against the novel coronavirus and ensuring the country can reopen safely, we are instead here today debating a bill that amounts to nothing more than political posturing. Rather than solve any pressing healthcare problems, including the Nation's response to the COVID–19 pandemic, this misguided legislation will limit healthcare options for patients, contribute to already skyrocketing healthcare costs, and double down on the many failures of the Affordable Care Act or the ACA.

As the Republican leader of the Committee on Education and Labor, I am committed to improving and enhancing employer-sponsored healthcare options for American workers and their families.

Yet today, we are debating legislation that would enlarge ObamaCare even further by providing subsidies for some of the wealthiest Americans, providing a blank check bailout for insurance companies, strong-arming States into expanding Medicaid, and eliminating lower cost healthcare options like short-term, limited-duration insurance plans.

Short-term insurance plans offer healthcare options for Americans who might find themselves between jobs or unable to afford rising premiums in the already expensive individual market. What is astonishing to me is that Democrats conveniently failed to mention that these short-term, limited-duration plans were legal under the Obama administration and that States still have the authority to regulate these plans.

As Republicans, we believe in federalism. If States choose to limit or prohibit the sale of these plans, they are free to do so. Instead of respecting the judgment of State lawmakers and local authorities to act in their States' and constituents' best interest, House Democrats are doubling down on a one-size-fits-all Federal mandate.

As we have seen over and over again, Washington-knows-best requirements simply do not work. In the case of the ill-advised legislation before us today, Federally dictated policies will only lead to fewer choices and higher premiums.

Additionally, House Democrats have missed the mark with H.R. 1425 when it comes to COBRA notices for millions of workers.

While there is room for improvement in this area, such as increasing transparency and allowing consumers to decide which plans work best for them, Democrats are instead blocking consumer access to information about other forms of valued coverage options outside of the ACA.

□ 1245

Just when you thought it couldn't get worse, the blatantly political bill we are considering today incorporates Speaker PELOSI's socialist drug-pricing scheme to cover up the hundreds of billions of dollars this government healthcare expansion would cost American taxpayers.

The rising costs of prescription drugs is an issue that resonates with everyone in this Chamber. Seventy percent of Americans consider reducing the price of prescription drugs to be a top priority, and they are looking to us, their elected representatives, to get the job done to get drug prices under control.

That is why Congress started a collaborative effort and bipartisan process last year to tackle this issue. Unfortunately, this bipartisan collaboration was abruptly cut short by Speaker PELOSI's introduction of H.R. 3, which was written in secret without Member input or the regular committee process.

Lowering drug costs should not be a partisan issue, yet the underlying partisan, socialist provisions in H.R. 3 are included in the legislation before us today.

Democrats are well aware that H.R. 3 will never become law. Senate Majority Leader MITCH MCCONNELL has said it will go nowhere in the Senate, and President Trump has said he will veto the bill if it comes to his desk.

Still, House Democrats continue to waste time during an unprecedented health and economic crisis on legislation that will die after House passage.

Their socialist drug-pricing scheme is nothing more than a leftwing down-payment on a government-run healthcare system that would eliminate private insurance and implement government-controlled rationing of prescription drugs.

As I have said many times before, governments don't negotiate; they dictate. The Democrats' radical drug-pricing scheme will eliminate choice and competition and jeopardize innovation, investment, and access to future cures. And we are considering this at a time when we are in the process of developing treatments and a vaccine for COVID–19.

This type of unprecedented government interference in private market negotiations and substantial increase in regulatory red tape proves one thing: The Democrat Party is being held hostage by their most radical leftwing Members.

The American people deserve better from Congress than the socialist drug-pricing scheme in the bill before us today. They deserve a real solution that will lower the cost of prescription drugs without jeopardizing access to new treatments and cures.

That is why House Republicans have introduced H.R. 19, the Lower Costs, More Cures Act. This bill contains bipartisan, bicameral measures, and it can become law this year. Specifically, H.R. 19 will help lower out-of-pocket costs, protect access to new medicines and cures, strengthen transparency and accountability, and champion competition.

Yet, House Democrats are ignoring this bipartisan, commonsense legislation. Clearly, they prefer politics over progress.

Madam Speaker, I am deeply disappointed that we are here today debating yet another partisan ploy from my colleagues on the other side of the aisle. There are bipartisan solutions to many pressing issues at our fingertips, including continuing to fight the COVID–19 pandemic, but Speaker PELOSI and her Democrat colleagues continue to turn their backs on bipartisan legislation to help the American people, and that is truly shameful.

Madam Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. SHALALA), a distinguished member of the Committee on Education and Labor, and

the former Secretary of the United States Department of Health and Human Services.

Ms. SHALALA. Madam Speaker, I rise today in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

Our country is facing multiple interwoven catastrophes: a global pandemic, an economic crisis, and a reckoning over the denial of racial justice. Our job as Congresspeople is to help the American people through these trying times. This bill does just that, and the time to pass it is long overdue.

Madam Speaker, my district has the highest enrollment in the Affordable Care Act's marketplaces, with more than 100,000 people getting their health insurance from the ACA. My constituents are likely to have never had health insurance before the Affordable Care Act became law, but there still are at least another 120,000 people in Miami-Dade County who do not have access to health insurance because my State, the State of Florida, has refused to expand Medicaid.

This bill will take critical steps to improve and expand the ACA and lower drug costs. It requires the Secretary of HHS to negotiate with drug manufacturers for affordable drugs for all Americans, a power I would have loved to have had when I was Secretary. It does exactly what the President asked for during his campaign. This provision alone will save Medicare $448 billion.

Other critical provisions include expanding tax credits deeper into the middle class so that everyone can get affordable, comprehensive health coverage.

My constituents are worried about their jobs, their loved ones, their healthcare, and their country. Let's help them not worry about how they will pay for critical healthcare if they get sick.

Ms. FOXX of North Carolina. Madam Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLER).

Mr. KELLER. Madam Speaker, I urge my colleagues to join me in opposing H.R. 1425.

While we can all agree that Americans pay too much for healthcare and that the rising costs of prescription drugs need to be addressed, this bill is not the answer.

The COVID–19 pandemic has affected each of our communities in different ways. We need to remain focused on helping our constituents reopen their businesses, get back to work, and remain protected from the virus. This bill does none of these things.

Once again, we are wasting the American people's time debating something that will harm the healthcare system, move us toward socialized medicine, and provide fewer cures.

This is especially troubling as it is at odds with the Trump administration's steadfast goal of finding treatments and a vaccine for COVID–19, as well as protecting Americans from future pandemics.

Just like H.R. 3, this bill irresponsibly coerces drug manufacturers into negotiating drug prices with the government, slapping a 65 percent tax on revenue if they don't come to terms, which increases to as much as 95 percent.

In any negotiations that I have been part of, that is not how it works.

In fact, according to the analysis done by the Congressional Research Service, letting the government set drug prices would violate both the Fifth Amendment's Takings Clause and the Eighth Amendment's Excessive Fines Clause.

Before the pandemic, I traveled across Pennsylvania's 12th Congressional District and met with patients and medical professionals, who have told me that the best way to address rising prescription drug costs include patent reform to get generics to market quickly, price transparency so consumers know the actual cost of the medication they are purchasing, and incentivizing innovation to help find new cures.

Rather than working toward fixing the disaster that has been brought about on the healthcare industry by ObamaCare, this bill expands its flawed structure and attempts to force non-Medicaid expansion States into complying with the radical fantasy that resembles socialized medicine.

There has been bipartisan work on healthcare reform, like H.R. 19, which Republicans put forward last year. If the majority were more interested in finding real results, they might have engaged with us in real discussions to find common ground. We are interested in lower prices, more cures, and a healthier healthcare marketplace.

Unfortunately, this legislation continues us down the wrong road. For these reasons, Madam Speaker, I oppose H.R. 1425 and urge all others to do so.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. DAVIS), the chair of the Subcommittee on Higher Education and Workforce Investment.

Mrs. DAVIS of California. Madam Speaker, I thank the chairman for yielding.

Usually, one's healthcare is not top of mind, until it is. This, Madam Speaker, is one of those times.

We have to protect people's healthcare, men and women, whether it is battling the coronavirus, finding a cure for cancer, or even birth.

Currently, Medicaid covers women for only 60 days postpartum, but life-threatening complications from pregnancy, as we all know, can continue much longer.

These illnesses don't follow the calendar. Regulations, of course, must align with reality.

This needs to be changed. Fortunately, this bill would extend Medicaid coverage to a year postpartum and provide women with critical coverage to help detect, diagnose, and treat potentially fatal complications.

By ensuring better health awareness from the beginning, we can ensure that all babies are protected and cared for as they grow.

When our Nation is facing a health crisis, the logical reaction should be to strengthen healthcare, not to weaken it.

We need to secure these smart policies to protect future Americans from the start.

Madam Speaker, I urge my colleagues to support the Affordable Care Enhancement Act.

Ms. FOXX of North Carolina. Madam Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. MURPHY).

Mr. MURPHY of North Carolina. Madam Speaker, I rise today in opposition to H.R. 1425.

To be honest, I am a little bit baffled. We are in the midst of a global pandemic the likes of which this world has not seen in over 100 years, but sadly enough, my Democratic colleagues think it is a good idea to pass a law that would handcuff the ability of industry to create a vaccine and medicines to fight this disease.

