I

115TH CONGRESS
2D SESSION

H. R. 7339

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

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 19, 2018

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

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A BILL

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

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 ''Medicare for America Act of 2018''.

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

TITLE I—TRANSITIONING TO AND ESTABLISHING MEDICARE FOR AMERICA

Subtitle A—Transitional Public Health Option

SEC. 101. ESTABLISHMENT.

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

SEC. 102. ELIGIBILITY.

(a) IN GENERAL.—Subject to subsection (b), an individual is eligible to enroll in such public health plan option if the individual is otherwise eligible to purchase individual health insurance coverage through an Exchange and the individual resides in a rating area in which the Secretary makes the public health plan option available.

(b) PRIORITY.—In determining in which rating areas the Secretary initially will make the public health plan option available, the Secretary shall give priority to rating areas in which—

(1) not more than 1 health insurance issuer offers plans on the applicable State or Federal American Health Benefit Exchange; or

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

SEC. 103. BENEFITS.

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

(1) meets all requirements applicable to qualified health plans under subtitle D of title I of the Patient Protection and Affordable Care Act (other than the requirement under section 1301(a)(1)(C)(ii) of such Act (42 U.S.C. 18021(a)(1)(C)(ii))) and title XXVII of the Public Health Service Act;

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

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

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

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

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

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

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

SEC. 104. PREMIUMS.

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

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

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

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

(B) administrative costs related to operating the plans; and

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

SEC. 105. PROVIDERS AND REIMBURSEMENT RATES.

(a) IN GENERAL.—The Secretary shall establish a rate schedule for reimbursing types of health care providers furnishing items and services under the public health insurance plan option at rates based on rates applied for such items and services under title XVIII of the Social Security Act, as of the date of the enactment of this Act, that are necessary to maintain network adequacy. The Secretary shall establish a rate schedule for items and services not currently covered under title XVIII of the Social Security Act at a level to ensure adequate access to providers.

(b) PARTICIPATING PROVIDERS.—

(1) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act or under the Medicaid program under title XIX of such Act on the date of enactment of this title shall be a participating provider for public health insurance plan option.

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

viders not described in paragraph (1) to become participating providers for the public health insurance plan option.

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

SEC. 106. ACCOUNT; FUNDING.

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

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

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

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

Subtitle B—Medicare for America

SEC. 111. ESTABLISHMENT AND ADMINISTRATION OF MEDICARE FOR AMERICA.

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

"TITLE XXII—MEDICARE FOR AMERICA

"PART A—COMPREHENSIVE HEALTH COVERAGE

"SEC. 2201. ESTABLISHMENT.

''The Secretary shall establish a public health insurance program, to be known as 'Medicare for America', which shall for calendar year 2022 and each subsequent calendar year provide comprehensive health benefits in accordance with this part to individuals enrolled for coverage under this title.

"SEC. 2202. ELIGIBILITY; AUTOMATIC ENROLLMENT.

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

vides criteria for determining residency for eligibility purposes under this title.

''(b) ENROLLMENTS.—Subject to subsection (c):

''(1) IN GENERAL.—Beginning in 2022, the Secretary shall provide a mechanism for the enrollment of individuals entitled to benefits under this title and, in conjunction with such enrollment, the issuance of a Medicare card which may be used for purposes of identification and processing of claims for benefits under this title. As a condition of participation in the program, participating providers shall facilitate enrollment as specified by the Secretary.

''(2) AUTOMATIC ENROLLMENTS.—The mechanism provided under paragraph (1) shall, subject to paragraph (4), provide, for plan years beginning with plan year 2022, for the following automatic enrollments under Medicare for America:

''(A) ENROLLMENT AT BIRTH.—For plan years (beginning with plan year 2022), a process, established by the Secretary in consultation with the Commissioner of Social Security, for the automatic enrollment of eligible individuals born during such plan year.

"(B) CURRENT MEDICARE BENEFICIARIES.—

"(i) CURRENT MEDICARE BENEFICIARIES.—For plan years (beginning with plan year 2022), a process established by the Secretary for the automatic enrollment of all individuals who are enrolled for benefits under part A or B of title XVIII (other than individuals who are enrolled for such benefits and receiving benefits under title XIX).

"(ii) CONTINUING POPULATION.—For plan years (beginning with plan year 2022), a process established by the Secretary for the automatic enrollment of eligible individuals who attain the age of 65 during such plan year.

"(iii) DUALS.—For plan years (beginning with plan year 2024), a process established by the Secretary for the automatic enrollment of eligible individuals who are enrolled for benefits under part A or B of title XVIII and receiving benefits under title XIX.

"(C) OTHER INDIVIDUALS WITHOUT QUALIFIED HEALTH COVERAGE.—For plan years (beginning with plan year 2022), a process established by the Secretary for the automatic enrollment of eligible individuals who are not enrolled in other qualified health coverage (as defined in paragraph (4)(B)) for such plan year.

"(3) OTHER ENROLLMENTS.—The mechanism provided under paragraph (1) shall provide for the following:

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

"(B) SMALL EMPLOYERS.—For plan years (beginning with plan year 2022), a process and methodology under which a small employer, as defined in section 124(d)(3) of the Medicare for America Act, may provide for the enrollment of the employees of such employer under Medicare for America. For purposes of the previous sentence, the term 'small employer' means any employer for any calendar year if the annual pay-

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

''(C) LARGE EMPLOYERS.—For plan years (beginning with plan year 2026), the Secretary shall provide for a process and methodology under which a large employer may provide for the enrollment of the employees of such employer under Medicare for America. For purposes of the preceding sentence, the term 'large employer' means an employer with at least 100 employees.

''(4) OPT OUT FOR INDIVIDUALS ENROLLED UNDER QUALIFIED HEALTH COVERAGE.—

''(A) IN GENERAL.—The mechanism provided under paragraph (1) shall provide, with respect to a plan year, for a process that enables individuals who are enrolled in qualified health coverage for such plan year to opt out of coverage under Medicare for America for such year.

''(B) QUALIFIED HEALTH COVERAGE DEFINED.—For purposes of this section, the term 'qualified health coverage' means coverage under any of the following:

''(i) For plan years 2022 and 2023:

''(I) Qualified employer coverage, as defined in section 124 of the Medicare for America Act.

''(II) Medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program.

''(III) A health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary.

''(IV) The health benefit program under chapter 89 of title 5, United States Code.

''(V) Medical benefits and services provided by or through the Indian Health Service.

''(VI) The Medicaid program under title XIX of the Social Security Act.

"(VII) The CHIP program under title XXI of the Social Security Act.

"(ii) For plan years 2024 and 2025:

"(I) Coverage described in subclause (I), (II), (III), (IV), or (V) of clause (i).

"(II) Coverage described in subclause (VI) of clause (i), but only with respect to coverage that is not for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) or who are also enrolled for benefits under title XVIII.

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

"(c) WAIVER.—The Secretary shall establish a process under which the Secretary may grant waivers to States for additional time before populations described in a previous subsection of this section of such State are automatically enrolled under Medicare for America.

"SEC. 2203. BENEFITS.

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

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

''(1) Ambulatory patient services.

''(2) Emergency care and urgent care services.

''(3) Hospitalization.

''(4) Maternity and newborn care.

''(5) Behavioral health, mental health and substance use disorder services, including the following:

''(A) Home-based services.

''(B) Acute services for mental health crises, including crisis stabilization services such as mobile crisis services, including emergency mobile psychiatric services.

''(C) 23-hour observation.

''(D) Outpatient services provided by hospitals, freestanding clinics, and behavioral health providers in independent practice.

''(E) Smoking and tobacco cessation.

''(F) Case management.

''(G) Peer support services.

''(H) Counseling.

