AMENDMENT

OFFERED BY M__. _____

Strike titles I through V and insert the following (and update the table of contents accordingly):

TITLE I—MEDICARE PARTS B AND D

Subtitle A—Medicare Part B Provisions

SEC. 101. IMPROVEMENTS TO MEDICARE SITE-OF-SERVICE TRANSPARENCY.

Section 1834(t) of the Social Security Act (42 U.S.C. 1395m(t)) is amended—

(1) in paragraph (1)—

(A) in the heading, by striking ''IN GENERAL'' and inserting ''SITE PAYMENT'';

(B) in the matter preceding subparagraph (A)—

(i) by striking ''or to'' and inserting '', to'';

(ii) by inserting '', or to a physician for services furnished in a physician's office'' and ''surgical center''; and

(iii) by inserting ''(or 2021 with respect to a physician for services furnished in a physician's office)'' after ''2018''; and

(C) in subparagraph (A)—

(i) by striking ''and the'' and inserting '', the''; and

(ii) by inserting '', and the physician fee schedule under section 1848 (with respect to the practice expense component of such payment amount)'' after ''such section'';

(2) by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), respectively; and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) PHYSICIAN PAYMENT.—Beginning in 2021, the Secretary may expand the information included on the Internet website described in paragraph (1) to include—

''(A) the amount paid to a physician under section 1848 for an item or service for the settings described in paragraph (1); and

''(B) the estimated amount of beneficiary liability applicable to the item or service.''.

SEC. 102. REQUIRING MANUFACTURERS OF CERTAIN SINGLE-DOSE CONTAINER OR SINGLE-USE PACKAGE DRUGS PAYABLE UNDER PART B OF THE MEDICARE PROGRAM TO PROVIDE REFUNDS WITH RESPECT TO DISCARDED AMOUNTS OF SUCH DRUGS.

Section 1847A of the Social Security Act (42 U.S.C. 1395–3a) is amended by adding at the end the following new subsection:

''(h) REFUND FOR CERTAIN DISCARDED SINGLE-DOSE CONTAINER OR SINGLE-USE PACKAGE DRUGS.—

''(1) SECRETARIAL PROVISION OF INFORMATION.—

''(A) IN GENERAL.—For each calendar quarter beginning on or after July 1, 2021, the Secretary shall, with respect to a refundable single-dose container or single-use package drug (as defined in paragraph (8)), report to each manufacturer (as defined in subsection (c)(6)(A)) of such refundable single-dose container or single-use package drug the following for the calendar quarter:

''(i) Subject to subparagraph (C), information on the total number of units of the billing and payment code of such drug, if any, that were discarded during such

quarter, as determined using a mechanism such as the JW modifier used as of the date of enactment of this subsection (or any such successor modifier that includes such data as determined appropriate by the Secretary).

''(ii) The refund amount that the manufacturer is liable for pursuant to paragraph (3).

''(B) DETERMINATION OF DISCARDED AMOUNTS.—For purposes of subparagraph (A)(i), with respect to a refundable single-dose container or single-use package drug furnished during a quarter, the amount of such drug that was discarded shall be determined based on the amount of such drug that was unused and discarded for each drug on the date of service.

''(C) EXCLUSION OF UNITS OF PACKAGED DRUGS.—The total number of units of the billing and payment code of a refundable single-dose container or single-use package drug of a manufacturer furnished during a calendar quarter for purposes of subparagraph (A)(i), and the determination of the estimated total allowed charges for the drug in the quarter for purposes

of paragraph (3)(A)(ii), shall not include such units that are packaged into the payment amount for an item or service and are not separately payable.

''(2) MANUFACTURER REQUIREMENT.—For each calendar quarter beginning on or after July 1, 2021, the manufacturer of a refundable single-dose container or single-use package drug shall, for such drug, provide to the Secretary a refund that is equal to the amount specified in paragraph (3) for such drug for such quarter.

''(3) REFUND AMOUNT.—

''(A) IN GENERAL.—The amount of the refund specified in this paragraph is, with respect to a refundable single-dose container or single-use package drug of a manufacturer assigned to a billing and payment code for a calendar quarter beginning on or after July 1, 2021, an amount equal to the estimated amount (if any) by which—

''(i) the product of—

''(I) the total number of units of the billing and payment code for such drug that were discarded during such

quarter (as determined under paragraph (1)); and

''(II)(aa) in the case of a refundable single-dose container or single-use package drug that is a single source drug or biological, the amount determined for such drug under subsection (b)(4); or

''(bb) in the case of a refundable single-dose container or single-use package drug that is a biosimilar biological product, the average sales price determined under subsection (b)(8)(A); exceeds

''(ii) an amount equal to the applicable percentage (as defined in subparagraph (B)) of the estimated total allowed charges for such drug during the quarter.

''(B) APPLICABLE PERCENTAGE DEFINED.—

''(i) IN GENERAL.—For purposes of subparagraph (A)(ii), the term 'applicable percentage' means—

''(I) subject to subclause (II), 10 percent; and

''(II) if applicable, in the case of a refundable single-dose container or single-use package drug described in clause (ii), a percentage specified by the Secretary pursuant to such clause.

''(ii) TREATMENT OF DRUGS THAT HAVE UNIQUE CIRCUMSTANCES.—In the case of a refundable single-dose container or single-use package drug that has unique circumstances involving similar loss of product as that described in paragraph (8)(B), the Secretary, through notice and comment rulemaking, may increase the applicable percentage otherwise applicable under clause (i)(I) as determined appropriate by the Secretary.

''(4) FREQUENCY.—Amounts required to be refunded pursuant to paragraph (2) shall be paid in regular intervals (as determined appropriate by the Secretary).

''(5) REFUND DEPOSITS.—Amounts paid as refunds pursuant to paragraph (2) shall be deposited into the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(6) ENFORCEMENT.—

''(A) AUDITS.—

''(i) MANUFACTURER AUDITS.—Each manufacturer of a refundable single-dose container or single-use package drug that is required to provide a refund under this subsection shall be subject to periodic audit with respect to such drug and such refunds by the Secretary.

''(ii) PROVIDER AUDITS.—The Secretary shall conduct periodic audits of claims submitted under this part with respect to refundable single-dose container or single-use package drugs in accordance with the authority under section 1833(e) to ensure compliance with the requirements applicable under this subsection.

''(B) CIVIL MONEY PENALTY.—

''(i) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer of a refundable single-dose container or single-use package drug who has failed to comply with the requirement under paragraph (2) for such drug for a calendar quarter in an amount equal to the sum of—

''(I) the amount that the manufacturer would have paid under such paragraph with respect to such drug for such quarter; and

''(II) 25 percent of such amount.

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

''(7) IMPLEMENTATION.—The Secretary shall implement this subsection through notice and comment rulemaking.

''(8) DEFINITION OF REFUNDABLE SINGLE-DOSE CONTAINER OR SINGLE-USE PACKAGE DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term 'refundable single-dose container or single-use package drug' means a single source drug or biological (as defined in section 1847A(c)(6)(D)) or a biosimilar biological product (as defined in section 1847A(c)(6)(H)) for which payment is established under this part and that is fur-

nished from a single-dose container or single-use package.

''(B) EXCLUSIONS.—The term 'refundable single-dose container or single-use package drug' does not include—

''(i) a drug or biological that is either a radiopharmaceutical or an imaging agent;

''(ii) a drug or biological for which dosage and administration instructions approved by the Commissioner of Food and Drugs require filtration during the drug preparation process, prior to dilution and administration, and require that any unused portion of such drug after the filtration process be discarded after the completion of such filtration process; or

''(iii) a drug or biological approved by the Food and Drug Administration on or after the date of enactment of this subsection and with respect to which payment has been made under this part for less than 18 months.''.

SEC. 103. PROVIDING FOR VARIATION IN PAYMENT FOR CERTAIN DRUGS COVERED UNDER PART B OF THE MEDICARE PROGRAM.

(a) COMPUTING PAYMENT RATES BY APPLYING VARIABLE PERCENTAGES OF AVERAGE SALES PRICE (ASP) BASED ON RELATIVE DRUG COST.—

(1) IN GENERAL.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting after ''or 106 percent'' the following: ''(or, for a multiple source drug furnished on or after January 1, 2021, the applicable percent specified in paragraph (9)(A) for the drug and quarter involved)''; and

(ii) in subparagraph (B), by inserting after ''106 percent'' the following: ''(or, for a single source drug or biological furnished on or after January 1, 2021, the applicable percent specified in paragraph (9)(A) for the drug or biological and quarter involved)''; and

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

''(9) APPLICATION OF VARIABLE PERCENTAGES BASED ON PERCENTILE RANKING OF PER BENEFICIARY ALLOWED CHARGES.—

''(A) APPLICABLE PERCENT TO BE APPLIED.—

''(i) IN GENERAL.—Subject to clause (ii), with respect to a drug or biological furnished in a calendar quarter beginning on or after January 1, 2021, if the Secretary determines that the percentile rank of a drug or biological under subparagraph (B)(i)(III), with respect to per beneficiary allowed charges for all such drugs or biologicals, is—

''(I) at least equal to the 85th percentile, the applicable percent for the drug for such quarter under this subparagraph is 102 percent;

''(II) at least equal to the 70th percentile, but less than the 85th percentile, such applicable percent is 104 percent;

''(III) at least equal to the 50th percentile, but less than the 70th per-

centile, such applicable percent is 106 percent; or

''(IV) less than the 50th percentile, such applicable percent is 108 percent.

''(ii) CASES WHERE DATA NOT SUFFICIENTLY AVAILABLE TO COMPUTE PER BENEFICIARY ALLOWED CHARGES.—In the case of a drug or biological furnished for which the amount of payment is determined under subparagraph (A) or (B) of paragraph (1) and not under subsection (c)(4), for calendar quarters during a period in which data are not sufficiently available to compute a per beneficiary allowed charges for the drug or biological, the applicable percent is 106 percent.

''(B) DETERMINATION OF PERCENTILE RANK OF PER BENEFICIARY ALLOWED CHARGES OF DRUGS.—

''(i) IN GENERAL.—With respect to a calendar quarter beginning on or after January 1, 2021, for drugs and biologicals for which the amount of payment is determined under subparagraph (A) or (B) of

paragraph (1), except for drugs or biologicals for which data are not sufficiently available, the Secretary shall—

''(I) compute the per beneficiary allowed charges (as defined in subparagraph (C)) for each such drug or biological;

''(II) adjust such per beneficiary allowed charges for the quarter, to the extent provided under subparagraph (D); and

''(III) array such adjusted per beneficiary allowed charges for all such drugs or biologicals from high to low and rank such drugs or biologicals by percentile of such arrayed per beneficiary allowed charges.

''(ii) FREQUENCY.—The Secretary shall make the computations under clause (i)(I) every 6 months (or, if necessary, as determined by the Secretary, every 9 or 12 months) and such computations shall apply to succeeding calendar quarters until a new computation has been made.

"(iii) APPLICABLE DATA PERIOD.—For purposes of this paragraph, the term 'applicable data period' means the most recent period for which the data necessary for making the computations under clause (i) are available, as determined by the Secretary.

"(C) PER BENEFICIARY ALLOWED CHARGES DEFINED.—In this paragraph, the term 'per beneficiary allowed charges' means, with respect to a drug or biological for which the amount of payment is determined under subparagraph (A) or (B) of paragraph (1)—

"(i) the allowed charges for the drug or biological for which payment is so made for the applicable data period, as estimated by the Secretary; divided by

"(ii) the number of individuals for whom any payment for the drug or biological was made under paragraph (1) for the applicable data period, as estimated by the Secretary.

"(D) ADJUSTMENT TO REFLECT CHANGES IN AVERAGE SALES PRICE.—In applying this paragraph for a particular calendar quarter, the

Secretary shall adjust the per beneficiary allowed charges for a drug or biological by multiplying such per beneficiary allowed charges under subparagraph (C) for the applicable data period by the ratio of—

''(i) the average sales price for the drug or biological for the most recent calendar quarter used under subsection (c)(5)(B); to

''(ii) the average sales price for the drug or biological for the calendar quarter (or the weighted average for the quarters involved) included in the applicable data period.''.

(2) APPLICATION OF JUDICIAL REVIEW PROVISIONS.—Section 1847A(g) of the Social Security Act (42 U.S.C. 1395w–3a(g)) is amended—

(A) by striking ''and'' at the end of paragraph (4);

(B) by striking the period at the end of paragraph (5) and inserting ''; and''; and

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

''(6) the determination of per beneficiary allowed charges of drugs or biologicals and ranking of such charges under subsection (b)(9).''.

(b) REQUIRING REGULATIONS ON ALLOCATION OF BUNDLED DISCOUNTS AMONG DRUG PRODUCTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall promulgate final regulations, to be effective no later than July 1, 2021, that require manufacturers, in implementing section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) and in order that the average sales price for each drug accurately reflects the average transaction price for that drug, to allocate the total value of all bundled discounts proportionately according to the dollar value of the units of each drug sold under a bundled arrangement.

(2) ALTERNATIVE APPROACHES.—After promulgating such regulations, the Secretary may revise such regulations to incorporate alternative approaches, such as allocating discounts to reflect contingencies in the contracts between manufacturers and purchasers of drugs, in a way that more accurately represents the average transaction prices for drugs with bundled discounts.

SEC. 104. TREATMENT OF DRUG ADMINISTRATION SERVICES FURNISHED BY CERTAIN EXCEPTED OFF-CAMPUS OUTPATIENT DEPARTMENTS OF A PROVIDER.

Section 1833(t)(16) of the Social Security Act (42 12 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

''(G) SPECIAL PAYMENT RULE FOR DRUG ADMINISTRATION SERVICES FURNISHED BY AN EXCEPTED DEPARTMENT OF A PROVIDER.—

''(i) IN GENERAL.—In the case of a covered OPD service that is a drug administration service (as defined by the Secretary) furnished by a department of a provider described in clause (ii) or (iv) of paragraph (21)(B), the payment amount for such service furnished on or after January 1, 2021, shall be the same payment amount (as determined in paragraph (21)(C)) that would apply if the drug administration service was furnished by an off-campus outpatient department of a provider (as defined in paragraph (21)(B)).

''(ii) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The reductions made under this subparagraph—

''(I) shall not be considered an adjustment under paragraph (2)(E); and

''(II) shall not be implemented in a budget neutral manner.''.

Subtitle B—METRIC Act

SEC. 111. REPORTING ON EXPLANATION FOR DRUG PRICE INCREASES.

(a) IN GENERAL.—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 EXPLANATION 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 licensed under section 351 of this Act; or

''(B) who is responsible for setting the wholesale acquisition cost 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, adjusted for inflation occurring after the date of enactment of this section, for a month's supply or a typical course of treatment that lasts less than a month, and is—

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

''(ii) administered or otherwise dispensed to treat a disease or condition affecting more than 200,000 persons in the United States; and

''(iii) not 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 increase in the price of a qualifying drug that results in an increase in the wholesale acquisition cost of that drug that is equal to—

''(A) 10 percent or more within a single calendar year beginning on or after January 1, 2019; or

''(B) 25 percent or more within three consecutive calendar years for which the first such calendar year begins on or after January 1, 2019.

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

''(A) in the case of a report with respect to an increase in the price of a qualifying drug that occurs during the period beginning on Jan-

uary 1, 2019, and ending on the day that is 60 days after the date of enactment of this section, not later than 90 days after such date of enactment; and

''(B) in the case of a report with respect to an increase in the price of a qualifying drug that occurs after the period described in subparagraph (A), not later than 30 days prior to the planned effective date of such price increase for such qualifying drug.

''(c) CONTENTS.—A report under subsection (b), consistent with the standard for disclosures described in section 213.3(d) of title 12, Code of Federal Regulations (as in effect on the date of enactment of this section), 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 within the calendar year or three consecutive calendar years as described in subsection (b)(1)(A) or (b)(1)(B), and the effective date of such price increase;

''(B) an explanation for, and description of, each price increase for such drug that will occur during the calendar year period described

in subsection (b)(1)(A) or the three consecutive calendar year period described in subsection (b)(1)(B), as applicable;

''(C) if known and different from the manufacturer of the qualifying drug, the identity of—

''(i) the sponsor or sponsors of any investigational new drug applications under section 505(i) of the Federal Food, Drug, and Cosmetic Act for clinical investigations with respect to such drug, for which the full reports are submitted as part of the application—

''(I) for approval of the drug under section 505 of such Act; or

''(II) for licensure of the drug under section 351 of this Act; and

''(ii) the sponsor of an application for the drug approved under such section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of this Act;

''(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 of this Act, or since the manufacturer acquired such approved application or license, if applicable;

''(E) the current wholesale acquisition cost 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 necessary to demonstrate that it meets applicable statutory standards for approval under section 505 of the Federal Food, Drug, and Cosmetic Act or licensure under section 351 of this Act, as applicable;

''(I) the total expenditures of the manufacturer on pursuing new or expanded indications or dosage changes for such drug under section 505 of the Federal Food, Drug, and Cosmetic Act or section 351 of this Act;

''(J) the total expenditures of the manufacturer on carrying out postmarket requirements related to such drug, including under section 505(o)(3) of the Federal Food, Drug, and Cosmetic Act;

''(K) 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

''(L) 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 each of the 1-year period described in subsection (b)(1)(A) or the 3-

year period described in subsection (b)(1)(B), as applicable;

''(B) all stock-based performance metrics used by the manufacturer to determine executive compensation for each of the 1-year period described in subsection (b)(1)(A) or the 3-year 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, including on drugs that failed to receive approval by the Food and Drug Administration; and

''(3) such other related information as the Secretary considers appropriate and as specified by the Secretary through notice-and-comment rulemaking.

''(d) INFORMATION PROVIDED.—The manufacturer of a qualifying drug that is required to submit a report under subsection (b), shall ensure that such report and any explanation for, and description of, each price increase described in subsection (c)(1)(B) shall be truthful, not misleading, and accurate.

''(e) CIVIL MONETARY PENALTY.—Any manufacturer of a qualifying drug that fails to submit a report for the drug as required by this section, following notification by the Secretary to the manufacturer that the manufacturer is not in compliance with this section, shall be subject to a civil monetary penalty of $75,000 for each day on which the violation continues.

''(f) FALSE INFORMATION.—Any manufacturer that submits a report for a drug as required by this section that knowingly provides false information in such report is subject to a civil monetary penalty in an amount not to exceed $75,000 for each item of false information.

''(g) PUBLIC POSTING.—

''(1) IN GENERAL.—Subject to paragraph (3), the Secretary shall post each report submitted under subsection (b) on the public website of the Department of Health and Human Services the day the price increase of a qualifying drug is scheduled to go into effect.

''(2) FORMAT.—In developing the format in which reports will be publicly posted under paragraph (1), the Secretary shall consult with stakeholders, including beneficiary groups, and shall seek feedback from consumer advocates and readability experts on the format and presentation of the con-

tent of such reports to ensure that such reports are—

''(A) user-friendly to the public; and

''(B) written in plain language that consumers can readily understand.

''(3) PROTECTED INFORMATION.—Nothing in this section shall be construed to authorize the public disclosure of information submitted by a manufacturer that is prohibited from disclosure by applicable laws concerning the protection of trade secrets, commercial information, and other information covered under such laws.

''SEC. 399OO–1. 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 user-friendly to the public and written in plain language that consumers can readily understand, an annual report—

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

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

''(3) detailing the costs and expenditures incurred by the Department of Health and Human Services in carrying out section 399OO; and

''(4) explaining how the Department of Health and Human Services is improving consumer and provider information about drug value and drug price transparency.

''(b) PROTECTED INFORMATION.—Nothing in this section shall be construed to authorize the public disclosure of information submitted by a manufacturer that is prohibited from disclosure by applicable laws concerning the protection of trade secrets, commercial information, and other information covered under such laws.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of enactment of this Act.

SEC. 112. PUBLIC DISCLOSURE OF DRUG DISCOUNTS.

Section 1150A of the Social Security Act (42 U.S.C. 1320b–23) is amended—

(1) in subsection (c), in the matter preceding paragraph (1), by inserting ''(other than as permitted under subsection (e))'' after ''disclosed by the Secretary''; and

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

''(e) PUBLIC AVAILABILITY OF CERTAIN INFORMATION.—

''(1) IN GENERAL.—In order to allow the comparison of PBMs' ability to negotiate rebates, discounts, direct and indirect remuneration fees, administrative fees, and price concessions and the amount of such rebates, discounts, direct and indirect remuneration fees, administrative fees, and price concessions that are passed through to plan sponsors, beginning January 1, 2020, the Secretary shall make available on the Internet website of the Department of Health and Human Services the information with respect to the second preceding calendar year provided to the Secretary on generic dispensing rates (as described in paragraph (1) of subsection (b)) and information provided to the Secretary under paragraphs (2) and (3) of such subsection that, as determined by the Secretary, is with respect to each PBM.

''(2) AVAILABILITY OF DATA.—In carrying out paragraph (1), the Secretary shall ensure the following:

''(A) CONFIDENTIALITY.—The information described in such paragraph is displayed in a manner that prevents the disclosure of informa-

tion, with respect to an individual drug or an individual plan, on rebates, discounts, direct and indirect remuneration fees, administrative fees, and price concessions.

''(B) CLASS OF DRUG.—The information described in such paragraph is made available by class of drug, using an existing classification system, but only if the class contains such number of drugs, as specified by the Secretary (but not fewer than three drugs), to ensure confidentiality of proprietary information or other information that is prevented to be disclosed under subparagraph (A).''.

SEC. 113. STUDY OF PHARMACEUTICAL SUPPLY CHAIN INTERMEDIARIES AND MERGER ACTIVITY.

(a) INITIAL REPORT.—Not later than 1 year after the date of enactment of this Act, the Commission shall submit to the appropriate committees of Congress a report that—

(1) addresses at minimum—

(A) whether pharmacy benefit managers—

(i) charge payers a higher price than the reimbursement rate at which the pharmacy benefit managers reimburse competing pharmacies;

(ii) steer patients for anticompetitive purposes to any pharmacies, including retail, mail-order, or any other type of pharmacy, in which the pharmacy benefit manager has an ownership interest;

(iii) audit or review proprietary data, including acquisition costs, patient information, or dispensing information, of competing pharmacies that can be used for anticompetitive purposes; or

(iv) use formulary designs to increase the market share of higher cost prescription drugs and depress the market share of lower cost prescription drugs (each net of rebates and discounts);

(B) how companies and payers assess the benefits, costs, and risks of contracting with intermediaries, including pharmacy services administrative organizations, and whether more information about the roles of intermediaries should be available to consumers and payers; and

(C) whether there are any specific legal or regulatory obstacles the Commission currently faces in ensuring a competitive and transparent

marketplace in the pharmaceutical supply chain, including the pharmacy benefit manager marketplace and pharmacy services administrative organizations; and

(2) provides—

(A) observations or conclusions drawn from the November 2017 roundtable entitled ''Understanding Competition in Prescription Drug Markets: Entry and Supply Chain Dynamics'', and any similar efforts;

(B) specific actions the Commission intends to take as a result of the November 2017 roundtable, and any similar efforts, including a detailed description of relevant forthcoming actions, additional research or roundtable discussions, consumer education efforts, or enforcement actions; and

(C) policy or legislative recommendations to—

(i) improve transparency and competition in the pharmaceutical supply chain;

(ii) prevent and deter anticompetitive behavior in the pharmaceutical supply chain; and

(iii) best ensure that consumers benefit from any cost savings or efficiencies that may result from mergers and consolidations.

(b) INTERIM REPORT.—Not later than 180 days after the date of enactment of this Act, the Commission shall submit to the appropriate committees of Congress an interim report on the progress of the report required by subsection (a), along with preliminary findings and conclusions based on information collected to that date.

(c) DEFINITIONS.—In this section:

(1) APPROPRIATE COMMITTEES OF CONGRESS.—The term ''appropriate committees of Congress'' means—

(A) the Committee on Energy and Commerce of the House of Representatives;

(B) the Committee on the Judiciary of the Senate; and

(C) the Committee on the Judiciary of the House of Representatives.

(2) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

SEC. 114. REQUIRING CERTAIN MANUFACTURERS TO REPORT DRUG PRICING INFORMATION WITH RESPECT TO DRUGS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (2)(A), by inserting ''or subsection (f)(2), as applicable'' before the period at the end;

(B) in paragraph (3), in the matter preceding subparagraph (A), by inserting ''or subsection (f)(2), as applicable,'' before ''determined by''; and

(C) in paragraph (6)(A), in the matter preceding clause (i), by inserting ''or subsection (f)(2), as applicable,'' before ''determined by''; and

(2) in subsection (f)—

(A) by striking ''For requirements'' and inserting the following:

''(1) IN GENERAL.—For requirements''; and

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

''(2) MANUFACTURERS WITHOUT A REBATE AGREEMENT UNDER TITLE XIX.—

"(A) IN GENERAL.—If the manufacturer of a drug or biological described in subparagraph (C), (E), or (G) of section 1842(o)(1) or in section 1881(b)(14)(B) that is payable under this part has not entered into and does not have in effect a rebate agreement described in subsection (b) of section 1927, for calendar quarters beginning on or after January 1, 2020, such manufacturer shall report to the Secretary the information described in subsection (b)(3)(A)(iii) of such section 1927 with respect to such drug or biological in a time and manner specified by the Secretary. For purposes of applying this paragraph, a drug or biological described in the previous sentence includes items, services, supplies, and products that are payable under this part as a drug or biological.

