Entitlement Modernization Act of 2025

A BILL To strengthen the financial sustainability of Social Security and Medicare through gradual modernization of eligibility and benefits, and to reduce federal costs by better targeting benefits and lowering prescription drug prices, while protecting core entitlements for future generations.

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

Title I – General Provisions

SEC. 101. SHORT TITLE. This Act may be cited as the **"Entitlement Modernization Act of 2025."**

SEC. 102. FINDINGS AND PURPOSE. (a) Findings.— Congress finds the following:

1. **Fiscal Challenges of Social Security and Medicare:** Social Security and Medicare face significant fiscal challenges. The Social Security Trustees project that by 2035 the combined Old-Age and Survivors Insurance and Disability Insurance Trust Funds will be unable to pay full benefits, with incoming tax revenue covering only about 83% of scheduled benefits, resulting in an across-the-board benefit reduction of roughly 17% absent reformstaxfoundation.org. Likewise, the Medicare Hospital Insurance Trust Fund (Part A) is projected to be depleted by 2036kff.org, jeopardizing full payment for inpatient hospital services. Congress recognizes an urgent need to shore up these vital programs' solvency for current and future retirees.
2. **Increases in Life Expectancy:** Since Social Security's inception in 1935, Americans are living significantly longer. Life expectancy at age 65 has increased from approximately 12.7 years in 1940 to about 18–20 years todayactuary.org. In other words, the average retiree now lives about 6.5 years longer in retirement than in the 1940s, while the statutory full retirement age has risen only modestly (from 65 to 67). These longevity gains, while welcome, put pressure on Social Security's finances as benefits are paid over longer lifespans. Gradually adjusting the retirement age to reflect improved longevity will help restore solvency while still allowing reasonable retirement timing.
3. **Protecting Vulnerable Beneficiaries and Strengthening Fairness:** Social Security and Medicare are safety net programs intended to prevent poverty in old age and provide health security for seniors. Currently, benefits are paid to all who are eligible, regardless of need, and the very wealthy receive the same base benefits as middle-income workers. Given fiscal pressures, modestly means-testing benefits for the wealthiest retirees – who have substantial alternative income and assets – can improve

solvency in a way that targets resources to those who most rely on these programsboulaygroup.com. Reducing or phasing out benefits for individuals with exceptionally high retirement incomes (e.g., above $250,000 annually) will only affect a small fraction of retirees and will not undermine the earned-right nature of Social Security for the vast majority. Similarly, expanding Medicare's income-related premiums to modestly higher-income brackets will ask more of those most able to contribute, strengthening Medicare's financing without harming lower-income seniors.

4. **Prescription Drug Costs and Need for Price Restraint:** The United States spends far more on prescription drugs than other developed nations. U.S. drug prices average approximately 2.5 to 3 times the prices paid in other high-income countriesrand.orgcommonwealthfund.org. Many brand-name drugs have seen annual price increases well above general inflation – in one recent period, about half of all drugs covered by Medicare had price hikes exceeding the inflation ratekff.org. These excessive price increases strain Medicare and beneficiaries, contributing to higher premiums and taxpayer costs.

5. **Medicare Drug Price Negotiation:** In 2022, Congress granted Medicare limited authority to negotiate prices of a small number of high-cost drugs each year (initially 10 drugs in 2026, increasing to 20 drugs by 2029). While a positive first step, this negotiation authority is restricted in scopecongress.gov. Empowering Medicare to negotiate a larger number of drugs (e.g., 30 drugs annually) and to use additional tools – such as inflation-based price caps and international reference pricing – will substantially increase savings and help align U.S. drug prices with fair levels.

6. **Purpose of this Act:** In light of these findings, the purpose of this Act is to modernize entitlement programs by gradually raising the Social Security full retirement age to reflect longevity, instituting means-testing for ultra-wealthy retirees to improve fairness and program solvency, and reducing Medicare spending growth through enhanced drug price negotiation and price-growth restraints. These reforms are intended to ensure the long-term viability of Social Security and Medicare for future generations while safeguarding essential benefits for those who depend on them.

(b) Purpose.— The provisions of this Act collectively implement the Entitlement Modernization Plan, which is designed to extend the solvency of the Social Security Trust Funds and Medicare Hospital Insurance Trust Fund, improve the targeting of benefits to those most in need, and reduce federal expenditures on healthcare by restraining excessive drug prices. Nothing in this Act shall be construed to cut benefits for middle- and lower-income Americans who rely on Social Security and Medicare; rather, the changes herein ask higher-income seniors to contribute more and curb profiteering in the pharmaceutical industry, in order to preserve these programs for all.

SEC. 103. DEFINITIONS. Unless otherwise specified, for purposes of this Act and the amendments made herein:

1. **"Social Security Act"** means the Social Security Act (42 U.S.C. §301 et seq.).

2. **"Commissioner"** means the Commissioner of Social Security.
3. **"Secretary"** means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (CMS) with respect to the Medicare program.
4. **"Full retirement age"** (FRA), also referred to as **"Normal Retirement Age"**, means the age at which an individual is eligible for an old-age insurance benefit under Title II of the Social Security Act that is not reduced for early retirement, as defined in section 216(l) of the Social Security Act (42 U.S.C. 416(l)).
5. **"Modified Adjusted Gross Income"** (MAGI) means modified adjusted gross income as defined in section 1839(i)(4) of the Social Security Act (42 U.S.C. 1395r(i)(4)), i.e., adjusted gross income for Federal income tax purposes plus any tax-exempt interest and other income exclusions, as reported to the Internal Revenue Service.
6. **"Medicare"** means the federal health insurance program established under Title XVIII of the Social Security Act. References to Medicare Part A, B, D, etc. refer to the parts of that title.
7. **"Negotiation program"** means the Medicare Drug Price Negotiation Program established under section 1191 of the Social Security Act (42 U.S.C. 1320f et seq.), as added by the Inflation Reduction Act of 2022.
8. **"Applicable inflation index"** means the Consumer Price Index for All Urban Consumers (CPI-U, U.S. City Average, all items) published by the Bureau of Labor Statistics, unless another specified index is provided.

