117TH CONGRESS
1ST SESSION

S. 386

To establish a public health plan.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 23, 2021

Mr. BENNET (for himself, Mr. KAINE, Ms. DUCKWORTH, Mr. DURBIN, Mr. CARDIN, Ms. STABENOW, Mr. LEAHY, Mr. WARNOCK, Mr. HICKENLOOPER, Ms. KLOBUCHAR, Ms. SMITH, Mrs. SHAHEEN, and Mr. PETERS) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To establish a public health plan.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare-X Choice Act of 2021''.

SEC. 2. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH PLAN.

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

"TITLE XXII—MEDICARE EXCHANGE HEALTH PLAN

"SEC. 2201. ESTABLISHMENT.

''(a) ESTABLISHMENT OF PLAN.—

''(1) IN GENERAL.—The Secretary shall establish a coordinated and low-cost health plan, to be known as the 'Medicare Exchange health plan' (referred to in this section as the 'health plan') to provide access to quality health care for enrollees.

''(2) TIMEFRAME.—

''(A) INDIVIDUAL MARKET AVAILABILITY.—

''(i) IN GENERAL.—In accordance with clause (ii), the Secretary shall make the health plan available in the individual market, in certain rating areas, for plan year 2022 and each subsequent plan year, and increase the availability such that the plan is available in the individual market to all residents of all rating areas in the United States for plan year 2025 and each subsequent plan year.

''(ii) PRIORITY AREAS.—In determining in which rating areas the Secretary initially will make the health plan avail-

able, the Secretary shall give priority to rating areas in which—

"(I) not more than 1 health insurance issuer offers plans on the applicable State or Federal American Health Benefit Exchange (referred to in this title as the 'Exchange'); or

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

"(B) SMALL GROUP MARKET.—The Secretary shall make the health plan available in the small group market in all rating areas for plan year 2025.

"(b) ESTABLISHMENT OF FUNDS.—

"(1) PLAN RESERVE FUND.—

"(A) IN GENERAL.—There is established in the Treasury of the United States a 'Plan Reserve Fund', to be administered by the Secretary of Health and Human Services, for purposes of establishing the Medicare Exchange health plan and administering such plan, consisting of amounts appropriated to such fund

during the period of fiscal years 2021 through 2030.

''(B) APPROPRIATION.—There is appropriated $1,000,000,000, out of monies in the Treasury not otherwise obligated, to the Plan Reserve Fund for fiscal year 2021, to remain available until expended.

''(2) DATA AND TECHNOLOGY FUND.—

''(A) IN GENERAL.—There is established in the Treasury of the United States a 'Data and Technology Fund', to be administered by the Secretary of Health and Human Services, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services, for purposes of updating technology and performing data collection under section 2205 in order to establish appropriate premiums for all geographic regions of the United States, consisting of amounts appropriated to such fund during the period of fiscal years 2021 through 2030.

''(B) APPROPRIATION.—There is appropriated $1,000,000,000, out of amounts in the Treasury not otherwise appropriated, to the Data and Technology Fund for fiscal year 2021, to remain available until expended.

''(c) RULEMAKING.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate such regulations as may be necessary to carry out this title. Rules promulgated under this subsection shall be finalized not later than 270 days after the date of enactment of this Act.

''SEC. 2202. AVAILABILITY OF PLAN.

''(a) ELIGIBILITY.—An individual shall be eligible to enroll in the health plan if such individual, for the entire period for which enrollment is sought—

''(1) is a qualified individual within the meaning of section 1312 of the Patient Protection and Affordable Care Act (42 U.S.C. 18032); and

''(2) is not eligible for benefits under the Medicare program under title XVIII.

''(b) EXCHANGES.—In accordance with the timeframe under section 2201(a)(2), the health plan shall be made available through the American Health Benefit Exchanges described in sections 1311 and 1321 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031, 18041), including the Small Business Health Options Program Exchange.

''SEC. 2203. PLAN REQUIREMENTS.

''(a) GENERAL REQUIREMENTS.—The health plan shall comply with all requirements, as applicable, of sub-

title D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) applicable to qualified health plans, and such health plan shall be a qualified health plan, including for purposes of the Internal Revenue Code of 1986.

''(b) LEVELS OF COVERAGE.—The Secretary—

''(1) shall make available a silver level and gold level version of the plan, in accordance with section 1301(a)(1)(C)(ii); and

''(2) may make available no more than 2 versions of the plan for each of the 4 levels of coverage described in subparagraphs (A) through (D) of section 1302(d)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(d)(1)).

''(c) PRIMARY CARE SERVICES.—The health plan shall provide coverage for primary care services, and shall not impose any cost-sharing requirements for such services.

''SEC. 2204. ADMINISTRATIVE CONTRACTING.