"(B) AUDIT.—Information reported under subparagraph (A) is subject to audit by the Inspector General of the Department of Health and Human Services.

"(C) VERIFICATION.—The Secretary may survey wholesalers and manufacturers that directly distribute drugs described in subpara-

graph (A), when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of such a drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(D) CONFIDENTIALITY.—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph (other than the wholesale acquisition cost for purposes of carrying out this section) is confidential and shall not be dis-

closed by the Secretary in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler, except—

''(i) as the Secretary determines to be necessary to carry out this section (including the determination and implementation of the payment amount), or to carry out section 1847B;

''(ii) to permit the Comptroller General of the United States to review the information provided; and

''(iii) to permit the Director of the Congressional Budget Office to review the information provided.''.

(b) ENFORCEMENT.—Section 1847A of such Act (42 U.S.C. 1395w–3a) is further amended—

(1) in subsection (d)(4)—

(A) in subparagraph (A), by striking ''IN GENERAL'' and inserting ''MISREPRESENTATION'';

(B) in subparagraph (B), by striking ''subparagraph (B)'' and inserting ''subparagraph (A), (B), or (C)'';

(C) by redesignating subparagraph (B) as subparagraph (D); and

(D) by inserting after subparagraph (A) the following new subparagraphs:

''(B) FAILURE TO PROVIDE TIMELY INFORMATION.—If the Secretary determines that a manufacturer described in subsection (f)(2) has failed to report on information described in section 1927(b)(3)(A)(iii) with respect to a drug or biological in accordance with such subsection, the Secretary shall apply a civil money penalty in an amount of $10,000 for each day the manufacturer has failed to report such information and such amount shall be paid to the Treasury.

''(C) FALSE INFORMATION.—Any manufacturer required to submit information under subsection (f)(2) that knowingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law.''; and

(2) in subsection (c)(6)(A), by striking the period at the end and inserting '', except that, for purposes of subsection (f)(2), the Secretary may, if the

Secretary determines appropriate, exclude repackagers of a drug or biological from such term.''.

(c) MANUFACTURERS WITH A REBATE AGREEMENT.—

(1) IN GENERAL.—Section 1927(b)(3)(A) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended by adding at the end the following new sentence: ''For purposes of applying clause (iii), a drug or biological described in the flush matter following such clause includes items, services, supplies, and products that are payable under this part as a drug or biological.''.

(2) TECHNICAL AMENDMENT.—Section 1927(b)(3)(A)(iii) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)(iii)) is amended by striking ''section 1881(b)(13)(A)(ii)'' and inserting ''section 1881(b)(14)(B)''.

(d) REPORT.—Not later than January 1, 2021, the Inspector General of the Department of Health and Human Services shall assess and submit to Congress a report on the accuracy of average sales price information submitted by manufacturers under section 1847A of the Social Security Act (42 U.S.C. 1395w–3a). Such report shall include any recommendations on how to improve the accuracy of such information.

SEC. 115. MAKING PRESCRIPTION DRUG MARKETING SAMPLE INFORMATION REPORTED BY MANUFACTURERS AVAILABLE TO CERTAIN INDIVIDUALS AND ENTITIES.

(a) IN GENERAL.—Section 1128H of the Social Security Act (42 U.S.C. 1320a–7i) is amended—

(1) by redesignating subsection (b) as subsection (e); and

(2) by inserting after subsection (a) the following new subsections:

''(b) DATA SHARING AGREEMENTS.—

''(1) IN GENERAL.—The Secretary shall enter into agreements with the specified data sharing individuals and entities described in paragraph (2) under which—

''(A) upon request of such an individual or entity, as applicable, the Secretary makes available to such individual or entity the information submitted under subsection (a) by manufacturers and authorized distributors of record; and

''(B) such individual or entity agrees to not disclose publicly or to another individual or entity any information that identifies a particular practitioner or health care facility.

''(2) SPECIFIED DATA SHARING INDIVIDUALS AND ENTITIES.—For purposes of paragraph (1), the

specified data sharing individuals and entities described in this paragraph are the following:

''(A) OVERSIGHT AGENCIES.—Health oversight agencies (as defined in section 164.501 of title 45, Code of Federal Regulations), including the Centers for Medicare & Medicaid Services, the Office of the Inspector General of the Department of Health and Human Services, the Government Accountability Office, the Congressional Budget Office, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission.

''(B) RESEARCHERS.—Individuals who conduct scientific research (as defined in section 164.501 of title 45, Code of Federal Regulations) in relevant areas as determined by the Secretary.

''(C) PAYERS.—Private and public health care payers, including group health plans, health insurance coverage offered by health insurance issuers, Federal health programs, and State health programs.

''(3) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Except as described in paragraph (1), the Secretary may not be compelled to disclose the

information submitted under subsection (a) to any individual or entity. For purposes of section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act), this paragraph shall be considered a statute described in subsection (b)(3)(B) of such section.

''(c) PENALTIES.—

''(1) DATA SHARING AGREEMENTS.—Subject to paragraph (3), any specified data sharing individual or entity described in subsection (b)(2) that violates the terms of a data sharing agreement the individual or entity has with the Secretary under subsection (b)(1) shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each such violation. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(2) FAILURE TO REPORT.—Subject to paragraph (3), any manufacturer or authorized distributor of record of an applicable drug under subsection (a) that fails to submit information required under such subsection in a timely manner in accordance with rules or regulations promulgated to carry out such subsection shall be subject to a civil money

penalty of not less than $1,000, but not more than $10,000, for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(3) LIMITATION.—The total amount of civil money penalties imposed under paragraph (1) or (2) with respect to a year and an individual or entity described in paragraph (1) or a manufacturer or distributor described in paragraph (2), respectively, shall not exceed $150,000.

''(d) DRUG SAMPLE DISTRIBUTION INFORMATION.—

''(1) IN GENERAL.—Not later than January 1 of each year (beginning with 2021), the Secretary shall maintain a list containing information related to the distribution of samples of applicable drugs. Such list shall provide the following information with respect to the preceding year:

''(A) The name of the manufacturer or authorized distributor of record of an applicable drug for which samples were requested or distributed under this section.

''(B) The quantity and class of drug samples requested.

''(C) The quantity and class of drug samples distributed.

''(2) PUBLIC AVAILABILITY.—The Secretary shall make the information in such list available to the public on the Internet website of the Food and Drug Administration.''.

(b) FDA MAINTENANCE OF INFORMATION.—The Food and Drug Administration shall maintain information available to affected reporting companies to ensure their ability to fully comply with the requirements of section 1128H of the Social Security Act.

(c) PROHIBITION ON DISTRIBUTION OF SAMPLES OF OPIOIDS.—Section 503(d) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(d)) is amended—

(1) by moving the margin of paragraph (4) 2 ems to the left; and

(2) by adding at the end the following:

''(5) No person may distribute a drug sample of a drug that is—

''(A) an applicable drug (as defined in section 1128H(e) of the Social Security Act);

''(B) a controlled substance (as defined in section 102 of the Controlled Substances Act) for which the findings required under section 202(b)(2) of such Act have been made; and

''(C) approved under section 505 for use in the management or treatment of pain (other than for the management or treatment of a substance use disorder).''.

(d) MEDPAC REPORT.—Not later than 3 years after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall conduct a study on the impact of drug samples on provider prescribing practices and health care costs and may, as the Commission deems appropriate, make recommendations on such study.

SEC. 116. REQUIRING PRESCRIPTION DRUG PLAN SPONSORS TO INCLUDE REAL-TIME BENEFIT INFORMATION AS PART OF SUCH SPONSOR'S ELECTRONIC PRESCRIPTION PROGRAM UNDER THE MEDICARE PROGRAM.

Section 1860D–4(e)(2) of the Social Security Act (42 U.S.C. 1395w–104(e)(2)) is amended—

(1) in subparagraph (D), by striking ''To the extent'' and inserting ''Except as provided in subparagraph (F), to the extent''; and

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

''(F) REAL-TIME BENEFIT INFORMATION.—

''(i) IN GENERAL.—Not later than January 1, 2021, the program shall implement real-time benefit tools that are capable of integrating with a prescribing health care professional's electronic prescribing or electronic health record system for the transmission of formulary and benefit information in real time to prescribing health care professionals. With respect to a covered part D drug, such tools shall be capable of transmitting such information specific to an individual enrolled in a prescription drug plan. Such information shall include the following:

''(I) A list of any clinically-appropriate alternatives to such drug included in the formulary of such plan.

''(II) Cost-sharing information for such drug and such alternatives, including a description of any variance in cost-sharing based on the pharmacy dispensing such drug or such alternatives.

''(III) Information relating to whether such drug is included in the

formulary of such plan and any prior authorization or other utilization management requirements applicable to such drug and such alternatives so included.

''(ii) ELECTRONIC TRANSMISSION.—The provisions of subclauses (I) and (II) of clause (ii) of subparagraph (E) shall apply to an electronic transmission described in clause (i) in the same manner as such provisions apply with respect to an electronic transmission described in clause (i) of such subparagraph.

''(iii) SPECIAL RULE FOR 2021.—The program shall be deemed to be in compliance with clause (i) for 2021 if the program complies with the provisions of section 423.160(b)(7) of title 42, Code of Federal Regulations (or a successor regulation), for such year.

''(iv) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as to allow a real-time benefits tool to steer an individual, without the consent of the individual, to a particular pharmacy

or pharmacy setting over their preferred pharmacy setting nor prohibit the designation of a preferred pharmacy under such tool.''.

SEC. 117. SENSE OF CONGRESS REGARDING THE NEED TO EXPAND COMMERCIALLY AVAILABLE DRUG PRICING COMPARISON PLATFORMS.

It is the sense of Congress that—

(1) commercially available drug pricing comparison platforms can, at no cost, help patients find the lowest price for their medications at their local pharmacy;

(2) such platforms should be integrated, to the maximum extent possible, in the health care delivery ecosystem; and

(3) pharmacy benefit managers should work to disclose generic and brand name drug prices to such platforms to ensure that—

(A) patients can benefit from the lowest possible price available to them; and

(B) overall drug prices can be reduced as more educated purchasing decisions are made based on price transparency.

SEC. 118. TECHNICAL CORRECTIONS.

(a) IN GENERAL.—Section 3022(b) of the Public Health Service Act (42 U.S.C. 300jj–52(b)) is amended by adding at the end the following new paragraph:

''(4) APPLICATION OF AUTHORITIES UNDER INSPECTOR GENERAL ACT OF 1978.—In carrying out this subsection, the Inspector General shall have the same authorities as provided under section 6 of the Inspector General Act of 1978 (5 U.S.C. App.).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the 21st Century Cures Act (Public Law 114–255).

Subtitle C—Medicare Part D Benefit Redesign

SEC. 121. MEDICARE PART D BENEFIT REDESIGN.

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

(1) in paragraph (2)—

(A) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''for a year preceding 2022 and for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket threshold specified in

paragraph (4)(B) for 2022 and each subsequent year'' after ''paragraph (3)''; and

(ii) in clause (i), by inserting after ''25 percent'' the following: ''(or, for 2022 and each subsequent year, 15 percent)'';

(B) in subparagraph (C)—

(i) in clause (i), in the matter preceding subclause (I), by inserting ''for a year preceding 2022,'' after ''paragraph (4),''; and

(ii) in clause (ii)(III), by striking ''and each subsequent year'' and inserting ''and 2021''; and

(C) in subparagraph (D)—

(i) in clause (i)—

(I) in the matter preceding subclause (I), by inserting ''for a year preceding 2022,'' after ''paragraph (4),''; and

(II) in subclause (I)(bb), by striking ''a year after 2018'' and inserting ''each of years 2018 through 2021''; and

(ii) in clause (ii)(V), by striking ''2019 and each subsequent year'' and in-

serting ''each of years 2019 through 2021'';

(2) in paragraph (3)(A)—

(A) in the matter preceding clause (i), by inserting ''for a year preceding 2022,'' after ''and (4),''; and

(B) in clause (ii), by striking ''for a subsequent year'' and inserting ''for each of years 2007 through 2021'';

(3) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i)—

(I) by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively, and indenting appropriately;

(II) in the matter preceding item (aa), as redesignated by subclause (I), by striking ''is equal to the greater of—'' and inserting ''is equal to—

''(I) for a year preceding 2022, the greater of—''.

(III) by striking the period at the end of item (bb), as redesignated by

subclause (I), and inserting ''; and''; and

(IV) by adding at the end the following:

''(II) for 2022 and each succeeding year, $0.''; and

(ii) in clause (ii)—

(I) by striking ''clause (i)(I)'' and inserting ''clause (i)(I)(aa)''; and

(II) by adding at the end the following new sentence: ''The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after 2021 for purposes of section 1860D–14(a)(1)(D)(iii).'';

(B) in subparagraph (B)—

(i) in clause (i)—

(I) in subclause (V), by striking ''or'' at the end;

(II) in subclause (VI)—

(aa) by striking ''for a subsequent year'' and inserting ''for 2021''; and

(bb) by striking the period at the end and inserting a semicolon; and

(III) by adding at the end the following new subclauses:

''(VII) for 2022, is equal to $3,100; or

''(VIII) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.''; and

(ii) in clause (ii), by striking ''clause (i)(II)'' and inserting ''clause (i)'';

(C) in subparagraph (C)(i), by striking ''and for amounts'' and inserting ''and for a year preceding 2022 for amounts''; and

(D) in subparagraph (E), by striking ''In applying'' and inserting ''For each of 2011 through 2021, in applying''.

(b) DECREASING REINSURANCE PAYMENT AMOUNT.—Section 1860D–15(b)(1) of the Social Security Act (42 U.S.C. 1395w–115(b)(1)) is amended—

(1) by striking ''equal to 80 percent'' and inserting ''equal to–

''(A) for a year preceding 2022, 80 percent'';

(2) in subparagraph (A), as added by paragraph (1), by striking the period at the end and inserting ''; and''; and

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

''(B) for 2022 and each subsequent year, the sum of—

''(i) an amount equal to 20 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B) with respect to applicable drugs (as defined in section 1860D–14B(g)(2)); and

''(ii) an amount equal to 30 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that

portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B) with respect to generic drugs (as defined in section 1860D–14B(g)(5)).''.

(c) MANUFACTURER DISCOUNT PROGRAM.—

(1) IN GENERAL.—Part D of title XVIII of the Social Security Act is amended by inserting after section 1860D–14A (42 U.S.C. 1495w–114) the following new section:

''SEC. 1860D–14B. MANUFACTURER DISCOUNT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish a manufacturer discount program (in this section referred to as the 'program'). Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c). The Secretary shall establish a model agreement for use under the program by not later than January 1, 2021, in consultation with manufacturers, and allow for comment on such model agreement.

''(b) TERMS OF AGREEMENT.—

''(1) IN GENERAL.—

''(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to—

''(i) discounted prices for applicable drugs of the manufacturer that are dispensed on or after January 1, 2022; and

''(ii) discounted prices for generic drugs of the manufacturer that are dispensed on or after January 1, 2022.

''(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—The discounted prices described in subparagraph (A) shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug or a generic drug, as the case may be.

''(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

''(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufac-

turer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under subparagraph (A) of subsection (c)(1) or procedures established under such subsection (c)(1).

''(4) LENGTH OF AGREEMENT.—

''(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 12 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

''(B) TERMINATION.—

''(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning

such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

''(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

''(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

''(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

''(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

''(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

''(5) EFFECTIVE DATE OF AGREEMENT.—An agreement under this section shall take effect on a date determined appropriate by the Secretary, which may be at the start of a calendar quarter.

''(c) DUTIES DESCRIBED.—The duties described in this subsection are the following:

''(1) ADMINISTRATION OF PROGRAM.—Administering the program, including—

''(A) the determination of the amount of the discounted price of an applicable drug of a manufacturer and of the discounted price of a generic drug of a manufacturer;

''(B) the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug or a generic drug, as the case may be;

''(C) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug or a generic drug, as the case may be, by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

''(i) the negotiated price of the applicable drug or generic drug, respectively; and

''(ii) the discounted price of the applicable drug or generic drug, respectively;

''(D) the establishment of procedures to ensure that the discounted price for an applicable drug or a generic drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify; and

''(E) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries,

and the third party with a contract under subsection (d)(3).

''(2) MONITORING COMPLIANCE.—

''(A) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

''(B) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

''(3) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA–PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs and generic drugs under this section.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c).

''(2) LIMITATION.—In providing for the implementation of this section, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

''(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

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

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

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

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

''(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

''(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

''(e) ENFORCEMENT.—

''(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

''(2) CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer or generic drugs of the manufacturer in accord-

ance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

''(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

''(ii) 25 percent of such amount.

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

''(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in.

''(g) DEFINITIONS.—In this section:

''(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who, on the date of dispensing a covered part D drug—

''(A) is enrolled in a prescription drug plan or an MA–PD plan;

''(B) is not enrolled in a qualified retiree prescription drug plan; and

''(C) has incurred costs for covered part D drugs in the year that are equal to or exceed the annual deductible specified in section 1860D–2(b)(1) for such year.

''(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

''(A) approved under a new drug application under section 505(c) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (including a product licensed under subsection (k) of such section); and

''(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or

MA–PD plan that the applicable beneficiary is enrolled in;

''(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

''(iii) is provided through an exception or appeal.

''(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

''(A) with respect to claims for reimbursement submitted electronically, 14 days; and

''(B) with respect to claims for reimbursement submitted otherwise, 30 days.

''(4) DISCOUNTED PRICE.—

''(A) IN GENERAL.—The term 'discounted price' means—

''(i) with respect to an applicable drug of a manufacturer furnished during a year to an applicable beneficiary—

''(I) who has not incurred costs for covered part D drugs in the year

that are equal to or exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B)(i) for the year, 90 percent of the negotiated price of such drug; and

''(II) who has incurred such costs in the year that are equal to or exceed such threshold for the year, 90 percent of the negotiated price of such drug; and

''(ii) with respect to a generic drug of a manufacturer furnished during a year to an applicable beneficiary who has not incurred costs for covered part D drugs in the year that are equal to or exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B)(i) for the year, 90 percent of the negotiated price of such drug.

''(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug or a generic drug.

''(C) SPECIAL CASE FOR CLAIMS SPANNING DEDUCTIBLE.—In the case where the entire amount of the negotiated price of an individual claim for an applicable drug or a generic drug with respect to an applicable beneficiary does not fall at or above the annual deductible specified in section 1860D–2(b)(1) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug or generic drug, respectively, that falls at or above such annual deductible.

''(5) GENERIC DRUG.—The term 'generic drug' means, with respect to an applicable beneficiary, a covered part D drug that is not an applicable drug.

''(6) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

''(7) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 1860D–2(d)(1)(B), except that such negotiated price shall not include any dispensing fee for an applicable drug or a generic drug.

''(8) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 11860D–22(a)(2).''.

(2) SUNSET OF MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Section 1860D–14A of the Social Security Act (42 U.S.C. 1395–114a) is amended—

(A) in subsection (a), in the first sentence, by striking ''The Secretary'' and inserting ''Subject to subsection (h), the Secretary''; and

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

''(h) SUNSET OF PROGRAM.—

''(1) IN GENERAL.—The program shall not apply to applicable drugs dispensed on or after January 1, 2022, and, subject to paragraph (2), agreements under this section shall be terminated as of such date.

''(2) CONTINUED APPLICATION FOR APPLICABLE DRUGS DISPENSED PRIOR TO SUNSET.—The provisions of this section (including all responsibilities and duties) shall continue to apply after January 1, 2022, with respect to applicable drugs dispensed prior to such date.''.

(3) INCLUSION OF ACTUARIAL VALUE OF MANUFACTURER DISCOUNTS IN BIDS.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended—

(A) in subsection (b)(2)(C)(iii)—

(i) by striking ''assumptions regarding the reinsurance'' and inserting ''assumptions regarding—

''(I) the reinsurance''; and

(ii) by adding at the end the following:

''(II) for 2022 and each subsequent year, the manufacturer discounts provided under section 1860D–14B subtracted from the actuarial value to produce such bid; and''; and

(B) in subsection (c)(1)(C)—

(i) by striking ''an actuarial valuation of the reinsurance'' and inserting ''an actuarial valuation of—

''(i) the reinsurance'';

(ii) in clause (i), as added by clause (i) of this subparagraph, by adding ''and'' at the end; and

(iii) by adding at the end the following:

''(ii) for 2022 and each subsequent year, the manufacturer discounts provided under section 1860D–14B;''.

(d) DETERMINATION OF ALLOWABLE REINSURANCE COSTS.—Section 1860D–15(b) of the Social Security Act (42 U.S.C. 1395w–115(b)) is amended—

(1) in paragraph (2)—

(A) by striking ''COSTS.—For purposes'' and inserting ''COSTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), for purposes''.

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

''(B) INCLUSION OF MANUFACTURER DISCOUNTS ON APPLICABLE DRUGS AND GENERIC DRUGS.—For purposes of applying subpara-

graph (A), the term 'allowable reinsurance costs' shall include the portion of the negotiated price (as defined in section 1860D–14B(g)(7)) of an applicable drug (as defined in section 1860D–14(g)(2)) that was paid by a manufacturer under the manufacturer discount program under section 1860D–14B and the portion of the negotiated price (as so defined) of a generic drug (as defined in section 1860D–14(g)(5)) that was paid by a manufacturer under such program.''; and

(2) in paragraph (3)—

(A) in the first sentence, by striking ''For purposes'' and inserting ''Subject to paragraph (2)(B), for purposes''; and

(B) in the second sentence, by inserting ''or, in the case of an applicable drug or a generic drug, by a manufacturer'' after ''by the individual or under the plan''.

(e) UPDATING RISK ADJUSTMENT METHODOLOGIES TO ACCOUNT FOR PART D MODERNIZATION REDESIGN.—Section 1860D–15(c) of the Social Security Act (42 U.S.C. 1395w–115(c)) is amended by adding at the end the following new paragraph:

''(3) UPDATING RISK ADJUSTMENT METHODOLOGIES TO ACCOUNT FOR PART D MODERNIZATION REDESIGN.—The Secretary shall update the risk adjustment model used to adjust bid amounts pursuant to this subsection as appropriate to take into account changes in benefits under this part pursuant to the amendments made by section 121 of the Lower Drug Costs Now Act of 2019.''.

(f) CONDITIONS FOR COVERAGE OF DRUGS UNDER THIS PART.—Section 1860D–43 of the Social Security Act (42 U.S.C. 1395w–153) is amended—

(1) in subsection (a)—

(A) in paragraph (2), by striking ''and'' at the end;

(B) in paragraph (3), by striking the period at the end and inserting a semicolon; and

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

''(4) participate in the manufacturer discount program under section 1860D–14B;

''(5) have entered into and have in effect an agreement described in subsection (b) of such section 1860D–14B with the Secretary; and

''(6) have entered into and have in effect, under terms and conditions specified by the Secretary, a

contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section 1860D–14B.'';

(2) by striking subsection (b) and inserting the following:

''(b) EFFECTIVE DATE.—Paragraphs (1) through (3) of subsection (a) shall apply to covered part D drugs dispensed under this part on or after January 1, 2011, and before January 1, 2022, and paragraphs (4) through (6) of such subsection shall apply to covered part D drugs dispensed on or after January 1, 2022.''; and

(3) in subsection (c), by striking paragraph (2) and inserting the following:

''(2) the Secretary determines that in the period beginning on January 1, 2011, and ending on December 31, 2011 (with respect to paragraphs (1) through (3) of subsection (a)) or the period beginning on January 1, 2022, and ending December 31, 2022 (with respect to paragraphs (4) through (6) of such subsection), there were extenuating circumstances.''.

(g) CONFORMING AMENDMENTS.—

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

(A) in subsection (a)(2)(A)(i)(I), by striking ", or an increase in the initial" and inserting "or for a year preceding 2022 an increase in the initial";

(B) in subsection (c)(1)(C)—

(i) in the subparagraph heading, by striking "AT INITIAL COVERAGE LIMIT"; and

(ii) by inserting "for a year preceding 2022 or the annual out-of-pocket threshold specified in subsection (b)(4)(B) for the year for 2022 and each subsequent year" after "subsection (b)(3) for the year" each place it appears; and

(C) in subsection (d)(1)(A), by striking "or an initial" and inserting "or for a year preceding 2022, an initial".