Are you kidding me?

The price controls and regulations proposed in this bill completely eliminate any incentive for these drug developers to spend money to invent new drugs. Can you imagine any company, pharmaceutical or not, being taxed at the rate of 65 to 95 percent of what they make?

We need the next remdesivir or dexamethazone to save people's lives, and such policy would not allow this to happen.

What has happened in the past because of overregulation of industry in the U.S.? These companies have left the U.S. and gone where? Gone to China. How has that worked out for us during this pandemic? China has thus had a stranglehold on this Nation when it comes to the drugs that we need.

At a time of national consensus that we need to purchase fewer drugs from China, the Democrats want to ensure that more of them are developed there and that we have to respond to them. This is insanity.

Madam Speaker, make no mistake: I absolutely do agree that the costs of drugs in this country are too high. I am a physician. I still practice. I still see patients when we are back in our districts, and this is their number one complaint. But there are bipartisan and commonsense measures that we can implement to decrease the cost of drugs.

Like I have said many times before, if we want to lower the cost of drugs, we need pharmacy benefit manager reform. We are the only country in the world that allows these middlemen to drive up costs. They cost this Nation over $800 million a year in unnecessary drug costs.

This is a bipartisan and commonsense reform, rather than this nonsense

legislation, that we can work on together to decrease the cost of drugs.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentleman from Connecticut (Mr. COURTNEY), a distinguished member of the Committee on Education and Labor.

Mr. COURTNEY. Madam Speaker, today, we vote on this bill that improves the Affordable Care Act by cutting the cost of healthcare for families at an unprecedented, anxious time in American life.

More than 2.5 million Americans have been diagnosed with COVID–19. In the insurance world, that means millions more with a preexisting condition.

Astonishingly, in the midst of this healthcare emergency, when we should be protecting coverage, the Trump administration, last week, asked the Supreme Court to strike down the entire ACA.

If Mr. Trump has his wish, those 2.5 million Americans, along with 130 million others with preexisting conditions, will lose the landmark pro-patient protection that has been on the books for the past 10 years, namely, the right to health coverage even if you have been sick before and the confidence and serenity to know that you won't be charged more because of an illness in your past.

It is right there on the first page of the ACA, section 2704: ''Prohibition of preexisting condition exclusions or other discrimination based on health status.''

Yet, the administration in its brief filed with the U.S. Supreme Court a few days ago says: ''The entire ACA must fall.'' That is a verbatim quote.

Well, Madam Speaker, if the ACA falls, preexisting condition protections fall with it, along with age-26 coverage for dependent children and the elimination of lifetime limits on health coverage, which will devastate patients with chronic illness.

□ 1300

Last night, The Wall Street Journal reported that the President once again admitted that neither he nor his Senate majority have the slightest clue what their plan is if their wrecking ball of the ACA succeeds.

Madam Speaker, during the last 4 months' avalanche of layoffs, millions of Americans have desperately reached out to their State's ACA exchanges in search of health coverage after losing job-based insurance, 54,000 just in Connecticut alone.

At this time of severe economic uncertainty when a deadly virus is ravaging communities both rural and urban, we must do everything in our power to strengthen health insurance and make it more affordable, which this bill does. To shrink from this challenge and roll back the clock on 10 years of progress would be a complete dereliction of duty.

Vote ''yes'' on this bill.

Ms. FOXX of North Carolina. Madam Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BISHOP).

Mr. BISHOP of North Carolina. Madam Speaker, I thank the gentlewoman for yielding.

Madam Speaker, Democrats present a false choice: either support the expansion of an already-failed, government-run healthcare scheme, or let people go without healthcare. They want you to think that Republicans and the Trump administration have no ideas about how to expand coverage—not the case.

One of the first bills I introduced after joining last September was the Increasing Health Coverage through HRAs Act. My legislation would codify the Trump administration's rule allowing employers to fund health reimbursement arrangements for their employees.

Thanks to President Trump, these HRAs can now be used to purchase individual market coverage. That change is expected to lead to covering 800,000 more people, all without costly and counterproductive government mandates.

The American people want more choices, lower costs, and increased access to care, not a continued government takeover. I urge Members to vote against H.R. 1425 and for Democrats to work with Republicans on commonsense proposals like mine.

Mr. SCOTT of Virginia. Madam Speaker, I yield 1 minute to the gentlewoman from Oregon (Ms. BONAMICI), the chair of the Subcommittee on Civil Rights and Human Services.

Ms. BONAMICI. Madam Speaker, this is the 10th anniversary of the Affordable Care Act. Over the past 10 years, our country has made significant progress in improving access to affordable healthcare—despite the Trump administration's constant assault on the ACA.

Now, in the middle of an unprecedented global health crisis, the administration is in court trying to get rid of the ACA, including its critical protections for people with preexisting conditions. This threatens the health coverage of more than 20 million Americans, nearly half a million of them Oregonians.

The coronavirus pandemic has been devastating for those with underlying conditions, disproportionately harming Black and Latinx people in communities of color. We should be doing all we can to expand access to affordable healthcare for everyone, not take it away.

I strongly support the Patient Protection and Affordable Care Enhancement Act. This bill will increase coverage, lower costs, and make quality care more accessible for all.

I urge my colleagues to join me in supporting this important legislation to keep millions of Americans covered and build on the legacy of the Affordable Care Act.

Ms. FOXX of North Carolina. Madam Speaker, I yield 2 minutes to the gentleman from Alabama (Mr. BYRNE).

Mr. BYRNE. Madam Speaker, I thank the distinguished ranking member for yielding.

Madam Speaker, to borrow a line from President Reagan: Here we go again.

In the midst of a nationwide pandemic where there is so much work we should be doing for the American people, the Democrat majority has again brought a partisan messaging bill to the floor of the House that is dead on arrival in the United States Senate.

As the majority knows, this bill includes numerous provisions that are nonstarters for Republicans in any legislation related to healthcare, including: expanding ObamaCare, no protections against taxpayer-funded abortion, the rolling back of numerous Trump administration regulations that have made health insurance more affordable, and financial penalties for States that don't expand Medicaid.

Certainly, it seems bad timing to be enacting legislation that the nonpartisan Congressional Budget Office has already confirmed will lead to fewer new drugs on the market, but the Democrats have again included their socialist prescription drug bill in this legislation.

Madam Speaker, there are real areas where we could be working together to find common ground in healthcare. There could be common ground on reinsurance.

Six months ago, Republicans suggested over 40 bipartisan prescription drug provisions we could actually enact that would encourage innovation and groundbreaking new cures and promote low-cost options for patients. We are still waiting on Speaker PELOSI to take up that package of bipartisan bills.

The truth is Democrats are not actually interested in finding solutions. They are interested in ramming political legislation through the House in an effort to influence the 2020 Presidential race and decry additional controversies for Democrat House Members to run on.

Republicans are ready to have a serious conversation about making healthcare more affordable and accessible, but just like with police reform last week, the other side is not.

The American people are ready for us to get back to working for them.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Pennsylvania (Ms. WILD), a distinguished member of the Committee on Education and Labor.

Ms. WILD. Madam Speaker, I thank the chairman for yielding.

I rise in support of the Patient Protection and Affordable Care Enhancement Act, which builds upon the achievements of the ACA, including its coverage of an additional 20 million people.

I am glad to see that the bill includes the tenets of H.R. 3, allowing the HHS to negotiate prescription drug prices rather than continuing to pay the outrageous prices set by companies that

have long blocked competitors from the market.

With the limited time I have to speak, though, I would like to highlight my appreciation that it includes my bill, the Family Health Care Affordability Act, which fixes the family glitch in the ACA.

Under the Affordable Care Act, workers are to have access to affordable healthcare plans, defined as healthcare plans that cost no more than 9.56 percent of the employee's monthly household income. But the interpretation of ''affordable'' only looks at whether coverage is affordable to cover the employee, not whether it is affordable to cover spouses and dependents.

When factoring in the family unit, coverage can easily surpass 25 percent of household income and still be deemed affordable and block the family from marketplace subsidies. This bill fixes that and makes sure that hardworking families have access to coverage without risk of financial ruin.

I call on my colleagues to pass this important bill.

Ms. FOXX of North Carolina. Madam Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. WALBERG).

Mr. WALBERG. Madam Speaker, thanks to my chairman in exile.

Madam Speaker, I rise in opposition to H.R. 1425, the slow coronavirus cures act.

There are many problematic provisions in this bill, but, ultimately, it is yet another political ploy that will not be considered in the Senate or become law, and we don't want it to be because it is not good.

This bill is a step toward nationalizing the drug industry and opening the door to one-size-fits-all, government-controlled rationing of prescription drugs.

Governments don't negotiate; they dictate.

The radical approach taken by H.R. 1425 includes troubling and unprecedented government interference in private, market negotiations, which will eliminate choice and competition and jeopardizes innovation and access to future cures.

Countries that have adopted drug pricing systems like the one proposed in this bill face decreased access to innovative new medicines, increased wait times for treatment, and supply shortages for in-demand drugs. The bill will negatively impact investment and research and development of future treatments, putting breakthrough cures for diseases like Alzheimer's, cancer, and sickle cell disease at risk.