Title II – Social Security Reforms

SEC. 201. GRADUAL INCREASE IN FULL RETIREMENT AGE WITH LONGEVITY INDEXING.
(a) Amendment to Full Retirement Age Schedule.— Section 216(l)(1) of the Social Security Act (42 U.S.C. 416(l)(1)) is amended:
1. in subparagraph (D), by **striking** "born after 1959" and **inserting** "born in 1960 through 1969"; and
2. by **adding after** subparagraph (D) the following new subparagraphs: "(E) in the case of an individual born in 1970, 67 years and 3 months; (F) in the case of an individual born in 1971, 67 years and 6 months; (G) in the case of an individual born in 1972, 67 years and 9 months; (H) in the case of an individual born in 1973, 68 years; (I) in the case of an individual born in 1974, 68 years and 3 months; (J) in the case of an individual born in 1975, 68 years and 6 months; (K) in the case of an individual born in 1976, 68 years and 9 months; (L) in the case of an individual born in 1977, 69 years; (M) in the case of an individual born in 1978, 69 years and 3 months; (N) in the case of an individual born in 1979, 69 years and 6 months; (O) in the case of an individual born in 1980, 69 years and 9 months; (P) in the case of an individual born in 1981, 70 years; and (Q) in the case of an individual born after 1981, 70 years, **subject to adjustment**

under paragraph (3)." *(Explanation:* The above schedule raises the full retirement age (FRA) from the current 67 (for those born 1960–69) by three months for each birth year starting with 1970, reaching 70 for individuals born in 1981. Those born before 1970 are **not** affected and retain their FRA under prior law.)*

3. **Conforming amendment:** Section 216(l)(2) of the Social Security Act is amended by striking "the age of 67 years" and inserting "the applicable retirement age as provided in paragraph (1)".

(b) Longevity Indexing for Future Cohorts.— Section 216(l) of the Social Security Act (42 U.S.C. 416(l)) is further amended by adding at the end the following new paragraph:

"(3) **Indexing of Retirement Age to Life Expectancy.** – For individuals born in years after the last year provided in paragraph (1) (i.e., after those who attain age 70 as their retirement age under paragraph (1)), the Commissioner shall, by regulation, periodically adjust the retirement age in accordance with increases in longevity, as follows: (A) **Maintenance of Ratio of Retirement Years to Working Years:** The Commissioner shall determine, based on data from the Social Security Board of Trustees or other appropriate actuarial data, the ratio of (i) the expected average remaining life expectancy at the full retirement age, to (ii) the number of years from age 20 until the full retirement age, for the cohort of individuals reaching age 62 in 2043 (those born in 1981). This ratio shall serve as the baseline. (B) **Periodic Adjustment:** Beginning with individuals attaining age 62 in 2045 (birth year 1983) and at least every two years thereafter, the Commissioner shall increase the full retirement age by such fractional amount (in whole months) as needed to ensure that the ratio defined in subparagraph (A) for each affected cohort does not exceed the baseline ratio. In making such adjustments, the increase in full retirement age shall not exceed **1 month for every 2 years** that elapse after 2043, unless a greater increase is separately authorized by Act of Congress. (C) **Notice and Rounding:** The Commissioner shall announce any such adjustment to the retirement age at least 8 years before the affected cohort reaches age 62. The adjusted retirement age shall be rounded down to the nearest full month. (D) **Hardship Exemption:** Nothing in this paragraph shall prevent Congress from enacting a hardship exemption for certain categories of workers (for example, long-term low-wage workers in physically demanding occupations) in conjunction with these longevity indexing adjustments. If at any time the Commissioner determines that longevity improvements have stagnated or reversed, the Commissioner may suspend or modify the indexing increases, subject to informing Congress. (E) **Retention of Early and Delayed Retirement Options:** The earliest eligibility age for Social Security retirement benefits (age 62) is not changed by this Act and remains available. Individuals will continue to be able to claim permanently reduced benefits as early as age 62, or to delay retirement past full retirement age (with actuarial delayed retirement credits) up to age 70 (or higher if adjusted pursuant to this subsection) consistent with current law."

(c) Effective Date and Application: The amendments made by subsection (a) shall not affect any individual born before January 1, 1970. The new full retirement age schedule shall first apply to individuals born in 1970 (who become eligible for early retirement in 2032 and reach full retirement age in 2037 under the schedule). The longevity indexing provided in subsection (b) shall be implemented by the Commissioner of Social Security such that any applicable adjustments for life expectancy shall first affect individuals attaining age 62 in the year 2045 (or later), with the Commissioner authorized to promulgate interim final regulations by 2035 to carry out these provisions. The Commissioner shall include in the annual Trustees' Reports an analysis of life expectancy data and any forthcoming adjustment to the retirement age.

SEC. 202. MEANS-TESTING OF SOCIAL SECURITY BENEFITS FOR HIGH-INCOME RETIREES.

(a) Reduction of Benefits for Ultra-High Retirement Incomes.— Section 203 of the Social Security Act (42 U.S.C. 403) (relating to reductions of benefits) is amended by adding at the end the following new subsection:

