

116TH CONGRESS
1ST SESSION

H. R. 2000

To establish a public health plan.

IN THE HOUSE OF REPRESENTATIVES

APRIL 1, 2019

Mr. DELGADO (for himself, Mr. LARSON of Connecticut, and Mr. HIGGINS of New York) 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

A BILL

To establish a public health plan.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare-X Choice Act
5 of 2019”.

6 **SEC. 2. ESTABLISHMENT AND ADMINISTRATION OF A PUB-** 7 **LIC HEALTH PLAN.**

8 The Social Security Act is amended by adding at the
9 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 2021 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 2024 and each subsequent plan year.

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

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

3 “(I) not more than 1 health in-
4 surance issuer offers plans on the ap-
5 plicable State or Federal American
6 Health Benefit Exchange (referred to
7 in this title as the ‘Exchange’); or

8 “(II) there is a shortage of
9 health providers or lack of competition
10 that results in a high cost of health
11 care services, including health profes-
12 sional shortage areas and rural areas.

13 “(B) SMALL GROUP MARKET.—The Sec-
14 retary shall make the health plan available in
15 the small group market in all rating areas for
16 plan year 2025.

17 “(b) ESTABLISHMENT OF FUNDS.—

18 “(1) PLAN RESERVE FUND.—

19 “(A) IN GENERAL.—There is established in
20 the Treasury of the United States a ‘Plan Re-
21 serve Fund’, to be administered by the Sec-
22 retary of Health and Human Services, for pur-
23 poses of establishing the Medicare Exchange
24 health plan and administering such plan, con-
25 sisting of amounts appropriated to such fund.

1 “(B) APPROPRIATION.—There is appro-
2 priated \$1,000,000,000, out of monies in the
3 Treasury not otherwise obligated, to the Plan
4 Reserve Fund for fiscal year 2020.

5 “(2) DATA AND TECHNOLOGY FUND.—There is
6 established in the Treasury of the United States a
7 ‘Data and Technology Fund’, to be administered by
8 the Secretary of Health and Human Services, acting
9 through the Chief Actuary of the Centers for Medi-
10 care & Medicaid Services, for purposes of updating
11 technology and performing data collection under sec-
12 tion 2205 in order to establish appropriate pre-
13 miums for all geographic regions of the United
14 States. There are authorized to be appropriated to
15 the Data and Technology Fund such sums as may
16 be necessary for fiscal year 2020.

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

20 **“SEC. 2202. AVAILABILITY OF PLAN.**

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

1 “(1) is a qualified individual within the mean-
2 ing of section 1312 of the Patient Protection and
3 Affordable Care Act (42 U.S.C. 18032); and

4 “(2) is not eligible for benefits under the Medi-
5 care program under title XVIII.

6 “(b) EXCHANGES.—In accordance with the time-
7 frame under section 2201(a)(2), the health plan shall be
8 made available through the American Health Benefit Ex-
9 changes described in sections 1311 and 1321 of the Pa-
10 tient Protection and Affordable Care Act (42 U.S.C.
11 18031, 18041), including the Small Business Health Op-
12 tions Program Exchange.

13 **“SEC. 2203. PLAN REQUIREMENTS.**

14 “(a) GENERAL REQUIREMENTS.—The health plan
15 shall comply with all requirements, as applicable, of sub-
16 title D of title I of the Patient Protection and Affordable
17 Care Act (42 U.S.C. 18021 et seq.) and title XXVII of
18 the Public Health Service Act (42 U.S.C. 300gg et seq.)
19 applicable to qualified health plans, and such health plan
20 shall be a qualified health plan, including for purposes of
21 the Internal Revenue Code of 1986.

22 “(b) LEVELS OF COVERAGE.—The Secretary—

23 “(1) shall make available a silver level and gold
24 level version of the plan, in accordance with section
25 1301(a)(1)(C)(ii); and

1 “(2) may make available no more than 2
2 versions of the plan for each of the 4 levels of cov-
3 erage described in subparagraphs (A) through (D) of
4 section 1302(d)(1) of the Patient Protection and Af-
5 fordable Care Act (42 U.S.C. 18022(d)(1)).

6 **“SEC. 2204. ADMINISTRATIVE CONTRACTING.**

7 “(a) IN GENERAL.—The Secretary may enter into
8 contracts for the purpose of performing administrative
9 functions (including functions described in subsection
10 (a)(4) of section 1874A) with respect to the health plan
11 in the same manner as the Secretary may enter into con-
12 tracts under subsection (a)(1) of such section. The Sec-
13 retary shall have the same authority with respect to the
14 public health insurance option as the Secretary has under
15 such subsection (a)(1) and subsection (b) of section 1874A
16 with respect to title XVIII.