''(I) Other intensive outpatient community-based services, such as Assertive Community

Treatment and supported employment, provided through the LTSS benefit.

''(J) Other intensive community-based services provided through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (as defined in subpart B of part 441 of title 42 of the Code of Federal Regulations).

''(K) Medication assisted treatment and maintenance services.

''(L) Inpatient detoxification.

''(M) Ambulatory detoxification.

''(N) Psychological testing.

''(O) Home health agency services.

''(6) Prescription drugs.

''(7) Rehabilitative and habilitative services and devices, including the following:

''(A) Physical therapy.

''(B) Speech therapy.

''(C) Occupational therapy.

''(8) Laboratory services.

''(9) Preventive and wellness services and chronic disease management.

''(10) Pediatric services, including oral and vision care and all services that would otherwise be

covered under Early and Periodic Screening, Diagnostic, and Treatment under the Medicaid program under title XIX.

''(11) Dental.

''(12) Hearing health services including aids and exams.

''(13) Home and community-based long-term supports and services.

''(14) Chiropractic services.

''(15) Durable medical equipment, including the following:

''(A) Wheelchairs and accessories.

''(B) Walking aides such as walkers, canes, and crutches.

''(C) Bathroom equipment such as commodes and safety equipment.

''(D) Inhalation therapy equipment such as nebulizers.

''(E) Hospital beds and accessories.

''(F) Other devices such as continuous positive airway pressure (CPAP) machines, apnea monitors, and ventilators.

''(G) Insulin pumps and glucometers.

''(H) Breast pumps.

''(I) Lymphedema compression treatment items.

''(J) Wigs.

''(K) Augmentative and alternative communication devices, including dual-use devices.

''(16) Family planning, including the following:

''(A) Reproductive health exams.

''(B) Patient counseling and education related to family planning.

''(C) Abortion.

''(D) Screening, testing, treatment, and pre- and post-test counseling for sexually transmitted diseases and HIV.

''(E) Contraceptives including pill, patch, medication, condom, implant, or other devices used to prevent pregnancy.

''(F) Sterilization for beneficiaries over the age of 21.

''(G) Infertility treatment.

''(17) Gender-confirming medical procedures and treatment.

''(18) Dietary and nutrition counseling.

''(19) Medically necessary food and vitamins for digestive and inherited metabolic disorders.

''(20) Nursing facilities.

''(21) Orthotic and prosthetics devices.

''(22) Oxygen.

''(23) Acupuncture.

''(24) Telehealth.

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

''(26) Any additional benefit or service not included in this section that is covered by any State plan (or waiver of such State plan) under title XIX on the date of the enactment of this title.

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

''(c) PROHIBITION AGAINST DUPLICATING COVERAGE.—

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

benefits provided under Medicare for America under this part.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this part, insofar as the coverage satisfies the conditions of paragraph (3).

''(3) APPLICATION OF PROTECTIONS.—For purposes of paragraph (2), health insurance coverage for any additional benefits must satisfy the following conditions:

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

''(B) The provisions of section 2702 of the Public Health Service Act, relating to guaranteed issue.

''(C) The provisions of section 2701 of the Public Health Service Act, relating to community rating.

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

''(d) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits

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

''(e) PROHIBITION AGAINST STEP THERAPY AND PRIOR AUTHORIZATION.—Items and services covered under Medicare for America shall be covered without any need for any prior authorization determination and without any limitation applied through the use of step therapy protocols.

"SEC. 2204. PREMIUMS.

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

''(2) GRANDFATHERED MEDICARE BENEFICIARIES.—In the case of an individual enrolled under part B of title XVIII as of the date of the enactment of this part, the premium applied under this section for such individual for benefits under this title shall be the lesser of—

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

''(B) the premium that would be applied to such individual under this title without the application of this paragraph.

''(b) PREMIUM CONTRIBUTION BASED ON INCOME.—The amount of a monthly premium, with respect to a plan year (beginning with 2022), under this section shall be established by the Secretary in accordance with the following:

''(1) Such premium shall be determined such that the collective premiums for the plan year are with respect to the costs of health benefits provided under this title for such year and related administrative costs.

''(2) Premiums shall vary by family composition only.

''(3) Federal subsidies shall be provided to ensure that the premium shall be—

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

''(B) determined by a linear sliding scale, in the case of an individual whose household income is at least 200 percent of the poverty line, but not more than 600 percent of the poverty line, with the premiums ranging between the

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

"(C) no individual or household will pay more than 9.69 percent of monthly income toward such monthly premium.

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

"(5) For an individual who has opted out of their employer sponsored insurance in order to enroll in Medicare for America as specified in section 124(c) of such Act, the individual shall pay the premium described in this subsection.

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

"(d) APPEALS FOR CERTAIN MEDICARE GRANDFATHERED POPULATION.—In calculating premiums for purposes of subsection (a)(2):

''(1) Any individual that was subject to a late enrollment penalty under part B of title XVIII shall have the right to appeal the assessment of the penalty for good faith enrollment mistakes.

''(2) In any case in which the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A of title XVIII pursuant to section 1818 is unintentional, inadvertent, or erroneous, whether the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government or its instrumentalities, an employer, a representative of a group health plan, a State, or for any other good faith reason on the part of such individual, the Secretary shall take such action (including the designation for such individual of a special initial or subsequent enrollment period, including retroactive enrollment, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction. The failure of an individual to enroll in the insurance program established by this part or part A pursuant to section 1818 due to enrollment under a group health plan; coverage pursu-

ant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, title VI of the Employee Retirement Income Security Act of 1974, or title XIX; or enrollment under a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act shall under this subsection absent exceptional circumstances, as determined by the Secretary.

''(3) The Secretary, in consultation with the Commissioner of Social Security, shall develop and publish a formal application for requesting an action of the Secretary under paragraph (1) to correct or eliminate the effects of an error, misrepresentation, or inaction described in such paragraph and determine and publish specific timelines for timely resolution of such a request.

''(4) The Secretary shall also require that all such determinations with respect to such requests shall be reached within 15 business days of the submission of such application. All determinations shall be in writing through a standard decision notice which shall include an explanation of the reasons for the determination.

''(5) The Commissioner of Social Security shall enter into contracts with independent review organizations in accordance with this subsection for the purpose of reviewing and determining individual appeals of determinations under paragraph (3) with respect to an application submitted pursuant to paragraph (2) relating to enrollment under part A or part B.

''(6) An individual who receives an adverse determination under paragraph (3) with respect to an application submitted pursuant to paragraph (2) may appeal to an independent review organization designated by the Commission. Any such appeal must be sent to the independent review organization within 90 days of the date the individual received the determination to be eligible for review. The independent review organization shall review and reach a determination of the review in writing within 45 days of the receipt of any such appeal.

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

''(A) unless the organization has staff that has the appropriate knowledge of, and experience with, the eligibility and coordination of

benefits rules and regulations under this title; and

''(B) to the extent the organization is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

''(8) The Secretary of Health and Human Services shall provide for access by independent review organizations conducting appeal determinations under this subsection, to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services as necessary in order to conduct the duties of such organizations to determine appeals pursuant to this subsection.

''SEC. 2205. PAYMENT OF BENEFITS; COST-SHARING; OUT-OF-POCKET LIMITS.

''(a) PAYMENT OF BENEFITS; COST-SHARING.—There shall be paid, in the case of each individual who is enrolled under Medicare for America and incurs expenses for items and services with respect to which benefits are payable under this part, after application of subsection (b) and subject to subsection (c), 80 percent of the reimbursement rates established pursuant to section 2206 for such items and services, except that with respect to USPTF recommended preventive and chronic disease

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

''(b) DEDUCTIBLE.—

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

''(A) $350 for an individual; or

''(B) $500 total for all members of a household.