"(h) Reduction of Old-Age Benefits Based on High Retirement Income.—(1) Notwithstanding any other provision of this title, in the case of any individual who is entitled to old-age insurance benefits under section 202 (or to whom such benefits are payable as an auxiliary or survivor beneficiary) for any month in a calendar year, and who had modified adjusted gross income (as defined in paragraph (3)) in the applicable preceding taxable year in excess of the high-income threshold amount specified in paragraph (4), the Commissioner **shall reduce** the monthly old-age insurance benefit amount otherwise payable to that individual as provided in this subsection. This reduction is in addition to (and applied after) any other adjustments under this section (such as the retirement earnings test in subsection (b) or reductions for early retirement in section 202(q)). (2) **Amount of Reduction; Phase-out Formula:** If an individual's modified adjusted gross income exceeds the threshold in paragraph (4) for the year, the total annual Social Security old-age benefits payable to that individual for months in the following calendar year shall be reduced by **$1 for every $2** of modified adjusted gross income above the threshold, up to a maximum reduction equal to 100% of the annual benefit amount. The reduction shall be pro-rated monthly and applied to benefits paid in the calendar year that begins in the second year following the taxable year for which the income is measured. If the computed reduction equals or exceeds the individual's scheduled annual benefit, the benefit shall be reduced to zero (suspended) for that year. Any such reduction shall not affect the individual's entitlement to Medicare under title XVIII or other entitlement rights, but merely the cash benefit amount. (3) **Definition of Modified Adjusted Gross Income:** For purposes of this subsection, the term "modified adjusted gross income" (MAGI) means the beneficiary's adjusted gross income as defined for federal income tax purposes, **plus** any tax-exempt interest income and amounts excluded from gross income as foreign earned income or income from

sources within Puerto Rico or Guam, for the taxable year. The Commissioner shall obtain MAGI data from the Secretary of the Treasury (Internal Revenue Service) as needed to administer this subsection. In general, the MAGI from the **taxable year two years prior** to the calendar year of benefit payment shall be used (so-called "prior-prior year" income), consistent with procedures for Medicare Part B income-related premiums, except that the Commissioner may adjust this look-back period by regulation if necessary to effectively target current high-income beneficiaries. (4) **High-Income Threshold Amount:** The high-income threshold amount for a taxable year is as follows – *(A)* for an individual who files an income tax return with a filing status of single (or as a married person filing separately), **$250,000** of modified adjusted gross income; and *(B)* for an individual who files a joint income tax return with their spouse, **$500,000** of combined modified adjusted gross income on the joint return. The Commissioner shall adjust these dollar threshold amounts after 2025 by indexing them to inflation in the same manner as tax bracket thresholds are adjusted under section 1(f) of the Internal Revenue Code. Rounded values of the thresholds (to the nearest $1,000) shall be announced by the Commissioner annually. (5) **Coordination in Case of Joint Entitlement:** In the case of a married couple who both receive Social Security benefits and who file a joint tax return, any income-related reduction under this subsection shall be applied proportionately to each spouse's benefit based on the proportion of each spouse's individual primary insurance amount to the sum of their primary insurance amounts, unless the Commissioner by regulation prescribes an alternative equitable method. If only one spouse is entitled to benefits, the reduction formula of $1 for $2 of excess joint MAGI shall apply to that individual's benefit as if all excess income were attributable to that person. (6) **Administration and Waiver in Unusual Cases:** The Commissioner, in coordination with the Secretary of the Treasury, shall establish procedures to implement this subsection, including the exchange of tax return information needed to identify affected beneficiaries. The Commissioner shall provide timely notice to any beneficiary who will have benefits reduced under this provision, including an explanation of the determination and an opportunity for the beneficiary to request a redetermination if the tax information is inaccurate or if the beneficiary's filing status or circumstances have changed in a way that would reduce the applicable MAGI. The Commissioner may waive or reduce the reduction under this subsection in rare and exceptional cases where the application of the reduction would be patently inequitable, such as when a one-time extraordinary income event (for example, sale of a primary residence or withdrawal of retirement savings due to terminal illness) causes temporary high income that is not reflective of ongoing retirement resources. The Commissioner shall report annually to Congress on the number of beneficiaries with benefits reduced to zero under this subsection and the aggregate savings to the Trust Funds. (7) **Ensuring No Impact on Middle-Class Beneficiaries:** It is the intent of Congress that this subsection only affect the wealthiest tier of retirees. The Commissioner shall monitor

the percentage of beneficiaries subject to benefit reduction under this subsection. If in any year the application of this provision would affect more than the top ten percent of Social Security beneficiaries by income, the Commissioner shall notify Congress and recommend adjustments to the threshold amounts to better target the highest-income cohort.)"

(b) Conforming amendment to information disclosure: Section 6103(l)(20) of the Internal Revenue Code of 1986 (26 U.S.C. 6103(l)(20)) is amended by adding ", or to the Commissioner of Social Security for purposes of administering section 203(h) of the Social Security Act" after "section 1860D-14A of the Social Security Act" each place it appears. This ensures the IRS may share tax return data with the Social Security Administration as needed to implement the means-testing of benefits.

(c) Effective Date: The Commissioner of Social Security shall develop the processes to implement the benefit reductions under section 203(h) of the Social Security Act, as added by subsection (a), in time for benefits payable in calendar year 2027. Accordingly, the first taxable year whose income will be considered for such reductions shall be tax year 2025 (for benefits paid in 2027). Beneficiaries will receive notice in late 2026 if their 2025 MAGI exceeds the threshold and their 2027 benefits will be affected. Reductions will begin with the monthly benefit for January 2027. Thereafter, adjustments for inflation to the threshold and annual determinations shall proceed as specified.

Title III – Medicare Reforms

SEC. 301. EXPANSION OF INCOME-RELATED PREMIUMS (MEANS-TESTING) UNDER MEDICARE PARTS B AND D.

(a) Lowering the Income Threshold for Medicare Premium Adjustments: Section 1839(i)(2)(A) of the Social Security Act (42 U.S.C. 1395r(i)(2)(A)) is amended —

1. in clause (i), by **striking** "$85,000" and inserting "$75,000", and by **striking** "$170,000" and inserting "$150,000";
2. in each of clauses (ii) through (v), by adjusting the dollar amounts specified for joint filers and single filers accordingly, such that the income bracket thresholds for higher premium percentage adjustments begin at $75,000 (or $150,000 for joint returns) and are scaled up in the same increments as under current law. (The Secretary shall publish updated tables of income-related monthly adjustment amount (IRMAA) brackets reflecting these changes.)