(2) Section 1860D–4(a)(4)(B)(i) of the Social Security Act (42 U.S.C. 1395w–104(a)(4)(B)(i)) is amended by striking "the initial" and inserting "for a year preceding 2022, the initial".

(3) Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (C), by striking ''The continuation'' and inserting ''For a year preceding 2022, the continuation'';

(ii) in subparagraph (D)(iii), by striking ''1860D–2(b)(4)(A)(i)(I)'' and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''; and

(iii) in subparagraph (E), by striking ''The elimination'' and inserting ''For a year preceding 2022, the elimination''; and

(B) in paragraph (2)—

(i) in subparagraph (C), by striking ''The continuation'' and inserting ''For a year preceding 2022, the continuation''; and

(ii) in subparagraph (E)—

(I) by inserting ''for a year preceding 2022,'' after ''subsection (c)''; and

(II) by striking ''1860D–2(b)(4)(A)(i)(I)'' and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''.

(4) Section 1860D–21(d)(7) of the Social Security Act (42 U.S.C. 1395w–131(d)(7)) is amended by striking ''section 1860D–2(b)(4)(B)(i)'' and inserting ''section 1860D–2(b)(4)(C)(i)''.

(5) Section 1860D–22(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–132(a)(2)(A)) is amended—

(A) by striking ''the value of any discount'' and inserting the following: ''the value of—

''(i) for years prior to 2022, any discount'';

(B) in clause (i), as inserted by subparagraph (A) of this paragraph, by striking the period at the end and inserting ''; and''; and

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

''(ii) for 2022 and each subsequent year, any discount provided pursuant to section 1860D–14B.''.

(6) Section 1860D–41(a)(6) of the Social Security Act (42 U.S.C. 1395w–151(a)(6)) is amended—

(A) by inserting ''for a year before 2022'' after ''1860D–2(b)(3)''; and

(B) by inserting ''for such year'' before the period.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2022 and subsequent plan years.

Subtitle D—Other Medicare Part D Provisions

SEC. 131. TRANSITIONAL COVERAGE AND RETROACTIVE MEDICARE PART D COVERAGE FOR CERTAIN LOW-INCOME BENEFICIARIES.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by adding after subsection (d) the following new subsection:

''(e) LIMITED INCOME NEWLY ELIGIBLE TRANSITION PROGRAM.—

''(1) IN GENERAL.—Beginning not later than January 1, 2021, the Secretary shall carry out a program to provide transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

''(2) LI NET ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'LI NET eligible individual' means a part D eligible individual who—

''(A) meets the requirements of clauses (ii) and (iii) of subsection (a)(3)(A); and

''(B) has not yet enrolled in a prescription drug plan or an MA–PD plan, or, who has so enrolled, but with respect to whom coverage under such plan has not yet taken effect.

''(3) TRANSITIONAL COVERAGE.—For purposes of this subsection, the term 'transitional coverage' means, with respect to an LI NET eligible individual—

''(A) immediate access to covered part D drugs at the point-of-sale during the period that begins on the first day of the month such individual is determined to meet the requirements of clauses (ii) and (iii) of subsection (a)(3)(A) and ends on the date that coverage under a prescription drug plan or MA–PD plan takes effect with respect to such individual; and

''(B) in the case of an LI NET eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a recipient of supplemental security income benefits under title XVI, retroactive coverage (in the form of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs

purchased by such individual during the period that begins on the date that is the later of—

''(i) the date that such individual was first eligible for a low-income subsidy under this part; or

''(ii) the date that is 36 months prior to the date such individual enrolls in a prescription drug plan or MA–PD plan, and ends on the date that coverage under such plan takes effect.

''(4) PROGRAM ADMINISTRATION.—

''(A) SINGLE POINT OF CONTACT.—The Secretary shall, to the extent feasible, administer the program under this subsection through a contract with a single program administrator.

''(B) BENEFIT DESIGN.—The Secretary shall ensure that the transitional coverage provided to LI NET eligible individuals under this subsection—

''(i) provides access to all covered part D drugs under an open formulary;

''(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

''(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and

''(iv) meets such other requirements as the Secretary may establish.

''(5) RELATIONSHIP TO OTHER PROVISIONS OF THIS TITLE; WAIVER AUTHORITY.—

''(A) IN GENERAL.—The following provisions shall not apply with respect to the program under this subsection:

''(i) Paragraphs (1) and (3)(B) of section 1860D–4(a) (relating to dissemination of general information; availability of information on changes in formulary through the internet).

''(ii) Subparagraphs (A) and (B) of section 1860D–4(b)(3) (relating to requirements on development and application of formularies; formulary development).

''(iii) Paragraphs (1)(C) and (2) of section 1860D–4(c) (relating to medication therapy management program).

''(B) WAIVER AUTHORITY.—The Secretary may waive such other requirements of title XI

and this title as may be necessary to carry out the purposes of the program established under this subsection.''.

SEC. 132. DRUG DISCOUNTS REQUIRED TO BE PASSED THROUGH TO THE PLAN SPONSOR.

(a) IN GENERAL.—Section 1150A of the Social Security Act (42 U.S.C. 1320b–23), as amended by section 112, is further amended—

(1) in the heading, by inserting ''**; DRUG DISCOUNTS REQUIRED TO BE PASSED THROUGH TO THE PLAN SPONSOR**'' before the period at the end; and

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

''(f) DRUG DISCOUNTS REQUIRED TO BE PASSED THROUGH TO THE PLAN SPONSOR.—

''(1) REQUIREMENT.—Beginning January 1, 2022, a PBM that manages prescription drug coverage under a contract with a PDP sponsor or MA organization described in subsection (b)(1) or a qualified health benefits plan described in subsection (b)(2), shall, with respect to the plan sponsor of a health benefits plan, pass through to the plan sponsor 100 percent of the aggregate amount of the rebates, discounts, or price concessions (other than

bona fide service fees (as defined in subsection (g))) that the PBM negotiates that are attributable to patient utilization under the plan (including any rebates, discounts, or other price concessions (other than bona fide service fees (as so defined)) that are received by an agent or affiliate of the PBM acting on the PBM's behalf). Such a PBM may retain bona fide service fees (as so defined), to the extent that such fees are not based on a percentage of the sales for a drug or otherwise linked in any way to the price or formulary position or placement of a drug.

''(2) ENFORCEMENT.—A PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan under part D of title XVIII may not contract with a PBM that is not in compliance with the requirement under paragraph (1).

''(g) BONA FIDE SERVICE FEES DEFINED.—The term 'bona fide service fees' means, with respect to a PBM, fees paid to such PBM (or an agent or affiliate of such PBM acting on the PBM's behalf) by a manufacturer, customer, or client of the PBM that represent the fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer, customer, or client, that the manufacturer, customer, or client would otherwise perform (or contract for) in the absence of the serv-

ice arrangement, and that the PBM does not pass on to another party.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2022.

SEC. 133. PART D NEGOTIATED PRICES REQUIRED TO TAKE INTO ACCOUNT CERTAIN PRICE CONCESSIONS AT THE POINT-OF-SALE.

(a) IN GENERAL.—Section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) is amended—

(1) by striking ''PRICES.—For purposes'' and inserting ''PRICES.—

''(i) IN GENERAL.—For purposes''; and

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

''(ii) NEGOTIATED PRICES AT POINT-OF-SALE.—

''(I) IN GENERAL.—Negotiated prices for covered part D drugs described in clause (i) shall be provided at the point-of-sale of the covered part D drug. If the negotiated price is not possible to calculate at the point-of-sale, an approximate negotiated price

(as established by the Secretary) shall be used under the prescription drug plan or MA–PD plan.

''(II) INCLUSION OF CERTAIN PRICE CONCESSIONS.—Negotiated prices described in subclause (I) shall include the value of at least 80 percent of all rebates, discounts, or other price concessions received by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan from a drug manufacturer, either directly or indirectly from a PBM to such PDP sponsor or MA organization.

''(III) APPROXIMATE NEGOTIATED PRICE.—In determining an approximate negotiated price for a covered part D drug under subclause (I), the Secretary shall ensure that—

''(aa) such price reflects the estimated negotiated price that is based on the previous year's negotiated price concessions negotiated under the plan for all or

similar covered part D drugs or is based on such other factors as the Secretary may determine appropriate; and

''(bb) the use of such price does not prevent the use of value-based contracts between drug manufacturers, PDP sponsors, MA organizations, and pharmacies.''.

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

SEC. 134. ALLOWING CERTAIN ENROLLEES OF PRESCRIPTION DRUGS PLANS AND MA–PD PLANS UNDER MEDICARE PROGRAM TO SPREAD OUT COST-SHARING UNDER CERTAIN CIRCUMSTANCES.

(a) STANDARD PRESCRIPTION DRUG COVERAGE.—Section 1860D–2(b)(2) of the Social Security Act (42 U.S.C. 1395w–102(b)(2)), as amended by section 121, is further amended—

(1) in subparagraph (A), by striking ''Subject to subparagraphs (C) and (D)'' and inserting ''Subject to subparagraphs (C), (D), and (E)''; and

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

"(E) ENROLLEE OPTION REGARDING SPREADING COST-SHARING.—

"(i) IN GENERAL.—The Secretary shall establish by regulation a process under which, with respect to plan year 2022 and subsequent plan years, a prescription drug plan or an MA–PD plan shall, in the case of a part D eligible individual enrolled with such plan for such plan year with respect to whom the plan projects that the dispensing of a covered part D drug to such individual will result in the individual incurring costs within a 30-day period that are equal to a significant percentage (as specified by the Secretary pursuant to such regulation) of the annual out-of-pocket threshold specified in paragraph (4)(B) for such plan year, provide such individual with the option to make the coinsurance payment required under subparagraph (A) for such costs in the form of equal monthly installments over the remainder of such plan year.

''(ii) SIGNIFICANT PERCENTAGE LIMITATIONS.—In specifying a significant percentage pursuant to the regulation established by the Secretary under clause (i), the Secretary may not specify a percentage that is less than 30 percent or greater than 100 percent.''.

(b) ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—Section 1860D–2(c) of the Social Security Act (42 U.S.C. 1395w–102(c)) is amended by adding at the end the following new paragraph:

''(4) SAME ENROLLEE OPTION REGARDING SPREADING COST-SHARING.—For plan year 2022 and subsequent plan years, the coverage provides the enrollee option regarding spreading cost-sharing described in and required under subsection (b)(2)(E).''.

Subtitle E—MedPAC

SEC. 141. PROVIDING THE MEDICARE PAYMENT ADVISORY COMMISSION AND MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION WITH ACCESS TO CERTAIN DRUG PAYMENT INFORMATION, INCLUDING CERTAIN REBATE INFORMATION.

(a) ACCESS TO CERTAIN PART D PAYMENT DATA.—Section 1860D–15(f) of the Social Security Act (42 U.S.C. 1395w–115(f)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)(ii), by striking ''and'' at the end;

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

(C) by inserting at the end the following new subparagraph:

''(C) by the Executive Director of the Medicare Payment Advisory Commission for purposes of monitoring, making recommendations, and analysis of the program under this title and by the Executive Director of the Medicaid and CHIP Payment and Access Commission for purposes of monitoring, making recommendations, and analysis of the Medicaid

program established under title XIX and the Children's Health Insurance Program under title XXI.''; and

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

''(3) ADDITIONAL RESTRICTIONS ON DISCLOSURE OF INFORMATION.—The Executive Directors described in paragraph (2)(C) shall not disclose any of the following information disclosed to such Executive Directors or obtained by such Executive Directors pursuant to such paragraph, with respect to a prescription drug plan offered by a PDP sponsor:

''(A) The specific amounts or the identity of the source of any rebates, price concessions, or other forms of direct or indirect remuneration under such prescription drug plan.

''(B) Information submitted with the bid submitted under section 1860D–11 by such PDP sponsor.

''(C) In the case of such information from prescription drug event records, in a form that would not be permitted under section 423.505(m) of title 42, Code of Federal Regulations, or any successor regulation, if made by the Centers for Medicare & Medicaid Services.''.

(b) ACCESS TO CERTAIN REBATE AND PAYMENT DATA UNDER MEDICARE AND MEDICAID.—Section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(D)) is amended—

(1) in the matter before clause (i), by striking ''subsection (a)(6)(A)(ii)'' and inserting ''subsection (a)(6)(A)'';

(2) in clause (v), by striking ''and'' at the end;

(3) in clause (vi), by striking the period at the end and inserting '', and'';

(4) by inserting after clause (vi) the following new clause:

''(vii) to permit the Executive Director of the Medicare Payment Advisory Commission and the Executive Director of the Medicaid and CHIP Payment and Access Commission to review the information provided.'';

(5) in the matter at the end, by striking ''1860D–4(c)(2)(E)'' and inserting ''1860D–4(c)(2)(G)''; and

(6) by adding at the end the following new sentence: ''Any information disclosed to the Executive Director of the Medicare Payment Advisory Commission or the Executive Director of the Medicaid and

CHIP Payment and Access Commission pursuant to this subparagraph shall not be disclosed by either such Executive Director in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler.''.

TITLE II—MEDICAID

SEC. 201. REQUIREMENT FOR CERTAIN COVERED ENTITIES PASS THROUGH SAVINGS FROM 340B DRUG DISCOUNT PROGRAM TO PATIENTS.

(a) IN GENERAL.—Section 340B(a)(5) of the Public Health Service Act (42 U.S.C. 256b(a)(5)) is amended by adding at the end the following new subparagraph:

''(E) PASS-THROUGH OF SAVINGS.—

''(i) IN GENERAL.—A hospital that is a covered entity described in subparagraph (L), (M), (N), or (O) of paragraph (4) shall, with respect to a covered outpatient drug subject to an agreement under this section that is purchased on or after the date that is 180 days after the date of the enactment of this subparagraph, pass through the savings amount determined under clause (ii) with respect to such drug to the patient receiving such drug.

''(ii) SAVINGS AMOUNT.—The savings amount determined under this clause, with respect to a covered outpatient drug subject to an agreement under this section, is the amount equal to 75 percent of the reduction in the price of the drug provided under such agreement.''.

(b) REQUIREMENT FOR COST-SHARING FOR 340B DRUGS TO BE BASED ON 340B PRICE.—

(1) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following new section:

''SEC. 2729A. COST-SHARING FOR DRUGS PURCHASED UNDER 340B DRUG DISCOUNT PROGRAM.

''If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides or covers any benefits for a covered outpatient drug (as defined in section 1927(k) of the Social Security Act) subject to an agreement under section 340B and an enrollee of such plan or coverage is furnished such drug, then such plan or issuer shall calculate the cost-sharing requirement for an enrollee of such plan or coverage for such drug as if the total amount charged for such drug

was the amount paid for such drug under an agreement under the drug discount program under section 340B.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to plan years beginning on or after the date that is 180 days after the date of the enactment of this Act.

SEC. 202. SENSE OF CONGRESS RELATING TO 340B DRUG DISCOUNT PROGRAM.

It is the sense of Congress that the purpose of the drug discount program under section 340B of the Public Health Service Act (42 U.S.C. 256b) is to lower out-of-pocket drugs costs for low-income and uninsured individuals.

SEC. 203. SUNSET OF LIMIT ON MAXIMUM REBATE AMOUNT FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.

Section 1927(c)(2)(D) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)(D)) is amended by inserting after ''December 31, 2009,'' the following: ''and before January 1, 2023,''.

SEC. 204. MEDICAID PHARMACY AND THERAPEUTICS COMMITTEE IMPROVEMENTS.

(a) IN GENERAL.—Subparagraph (A) of section 1927(d)(4) of the Social Security Act (42 U.S.C. 1396r–8(d)(4)) is amended to read as follows:

''(A)(i) The formulary is developed and reviewed by a pharmacy and therapeutics committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State.

''(ii) Subject to clause (vi), the State establishes and implements a conflict of interest policy for the pharmacy and therapeutics committee that—

''(I) is publicly accessible;

''(II) requires all committee members to complete, on at least an annual basis, a disclosure of relationships, associations, and financial dealings that may affect their independence of judgement in committee matters; and

''(III) contains clear processes, such as recusal from voting or discussion, for those members who report a conflict of interest, along with appropriate processes to address any instance where a member fails to report a conflict of interest.

''(iii) The membership of the pharmacy and therapeutics committee—

''(I) includes at least 1 actively practicing physician and at least 1 actively practicing pharmacist, each of whom—

''(aa) is independent and free of conflict with respect to manufacturers and Medicaid participating plans or subcontractors, including pharmacy benefit managers; and

''(bb) has expertise in the care of 1 or more Medicaid-specific populations such as elderly or disabled individuals, children with complex medical needs, or low-income individuals with chronic illnesses; and

''(II) is made publicly available.

''(iv) At the option of the State, the State's drug use review board established under subsection (g)(3) may serve as the pharmacy and therapeutics committee provided the State ensures that such board meets the requirements of clauses (ii) and (iii).

''(v) The State reviews and has final approval of the formulary established by the pharmacy and therapeutics committee.

''(vi) If the Secretary determines it appropriate or necessary based on the findings and recommendations of the Comptroller General of the United States in the report submitted to Congress under section 205 of the Lower Drug Costs Now Act of 2019, the Secretary shall issue guidance that States must follow for establishing conflict of interest policies for the pharmacy and therapeutics committee in accordance with the requirements of clause (ii), including appropriate standards and requirements for identifying, addressing, and reporting on conflicts of interest.''.

(b) APPLICATION TO MEDICAID MANAGED CARE ORGANIZATIONS.—Clause (xiii) of section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) by striking ''and (III)'' and inserting ''(III)'';

(2) by striking the period at the end and inserting '', and (IV) any formulary used by the entity for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity is developed and reviewed by a pharmacy and therapeutics committee that meets the require-

ments of clauses (ii) and (iii) of section 1927(d)(4)(A).''; and

(3) by moving the left margin 2 ems to the left.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of enactment of this Act.

SEC. 205. GAO REPORT ON CONFLICTS OF INTEREST IN STATE MEDICAID PROGRAM DRUG USE REVIEW BOARDS AND PHARMACY AND THERAPEUTICS (P&T) COMMITTEES.

(a) INVESTIGATION.—The Comptroller General of the United States shall conduct an investigation of potential or existing conflicts of interest among members of State Medicaid program State drug use review boards (in this section referred to as ''DUR Boards'') and pharmacy and therapeutics committees (in this section referred to as ''P&T Committees'').

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the investigation conducted under subsection (a) that includes the following:

(1) A description outlining how DUR Boards and P&T Committees operate in States, including details with respect to—

(A) the structure and operation of DUR Boards and statewide P&T Committees;

(B) States that operate separate P&T Committees for their fee-for-service Medicaid program and their Medicaid managed care organizations or other Medicaid managed care arrangements (collectively referred to in this section as ''Medicaid MCOs)''; and

(C) States that allow Medicaid MCOs to have their own P&T Committees and the extent to which pharmacy benefit managers administer or participate in such P&T Committees.

(2) A description outlining the differences between DUR Boards established in accordance with section 1927(g)(3) of the Social Security Act (42 U.S.C. 1396r(g)(3)) and P&T Committees.

(3) A description outlining the tools P&T Committees may use to determine Medicaid drug coverage and utilization management policies.

(4) An analysis of whether and how States or P&T Committees establish participation and independence requirements for DUR Boards and P&T Committees, including with respect to entities with connections with drug manufacturers, State Medicaid programs, managed care organizations, and

other entities or individuals in the pharmaceutical industry.

(5) A description outlining how States, DUR Boards, or P&T Committees define conflicts of interest.

(6) A description of how DUR Boards and P&T Committees address conflicts of interest, including who is responsible for implementing such policies.

(7) A description of the tools, if any, States use to ensure that there are no conflicts of interest on DUR Boards and P&T Committees.

(8) An analysis of the effectiveness of tools States use to ensure that there are no conflicts of interest on DUR Boards and P&T Committees and, if applicable, recommendations as to how such tools could be improved.

(9) A review of strategies States may use to guard against conflicts of interest on DUR Boards and P&T Committees and to ensure compliance with the requirements of titles XI and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1396 et seq.) and access to effective, clinically appropriate, and medically necessary drug treatments for Medicaid beneficiaries, including recommendations for such

legislative and administrative actions as the Comptroller General determines appropriate.

SEC. 206. ENSURING THE ACCURACY OF MANUFACTURER PRICE AND DRUG PRODUCT INFORMATION UNDER THE MEDICAID DRUG REBATE PROGRAM.

(a) AUDIT OF MANUFACTURER PRICE AND DRUG PRODUCT INFORMATION.—

(1) IN GENERAL.—Subparagraph (B) of section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)) is amended to read as follows:

"(B) AUDITS AND SURVEYS OF MANUFACTURER PRICE AND DRUG PRODUCT INFORMATION.—

"(i) AUDITS.—The Secretary shall conduct ongoing audits of the price and drug product information reported by manufacturers under subparagraph (A) for the most recently ended rebate period to ensure the accuracy and timeliness of such information. In conducting such audits, the Secretary may employ evaluations, surveys, statistical sampling, predictive analytics and other relevant tools and methods.

"(ii) VERIFICATIONS SURVEYS OF AVERAGE MANUFACTURER PRICE AND MANUFACTURER'S AVERAGE SALES PRICE.—In addition to the audits required under clause (i), the Secretary may survey wholesalers and manufacturers (including manufacturers that directly distribute their covered outpatient drugs (in this subparagraph referred to as 'direct sellers')), when necessary, to verify manufacturer prices and manufacturer's average sales prices (including wholesale acquisition cost) to make payment reported under subparagraph (A).

"(iii) PENALTIES.—In addition to other penalties as may be prescribed by law, including under subparagraph (C) of this paragraph, the Secretary may impose a civil monetary penalty in an amount not to exceed $185,000 on an annual basis on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in con-

nection with an audit or survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(iv) REPORTS.—

''(I) REPORT TO CONGRESS.—The Secretary shall, not later than 18 months after date of enactment of this subparagraph, submit a report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate regarding additional regulatory or statutory changes that may be required in order to ensure accurate and timely reporting and oversight of manufacturer price and drug product information, including whether changes should be made to reasonable

assumption requirements to ensure such assumptions are reasonable and accurate or whether another methodology for ensuring accurate and timely reporting of price and drug product information should be considered to ensure the integrity of the drug rebate program under this section.

''(II) ANNUAL REPORTS.—The Secretary shall, on at least an annual basis, submit a report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate summarizing the results of the audits and surveys conducted under this subparagraph during the period that is the subject of the report.

''(III) CONTENT.—Each report submitted under subclause (II) shall, with respect to the period that is the subject of the report, include summaries of—

''(aa) error rates in the price, drug product, and other

relevant information supplied by manufacturers under subparagraph (A);

''(bb) the timeliness with which manufacturers, wholesalers, and direct sellers provide information required under subparagraph (A) or under clause (i) or (ii) of this subparagraph;

''(cc) the number of manufacturers, wholesalers, and direct sellers and drug products audited under this subparagraph;

''(dd) the types of price and drug product information reviewed under the audits conducted under this subparagraph;

''(ee) the tools and methodologies employed in such audits;

''(ff) the findings of such audits, including which manufacturers, if any, were penalized under this subparagraph; and

''(gg) such other relevant information as the Secretary shall deem appropriate.

''(IV) PROTECTION OF INFORMATION.—In preparing a report required under subclause (II), the Secretary shall redact such proprietary information as the Secretary determines appropriate to prevent disclosure of, and to safeguard, such information.

''(v) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary $2,000,000 for fiscal year 2020 and each fiscal year thereafter to carry out this subparagraph.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the first day of the first fiscal quarter that begins after the date of enactment of this Act.

(b) INCREASED PENALTIES FOR NONCOMPLIANCE WITH REPORTING REQUIREMENTS.—

(1) INCREASED PENALTY FOR LATE REPORTING OF INFORMATION.—Section 1927(b)(3)(C)(i) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(C)(i))

is amended by striking ''increased by $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury'' and inserting '', for each covered outpatient drug with respect to which such information is not provided, $50,000 for the first day that such information is not provided on a timely basis and $19,000 for each subsequent day that such information is not provided''.

(2) INCREASED PENALTY FOR KNOWINGLY REPORTING FALSE INFORMATION.—Section 1927(b)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(C)(ii)) is amended by striking ''$100,000'' and inserting ''$500,000''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the first day of the first fiscal quarter that begins after the date of enactment of this Act.

SEC. 207. IMPROVING TRANSPARENCY AND PREVENTING THE USE OF ABUSIVE SPREAD PRICING AND RELATED PRACTICES IN MEDICAID.