At a time when we have the best minds urgently working on a vaccine for COVID–19, why would we want to slow down the development of lifesaving medications? Congress should be putting in place policies to incentivize difficult research and development for these rare and devastating diseases, not discouraging it.

I stand ready to work with my Democrat colleagues and advance bipartisan legislation that would lower healthcare and drug costs without sacrificing innovation.

But that is not the bill before us today. Sadly, like last week's police reform bill, the majority is once again focused on messaging, not legislating, and that is too bad.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Georgia (Mrs. MCBATH), a distinguished member of the Committee on Education and Labor.

Mrs. MCBATH. Madam Speaker, I thank the chair for yielding.

Madam Speaker, I rise today in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

As a two-time breast cancer survivor, I know how important it is to have access to quality, affordable healthcare, especially for those like me who have preexisting conditions.

This pandemic has shown us that every American needs access to quality, affordable healthcare. Many Americans have lost their employer-sponsored insurance and found affordable health coverage outside of their grasp, outside of their own reach.

The Patient Protection and Affordable Care Enhancement Act incentivizes Medicaid expansion, improves Medicaid coverage, fixes the family glitch, and ensures that every American has access to quality, affordable healthcare. That is our right. That is our right as Americans, to have affordable healthcare, to be able to take care of our loved ones, take care of ourselves and live a good, sustainable quality of life.

There is so much work that needs to be done, but this legislation truly takes important steps to ensuring that every American has the ability to be able to have access to health coverage.

Madam Speaker, I urge my colleagues across the aisle to vote ''yes.''

I am a preexisting condition, and in my district there are over 300,000 people like me who have preexisting conditions—45,000 of those in my district are children under the age of 17—and we deserve to be cared for, and we deserve to have a good quality of life afforded by affordable and good, quality healthcare.

Ms. FOXX of North Carolina. Madam Speaker, I yield 5 minutes to the distinguished gentleman from Tennessee (Mr. DAVID P. ROE).

Mr. DAVID P. ROE of Tennessee. Madam Speaker, I rise today in opposition to H.R. 1425, which doubles down on the flawed premise underlying the ACA and threatens access to lifesaving treatments in the middle of an ongoing public health epidemic.

All of us agree in this country that there is a dire need for healthcare reform. Our current system costs too much, is too complex, and often doesn't promote quality or value. This hasn't changed since the ACA was first passed into law.

Remember, the premise of the ACA was to lower costs and increase access. The scheme that the Democrats set up to accomplish this was an individual mandate to force people to purchase insurance they sometimes couldn't afford, a requirement for all plans to cover government-mandated essential health benefits—10 of them, to be exact—community rating to drive costs up for the youngest consumers, and massive subsidies that, today, are available to families of four with incomes as much as $104,000.

In addition, the bill requires States to greatly expand their Medicaid programs, a requirement that was subsequently mitigated by the Supreme Court.

What are the results? The CBO estimated 4 million individuals would receive coverage through the ACA. In reality, approximately 9 million received coverage, 80 percent of whom are on a highly subsidized plan. Costs exploded, as they tend to do with highly subsidized care, and plans responded by raising copays and deductibles.

I said it before and I will say it again: If you have a $5,000 out-of-pocket, Madam Speaker, for most folks, you don't have insurance; you have a card.

Meanwhile, the competition and plan choice that was promised never materialized. Plan options have decreased over time.

Seventy-five percent of the increases in coverage most likely would have occurred with two reforms: allowing individuals to stay on their parents' plan until age 26, which I agree with, and a simple Medicaid expansion.

□ 1315

Here we are again. Democrats appear to have learned none of the lessons that have become plainly evident since they passed their first government takeover of healthcare. Today we are considering legislation that will significantly expand premium subsidies for ACA insurance while prohibiting the 1332 waivers from States designing their own plans for their populations' unique needs.

One of the best examples of these waivers is Maryland—hardly a conservative State—which reduced premiums for its residents an average of 13 percent in 2019 and an average of 10 percent in 2020. The Democrats want to block this. I have no Earthly idea why.

That is not all.

The most outrageous aspect of this legislation is that it would offset the cost expansion of the ACA by allowing government bureaucrats to set drug prices. This is a provision that—if it sounds familiar, it is, because it was the heart and soul of H.R. 3, the Democrats' flawed drug pricing plan from December—that would have reduced access to new lifesaving treatments. Every study that examined H.R. 3 concluded that it would stop cures from coming to market. They only disagreed on how many cures it would stop. Our country currently leads the way in bringing new medications to market. It would save lives and improve patients' quality of life.

In fact, at this very moment American innovators are working at light speed to develop and mass-produce a COVID vaccine. The idea of passing legislation that discourages this type of innovation is absurd.

My first in-patient pediatric rotation in medical school in Memphis was at St. Jude's Children's Hospital. At that time, Madam Speaker, 80 percent of those children that I saw died. Today, 80 percent of those children live. If we don't stifle innovation, my prayer is that 100 percent of these children will survive in the future.

While Democrats continue to double down on the failure of ObamaCare, the Trump administration has been working to implement reforms that actually work and has acted aggressively in these last few months, in particular, to modernize our healthcare system and ensure patients continue receiving care during this pandemic. The Trump administration has been working to give patients new insurance options through short-term plans which cover only benefits essential to that patient. They have a potentially game-changing rule to increase transparency in hospital prices. They have expanded telehealth in Medicare—which I use today—given States the authority to experiment with plan design and encouraged States to innovate with their Medicaid programs.

This should be a time for Congress to work together and pursue patient-centered policies that will ensure we have a strong healthcare system to come back to. I hope my Democratic colleagues will work with Republicans in a bipartisan manner to advance policies that increase access to quality care, lower costs for all Americans, and put patients back in charge of their healthcare decision-making.

Madam Speaker, I, once again, urge my colleagues to vote against H.R. 1425.

Mr. SCOTT of Virginia. Madam Speaker, I yield 1 minute to the distinguished gentlewoman from California (Ms. PELOSI), who is the distinguished Speaker of the United States House of Representatives.

Ms. PELOSI. Madam Speaker, I thank the gentleman for his tremendous leadership in bringing this important and historic legislation to the floor. He has been a part of advancing lower costs for healthcare and better benefits for all Americans in his career in Congress. I thank Mr. SCOTT for his tremendous leadership as chair of the Education and Labor Committee and for the opportunity he is giving us today. I salute the gentleman and Chairman PALLONE, the chair of the Energy and Commerce Committee, who has played such an important role in all of this, as well as Mr. RICHARD NEAL, chair of the Ways and Means Committee, so much an important part. These three committees of jurisdiction and the members of their committees have been so essential to its excellence and to its success.

I also salute our freshmen who have been leading the charge to lower healthcare costs and strengthen healthcare protections every step of the way from the first day they arrived in the Congress.

In the election of this past 2018, Democrats made a pledge to the American people. For the people we would do three things. For the people we would lower the cost of healthcare by lowering the cost of prescription drugs and preserving the preexisting medical condition. We are doing that today.

For the people we would not only lower healthcare costs, we had bigger paychecks by building the infrastructure of America in a green way with good paying jobs. We will be doing that the rest of the week.

For the people we would be having cleaner government, and that is what we did the end of last week with the Justice in Policing Act, as well as part of our H.R. 1, voting for statehood for the District of Columbia. There is certainly more to come on the cleaner government front as we fight for voting at home and removing obstacles to participation.

But here today we are focused on that first for the people priority. Access to affordable care is a matter of life and death. That is so self-evident as we see every day during the COVID–19 crisis which now has killed more than 125,000 Americans, infected over 2.5 million Americans, and left tens of millions of people without jobs.

As Dr. Martin Luther King, Jr. once said: ''Of all the forms of inequality, injustice in health is the most shocking and most inhuman because it often results in physical death.'' Yes. As lives and livelihoods are shattered by the coronavirus, the protections of the Affordable Care Act are more important now than ever, and this is a health justice issue.

Democrats with this bill will strengthen America's health and financial security during this time of crisis and for years to come. It lowers Americans' healthcare coverage costs: Significantly increasing the Affordable Care Act's affordability subsidies to be more generous and cover more middle class families. It negotiates lower prescription drug prices: Drawing from our H.R. 3 legislation to ensure that Americans no longer have to pay more for our medicines than Big Pharma charges for the same drugs overseas.

This has been a long-term goal of Democrats in the Congress. In 2006 when we were running and won the majority, our For the People equivalent agenda was a new direction for America, Six for '06, and we had six bills that we said we would pass immediately upon obtaining the majority. We passed all six of them in the House of Representatives. Five of them became law. Only one of them did not, the law enabling the Secretary of HHS to negotiate for lower prescription drug prices. This has been a fight over the years we continue to make because it is central to not only the health but the financial health security of America's working families.

In addition, this legislation expands coverage and pushes holdout States to adopt Medicaid expansion for the 4.8 million cruelly excluded from the coverage.

It combats inequity in health coverage faced by communities of color, expands more affordable coverage to vulnerable populations, and fights the maternal mortality epidemic.

And it cracks down on junk plans which are such a rip—let me just pay you all the time for my health insurance but you won't be there for me when I need care. So it cracks down on those junk plans and strengthens protections for people with preexisting conditions.