''(a) IN GENERAL.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A) with respect to the health plan in the same manner as the Secretary may enter into con-

tracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to the public health insurance option as the Secretary has under such subsection (a)(1) and subsection (b) of section 1874A with respect to title XVIII.

''(b) TRANSFER OF INSURANCE RISK.—Any contract under subsection (a) shall not involve the transfer of insurance risk from the Secretary to the entity entering into such contract with the Secretary, except in the case of an alternative payment model under section 2209(h).

''SEC. 2205. DATA COLLECTION.

''Subject to all applicable privacy requirements, including the requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), the Secretary may collect data from State insurance commissioners and other relevant entities to establish rates for premiums and for other purposes including to improve quality, and reduce racial, ethnic, socioeconomic, geographic, gender, sexual identity, and other health disparities, including such disparities experienced by people with disabilities and older adults, with respect to the health plan.

''SEC. 2206. PREMIUMS; RISK POOL.

''(a) SETTING PREMIUMS.—

''(1) IN GENERAL.—The Secretary shall establish premiums for the health plan that cover the full actuarial cost of offering such plan, including the administrative costs of offering such plan. Such premiums shall vary geographically and between the small group market and the individual market in accordance with differences in the cost of providing such coverage. If, for any plan year, the amount collected in premiums exceeds the amount required for health care benefits and administrative costs in that plan year, such excess amounts shall remain available to the Secretary to administer the health plan and finance beneficiary costs in subsequent years.

''(2) INITIAL PLAN YEAR.—For plan year 2022, the Secretary shall set premiums for the health plan for each rating area in which the health plan is available for such plan year, taking into consideration the premium rates for plans offered in each such rating area for plan year 2021.

''(b) RISK POOL.—After plan year 2022, all enrollees in the health plan within a State shall be members of a single risk pool, except that the Secretary may establish separate risk pools for the individual market and small group market if the State has not exercised its authority

under section 1312(c)(3) of the Patient Protection and Affordable Care Act.

"SEC. 2207. REIMBURSEMENT RATES.

"(a) MEDICARE RATES.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsections (b) and (c) and subject to subsection (d), the Secretary shall reimburse health care providers furnishing items and services under the health plan at rates determined for equivalent items and services under the original Medicare fee-for-service program under parts A and B of title XVIII.

"(2) AUTHORITY TO INCREASE PAYMENTS RATES IN RURAL AREAS.—If the Secretary determines appropriate, the Secretary may increase the reimbursements rates described in paragraph (1) by up to 50 percent for items and services furnished in rural areas (as defined in section 1886(d)(2)(D)).

"(b) PRESCRIPTION DRUGS.—Subject to subsection (d), payment rates for prescription drugs shall be at a rate negotiated by the Secretary. Such negotiations may be in conjunction with negotiations for covered part D drugs under part D of title XVIII.

"(c) ADDITIONAL ITEMS AND SERVICES.—Subject to subsection (d), the Secretary shall establish reimburse-

ment rates for any items and services provided under the health plan that are not items and services provided under the original Medicare fee-for-service program under parts A and B of title XVIII.

''(d) INNOVATIVE PAYMENT METHODS.—The Secretary may utilize innovative payment methods, including value-based payment arrangements, in making payments for items and services (including prescription drugs) furnished under the health plan.

''(e) COMPREHENSIVE STUDY ON COVERING ADDITIONAL SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a comprehensive study, in consultation with stakeholders, and develop recommendations for Congress on the need for, and cost of providing coverage for, additional services under the health plan.

''(2) CONTENT.—The study shall under paragraph (1) shall include—

''(A) consideration of providing coverage for long-term services and supports, home and community based services, assistive and enabling technologies, and vision, hearing, and dental services;

''(B) consideration of providing coverage for other services in addition to the services described in subparagraph (A) that could most benefit the health and financial well-being of beneficiaries, including by reducing health disparities, if included for coverage under the plan;

''(C) the costs associated with covering additional services described in subparagraphs (A) and (B), for beneficiaries through cost-sharing and premiums, and for the Federal Government; and

''(D) an assessment of the implications of covering such additional services for the risk pool of the health plan and for the individual and small group markets.

''(3) SUBMISSION OF REPORT.—Not later than 2 years after the date of enactment of this title, the Secretary shall submit to Congress a report on the findings and recommendations of the study under this subsection and shall make such report publicly available on the website of the Department of Health and Human Services.

''SEC. 2208. PARTICIPATING PROVIDERS.

''(a) REQUIREMENT TO PARTICIPATE IN ORDER TO BE ENROLLED UNDER MEDICARE.—Subject to sub-

section (d), beginning January 1, 2022, a health care provider may not be enrolled under the Medicare program under section 1866(j) unless the provider is also a participating provider under the health plan.