(a) PASS-THROUGH PRICING REQUIRED.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended by adding at the end the following:

''(6) PASS-THROUGH PRICING REQUIRED.—A contract between the State and a pharmacy benefit manager (referred to in this paragraph as a 'PBM'), or a contract between the State and a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D)) that includes provisions making the entity responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or entity, is based on a pass-through pricing model under which—

''(A) any payment made by the entity of the PBM (as applicable) for such a drug—

''(i) is limited to—

''(I) ingredient cost; and

''(II) a professional dispensing fee that is not less than the professional dispensing fee that the State plan or waiver would pay if the plan or waiver was making the payment directly;

''(ii) is passed through in its entirety by the entity or PBM to the pharmacy that dispenses the drug; and

''(iii) is made in a manner that is consistent with section 1902(a)(30)(A) and sections 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the entity or the PBM;

''(B) payment to the entity or the PBM (as applicable) for administrative services performed by the entity or PBM is limited to a reasonable administrative fee that covers the reasonable cost of providing such services;

''(C) the entity or the PBM (as applicable) shall make available to the State, and the Secretary upon request, all costs and payments related to covered outpatient drugs and accompanying administrative services incurred, received, or made by the entity or the PBM, including ingredient costs, professional dispensing fees, administrative fees, post-sale and post-invoice fees. Discounts, or related adjustments

such as direct and indirect remuneration fees, and any and all remuneration; and

''(D) any form of spread pricing whereby any amount charged or claimed by the entity or the PBM (as applicable) is in excess of the amount paid to the pharmacies on behalf of the entity, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments (after allowing for a reasonable administrative fee as described in subparagraph (B)) is not allowable for purposes of claiming Federal matching payments under this title.''.

(2) CONFORMING AMENDMENT.—Clause (xiii) of section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)), as amended by section 204, is further amended—

(A) by striking ''and (IV)'' and inserting ''(IV)''; and

(B) by inserting before the period at the end the following: '', and (V) pharmacy benefit management services provided by the entity, or provided by a pharmacy benefit manager on behalf of the entity under a contract or other arrangement between the entity and the phar-

macy benefit manager, shall comply with the requirements of section 1927(e)(6)''.

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to contracts between States and managed care entities, other specified entities, or pharmacy benefits managers that are entered into or renewed on or after the date that is 18 months after the date of enactment of this Act.

(b) SURVEY OF RETAIL PRICES.—

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

(A) by striking ''and'' after the semicolon at the end of paragraph (1)(A)(i) and all that precedes it through ''(1)'' and inserting the following:

''(1) SURVEY OF RETAIL PRICES.—The Secretary shall conduct a survey of retail community drug prices, to include at least the national average drug acquisition cost, as follows:

''(A) USE OF VENDOR.—The Secretary may contract services for—

''(i) with respect to retail community pharmacies, the determination on a monthly basis of retail survey prices of the national average drug acquisition cost for

covered outpatient drugs for such pharmacies, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available), the average reimbursement received for such drugs by such pharmacies from all sources of payment, including third parties, and, to the extent available, the usual and customary charges to consumers for such drugs; and'';

(B) by adding at the end of paragraph (1) the following:

''(F) SURVEY REPORTING.—In order to meet the requirement of section 1902(a)(54), a State shall require that any retail community pharmacy in the State that receives any payment, administrative fee, discount, or rebate related to the dispensing of covered outpatient drugs to individuals receiving benefits under this title, regardless of whether such payment, fee, discount, or rebate is received from the State or a managed care entity directly or from a pharmacy benefit manager or another entity that has a contract with the State or a man-

aged care entity, shall respond to surveys of retail prices conducted under this subsection.

''(G) SURVEY INFORMATION.—Information on retail community prices obtained under this paragraph shall be made publicly available and shall include at least the following:

''(i) The monthly response rate of the survey including a list of pharmacies not in compliance with subparagraph (F).

''(ii) The sampling frame and number of pharmacies sampled monthly.

''(iii) Characteristics of reporting pharmacies, including type (such as independent or chain), geographic or regional location, and dispensing volume.

''(iv) Reporting of a separate national average drug acquisition cost for each drug for independent retail pharmacies and chain operated pharmacies.

''(v) Information on price concessions including on and off invoice discounts, rebates, and other price concessions.

''(vi) Information on average professional dispensing fees paid.

''(H) PENALTIES.—

''(i) FAILURE TO PROVIDE TIMELY INFORMATION.—A retail community pharmacy that fails to respond to a survey conducted under this subsection on a timely basis may be subject to a civil monetary penalty in the amount of $10,000 for each day in which such information has not been provided.

''(ii) FALSE INFORMATION.—A retail community pharmacy that knowingly provides false information in response to a survey conducted under this subsection may be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

''(iii) OTHER PENALTIES.—Any civil money penalties imposed under this subparagraph shall be in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceedings under section 1128A(a).

"(I) REPORT ON SPECIALTY PHARMACIES.—

"(i) IN GENERAL.—Not later than 1 year after the effective date of this subparagraph, the Secretary shall submit a report to Congress examining specialty drug coverage and reimbursement under this title.

"(ii) CONTENT OF REPORT.—Such report shall include a description of how State Medicaid programs define specialty drugs, how much State Medicaid programs pay for specialty drugs, how States and managed care plans determine payment for specialty drugs, the settings in which specialty drugs are dispensed (such as retail community pharmacies or specialty pharmacies), whether acquisition costs for specialty drugs are captured in the national average drug acquisition cost survey, and recommendations as to whether specialty pharmacies should be included in the survey of retail prices to ensure national average drug acquisition costs capture drugs

sold at specialty pharmacies and how such specialty pharmacies should be defined.'';

(C) in paragraph (2)—

(i) in subparagraph (A), by inserting '', including payments rates under Medicaid managed care plans,'' after ''under this title''; and

(ii) in subparagraph (B), by inserting ''and the basis for such dispensing fees'' before the semicolon; and

(D) in paragraph (4), by inserting '', and $5,000,000 for fiscal year 2020 and each fiscal year thereafter,'' after ''2010''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the 1st day of the 1st quarter that begins on or after the date that is 18 months after the date of enactment of this Act.

(c) MANUFACTURER REPORTING OF WHOLESALE ACQUISITION COST.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)), as amended by section 141, is further amended—

(1) in subparagraph (A)(i)—

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

(B) in subclause (II), by adding ''and'' after the semicolon;

(C) by moving the left margins of subclause (I) and (II) 2 ems to the right; and

(D) by adding at the end the following:

''(III) in the case of rebate periods that begin on or after the date of enactment of this subclause, on the wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act);''; and

(2) in subparagraph (D)—

(A) in the matter preceding clause (i), by inserting ''and clause (vii) of this subparagraph'' after ''1847A'';

(B) in clause (vi), by striking ''and'' after the comma;

(C) in clause (vii), by striking the period and inserting '', and''; and

(D) by inserting after clause (vii) the following:

''(viii) to the Secretary to disclose (through a website accessible to the public) the most recently reported wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) for each covered outpatient drug (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), as reported under subparagraph (A)(i)(III).''.

SEC. 208. T–MSIS DRUG DATA ANALYTICS REPORTS.

(a) IN GENERAL.—Not later than May 1 of each calendar year beginning with calendar year 2021, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall publish on a website of the Centers for Medicare & Medicaid Services that is accessible to the public a report of the most recently available data on provider prescribing patterns under the Medicaid program.

(b) CONTENT OF REPORT.—

(1) REQUIRED CONTENT.—Each report required under subsection (a) for a calendar year shall include the following information with respect to

each State (and, to the extent available, with respect to Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa):

(A) A comparison of covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act (42 U.S.C. 1396r–8(k)(2))) prescribing patterns under the State Medicaid plan or waiver of such plan (including drugs prescribed on a fee-for-service basis and drugs prescribed under managed care arrangements under such plan or waiver)—

(i) across all forms or models of reimbursement used under the plan or waiver;

(ii) within specialties and subspecialties, as defined by the Secretary;

(iii) by episodes of care for—

(I) each chronic disease category, as defined by the Secretary, that is represented in the 10 conditions that accounted for the greatest share of total spending under the plan or waiver during the year that is the subject of the report;

(II) procedural groupings; and

(III) rare disease diagnosis codes;

(iv) by patient demographic characteristics, including race (to the extent that the Secretary determines that there is sufficient data available with respect to such characteristic in a majority of States), gender, and age;

(v) by patient high-utilizer or risk status; and

(vi) by high and low resource settings by facility and place of service categories, as determined by the Secretary.

(B) In the case of medical assistance for covered outpatient drugs (as so defined) provided under a State Medicaid plan or waiver of such plan in a managed care setting, an analysis of the differences in managed care prescribing patterns when a covered outpatient drug is prescribed in a managed care setting as compared to when the drug is prescribed in a fee-for-service setting.

(2) ADDITIONAL CONTENT.—A report required under subsection (a) for a calendar year may include State-specific information about prescription utiliza-

tion management tools under State Medicaid plans or waivers of such plans, including—

(A) a description of prescription utilization management tools under State programs to provide long-term services and supports under a State Medicaid plan or a waiver of such plan;

(B) a comparison of prescription utilization management tools applicable to populations covered under a State Medicaid plan waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) and the models applicable to populations that are not covered under the waiver;

(C) a comparison of the prescription utilization management tools employed by different Medicaid managed care organizations, pharmacy benefit managers, and related entities within the State;

(D) a comparison of the prescription utilization management tools applicable to each enrollment category under a State Medicaid plan or waiver; and

(E) a comparison of the prescription utilization management tools applicable under the State Medicaid plan or waiver by patient high-utilizer or risk status.

(3) ADDITIONAL ANALYSIS.—To the extent practicable, the Secretary shall include in each report published under subsection (a)—

(A) analyses of national, State, and local patterns of Medicaid population-based prescribing behaviors; and

(B) recommendations for administrative or legislative action to improve the effectiveness of, and reduce costs for, covered outpatient drugs under Medicaid while ensuring timely beneficiary access to medically necessary covered outpatient drugs.

(c) USE OF T–MSIS DATA.—Each report required under subsection (a) shall—

(1) be prepared using data and definitions from the Transformed Medicaid Statistical Information System (T–MSIS) data set (or a successor data set) that is not more than 24 months old on the date that the report is published; and

(2) as appropriate, include a description with respect to each State of the quality and completeness of the data, as well as any necessary caveats describing the limitations of the data reported to the Secretary by the State that are sufficient to communicate the appropriate uses for the information.

(d) PREPARATION OF REPORT.—Each report required under subsection (a) shall be prepared by the Administrator for the Centers for Medicare & Medicaid Services.

(e) APPROPRIATION.—For fiscal year 2020 and each fiscal year thereafter, there is appropriated to the Secretary $2,000,000 to carry out this section.

SEC. 209. RISK-SHARING VALUE-BASED PAYMENT AGREEMENTS FOR COVERED OUTPATIENT DRUGS UNDER MEDICAID.

(a) IN GENERAL.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) STATE OPTION TO PAY FOR COVERED OUTPATIENT DRUGS THROUGH RISK-SHARING VALUE-BASED AGREEMENTS.—

''(1) IN GENERAL.—Beginning January 1, 2022, a State shall have the option to pay (whether on a fee-for-service or managed care basis) for covered outpatient drugs that are potentially curative treatments intended for one-time use that are administered to individuals under this title by entering into a risk-sharing value-based payment agreement with the manufacturer of the drug in accordance with the requirements of this subsection.

''(2) SECRETARIAL APPROVAL.—

''(A) IN GENERAL.—A State shall submit a request to the Secretary to enter into a risk-sharing value based payment agreement, and the Secretary shall not approve a proposed risk-sharing value-based payment agreement between a State and a manufacturer for payment for a covered outpatient drug of the manufacturer unless the following requirements are met:

''(i) MANUFACTURER IS PARTY TO REBATE AGREEMENT AND IN COMPLIANCE WITH REQUIREMENTS.—The manufacturer has a rebate agreement in effect as required under subsection (a) and (b) of this section and is in compliance with all applicable requirements under this title.

''(ii) NO INCREASE TO PROJECTED NET FEDERAL SPENDING.—

''(I) IN GENERAL.—The Chief Actuary certifies that the projected payments for each covered outpatient drug under such proposed agreement would not result in greater estimated Federal spending under this title than the net Federal spending that would

result in the absence of the agreement.

''(II) NET FEDERAL SPENDING DEFINED.—For purposes of this subsection, the term 'net Federal spending' means the amount of Federal payments the Chief Actuary estimates would be made under this title for administering a covered outpatient drug to an individual eligible for medical assistance under a State plan or a waiver of such plan, reduced by the amount of all rebates the Chief Actuary estimates would be paid with respect to the administering of such drug, including all rebates under this title and any supplemental or other additional rebates, in the absence of such an agreement.

''(III) INFORMATION.—The Chief Actuary shall make the certifications required under this clause based on the most recently available and reliable drug pricing and product information. The State and manufacturer

shall provide the Secretary and the Chief Actuary with all necessary information required to make the estimates needed for such certifications.

''(iii) LAUNCH AND LIST PRICE JUSTIFICATIONS.—The manufacturer submits all relevant information and supporting documentation necessary for pricing decisions as deemed appropriate by the Secretary, which shall be truthful and nonmisleading, including manufacturer information and supporting documentation for launch price or list price increases, and any applicable justification required under section 1128L.

''(iv) CONFIDENTIALITY OF INFORMATION; PENALTIES.—The provisions of subparagraphs (C) and (D) of subsection (b)(3) shall apply to a manufacturer that fails to submit the information and documentation required under clauses (ii) and (iii) on a timely basis, or that knowingly provides false or misleading information, in the same manner as such provisions apply

to a manufacturer with a rebate agreement under this section.

''(B) CONSIDERATION OF STATE REQUEST FOR APPROVAL.—

''(i) IN GENERAL.—The Secretary shall treat a State request for approval of a risk-sharing value-based payment agreement in the same manner that the Secretary treats a State plan amendment, and subpart B of part 430 of title 42, Code of Federal Regulations, including, subject to clause (ii), the timing requirements of section 430.16 of such title (as in effect on the date of enactment of this subsection), shall apply to a request for approval of a risk-sharing value-based payment agreement in the same manner as such subpart applies to a State plan amendment.

''(ii) TIMING.—The Secretary shall consult with the Commissioner of Food and Drugs as required under subparagraph (C) and make a determination on whether to approve a request from a State for approval of a proposed risk-sharing value-based payment agreement (or request

additional information necessary to allow the Secretary to make a determination with respect to such request for approval) within the time period, to the extent practicable, specified in section 430.16 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this subsection), but in no case shall the Secretary take more than 180 days after the receipt of such request for approval or response to such request for additional information to make such a determination (or request additional information).

''(C) CONSULTATION WITH THE COMMISSIONER OF FOOD AND DRUGS.—In considering whether to approve a risk-sharing value-based payment agreement, the Secretary, to the extent necessary, shall consult with the Commissioner of Food and Drugs to determine whether the relevant clinical parameters specified in such agreement are appropriate.

''(3) INSTALLMENT-BASED PAYMENT STRUCTURE.—

''(A) IN GENERAL.—A risk-sharing value-based payment agreement shall provide for a

payment structure under which, for every installment year of the agreement (subject to subparagraph (B)), the State shall pay the total installment year amount in equal installments to be paid at regular intervals over a period of time that shall be specified in the agreement.

''(B) REQUIREMENTS FOR INSTALLMENT PAYMENTS.—

''(i) TIMING OF FIRST PAYMENT.—The State shall make the first of the installment payments described in subparagraph (A) for an installment year not later than 30 days after the end of such year.

''(ii) LENGTH OF INSTALLMENT PERIOD.—The period of time over which the State shall make the installment payments described in subparagraph (A) for an installment year shall not be longer than 5 years.

''(iii) NONPAYMENT OR REDUCED PAYMENT OF INSTALLMENTS FOLLOWING A FAILURE TO MEET CLINICAL PARAMETER.—If, prior to the payment date (as specified in the agreement) of any installment payment described in subparagraph

(A) or any other alternative date or time frame (as otherwise specified in the agreement), the covered outpatient drug which is subject to the agreement fails to meet a relevant clinical parameter of the agreement, the agreement shall provide that—

"(I) the installment payment shall not be made; or

"(II) the installment payment shall be reduced by a percentage specified in the agreement that is based on the outcome achieved by the drug relative to the relevant clinical parameter.

"(4) NOTICE OF INTENT.—

"(A) IN GENERAL.—Subject to subparagraph (B), a manufacturer of a covered outpatient drug shall not be eligible to enter into a risk-sharing value-based payment agreement under this subsection with respect to such drug unless the manufacturer notifies the Secretary that the manufacturer is interested in entering into such an agreement with respect to such drug. The decision to submit and timing of a request to enter into a proposed risk-sharing

value-based payment agreement shall remain solely within the discretion of the State and shall only be effective upon Secretarial approval as required under this subsection.

''(B) TREATMENT OF SUBSEQUENTLY APPROVED DRUGS.—

''(i) IN GENERAL.—In the case of a manufacturer of a covered outpatient drug approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act after the date of enactment of this subsection, not more than 90 days after meeting with the Food and Drug Administration following phase II clinical trials for such drug (or, in the case of a drug described in clause (ii), not later than March 31, 2022), the manufacturer must notify the Secretary of the manufacturer's intent to enter into a risk-sharing value-based payment agreement under this subsection with respect to such drug. If no such meeting has occurred, the Secretary may use discretion as to whether a potentially curative treatment intended for one-

time use may qualify for a risk-sharing value-based payment agreement under this section. A manufacturer notification of interest shall not have any influence on a decision for approval by the Food and Drug Administration.

''(ii) APPLICATION TO CERTAIN SUBSEQUENTLY APPROVED DRUGS.—A drug described in this clause is a covered outpatient drug of a manufacturer—

''(I) that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act after the date of enactment of this subsection; and

''(II) with respect to which, as of January 1, 2022, more than 90 days have passed after the manufacturer's meeting with the Food and Drug Administration following phase II clinical trials for such drug.

''(iii) PARALLEL APPROVAL.—The Secretary, in coordination with the Administrator of the Centers for Medicare &

Medicaid Services and the Commissioner of Food and Drugs, shall, to the extent practicable, approve a State's request to enter into a proposed risk-sharing value-based payment agreement that otherwise meets the requirements of this subsection at the time that such a drug is approved by the Food and Drug Administration to help provide that no State that wishes to enter into such an agreement is required to pay for the drug in full at one time if the State is seeking to pay over a period of time as outlined in the proposed agreement.

''(iv) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be applied or construed to modify or affect the timeframes or factors involved in the Secretary's determination of whether to approve or license a drug under section 505 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act.

''(5) SPECIAL PAYMENT RULES.—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, with respect to an

individual who is administered a unit of a covered outpatient drug that is purchased under a State plan by a State Medicaid agency under a risk-sharing value-based payment agreement in an installment year, the State shall remain liable to the manufacturer of such drug for payment for such unit without regard to whether the individual remains enrolled in the State plan under this title (or a waiver of such plan) for each installment year for which the State is to make installment payments for covered outpatient drugs purchased under the agreement in such year.

''(B) DEATH.—In the case of an individual described in subparagraph (A) who dies during the period described in such subparagraph, the State plan shall not be liable for any remaining payment for the unit of the covered outpatient drug administered to the individual which is owed under the agreement described in such subparagraph.

''(C) WITHDRAWAL OF APPROVAL.—In the case of a covered outpatient drug that is the subject of a risk-sharing value-based agreement between a State and a manufacturer under this

subsection, including a drug approved in accordance with section 506(c) of the Federal Food, Drug, and Cosmetic Act, and such drug is the subject of an application that has been withdrawn by the Secretary, the State plan shall not be liable for any remaining payment that is owed under the agreement.

''(D) ALTERNATIVE ARRANGEMENT UNDER AGREEMENT.—Subject to approval by the Secretary, the terms of a proposed risk-sharing value-based payment agreement submitted for approval by a State may provide that subparagraph (A) shall not apply.

''(E) GUIDANCE.—Not later than January 1, 2022, the Secretary shall issue guidance to States establishing a process for States to notify the Secretary when an individual who is administered a unit of a covered outpatient drug that is purchased by a State plan under a risk-sharing value-based payment agreement ceases to be enrolled under the State plan under this title (or a waiver of such plan) or dies before the end of the installment period applicable to such unit under the agreement.

''(6) TREATMENT OF PAYMENTS UNDER RISK-SHARING VALUE-BASED AGREEMENTS FOR PURPOSES OF AVERAGE MANUFACTURER PRICE; BEST PRICE.—The Secretary shall treat any payments made to the manufacturer of a covered outpatient drug under a risk-sharing value-based payment agreement under this subsection during a rebate period in the same manner that the Secretary treats payments made under a State supplemental rebate agreement under sections 447.504(c)(19) and 447.505(c)(7) of title 42, Code of Federal Regulations (or any successor regulations) for purposes of determining average manufacturer price and best price under this section with respect to the covered outpatient drug and a rebate period and for purposes of offsets required under subsection (b)(1)(B).

''(7) ASSESSMENTS AND REPORT TO CONGRESS.—

''(A) ASSESSMENTS.—

''(i) IN GENERAL.—Not later than 180 days after the end of each assessment period of any risk-sharing value-based payment agreement for a State approved under this subsection, the Secretary shall conduct an evaluation of such agreement

which shall include an evaluation by the Chief Actuary to determine whether program spending under the risk-sharing value-based payment agreement aligned with the projections for the agreement made under paragraph (2)(A)(ii), including an assessment of whether actual Federal spending under this title under the agreement was less or more than net Federal spending would have been in the absence of the agreement.

''(ii) ASSESSMENT PERIOD.—For purposes of clause (i)—

''(I) the first assessment period for a risk-sharing value-based payment agreement shall be the period of time over which payments are scheduled to be made under the agreement for the first 10 individuals who are administered covered outpatient drugs under the agreement except that such period shall not exceed the 5-year period after the date on which the Secretary approves the agreement; and

"(II) each subsequent assessment period for a risk-sharing value-based payment agreement shall be the 5-year period following the end of the previous assessment period.

"(B) RESULTS OF ASSESSMENTS.—

"(i) TERMINATION OPTION.—If the Secretary determines as a result of the assessment by the Chief Actuary under subparagraph (A) that the actual Federal spending under this title for any covered outpatient drug that was the subject of the State's risk-sharing value-based payment agreement was greater than the net Federal spending that would have resulted in the absence of the agreement, the Secretary may terminate approval of such agreement and shall immediately conduct an assessment under this paragraph of any other ongoing risk-sharing value-based payment agreement to which the same manufacturer is a party.

"(ii) REPAYMENT REQUIRED.—

"(I) IN GENERAL.—If the Secretary determines as a result of the

assessment by the Chief Actuary under subparagraph (A) that the Federal spending under the risk-sharing value-based agreement for a covered outpatient drug that was subject to such agreement was greater than the net Federal spending that would have resulted in the absence of the agreement, the manufacturer shall repay the difference to the State and Federal governments in a timely manner as determined by the Secretary.

''(II) TERMINATION FOR FAILURE TO PAY.—The failure of a manufacturer to make repayments required under subclause (I) in a timely manner shall result in immediate termination of all risk-sharing value-based agreements to which the manufacturer is a party.

''(III) ADDITIONAL PENALTIES.—In the case of a manufacturer that fails to make repayments required under subclause (I), the Secretary may treat such manufacturer

in the same manner as a manufacturer that fails to pay required rebates under this section, and the Secretary may—

"(aa) suspend or terminate the manufacturer's rebate agreement under this section; and

"(bb) pursue any other remedy that would be available if the manufacturer had failed to pay required rebates under this section.

"(C) REPORT TO CONGRESS.—Not later than 5 years after the first risk-sharing value-based payment agreement is approved under this subsection, the Secretary shall submit to Congress and make available to the public a report that includes—

"(i) an assessment of the impact of risk-sharing value-based payment agreements on access for individuals who are eligible for benefits under a State plan or waiver under this title to medically necessary covered outpatient drugs and related treatments;

''(ii) an analysis of the impact of such agreements on overall State and Federal spending under this title;

''(iii) an assessment of the impact of such agreements on drug prices, including launch price and price increases; and

''(iv) such recommendations to Congress as the Secretary deems appropriate.

''(8) GUIDANCE AND REGULATIONS.—

''(A) IN GENERAL.—Not later than January 1, 2022, the Secretary shall issue guidance to States seeking to enter into risk-sharing value-based payment agreements under this subsection that includes a model template for such agreements. The Secretary may issue any additional guidance or promulgate regulations as necessary to implement and enforce the provisions of this subsection.

''(B) MODEL AGREEMENTS.—

''(i) IN GENERAL.—If a State expresses an interest in pursuing a risk-sharing value-based payment agreement under this subsection with a manufacturer for the purchase of a covered outpatient drug, the Secretary may share with such State

any risk-sharing value-based agreement between a State and the manufacturer for the purchase of such drug that has been approved under this subsection. While such shared agreement may serve as a template for a State that wishes to propose, the use of a previously approved agreement shall not affect the submission and approval process for approval of a proposed risk-sharing value-based payment agreement under this subsection, including the requirements under paragraph (2)(A).