What is interesting in this whole debate is to hear the President and Members on the other side of the side say that, oh, they are all for protecting preexisting conditions.

Oh, really?

Then why are you in the Supreme Court of the United States to overturn them?

Now, just back to this bill. According to analysis from the Center for Budget and Policy Priorities, our legislation that we have on the floor today will help lower the costs for well over 17 million more Americans and safeguard the Affordable Care Act's lifesaving protections for 130 million Americans with preexisting conditions.

When they say they are for allowing people with preexisting conditions to get coverage, they don't say at what cost. This is one of the biggest differences—well, with stiff competition—but one of the biggest differences between Democrats and Republicans on healthcare for Americans. We guarantee affordability and protect the preexisting medical condition as not being an obstacle to access. They are in Court trying to overturn it.

Sadly—and this is a stark contrast, as I point out—as Democrats unveiled our lifesaving legislation last week, President Trump went to the Court doubling down on his lawsuit to tear down the ACA and dismantle every one of its protections, including the preexisting medical condition benefit. At a time when families need healthcare more than ever, the President is trying to strip protections from about 130 million Americans with preexisting conditions and take coverage away from 23 million Americans. That does not even go into what he is trying to do to the enhanced benefits that all Americans with healthcare enjoy.

We need to build on the progress of the Patient Protection and Affordable Care Act to lower health costs and prescription drug prices, not rip away American healthcare in the middle of a pandemic.

What sense does that make?

On day one of this Congress led by Representative COLIN ALLRED, the House voted to throw our full legal

weight into defending this lawsuit. Yet more than 190 Republicans have voted against that resolution, choosing to be fully complicit in the President's attempt to tear away health protections. We continue to call on the President to abandon his lawsuit to destroy the Affordable Care Act and urge him instead to call on the 14 States who have refused to expand Medicaid to do so.

Doesn't it just make sense at the time of a pandemic? It is always important.

It would have been amusing if this were not so deadly serious to hear Senator CORNYN say: Well, these people who have lost their jobs because of this pandemic could always sign up for the Affordable Care Act.

Really?

But he is trying to take it down.

The administration has a responsibility to defend the law of the land, not to tear it down. Today, Members of Congress have a choice to strengthen America's healthcare protections and lower healthcare costs or to be complicit—once again, I use that word—in President Trump's campaign to dismantle families' healthcare. Make no mistake. A vote against this bill is a vote to weaken America's health and financial security during a pandemic.

When I was growing up, I remember my mother used to always say: If you don't have your health, you don't have anything.

Health is so central. As you see, the American people place a high value on it when they say they don't want to go out too soon to jeopardize their health or the health of those they have at home.

So, in every language when people salute each other they salute people to their health. The Spanish say salud, the Dutch say proost, the French say sante, the Germans say prost, the Irish say—now, this is hard because Gaelic is a hard language—slainte, the Italian I can say better, salute, and in Hebrew it is l'chaim.

It is all about life and health. That is the salute. Everybody knows it is centrally important. With this bill Democrats in the House are offering our salute to good health to the American people, and we hope the Republicans will join us in that salute to good health to the American people.

Madam Speaker, I urge a strong vote for the Patient Protection and Affordable Care Enhancement Act for the people, for the children, and for the future.

□ 1330

Ms. FOXX of North Carolina. Madam Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. ALLEN).

Mr. ALLEN. Madam Speaker, I am really disappointed with, once again, my colleagues across the aisle using this COVID–19 crisis as an opportunity to push their partisan agenda. You would think a crisis like this would bring us together.

And this thing is going nowhere. H.R. 1425 is nothing more than another government power grab in an attempt to double down on the failed policies of ObamaCare.

Remember the promise that was made to lower your premiums? Yet, they have skyrocketed. Not only does this bill rescind the Trump administration's rule on short-term, limited duration insurance, which aims to provide relief from rising premiums and flexibility for consumers, it also implements government price-setting for drugs.

The American people want choice, not one-size-fits-all, top-down, Big Government programs. Why in the world would you send a hard-earned tax dollar to Washington and maybe get 20 cents back to take care of a patient?

Madam Speaker, I made a promise to the people of Georgia's 12th District that I would fight to lower drug prices, and this bill would lead to drug price hikes and shortages. Under this proposal, the Secretary of HHS would be required to set government rates for a number of lifesaving drugs, like insulin. The CBO estimates that price-setting policies like these will result in fewer cures and treatments coming to the market.

H.R. 1425 would expand ObamaCare after we spent years working to roll back the burdensome mandates that the American people cried out for Congress to repeal.

As I said, the American people want choice. My Democrat colleagues have allowed the far-left radicals within their party to take over their agenda.

Let's be clear what the Democrats want here. They want the government to be in charge of your healthcare, of everyone's healthcare. Democrats believe they and their fellow bureaucrat friends know what is best for your healthcare, not your doctor. I can tell you right now that, in my district, we know better and can see right through these schemes.

Now more than ever, for the sake of our country, we must come together to provide real healthcare solutions, not far-left political messaging bills. Unfortunately, it is business-as-usual here for the Democrats, putting policies over country.

Madam Speaker, I urge my colleagues to oppose this bill.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. SCHRIER), a distinguished member of the Committee on Education and Labor.

Ms. SCHRIER. Madam Speaker, I thank the chairman for yielding.

Madam Speaker, I rise in support of the Patient Protection and Affordable Care Enhancement Act.

As a pediatrician, and a patient with type 1 diabetes, I know how important it is to have real access to healthcare. The Affordable Care Act was a phenomenal first step. It provided protection for 26 million Americans with preexisting conditions who otherwise would not have had access to health insurance, made sure young people were covered until age 26, and designated primary care and access to birth control as essential.

Of course, it was imperfect. It was intended to be a first step. Now, with 10 years of experience, we know how to improve it by addressing the serious issues of cost and access.

The Patient Protection and Affordable Care Enhancement Act does just that, with a special emphasis on children and communities of color who, for too long, have faced health disparities.

Also, with this bill, a family of four in my district would save an estimated $8,000 a year on health insurance. This legislation provides permanent funding for the Children's Health Insurance Program so that children will be able to get healthcare they need right from the start. I am particularly excited that this bill also includes the Kids' Access to Primary Care Act, a bipartisan bill I introduced to expand primary care access for children and families on Medicaid.

By matching Medicaid reimbursement rates to higher Medicare rates, Medicaid patients will have access to more physicians, and children will get the care they need when they need it from their very own primary care physician. That kind of access to care should not depend on ZIP Code, income, or skin color.

The toll this pandemic has taken on already disadvantaged communities drives home the need for everyone to have affordable access to the care they need. That is why this bill, the Patient Protection and Affordable Care Enhancement Act, is so important.

No family should ever face bankruptcy because of medical expenses. As one of the few doctors in Congress, I will always work to ensure that everyone can afford the care they need.

Ms. FOXX of North Carolina. Madam Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. SMUCKER).

Mr. SMUCKER. Madam Speaker, I start by wishing the ranking member of the committee a very happy birthday and a wonderful day.

Madam Speaker, I rise today in opposition to H.R. 1425.

I do agree with my colleagues on both sides of the aisle that we need to enact reforms that will make health insurance and access to care more affordable. I also agree that we need to protect individuals with preexisting conditions. But the approach under the legislation being debated today will not bring us closer to a better-functioning marketplace. It is like putting a Band-Aid on a broken system.

To truly lower the costs of insurance and care, we need to address the underlying cost drivers of healthcare. Yet, the legislation before us today ignores what is driving prices higher. Instead, it broadens government subsidies to

more individuals, including the wealthy, so that, on its face, the price of insurance looks cheaper. But don't be fooled by generous tax credits. These credits will be paid for by all taxpayers when they are passed along to hardworking families in the form of higher taxes.

Madam Speaker, I would welcome the opportunity to work with my colleagues on the other side of the aisle on real reforms that will increase choices for insurance and care options; that will cut through healthcare monopolies to increase competition in the marketplace; that will allow for more personalized plans that will better target taxpayer-funded subsidies to the poor, the sick, and the vulnerable, not high-earning individuals; and that would enable a system that fosters innovation in patient care, not stifle it through burdensome government mandate.

Before I close, I want to touch on my colleagues' decision to include the same government-controlled drug-pricing scheme in this patchwork of stale proposals that was passed a few months ago. At a time when the world is fighting to emerge from a global pandemic, my colleagues on the other side of the aisle believe it is an appropriate time to raise taxes on lifesaving cures by 95 percent.

We have already worked, in a bipartisan manner, on policy ideas that we all agree will help lower drug prices. Each of those policies was included in H.R. 19, the Lower Costs, More Cures Act.

Madam Speaker, I hope, one day, we can set the shenanigans aside and bring real reforms, like those included in H.R. 19, up for consideration.

Mr. SCOTT of Virginia. Madam Speaker, I yield 1 minute to the gentleman from Maryland (Mr. HOYER), the distinguished majority leader of the United States House of Representatives.

Mr. HOYER. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, I have only been on the floor a short time, but I am sure there have been the repeated opposition statements that: ''Oh, if only we could get agreement.'' ''If only we could do this, we would have a wonderful healthcare program.''

Madam Speaker, frankly, my friends on the other side of the aisle have had 12, 14 years, at least, to come up with a program.