(b) Top 10% Inclusion and Indexing: Section 1839(i)(5) of the Social Security Act (42 U.S.C. 1395r(i)(5)) (which provides for inflation adjustment of the threshold) is amended by treating the dollar amount "$75,000" (single) and "$150,000" (joint) as the base year amounts for purposes of indexing after 2025. The Secretary shall adjust such amounts annually by the Consumer Price Index as provided in section 1839(i)(5). The intent of these adjustments is that approximately the top ten percent of Medicare Part B enrollees, ranked by income, will be subject to income-related premiums. The Secretary

shall monitor the share of beneficiaries paying IRMAA and, if it differs significantly from 10%, shall report to Congress with recommendations (including possibly further adjustments to thresholds) to achieve the target inclusion percentage.

(c) Conforming Part D Amendment: Section 1860D-13(a)(7) of the Social Security Act (42 U.S.C. 1395w-113(a)(7)) (relating to income-related premium adjustment for Medicare Part D) is amended by substituting references to "section 1839(i)(2)" with the thresholds as modified by this section, so that the same modified MAGI brackets and dollar amounts apply to Part D premium adjustments. In particular, any individual whose income exceeds $75,000 (single) / $150,000 (joint), as adjusted, shall be subject to an income-related monthly adjustment amount on their Medicare prescription drug plan premium, in parallel with the Part B premium adjustment.

(d) Effective Date: The adjustments made by this section shall apply to premiums for months beginning on or after **January 1, 2026**. Thus, the determination of income-related premiums for 2026 (which uses tax year 2024 income data) shall utilize the new threshold of $75,000 (single) / $150,000 (married filing jointly), with subsequent brackets adjusted accordingly. The Secretary of Health and Human Services shall ensure that beneficiaries are notified of these changes in the fall of 2025 during the annual Medicare open enrollment period, including illustrative examples of the premium amounts for various income levels under the new brackets.

SEC. 302. ENHANCED MEDICARE DRUG PRICE NEGOTIATION AUTHORITY.

(a) Increase in Number of Negotiated Drugs Per Year: Section 1192(a) of the Social Security Act (42 U.S.C. 1320f-1(a)) (as added by the Inflation Reduction Act of 2022, concerning selection of drugs for price negotiation) is amended as follows:

1. In paragraph (2), **strike** "15" and **insert** "30".
2. In paragraph (3), **strike** "15" and **insert** "30".
3. In paragraph (4), **strike** "20" and **insert** "30".

Explanation: This amendment expands the annual number of Medicare Part B and Part D drugs subject to price negotiation. Beginning with the initial price applicability year **2027**, the Secretary may select up to **30** negotiation-eligible drugs each year for negotiation (instead of 15 in years 2027 and 2028, and 20 in 2029 and later, as under previous law). The first year (2026) remains at 10 drugs as already determined, but for 2027 and every year thereafter, up to 30 additional drugs can be negotiated. This will accelerate and broaden Medicare's ability to obtain fair prices on high-cost medications.

(b) Use of Savings: Section 1191(e) of the Social Security Act (42 U.S.C. 1320f(e)) (if applicable) or other appropriate provisions shall be amended to clarify that any cost savings to Medicare resulting from the increased scope of drug price negotiations under this section shall be credited to the Medicare Part B Trust Fund and the Part D program (through reduced subsidy payments), strengthening Medicare's finances and helping reduce premiums and out-of-pocket costs for beneficiaries. The Secretary shall include

the effect of the expanded negotiations in the annual reports to Congress on the program's implementation.

(c) Timelines: The Secretary shall begin implementation of the expanded drug selection authority immediately upon enactment. In particular, not later than 60 days after the date of enactment of this Act, the Secretary shall revise any guidance or regulation as necessary to select up to 30 drugs for negotiation for price applicability year 2027 (to be effective in 2027). The negotiated maximum fair prices for those drugs shall be published in accordance with the timelines already set forth in section 1192 (e.g., by September 1, 2025 for the 2027 price year, subject to adjustment by the Secretary if needed to accommodate the larger selection).

SEC. 303. INFLATION-BASED CAP ON MEDICARE DRUG PRICE INCREASES.

(a) Part D Inflation Rebate Program Codification: Title XVIII of the Social Security Act is amended by inserting after section 1860D-14B (42 U.S.C. 1395w-114b) a new section as follows:

"SEC. 1860D-14C. Inflation-Based Limitations on Price Increases for Part D Drugs. (a) In order to protect Medicare beneficiaries and the Medicare program from excessive price increases for prescription drugs, the Secretary shall establish an inflation rebate program as described in this section. This program shall require that for each rebate period (as defined in subsection (e)) the manufacturer of a prescription drug covered under this part (Medicare Part D) must pay to Medicare a rebate for each unit of the drug dispensed to Part D enrollees, if the price increase of the drug during the period exceeds the rate of inflation. **(b) Determination of Excess Price Increase:** For each dosage form and strength of each Part D covered drug, the Secretary shall compute: (1) the drug's **benchmark price**, defined as the average price (such as the Average Manufacturer Price or other suitable measure) for a reference quarter (which for implementation shall be a quarter in 2024 or 2025 as the Secretary specifies as a base period), increased by the percentage increase in the Consumer Price Index (all urban consumers) from that reference quarter to the current rebate period; and (2) the drug's **actual average price** for the current rebate period. If the actual average price for the drug exceeds the inflation-adjusted benchmark price, the difference shall be deemed the **excess price increase** per unit. **(c) Manufacturer Rebate Responsibility:** The manufacturer of a Part D drug with an excess price increase (as determined under (b)) shall, not later than 9 months after the end of each rebate period, pay to the Medicare Prescription Drug Account an inflation rebate equal to the amount of the excess price increase per unit, multiplied by the total number of units of the drug paid for by Part D plans or by Part D beneficiaries (above the catastrophic threshold) during the rebate period. Such rebate amounts shall be deposited in the Treasury to the credit of the Medicare Part D program and used to reduce federal reinsurance or subsidy costs under Part D, in a manner specified by the Secretary that also allows pass-through of savings to reduce beneficiary premiums or cost-sharing. **(d) Alternative Compliance via Price**