''(ii) CONFIDENTIALITY.—In the case of a risk-sharing value-based payment agreement that is disclosed to a State by the Secretary under this subparagraph and that is only in effect with respect to a single State, the confidentiality of information provisions described in subsection (b)(3)(D) shall apply to such information.

''(C) OIG CONSULTATION.—

''(i) IN GENERAL.—The Secretary shall consult with the Office of the Inspector General of the Department of Health and Human Services to determine whether

there are potential program integrity concerns with agreement approvals or templates and address accordingly.

''(ii) OIG POLICY UPDATES AS NECESSARY.—The Inspector General of the Department of Health and Human Services shall review and update, as necessary, any policies or guidelines of the Office of the Inspector General of the Department of Human Services (including policies related to the enforcement of section 1128B) to accommodate the use of risk-sharing value-based payment agreements in accordance with this section.

''(9) RULES OF CONSTRUCTION.—

''(A) MODIFICATIONS.—Nothing in this subsection or any regulations promulgated under this subsection shall prohibit a State from requesting a modification from the Secretary to the terms of a risk-sharing value-based payment agreement. A modification that is expected to result in any increase to projected net State or Federal spending under the agreement shall be subject to recertification by the Chief Actuary as described in paragraph

(2)(A)(ii) before the modification may be approved.

''(B) REBATE AGREEMENTS.—Nothing in this subsection shall be construed as requiring a State to enter into a risk-sharing value-based payment agreement or as limiting or superseding the ability of a State to enter into a supplemental rebate agreement for a covered outpatient drug.

''(C) FFP FOR PAYMENTS UNDER RISK-SHARING VALUE-BASED PAYMENT AGREEMENTS.—Federal financial participation shall be available under this title for any payment made by a State to a manufacturer for a covered outpatient drug under a risk-sharing value-based payment agreement in accordance with this subsection, except that no Federal financial participation shall be available for any payment made by a State to a manufacturer under such an agreement on and after the effective date of a disapproval of such agreement by the Secretary.

''(D) CONTINUED APPLICATION OF OTHER PROVISIONS.—Except as expressly provided in this subsection, nothing in this subsection or in

any regulations promulgated under this subsection shall affect the application of any other provision of this Act.

''(10) APPROPRIATIONS.—For fiscal year 2020 and each fiscal year thereafter, there are appropriated to the Secretary $5,000,000 for the purpose of carrying out this subsection.

''(11) DEFINITIONS.—In this subsection:

''(A) CHIEF ACTUARY.—The term 'Chief Actuary' means the Chief Actuary of the Centers for Medicare & Medicaid Services.

''(B) INSTALLMENT YEAR.—The term 'installment year' means, with respect to a risk-sharing value-based payment agreement, a 12-month period during which a covered outpatient drug is administered under the agreement.

''(C) POTENTIALLY CURATIVE TREATMENT INTENDED FOR ONE-TIME USE.—The term 'potentially curative treatment intended for one-time use' means a treatment that consists of the administration of a covered outpatient drug that—

''(i) is a form of gene therapy for a rare disease, as defined by the Commissioner of Food and Drugs, designated

under section 526 of the Federal Food, Drug, and Cosmetics Act, and approved under section 505 of such Act or licensed under subsection (a) or (k) of section 351 of the Public Health Service Act to treat a serious or life-threatening disease or condition;

''(ii) if administered in accordance with the labeling of such drug, is expected to result in either—

''(I) the cure of such disease or condition; or

''(II) a reduction in the symptoms of such disease or condition to the extent that such disease or condition is not expected to lead to early mortality; and

''(iii) is expected to achieve a result described in clause (ii), which may be achieved over an extended period of time, after not more than 3 administrations.

''(D) RELEVANT CLINICAL PARAMETER.—The term 'relevant clinical parameter' means, with respect to a covered outpatient drug that

is the subject of a risk-sharing value-based payment agreement—

''(i) a clinical endpoint specified in the drug's labeling or supported by one or more of the compendia described in section 1861(t)(2)(B)(ii)(I) that—

''(I) is able to be measured or evaluated on an annual basis for each year of the agreement on an independent basis by a provider or other entity; and

''(II) is required to be achieved (based on observed metrics in patient populations) under the terms of the agreement; or

''(ii) a surrogate endpoint (as defined in section 507(e)(9) of the Federal Food, Drug, and Cosmetic Act), including those developed by patient-focused drug development tools, that—

''(I) is able to be measured or evaluated on an annual basis for each year of the agreement on an independent basis by a provider or other entity; and

''(II) has been qualified by the Food and Drug Administration.

''(E) RISK-SHARING VALUE-BASED PAYMENT AGREEMENT.—The term 'risk-sharing value-based payment agreement' means an agreement between a State plan and a manufacturer—

''(i) for the purchase of a covered outpatient drug of the manufacturer that is a potentially curative treatment intended for one-time use;

''(ii) under which payment for such drug shall be made pursuant to an installment-based payment structure that meets the requirements of paragraph (3);

''(iii) which conditions payment on the achievement of at least 2 relevant clinical parameters (as defined in subparagraph (C));

''(iv) which provides that—

''(I) the State plan will directly reimburse the manufacturer for the drug; or

''(II) a third party will reimburse the manufacture in a manner approved by the Secretary; and

''(v) is approved by the Secretary in accordance with paragraph (2).

''(F) TOTAL INSTALLMENT YEAR AMOUNT.—The term 'total installment year amount' means, with respect to a risk-sharing value-based payment agreement for the purchase of a covered outpatient drug and an installment year, an amount equal to the product of—

''(i) the unit price of the drug charged under the agreement; and

''(ii) the number of units of such drug administered under the agreement during such installment year.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1903(i)(10)(A) of the Social Security Act (42 U.S.C. 1396b(i)(10)(A)) is amended by striking ''or unless section 1927(a)(3) applies'' and inserting '', section 1927(a)(3) applies with respect to such drugs, or such drugs are the subject of a risk-sharing value-based payment agreement under section 1927(l)''.

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

(A) in paragraph (1)(A), by inserting ''(except for drugs for which payment is made by a State under a risk-sharing value-based payment agreement under subsection (l))'' after ''under the State plan for such period''; and

(B) in paragraph (3)—

(i) in subparagraph (C)(i), by inserting ''or subsection (l)(2)(A)'' after ''subparagraph (A)''; and

(ii) in subparagraph (D), in the matter preceding clause (i), by inserting '', under subsection (l)(2)(A),'' after ''under this paragraph''.

SEC. 210. APPLYING MEDICAID DRUG REBATE REQUIREMENT TO DRUGS PROVIDED AS PART OF OUTPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1927(k)(3) of the Social Security Act (42 U.S.C. 1396r–8(k)(3)) is amended to read as follows:

''(3) LIMITING DEFINITION.—

''(A) IN GENERAL.—The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as part of,

or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

''(i) Inpatient hospital services.

''(ii) Hospice services.

''(iii) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

''(iv) Physicians' services.

''(v) Outpatient hospital services.

''(vi) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

''(vii) Other laboratory and x-ray services.

''(viii) Renal dialysis.

''(B) OTHER EXCLUSIONS.—Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used for a medical indi-

cation which is not a medically accepted indication.

''(C) STATE OPTION.—At the option of a State, such term may include any drug, biological product, or insulin for which the State is the primary payer under this title or a demonstration project concerning this title, and that is provided on an outpatient basis as part of, or as incident to and in the same setting as, described in clause (iv) or (v) of subparagraph (A) and for which payment is made as part of payment for such services.

''(D) NO EFFECT ON BEST PRICE.—Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.''.

(b) EFFECTIVE DATE; IMPLEMENTATION GUIDANCE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date that is 1 year after the date of enactment of this Act.

(2) IMPLEMENTATION AND GUIDANCE.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance and relevant informational bulletins for States, manufacturers (as defined in section 1927(k)(5) of the Social Security Act (42 U.S.C. 1396r–8(k)(5)), and other relevant stakeholders, including health care providers, regarding implementation of the amendment made by subsection (a).

SEC. 211. PROHIBITION ON ADDITIONAL REBATE UNDER MEDICAID FOR CERTAIN NONINNOVATOR MULTIPLE SOURCE DRUGS.

Section 1927(c)(3)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(3)(C)) is amended—

(1) in clause (i), by striking ''The amount'' and inserting ''Subject to clause (v), the amount''; and

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

''(v) PROHIBITION ON ADDITIONAL REBATE FOR CERTAIN NONINNOVATOR MULTIPLE SOURCE DRUGS.—With respect to a rebate period beginning on or after January 1, 2020, and a dosage form and strength of a covered outpatient drug de-

scribed in clause (i), the amount of the rebate specified in subparagraph (A) for such dosage form and strength for such rebate period may not be increased if the average manufacturer price for a unit of such dosage form and strength for such rebate period is less than $1.''.

SEC. 212. EXEMPTING EXCHANGE PLANS AND CHILD HEALTH PLANS FROM DETERMINATION OF BEST PRICE UNDER MEDICAID OUTPATIENT DRUG PROGRAM.

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

(1) in subclause (V), by striking ''and'' at the end;

(2) in subclause (VI), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end of the following new subclauses:

''(VII) any prices charged which are negotiated by a qualified health plan offered in the individual market (as defined in section 2791 of the Public Health Service Act), whether

or not through an exchange established under title I of the Patient Protection and Affordable Care Act, with respect to drugs on behalf of individuals enrolled in such plan; and

''(VIII) any prices charged under a State child health plan under title XXI (or a waiver of such plan).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to rebate periods beginning on or after January 1, 2021.

TITLE III—FOOD AND DRUG ADMINISTRATION

Subtitle A—CREATES Act

SEC. 301. ACTIONS FOR DELAYS OF GENERIC DRUGS AND BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) DEFINITIONS.—In this section—

(1) the term ''commercially reasonable, market-based terms'' means—

(A) a nondiscriminatory price for the sale of the covered product at or below, but not greater than, the most recent wholesale acquisition cost for the drug, as defined in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B));

(B) a schedule for delivery that results in the transfer of the covered product to the eligible product developer consistent with the timing under subsection (b)(2)(A)(iv); and

(C) no additional conditions are imposed on the sale of the covered product;

(2) the term ''covered product''—

(A) means—

(i) any drug approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or biological product licensed under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262);

(ii) any combination of a drug or biological product described in clause (i); or

(iii) when reasonably necessary to support approval of an application under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), or section 351 of the Public Health Service Act (42 U.S.C. 262), as applicable, or otherwise meet the requirements for approval under either such section, any product, in-

cluding any device, that is marketed or intended for use with such a drug or biological product; and

(B) does not include any drug or biological product that appears on the drug shortage list in effect under section 506E of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356e), unless—

(i) the drug or biological product has been on the drug shortage list in effect under such section 506E continuously for more than 6 months; or

(ii) the Secretary determines that inclusion of the drug or biological product as a covered product is likely to contribute to alleviating or preventing a shortage;

(3) the term ''device'' has the meaning given the term in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321);

(4) the term ''eligible product developer'' means a person that seeks to develop a product for approval pursuant to an application for approval under subsection (b)(2) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or for licensing pursuant to an application under sec-

tion 351(k) of the Public Health Service Act (42 U.S.C. 262(k));

(5) the term ''license holder'' means the holder of an application approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or the holder of a license under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262) for a covered product;

(6) the term ''REMS'' means a risk evaluation and mitigation strategy under section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1);

(7) the term ''REMS with ETASU'' means a REMS that contains elements to assure safe use under section 505–1(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(f));

(8) the term ''Secretary'' means the Secretary of Health and Human Services;

(9) the term ''single, shared system of elements to assure safe use'' means a single, shared system of elements to assure safe use under section 505–1(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1(f)); and

(10) the term ''sufficient quantities'' means an amount of a covered product that the eligible product developer determines allows it to—

(A) conduct testing to support an application under—

(i) subsection (b)(2) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); or

(ii) section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)); and

(B) fulfill any regulatory requirements relating to approval of such an application.

(b) CIVIL ACTION FOR FAILURE TO PROVIDE SUFFICIENT QUANTITIES OF A COVERED PRODUCT.—

(1) IN GENERAL.—An eligible product developer may bring a civil action against the license holder for a covered product seeking relief under this subsection in an appropriate district court of the United States alleging that the license holder has declined to provide sufficient quantities of the covered product to the eligible product developer on commercially reasonable, market-based terms.

(2) ELEMENTS.—

(A) IN GENERAL.—To prevail in a civil action brought under paragraph (1), an eligible product developer shall prove, by a preponderance of the evidence—

(i) that—

(I) the covered product is not subject to a REMS with ETASU; or

(II) if the covered product is subject to a REMS with ETASU—

(aa) the eligible product developer has obtained a covered product authorization from the Secretary in accordance with subparagraph (B); and

(bb) the eligible product developer has provided a copy of the covered product authorization to the license holder;

(ii) that, as of the date on which the civil action is filed, the product developer has not obtained sufficient quantities of the covered product on commercially reasonable, market-based terms;

(iii) that the eligible product developer has submitted a written request to pur-

chase sufficient quantities of the covered product to the license holder and such request—

(I) was sent to a named corporate officer of the license holder;

(II) was made by certified or registered mail with return receipt requested;

(III) specified an individual as the point of contact for the license holder to direct communications related to the sale of the covered product to the eligible product developer and a means for electronic and written communications with that individual; and

(IV) specified an address to which the covered product was to be shipped upon reaching an agreement to transfer the covered product; and

(iv) that the license holder has not delivered to the eligible product developer sufficient quantities of the covered product on commercially reasonable, market-based terms—

(I) for a covered product that is not subject to a REMS with ETASU, by the date that is 31 days after the date on which the license holder received the request for the covered product; and

(II) for a covered product that is subject to a REMS with ETASU, by 31 days after the later of—

(aa) the date on which the license holder received the request for the covered product; or

(bb) the date on which the license holder received a copy of the covered product authorization issued by the Secretary in accordance with subparagraph (B).

(B) AUTHORIZATION FOR COVERED PRODUCT SUBJECT TO A REMS WITH ETASU.—

(i) REQUEST.—An eligible product developer may submit to the Secretary a written request for the eligible product developer to be authorized to obtain sufficient quantities of an individual covered product subject to a REMS with ETASU.

(ii) AUTHORIZATION.—Not later than 120 days after the date on which a request under clause (i) is received, the Secretary shall, by written notice, authorize the eligible product developer to obtain sufficient quantities of an individual covered product subject to a REMS with ETASU for purposes of—

(I) development and testing that does not involve human clinical trials, if the eligible product developer has agreed to comply with any conditions the Secretary determines necessary; or

(II) development and testing that involves human clinical trials, if the eligible product developer has—

(aa)(AA) submitted protocols, informed consent documents, and informational materials for testing that include protections that provide safety protections comparable to those provided by the REMS for the covered product; or

(BB) otherwise satisfied the Secretary that such protections will be provided; and

(bb) met any other requirements the Secretary may establish.

(iii) NOTICE.—A covered product authorization issued under this subparagraph shall state that the provision of the covered product by the license holder under the terms of the authorization will not be a violation of the REMS for the covered product.

(3) AFFIRMATIVE DEFENSE.—In a civil action brought under paragraph (1), it shall be an affirmative defense, on which the defendant has the burden of persuasion by a preponderance of the evidence—

(A) that, on the date on which the eligible product developer requested to purchase sufficient quantities of the covered product from the license holder—

(i) neither the license holder nor any of its agents, wholesalers, or distributors was engaged in the manufacturing or com-

mercial marketing of the covered product; and

(ii) neither the license holder nor any of its agents, wholesalers, or distributors otherwise had access to inventory of the covered product to supply to the eligible product developer on commercially reasonable, market-based terms;

(B) that—

(i) the license holder sells the covered product through agents, distributors, or wholesalers;

(ii) the license holder has placed no restrictions, explicit or implicit, on its agents, distributors, or wholesalers to sell covered products to eligible product developers; and

(iii) the covered product can be purchased by the eligible product developer in sufficient quantities on commercially reasonable, market-based terms from the agents, distributors, or wholesalers of the license holder; or

(C) that the license holder made an offer to the individual specified pursuant to para-

graph (2)(A)(iii)(III), by a means of communication (electronic, written, or both) specified pursuant to such paragraph, to sell sufficient quantities of the covered product to the eligible product developer at commercially reasonable market-based terms—

(i) for a covered product that is not subject to a REMS with ETASU, by the date that is 14 days after the date on which the license holder received the request for the covered product, and the eligible product developer did not accept such offer by the date that is 7 days after the date on which the eligible product developer received such offer from the license holder; or

(ii) for a covered product that is subject to a REMS with ETASU, by the date that is 20 days after the date on which the license holder received the request for the covered product, and the eligible product developer did not accept such offer by the date that is 10 days after the date on which the eligible product developer received such offer from the license holder.

(4) REMEDIES.—

(A) IN GENERAL.—If an eligible product developer prevails in a civil action brought under paragraph (1), the court shall—

(i) order the license holder to provide to the eligible product developer without delay sufficient quantities of the covered product on commercially reasonable, market-based terms;

(ii) award to the eligible product developer reasonable attorney's fees and costs of the civil action; and

(iii) award to the eligible product developer a monetary amount sufficient to deter the license holder from failing to provide eligible product developers with sufficient quantities of a covered product on commercially reasonable, market-based terms, if the court finds, by a preponderance of the evidence—

(I) that the license holder delayed providing sufficient quantities of the covered product to the eligible product developer without a legitimate business justification; or

(II) that the license holder failed to comply with an order issued under clause (i).

(B) MAXIMUM MONETARY AMOUNT.—A monetary amount awarded under subparagraph (A)(iii) shall not be greater than the revenue that the license holder earned on the covered product during the period—

(i) beginning on—

(I) for a covered product that is not subject to a REMS with ETASU, the date that is 31 days after the date on which the license holder received the request; or

(II) for a covered product that is subject to a REMS with ETASU, the date that is 31 days after the later of—

(aa) the date on which the license holder received the request; or

(bb) the date on which the license holder received a copy of the covered product authorization issued by the Secretary in ac-

cordance with paragraph (2)(B); and

(ii) ending on the date on which the eligible product developer received sufficient quantities of the covered product.

(C) AVOIDANCE OF DELAY.—The court may issue an order under subparagraph (A)(i) before conducting further proceedings that may be necessary to determine whether the eligible product developer is entitled to an award under clause (ii) or (iii) of subparagraph (A), or the amount of any such award.

(c) LIMITATION OF LIABILITY.—A license holder for a covered product shall not be liable for any claim under Federal, State, or local law arising out of the failure of an eligible product developer to follow adequate safeguards to assure safe use of the covered product during development or testing activities described in this section, including transportation, handling, use, or disposal of the covered product by the eligible product developer.

(d) NO VIOLATION OF REMS.—Section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1) is amended by adding at the end the following new subsection:

''(l) PROVISION OF SAMPLES NOT A VIOLATION OF STRATEGY.—The provision of samples of a covered product to an eligible product developer (as those terms are defined in section 301(a) of the Lower Drug Costs Now Act of 2019) shall not be considered a violation of the requirements of any risk evaluation and mitigation strategy that may be in place under this section for such drug.''.

(e) RULE OF CONSTRUCTION.—

(1) DEFINITION.—In this subsection, the term ''antitrust laws''—

(A) has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12); and

(B) includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section applies to unfair methods of competition.

(2) ANTITRUST LAWS.—Nothing in this section shall be construed to limit the operation of any provision of the antitrust laws.

SEC. 302. REMS APPROVAL PROCESS FOR SUBSEQUENT FILERS.

Section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1), as amended by section 301, is further amended—

(1) in subsection (g)(4)(B)—

(A) in clause (i) by striking ''or'' after the semicolon;

(B) in clause (ii) by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) accommodate different, comparable aspects of the elements to assure safe use for a drug that is the subject of an application under section 505(j), and the applicable listed drug.'';

(2) in subsection (i)(1), by striking subparagraph (C) and inserting the following:

''(C)(i) Elements to assure safe use, if required under subsection (f) for the listed drug, which, subject to clause (ii), for a drug that is the subject of an application under section 505(j) may use—

''(I) a single, shared system with the listed drug under subsection (f); or

''(II) a different, comparable aspect of the elements to assure safe use under subsection (f).

''(ii) The Secretary may require a drug that is the subject of an application under section 505(j) and the listed drug to use a single, shared system under subsection (f), if the Secretary determines that no different, comparable aspect of the elements to assure safe use could satisfy the requirements of subsection (f).'';

(3) in subsection (i), by adding at the end the following:

''(3) SHARED REMS.—If the Secretary approves, in accordance with paragraph (1)(C)(i)(II), a different, comparable aspect of the elements to assure safe use under subsection (f) for a drug that is the subject of an abbreviated new drug application under section 505(j), the Secretary may require that such different comparable aspect of the elements to assure safe use can be used with respect to any other drug that is the subject of an application under section 505(j) or 505(b) that references the same listed drug.''; and

(4) by adding at the end the following:

''(m) SEPARATE REMS.—When used in this section, the terms 'different, comparable aspect of the elements to assure safe use' or 'different, comparable approved risk evaluation and mitigation strategies' means a risk evaluation and mitigation strategy for a drug that is the subject of an application under section 505(j) that uses different methods or operational means than the strategy required under subsection (a) for the applicable listed drug, or other application under section 505(j) with the same such listed drug, but achieves the same level of safety as such strategy.''.

SEC. 303. RULE OF CONSTRUCTION.

(a) IN GENERAL.—Nothing in this subtitle, the amendments made by this subtitle, or in section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1), shall be construed as—

(1) prohibiting a license holder from providing an eligible product developer access to a covered product in the absence of an authorization under this subtitle; or

(2) in any way negating the applicability of a REMS with ETASU, as otherwise required under such section 505–1, with respect to such covered product.

(b) DEFINITIONS.—In this section, the terms ''covered product'', ''eligible product developer'', ''license holder'', and ''REMS with ETASU'' have the meanings given such terms in section 301(a).

Subtitle B—Pay-for-Delay

SEC. 311. UNLAWFUL AGREEMENTS.

(a) AGREEMENTS PROHIBITED.—Subject to subsections (b) and (c), it shall be unlawful for an NDA or BLA holder and a subsequent filer (or for two subsequent filers) to enter into, or carry out, an agreement resolving or settling a covered patent infringement claim on a final or interim basis if under such agreement—

(1) a subsequent filer directly or indirectly receives from such holder (or in the case of such an agreement between two subsequent filers, the other subsequent filer) anything of value, including a license; and

(2) the subsequent filer agrees to limit or forego research on, or development, manufacturing, marketing, or sales, for any period of time, of the covered product that is the subject of the application described in subparagraph (A) or (B) of subsection (g)(8).

(b) EXCLUSION.—It shall not be unlawful under subsection (a) if a party to an agreement described in such

subsection demonstrates by clear and convincing evidence that the value described in subsection (a)(1) is compensation solely for other goods or services that the subsequent filer has promised to provide.

(c) LIMITATION.—Nothing in this section shall prohibit an agreement resolving or settling a covered patent infringement claim in which the consideration granted by the NDA or BLA holder to the subsequent filer (or from one subsequent filer to another) as part of the resolution or settlement includes only one or more of the following:

(1) The right to market the covered product that is the subject of the application described in subparagraph (A) or (B) of subsection (g)(8) in the United States before the expiration of—

(A) any patent that is the basis of the covered patent infringement claim; or

(B) any patent right or other statutory exclusivity that would prevent the marketing of such covered product.

(2) A payment for reasonable litigation expenses not to exceed $7,500,000 in the aggregate.

(3) A covenant not to sue on any claim that such covered product infringes a patent.

(d) ENFORCEMENT BY FEDERAL TRADE COMMISSION.—

(1) GENERAL APPLICATION.—The requirements of this section apply, according to their terms, to an NDA or BLA holder or subsequent filer that is—

(A) a person, partnership, or corporation over which the Commission has authority pursuant to section 5(a)(2) of the Federal Trade Commission Act (15 U.S.C. 45(a)(2)); or

(B) a person, partnership, or corporation over which the Commission would have authority pursuant to such section but for the fact that such person, partnership, or corporation is not organized to carry on business for its own profit or that of its members.

(2) UNFAIR OR DECEPTIVE ACTS OR PRACTICES ENFORCEMENT AUTHORITY.—

(A) IN GENERAL.—A violation of this section shall be treated as an unfair or deceptive act or practice in violation of section 5(a)(1) of the Federal Trade Commission Act (15 U.S.C. 45(a)(1)).

(B) POWERS OF COMMISSION.—Except as provided in subparagraph (C) and paragraphs (1)(B) and (3)—

(i) the Commission shall enforce this section in the same manner, by the same

means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section; and

(ii) any NDA or BLA holder or subsequent filer that violates this section shall be subject to the penalties and entitled to the privileges and immunities provided in the Federal Trade Commission Act.