''(b) REQUIREMENT TO PARTICIPATE IN ORDER TO PARTICIPATE IN MEDICAID.—Subject to subsection (d), beginning January 1, 2022, a health care provider may not be a participating provider under a State Medicaid plan under title XIX unless the provider is also a participating provider under the health plan.

''(c) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in subsection (a) or (b) to become a participating provider under the health plan.

''(d) OPT-OUT.—The Secretary shall establish a process by which a health care provider described in subsection (a) or (b) may opt out of being a participating provider under the health plan, under exceptional circumstances where participation in the health plan threatens the provider's ability to operate.

''SEC. 2209. DELIVERY SYSTEM REFORM FOR AN ENHANCED HEALTH PLAN.

''(a) IN GENERAL.—For plan years beginning with plan year 2022, the Secretary may utilize innovative payment mechanisms and policies to determine payments for

items and services under the health plan. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, accountable communities for health, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, telehealth, remote patient monitoring, partial capitation, and direct contracting with providers.

''(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

''(1) seeks to—

''(A) improve health outcomes;

''(B) reduce health disparities (including racial, ethnic, socioeconomic, geographic, gender, sexual identity, and other disparities, including such disparities experienced by people with disabilities and older adults);

''(C) improve coordination to provide more efficient and affordable quality care;

''(D) address geographic variation in the provision of health services; or

''(E) prevent or manage chronic illness;

''(2) promotes care that is integrated, patient-centered, quality, and efficient;

''(3) implements patient feedback mechanisms, including culturally- and disability-competent mechanisms; and

''(4) uses person-reported experiences to improve service delivery.

''(c) ENCOURAGING THE USE OF HIGH-VALUE SERVICES.—To the extent allowed by the benefit standards applied to all health benefits plans participating in the Exchanges (as described in section 2202(b)), the health plan may modify cost-sharing and payment rates to encourage the use of services that promote health and value.

''(d) PROMOTION OF DELIVERY SYSTEM REFORM.—The Secretary shall monitor and evaluate the progress of payment and delivery system reforms under this section and shall seek to implement such reforms subject to the following:

''(1) To the extent that the Secretary finds a payment and delivery system reform successful in improving quality and reducing costs, the Secretary shall implement such reform on as large a geographic scale as practical and economical.

''(2) The Secretary may delay the implementation of such a reform in geographic areas in which

such implementation would place the public health insurance option at a competitive disadvantage.

''(3) The Secretary may prioritize implementation of such a reform in high-cost geographic areas or otherwise in order to reduce total program costs or to promote high-value care.

''(4) The Secretary may prioritize implementation of such a reform to reduce racial, ethnic, socioeconomic, geographic, gender, sexual identity, or other health disparities, including such disparities experienced by people with disabilities or older adults.

''(e) NON-UNIFORMITY PERMITTED.—Nothing in this section shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the health plan for different geographic areas.

''(f) INTEGRATION WITH SOCIAL SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish processes and, when appropriate, collaborate with other agencies to integrate medical care under the health plan with food, housing, transportation, and income assistance if the Secretary determines that such integration is expected to—

"(A) reduce spending without reducing the quality of patient care;

"(B) improve the quality of patient care without increasing spending; or

"(C) reduce racial, ethnic, socioeconomic, geographic, gender, sexual identity, or other health disparities, including any such disparities experienced by people with disabilities or older adults.

"(2) AUTHORIZATION OF A GRANT PROGRAM.—

"(A) IN GENERAL.—The Secretary may establish a grant program to permit broader experimentation with accountable communities for health model.

"(B) ELIGIBLE RECIPIENTS.—The Secretary may award a grant under this section to—

"(i) an institution of higher learning (as defined in section 3452(f) of title 38, United States Code);

"(ii) a local educational agency (as defined in section 8101 of the Elementary and Secondary Education Act of 1965) or health care agency;

''(iii) a nonprofit entity that the Secretary determines has a demonstrated history of community engagement; or

''(iv) any other entity, as the Secretary determines appropriate.

''(C) USE OF FUNDS.—A recipient of a grant under this section may use the grant to—

''(i) support community needs assessment;

''(ii) establish social service partnerships; or

''(iii) establish interactive data systems across health and social service providers.

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

''(3) REGULATIONS.—If the Secretary establishes a grant program under this section, the Secretary shall promulgate regulations on—

''(A) the evaluation of applications for grants under the program; and

''(B) administration of the program.

''(g) TELEHEALTH.—The Secretary shall ensure the integration of telehealth tools, including technology-enabled collaborative learning and capacity building models, that increase patient access to medical care (including specialty care), particularly in remote or underserved areas, if the Secretary determines that such integration is expected to—

''(1) reduce spending without reducing the quality of patient care; or

''(2) improve the quality of patient care without increasing spending.