''(2) INDEXING.—In the case of plan years beginning after 2021, the dollar amounts described in paragraph (1) shall be increased by the percentage increase over the previous year in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics.

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

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

"(c) MAXIMUM OUT-OF-POCKET LIMIT.—

"(1) IN GENERAL.—The coverage under Medicare shall provide benefits, after the eligible individual has incurred out-of-pocket expenses for items and services with respect to which benefits are payable under this part in a year equal to the annual out-of-pocket threshold specified in paragraph (2), with cost-sharing that is equal to $0.

"(2) ANNUAL OUT-OF-POCKET THRESHOLD.—

"(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraphs (B) and (C), the annual out-of-pocket threshold specified in this paragraph is a threshold that shall be determined on a linear sliding scale for household income that is at least 200 percent of the poverty line, but not more than 600 percent of the poverty line, and that shall not exceed—

"(i) with respect to an individual, $3,500; or

"(ii) with respect to a household, $5,000.

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

subparagraph (A) (as in effect for the preceding plan year after application of this subparagraph) shall be increased by the percentage increase over the previous year in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics.

''(C) EXCEPTION.—For purposes of paragraph (1), the annual out-of-pocket threshold for individuals and households with annual income below 200 percent of the federal poverty line is $0.

''(d) NO BALANCE BILLING.—No provider may impose a charge to an enrolled individual for covered services for which benefits are provided under this part in an amount higher than the reimbursement rate for such services under section 2206 and may not impose a charge to such individual for such service other than with respect to the deductible or other cost-sharing described in this section.

''SEC. 2206. PROVIDERS NETWORK AND REIMBURSEMENT RATES.

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

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

''(b) RATES.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the Secretary shall provide for rates to be provided to health care providers and suppliers furnishing items and services under Medicare for America based on rates that would be applied (including as computed, updated, and adjusted) under title XVIII for such type of health care providers and suppliers and item and service if such title remained in effect and, in the case of a type of provider and supplier or item or service covered under Medicare for America but not otherwise covered under title XVIII, shall provide for rates that ensure adequate access to care.

''(2) EXCEPTIONS.—For purposes of this section, in applying paragraph (1) the Secretary shall ensure that rates to hospitals for inpatient services or outpatient services furnished under Medicare for America are at least 110 percent of such rates on average or in the aggregate for furnishing such inpatient or outpatient services otherwise applied under title XVIII, except that for hospitals serving under-

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

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

''(A) The Secretary shall provide for site-neutral payments for items and services furnished in an outpatient hospital and physician office, the rate of payment for such service shall be the same.

''(B) The Secretary shall increase the average relative value of primary care and other mental and behavioral health and cognitive services by not less than 20 percent in order to ensure adequate access to inpatient and outpatient care.

''(C) As a condition of participation in the program, participating providers shall accept Medicare for America rates paid by employer-sponsored insurance plans and Medicare Advantage plans.

''(c) PARTICIPATING PROVIDERS.—

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

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

''(2) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in paragraph (1) to become participating providers for Medicare for America.

''(d) PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Any payment rate under this part for a prescription drug shall be at a rate negotiated by the Secretary based on value assessments by one or more independent nonprofit organizations certified by the National Academy of Medicine and MedPAC. If the Secretary is unable to reach a negotiated agreement on such a reimbursement rate, the Secretary shall apply prices paid by the Department of Veterans Affairs for such drugs or the average price of such drugs in nations which are members of the Organization for Economic Cooperation and Development, whichever is lower.

''(2) FAILURE TO NEGOTIATE.—If a drug manufacturer refuses to negotiate with the Secretary, then Medicare for America will not cover any of the manufacturer's products. There shall be an exceptions process for drugs that are otherwise unavail-

able for people with chronic conditions. Individuals shall continue to have access to drugs during the appeals process. The Secretary shall modify such rates in order to accommodate payments for drugs that are not otherwise covered under the original Medicare fee-for-service program under title XVIII.

''(3) VALUE OR COST-EFFECTIVENESS ASSESSMENTS.—The use of Quality-Adjusted Life Years, Disability-Adjusted Life Years, or other similar mechanisms is prohibited for use in value or cost-effectiveness assessments for purposes of this subsection.

''SEC. 2207. TRUST FUND; FUNDING.

''(a) TRUST FUND.—There shall be established a unified Medicare Trust Fund in which funds provided under this title are deposited and from which expenditures under this title are made. The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

''(b) FUNDING.—

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

100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by title II of the Medicare for America Act and premiums collected under this title. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

''(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year, beginning with fiscal year 2022, the amounts that would otherwise have been appropriated to carry out the following programs:

''(A) The Medicare program under title XVIII.

''(B) The Medicaid program under title XIX, beginning as of 2026.

''(3) ADDITIONAL APPROPRIATIONS.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under this part.

''(4) MEDICAID MAINTENANCE OF EFFORT PAYMENTS.—There shall be transferred to the Trust Fund the maintenance of effort payments made under section 2209.

''(c) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this title restricting the use of Federal funds for any reproductive health service, including abortion, shall not apply to monies in the Trust Fund.

''(d) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust Fund under such section 1817, except that, for purposes of applying such subsections to this section, the 'Board of Trustees of the Trust Fund' shall mean the 'Secretary'.

''(e) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 or the Federal Supplementary Medical Insurance Trust Fund under section 1841 after the payment

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

"SEC. 2208. ADMINISTRATIVE PROVISIONS.

"(a) CENTER FOR MEDICARE.—Beginning 2022, the Centers for Medicare & Medicaid Services shall be renamed the Center for Medicare and all references in law and regulation to such Centers shall be deemed a reference to such Center. All powers, duties, and responsibilities of the Centers for Medicare & Medicaid Services shall be transferred to the Center for Medicare.

"(b) AUTHORITY.—The Secretary shall have the authority to issue interim final rules with respect to any provision in this part.

"(c) ADMINISTRATIVE LAW JUDGES.—

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

"(2) TIMING.—Under this title, administrative law judges must issue a decision within 90 days of receipt of a hearing request, as specified in subsections (a) and (c) of section 405.1016 of title 2, Code of Federal Regulations.

"(d) COVERAGE DETERMINATIONS APPEALS.—

''(1) Individuals may appeal a coverage determination under this title before the individual obtains the service or item that is the subject of the appeal.

''(2) The Secretary shall eliminate the redetermination by a Medicare administrative contractor from the appeals process under the Medicare program for beneficiaries.

''(e) PRIVATE RIGHT OF ACTION.—

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

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

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

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

"SEC. 2209. MAINTENANCE OF EFFORT REQUIREMENT.

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

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

"(1) for plan year 2027 and a State, a payment in an amount equal to the total amount of expenditures of the State for medical assistance under title XIX and child health assistance under title XXI including administrative costs for the plan year before the date of the enactment of this title;

"(2) for plan year 2028 and each subsequent plan year before plan year 2032—

"(A) in the case of a State that is a PPACA expansion State, the payment amount applied under this subsection for the previous plan year, increased by growth in GDP per capita plus 0.4 percent; and

"(B) in the case of a State that is not a PPACA expansion State, the payment amount applied under this subsection for the previous plan year, increased by growth in GDP per capita plus 0.7 percent; and

"(3) beginning in 2032, for each subsequent plan year, with respect to any State, the payment amount applied under this subsection for the previous year, increased by growth in GDP per capita plus 0.7 percent.

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

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

"(2) Block grants and programs for social services and elder justice under title XX of the Social Security Act.

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

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

''(5) State Targeted Response to Opioid Crisis Grant Community Services Block Grant.

''(6) Grants under section 330 of the Public Health Service Act.

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

''SEC. 2210. APPLICATION OF TITLE XVIII PROVISIONS.