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

22 **“SEC. 2205. DATA COLLECTION.**

23 “Subject to all applicable privacy requirements, in-
24 cluding the requirements under the regulations promul-
25 gated pursuant to section 264(c) of the Health Insurance

1 Portability and Accountability Act of 1996 (42 U.S.C.
2 1320d–2 note), the Secretary may collect data from State
3 insurance commissioners and other relevant entities to es-
4 tablish rates for premiums and for other purposes includ-
5 ing to improve quality, and reduce racial, ethnic, and other
6 disparities, with respect to the health plan.

7 **“SEC. 2206. PREMIUMS; RISK POOL.**

8 “(a) SETTING PREMIUMS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish premiums for the health plan that cover the full
11 actuarial cost of offering such plan, including the
12 administrative costs of offering such plan. Such pre-
13 miums shall vary geographically and between the
14 small group market and the individual market in ac-
15 cordance with differences in the cost of providing
16 such coverage. If, for any plan year, the amount col-
17 lected in premiums exceeds the amount required for
18 health care benefits and administrative costs in that
19 plan year, such excess amounts shall remain avail-
20 able to the Secretary to administer the health plan
21 and finance beneficiary costs in subsequent years.

22 “(2) INITIAL PLAN YEAR.—For plan year 2021,
23 the Secretary shall set premiums for the health plan
24 for each rating area in which the health plan is
25 available for such plan year, taking into consider-

1 ation the premium rates for plans offered in each
 2 such rating area for plan year 2020.

3 “(b) RISK POOL.—After plan year 2021, all enrollees
 4 in the health plan within a State shall be members of a
 5 single risk pool, except that the Secretary may establish
 6 separate risk pools for the individual market and small
 7 group market if the State has not exercised its authority
 8 under section 1312(c)(3) of the Patient Protection and Af-
 9 fordable Care Act.

10 **“SEC. 2207. REIMBURSEMENT RATES.**

11 “(a) MEDICARE RATES.—

12 “(1) IN GENERAL.—Except as provided in para-
 13 graph (2) and subsections (b) and (c) and subject to
 14 subsection (d), the Secretary shall reimburse health
 15 care providers furnishing items and services under
 16 the health plan at rates determined for equivalent
 17 items and services under the original Medicare fee-
 18 for-service program under parts A and B of title
 19 XVIII.

20 “(2) AUTHORITY TO INCREASE PAYMENTS
 21 RATES IN RURAL AREAS.—If the Secretary deter-
 22 mines appropriate, the Secretary may increase the
 23 reimbursements rates described in paragraph (1) by
 24 up to 25 percent for items and services furnished in
 25 rural areas (as defined in section 1886(d)(2)(D)).

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

6 “(c) ADDITIONAL ITEMS AND SERVICES.—Subject to
7 subsection (d), the Secretary shall establish reimburse-
8 ment rates for any items and services provided under the
9 health plan that are not items and services provided under
10 the original Medicare fee-for-service program under parts
11 A and B of title XVIII.

12 “(d) INNOVATIVE PAYMENT METHODS.—The Sec-
13 retary may utilize innovative payment methods, including
14 value-based payment arrangements, in making payments
15 for items and services (including prescription drugs) fur-
16 nished under the health plan.

17 **“SEC. 2208. PARTICIPATING PROVIDERS.**

18 “(a) REQUIREMENT TO PARTICIPATE IN ORDER TO
19 BE ENROLLED UNDER MEDICARE.—Subject to sub-
20 section (d), beginning January 1, 2021, a health care pro-
21 vider may not be enrolled under the Medicare program
22 under section 1866(j) unless the provider is also a partici-
23 pating provider under the health plan.

24 “(b) REQUIREMENT TO PARTICIPATE IN ORDER TO
25 PARTICIPATE IN MEDICAID.—Subject to subsection (d),

1 beginning January 1, 2021, a health care provider may
2 not be a participating provider under a State Medicaid
3 plan under title XIX unless the provider is also a partici-
4 pating provider under the health plan.

5 “(c) **ADDITIONAL PROVIDERS.**—The Secretary shall
6 establish a process to allow health care providers not de-
7 scribed in subsection (a) or (b) to become a participating
8 provider under the health plan.