Reduction: In lieu of paying a rebate after the fact, a manufacturer may elect to **roll back or limit** the price increase of a drug such that its average price for the period does not exceed the inflation-indexed benchmark. If the manufacturer does so (and attests to and substantiates such pricing to the Secretary's satisfaction), the rebate under (c) will not be owed for that drug for that period. The Secretary is authorized to negotiate agreements with manufacturers to voluntarily comply with inflation caps, and to publicize those manufacturers that fail to comply. **(e) Definitions and Miscellaneous:** For purposes of this section, the Secretary shall define the "rebate period" (such as calendar year or calendar quarter) and the "price" measure (Average Manufacturer Price, or another metric that reflects the average net price to plans, net of typical rebates or discounts) by regulation, consistent with the structure of the inflation rebate program established under the Inflation Reduction Act of 2022 for Part D drugs. The Secretary may exempt a drug from rebates under this section for a period if it is a generic drug or biosimilar that experiences a price increase from a very low base price such that the absolute dollar increase is minimal (for example, if the price is under $5 and increases by a few cents, even if that exceeds CPI percentage). The Secretary shall also ensure that drugs designated as having **small biotech manufacturer** status under the Inflation Reduction Act inflation rebate provisions are treated in accordance with any applicable statutory exemptions or delays during the specified period (e.g., 2022–2028) for Part D inflation rebates. **(f) Enforcement:** If a manufacturer fails to pay a required rebate under this section, the amount of the rebate shall be treated as a debt owed to the United States. The Secretary is authorized to collect such amounts, along with applicable interest and penalties, using the same authorities as are available under section 1927 (Medicaid drug rebate program) for collection of unpaid rebates. Additionally, the Secretary may impose a civil monetary penalty for failure to timely furnish information needed to calculate the inflation rebate or for other failure to comply, up to 125% of the rebate amount owed. **(g) Effect on Beneficiaries:** Nothing in this section shall be construed to permit a Part D plan sponsor to increase a beneficiary's cost-sharing or premium as a result of the manufacturer's rebate liability. The intent is that manufacturers either constrain their price increases to the inflation rate or pay rebates to Medicare, and that beneficiaries are held harmless from unjustified price hikes. The Secretary shall monitor for any indirect effects and take appropriate action (including potentially adjusting plan bids or risk corridors) if necessary to ensure beneficiary costs are not adversely impacted by this section. **(h) Implementation:** The Secretary may implement this section by program instruction or interim final rule, and with appropriate adaptation of methodologies from the Medicaid drug rebate program or the Part D inflation rebate program under Public Law 117-169, so as to begin capturing rebates for price increases occurring on or after January 1, 2025. Full implementation (including invoicing of manufacturers) shall occur for drug price increases in calendar quarters beginning on or after January 1, 2026, giving

manufacturers due notice. The Secretary shall include information on the operation of this inflation cap program in the annual report to Congress on Medicare and shall project the savings achieved for the Part D program and for beneficiaries."

(b) Part B Drug Inflation Cap: Section 1847A of the Social Security Act (42 U.S.C. 1395w-3a) is amended by adding at the end a new subsection:

"**(h) Inflation Limit on Part B Drug Payment Updates.—** In the case of a covered Part B drug or biological described in subsection (c)(6)(C) (single source drugs and biologicals) or a biosimilar biological described in subsection (c)(6)(D), for which payment is made under this section, the following rule shall apply: If the Average Sales Price (ASP) for the drug for a calendar quarter exceeds the inflation-adjusted ASP for the drug, the Secretary shall substitute the inflation-adjusted ASP for the actual ASP in determining the payment limit for that quarter. For purposes of this subsection, the **inflation-adjusted ASP** means the ASP for the drug in a designated base period (such as ASP for the first quarter of 2023) increased by the percentage increase in the consumer price index for all urban consumers (CPI-U) from the base period to the quarter in question. The Secretary shall establish this inflation cap mechanism such that Medicare and its beneficiaries do not pay more for a Part B drug than they would have if the drug's price had only increased at the general inflation rate since the base period. If a drug's reported ASP exceeds the inflation-adjusted ASP, the Secretary shall calculate the amount of the excess and may require the manufacturer to provide a rebate or credit to Medicare equal to the amount of additional payment that resulted from the excess ASP, or the Secretary may choose to disregard the excess portion of the ASP in setting the payment allowance (effectively capping the payment update at inflation). The Secretary shall implement this subsection in a manner as consistent as possible with the Part B inflation rebate provisions enacted in section 11101 of Public Law 117-169, to the extent applicable. This subsection shall apply with respect to Part B drug payment beginning with calendar quarters in 2025, with a base period of the first quarter of 2023 (or another quarter as the Secretary deems appropriate for newly introduced drugs). The Secretary shall promulgate regulations defining the operational details, exceptions for shortages or newly launched drugs, and enforcement mechanisms (including civil monetary penalties for false ASP reporting to circumvent the cap)."

(c) Purpose and Effective Date: The provisions of this section codify and strengthen the inflation-based rebates established by the Inflation Reduction Act of 2022 for Medicare Parts B and D. Manufacturers are hereby on notice that price increases beyond inflation will either be **refunded to Medicare** or **not recognized in Medicare payment rates**. The Secretary shall begin applying the Part D inflation rebate (section 1860D-14C) for drug price increases that occur on or after January 1, 2025 (with rebates first payable for 2025). The Part B inflation cap (section 1847A(h)) shall be effective for Part B drug payment calculations for calendar quarters beginning on or after January 1, 2025. If feasible, the Secretary may apply the Part B provision to price increases in the year 2024

as well, through the rebate mechanism, to ensure no manufacturer accelerates price hikes in advance of the effective date. The Secretary shall issue implementing instructions within 6 months of enactment. These measures are expected to curtail the practice of aggressive annual price hikes on drugs and thereby slow the growth of Medicare expenditures and beneficiary costs.

SEC. 304. INTERNATIONAL REFERENCE PRICING FOR HIGH-COST DRUGS.