''Except as specified otherwise in this title, in implementing Medicare for America, the Secretary shall to the greatest extent practicable apply the following provisions of title XVIII to the program under this title, benefits covered under this title, individuals entitled to benefits under this title, and providers of services and suppliers participating under the program under this title in a similar manner as such provisions applied to the program under title XVIII, benefits covered under such title, individuals entitled to benefits or enrolled under such title, and providers of services and suppliers participating under the program under such title:

''(1) Section 1801.

‘‘(2) Section 1805.

‘‘(3) Section 1806.

‘‘(4) Section 1807.

‘‘(5) Section 1809.

‘‘(6) Section 1812.

‘‘(7) Section 1814.

‘‘(8) Section 1815.

‘‘(9) Section 1816.

‘‘(10) Section 1818.

‘‘(11) Section 1818A.

‘‘(12) Section 1819.

‘‘(13) Section 1820.

‘‘(14) Section 1832.

‘‘(15) Section 1834.

‘‘(16) Section 1834A.

‘‘(17) Section 1835.

‘‘(18) Section 1843.

‘‘(19) Section 1846.

‘‘(20) Section 1847.

‘‘(21) Section 1851.

‘‘(22) Section 1852.

‘‘(23) Section 1855.

‘‘(24) Section 1856.

‘‘(25) Section 1857.

‘‘(26) Section 1858.

''(27) Section 1861.

''(28) Section 1863.

''(29) Section 1864.

''(30) Section 1866B.

''(31) Section 1866C.

''(32) Section 1866E.

''(33) Section 1867.

''(34) Section 1868.

''(35) Section 1869.

''(36) Section 1871.

''(37) Section 1874A.

''(38) Section 1880.

''(39) Section 1881.

''(40) Section 1881A.

''(41) Section 1891.

''(42) Section 1894.

''(43) Section 1895.

''(44) Section 1896.

''PART B—LONG-TERM SERVICES AND SUPPORTS

''SEC. 2221. LONG-TERM SERVICES AND SUPPORTS BENEFIT.

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

"SEC. 2222. ELIGIBILITY.

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

''(1) The individual is eligible for Medicare for America.

''(2) The individual is determined to have a condition, as certified by a licensed health care practitioner, that results in substantially reduced functional capacity in one or more of the following areas:

''(A) Communication.

''(B) Social interaction.

''(C) Learning.

''(D) Mobility.

''(E) Self-care.

''(F) Self-management.

''(G) Impairments that affect the person's capacity for social or economic participation.

''(b) CLARIFICATION.—Under this part, in the case of an individual described in subsection (a) who, due to the nature of the condition of the individual, experience periods in which their functional capacity changes or improves, such individual shall continue to have access to benefits under this part as needed. If such an individual's functional capacity improves to a point in which the individual no longer requires long term supports and services,

or requires fewer services, the individual shall be able to immediately and seamlessly resume receiving all needed services if and when their functional needs recur. Eligibility for services shall be maintained if, without the services, the individual would have reduced functional capacity. The presence of supports and services or other mitigating measures shall not be taken into account when looking at functional impairment.

''(c) BENEFITS.—

''(1) DEFINITION.—For purposes of this title, the term 'long-term services and supports benefit' means the daily living supports needed by eligible individuals and includes all long-term services and supports covered, as of the date of the enactment of this title, under any State plan under title XIX, including—

''(A) home and community-based services; and

''(B) any additional services and supports developed to help people with disabilities live, work, and participate in their communities, including—

''(i) home health aides and homemakers;

"(ii) direct support professionals and personal attendant care services;

"(iii) hospice;

"(iv) nursing care;

"(v) medical social services;

"(vi) case management, fiscal intermediary, and support brokerage services;

"(vii) short-term inpatient care, including respite care and care for pain control;

"(viii) behavioral health long-term services and supports, including assertive community treatment, peer support services, intensive case management, supported employment, and supported housing wraparound; and

"(ix) all additional services coverable in Medicaid under state plan services, sections 1115, 1915(c), 1915(k), 1915(i), and 1915(j), for people with disabilities.

"(2) SELF-DIRECTED MODEL.—All eligible individuals shall be defaulted into a self-directed care option (as defined by the Secretary).

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

presumption and eligible individuals should be initially provided home and community-based services, as defined for purposes of section 1915(i). Before an eligible individual is admitted into a long term care institution, the State mental health or developmental disability authority or State agency that administers the State plan under title XIX shall conduct a mandatory assessment to determine whether their needs could be met through home and community-based services and if so, the services would have to be arranged for by the State and the coverage would not be provided for the individual with respect to such an admission. This assessment shall be conducted at least annually or upon a change in condition for all individual already admitted to an institution.

''(d) COORDINATION WITH OTHER FEDERAL BENEFITS.—

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

''(2) DEPENDENT RELATIVE DEFINED.—The term 'dependent relative' means—

''(A) a child, grandchild, niece, or nephew (of such caregiver or such caregiver's spouse or domestic partner);

''(B) a child to which the caregiver or the caregiver's spouse or domestic partner is standing in loco parentis;

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

''(D) such caregiver's spouse or domestic partner, if such child, grandchild, niece, nephew, parent, grandparent, sibling, aunt, uncle, spouse, or domestic partner is an eligible individual.

''(3) SUPPLEMENT NOT SUPPLANT.—Benefits received under this part by a caregiver shall supplement, but not supplant, other benefits for which the individual is eligible under any other Federally funded program that provides benefits or assistance.

''(4) DISREGARD.—Benefits paid to a caregiver under this part shall be disregarded for purposes of determining or continuing the eligibility of the individual or the spouse of the individual for receipt of

benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II or XVI under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008, or under programs administered by State vocational rehabilitation agencies.

"PART C—MEDICARE ADVANTAGE FOR AMERICA

"SEC. 2231. ALL PRIVATE PLANS.

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

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

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

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

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

''(2) MA FOR AMERICA SPONSOR.—An MA for America sponsor is a sponsor of an MA for America plan.

''SEC. 2232. APPLICATION OF MEDICARE ADVANTAGE PROVISIONS.

''For purposes of applying this part, except as otherwise specified under this part, the provisions of part C of title XVIII, as in effect as of the date of the enactment of this title shall apply with respect to an MA for America sponsor, MA for America plan, individuals eligible for coverage under this part, individuals enrolled under such plan, and benefits covered under part A in a similar manner and to a similar extent as such provisions applied to an MA organization, MA plan, individuals eligible for under part C of such title, individuals enrolled under an MA plan, and benefits covered under fee-for-service Medicare as of such date.

''SEC. 2233. INCREASED PREMIUM FOR MEDICARE ADVANTAGE FOR AMERICA PLANS.

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

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

"SEC. 2234. REFERENCES.

"Beginning in 2022, all references in law and regulation to Medicare Advantage shall be deemed a reference to Medicare Advantage for America.".

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

(a) MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

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

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

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

(ii) beginning on or after January 1, 2024, with respect to all individuals, including individuals enrolled under such title and title XIX of such Act;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act—

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

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

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

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

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

of an individual enrolled under such title and title XVIII of the Social Security Act or an individual described in subclause (VIII) of section 1902(a)(10)(A)(i); and

(ii) for any item or service furnished on or after January 1, 2026.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2024 for Medicare and 2026 for Medicaid or CHIP, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI such Act, the Secretary of Health and Human Services shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) OTHER FEDERAL HEALTH PROGRAMS.—

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

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

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

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

(A) IN GENERAL.—Nothing in this Act, or the amendments made by this Act, shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

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

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

(d) SEVERABILITY.—Every provision in this Act and every application of the provisions in this Act are severable from each other as a matter of Federal law. If any application of any provision in this Act to any person or group of persons or circumstances is found by a court to be invalid, the remainder of this Act and the application of the Act's provisions to all other persons and circumstances may not be affected.

