I

115TH CONGRESS
1ST SESSION

H. R. 4094

To establish a public health plan.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 23, 2017

Mr. HIGGINS of New York (for himself, Mr. LARSON of Connecticut, Mr. COURTNEY, Mr. SCOTT of Virginia, Mr. O'ROURKE, and Mr. POLIS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To 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 2017''.

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 2020 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 2023 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 2024.

"(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.

''(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 2018.

''(2) DATA AND TECHNOLOGY FUND.—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. There are authorized to be appropriated to the Data and Technology Fund such sums as may be necessary for fiscal year 2018.

''(c) RULEMAKING.—The Secretary may promulgate such regulations as may be necessary to carry out this title.

''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 of subtitle 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)).

''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 contracts 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, and other disparities, with respect to the health plan.

"SEC. 2206. PREMIUMS; RISK POOLS; REINSURANCE.

''(a) PREMIUM AMOUNTS.—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.

''(b) RISK POOL.—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 (42 U.S.C. 18032(c)(3)).

''(c) REINSURANCE.—Notwithstanding subsection (b), the Secretary may establish a mechanism to pool the costs of the highest-cost patients on a nationwide basis 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).

''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 25 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 reimbursement 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.

''SEC. 2208. PARTICIPATING PROVIDERS.

''(a) IN GENERAL.—A health care provider that is enrolled under the Medicare program under section 1866(j) or is a participating provider under a State Medicaid plan under title XIX on the date of enactment of this Act shall be a participating provider under the health plan.

''(b) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not de-

scribed in subsection (a) to become a participating provider under the health plan.

''(c) OPT-OUT.—The Secretary shall establish a process by which a health care provider that is a participating provider under the health plan pursuant to subsection (a) or (b) may opt-out of being such a participating provider.

''(d) REQUIREMENT TO PARTICIPATE IN ORDER TO BE ENROLLED UNDER MEDICARE.—Beginning January 1, 2019, 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.

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

''(a) IN GENERAL.—For plan years beginning with plan year 2020, 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, 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, and other disparities);

''(C) provide efficient and affordable care;

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

''(E) prevent or manage chronic illness; and

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

''(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.

''(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.—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—

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

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

''(g) TELEHEALTH.—The Secretary shall ensure the integration of telehealth tools that increase patient access to medical 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. 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.

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