(a) Authority to Use International Reference Prices: Title XI of the Social Security Act (42 U.S.C. Chapter 7, Title XI) is amended by adding at the end of Part E (the Medicare drug price negotiation program) the following new section:

"SEC. 1198. INTERNATIONAL REFERENCE PRICING FOR CERTAIN HIGH-COST MEDICATIONS. (a) Identification of High-Cost Drugs: The Secretary shall establish criteria to identify **high-cost medications** for purposes of this section. Such criteria shall include: *(1)* drugs or biologicals that are **selected for price negotiation** under this Part (being among those with the highest total Medicare expenditure); and *(2)* any other drugs or biological products covered under Medicare Part B or Part D that the Secretary determines have an excessively high cost, whether measured by an unusually high **per-patient annual treatment cost** (for example, exceeding $50,000 per Medicare beneficiary per year) or extremely high **aggregate annual spending** under Medicare (for example, among the top 50 drugs in total annual Medicare spending), even if not yet eligible for the negotiation program due to exclusivity or other limitations. The Secretary shall publish annually a list of drugs meeting the high-cost criteria. **(b) Reference Countries and Reference Price:** For each drug identified as a high-cost medication, the Secretary shall determine an **international reference price**. The reference price shall be calculated as a volume-weighted average of the list prices (or typical net prices, if available) for an equivalent course of therapy of the drug in a set of comparator countries with advanced economies and regulatory standards comparable to the United States. Unless the Secretary specifies otherwise by regulation, the **reference countries** shall include at minimum the following: **Canada, the United Kingdom, France, Germany, Japan, and Australia** (and any other country in the Group of Seven (G7) nations not listed, excluding the U.S.). The Secretary may substitute or add other major developed countries (for example, countries in the European Union with significant pharmaceutical markets) as needed to obtain a representative average price, and may exclude a country's price in the calculation if data is not available or reliable for that drug. If a drug is not sold or available in a majority of the reference countries, the Secretary may use the price of therapeutically similar alternatives in those countries, or may determine that insufficient data exists to compute a reference price (in which case this section would not apply to that drug until such data becomes available). The Secretary shall establish a process for obtaining and verifying pricing data from international sources. **(c) Price Limitation Based on Reference Price:** For any high-cost drug identified under (a), the Secretary **shall not** (beginning in 2027 or the first year

after the drug becomes eligible for negotiation or price setting) allow Medicare (whether under Part B or Part D) to pay a price higher than **1.20 times** (120% of) the international reference price determined under (b), except as provided under subsection (d). In the case of a drug subject to negotiation under this Part, the **maximum fair price** negotiated by the Secretary **shall not exceed 120% of the average international price** unless the Secretary issues a written justification that applying the reference price cap would severely limit beneficiary access to the drug (for example, if the drug addresses an unmet medical need and is not readily available in other countries) and that paying above the reference price is in the public interest. In the case of a high-cost Part B drug not yet in the negotiation program, the Secretary shall use the reference price cap in one of the following ways: (1) by directly substituting the reference price (or 120% of it) as the basis for the Medicare payment amount for the drug (notwithstanding the ASP-based formula otherwise applicable), or (2) by requiring the manufacturer to provide rebates or refunds to Medicare to the extent Medicare's payment (based on ASP or other formula) exceeds 120% of the international reference price. The Secretary may choose the operational method that is most feasible administratively and that achieves the same economic result. **(d) Exception and Adjustments:** The Secretary may waive the application of subsection (c) for a specific drug for a specified period if the Secretary certifies that: (1) the drug offers a significant therapeutic advancement and has no close substitutes, and (2) application of the reference price cap would likely impede patient access or discourage the manufacturer from launching the drug in the U.S. (for instance, if the drug addresses a public health emergency or is a breakthrough therapy first available in the U.S.). In such cases, the Secretary shall negotiate an alternative payment arrangement to ensure Medicare is not paying an exorbitant price relative to value. Additionally, the Secretary shall monitor for any **changes in foreign pricing** that could affect the reference price – if, for example, manufacturers sharply raise prices abroad after U.S. adoption of reference pricing, the Secretary may adjust the reference price calculation methodology or add more countries to the reference group to prevent manipulation. The Secretary is authorized to enter into agreements with manufacturers to obtain necessary data and to ensure compliance. Manufacturers of drugs subject to this section are required, as a condition of Medicare payment for their product, to report to the Secretary the list price (and, if available, typical net reimbursement price) of the product in each of the reference countries, updated annually or as specified by the Secretary. Failure to timely and accurately report such data or to provide rebates required under (c) shall be subject to a civil monetary penalty of up to 2% of the total Medicare payments for the drug in question for the relevant year, and persistent failure may result in the drug's exclusion from Medicare coverage (after reasonable notice and opportunity to remediate). **(e) Implementation Timeline:** The Secretary shall promulgate regulations to implement this section not later than **January 1, 2026**. The regulations shall specify the initial list of

reference countries, the formula for computing the reference price, data sources to be used, and procedures for applying the price limits in both Part B and Part D contexts. The Secretary shall initially apply reference pricing for drugs selected for the 2027 negotiation cycle and for any other high-cost drugs (as per criteria in (a)(2)) by 2027. Reference pricing may be phased in, with an initial focus on the costliest brand-name drugs lacking competition. By **January 1, 2028**, reference pricing under this section should be fully operational for all drugs that meet the high-cost criteria. **(f) Reporting to Congress:** The Secretary shall provide an annual report to Congress on the implementation of international reference pricing. The report shall list the drugs subject to reference pricing, the reference price vs. the prior U.S. price, and the savings to Medicare and beneficiaries achieved. The report shall also note any access exceptions granted under (d). Congress finds that leveraging international reference prices will help bring U.S. drug prices more in line with prices in other wealthy nationsbio.org and deter manufacturers from imposing unfairly high prices on U.S. patients. **(g) Rule of Construction:** Nothing in this section shall be construed as preventing the Secretary from achieving an even lower price through the negotiation process or other authority. The 120% of international average is a **ceiling**, not a target. The Secretary should aim to secure the best deal for the American people, using the international reference as one tool among others. If a manufacturer declines to offer a price at or below the cap, the penalties and excise tax provisions of this Part (such as those for non-compliance in section 1197) shall apply as if the manufacturer had refused a negotiated price, with the reference price used as the basis for the Secretary's final offer."