(C) JUDICIAL REVIEW.—In the case of a cease and desist order issued by the Commission under section 5 of the Federal Trade Commission Act (15 U.S.C. 45) for violation of this section, a party to such order may obtain judicial review of such order as provided in such section 5, except that—

(i) such review may only be obtained in—

(I) the United States Court of Appeals for the District of Columbia Circuit;

(II) the United States Court of Appeals for the circuit in which the

ultimate parent entity, as defined in section 801.1(a)(3) of title 16, Code of Federal Regulations, or any successor thereto, of the NDA or BLA holder (if any such holder is a party to such order) is incorporated as of the date that the application described in subparagraph (A) or (B) of subsection (g)(8) or an approved application that is deemed to be a license for a biological product under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 (Public Law 111–148; 124 Stat. 817) is submitted to the Commissioner of Food and Drugs; or

(III) the United States Court of Appeals for the circuit in which the ultimate parent entity, as so defined, of any subsequent filer that is a party to such order is incorporated as of the date that the application described in subparagraph (A) or (B) of subsection

(g)(8) is submitted to the Commissioner of Food and Drugs; and

(ii) the petition for review shall be filed in the court not later than 30 days after such order is served on the party seeking review.

(3) ADDITIONAL ENFORCEMENT AUTHORITY.—

(A) CIVIL PENALTY.—The Commission may commence a civil action to recover a civil penalty in a district court of the United States against any NDA or BLA holder or subsequent filer that violates this section.

(B) SPECIAL RULE FOR RECOVERY OF PENALTY IF CEASE AND DESIST ORDER ISSUED.—

(i) IN GENERAL.—If the Commission has issued a cease and desist order in a proceeding under section 5 of the Federal Trade Commission Act (15 U.S.C. 45) for violation of this section—

(I) the Commission may commence a civil action under subparagraph (A) to recover a civil penalty against any party to such order at any time before the expiration of the

1-year period beginning on the date on which such order becomes final under section 5(g) of such Act (15 U.S.C. 45(g)); and

(II) in such civil action, the findings of the Commission as to the material facts in such proceeding shall be conclusive, unless—

(aa) the terms of such order expressly provide that the Commission's findings shall not be conclusive; or

(bb) such order became final by reason of section 5(g)(1) of such Act (15 U.S.C. 45(g)(1)), in which case such findings shall be conclusive if supported by evidence.

(ii) RELATIONSHIP TO PENALTY FOR VIOLATION OF AN ORDER.—The penalty provided in clause (i) for violation of this section is separate from and in addition to any penalty that may be incurred for violation of an order of the Commission under

section 5(l) of the Federal Trade Commission Act (15 U.S.C. 45(l)).

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The amount of a civil penalty imposed in a civil action under subparagraph (A) on a party to an agreement described in subsection (a) shall be sufficient to deter violations of this section, but in no event greater than—

(I) if such party is the NDA or BLA holder (or, in the case of an agreement between two subsequent filers, the subsequent filer who gave the value described in subsection (a)(1)), the greater of—

(aa) 3 times the value received by such NDA or BLA holder (or by such subsequent filer) that is reasonably attributable to the violation of this section; or

(bb) 3 times the value given to the subsequent filer (or to the other subsequent filer) reason-

ably attributable to the violation of this section; and

(II) if such party is the subsequent filer (or, in the case of an agreement between two subsequent filers, the subsequent filer who received the value described in subsection (a)(1)), 3 times the value received by such subsequent filer that is reasonably attributable to the violation of this section.

(ii) FACTORS FOR CONSIDERATION.—In determining such amount, the court shall take into account—

(I) the nature, circumstances, extent, and gravity of the violation;

(II) with respect to the violator, the degree of culpability, any history of violations, the ability to pay, any effect on the ability to continue doing business, profits earned by the NDA or BLA holder (or, in the case of an agreement between two subsequent filers, the subsequent filer who gave the value described in subsection (a)(1)),

compensation received by the subsequent filer (or, in the case of an agreement between two subsequent filers, the subsequent filer who received the value described in subsection (a)(1)), and the amount of commerce affected; and

(III) other matters that justice requires.

(D) INJUNCTIONS AND OTHER EQUITABLE RELIEF.—In a civil action under subparagraph (A), the United States district courts are empowered to grant mandatory injunctions and such other and further equitable relief as they deem appropriate.

(4) REMEDIES IN ADDITION.—Remedies provided in this subsection are in addition to, and not in lieu of, any other remedy provided by Federal law.

(5) PRESERVATION OF AUTHORITY OF COMMISSION.—Nothing in this section shall be construed to affect any authority of the Commission under any other provision of law.

(e) FEDERAL TRADE COMMISSION RULEMAKING.—The Commission may, in its discretion, by rule promul-

gated under section 553 of title 5, United States Code, exempt from this section certain agreements described in subsection (a) if the Commission finds such agreements to be in furtherance of market competition and for the benefit of consumers.

(f) ANTITRUST LAWS.—Nothing in this section shall modify, impair, limit, or supersede the applicability of the antitrust laws as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), and of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition. Nothing in this section shall modify, impair, limit, or supersede the right of a subsequent filer to assert claims or counterclaims against any person, under the antitrust laws or other laws relating to unfair competition.

(g) DEFINITIONS.—In this section:

(1) AGREEMENT RESOLVING OR SETTLING A COVERED PATENT INFRINGEMENT CLAIM.—The term ''agreement resolving or settling a covered patent infringement claim'' means any agreement that—

(A) resolves or settles a covered patent infringement claim; or

(B) is contingent upon, provides for a contingent condition for, or is otherwise related to the resolution or settlement of a covered patent infringement claim.

(2) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(3) COVERED PATENT INFRINGEMENT CLAIM.—The term ''covered patent infringement claim'' means an allegation made by the NDA or BLA holder to a subsequent filer (or, in the case of an agreement between two subsequent filers, by one subsequent filer to another), whether or not included in a complaint filed with a court of law, that—

(A) the submission of the application described in subparagraph (A) or (B) of paragraph (9), or the manufacture, use, offering for sale, sale, or importation into the United States of a covered product that is the subject of such an application—

(i) in the case of an agreement between an NDA or BLA holder and a subsequent filer, infringes any patent owned by, or exclusively licensed to, the NDA or BLA holder of the covered product; or

(ii) in the case of an agreement between two subsequent filers, infringes any patent owned by the subsequent filer; or

(B) in the case of an agreement between an NDA or BLA holder and a subsequent filer, the covered product to be manufactured under such application uses a covered product as claimed in a published patent application.

(4) COVERED PRODUCT.—The term ''covered product'' means a drug (as defined in section 201(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g))), including a biological product (as defined in section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)).

(5) NDA OR BLA HOLDER.—The term ''NDA or BLA holder'' means—

(A) the holder of—

(i) an approved new drug application filed under section 505(b)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(1)) for a covered product; or

(ii) a biologics license application filed under section 351(a) of the Public Health

Service Act (42 U.S.C. 262(a)) with respect to a biological product;

(B) a person owning or controlling enforcement of the patent on—

(i) the list published under section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) in connection with the application described in subparagraph (A)(i); or

(ii) any list published under section 351 of the Public Health Service Act (42 U.S.C. 262) comprised of patents associated with biologics license applications filed under section 351(a) of such Act (42 U.S.C. 262(a)); or

(C) the predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with any entity described in subparagraph (A) or (B) (such control to be presumed by direct or indirect share ownership of 50 percent or greater), as well as the licensees, licensors, successors, and assigns of each of the entities.

(6) PATENT.—The term ''patent'' means a patent issued by the United States Patent and Trademark Office.

(7) STATUTORY EXCLUSIVITY.—The term ''statutory exclusivity'' means those prohibitions on the submission or approval of drug applications under clauses (ii) through (iv) of section 505(c)(3)(E) (5- and 3-year exclusivity), clauses (ii) through (iv) of section 505(j)(5)(F) (5-year and 3-year exclusivity), section 505(j)(5)(B)(iv) (180-day exclusivity), section 527 (orphan drug exclusivity), section 505A (pediatric exclusivity), or section 505E (qualified infectious disease product exclusivity) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)(3)(E), 355(j)(5)(B)(iv), 355(j)(5)(F), 360cc, 355a, 355f), or prohibitions on the submission or licensing of biologics license applications under section 351(k)(6) (interchangeable biological product exclusivity) or section 351(k)(7) (biological product reference product exclusivity) of the Public Health Service Act (42 U.S.C. 262(k)(6), (7)).

(8) SUBSEQUENT FILER.—The term ''subsequent filer'' means—

(A) in the case of a drug, a party that owns or controls an abbreviated new drug appli-

cation submitted pursuant to section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) or a new drug application submitted pursuant to section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act (21U.S.C. 355(b)(2)) and filed under section 505(b)(1) of such Act (21 U.S.C. 355(b)(1)) or has the exclusive rights to distribute the covered product that is the subject of such application; or

(B) in the case of a biological product, a party that owns or controls an application filed with the Food and Drug Administration under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) or has the exclusive rights to distribute the biological product that is the subject of such application.

(h) EFFECTIVE DATE.—This section applies with respect to agreements described in subsection (a) entered into on or after the date of the enactment of this Act.

SEC. 312. NOTICE AND CERTIFICATION OF AGREEMENTS.

(a) NOTICE OF ALL AGREEMENTS.—Section 1111(7) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 355 note) is amended by inserting ''or the owner of a patent for which

a claim of infringement could reasonably be asserted against any person for making, using, offering to sell, selling, or importing into the United States a biological product that is the subject of a biosimilar biological product application'' before the period at the end.

(b) CERTIFICATION OF AGREEMENTS.—Section 1112 of such Act (21 U.S.C. 355 note) is amended by adding at the end the following:

''(d) CERTIFICATION.—The Chief Executive Officer or the company official responsible for negotiating any agreement under subsection (a) or (b) that is required to be filed under subsection (c) shall, within 30 days of such filing, execute and file with the Assistant Attorney General and the Commission a certification as follows: 'I declare that the following is true, correct, and complete to the best of my knowledge: The materials filed with the Federal Trade Commission and the Department of Justice under section 1112 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, with respect to the agreement referenced in this certification—

'''(1) represent the complete, final, and exclusive agreement between the parties;

'''(2) include any ancillary agreements that are contingent upon, provide a contingent condition for,

were entered into within 30 days of, or are otherwise related to, the referenced agreement; and

"'(3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to subsection (a) or (b) of such section 1112 and have not been reduced to writing.'.".

SEC. 313. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

Section 505(j)(5)(D)(i)(V) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(D)(i)(V)) is amended by inserting "section 311 of the Lower Drug Costs Now Act of 2019 or" after "that the agreement has violated".

SEC. 314. COMMISSION LITIGATION AUTHORITY.

Section 16(a)(2) of the Federal Trade Commission Act (15 U.S.C. 56(a)(2)) is amended—

(1) in subparagraph (D), by striking "or" after the semicolon;

(2) in subparagraph (E), by inserting "or" after the semicolon; and

(3) by inserting after subparagraph (E) the following:

"(F) under section 311(d)(3)(A) of the Lower Drug Costs Now Act of 2019;".

SEC. 315. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Except as provided in subsection (b), the Commission shall commence any administrative proceeding or civil action to enforce section 311 of this Act not later than 6 years after the date on which the parties to the agreement file the Notice of Agreement as provided by section 1112(c)(2) and (d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 355 note).

(b) CIVIL ACTION AFTER ISSUANCE OF CEASE AND DESIST ORDER.—If the Commission has issued a cease and desist order under section 5 of the Federal Trade Commission Act (15 U.S.C. 45) for violation of section 311 of this Act and the proceeding for the issuance of such order was commenced within the period required by subsection (a) of this section, such subsection does not prohibit the commencement, after such period, of a civil action under section 311(d)(3)(A) against a party to such order or a civil action under subsection (l) of such section 5 for violation of such order.

Subtitle C—BLOCKING Act

SEC. 321. CHANGE CONDITIONS OF FIRST GENERIC EXCLUSIVITY TO SPUR ACCESS AND COMPETITION.

Section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) is amended—

(1) in subclause (I), by striking ''180 days after'' and all that follows through the period at the end and inserting the following: ''180 days after the earlier of—

''(aa) the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant; or

''(bb) the applicable date specified in subclause (III).''; and

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

''(III) APPLICABLE DATE.—The applicable date specified in this subclause, with respect to an application for a drug described in subclause (I), is the date on which each of the following conditions is first met:

''(aa) The approval of such an application could be made effective, but for the eligibility of a first applicant for 180-day exclusivity under this clause.

''(bb) At least 30 months have passed since the date of submission of

an application for the drug by at least one first applicant.

''(cc) Approval of an application for the drug submitted by at least one first applicant is not precluded under clause (iii).

''(dd) No application for the drug submitted by any first applicant is approved at the time the conditions under items (aa), (bb), and (cc) are all met, regardless of whether such an application is subsequently approved.''.

Subtitle D—Purple Book

SEC. 331. PUBLIC LISTING.

Section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) is amended by adding at the end the following:

''(9) PUBLIC LISTING.—

''(A) IN GENERAL.—

''(i) INITIAL PUBLICATION.—Not later than 180 days after the date of enactment of the Lower Drug Costs Now Act 2019, the Secretary shall publish and make avail-

able to the public in a searchable, electronic format—

''(I) a list in alphabetical order of the nonproprietary or proper name of each biological product for which a biologics license under subsection (a) or this subsection is in effect, or that has been deemed to be licensed under this section pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009, as of such date of enactment;

''(II) the date of approval of the marketing application and the application number; and

''(III) the marketing or licensure status of the biological product for which a biologics license under subsection (a) or this subsection is in effect or that has been deemed to be licensed under this section pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009.

"(ii) REVISIONS.—Every 30 days after the publication of the first list under clause (i), the Secretary shall revise the list to include each biological product which has been licensed under subsection (a) or this subsection during the 30-day period.

"(iii) PATENT INFORMATION.—Not later than 30 days after a list of patents under subsection (l)(3)(A), or a supplement to such list under subsection (l)(7), has been provided by the reference product sponsor to the subsection (k) applicant respecting a biological product included on the list published under this subparagraph, the reference product sponsor shall provide such list of patents (or supplement thereto) and their corresponding expiry dates to the Secretary, and the Secretary shall, in revisions made under clause (ii), include such information for such biological product. Within 30 days of providing any subsequent or supplemental list of patents to any subsequent subsection (k) applicant under subsection (l)(3)(A) or (l)(7), the reference product sponsor shall update the

information provided to the Secretary under this clause with any additional patents from such subsequent or supplemental list and their corresponding expiry dates.

''(iv) LISTING OF EXCLUSIVITIES.—For each biological product included on the list published under this subparagraph, the Secretary shall specify each exclusivity period that is applicable and has not concluded under paragraph (6) or paragraph (7).

''(B) WITHDRAWAL OR SUSPENSION OF LICENSURE.—If the licensing of a biological product was withdrawn or suspended for safety, purity, or potency reasons, it may not be published in the list under subparagraph (A). If the withdrawal or suspension occurred after its publication in such list, the reference product sponsor shall notify the Secretary that—

''(i) the biological product shall be immediately removed from such list—

''(I) for the same period as the withdrawal or suspension; or

''(II) if the biological product has been withdrawn from sale, for the pe-

riod of withdrawal from sale or, if earlier, the period ending on the date the Secretary determines that the withdrawal from sale is not for safety, purity, or potency reasons; and

''(ii) a notice of the removal shall be published in the Federal Register.''.

SEC. 332. REVIEW AND REPORT ON TYPES OF INFORMATION TO BE LISTED.

Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) solicit public comment regarding the type of information, if any, that should be added to or removed from the list required by paragraph (9) of section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)), as added by section 331; and

(2) transmit to Congress an evaluation of such comments, including any recommendations about the types of information that should be added to or removed from the list.

Subtitle E—Orange Book

SEC. 341. ORANGE BOOK.

(a) SUBMISSION OF PATENT INFORMATION FOR BRAND NAME DRUGS.—Paragraph (1) of section 505(b)

of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) is amended to read as follows:

''(b)(1) Any person may file with the Secretary an application with respect to any drug subject to the provisions of subsection (a). Such persons shall submit to the Secretary as part of the application—

''(A) full reports of investigations which have been made to show whether or not such drug is safe for use and whether such drug is effective in use;

''(B) a full list of the articles used as components of such drug;

''(C) a full statement of the composition of such drug;

''(D) a full description of the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of such drug;

''(E) such samples of such drug and of the articles used as components thereof as the Secretary may require;

''(F) specimens of the labeling proposed to be used for such drug;

''(G) any assessments required under section 505B; and

''(H) patent information, with respect to each patent for which a claim of patent infringement

could reasonably be asserted if a person not licensed by the owner engaged in the manufacture, use, or sale of the drug, and consistent with the following requirements:

''(i) The applicant shall file with the application the patent number and the expiration date of—

''(I) any patent which claims the drug for which the applicant submitted the application and is a drug substance (including active ingredient) patent or a drug product (including formulation and composition) patent; and

''(II) any patent which claims the method of using such drug.

''(ii) If an application is filed under this subsection for a drug and a patent of the type described in clause (i) which claims such drug or a method of using such drug is issued after the filing date but before approval of the application, the applicant shall amend the application to include such patent information.

Upon approval of the application, the Secretary shall publish the information submitted under subparagraph (H). The Secretary shall, in consultation with the Director of

the National Institutes of Health and with representatives of the drug manufacturing industry, review and develop guidance, as appropriate, on the inclusion of women and minorities in clinical trials required by subparagraph (A).''.

(b) CONFORMING CHANGES TO REQUIREMENTS FOR SUBSEQUENT SUBMISSION OF PATENT INFORMATION.—Section 505(c)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) is amended—

(1) by inserting after ''the patent number and the expiration date of any patent which'' the following: ''fulfills the criteria in subsection (b) and'';

(2) by inserting after the first sentence the following: ''Patent information that is not the type of patent information required by subsection (b) shall not be submitted.''; and

(3) by inserting after ''could not file patent information under subsection (b) because no patent'' the following: ''of the type required to be submitted in subsection (b)''.

(c) LISTING OF EXCLUSIVITIES.—Subparagraph (A) of section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) is amended by adding at the end the following:

''(iv) For each drug included on the list, the Secretary shall specify each exclusivity period that is applicable and has not concluded under—

''(I) clause (ii), (iii), or (iv) of subsection (c)(3)(E) of this section;

''(II) clause (iv) or (v) of paragraph (5)(B) of this subsection;

''(III) clause (ii), (iii), or (iv) of paragraph (5)(F) of this subsection;

''(IV) section 505A;

''(V) section 505E; or

''(VI) section 527(a).''.

(d) REMOVAL OF INVALID PATENTS.—

(1) IN GENERAL.—Section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)) is amended by adding at the end the following:

''(D)(i) The holder of an application approved under subsection (c) for a drug on the list shall notify within 14 days the Secretary in writing if either of the following occurs:

''(I) The Patent Trial and Appeals Board issues a decision from which no appeal has been or can be taken that a patent for such drug is invalid.

''(II) A court issues a decision from which no appeal has been or can be taken that a patent for such drug is invalid.

''(ii) The holder of an approved application shall include in any notification under clause (i) a copy of the decision described in subclause (I) or (II) of clause (i).

''(iii) The Secretary shall remove from the list any patent that is determined to be invalid in a decision described in subclause (I) or (II) of clause (i)—

''(I) promptly; but

''(II) not before the expiration of any 180-day exclusivity period under paragraph (5)(B)(iv) that relies on a certification described in paragraph (2)(A)(vii)(IV) that such patent was invalid.''.

(2) APPLICABILITY.—Subparagraph (D) of section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)), as added by paragraph (1), applies only with respect to a decision described in such subparagraph that is issued on or after the date of enactment of this Act.

(e) REVIEW AND REPORT.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall—

(1) solicit public comment regarding the types of patent information that should be included on the list under section 507(j)(7) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(7)); and

(2) transmit to the Congress an evaluation of such comments, including any recommendations about the types of patent information that should be included on or removed from such list.

SEC. 342. GAO REPORT TO CONGRESS.

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States (referred to in this section as the ''Comptroller General'') shall submit to the Committee on Energy and Commerce of the House of Representatives a report on the patents included in the list published under section 505(j)(7) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 355(j)(7)), including an analysis and evaluation of the types of patents included in such list and the claims such patents make about the products they claim.

(b) CONTENTS.—The Comptroller General shall include in the report under subsection (a)—

(1) data on the number of—

(A) patents included in the list published under paragraph (7) of section 505(j) of the

Federal Food, Drug and Cosmetic Act (21 U.S.C. 355(j)), that claim the active ingredient or formulation of a drug in combination with a device that is used for delivery of the drug, together comprising the finished dosage form of the drug; and

(B) claims in each patent that claim a device that is used for the delivery of the drug, but do not claim such device in combination with an active ingredient or formulation of a drug;

(2) data on the date of inclusion in the list under paragraph (7) of such section 505(j) for all patents under such list, as compared to patents that claim a method of using the drug in combination with a device;

(3) an analysis regarding the impact of including on the list under paragraph (7) of such section 505(j) certain types of patent information for drug product applicants and approved application holders, including an analysis of whether—

(A) the listing of the patents described in paragraph (1)(A) delayed the market entry of one or more drugs approved under such section 505(j); and

(B) not listing the patents described in paragraph (1)(A) would delay the market entry of one or more such drugs; and

(4) recommendations about which kinds of patents relating to devices described in paragraph (1)(A) should be submitted to the Secretary of Health and Human Services for inclusion on the list under paragraph (7) of such section 505(j) and which patents should not be required to be so submitted.

Subtitle F—Advancing Education on Biosimilars

SEC. 351. EDUCATION ON BIOLOGICAL PRODUCTS.

(a) WEBSITE; CONTINUING EDUCATION.—Subpart 1 of part F of title III of the Public Health Service Act (42 U.S.C. 262 et seq.) is amended by adding at the end the following:

"SEC. 352A. EDUCATION ON BIOLOGICAL PRODUCTS.

''(a) INTERNET WEBSITE.—

''(1) IN GENERAL.—The Secretary shall maintain and operate an internet website to provide educational materials for health care providers, patients, and caregivers, regarding the meaning of the terms, and the standards for review and licensing of, biological products, including biosimilar biological prod-

ucts and interchangeable biosimilar biological products.

''(2) CONTENT.—Educational materials provided under paragraph (1) may include—

''(A) explanations of key statutory and regulatory terms, including 'biosimilar' and 'interchangeable', and clarification regarding the use of interchangeable biosimilar biological products;

''(B) information related to development programs for biological products, including biosimilar biological products and interchangeable biosimilar biological products and relevant clinical considerations for prescribers, which may include, as appropriate and applicable, information related to the comparability of such biological products;

''(C) an explanation of the process for reporting adverse events for biological products, including biosimilar biological products and interchangeable biosimilar biological products; and

''(D) an explanation of the relationship between biosimilar biological products and interchangeable biosimilar biological products li-

censed under section 351(k) and reference products (as defined in section 351(i)), including the standards for review and licensing of each such type of biological product.

''(3) FORMAT.—The educational materials provided under paragraph (1) may be—

''(A) in formats such as webinars, continuing medical education modules, videos, fact sheets, infographics, stakeholder toolkits, or other formats as appropriate and applicable; and

''(B) tailored for the unique needs of health care providers, patients, caregivers, and other audiences, as the Secretary determines appropriate.

''(4) OTHER INFORMATION.—In addition to the information described in paragraph (2), the Secretary shall continue to publish the following information:

''(A) The action package of each biological product licensed under subsection (a) or (k).

''(B) The summary review of each biological product licensed under subsection (a) or (k).

''(5) CONFIDENTIAL AND TRADE SECRET INFORMATION.—This subsection does not authorize

the disclosure of any trade secret, confidential commercial or financial information, or other matter described in section 552(b) of title 5.

''(b) CONTINUING EDUCATION.—The Secretary shall advance education and awareness among health care providers regarding biological products, including biosimilar biological products and interchangeable biosimilar biological products, as appropriate, including by developing or improving continuing education programs that advance the education of such providers on the prescribing of, and relevant clinical considerations with respect to, biological products, including biosimilar biological products and interchangeable biosimilar biological products.''.

(b) APPLICATION UNDER THE MEDICARE MERIT-BASED INCENTIVE PAYMENT SYSTEM.—Section 1848(q)(5)(C) of the Social Security Act (42 U.S.C. 1395w–4(q)(5)(C)) is amended by adding at the end the following new clause:

''(iv) CLINICAL MEDICAL EDUCATION PROGRAM ON BIOSIMILAR BIOLOGICAL PRODUCTS.—Completion of a clinical medical education program developed or improved under section 352A(b) of the Public Health Service Act by a MIPS eligible professional during a performance period shall

earn such eligible professional one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period. A MIPS eligible professional may only count the completion of such a program for purposes of such category one time during the eligible professional's lifetime.''.

TITLE IV—NO SURPRISES ACT

SEC. 401. SHORT TITLE.