Madam Speaker, they did come up with a program, and they passed it through the House—they were in charge—and it went to the Senate. The Republicans were in charge of the Senate.

When they passed it through the House, they all went down to the White House, and they had a big party. ''What a wonderful deal this is.'' Lo and behold, within 2 weeks, the President, who was extolling that bill, called it a ''mean'' bill.

That is not me. That is the President of the United States about the bill that he was celebrating with his Republican colleagues.

The Republicans talk a good game, but they don't play a game. It is not that they don't play a good game. They don't play a game. There is no bill coming from the President of the United States.

Madam Speaker, last week, in the middle of the worst pandemic in our lifetimes, the Trump administration submitted briefs to the Supreme Court in support of a lawsuit by Republican-led States seeking to overturn the law that provides millions of Americans with access to affordable healthcare. They offer no substitute. They said they were going to, but they have never done it.

In spite of a decade of Republican efforts—a decade, 10 years—they have had to work on this and come up with a plan that all of them are talking about—''Oh, we want to protect preexisting conditions.'' ''We don't want to have lifetime limits''—you know, all these things.

Where is the bill? Where is the meat? It is not here. It hasn't been offered. The one bill that was offered and passed in this House was called by the President of the United States a ''mean'' bill.

Not our President, their President—I mean, he is the President of all of us, but he is a member of the Republican Party, just like Obama was a member of the Democratic Party.

We passed an alternative. It was signed, and the majority of the American people supported it. As a matter of fact, 53 percent of independents supported it.

Madam Speaker, when the Supreme Court hears oral arguments in the Republican lawsuit this autumn—in the Republicans' lawsuit; these are Republican AGs—it will hear their arguments for taking away protections for those with preexisting conditions, those most vulnerable to COVID–19, at the very moment healthcare experts predict another wave of infections and the start of the flu season. And where do we see the spike? Along the southern border: Texas, Florida, Arizona.

Madam Speaker, taking away Americans' coverage and throwing our healthcare system into chaos is not what the American people want or need during this global public health and economic crisis. When President Trump ran for office—this was before he called the bill that the House passed a ''mean'' bill, under Republican leadership—President Trump falsely promised that he would offer an alternative to the Affordable Care Act that was far less expensive and better quality.

Madam Speaker, I ask any of my colleagues if they have seen that bill, either side of the aisle, have they seen that bill. This President has been President for 3.5 years. There is no Republican bill to make sure that Americans have affordable quality healthcare and have them able to get insurance irrespective of preexisting conditions. There is no such legislation.

Now, having failed to produce an alternative, the President and his Republican allies are determined simply to repeal it entirely. That has been their position for the last 12 years.

I am proud that one of the first acts of our Democrat House majority was to defend the ACA in the Republican lawsuit. Indeed, Americans don't want to scrap the law. They want to strengthen and expand it.

They understand that it is not an option, having healthcare coverage. Protecting your health is not an option.

When Democrats won the majority in the House, we did so promising to work to expand coverage, lower out-of-pocket costs, and provide greater stability for health insurance marketplaces. That is what we promised, and we picked up 40 net seats. This bill is part of that promise.

Now, we passed another one. It sits untouched in the Senate, as some of my Republican colleagues predict for this one. I understand that. The Republicans are not for healthcare being affordable, being quality, being accessible for people. At least, they haven't offered a bill to accomplish that objective, notwithstanding what the President said.

Importantly, among the other provisions that you have heard about from my colleagues this morning, this legislation addresses the racial disparities in healthcare that have become so starkly evident during this pandemic. Expanding Medicaid will help close those disparities, and the bill's provision to require Medicaid coverage of maternal healthcare for 12 months postpartum will help reduce disparities that make African-American women as much as four times as likely to die as a result of a birth or pregnancy complication than White women.

Those disparities aren't acceptable, and our House majority is taking action to address them.

Madam Speaker, I congratulate Mr. SCOTT. I congratulate Mr. PALLONE. I congratulate Mr. NEAL. And I congratulate Speaker PELOSI.

Moreover, this bill would require the Secretary of Health and Human Services to negotiate over the most expensive prescription drugs that do not have marketplace competition, that do not have market competition. That is what keeps prices down, consumers having choices. If they don't have choices, they have to take the drug, no matter what it costs, which is a key component to lowering prices.

That said, I want to be clear that, while we use international measures, we will continue to work with the patient and disability community to ensure that our efforts to reduce out-of-pocket costs do not have the unintended result of rationing lifesaving and life-sustaining treatments or discriminate against our most vulnerable communities.

Madam Speaker, I thank all the chairs and their committees that came together to produce this bill. I have

mentioned Chairman PALLONE, Chairman SCOTT, Chairman NEAL, and others, and I thank all the Members who were instrumental in bringing these policies together, including the many freshman Members who ran on strengthening the ACA.

I see Ms. UNDERWOOD on the floor, but there are many others in the freshman class who have worked very hard. Why? Because they campaigned on For the People, bringing costs down.

I urge every Member of the House to join in supporting this bill. Now is the time, Madam Speaker, to strengthen access to high-quality, affordable healthcare, to bring costs down, and to address the stark racial disparities in our healthcare system that have come into full view with COVID–19.

I urge all my colleagues on both sides of the aisle, if your rhetoric is about bringing costs down, if your rhetoric is about accessibility, if your rhetoric is about equality, walk the walk; don't just talk the talk. Vote for this bill, because it does what you say you want to do.

□ 1345

Ms. FOXX of North Carolina. Madam Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. UNDERWOOD), a distinguished member of the Committee on Education and Labor.

Ms. UNDERWOOD. Madam Speaker, I rise today in strong support of the Patient Protection and Affordable Care Enhancement Act.

Last June, I visited Kaylee Heap at her family's farm in Minooka, Illinois. Mrs. Heap told me: It would be really nice to come home and work on the farm with my husband and grow our business, but I can't do that until we overcome the obstacle of getting quality, affordable health insurance.

People like Kaylee are why I introduced legislation, the Healthcare Affordability Act, to improve premium tax credits to make insurance more affordable to more Americans, including those who don't currently qualify for tax credits.

This legislation would reduce premiums by hundreds or thousands of dollars for nearly 20 million Americans, and I am so pleased that it was included in this bill today.

This bill delivers on our promise to ensure that all Americans have access to quality, affordable healthcare. I urge all of my colleagues to support this bill and join me in this effort.

Ms. FOXX of North Carolina. Madam Speaker, I reserve the balance of time.

Mr. SCOTT of Virginia. Madam Speaker, may I inquire as to how much time each side has remaining.

The SPEAKER pro tempore. The gentleman from Virginia has 11 minutes remaining. The gentlewoman from North Carolina has 4½ minutes remaining.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. TRONE), a distinguished member of the Committee on Education and Labor.

Mr. TRONE. Madam Speaker, healthcare is a human right. The Affordable Care Act helped us live up to that value by giving over 20 million American people healthcare coverage, including millions with preexisting conditions.

But still, too many Americans don't have access to good, affordable healthcare, and drug prices are through the roof.

One of those Americans is Suzette from Germantown, Maryland. Suzette told me that her insulin prices have skyrocketed over the last year, making it hard to afford a drug that she needs to survive. As Elijah Cummings said: We are better than that.

The Patient Protection and Affordable Care Enhancement Act will cut premiums in half; allow negotiations for drug prices; and expand Medicaid, a lifeline for many who need support for mental health and addiction treatment services.

During a global pandemic, we should be acting with compassion for the most vulnerable in our country. This bill does just that. I urge a ''yes'' vote.

Ms. FOXX of North Carolina. Madam Speaker, I reserve the balance of time.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentlewoman from Nevada (Mrs. LEE), a distinguished member of the Committee on Education and Labor.

Mrs. LEE of Nevada. Madam Speaker, on behalf of the people of Nevada's Third Congressional District, I rise today to stand up for my constituents' access to healthcare and lifesaving treatments and support the Patient Protection and Affordable Care Enhancement Act.

A constituent of mine, Mark, wrote to me recently. He is retired and on Medicare, and he is also a diabetic who requires insulin to survive. He told me that the cost of his insulin is going up 400 percent, with no warning or explanation. It is life or death for him, because he needs the insulin but can't afford it.

This moment should give us all pause. Millions are out of work; thousands are sick and dying from a global pandemic; yet lifesaving medications are still out of reach for Americans who need them.

It is unbelievable that this administration continues its campaign to take away people's healthcare. Seniors like Mark deserve better, Nevadans deserve better, and Americans deserve better.

Medication costs, rising premiums, and junk insurance plans are forcing people to choose between lifesaving treatment and paying their bills. No one in this great country should have to make that choice.

I urge my colleagues to vote for the Patient Protection and Affordable Care Enhancement Act, and give every American access to affordable health care.

Ms. FOXX of North Carolina. Madam Speaker, I reserve the balance of time.

Mr. SCOTT of Virginia. Madam Speaker, I yield 2 minutes to the gentleman from Rhode Island (Mr. CICILLINE).

Mr. CICILLINE. Madam Speaker, I thank the gentleman for his extraordinary leadership. I thank Chairman SCOTT, Chairman NEAL, and Chairman PALLONE.