(b) Incorporation into Part B and D Payment Methods: The Secretary shall exercise existing authority under sections 1847A and 1860D-12(b)(3) of the Social Security Act, and any other relevant provision, to implement the payment caps or rebate mechanisms described in subsection (a)(c) for Medicare Part B and Part D drugs. If additional statutory authority is required for Part B implementation, the Secretary shall promptly report to Congress and recommend such legislation. It is the sense of Congress that the Secretary *already* has broad authority under sections 1102 and 1871 of the Social Security Act to promulgate regulations necessary for the efficient administration of Medicare and to prevent excessive payments, which should encompass adopting payment limits based on external benchmarks in order to be a prudent purchaser.

(c) Effective Date: The provisions of this section shall be effective upon enactment, with the Secretary authorized to implement reference pricing for negotiated drugs starting with price applicability year 2027, and for other high-cost drugs by 2027 as well. The Secretary shall, if practicable, test a pilot of international reference pricing for a subset of Part B drugs in 2026 (for example, via the Center for Medicare & Medicaid Innovation, which is hereby encouraged to incorporate international price comparisons in its model tests). Full implementation as outlined in section 1198 of the Social Security Act (as added by this Act) is expected by January 1, 2027, except that the Secretary may

phase in enforcement penalties (such as exclusion from coverage) over a 1-year period to allow manufacturers to adjust. Congress encourages the Secretary to utilize this tool aggressively to drive down drug costs, consistent with preserving access to important medications.

Title IV – Implementation and General Provisions

SEC. 401. ADMINISTRATIVE FUNDING AND CAPACITY. (a) Appropriation to Social Security Administration: In addition to amounts otherwise made available, there is **appropriated** to the Social Security Administration, out of any money in the Treasury not otherwise appropriated, the sum of **$100,000,000 for each of fiscal years 2025 through 2030**, to remain available until expended. These funds shall be used to carry out the amendments made by Title II of this Act and related provisions, including but not limited to: upgrading information technology systems to calculate and apply means-tested benefit reductions, conducting public outreach and communication about the new retirement age provisions and options, staff training and actuarial analyses, and improving agency capacity to handle inquiries and claims related to these changes. The Commissioner shall provide an annual report to Congress on the use of these funds and certify that they are used to supplement, not supplant, the base administrative budget of the agency.

(b) Appropriation to Centers for Medicare & Medicaid Services: In addition to amounts otherwise made available, there is **appropriated** to the Centers for Medicare & Medicaid Services Program Management account **$100,000,000 for each of fiscal years 2025 through 2030**, to remain available until expended, to implement the Medicare provisions of this Act. The CMS Administrator shall allocate these funds for activities including: hiring and training staff (such as drug pricing negotiators, actuaries, and data analysts), establishing the systems for expanded drug negotiations and inflation rebates, collecting and analyzing international price data, updating premium processing systems for the new income thresholds, beneficiary education about changes, and enhanced program integrity efforts. The Administrator shall report annually to Congress on the obligation and expenditure of these funds and the status of implementation of the reforms in Title III of this Act.

(c) OMB Coordination: The Office of Management and Budget shall facilitate coordination between the Social Security Administration and CMS to ensure efficient implementation. If either agency identifies additional funding needs specifically attributable to the implementation of this Act's provisions, OMB shall include such requests in the President's budget or provide expedited apportionment of funds, as appropriate, to avoid any delay in carrying out this Act.

SEC. 402. REGULATIONS AND DEADLINES. (a) Interim Final Rule Authority: The Commissioner of Social Security and the Secretary of Health and Human Services (with

respect to Medicare) may promulgate interim final regulations or other guidance as necessary to implement the provisions of this Act by the effective dates specified. All such regulations shall be issued no later than 18 months after the date of enactment, unless a different deadline is explicitly stated in this Act. The agencies shall provide an opportunity for public comment on any interim final rules and shall subsequently finalize them in light of comments received.

(b) Specific Deadlines: Without limiting subsection (a):

1. Not later than **12 months** after enactment, the Commissioner of Social Security shall issue regulations or other guidance to implement the new benefit reduction for high-income beneficiaries under section 203(h) of the Social Security Act, including processes for data matching with IRS and beneficiary appeals.
2. Not later than **January 1, 2026**, the Secretary of HHS shall issue regulations establishing the revised IRMAA income brackets (Sec. 301), the expanded drug negotiation process (Sec. 302), the inflation rebate programs (Sec. 303), and the international reference pricing program (Sec. 304). Earlier guidance through sub-regulatory means should be issued in 2025 to inform affected stakeholders (e.g., drug manufacturers, Medicare Advantage plans, Part D plan sponsors) of the coming changes.
3. The Secretary of HHS, in consultation with the Inspector General and the Attorney General, shall also issue guidelines for enforcement of the drug pricing provisions (including civil monetary penalties and excise taxes for non-compliance as applicable, and coordination with the Department of Justice for any antitrust or anti-competitive concerns that may arise if manufacturers attempt to collude to raise foreign prices).

(c) Public Outreach and Transparency: The implementing agencies shall conduct robust outreach to beneficiaries and stakeholders. This includes updates to the Social Security annual statements and website to inform future retirees of the gradual increase in full retirement age, and updates to Medicare & You handbook and plan marketing guidelines to explain the Part B and D premium changes. The Secretary of HHS shall also publicly post information about drugs selected for negotiation, inflation rebate amounts collected, and reference price calculations (respecting confidentiality of proprietary data as required by law, but aiming for maximal transparency about how prices are derived and savings achieved).