This title may be cited as the ''No Surprises Act''.

SEC. 402. PREVENTING SURPRISE MEDICAL BILLS.

(a) COVERAGE OF EMERGENCY SERVICES.—Section 2719A(b) of the Public Health Service Act (42 U.S.C. 300gg–19a(b)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A)—

(i) by striking ''a group health plan, or a health insurance issuer offering group or individual health insurance issuer,'' and inserting ''a health plan (as defined in subsection (e)(2)(A))'';

(ii) by inserting ''or, for plan year 2021 or a subsequent plan year, with re-

spect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D))'' after ''emergency department of a hospital'';

(iii) by striking ''the plan or issuer'' and inserting ''the plan''; and

(iv) by striking ''paragraph (2)(B)'' and inserting ''paragraph (3)(C)'';

(B) in subparagraph (B), by inserting ''or a participating emergency facility, as applicable,'' after ''participating provider''; and

(C) in subparagraph (C)—

(i) in the matter preceding clause (i), by inserting ''by a nonparticipating provider or a nonparticipating emergency facility'' after ''enrollee'';

(ii) by striking clause (i);

(iii) by striking ''(ii)(I) such services'' and inserting ''(i) such services'';

(iv) by striking ''where the provider of services does not have a contractual relationship with the plan for the providing of services'';

(v) by striking ''emergency department services received from providers who do have such a contractual relationship with the plan; and'' and inserting ''emergency services received from participating providers and participating emergency facilities with respect to such plan;'';

(vi) by striking ''(II) if such services'' and all that follows through ''were provided in-network;'' and inserting the following:

''(ii) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;''; and

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

''(iii) such requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to—

''(I) in the case of such services furnished in a State described in paragraph (3)(H)(ii), the median contracted rate (as defined in paragraph (3)(E)(i)) for such services; and

''(II) in the case of such services furnished in a State described in paragraph (3)(H)(i), the lesser of—

''(aa) the amount determined by such State for such services in accordance with the method described in such paragraph; and

''(bb) the median contracted rate (as so defined) for such services;

''(iv) the health plan pays to such provider or facility, respectively, the amount by which the recognized amount (as defined in paragraph (3)(H)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)); and

''(v) any cost-sharing payments made by the participant, beneficiary, or enrollee

with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan (and such in-network deductible shall be applied) in the same manner as if such cost-sharing payments were with respect to emergency services furnished by a participating provider and a participating emergency facility; and''.

(2) by redesignating paragraph (2) as paragraph (3);

(3) by inserting after paragraph (1) the following new paragraph:

''(2) AUDIT PROCESS FOR MEDIAN CONTRACTED RATES.—

''(A) IN GENERAL.—Not later than July 1, 2020, the Secretary, in consultation with appropriate State agencies, shall establish through rulemaking a process, in accordance with subparagraph (B), under which health plans are audited by such Secretaries to ensure that—

''(i) such plans are in compliance with the requirement of applying a median contracted rate under this section; and

''(ii) that such median contracted rate so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a health plan described in clause (ii) of such paragraph.

''(B) AUDIT SAMPLES.—Under the process established pursuant to subparagraph (A), the Secretary—

''(i) shall conduct audits described in such subparagraph, with respect to a year (beginning with 2021), of a sample with respect to such year of claims data from not more than 25 health plans; and

''(ii) may audit any health plan if the Secretary has received any complaint about such plan that involves the compliance of the plan with either of the requirements described in clauses (i) and (ii) of such subparagraph.''; and

(4) in paragraph (3), as redesignated by paragraph (2) of this subsection—

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

(B) by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively;

(C) by inserting before subparagraph (B), as redesignated by subparagraph (B) of this paragraph, the following new subparagraph:

''(A) EMERGENCY DEPARTMENT OF A HOSPITAL.—The term 'emergency department of a hospital' includes a hospital outpatient department that provides emergency services.'';

(D) by amending subparagraph (C), as redesignated by subparagraph (B) of this paragraph, to read as follows:

''(C) EMERGENCY SERVICES.—

''(i) IN GENERAL.—The term 'emergency services', with respect to an emergency medical condition, means—

''(I) a medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hos-

pital or of an independent free-standing emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

''(II) within the capabilities of the staff and facilities available at the hospital or the independent free-standing emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient.

''(ii) INCLUSION OF POSTSTABILIZATION SERVICES.—For purposes of this subsection and section 2799, in the case of an individual enrolled in a health plan who is furnished services described in clause (i) by a provider or facility to stabilize such individual with respect to an emergency medical condition, the

term 'emergency services' shall include such items and services in addition to those described in clause (i) that such a provider or facility determines are needed to be furnished (after such stabilization but during such visit in which such individual is so stabilized) to such individual, unless each of the following conditions are met:

''(I) Such a provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

''(II) Such provider furnishing such additional items and services is in compliance with section 2799A(d) with respect to such items and services.'';

(E) by redesignating subparagraph (D), as redesignated by subparagraph (B) of this paragraph, as subparagraph (I); and

(F) by inserting after subparagraph (C), as redesignated by subparagraph (B) of this paragraph, the following new subparagraphs:

"(D) INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT.—The term 'independent freestanding emergency department' means a facility that—

"(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

"(ii) provides emergency services.

"(E) MEDIAN CONTRACTED RATE.—

"(i) IN GENERAL.—The term 'median contracted rate' means, with respect to an item or service and a health plan (as defined in subsection (e)(2)(A))—

"(I) for 2021, the median of the negotiated rates recognized by the sponsor or issuer of such plan (determined with respect to all such plans of such sponsor or such issuer that are within the same line of business) as the total maximum payment (including the cost-sharing amount imposed for such services (as determined in accordance with clauses (ii) and (iii) of paragraph (1)(C) or subparagraphs (A) and (B) of subsection

(e)(1), as applicable) and the amount to be paid by the plan or issuer) under such plans in 2019 for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under section 402(e) of the No Surprises Act, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019 and 2020; and

''(II) for 2022 and each subsequent year, the median contracted rate determined under this clause for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(ii) SPECIAL RULE.—The Secretary shall provide pursuant to rulemaking de-

scribed in section 402(e) of the No Surprises Act that—

''(I) if the sponsor or issuer of a health plan does not have sufficient information to calculate a median contracted rate for an item or service or provider type, or amount of, claims for items or services (as determined by the Secretary) provided in a particular geographic area (other than in a case described in item (bb)), such sponsor or issuer shall demonstrate that such sponsor or issuer will use any database free of conflicts of interest that has sufficient information reflecting allowed amounts paid to a health care provider for relevant services provided in the applicable geographic region (such as State All Payer Claims Databases (as defined in section 404(d) of such Act)), and that such sponsor or issuer will use any such database to determine a median contracted rate and cover the

cost of accessing any such database; and

''(II) in the case of a sponsor or issuer offering a health plan in a geographic region that did not offer any health plan in such region during 2019, such sponsor or issuer shall use a methodology established by the Secretary for determining the median contracted rate for items and services covered by such plan for the first year in which such plan is offered in such region, and that, for each succeeding year, the median contracted rate for such items and services under such plan shall be the median contracted rate for such items and services under such plan for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(F) NONPARTICIPATING EMERGENCY FACILITY; PARTICIPATING EMERGENCY FACILITY.—

''(i) NONPARTICIPATING EMERGENCY FACILITY.—The term 'nonparticipating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

''(ii) PARTICIPATING EMERGENCY FACILITY.—The term 'participating emergency facility' means, with respect to an item or service and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

''(G) NONPARTICIPATING PROVIDERS; PARTICIPATING PROVIDERS.—

''(i) NONPARTICIPATING PROVIDER.—The term 'nonparticipating provider' means, with respect to an item or service

and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

''(ii) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service under the plan.

''(H) RECOGNIZED AMOUNT.—The term 'recognized amount' means, with respect to an item or service—

''(i) in the case of such item or service furnished in a State that has in effect a

State law that provides for a method for determining the amount of payment that is required to be covered by a health plan regulated by such State in the case of a participant, beneficiary, or enrollee covered under such plan and receiving such item or service from a nonparticipating provider or facility, not more than the amount determined in accordance with such law plus the cost-sharing amount imposed under the plan for such item or service (as determined in accordance with clauses (ii) and (iii) of paragraph (1)(C) or subparagraphs (A) and (B) of subsection (e)(1), as applicable); or

''(ii) in the case of such item or service furnished in a State that does not have in effect such a law, an amount that is at least the median contracted rate (as defined in subparagraph (E)(i) and determined in accordance with rulemaking described in section 402(e) of the No Surprises Act) for such item or service.''.

(b) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN

PARTICIPATING FACILITIES; INDEPENDENT DISPUTE RESOLUTION PROCESS.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following new subsections:

''(e) COVERAGE OF NON-EMERGENCY SERVICES PERFORMED BY NONPARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.—

''(1) IN GENERAL.—Subject to paragraph (3), in the case of items or services (other than emergency services to which subsection (b) applies) furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (2)(A)) by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) during a visit (as defined by the Secretary in accordance with paragraph (2)(C)) at a participating health care facility (as defined in paragraph (2)(B)), with respect to such plan, the plan—

''(A) shall not impose on such participant, beneficiary, or enrollee a cost-sharing amount (expressed as a copayment amount or coinsurance rate) for such items and services so furnished that is greater than the cost-sharing amount that would apply under such plan had such items or services been furnished by a par-

ticipating provider (as defined in subsection (b)(3)(G)(ii));

''(B) shall calculate such cost-sharing amount as if the amount that would have been charged for such items and services by such participating provider were equal to—

''(i) in the case of such items and services furnished in a State described in subsection (b)(3)(H)(ii), the median contracted rate (as defined in subsection (b)(3)(E)(i)) for such items and services; and

''(ii) in the case of such items and services furnished in a State described in subsection (b)(3)(H)(i), the lesser of—

''(I) the amount determined by such State for such items and services in accordance with the method described in such subsection; and

''(II) the median contracted rate (as so defined) for such items and services;

''(C) shall pay to such provider furnishing such items and services to such participant, beneficiary, or enrollee the amount by which the

recognized amount (as defined in subsection (b)(3)(H)) for such items and services exceeds the cost-sharing amount imposed under the plan for such items and services (as determined in accordance with subparagraphs (A) and (B)); and

''(D) shall count toward any in-network deductible or out-of-pocket maximums applied under the plan any cost-sharing payments made by the participant, beneficiary, or enrollee (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

''(2) DEFINITIONS.—In this subsection and subsection (b):

''(A) HEALTH PLAN.—The term 'health plan' means a group health plan and health insurance coverage offered by a heath insurance issuer in the group or individual market and includes a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act).

''(B) PARTICIPATING HEALTH CARE FACILITY.—

''(i) IN GENERAL.—The term 'participating health care facility' means, with respect to an item or service and a health plan, a health care facility described in clause (ii) that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such item or service.

''(ii) HEALTH CARE FACILITY DESCRIBED.—A health care facility described in this clause is each of the following:

''(I) A hospital (as defined in 1861(e) of the Social Security Act).

''(II) A critical access hospital (as defined in section 1861(mm) of such Act).

''(III) An ambulatory surgical center (as defined in section 1833(i)(1)(A) of such Act).

''(IV) A laboratory.

''(V) A radiology facility or imaging center.

"(C) DURING A VISIT.—The term 'during a visit' shall, with respect to items and services furnished to an individual at a participating health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

"(3) EXCEPTION.—Paragraph (1) shall not apply to a health plan in the case of items or services (other than emergency services to which subsection (b) applies) furnished to a participant, beneficiary, or enrollee of a health plan (as defined in paragraph (2)(A)) by a nonparticipating provider (as defined in subsection (b)(3)(G)(i)) during a visit (as defined by the Secretary in accordance with paragraph (2)(C)) at a participating health care facility (as defined in paragraph (2)(B)) if such provider is in compliance with section 2799A(d) with respect to such items and services.

"(f) INDEPENDENT DISPUTE RESOLUTION PROCESS.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary, in consultation with the Secretary of Labor, shall establish by regulation an independent dispute resolution process (referred to in this subsection as the 'IDR process') under which—

"(i) a nonparticipating provider (as defined in subparagraph (G) of subsection (b)(3)), nonparticipating emergency facility (as defined in subparagraph (F) of such subsection), or health plan (as defined in subsection (e)(2)(A)) may submit a request for resolution by an entity certified under paragraph (2) (in this subsection referred to as a 'certified IDR entity') of a specified claim; and

"(ii) in the case a settlement described in subparagraph (B) of paragraph (4) is not reached with respect to such claim, such entity so resolves such claim in accordance with such paragraph.

"(B) DEFINITIONS.—In this subsection:

"(i) SPECIFIED CLAIM.—

"(I) IN GENERAL.—Subject to subclause (II), the term 'specified claim' means a claim by a nonparticipating provider, a nonparticipating emergency facility, or a health plan with respect to qualifying items and services (as defined in clause (ii)) furnished by such provider or facility in a State described in subparagraph (H)(ii) of subsection (b)(3) for which a health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1)—

"(aa) that such payment should be increased or decreased; and

"(bb) that is made not later than—

"(AA) in the case of such a claim filed by such a provider or facility, the date on which the appeal with respect to such items and services described in clause (ii)(I)(aa)(AA) has been re-

solved (or the date that is 30 days after such appeal is filed, whichever is earlier); or

''(BB) in the case of such a claim filed by such plan, the date on which the period described in clause (ii)(I)(bb)(BB) with respect to such items and services elapses.

''(II) LIMITATION ON PACKAGING OF ITEMS AND SERVICES IN A SPECIFIED CLAIM.—The term 'specified claim' shall not include, in the case such claim is made by such provider, facility, or plan with respect to multiple items and services, any claim with respect to items and services furnished by such provider or facility if—

''(aa) such items and services were not furnished by the same provider or facility;

''(bb) payment for such items and services made pursu-

ant to subsection (b)(1) or subsection (e)(1) was made by multiple health plans;

"(cc) such items and services are not related to the treatment of the same condition; or

"(dd) such items and services were not furnished within 30 days of the date of the earliest item or service furnished that is included in such claim.

"(ii) QUALIFYING ITEMS AND SERVICES.—

"(I) IN GENERAL.—Subject to subclause (II), the term 'qualifying items and services' means—

"(aa) with respect to a specified claim made by a nonparticipating provider or nonparticipating emergency facility, items and services furnished by such provider or facility for which a health plan is required to make payment pursuant to subsection

(b)(1) or subsection (e)(1), but only if—

''(AA) such items and services are included in an appeal filed under such plan's internal appeals process not later than 30 days after such payment is received; and

''(BB) such appeal under such plan's internal appeals process has been resolved, or a 30-day period has elapsed since such appeal was so filed; and

''(bb) with respect to a specified claim made by a health plan, items and services furnished by such a provider or facility for which such health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1), but only if—

''(AA) such plan submits a notice to such pro-

vider or facility not later than 30 days after such provider or facility receives such payment that such plan disputes the amount of such payment with respect to such items and services; and

''(BB) a 30-day period has elapsed since the submission of such notice.

''(II) LIMITATION.—The term 'qualifying items and services' shall not include an item or service furnished in a geographic area during a year by such provider or facility for which a health plan is required to make payment pursuant to subsection (b)(1) or subsection (e)(1) if the median contracted rate (as defined in subsection (b)(3)(E)) under such plan for such year with respect to such item or service furnished by such a provider or such a facility in such area does not exceed—

''(aa) with respect to an item or service furnished during 2021, $1,250; and

''(bb) with respect to an item or service furnished during a subsequent year, the amount specified under this subclause for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

''(2) CERTIFICATION OF ENTITIES.—

''(A) PROCESS OF CERTIFICATION.—The process described in paragraph (1) shall include a certification process under which eligible entities may be certified to carry out the IDR process.

''(B) ELIGIBILITY.—

''(i) IN GENERAL.—For purposes of subparagraph (A), an eligible entity is an entity that is a nongovernmental entity that agrees to comply with the fee limitations described in clause (ii).

''(ii) FEE LIMITATION.—For purposes of clause (i), the fee limitations described in this clause are limitations established by the Secretary on the amount a certified IDR entity may charge a nonparticipating provider, nonparticipating emergency facility, or health plan for services furnished by such entity with respect to the resolution of a specified claim of such provider, facility, or plan under the process described in paragraph (1).

''(3) SELECTION OF CERTIFIED IDR ENTITY FOR A SPECIFIED CLAIM.—With respect to the resolution of a specified claim under the IDR process, the health plan and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved shall agree on a certified IDR entity to resolve such claim. In the case that such plan and such provider or facility (as applicable) cannot so agree, such an entity shall be selected by the Secretary at random.

''(4) PAYMENT DETERMINATION.—

''(A) TIMING.—A certified IDR entity selected under paragraph (3) by a health plan and a nonparticipating provider or a nonpartici-

pating emergency facility (as applicable) with respect to a specified claim shall, subject to subparagraph (B), not later than 30 days after being so selected, determine the total reimbursement that should have been made for items and services included in such claim in accordance with subparagraph (C).

''(B) SETTLEMENT.—

''(i) IN GENERAL.—If such entity determines that a settlement between the health plan and the provider or facility is likely with respect to a specified claim, the entity may direct the parties to attempt, for a period not to exceed 10 days, a good faith negotiation for a settlement of such claim.

''(ii) TIMING.—The period for a settlement described in clause (i) shall accrue towards the 30-day period described in subparagraph (A).

''(C) DETERMINATION OF AMOUNT.—

''(i) IN GENERAL.—The health plan and the nonparticipating provider or nonparticipating emergency facility (as applicable) shall, with respect to a specified

claim, each submit to the certified IDR entity a final offer of payment or reimbursement (as applicable) with respect to items and services which are the subject of the specified claim. Such entity shall determine which such offer is the most reasonable in accordance with clause (ii).

''(ii) CONSIDERATIONS IN DETERMINATION.—

''(I) IN GENERAL.—In determining which final offer is the most reasonable under clause (i), the certified IDR entity shall consider—

''(aa) the median contracted rates (as defined in subsection (b)(3)(E)) for items or services that are comparable to the items and services included in the specified claim and that are furnished in the same geographic area (as defined by the Secretary for purposes of such subsection) as such items and services (not including any facility fees with respect to such rates); and

''(bb) the circumstances described in subclause (II), if any information with respect to such circumstances is submitted by either party.

''(II) ADDITIONAL CIRCUMSTANCES.—For purposes of subclause (I)(bb), the circumstances described in this subclause are, with respect to items and services included in the specified claim of a nonparticipating provider, nonparticipating emergency facility, or health plan, the following:

''(aa) The level of training, education, experience, and quality and outcomes measurements of the provider or facility that furnished such items and services.

''(bb) Any other extenuating circumstances with respect to the furnishing of such items and services that relate to the acuity of the individual receiving such items and services or the com-

plexity of furnishing such items and services to such individual.

''(III) PROHIBITION ON CONSIDERATION OF BILLED CHARGES.—In determining which final offer is the most reasonable under clause (i) with respect to items and services furnished by a provider or facility and included in a specified claim, the certified IDR entity may not consider the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 2799 or 2799A (as applicable) not applied.

''(iii) EFFECT OF DETERMINATION.—A determination of a certified IDR entity under clause (i)—

''(I) shall be binding; and

''(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

''(iv) COSTS OF INDEPENDENT DISPUTE RESOLUTION PROCESS.—In the case of a specified claim made by a nonparticipating provider, nonparticipating emergency facility, or health plan and submitted to a certified IDR entity—

''(I) if such entity makes a determination with respect to such claim under clause (i), the party whose offer is not chosen under such clause shall be responsible for paying all fees charged by such entity; and

''(II) if the parties reach a settlement with respect to such claim prior to such a determination, such fees shall be divided equally between the parties, unless the parties otherwise agree.

''(v) PAYMENT.—Not later than 30 days after a determination described in clause (i) is made with respect to a specified claim of a nonparticipating provider, nonparticipating emergency facility, or health plan—

''(I) in the case that such determination finds that the amount paid with respect to such specified claim by the health plan should have been greater than the amount so paid, such plan shall pay directly to the provider or facility (as applicable) the difference between the amount so paid and the amount so determined; and

''(II) in the case that such determination finds that the amount paid with respect to such specified claim by the health plan should have been less than the amount so paid, the provider or facility (as applicable) shall pay directly to the plan the difference between the amount so paid and the amount so determined.

''(5) PUBLICATION OF INFORMATION RELATING TO DISPUTES.—

''(A) IN GENERAL.—For 2021 and each subsequent year, the Secretary and the Secretary of Labor shall publish on the public website of the Department of Health and

Human Services and the Department of Labor, respectively—

''(i) the number of specified claims filed during such year;

''(ii) the number of such claims with respect to which a final determination was made under paragraph (4)(C)(i); and

''(iii) the information described in subparagraph (B) with respect to each specified claim with respect to which such a decision was so made.

''(B) INFORMATION WITH RESPECT TO SPECIFIED CLAIMS.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a specified claim of a nonparticiapting provider, nonparticipating emergency facility, or health plan—

''(i) a description of each item and service included in such claim;

''(ii) the amount of the offer submitted under paragraph (4)(C)(i) by the health plan and by the nonparticipating provider or nonparticipating emergency facility (as applicable);

''(iii) whether the offer selected by the certified IDR entity under such paragraph was the offer submitted by such plan or by such provider or facility (as applicable) and the amount of such offer so selected; and

''(iv) the category and practice specialty of each such provider or facility involved in furnishing such items and services.

''(C) CONFIDENTIALITY OF PARTIES.—None of the information published under this paragraph may specify the identity of a health plan, provider, facility, or individual with respect to a specified claim.''.

(c) PROVIDER DIRECTORY REQUIREMENTS; DISCLOSURE ON PATIENT PROTECTIONS.—Section 2719A of the Public Health Service Act, as amended by subsection (b), is further amended by adding at the end the following new subsections:

''(g) PROVIDER DIRECTORY INFORMATION REQUIREMENTS.—

''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, each group health plan and health insurance issuer offer-

ing group or individual health insurance coverage shall—

''(A) establish the verification process described in paragraph (2);

''(B) establish the response protocol described in paragraph (3);

''(C) establish the database described in paragraph (4); and

''(D) include in any print directory containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

''(2) VERIFICATION PROCESS.—The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process—

''(A) under which not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database; and

''(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer.

''(3) RESPONSE PROTOCOL.—The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group or individual health insurance coverage offered by a health insurance issuer who requests information on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

''(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received through a written electronic communication; and

''(B) retains such communication in such individual's file for at least 2 years following such response.

''(4) DATABASE.—The database described in this paragraph is, with respect to a group health

plan or health insurance issuer offering group or individual health insurance coverage, a database on the public website of such plan or issuer that contains—

''(A) a list of each health care provider and health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage; and

''(B) provider directory information with respect to each such provider and facility.

''(5) INFORMATION.—The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or individual or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

''(6) DEFINITION.—For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group or individual health insurance coverage, the name, address, specialty, and telephone number of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

''(h) DISCLOSURE ON PATIENT PROTECTIONS.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall make publicly available, and (if applicable) post on a public website of such plan or issuer—

''(1) information in plain language on—

''(A) the requirements and prohibitions applied under sections 2799 and 2799A (relating to prohibitions on balance billing in certain circumstances);

''(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or en-

rollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(C) the requirements applied under subsections (b) and (e); and

''(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.''.

(d) PREVENTING CERTAIN CASES OF BALANCE BILLING.—Title XXVII of the Public Health Service Act is amended by adding at the end the following new part:

''PART D—PREVENTING CERTAIN CASES OF BALANCE BILLING

''SEC. 2799. BALANCE BILLING IN CASES OF EMERGENCY SERVICES.

''(a) IN GENERAL.—In the case of a participant, beneficiary, or enrollee with benefits under a health plan who is furnished on or after January 1, 2021, emergency serv-

ices with respect to an emergency medical condition during a visit at an emergency department of a hospital or an independent freestanding emergency department—

''(1) the emergency department of a hospital or independent freestanding emergency department shall not hold the participant, beneficiary, or enrollee liable for a payment amount for such emergency services so furnished that is more than the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C)); and

''(2) a health care provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing amount for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 2719A(b)(1)(C)).

''(b) DEFINITIONS.—In this section:

''(1) The terms 'emergency department of a hospital', 'emergency medical condition', 'emergency services', and 'independent freestanding emergency

department' have the meanings given such terms, respectively, in section 2719A(b)(3).

''(2) The term 'health plan' has the meaning given such term in section 2719A(e).

''(3) The term 'during a visit' shall have such meaning as applied to such term for purposes of section 2719A(e).

"SEC. 2799A. BALANCE BILLING IN CASES OF NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT CERTAIN PARTICIPATING FACILITIES.

''(a) IN GENERAL.—Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a health plan (as defined in section 2799(b)) who is furnished on or after January 1, 2021, items or services (other than emergency services to which section 2799 applies) at a participating health care facility by a non-participating provider, such provider shall not hold such participant, beneficiary, or enrollee liable for a payment amount for such an item or service furnished by such provider during a visit at such facility that is more than the cost-sharing amount for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 2719A(e)(1)).