122,000 Americans have died from COVID–19, nearly 2.6 million are infected. And, in the midst of this deadly and historic global health pandemic, with infection rates continuing to rise all across our country, there has never been a worse time to try to rip away healthcare from the American people.

But just last week, President Trump and my Republican colleagues filed a pleading in the Supreme Court to take away healthcare from 20 million Americans and to gut protections for 135 million Americans with preexisting conditions.

Now, more than ever, Democrats are standing up to fight to protect access to quality, affordable healthcare. And the Patient Protection and Affordable Care Enhancement Act does just that. It lowers healthcare costs; it protects patients with preexisting conditions; it expands Medicaid; and it lowers the cost of prescription drugs.

Our colleagues on the other side of the aisle have described these ideas as radical. Only in the Republican Conference is expanding health coverage and driving down costs and covering more people with preexisting conditions radical. For the rest of the American people, it is a basic human right: access to quality, affordable healthcare. The Patient Protection and Affordable Healthcare Enhancement Act will do just that.

My colleagues have been on a relentless campaign to repeal the Affordable Care Act in its entirety and promised they were going to repeal and replace. They have only tried to repeal. There has never been a replacement.

Once again, we are stepping into the breach, building on the success of the Affordable Care Act in the midst of a global health pandemic to drive down healthcare costs, expand coverage, and protect people with preexisting conditions.

I urge my colleagues to vote ''aye.''

Ms. FOXX of North Carolina. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, propagandists have said that if one repeats a lie often enough, people will soon believe the lie and not the truth. My colleagues are entitled to their own opinion but not to their own facts or rewriting history.

I want to repeat some comments from my Texas colleague, Mr. BRADY, who spoke earlier in this debate.

Republicans support children, seniors, and patients with preexisting conditions.

Republicans created the popular Children's Health Insurance Program that millions of families rely on today.

Republicans created the prescription drug program in Medicare to help seniors get the medicine they need.

Republicans created the first law that established protection for patients with preexisting conditions. That law, passed in 1996, is the Health Insurance and Portability Act of 1996.

We want people to have access to high-quality, affordable healthcare that fits their needs and make their own choices, not what Speaker PELOSI demands for them.

Madam Speaker, the devastating effects of COVID–19 are still being felt across our Nation, yet today Democrats are spending time pushing a deeply flawed, partisan bill that is being used to score cheap political points instead of working on bipartisan solutions like lowering drug costs, ending surprise billing, and getting our economy back on its feet.

We are left with H.R. 1425, a radical bill which will limit healthcare choices, increase costs, and double down on the failures of the Affordable Care Act. No innovation, investment, or solutions, just more of the failed status quo from House Democrats, which will go nowhere after the vote today.

Contrary to what Speaker PELOSI said, Democrats do not and cannot, in this bill, guarantee affordability of healthcare. What they do guarantee is government control with rationing, fewer cures, and less freedom for Americans. Republicans believe in just the opposite.

Madam Speaker, I strongly urge a ''no'' vote on H.R. 1425, and I yield back the balance of my time.

Mr. SCOTT of Virginia. Madam Speaker, I yield myself the balance of my time.

Madam Speaker, this bill will reduce the cost of prescription drugs. Americans pay twice as much, three times as much, as much as 10 times more than those in other countries pay for the exact same drugs. This bill will allow the Department of Health and Human Services to try to negotiate better prices.

Those on the other side have criticized reduced prices because they potentially could reduce investments and research, but this bill offsets any such reductions with significant increases in investment in research at the National Institutes of Health.

This bill makes improvements to the Affordable Care Act by reducing premiums, expanding coverage to families, protecting those with preexisting conditions, and reducing the number of uninsured.

We have heard criticisms but no description of a better alternative.

We have heard about the 1996 law on preexisting conditions, but that did nothing in the individual market. And that is what the Affordable Care Act protects: preexisting conditions in the individual market.

But look at what the CBO said about the Republican bill when they had the majority and were able to pass a bill. They actually passed a bill that CBO scored, and they said that it would increase costs 20 percent the first year, 20-some-million fewer people would be insured, those with preexisting conditions would lose some of their protections, and the insurance you get is worse than what you have.

We can do better than that by passing the Patient Protection and Affordable Care Enhancement Act, and that is what we should do today by voting ''yes'' on this legislation.

Madam Speaker, I yield back the balance of my time.

Ms. JOHNSON of Texas. Madam Speaker, today, I rise in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act. This bill will make critical improvements to our current health care system by ensuring affordable access to medical services and lifesaving prescriptions. By expanding the insurance affordability subsidies, establishing a federal negotiating authority for lower drug prices, and extending Medicaid coverage to crucial populations, this legislation will ensure that our communities can better withstand and recover from the seismic impact of this COVID–19 pandemic.

It is inacceptable that during this public health emergency, our federal government should act in any manner except to strengthen and protect our health system. The current administration's request last week to the Supreme Court to overturn the Affordable Care Act threatens the very protections and medical services that our constituents and communities are relying on for life saving care during this pandemic.

As the first registered nurse elected to Congress, I can attest to the importance of the Affordable Care Act in improving our country's health care, especially through the protections for the 133 million Americans living with preexisting conditions—of which 11.5 million live in my home state of Texas. If our country were to lose the gains of the Affordable Care Act, all these individuals will have to face uncertain insurance markets without critical protections. It is more abhorrent for any efforts to be made to destabilize our health system during a time of crisis, especially since our communities of color are already facing disproportionate impacts of this virus through higher rates of comorbidities and higher reported rates of hospitalizations and deaths. To further jeopardize access to existing health care services amidst these compounding factors would prove devastating for the health and wellbeing of our minority communities.

Therefore, I am proud to support the Patient Protection and Affordable Care Enhancement Act, and I am committed to fighting for the preservation of accessible and quality health care services for the families throughout North Texas.

Ms. MATSUI. Madam Speaker, I rise today to support the Patient Protection and Affordable Care Enhancement Act.

This legislation is the collective achievement of House Democrats from across the country who are working to reverse the Trump Administration's health care sabotage by updating and improving the Affordable Care Act.

This bill expands eligibility for health care tax credits to purchase ACA plans and encourages remaining states to expand Medicaid. These concrete steps will provide new coverage options to those navigating recent job loss and economic uncertainty.

Critically, this legislation also empowers Medicare to negotiate a better deal on prescription drug prices, which will bring an end to price gouging of American consumers and finally allow people to afford the drugs they need.

As the pandemic continues to challenge our collective public health and well-being, now, more than ever, American families need relief from soaring health care and prescription drug costs.

I encourage my colleagues to support this effort to protect patients, expand access, and lower health care costs.

Mr. CURTIS. Madam Speaker, today, I rise in opposition to H.R. 1425. Right now, we must deliver the most effective treatments to patients infected with COVID–19 and all those suffering from other life-threatening illnesses. Breaking down barriers to receiving timely care must remain our number one priority in order to halt transmission of the virus.

H.R. 1425 does the opposite by dramatically expanding the role of government through unconstitutional inventions in our pharmaceutical industry and broader healthcare system. This would put our brightest scientific minds in handcuffs and threaten their ability to develop future cures for COVID–19 and other life-threatening diseases.

These are especially concerning decisions to make without bipartisan input. We have to work together in order to deliver solutions that give Americans more control over how they are receiving their health care. Solutions could include expanding access to health savings accounts or association health plans to be sold across state lines and with more portability. I recently introduced legislation to increase access to both options and I encourage my Democratic colleagues to join me as I look for creative solutions to make health care more affordable for millions of hard-working Americans.

Finally, I want to point out that Congress has already taken unprecedented steps to increase access to care for the uninsured and any American household dealing with the effects of COVID–19. It is critical that our focus remains defeating this virus, keeping Americans healthy, and allowing hard-working men and women across our great nation to return to work. We cannot place greater strains on our already over-worked health care system through one-size-fits-all policy making.

Ms. ROYBAL-ALLARD. Madam Speaker, ten years ago, this March, I proudly cast my vote in support of the Patient Protection and Affordable Care Act. The ACA built on the promise that was begun with the passage of Medicare in 1965, which represented a milestone in our nation's history by framing healthcare as a universal right for all Americans.

Like many of my colleagues at that time, I would have preferred to see the bill go much further towards granting universal access to health care for every man, woman, and child in this country. Nevertheless, it was an important first step to improving the quality and affordability of health services, prioritizing prevention and the reduction of health disparities, and taking the necessary albeit difficult steps to rein in the escalating costs of health care in this country.

The intent of the Democrat Majority in the 111th Congress was always to build on the ACA and modify and improve its programs and policies. Instead, what followed was at least 70 Republican led attempts over the next 8 years to defund benefits, dismantle programs, and repeal parts, or all, of the Affordable Care Act, with no serious effort to fix problems or replace the critical law with a viable alternative.

For the last three years, Democrats have watched in frustration as a series of misguided and meanspirited Presidential executive orders have slashed funding, delayed implementation of programs, and limited benefits for consumers. And when President Trump's ''Repeal and Replace'' efforts failed, his administration turned to the courts to declare unconstitutional all, or parts, of the ACA.

Today, with the Patient Protection and Affordable Care Enhancement Act, we say ENOUGH IS ENOUGH. This important legislation will strengthen and expand the Affordable Care Act by including provisions to reduce the cost of prescription drugs, reduce the number of uninsured Americans, expand access to quality and affordable health coverage, and protect people with pre-existing conditions.