Subtitle C—Targeted Reforms

SEC. 121. LIMITATION ON REMOVAL OF MEDICARE ADVANTAGE PROVIDERS BY MA ORGANIZATIONS.

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

''(7) LIMITATION ON REMOVAL OF PROVIDERS FROM MA PLANS BY MA ORGANIZATIONS.—

''(A) REMOVAL OF PROVIDERS WITH CAUSE.—Beginning with plan year 2019, except as provided in subparagraph (C), an MA organization offering an MA plan may only remove a provider of services or a supplier from a network of such plan if the organization has cause to remove such provider or supplier.

''(B) CAUSE TO REMOVE PROVIDERS.—

''(i) IN GENERAL.—An MA organization offering an MA plan has cause to remove a provider of services or a supplier from a network of such plan if the Secretary determines that the provider or supplier is—

''(I) medically negligent;

''(II) in violation of any legal or contractual requirement applicable to the provider or supplier acting within the lawful scope of practice, including any participation or other requirement applicable to such provider or supplier under this title or under any contractual term for such plan; or

''(III) otherwise unfit to furnish items and services in accordance with requirements of this title.

''(ii) CONSIDERATION OF COST TO MA ORGANIZATIONS.—For purposes of subparagraph (A), cost to an MA organization offering an MA plan due to the participation of a provider of services or supplier in a network of such plan does not constitute cause for the MA organization to remove

such provider or supplier from the network mid-year, and such cost may not be considered as a factor in favor of a determination that such organization has cause to remove the provider.

''(C) EXCEPTION.—With respect to each upcoming plan year, beginning with plan year 2019, an MA organization offering an MA plan may only remove a provider of services or supplier from a network of such plan for reasons not specified in subparagraph (B)(i) before the date that is 60 days before the first day of the annual coordinated election period for such plan year under section 1851(e)(3).

''(D) NOTICE AND APPEAL PROCESS.—

''(i) IN GENERAL.—Any removal of a provider of services or supplier from a network of an MA plan may occur only after the completion of a fair notice and appeal process that the Secretary shall establish by regulation. Such process shall require the MA organization to provide to such provider or supplier and to the Secretary an explanation of the reason or reasons for the removal.

"(ii) APPLICATION.—

"(I) APPLICATION OF NEW PROCESS.—In the case of a removal of a provider of services or supplier from a network of an MA plan occurring on or after the effective date published in a final rule for such fair notice and appeal process, such process shall apply in lieu of the process for the termination or suspension of a provider contract under section 422.202(a) of title 42, Code of Federal Regulations.

"(II) CONTINUATION OF OLD PROCESS.—In the case of a removal of a provider of services or supplier from a network of an MA plan occurring before such effective date, the process for the termination or suspension of a provider contract under section 422.202(a) of title 42, Code of Federal Regulations, shall apply.

"(E) PARTICIPANT NOTICE AND PROTECTION.—

"(i) NOTICE TO PARTICIPANTS OF PROVIDER REMOVAL.—Not less than 60 days before the date on which a provider of services or supplier is removed from a network of an MA plan, the MA organization offering such plan shall provide written notification of the removal to each individual enrolled in such plan receiving items or services from the provider or supplier during the plan year in effect on the date of removal or during the previous plan year. Such notification shall include at the minimum—

"(I) the names and telephone numbers of available in-network providers of services and suppliers offering items and services that are the same or similar to the items and services offered by the removed provider or supplier;

"(II) information regarding the options available to an individual enrolled in such plan to request the continuation of medical treatment or

therapy with the removed provider or supplier; and

"(III) one or more customer service telephone numbers that an individual enrolled in such plan may access to obtain information regarding changes to the network of the plan.

"(ii) ANNUAL NOTICE OF CHANGE.—In addition to providing the notification of removal as required under clause (i), the MA organization offering such MA plan shall include such notification in the annual notice of change for the MA plan for the upcoming plan year.

"(iii) CONTINUITY OF CARE.—In any case in which a provider of services or supplier is removed from a network of an MA plan, such plan shall ensure that the removal satisfies the continuity of care requirements under paragraph (1)(A) with respect to each individual enrolled in such plan receiving items or services from the provider or supplier during the plan year in effect on the date of removal or during the previous plan year.

"(F) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the ability of a provider of services or supplier to decline to participate in a network of an MA plan.

"(8) TRANSPARENCY IN MEASURES USED BY MA ORGANIZATIONS TO ESTABLISH OR MODIFY PROVIDER NETWORKS.—

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

"(i) in the annual bid information submitted by the MA organization with respect to the MA plan under section 1854; and

"(ii) on the Internet Web Site for the MA plan.

"(B) INFORMATION DESCRIBED.—The information described in this subparagraph is the following:

"(i) Information regarding the measures used by the MA organization to establish or modify the provider network of the MA plan, including measures of the quality

and efficiency of providers. Such information shall include the specifications, methodology, and sample size of such measures.

''(ii) Other information related to the establishment or modification of such provider network that the Secretary determines appropriate.

''(C) LIMITATION.—The information described in subparagraph (B) shall not include any individually identifiable information of any provider or supplier of services.''.

(b) ENFORCEMENT.—

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

(A) in subparagraph (J), by striking ''or'';

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

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

''(K) fails to comply with section 1852(d)(7) or 1852(d)(8); or''; and

(D) in subparagraph (L) (as so redesignated), by striking ''through (J)'' and inserting ''through (K)''.

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

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

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

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

SEC. 122. NETWORK ADEQUACY.

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

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

''(A) PROVIDER AVAILABILITY.—When establishing a plan network, a Medicare Advan-

tage organization offering an MA plan shall, among other factors determined by the Secretary, consider the following:

"(i) The anticipated enrollment in the plan.

"(ii) The expected types of services provided and utilization of services by enrollees under the plan.

"(iii) The number and types of providers needed to provide such services.

"(iv) The number of network providers who are not accepting new patients.

"(v) The location of providers and enrollees.

"(vi) The full-time equivalent availability of a provider to provide such services.

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

"(C) APPLICATION OF NETWORK ACCESS ADEQUACY STANDARDS.—In applying the network access adequacy standards pursuant to

paragraph (1), the Secretary shall seek input from patient advocacy groups, providers of services and suppliers, and MA plans under this part.

''(D) CERTIFICATION.—Each plan year, a Medicare Advantage organization shall certify to the Secretary, with respect to each MA plan offered by the organization, that the providers, including specialists and subspecialists, in the plan network are able to provide the services required under the organization's contract with the Secretary under section 1857 with respect to the offering of such plan and to meet the needs of the enrollees within the plan service area during the year.

''(E) ANNUAL REPORTING.—Each plan year, a Medicare Advantage organization shall report to the Secretary the following with respect to each MA plan offered by the organization:

''(i) AVERAGE WAIT TIME.—The average wait time for primary and specialty care for enrollees under the plan.

''(ii) UTILIZATION OF OUT-OF-NETWORK PROVIDERS.—The utilization of out-of-network providers under the plan.

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

''(F) CERTIFICATION.—In advance of the annual, coordinated election period under section 1851(e)(3), a Medicare Advantage organization shall certify to the Secretary the accuracy of provider directories for each plan offered by the organization.

''(G) NETWORK REVIEW.—The Secretary shall ensure that the network of each MA plan offered by a Medicare Advantage organization meets the network adequacy guidelines established under this paragraph and under section 422.112(a)(4) of title 42, Code of Federal Regulations (or any successor regulation to such section), at least once every 3 years or when a material change in network occurs.''.