SEC. 403. PROTECTION OF TRUST FUNDS AND USE OF SAVINGS. (a) Social Security Trust Funds: All reductions in expenditures of the OASDI Trust Funds (Old-Age and Survivors Insurance and Disability Insurance) resulting from the provisions of this Act (such as those attributable to the increased FRA and means-testing of benefits) shall **remain in the Trust Funds** and prolong their solvency. Nothing in this Act authorizes using such savings for any purpose other than paying Social Security benefits and related administrative costs. The Secretary of the Treasury, in consultation with the

Commissioner, shall annually report on the actuarial improvement to the Trust Funds as a result of this Act's implementation. The Social Security Chief Actuary shall, within one year after enactment, provide an updated solvency projection reflecting these changestaxfoundation.org.

(b) Medicare Savings: Similarly, any savings to the Medicare program from Title III of this Act – including increased beneficiary premium collections from IRMAA expansion, and reduced outlays from drug price negotiations and rebates – shall be deposited in the Medicare Trust Funds or otherwise applied to reduce Medicare program costs and beneficiary premiums. Specifically, savings attributable to Part B (e.g., lower drug spending under Part B, increased Part B premiums from high-income individuals) shall accrue to the Federal Supplementary Medical Insurance Trust Fund, thereby reducing general revenue subsidy needs or Part B premium levels for all beneficiaries. Savings attributable to Part D (e.g., manufacturer rebates for inflation, or lower subsidy payments due to negotiated prices) shall be used to reduce government Part D expenditures and shall be factored into Part D premium bids, thereby passing savings to beneficiaries in the form of slower premium growth. The Secretary of HHS and the CMS Chief Actuary shall each report annually on the financial impact of these provisions on the Medicare Trust Funds and on beneficiary costs.

(c) No Reduction in Benefits to Offset New Costs: Congress finds that the benefit improvements and expansions under Social Security and Medicare enacted in prior laws (such as out-of-pocket caps in Part D and increased eligibility for low-income subsidies) are important to beneficiaries. Nothing in this Act shall be construed to roll back or pay for those improvements; rather, the measures in this Act are designed to provide new resources and cost savings that strengthen program finances and offset the new obligations without cutting benefits. If, for accounting purposes, any savings from this Act are counted toward the cost of benefit improvements enacted in the same fiscal year (or vice versa), the Secretary of HHS and the Commissioner shall clearly delineate those in their financial reports for transparency, but such accounting shall not alter the directives of subsections (a) and (b) that savings remain within the respective programs.

SEC. 404. SEVERABILITY. If any provision of this Act, or any amendment made by it, or the application of a provision to any person or circumstance, is held to be unconstitutional or invalid by a court of competent jurisdiction, the remainder of this Act and the amendments made by it, and the application of the provisions to other persons or circumstances, shall not be affected. The Congress hereby declares that it would have passed each provision and amendment in this Act irrespective of the fact that any one or more provisions might be judged invalid. In particular, if any of the drug pricing reforms in Title III are struck down, that shall not affect the implementation of the Social Security reforms in Title II, and vice versa.

SEC. 405. EFFECTIVE DATE. Except as otherwise provided explicitly, this Act and the amendments made by it shall take effect upon enactment. The changes to law made by

Title II (Social Security) shall be incorporated in determinations of benefits and eligibility beginning in the year 2025 for notices and projections (with actual benefit payment changes as specified in Title II), and the changes made by Title III (Medicare) shall be implemented in plan or benefit years 2026 and beyond as detailed above. The Secretary of Health and Human Services and the Commissioner of Social Security are authorized and directed to implement any provision of this Act prior to the effective dates, to the extent necessary to ensure smooth transitions (for example, using 2025 as a planning year for new systems and processes). All regulations, program instructions, technical changes, and public notifications should be completed in advance of the operative dates to the maximum extent practicable.

SEC. 406. BUDGETARY EFFECTS. Consistent with section 4(d) of the Statutory Pay-As-You-Go Act of 2010, the budgetary effects of this Act (and the savings achieved) shall be entered on the scorecards maintained under section 4(d) as savings to offset other spending as applicable. Congress notes that according to preliminary estimates, this Act will significantly reduce federal deficits over the 10-year budget window and beyond, by moderating the growth of entitlement spending while protecting beneficiaries. The Office of Management and Budget shall include the budgetary effects of this Act in the next baseline and shall include the estimated Trust Fund solvency extension in the President's budget.

SEC. 407. NO CUTS TO EARNED BENEFITS FOR MIDDLE CLASS. *(Rule of construction.)* Nothing in this Act shall be interpreted to reduce the Social Security or Medicare benefits of any individual with non-high income (i.e., below the thresholds set in this Act) or to otherwise alter the entitlement to benefits except as expressly provided for very high-income individuals. The full cost-of-living adjustments and benefit formulas under current law for Social Security remain unchanged, and Medicare benefits, covered services, and cost-sharing structure for all beneficiaries remain unchanged except for the income-related premium adjustments and drug price savings measures described. The Act's provisions are intended to strengthen these programs for beneficiaries, not weaken them. All implementing officials shall act consistently with this intent.

SEC. 408. REFERENCES AND TECHNICAL CORRECTIONS. (a) Amendatory instructions in this Act refer to the laws as in effect on the date of enactment. The Secretary of HHS and the Commissioner of Social Security may make technical and formatting modifications as necessary when codifying these provisions into the United States Code or the Social Security Act, to ensure consistency of numbering, indentation, and terminology. Cross-references in this Act to a section of the Social Security Act shall be deemed to refer to that section or subsection as renumbered or re-lettered if such changes occur during codification. (b) The Secretary and the Commissioner shall jointly develop public-facing materials (including updates to the Code of Federal Regulations, handbooks, and online resources) that incorporate the changes made by this Act in plain language for the understanding of beneficiaries.

SEC. 409. AUTHORIZATION OF APPROPRIATIONS. *(In the event that the direct appropriations in Sec. 401 are not deemed sufficient or valid within an entitlement statute.)* There are authorized to be appropriated such sums as may be necessary to carry out this Act and the amendments made by it, to the extent not otherwise provided. Congress commits to ensuring the administering agencies have adequate resources to successfully execute these reforms.