The bill expands Marketplace tax credits to lower health insurance premiums and allows more middle-class individuals and families to qualify for subsidies. It expands Medicaid coverage for states who have not taken advantage of this provision and reverses the Trump Administration's expansion of junk health insurance plans that discriminate against people with pre-existing conditions. The bill also requires the federal government to negotiate certain drug prices to ensure consumers have access to affordable and fair prices for drugs they depend upon to live healthy and productive lives.

According to the Congressional Budget Office (CBO), this bill would reduce the number of uninsured by 4 million below the current law, and it would lower individual market premiums by 10 percent and drug prices by up to 55 percent.

Americans have overwhelmingly told us their number one concern is access to high quality and affordable health care. H.R. 1425 builds on the ACA and takes the next critical step towards reducing health disparities and providing more families with affordable and comprehensive health insurance. I am proud to vote YES for the Patient Protection and Affordable Care Enhancement Act.

Mr. DEFAZIO. Madam Speaker, today I will vote in support of H.R. 1425, the Patient Protection and Affordable Care Enhancement Act.

I am pleased that this legislation bolsters the Affordable Care Act (ACA) and further protects it against years of attempts by the Trump administration and congressional Republicans to undermine and repeal this important healthcare legislation—and thus take away health coverage and protections from millions of Americans—all without ever proposing a viable replacement.

The timing of this legislation could not be more crucial. Just last week, in the midst of a global pandemic that has killed more than 120,000 Americans and threatened the health insurance coverage of millions more, the Trump administration filed a legal brief to the Supreme Court supporting a case that would fully repeal the ACA. This reckless and heartless move would strip healthcare coverage from an estimated 23 million Americans and threaten coverage for 135 million Americans with pre-existing medical conditions—all while delivering a huge tax cut to millionaires. In my congressional district alone, repealing the ACA would cause 72,000 Oregonians to lose their health insurance and threaten the coverage of 317,000 Oregonians with pre-existing conditions. This is absurd.

That's why I strongly support H.R. 1425's provisions to strengthen protections for individuals with pre-existing conditions, as well as its reversal of the Trump administration's expansion of junk short-term health insurance plans that do not provide coverage for essential medical treatments and drugs—and which are allowed to discriminate against people with pre-existing conditions. I am also pleased that this legislation increases healthcare coverage by delivering additional support for states to expand Medicaid, establish state-based health insurance marketplaces, and bolster efforts to increase enrollment and help individuals sign up for ACA coverage.

I also strongly support this legislation's efforts to lower Americans' health insurance costs by expanding tax credits to reduce ACA marketplace premiums, placing a cap on premium costs, allowing more individuals and families to qualify for ACA subsidies, and providing funding for reinsurance initiatives to further lower premiums, deductibles, and other out-of-pocket costs.

This legislation also takes long-overdue steps to help combat inequalities in health coverage faced by communities of color in Oregon and throughout the United States. This includes fighting the maternal mortality epidemic by requiring states to extend Medicaid or CHIP coverage to new mothers for 1-year post-partum; improving Medicaid beneficiaries' access to primary care physicians; and protecting vulnerable populations from losing health coverage by ensuring that Medicaid and CHIP beneficiaries receive a full 12 months of coverage once enrolled—thereby protecting them from interruptions due to fluctuations in their income throughout the year.

I have always said that the ACA is not perfect, but I believe the law should be reformed rather than repealed. The original ACA bill that passed the House in 2009, with national exchanges and a government not-for-profit option, was far superior than the final bill that became law. In my opinion, a government-run, not-for-profit health plan would have paved the way to a single-payer system with more comprehensive coverage at a lower cost. That's why I have once again introduced legislation, H.R. 1419, that would establish such a plan and bring down premium costs.

I am also once again an original cosponsor of H.R. 1384, the Medicare for All Act, which would transition the U.S. to a universal single-payer system to ensure that everyone has access to health insurance coverage, no matter their income.

Additionally, because of pharmaceutical companies' price gouging, Americans pay more out-of-pocket for prescription drugs than individuals in any other country. Americans need lower drug prices now, and Congress has the ability to enact important reforms to deliver immediate relief.

By incorporating provisions from H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act—which passed the House in December—I believe H.R. 1425 takes some important first steps towards delivering drug price relief and improving the health and financial security of American seniors and families. Specifically, H.R. 1425 requires the federal government to negotiate affordable prices for at least 25—and eventually 50—prescription drugs, as well as insulin, every year. It also imposes an excise tax on drug manufacturers who do not comply with this affordable pricing provision.

While I believe these provisions will ultimately deliver relief to millions of Americans, including seniors, I believe Congress can and must do more to combat rising drug prices and price-gouging pharmaceutical companies.

To combat this ridiculous practice, I reintroduced H.R. 4640, the Affordable Drug Pricing for Taxpayer-Funded Prescription Drugs Act, which would end price-gouging on prescription drugs developed with taxpayer-funded research. Americans should not pay to develop a drug only to see it put on the shelves in the U.S. at a much higher price than other nations. I am also co-leading legislation, the Make Medications Affordable by Preventing Pandemic Pricegouging Act, to prevent price-gouging for any taxpayer-funded drug or vaccine developed to treat COVID–19.

Moreover, I have consistently supported legislation to allow the federal government to negotiate affordable drug prices for Medicare Part D, and I am also cosponsor of legislation to require the federal government to secure affordable pricing agreements for all prescription drugs, as well as to approve cheaper generic versions of drugs if manufacturers refuse to negotiate.

The bottom line is that seniors shouldn't have to ration their pills or limit their dosage because they can't afford to pay for prescriptions each month, and drug companies should not be free to charge Medicare recipients—or any American—prices that are higher than anywhere else in the world. These practices are wholly unacceptable, and I will continue fighting to ensure that every American can afford the prescription drugs they need.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 1017, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

□ 1400

MOTION TO RECOMMIT

Mr. WALDEN. Madam Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. WALDEN. Madam Speaker, in its current form, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Walden moves to recommit the bill H.R. 1425 to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

After section 2, insert the following:

SEC. 3. EFFECTIVE DATE.

This Act and the amendments made by this Act shall not take effect unless the Secretary of Health and Human Services, in consultation with the Commissioner of Food and

Drugs, the Director of the National Institutes of Health, and the Director of the National Institute of Allergy and Infectious Diseases, certifies that no provision of this Act and the amendments made by this Act will adversely affect research on, development of, or approval of any drug (including any biological product) intended to treat or prevent infection with the virus that causes COVID–19.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Oregon is recognized for 5 minutes in support of his motion.

Mr. WALDEN. Madam Speaker, this motion should be adopted. It would prevent the bill from upending the very progress we are all counting on for our innovators to develop new vaccines and therapies to confront this killer coronavirus.

You see, it simply states the legislation cannot take effect unless the Secretary of Health and Human Serves certifies that no provision will adversely impact the research, the development, or the approval of any drug intended to treat or prevent COVID–19.

Now, Democrats, with a straight face, come to the floor today to move a bill that would do grave damage to medical innovation. The Congressional Budget Office has told us that on many occasions. Upwards of 30 to 100 drugs, depending upon the source, could never make it into the pipeline. Will that be a cure for COVID or a cure for ALS or a cure for cancer? We don't know, and neither do the Democrats bringing it. But we do know the independent analyses show we will not see a lot of new medicines.

So let's make sure one of those new medicines is not the cure to COVID or a treatment to save lives for people who are on ventilators. That is what our motion to recommit says: Before you move forward with a known innovation killer, let's at least exclude treatments and cures for COVID–19.

Communities are being ravaged, we all know these stories. We all share them with each other about incredible damage done to lungs, organs, and lives as a result of COVID–19. In the wake of this public health crisis, medical innovators have worked at an unprecedented speed to develop safe and effective products so we can safely begin to open our country back up and eventually return to normal lives.

We have seen public-private partnerships to a degree never seen before. Private companies are joining forces with competitors, government agencies, and nonprofits, and they have taken on substantial financial risk in order to bring safe and effective vaccines and treatment to patients as quickly as possible.

But now Democrats, with passage of this bill, want to gut innovation in America.

California Life Sciences tells us the provisions of this bill that were included in H.R. 3 can result in 88,000 innovation tech jobs, R&D jobs going away from America to somewhere else. That is the price of this bill. We know House Democrats voted to impose these dangerous price controls with passage of H.R. 3.

We also know that one of the side benefits, shall we say, of adopting socialized medicine is you don't get access to new medicines when they do become available in as timely a manner as you do here. Compared to the U.S., in Australia, it takes an average of 19 months longer for medicines to become available to patients; for Canada, it is up to 14 months longer; United Kingdom, 11 months longer for those cures for cancer, those new medicines on the market, revolutionary sort of new innovations we all want.

So all we are asking for here is, before your bill becomes law—and, by the way, the administration said they will recommend a veto—before it moves through the path, let's at least make sure that an unintended but dangerous consequence of this bill does not take effect, and that is let's make sure that it will not inhibit research and innovation for a treatment or cure to COVID–19. That is what our motion asks for.

Madam Speaker, I urge a ''yes'' vote on the motion to recommit.

Madam Speaker, I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from New Jersey is recognized for 5 minutes.