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

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

SEC. 123. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

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

(2) in paragraph (2)(B), by striking '', and has been for not less than 24 months,'';

(3) in paragraph (2)(C)(ii), by striking '', including the requirement that he has been entitled to the specified benefits for 24 months,'';

(4) in the first sentence, by striking ''for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and'' and inserting ''for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and''; and

(5) in the second sentence, by striking ''the 'twenty-fifth month of his entitlement' '' and all that follows through ''paragraph (2)(C) and''.

(b) CONFORMING AMENDMENTS.—

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

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking ''have been entitled for not less than 24 months'' and inserting ''are entitled''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''25th month of'' and inserting ''month following the first month of''.

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

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking ", for not less than 24 months"; and

(C) by striking "could have been entitled for 24 calendar months, and".

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

SEC. 124. EMPLOYER HEALTH PLAN OPTIONS.

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

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

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

that provides health coverage that is equivalent to an actuarial value of at least 80 percent and makes a premium contribution of at least 70 percent.

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

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

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

(c) EMPLOYEE CHOICE.—An employee may opt out of a qualifying employer sponsored plan as satisfied by subsection (b)(1) in order to enroll in Medicare for America. The employer shall be exempt from the contribution specified in subsection (b)(2). The Secretary of Health and Human Services shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within Medicare for America by inducing individuals to decline coverage under a qualifying employer sponsored plan and instead to enroll in Medicare for America. An employer violating such standards shall be treated as not meeting the requirements of subsection (a).

(d) SPECIAL RULES.—

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

(2) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

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

(4) RULES RELATED TO PART-TIME EMPLOYMENT.—For purposes of this subsection—

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

(B) PART-TIME EMPLOYMENT RATIO.—The term ''part-time employment ratio'' means, with respect to a part-time employee of an employer in a month, a fraction—

(i) the numerator of which is the number of hours in the employee's normal work week, and

(ii) the denominator of which is 30 hours.

(C) SPECIAL RULES.—Under rules prescribed by the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, in the case of an employee for an employer whose defined work week for full-time employees is less than 30 hours, any reference in this subsection to 30 hours is deemed a reference to the number of hours in the work week so defined.

(D) CONVERSION TO HOURS OF EMPLOYMENT.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish rules for the conversion of compensation to hours of employment, for purposes of this subsection in the case of employees that receive compensation on a salaried basis, or on the basis of a commission, or other contingent or bonus basis, rather than based on an hourly wage.

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

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

(f) NON-DISCRIMINATION.—

(1) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments) or any employer-sponsored insurance.

(2) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of

the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in paragraph (1).

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

SEC. 125. PROHIBITION ON STEP THERAPY AND PRIOR AUTHORIZATION UNDER GROUP HEALTH PLANS.

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

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

SEC. 126. MEDICARE OUTPATIENT OBSERVATION SERVICES.

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

SEC. 127. ABORTION COVERAGE.

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

(1) Indian Health Service.

(2) Benefits provided to women veterans.

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

TITLE II—TAX PROVISIONS

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

(a) IN GENERAL.—All provisions of, and amendments made by, Public Law 115–97 shall not apply to calendar, taxable, plan, or limitation years beginning after December 22, 2017.

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

SEC. 202. SURTAX.

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

SEC. 203. BASIS OF PROPERTY ACQUIRED FROM A DECEDENT.

(a) IN GENERAL.—Section 1014 of the Internal Revenue Code of 1986 is amended by striking ''person, be'' and all that follows through the period at the end and inserting the following: ''person, be the basis in the hands of the decedent.''.

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

SEC. 204. MEDICARE PAYROLL TAX.

(a) IN GENERAL.—Section 3101(b)(2) of the Internal Revenue Code of 1986 is amended by striking ''0.9 percent'' and inserting ''4 percent''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after the date of the enactment of this Act.

SEC. 205. NET INVESTMENT INCOME TAX.

(a) IN GENERAL.—Section 1411(a) of the Internal Revenue Code of 1986 is amended by striking ''3.8 percent'' each place such term appears and inserting ''6.9 percent''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after the date of the enactment of this Act.

SEC. 206. TERMINATION OF HEALTH SAVINGS ACCOUNTS.

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

SEC. 207. TERMINATION OF FLEXIBLE SPENDING ARRANGEMENTS.

Section 125(i)(1) of the Internal Revenue Code of 1986 is amended by striking ''may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement'' and inserting the following: ''may not elect to have salary reduction contributions made to such arrangement—

''(A) for taxable years beginning before January 1, 2020, in excess of $2,500, and

''(B) for taxable years beginning after December 31, 2019, in excess of $0.''.

SEC. 208. INCREASE IN EXCISE TAX ON SMALL CIGARS AND CIGARETTES AND OTHER TOBACCO PRODUCTS.

(a) SMALL CIGARS.—Section 5701(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

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

(1) by striking ''$50.33'' in paragraph (1) and inserting ''$100.66'', and

(2) by striking ''$105.69'' in paragraph (2) and inserting ''$211.38''.

(c) PIPE TOBACCO.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking ''$2.8311 cents'' and inserting ''$50.00''.

(d) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$24.78'' and inserting ''$49.56''.

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

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

(f) SMOKELESS TOBACCO.—

(1) IN GENERAL.—Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking ''$1.51'' and inserting ''$28.04'',

(B) in paragraph (2), by striking ''50.33 cents'' and inserting ''$12.42'', and

(C) by adding at the end the following:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $107.65 per each 1,000 single-use units.''.

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

(A) in paragraph (1), by striking ''or chewing tobacco'' and inserting ''chewing tobacco, discrete single-use unit'';

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

(C) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked, and

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

SEC. 209. EXCISE TAX ON ALCOHOL.

(a) DISTILLED SPIRITS.—Section 5001(a)(1) of the Internal Revenue Code of 1986 is amended by striking ''$13.50'' and inserting ''$16.00''.

(b) WINE.—

(1) Section 5041(b)(1) of the Internal Revenue Code of 1986 is amended by striking ''$1.07 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(2) Section 5041(b)(2) of the Internal Revenue Code of 1986 is amended by striking ''$1.57 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(3) Section 5041(b)(3) of the Internal Revenue Code of 1986 is amended by striking ''$3.15 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(4) Section 5041(b)(4) of the Internal Revenue Code of 1986 is amended by striking ''$3.40 per wine gallon'' and inserting ''$16.00 per proof gallon''.

(5) Section 5041(b)(5) of the Internal Revenue Code of 1986 is amended by striking ''$3.30 per wine gallon'' and inserting ''$16.00 per proof gallon''.

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

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

SEC. 210. TAX ON SUGARED DRINKS.

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

''PART II—SUGAR-SWEETENED BEVERAGES

''SEC. 4171. IMPOSITION OF TAX.

''(a) IN GENERAL.—There is hereby imposed a tax on the sale or transfer of any specified sugar-sweetened beverage product by the manufacturer, producer, or importer thereof.

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

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

''(c) PERSONS LIABLE FOR TAX.—The manufacturer, producer, or importer referred to in subsection (a) shall be liable for the tax imposed by such subsection.

''SEC. 4172. DEFINITIONS.

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

''(1) IN GENERAL.—For purposes of this part, the term 'specified sugar-sweetened beverage product' means—

''(A) any liquid intended for human consumption which contains a caloric sweetener, and

''(B) any liquid, or solid mixture of ingredients, which—

''(i) contains a caloric sweetener, and

''(ii) is intended for use as an ingredient in a liquid described in subparagraph (A).

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

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

''(B) Any liquid composed entirely of one or more of the following:

''(i) The original liquid resulting from the pressing of fruit or vegetables.

''(ii) The liquid resulting from the reconstitution of fruit or vegetable juice concentrate.

''(iii) The liquid resulting from the restoration of water to dehydrated fruit or vegetable juice.