''(b) EXCEPTION.—

''(1) IN GENERAL.—Subsection (a) shall not apply to a nonparticipating provider (other than a specified provider at a participating health care facility), with respect to items or services furnished by the provider to a participant, beneficiary, or enrollee of a health plan, if the provider is in compliance with the notice and consent requirements of subsection (d).

''(2) SPECIFIED PROVIDER DEFINED.—For purposes of paragraph (1), the term 'specified provider', with respect to a participating health care facility—

''(A) means a facility-based provider, including emergency medicine providers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers as determined by the Secretary; and

''(B) includes, with respect to an item or service, a nonparticipating provider if there is no participating provider at such facility who can furnish such item or service.

''(c) CLARIFICATION.—In the case of a nonparticipating provider (other than a specified provider at a participating health care facility) that complies with the notice and consent requirements of subsection (d) with re-

spect to an item or service (referred to in this subsection as a 'covered item or service'), such notice and consent requirements may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen medical needs that arise at the time such covered item or service is furnished.

''(d) COMPLIANCE WITH NOTICE AND CONSENT REQUIREMENTS.—

''(1) IN GENERAL.—A nonparticipating provider or nonparticipating facility is in compliance with this subsection, with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee of a health plan, if the provider (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

''(A) provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on the date on which the individual is furnished such items or services and, in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services, on such date the appointment is made—

''(i) an oral explanation of the written notice described in clause (ii); and

''(ii) a written notice specified by the Secretary, not later than July 1, 2020, through guidance (which shall be updated as determined necessary by the Secretary) that—

''(I) contains the information required under paragraph (2); and

''(II) is signed and dated by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed and dated not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider; and

''(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized

representative) the consent described in paragraph (3).

''(2) INFORMATION REQUIRED UNDER WRITTEN NOTICE.—For purposes of paragraph (1)(A)(ii)(I), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a health plan, is each of the following:

''(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

''(B) Notification of the estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved.

''(C) In the case of a nonparticipating facility, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

''(3) CONSENT DESCRIBED.—For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a health plan who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary through rulemaking that—

''(A) is signed by the participant, beneficiary, or enrollee (or by an authorized representative of the participant, beneficiary, or enrollee) and, with respect to items or services to be furnished by such a provider or facility that are not poststabilization services described in section 2719A(b)(3)(C)(ii), is so signed not less than 72 hours prior to the participant, beneficiary, or enrollee being furnished such items or services by such provider or facility;

''(B) acknowledges that the participant, beneficiary, or enrollee has been—

''(i) provided with a written estimate and an oral explanation of the charge that the participant, beneficiary, or enrollee will be assessed for the items or services anticipated to be furnished to the participant,

beneficiary, or enrollee by such provider or facility; and

''(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the health plan places on cost-sharing; and

''(C) documents the consent of the participant, beneficiary, or enrollee to—

''(i) be furnished with such items or services by such provider or facility; and

''(ii) in the case that the individual is so furnished such items or services, be charged an amount that may be greater than the amount that would otherwise be charged the individual if furnished by a participating provider or participating facility with respect to such items or services and plan.

''(e) RETENTION OF CERTAIN DOCUMENTS.—A nonparticipating provider (or, in the case of a nonparticipating provider at a participating health care facility, such facility) or nonparticipating facility that obtains from a participant, beneficiary, or enrollee of a health plan (or an authorized representative of such participant, bene-

ficiary, or enrollee) a written notice in accordance with subsection (c)(1)(ii), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 2-year period after the date on which such item or service is so furnished.

''(f) DEFINITIONS.—In this section:

''(1) The terms 'nonparticipating provider' and 'participating provider' have the meanings given such terms, respectively, in subsection (b)(3) of section 2719A.

''(2) The terms 'participating health care facility' and 'health plan' have the meanings given such terms, respectively, in subsection (e)(2) of section 2719A.

''(3) The term 'nonparticipating facility' means—

''(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan; and

''(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency department, that does not have a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan.

''(4) The term 'participating facility' means—

''(A) with respect to emergency services (as defined in section 2719A(b)(3)(C)(i)) and a health plan, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering the plan) for furnishing such services under the plan; and

''(B) with respect to poststabilization services described in section 2719A(b)(3)(C)(ii) and a health plan, an emergency department of a hospital (or other department of such hospital), or an independent freestanding emergency department, that has a contractual relationship with the plan (or, if applicable, issuer offering

the plan) for furnishing such services under the plan.

"SEC. 2799B. PROVIDER REQUIREMENTS WITH RESPECT TO PROVIDER DIRECTORY INFORMATION.

"Not later than 1 year after the date of the enactment of this section, each health care provider and health care facility shall establish a process under which such provider or facility transmits, to each health insurance issuer offering group or individual health insurance coverage and group health plan with which such provider or facility has in effect a contractual relationship for furnishing items and services under such coverage or such plan, provider directory information (as defined in section 2719A(g)(6)) with respect to such provider or facility, as applicable. Such provider or facility shall so transmit such information to such issuer offering such coverage or such group health plan—

"(1) when the provider or facility enters into such a relationship with respect to such coverage offered by such issuer or with respect to such plan;

"(2) when the provider or facility terminates such relationship with respect to such coverage offered by such issuer or with respect to such plan;

"(3) when there are any other material changes to such provider directory information of the pro-

vider or facility with respect to such coverage offered by such issuer or with respect to such plan; and

''(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

''SEC. 2799C. PROVIDER REQUIREMENT WITH RESPECT TO PUBLIC PROVISION OF INFORMATION.

''Each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility—

''(1) information in plain language on—

''(A) the requirements and prohibitions of such provider or facility under sections 2799 and 2799A (relating to prohibitions on balance billing in certain circumstances); and

''(B) if provided for under applicable State law, any other requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a health plan (as defined in section 2719A(e)(2)) with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan after receiving payment from

the plan for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

''(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

''SEC. 2799D. ENFORCEMENT.

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Each State may require a provider or health care facility subject to the requirements of sections 2719A(f), 2799, 2799A, 2799B, or 2799C to satisfy such requirements applicable to the provider or facility.

''(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements specified in paragraph (1) with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

''(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—If a provider or facility is found to be in violation specified in subsection (a)(1) by the Secretary, the Secretary may apply a civil monetary penalty with respect to such provider or facility in an amount not to exceed $10,000 per violation. The provisions of subsections (c), (d), (e), (g), (h), (k), and (l) of section 1128A of the Social Security Act shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

''(2) LIMITATION.—The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

''(3) COMPLAINT PROCESS.—The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and resolve such complaints within 60 days of receipt of such complaints.

''(4) EXCEPTION.—The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider who does not knowingly violate, and should not have reasonably known

it violated, section 2799 or 2799A with respect to a participant, beneficiary, or enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

''(5) HARDSHIP EXEMPTION.—The Secretary may establish a hardship exemption to the penalties under this subsection.

''(c) CONTINUED APPLICABILITY OF STATE LAW.—The sections specified in subsection (a)(1) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.''.

(e) RULEMAKING FOR MEDIAN CONTRACTED RATES.—Not later than July 1, 2020, the Secretary of Health and Human Services, jointly with the Secretary of Labor, shall establish through rulemaking—

(1) the methodology the sponsor or issuer of a health plan (as defined in subsection (e) of section

2719A of the Public Health Service Act (42 U.S.C. 300gg–19a), as added by subsection (b) of this section) shall use to determine the median contracted rate (as defined in section 2719A(b) of such Act, as amended by subsection (a) of this section), differentiating by business line;

(2) the information such sponsor or issuer shall share with the nonparticipating provider (as defined in such section) involved when making such a determination; and

(3) the geographic regions applied for purposes of subparagraph (E) of section 2719A(b)(3), as amended by subsection (a) of this section, taking into account the needs of rural and underserved areas, including health professional shortage areas.

Such rulemaking shall take into account payments that are made by such sponsor or issuer that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities.

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

SEC. 403. GOVERNMENT ACCOUNTABILITY OFFICE STUDY ON PROFIT- AND REVENUE-SHARING IN HEALTH CARE.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to—

(1) describe what is known about profit- and revenue-sharing relationships in the commercial health care markets, including those relationships that—

(A) involve one or more—

(i) physician groups that practice within a hospital included in the profit- or revenue-sharing relationship, or refer patients to such hospital;

(ii) laboratory, radiology, or pharmacy services that are delivered to privately insured patients of such hospital;

(iii) surgical services;

(iv) hospitals or group purchasing organizations; or

(v) rehabilitation or physical therapy facilities or services; and

(B) include revenue- or profit-sharing whether through a joint venture, management or professional services agreement, or other form of gain-sharing contract;

(2) describe Federal oversight of such relationships, including authorities of the Department of Health and Human Services and the Federal Trade Commission to review such relationships and their potential to increase costs for patients, and identify limitations in such oversight; and

(3) as appropriate, make recommendations to improve Federal oversight of such relationships.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit a report on the study conducted under subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and Committee on Energy and Commerce of the House of Representatives.

SEC. 404. STATE ALL PAYER CLAIMS DATABASES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make one-time grants to eligible States for the purposes described in subsection (b).

(b) USES.—A State may use a grant received under subsection (a) for one of the following purposes:

(1) To establish an All Payer Claims Database for the State.

(2) To maintain an existing All Payer Claims Databases for the State.

(c) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary specifies. Such information shall include, with respect to an All Payer Claims Database for the State, at least specifics on how the State will ensure uniform data collection through the database and the security of such data submitted to and maintained in the database.

(d) ALL PAYER CLAIMS DATABASE.—For purposes of this section, the term ''All Payer Claims Database'' means, with respect to a State, a State database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000, to remain available until expended.

SEC. 405. AIR AMBULANCE COST DATA REPORTING PROGRAM.

(a) COST DATA REPORTING PROGRAM.—

(1) IN GENERAL.—Not later than 6 months after the date of the promulgation of the rule under subsection (c), and annually thereafter, a provider of emergency air medical services shall submit to the Secretary of Health and Human Services the information specified in subsection (b) with respect to the preceding 180-day period (in the case of the initial period) and the preceding 1-year period (in each subsequent period).

(2) PUBLICATION.—Not later than 180 days after the date the Secretary of Health and Human Services receives from a provider described in paragraph (1) the information specified in subsection (b), the Secretary shall make publicly available such information.

(b) SPECIFIED INFORMATION.—Information described in subsection (a) is—

(1) information, with respect to a claim for an item or service—

(A) identified as paid by health insurance coverage offered in the group or individual market or a group health plan (including a self-insured plan);

(B) identified as paid for non-emergent transport requiring prior authorization and emergent transport;

(C) identified as paid for hospital-affiliated providers and independent providers;

(D) identified as paid for rural transport and urban transport;

(E) identified as provided using rotor transport and fixed wing transport; and

(F) identified as furnished by a provider of emergency air medical services that has a contractual relationship with the plan or coverage of an individual for which such item or service is provided and such a provider that does not have a contractual relationship with the plan or coverage or such an individual; and

(2) cost data for an air ambulance service furnished by such a provider of emergency air medical services that the Secretary of Health and Human Services, in consultation with suppliers and providers of such services, determines appropriate, separated by the cost of air travel and the cost of emergency medical services and supplies.

(c) RULEMAKING.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health

and Human Services shall determine the form and manner for submitting the information described in subsection (b) through notice and comment rulemaking.

(d) CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—A provider of emergency air medical services who violates the requirements of subsection (a)(1) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

(2) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such subsection, shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under such section.

(e) REPORTING.—

(1) SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than July 1, 2023, the Secretary of Health and Human Services shall submit to Congress a report summarizing the information and data specified in subsection (b).

(2) COMPTROLLER GENERAL.—Not later than July 1, 2023, the Comptroller General of the United

States shall submit to Congress a report that includes—

(A) an analysis of the cost variation of providers of emergency air ambulance services by geography and status; and

(B) any other recommendations the Comptroller General determines appropriate, which may include a recommendation of an adequate amount of reimbursement for such services that reflects operational costs of such providers in order to preserve access to emergency air ambulance services.

(f) LIMITATION.—The information publicly disclosed under subsection (a) and the reports under subsection (f) may not contain any proprietary information.

SEC. 406. REPORT BY SECRETARY OF LABOR.

Not later than one year after the date of the enactment of this Act, and annually thereafter for each of the following 5 years, the Secretary of Labor shall—

(1) conduct a study of—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs in group health plans, including out-of-pocket costs that are permitted by reason of compliance with section

2799A(d) of the Public Health Service Act, as added by section 2(d);

(B) the adequacy of provider networks in group health plans; and

(C) such other effects of such provisions, and amendments, as the Secretary deems relevant; and

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor and the Committee on Energy and Commerce of the House of Representatives.

SEC. 407. BILLING STATUTE OF LIMITATIONS.

Notwithstanding any other provision of law, a health care provider or health care facility (or health insurance issuer offering health insurance coverage or group health plan) may not initiate a process to seek reimbursement from an individual for a service furnished by such provider or facility to such individual more than a year after such date of service. Any provider, facility, issuer, or plan that bills an individual in violation of the previous sentence shall be subject to a civil monetary penalty in such amount as specified by the Secretary of Health and Human Services.

SEC. 408. GAO REPORT ON IMPACT OF SURPRISE BILLING PROVISIONS.

Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the following:

(1) What is known about the impacts of the provisions of this Act, including the amendments made by this Act, on the incidence and prevalence of the furnishing of items and services to individuals enrolled under a group health plan or health insurance coverage by health care providers and health care facilities that do not have a contractual relationship with such plan or such coverage (as applicable) for furnishing such items and services to such an individual.

(2) What is known about such impacts on provider shortages and accessibility to such providers, focusing on rural and medically underserved communities.

(3) The number of grants that have been awarded under section 404 (relating to State All Payer Claims Databases) and for what purposes States have used funds made available under such grants.

(4) An analysis of how data made available through State All Payer Claims Databases receiving funding under such grants has been used.

SEC. 409. REPORT BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Not later than one year after the date of the enactment of this Act, and annually thereafter for each of the following 5 years, the Secretary of Health and Human Services shall—

(1) conduct a study of—

(A) the effects of the provisions of, including amendments made by, this Act on premiums and out-of-pocket costs with respect to individual health insurance coverage and small group health plans;

(B) the adequacy of provider networks with respect to individual health insurance coverage and small group health plans, taking into consideration maximum travel time and distance; and

(C) such other effects of such provisions, and amendments, as the Secretary deems relevant; and

(2) submit a report on such study to the Committee on Health, Education, Labor, and Pensions

of the Senate and the Committee on Education and Labor and the Committee on Energy and Commerce of the House of Representatives.

TITLE V—MISCELLANEOUS

SEC. 501. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS DURING INITIAL PERIOD.

Section 1847A(c)(4) of the Social Security Act (42 U.S.C. 1395w–3a(c)(4)) is amended—

(1) in each of subparagraphs (A) and (B), by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and moving such subclauses 2 ems to the right;

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii) and moving such clauses 2 ems to the right;

(3) by striking ''UNAVAILABLE.—In the case'' and inserting ''UNAVAILABLE.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case''; and

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

''(B) LIMITATION ON PAYMENT AMOUNT FOR BIOSIMILAR BIOLOGICAL PRODUCTS DURING INITIAL PERIOD.—In the case of a biosimilar biological product furnished on or after

July 1, 2020, in lieu of applying subparagraph (A) during the initial period described in such subparagraph with respect to the biosimilar biological product, the amount payable under this section for the biosimilar biological product is the lesser of the following:

''(i) The amount determined under clause (ii) of such subparagraph for the biosimilar biological product.

''(ii) The amount determined under subsection (b)(1)(B) for the reference biological product.''.

SEC. 502. GAO STUDY AND REPORT ON AVERAGE SALES PRICE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on spending for applicable drugs under part B of title XVIII of the Social Security Act.

(2) APPLICABLE DRUGS DEFINED.—In this section, the term ''applicable drugs'' means drugs and biologicals—

(A) for which reimbursement under such part B is based on the average sales price of the drug or biological; and

(B) that account for the largest percentage of total spending on drugs and biologicals under such part B (as determined by the Comptroller General, but in no case less that 25 drugs or biologicals).

(3) REQUIREMENTS.—The study under paragraph (1) shall include an analysis of the following:

(A) The extent to which each applicable drug is paid for—

(i) under such part B for Medicare beneficiaries; or

(ii) by private payers in the commercial market.

(B) Any change in Medicare spending or Medicare beneficiary cost-sharing that would occur if the average sales price of an applicable drug was based solely on payments by private payers in the commercial market.

(C) The extent to which drug manufacturers provide rebates, discounts, or other price concessions to private payers in the commercial market for applicable drugs, which the manu-

facturer includes in its average sales price calculation, for—

(i) formulary placement;

(ii) utilization management considerations; or

(iii) other purposes.

(D) Barriers to drug manufacturers providing such price concessions for applicable drugs.

(E) Other areas determined appropriate by the Comptroller General.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 503. REQUIRING PRESCRIPTION DRUG PLANS AND MA–PD PLANS TO REPORT POTENTIAL FRAUD, WASTE, AND ABUSE TO THE SECRETARY OF HHS.

Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(p) REPORTING POTENTIAL FRAUD, WASTE, AND ABUSE.—Beginning January 1, 2021, the PDP sponsor of a prescription drug plan shall report to the Secretary, as specified by the Secretary—

''(1) any substantiated or suspicious activities (as defined by the Secretary) with respect to the program under this part as it relates to fraud, waste, and abuse; and

''(2) any steps made by the PDP sponsor after identifying such activities to take corrective actions.''.

SEC. 504. ESTABLISHMENT OF PHARMACY QUALITY MEASURES UNDER MEDICARE PART D.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(8) APPLICATION OF PHARMACY QUALITY MEASURES.—

''(A) IN GENERAL.—A PDP sponsor that implements incentive payments to a pharmacy or price concessions paid by a pharmacy based on quality measures shall use measures established or approved by the Secretary under subparagraph (B) with respect to payment for covered part D drugs dispensed by such pharmacy.

''(B) STANDARD PHARMACY QUALITY MEASURES.—The Secretary shall establish or approve standard quality measures from a consensus and evidence-based organization for payments described in subparagraph (A). Such measures shall focus on patient health outcomes and be based on proven criteria measuring pharmacy performance.

''(C) EFFECTIVE DATE.—The requirement under subparagraph (A) shall take effect for plan years beginning on or after January 1, 2023, or such earlier date specified by the Secretary if the Secretary determines there are sufficient measures established or approved under subparagraph (B) to meet the requirement under subparagraph (A).''.

SEC. 505. IMPROVING COORDINATION BETWEEN THE FOOD AND DRUG ADMINISTRATION AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES.

(a) IN GENERAL.—

(1) PUBLIC MEETING.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Sec-

retary'') shall convene a public meeting for the purposes of discussing and providing input on improvements to coordination between the Food and Drug Administration and the Centers for Medicare & Medicaid Services in preparing for the availability of novel medical products described in subsection (c) on the market in the United States.

(B) ATTENDEES.—The public meeting shall include—

(i) representatives of relevant Federal agencies, including representatives from each of the medical product centers within the Food and Drug Administration and representatives from the coding, coverage, and payment offices within the Centers for Medicare & Medicaid Services;

(ii) stakeholders with expertise in the research and development of novel medical products, including manufacturers of such products;

(iii) representatives of commercial health insurance payers;

(iv) stakeholders with expertise in the administration and use of novel medical products, including physicians; and

(v) stakeholders representing patients and with expertise in the utilization of patient experience data in medical product development.

(C) TOPICS.—The public meeting shall include a discussion of—

(i) the status of the drug and medical device development pipeline related to the availability of novel medical products;

(ii) the anticipated expertise necessary to review the safety and effectiveness of such products at the Food and Drug Administration and current gaps in such expertise, if any;

(iii) the expertise necessary to make coding, coverage, and payment decisions with respect to such products within the Centers for Medicare & Medicaid Services, and current gaps in such expertise, if any;

(iv) trends in the differences in the data necessary to determine the safety and effectiveness of a novel medical product

and the data necessary to determine whether a novel medical product meets the reasonable and necessary requirements for coverage and payment under title XVIII of the Social Security Act pursuant to section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A));

(v) the availability of information for sponsors of such novel medical products to meet each of those requirements; and

(vi) the coordination of information related to significant clinical improvement over existing therapies for patients between the Food and Drug Administration and the Centers for Medicare & Medicaid Services with respect to novel medical products.

(D) TRADE SECRETS AND CONFIDENTIAL INFORMATION.—No information discussed as a part of the public meeting under this paragraph shall be construed as authorizing the Secretary to disclose any information that is a trade secret or confidential information subject to section 552(b)(4) of title 5, United States Code.

(2) IMPROVING TRANSPARENCY OF CRITERIA FOR MEDICARE COVERAGE.—

(A) DRAFT GUIDANCE.—Not later than 18 months after the public meeting under paragraph (1), the Secretary shall update the final guidance titled ''National Coverage Determinations with Data Collection as a Condition of Coverage: Coverage with Evidence Development'' to address any opportunities to improve the availability and coordination of information as described in clauses (iv) through (vi) of paragraph (1)(C).

(B) FINAL GUIDANCE.—Not later than 12 months after issuing draft guidance under subparagraph (A), the Secretary shall finalize the updated guidance to address any such opportunities.

(b) REPORT ON CODING, COVERAGE, AND PAYMENT PROCESSES UNDER MEDICARE FOR NOVEL MEDICAL PRODUCTS.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall publish a report on the Internet website of the Department of Health and Human Services regarding processes under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) with respect to the coding, coverage, and payment of novel medical products

described in subsection (c). Such report shall include the following:

(1) A description of challenges in the coding, coverage, and payment processes under the Medicare program for novel medical products.

(2) Recommendations to—

(A) incorporate patient experience data (such as the impact of a disease or condition on the lives of patients and patient treatment preferences) into the coverage and payment processes within the Centers for Medicare & Medicaid Services;

(B) decrease the length of time to make national and local coverage determinations under the Medicare program (as those terms are defined in subparagraph (A) and (B), respectively, of section 1862(l)(6) of the Social Security Act (42 U.S.C. 1395y(l)(6));

(C) streamline the coverage process under the Medicare program and incorporate input from relevant stakeholders into such coverage determinations; and

(D) identify potential mechanisms to incorporate novel payment designs similar to those in development in commercial insurance plans

and State plans under title XIX of such Act (42 U.S.C. 1396 et seq.) into the Medicare program.

(c) NOVEL MEDICAL PRODUCTS DESCRIBED.—For purposes of this section, a novel medical product described in this subsection is a medical product, including a drug, biological (including gene and cell therapy), or medical device, that has been designated as a breakthrough therapy under section 506(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 356(a)), a breakthrough device under section 515B of such Act (21 U.S.C. 360e–3), or a regenerative advanced therapy under section 506(g) of such Act (21 U.S.C. 356(g)).

SEC. 506. PATIENT CONSULTATION IN MEDICARE NATIONAL AND LOCAL COVERAGE DETERMINATIONS IN ORDER TO MITIGATE BARRIERS TO INCLUSION OF SUCH PERSPECTIVES.

Section 1862(l) of the Social Security Act (42 U.S.C. 1395y(l)) is amended by adding at the end the following new paragraph:

''(7) PATIENT CONSULTATION IN NATIONAL AND LOCAL COVERAGE DETERMINATIONS.—The Secretary may consult with patients and organizations representing patients in making national and local coverage determinations.''.

SEC. 507. MEDPAC REPORT ON SHIFTING COVERAGE OF CERTAIN MEDICARE PART B DRUGS TO MEDICARE PART D.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on shifting coverage of certain drugs and biologicals for which payment is currently made under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) to part D of such title (42 U.S.C. 1395w–21 et seq.). Such study shall include an analysis of—

(1) differences in program structures and payment methods for drugs and biologicals covered under such parts B and D, including effects of such a shift on program spending, beneficiary cost-sharing liability, and utilization management techniques for such drugs and biologicals; and

(2) the feasibility and policy implications of shifting coverage of drugs and biologicals for which payment is currently made under such part B to such part D.

(b) REPORT.—

(1) IN GENERAL.—Not later than June 30, 2021, the Commission shall submit to Congress a report containing the results of the study conducted under subsection (a).

(2) CONTENTS.—The report under paragraph (1) shall include information, and recommendations as the Commission deems appropriate, regarding—

(A) formulary design under such part D;

(B) the ability of the benefit structure under such part D to control total spending on drugs and biologicals for which payment is currently made under such part B;

(C) changes to the bid process under such part D, if any, that may be necessary to integrate coverage of such drugs and biologicals into such part D; and

(D) any other changes to the program that Congress should consider in determining whether to shift coverage of such drugs and biologicals from such part B to such part D.

☒