Mr. PALLONE. Madam Speaker, I urge my colleagues to vote against the Republican motion to recommit.

This motion to recommit is a distraction, and it provides cover to the pharmaceutical industry to continue to raise prices, just as we have seen them do on thousands of drugs this year alone.

Moreover, my Republican colleagues would have you believe that it is the pharmaceutical industry alone that is responsible for innovation and for funding innovation in this country, which omits the critical role that the Federal Government has played and will continue to play in drug development and the discovery of novel therapies.

Let me be clear, Madam Speaker: The investments in research for COVID–19 treatments and vaccines aren't being put on the backs of the pharmaceutical industry. It is Congress and the American taxpayer who have made unprecedented investments as we race to find a cure for COVID–19.

In response to COVID–19, Congress has invested over $8 billion for innovative biomedical research development and the purchase of new vaccines and therapeutics, including $4.4 billion in the CARES Act, and $3.8 billion in the Supplemental Appropriations Act in the last month or so.

This Enhancement Act combined with the HEROES Act, which the Senate has still not taken up, would more than double this historic investment, bringing it to over $19 billion. And the manager's amendment to this bill is another $2 billion.

So, based on the claims by Republicans here today and this motion to recommit, my colleagues on the other side of the aisle would have you believe that we are forced to choose between two competing alternatives: either finding vaccines and treatments for diseases and viruses like COVID, or reducing drug prices that are gouging American families at the pharmacy counter every day. This is a false choice.

From the Republican perspective, we have no choice but to allow the pharmaceutical industry to continue to go unchecked and rake in record profits at the expense of those who need lifesaving medicines. But it is fearmongering at its worst, and it is blatantly untrue. This Nation can and is doing both. There is more than enough spending in the system to reduce drug prices and ensure we do not impact research and development for treatments and cures, including a vaccine for COVID–19.

We know that most big pharmaceutical companies spend more on marketing, sales, and overhead than research and development, and there is no reason why American families are forced to pay 3, 5, or 10 times more for the same treatments as those in other countries. It is simply unfair.

That is why new polling has shown that 9 out of 10 Americans support direct negotiations by the Federal Government for the price of a treatment for COVID–19 and why people are scared that they are going to be gouged for coronavirus treatment when it is available, just like they have been so often gouged by other drugs that their families have needed to stay healthy.

So the bottom line, Madam Speaker: We can have innovation and lower costs, and that is what this underlying bill does. This bill will establish a fair price negotiating program that rewards true innovation by directing the Secretary to prioritize a drug's research and development spending, as well as the extent to which a drug represents a true therapeutic advance over existing drugs.

Madam Speaker, I urge my colleagues to reject the motion to recommit. We know that, in the last few months, drug prices have gone up tremendously around the country, and drug prices increasingly take a larger percent of your healthcare cost. People simply can't afford it, and that is why this bill is necessary. Do not believe the false choice of my Republican colleagues.

Madam Speaker, I urge my colleagues to vote against the motion to recommit.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. WALDEN. Madam Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 965, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

EMERGENCY HOUSING PROTECTIONS AND RELIEF ACT OF 2020

Ms. WATERS. Mr. Speaker, pursuant to House Resolution 1017, I call up the bill (H.R. 7301) to prevent evictions, foreclosures, and unsafe housing conditions resulting from the COVID–19 pandemic, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. CUELLAR). Pursuant to House Resolution 1017, the bill is considered read.

The text of the bill is as follows:

H.R. 7301

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Emergency Housing Protections and Relief Act of 2020''.

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

TITLE I—PROTECTING RENTERS AND HOMEOWNERS FROM EVICTIONS AND FORECLOSURES

SEC. 101. EMERGENCY RENTAL ASSISTANCE.

(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Housing and Urban Development (referred to in this section as the ''Secretary'') $100,000,000,000 for an additional amount for grants under the Emergency Solutions Grants program under subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371 et seq.), to remain available until expended (subject to subsections (d) and (n) of this section), to be used for providing short- or medium-term assistance with rent and rent-related costs (including tenant-paid utility costs, utility- and rent-arrears, fees charged for those arrears, and security and utility deposits) in accordance with paragraphs (4) and (5) of section 415(a) of such Act (42 U.S.C. 11374(a)) and this section.

(b) DEFINITION OF AT RISK OF HOMELESSNESS.—Notwithstanding section 401(1) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(1)), for purposes of assistance made available with amounts made available pursuant to subsection (a), the term ''at risk of homelessness'' means, with respect to an individual or family, that the individual or family—

(1) has an income below 80 percent of the median income for the area as determined by the Secretary; and

(2) has an inability to attain or maintain housing stability or has insufficient resources to pay for rent or utilities due to financial hardships.

(c) INCOME TARGETING AND CALCULATION.—For purposes of assistance made available with amounts made available pursuant to subsection (a)—

(1) each recipient of such amounts shall use—

(A) not less than 40 percent of the amounts received only for providing assistance for individuals or families experiencing homelessness, or for persons or families at risk of homelessness who have incomes not exceeding 30 percent of the median income for the area as determined by the Secretary;

(B) not less than 70 percent of the amounts received only for providing assistance for individuals or families experiencing homelessness, or for persons or families at risk of homelessness who have incomes not exceeding 50 percent of the median income for the area as determined by the Secretary; and

(C) the remainder of the amounts received only for providing assistance to individuals or families experiencing homelessness, or for persons or families at risk of homelessness who have incomes not exceeding 80 percent of the median income for the area as determined by the Secretary, but such recipient may establish a higher percentage limit for purposes of subsection (b)(1), which shall not in any case exceed 120 percent of the area median income, if the recipient states that it will serve such population in its plan; and

(2) in determining the income of a household for homelessness prevention assistance—

(A) the calculation of income performed at the time of application for such assistance, including arrearages, shall consider only income that the household is currently receiving at such time and any income recently terminated shall not be included;

(B) any calculation of income performed with respect to households receiving ongoing assistance (such as medium-term rental assistance) 3 months after initial receipt of assistance shall consider only the income that the household is receiving at the time of such review; and

(C) the calculation of income performed with respect to households receiving assistance for arrearages shall consider only the income that the household was receiving at the time such arrearages were incurred.

(d) 3-YEAR AVAILABILITY.—

(1) IN GENERAL.—Each recipient of amounts made available pursuant to subsection (a) shall—

(A) expend not less than 60 percent of such grant amounts within 2 years of the date that such funds became available to the recipient for obligation; and

(B) expend 100 percent of such grant amounts within 3 years of such date.

(2) REALLOCATION AFTER 2 YEARS.—The Secretary may recapture any amounts not expended in compliance with paragraph (1)(A) and reallocate such amounts to recipients in compliance with the formula referred to in subsection (h)(1)(A).

(e) RENT RESTRICTIONS.—

(1) INAPPLICABILITY.—Section 576.106(d) of title 24, Code of Federal Regulations, shall not apply with respect to homelessness prevention assistance made available with amounts made available under subsection (a).

(2) AMOUNT OF RENTAL ASSISTANCE.—In providing homelessness prevention assistance with amounts made available under subsection (a), the maximum amount of rental assistance that may be provided shall be the greater of—

(A) 120 percent of the higher of—

(i) the Fair Market Rent established by the Secretary for the metropolitan area or county; or

(ii) the applicable Small Area Fair Market Rent established by the Secretary; or

(B) such higher amount as the Secretary shall determine is needed to cover market rents in the area.

(f) SUBLEASES.—A recipient shall not be prohibited from providing assistance authorized under subsection (a) with respect to subleases that are valid under State law.

(g) HOUSING RELOCATION OR STABILIZATION ACTIVITIES.—A recipient of amounts made available pursuant to subsection (a) may expend up to 25 percent of its allocation for activities under section 415(a)(5) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11374(a)(5)), except that notwithstanding such section, activities authorized under this subsection may be provided only for individuals or families who have incomes not exceeding 50 percent of the area median income and meet the criteria in subsection (b)(2) of this section or section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302). This subsection shall not apply to rent-related costs that are specifically authorized under subsection (a) of this section.

(h) ALLOCATION OF ASSISTANCE.—

(1) IN GENERAL.—In allocating amounts made available pursuant to subsection (a), the Secretary shall—

(A)(i) for any purpose authorized in this section—

(I) allocate 2 percent of such amount for Indian tribes and tribally designated housing entities (as such terms are defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) under the formula established pursuant to section 302 of such Act (25 U.S.C. 4152), except that 0.3 percent of the amount allocated under this clause shall be allocated for the Department of Hawaiian Home Lands; and

(II) allocate 0.3 percent of such amount for the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands;

(ii) not later than 30 days after the date of enactment of this Act, obligate and disburse the amounts allocated pursuant to clause (i) in accordance with such allocations and provide such recipient with any necessary guidance for use of the funds; and

(B)(i) not later than 7 days after the date of enactment of this Act and after setting aside amounts under subparagraph (A), allocate 50 percent of any such remaining amounts under the formula specified in subsections (a), (b), and (e) of section 414 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11373) for, and notify, each State, metropolitan city, and urban county that is to receive a direct grant of such amounts; and

(ii) not later than 30 days after the date of enactment of this Act, obligate and disburse the amounts allocated pursuant to clause (i)