''(C) Infant formula.

''(D) Any liquid products manufactured for use as—

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

''(ii) a source of necessary nutrition used due to a medical condition, or

''(iii) an oral electrolyte solution for infants and children formulated to prevent dehydration due to illness.

''(E) Any liquid with respect to which tax is imposed under chapter 51 (relating to distilled spirits, wines, and beer) or under section 7652 by reason of the tax imposed under chap-

ter 51 being imposed on like articles of domestic manufacture.

''(b) CALORIC SWEETENER.—For purposes of this part, the term 'caloric sweetener' means monosaccharides, disaccharides, and high-fructose corn syrup.

''SEC. 4173. SPECIAL RULES.

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

''(b) INFLATION ADJUSTMENT.—In the case of any sale after December 31, 2015, the one cent amount in section 4171(b) shall be increased by an amount equal to—

''(1) such amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such sale occurs, determined by substituting 'calendar year 2014' for 'calendar year 1992' in subparagraph (B) thereof.

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

(b) CONFORMING AMENDMENTS.—

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

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

''PART II—SUGAR-SWEETENED BEVERAGES''.

(c) REVENUES USED FOR PREVENTION, TREATMENT, AND RESEARCH OF DIET-RELATED HEALTH CONDITIONS IN PRIORITY POPULATIONS.—

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

(2) RESTRICTION ON USE OF FUNDS.—Notwithstanding subsections (c) and (d) of section 4002 of the Patient Protection and Affordable Care Act, amounts appropriated to the Prevention and Public Health Fund under paragraph (1) may be transferred to accounts in the Department of Health and Human Services only for the purpose of making expenditures for programs and research designed to reduce the human and economic costs of diabetes, obesity, dental caries, and other diet-related health conditions in priority populations (within the meaning of section 901(c) of the Public Health Service Act).

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

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

TITLE III—DRUG-RELATED PROVISIONS

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

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

SEC. 302. MEMBERSHIP; STAFF.

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

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

(2) The Administrator of the Centers for Medicare & Medicaid Services or, beginning with 2022, the Administrator of the Center for Medicare (or the Administrator's designee).

(3) The Assistant Director for the Health Services Division of the Federal Bureau of Prisons (or the Assistant Director's designee).

(4) The Secretary of Defense (or the Secretary's designee).

(5) The Secretary of Veterans Affairs (or the Secretary's designee).

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

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

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

(c) DIRECTOR AND STAFF.—

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

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

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The director and staff of the Board shall be appointed subject to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid in accordance with the requirements of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates; except that an individual so appointed may not receive pay in excess of the maximum annual rate of basic pay payable for grade GS–15 of the General Schedule.

(d) ASSISTANCE FOR THE BOARD.—Subject to section 306(g), in carrying out this title, the Board—

(1) may seek assistance from outside experts in the fields of consumer advocacy, medicine, pharmacology, pharmacy, and prescription drug reimbursement; and

(2) shall establish and maintain an advisory group and a stakeholder group for purposes of seeking such assistance.

(e) INITIAL MEETING.—The Board shall hold its initial meeting not later than 90 days after the date of the enactment of this Act.

SEC. 303. REPORTING REQUIREMENTS.

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

(1) Each type of prescription drug and medical device that is sold by the manufacturer or an affiliate of the manufacturer—

(A) in the United States; or

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

(2) The price charged by the manufacturer and the affiliate for the prescription drug or medical device in the United States and in any such country, as applicable.

(3) The costs of the manufacturer and the affiliate to produce and market the prescription drug or medical device for sale in the United States and in any such country, as applicable.

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

SEC. 304. PROHIBITION AGAINST EXCESSIVE PRICE.

(a) PROHIBITION.—Beginning on the effective date of the regulation required by subsection (b), the manufacturer of a prescription drug or medical device shall not charge an excessive price, as determined pursuant to such regulation, for such drug or device.

(b) FORMULA.—The Board shall by regulation prescribe a formula for determining whether the average manufacturer price of such drug or device over an annual quarter is an excessive price.

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

(1) the Board shall give the manufacturer—

(A) notice of such violation; and

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

(2) if the manufacturer fails to correct the violation by the end of such period, the manufacturer shall be subject to section 305, section 1927(c)(2)(E) of the Social Security Act (as added by subsection (c) of section 305), and section 4192 of the Internal Revenue Code of 1986, as added by subsection (d) of section 305.

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

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

(2) decline to make such a determination.

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

(1) the Board has already provided such an opportunity to correct to the manufacturer; and

(2) the Board finds that the violation of subsection (a) is a continuation of an earlier violation with respect to which such an opportunity was provided.

(f) CONSIDERATIONS.—The formula required by subsection (a) shall at a minimum take into consideration—

(1) the average manufacturer price of the prescription drug or medical device over the respective annual quarter or quarters;

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

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

(4) the costs associated with producing and marketing the prescription drug or medical device, the value of the drug or device to patients where sufficient data is available to determine such value, the total Federal investment in the development of the drug or device, the size of the patient population receiving the drug or device, and other factors determinative as to the true cost of production; and

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

SEC. 305. ENFORCEMENT PROVISIONS.

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

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

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

than 5 years, of another patent owned by the patent owner relating to a prescription drug or medical device.

(b) CIVIL PENALTIES.—If the Board determines under section 304(c) that a manufacturer of a prescription drug or medical device charged an excessive price for a prescription drug or medical device in violation of section 304(a), the Board may impose a civil penalty on the manufacturer of not more than 10 percent of the manufacturer's gross sales of the drug or device during the period beginning on the date on which an excessive price is first charged and ending on the date on which the manufacturer ceases to charge an excessive price.

(c) ENFORCEMENT THROUGH INCREASED MEDICAID REBATES.—

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

(A) in subparagraph (A), by inserting ", subject to subparagraph (E)," after "increased by"; and

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

"(E) DISCOURAGING EXCESSIVE PRICES.—

"(i) IN GENERAL.—In the case of a manufacturer of a single source drug or an innovator multiple source drug with a rebate agreement under this section, if the Prescription Drug and Medical Device Price Review Board established under section 301 of the Medicare for America Act determines under section 304(a) of such Act that such manufacturer charged, with respect to a 30-day period, an excessive price for such drug, and the Board determines under clause (ii) to apply an increased amount described in such clause with respect to such manufacturer and drug, the amount of the rebate determined under subparagraph (A) for such manufacturer and drug shall be, subject to subparagraph (D), increased by such amount for the 4 rebate periods following such 30-day period.

"(ii) INCREASED AMOUNT DETERMINATION.—For purposes of clause (i), if the Board described in such clause makes such a determination under such section 304(a), with respect to a manufacturer

and drug described in such clause, the Board may determine an increased amount to apply with respect to such manufacturer and drug and rebate period described in such clause. Such increased amount may not exceed the rebate amount that would otherwise be applied to such manufacturer and drug under this section for such rebate period, without regard to this subparagraph.''.

(2) EFFECTIVE DATE.—This subsection and the amendments made by this subsection shall apply with respect to rebate agreements entered into after the date that is 60 days after the date of the enactment of this Act.

(d) TAX ON EXCESS PRESCRIPTION DRUG AND MEDICAL DEVICE PROFITS.—

(1) DETERMINATION OF AMOUNT.—If the Board determines under section 304(a) that a manufacturer, producer, or importer of a prescription drug or medical device charged an excessive price for such prescription drug or medical device during a taxable year, the Board may determine under this paragraph a reasonable price for such drug or device for such taxable year.

(2) IMPOSITION OF TAX.—

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

"SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL DEVICE PRICE.