''(h) ALTERNATIVE PAYMENT MODEL.—

''(1) IN GENERAL.—The Secretary shall evaluate the possibility of providing incentives, and, if appropriate, apply incentives, for enrollees in the health plan who receive services from providers who are participating in an alternative payment model (as defined in section 1833(z)(3)(C)).

''(2) AUTHORITY TO USE APMS IN USE UNDER TRADITIONAL MEDICARE.—Nothing in this section shall preclude the Secretary from using alternative payment models (as so defined) under this title that are in use under title XVIII.

"SEC. 2210. NO EFFECT ON MEDICARE BENEFITS OR MEDICARE TRUST FUNDS.

''Nothing in this title shall—

''(1) affect the benefits available under title XVIII; or

''(2) impact the Federal Hospital Insurance Trust Fund under section 1817 or the Federal Supplementary Medical Insurance Trust Fund under section 1841 (including the Medicare Prescription Drug Account within such Trust Fund).''.

SEC. 3. EXCLUSION OF PROVIDERS THAT PLACE ADDITIONAL RESTRICTIONS ON MEDICARE EXCHANGE HEALTH PLAN PATIENTS FROM FEDERAL HEALTH CARE PROGRAMS.

Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(18) PLACEMENT OF RESTRICTIONS ON MEDICARE EXCHANGE HEALTH PLAN PATIENTS.—Any individual or entity that places restrictions on the individuals the individual or provider will accept for treatment and fails to either—

''(A) exempt enrollees in the Medicare Exchange health plan established under title XXII from such restrictions; or

''(B) apply such restrictions to enrollees in the Medicare Exchange health plan in the same manner and to the same extent the restrictions are applied to all other individuals seeking care.''.

SEC. 4. REINSURANCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a mechanism to pool, on a nationwide basis, the costs of the highest-cost patients enrolled in individual health insurance coverage (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) offered on or off the Exchanges, to the extent such costs are not already pooled pursuant to section 1343 of the Patient Protection and Affordable Care Act (42 U.S.C. 18063), for the purpose of reducing premiums for such individual health insurance coverage.

(b) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out paragraph (1), there is authorized to be appropriated $10,000,000,000 for each of fiscal years 2022, 2023, and 2024.

SEC. 5. EXPANSION OF TAX CREDIT.

(a) IN GENERAL.—Subparagraph (A) of section 36B(c)(1) of the Internal Revenue Code of 1986 is amended by striking ''but does not exceed 400 percent''.

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

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

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150 percent	0	0
150 percent up to 200 percent	0	2.0
200 percent up to 250 percent	2.0	4.0
250 percent up to 300 percent	4.0	6.0
300 percent up to 400 percent	6.0	8.5
400 percent and up	8.5	8.5.".

(c) LIMITATION ON RECAPTURE.—Clause (i) of section 36B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(1) by striking "In the case of a taxpayer" and all that follows through "the amount of the increase" and inserting "The amount of the increase";

(2) by striking the period at the end of the last row of the table; and

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

"400 percent and up	$5,000.".

(d) FIXING THE FAMILY GLITCH.—

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

"(i) COVERAGE MUST BE AFFORDABLE.—

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

"(II) FAMILY MEMBERS.—An individual who is eligible to enroll in an eligible employer-sponsored plan (as

defined in section 5000A(f)(2)) by reason of a relationship the individual bears to the employee shall not be treated as eligible for minimum essential coverage by reason of such eligibility to enroll if the employee's required contribution (within the meaning of section 5000A(e)(1)(B), determined by substituting 'family' for 'self-only') with respect to the plan exceeds 9.5 percent of the employee's household income.''.

(2) CONFORMING AMENDMENTS.—

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

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

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

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

SEC. 6. AUTHORITY TO NEGOTIATE FAIR PRICES FOR MEDICARE PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i).

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of the enactment of this Act.

SEC. 7. STRENGTHENING ANTITRUST ENFORCEMENT IN HEALTH CARE MARKETS.

There are authorized to be appropriated for the purpose of studying healthcare markets, including anticompetitive practices within those markets, and taking appropriate antitrust enforcement action for each of fiscal years 2021 through 2025, to remain available until expended—

(1) $50,000,000 to the Antitrust Division of the Department of Justice; and

(2) $100,000,000 to the Federal Trade Commission.

SEC. 8. REPORTS.

The Antitrust Division of the Department of Justice and the Federal Trade Commission shall submit to Congress a report—

(1) not later than the date that is 1 year after the date of enactment of this Act, detailing the activities on which the Antitrust Division or the Commission spent funds authorized under section 7; and

(2) not later than September 30, 2026, that includes—

(A) the findings of any study conducted by the Antitrust Division or the Commission on or after the date of enactment of this Act;

(B) the activities on which the Antitrust Division or the Commission spent funds authorized under section 7; and

(C) the impact of any enforcement action taken on or after the date of enactment of this Act by the Antitrust Division or the Commission on improving consumer access to affordable health care.

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