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

"(b) PRESCRIPTION DRUG OR MEDICAL DEVICE.—For purposes of this section, the term 'prescription drug or medical device' means any prescription drug (as defined in section 9008 of the Patient Protection and Affordable Care Act) or device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.".

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

(i) in the item relating to subchapter E, by striking ''Medical'' and inserting ''Drugs and medical'', and

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

''SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL DEVICE PRICE.''.

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

SEC. 306. AUTHORITY.

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

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

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

bursable basis, the administrative support services necessary for the Board to carry out its duties.

(d) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons for the purpose of conducting research, surveys, and other services necessary to enable the Board to carry out its duties.

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

(f) SUBPOENA POWER.—

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

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the Board may apply to a United States district court for an order requiring that person to appear before the Board to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

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

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

(5) NOTICE.—Upon issuing any subpoena under this subsection, the Board shall give notice of such issuance to the appropriate committees of Congress, including the Committee on Appropriations of

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

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

SEC. 307. REGULATIONS.

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

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

SEC. 308. REPORT TO FEDERAL AGENCIES.

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

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

(2) recommendations to the Federal agency against dispensing or making payments for the dispensing of the prescription drug or medical device; and

(3) recommendations to the Federal agency to substitute, in place of any drug or device listed pursuant to paragraph (1), a similar prescription drug or medical device that is not sold at an excessive price.

SEC. 309. DEFINITIONS.

In this title:

(1) The term ''affiliate'' means, with respect to a manufacturer, any entity that controls, is controlled by, or is under common control with such manufacturer.

(2) The term ''average manufacturer price'' means the average price charged by the manufacturer of a prescription drug or medical device, as applicable, for sales of the drug or device by the manufacturer in the United States over the respective annual quarter.

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

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

SEC. 310. MORATORIUM ON DIRECT-TO-CONSUMER DRUG ADVERTISING.

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

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

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

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

''SEC. 506J. DIRECT-TO-CONSUMER DRUG ADVERTISING.

''(a) PROHIBITIONS.—

''(1) FIRST THREE YEARS.—

''(A) IN GENERAL.—Subject to subparagraph (B), no person shall conduct direct-to-consumer advertising of a drug for which an application is submitted under section 505(b) before the end of the 3-year period beginning on the date of the approval of such application.

''(B) WAIVER.—The Secretary may waive the application of subparagraph (A) to a drug during the third year of the 3-year period described in such subparagraph if—

''(i) the sponsor of the drug submits an application to the Secretary pursuant to subparagraph (C); and

''(ii) the Secretary, after considering the application and any accompanying materials, determines that direct-to-consumer advertising of the drug would have an affirmative value to public health.

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

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

entific literature, any clinical or observational studies, or any other appropriate resource.

''(b) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall revise the regulations promulgated under this Act governing drug advertisements to the extent necessary to implement this section.

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

SEC. 311. REPORTING ON JUSTIFICATION FOR DRUG PRICE INCREASES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''PART W—DRUG PRICE REPORTING; DRUG VALUE FUND

''SEC. 399OO. REPORTING ON JUSTIFICATION FOR DRUG PRICE INCREASES.

''(a) DEFINITIONS.—In this section:

''(1) MANUFACTURER.—The term 'manufacturer' means the person—

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

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

"(B) who is responsible for setting the price for the drug.

"(2) QUALIFYING DRUG.—The term 'qualifying drug' means any drug 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 this Act—

"(A) that has a wholesale acquisition cost of $100 or more per month supply or per a course of treatment that lasts less than a month and is—

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

"(II) commonly administered by hospitals (as determined by the Secretary);

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

"(iii) not designated by the Secretary as a vaccine; and

"(B) for which, during the previous calendar year, at least 1 dollar of the total amount of sales were for individuals enrolled under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.

"(3) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given that term in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

"(b) REPORT.—

"(1) REPORT REQUIRED.—The manufacturer of a qualifying drug shall submit a report to the Secretary for each price increase of a qualifying drug that will result in an increase in the wholesale acquisition cost of that drug that is equal to—

"(A) 10 percent or more over a 12-month period; or

"(B) 25 percent or more over a 36-month period.

"(2) REPORT DEADLINE.—Each report described in paragraph (1) shall be submitted to the

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

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

''(1) with respect to the qualifying drug—

''(A) the percentage by which the manufacturer will raise the wholesale acquisition cost of the drug on the planned effective date of such price increase;

''(B) a justification for, and description of, each manufacturer's price increase that occurred during the 12-month period described in subsection (b)(1)(A) or the 36-month period described in subsection (b)(1)(B), as applicable;

''(C) the identity of the initial developer of the drug;

''(D) a description of the history of the manufacturer's price increases for the drug since the approval of the application for the drug under section 505 of the Federal Food, Drug, and Cosmetic Act or the issuance of the license for the drug under section 351, or since the manufacturer acquired such approved application or license;

''(E) the current list price of the drug;

''(F) the total expenditures of the manufacturer on—

''(i) materials and manufacturing for such drug; and

''(ii) acquiring patents and licensing for such drug;

''(G) the percentage of total expenditures of the manufacturer on research and development for such drug that was derived from Federal funds;

''(H) the total expenditures of the manufacturer on research and development for such drug that is used for—

''(i) basic and preclinical research;

''(ii) clinical research;

''(iii) new drug development;

''(iv) pursuing new or expanded indications for such drug through supplemental applications under section 505 of the Federal Food, Drug, and Cosmetic Act; and

''(v) carrying out postmarket requirements related to such drug, including those under section 505(o)(3) of such Act;

''(I) the total revenue and the net profit generated from the qualifying drug for each calendar year since the approval of the application for the drug under section 505 of the Federal Food, Drug, and Cosmetic Act or the issuance of the license for the drug under section 351, or since the manufacturer acquired such approved application or license; and

''(J) the total costs associated with marketing and advertising for the qualifying drug;

''(2) with respect to the manufacturer—

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

''(B) all stock-based performance metrics used by the manufacturer to determine executive compensation for the 12-month period described in subsection (b)(1)(A) or the 36-month period described in subsection (b)(1)(B), as applicable; and

''(C) any additional information the manufacturer chooses to provide related to drug pricing decisions, such as total expenditures on—

"(i) drug research and development; or

"(ii) clinical trials on drugs that failed to receive approval by the Food and Drug Administration; and

"(3) such other related information as the Secretary considers appropriate.

"(d) CIVIL PENALTY.—Any manufacturer of a qualifying drug that fails to submit a report for the drug as required by this section shall be subject to a civil penalty of $100,000 for each day on which the violation continues.

"(e) PUBLIC POSTING.—

"(1) IN GENERAL.—Subject to paragraph (3), not later than 30 days after the submission of a report under subsection (b), the Secretary shall post the report on the public website of the Department of Health and Human Services.

"(2) FORMAT.—In developing the format of such report for public posting, the Secretary shall consult stakeholders, including beneficiary groups, and shall seek feedback on the content and format from consumer advocates and readability experts to ensure such public reports are user-friendly to the public and are written in plain language that consumers can readily understand.

''(3) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—In carrying out this section, the Secretary shall enforce applicable law concerning the protection of confidential commercial information and trade secrets.

"SEC. 399OO–1. USE OF CIVIL PENALTY AMOUNTS.

''The Secretary shall collect the civil penalties under section 399OO, in addition to any other amounts available, and without further appropriation, and shall use such funds to carry out activities described in this part and to improve consumer and provider information about drug value and drug price transparency.

"SEC. 399OO–2. ANNUAL REPORT TO CONGRESS.

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

''(1) summarizing the information reported pursuant to section 399OO; and

''(2) including copies of the reports and supporting detailed economic analyses submitted pursuant to such section.

''(b) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—In carrying out this section, the Secretary shall

enforce applicable law concerning the protection of confidential commercial information and trade secrets.''.

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