9 “(d) **OPT-OUT.**—The Secretary shall establish a
10 process by which a health care provider described in sub-
11 section (a) or (b) may opt out of being a participating
12 provider under the health plan.

13 **“SEC. 2209. DELIVERY SYSTEM REFORM FOR AN ENHANCED**
14 **HEALTH PLAN.**

15 “(a) **IN GENERAL.**—For plan years beginning with
16 plan year 2021, the Secretary may utilize innovative pay-
17 ment mechanisms and policies to determine payments for
18 items and services under the health plan. The payment
19 mechanisms and policies under this section may include
20 patient-centered medical home and other care manage-
21 ment payments, accountable care organizations, account-
22 able communities for health, value-based purchasing, bun-
23 dling of services, differential payment rates, performance
24 or utilization based payments, telehealth, remote patient

1 monitoring, partial capitation, and direct contracting with
2 providers.

3 “(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—

4 The Secretary shall design and implement the payment
5 mechanisms and policies under this section in a manner
6 that—

7 “(1) seeks to—

8 “(A) improve health outcomes;

9 “(B) reduce health disparities (including
10 racial, ethnic, and other disparities);

11 “(C) provide efficient and affordable care;

12 “(D) address geographic variation in the
13 provision of health services; or

14 “(E) prevent or manage chronic illness;

15 and

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

18 “(c) ENCOURAGING THE USE OF HIGH VALUE SERV-
19 ICES.—To the extent allowed by the benefit standards ap-
20 plied to all health benefits plans participating in the Ex-
21 changes (as described in section 2202(b)), the health plan
22 may modify cost-sharing and payment rates to encourage
23 the use of services that promote health and value.

24 “(d) PROMOTION OF DELIVERY SYSTEM REFORM.—

25 The Secretary shall monitor and evaluate the progress of

1 payment and delivery system reforms under this section
2 and shall seek to implement such reforms subject to the
3 following:

4 “(1) To the extent that the Secretary finds a
5 payment and delivery system reform successful in
6 improving quality and reducing costs, the Secretary
7 shall implement such reform on as large a geo-
8 graphic scale as practical and economical.

9 “(2) The Secretary may delay the implementa-
10 tion of such a reform in geographic areas in which
11 such implementation would place the public health
12 insurance option at a competitive disadvantage.

13 “(3) The Secretary may prioritize implementa-
14 tion of such a reform in high-cost geographic areas
15 or otherwise in order to reduce total program costs
16 or to promote high value care.

17 “(e) NON-UNIFORMITY PERMITTED.—Nothing in
18 this section shall prevent the Secretary from varying pay-
19 ments based on different payment structure models (such
20 as accountable care organizations and medical homes)
21 under the health plan for different geographic areas.

22 “(f) INTEGRATION WITH SOCIAL SERVICES.—

23 “(1) IN GENERAL.—The Secretary shall estab-
24 lish processes and, when appropriate, collaborate
25 with other agencies to integrate medical care under

1 the health plan with food, housing, transportation,
2 and income assistance if the Secretary determines
3 that such integration is expected to—

4 “(A) reduce spending without reducing the
5 quality of patient care; or

6 “(B) improve the quality of patient care
7 without increasing spending.

8 “(2) AUTHORIZATION OF A GRANT PROGRAM.—

9 “(A) IN GENERAL.—The Secretary may es-
10 tablish a grant program to permit broader ex-
11 perimentation with accountable communities for
12 health model.

13 “(B) ELIGIBLE RECIPIENTS.—The Sec-
14 retary may award a grant under this section
15 to—

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

19 “(ii) a local educational agency (as de-
20 fined in section 8101 of the Elementary
21 and Secondary Education Act of 1965) or
22 health care agency;

23 “(iii) a nonprofit entity that the Sec-
24 retary determines has a demonstrated his-
25 tory of community engagement; or

1 “(iv) any other entity, as the Sec-
2 retary determines appropriate.

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

5 “(i) support community needs assess-
6 ment;

7 “(ii) establish social service partner-
8 ships; or

9 “(iii) establish interactive data sys-
10 tems across health and social service pro-
11 viders.

12 “(D) AUTHORIZATION OF APPROPRIA-
13 TIONS.—There are authorized to be appro-
14 priated such sums as may be necessary to carry
15 out this paragraph.

16 “(3) REGULATIONS.—If the Secretary estab-
17 lishes a grant program under this section, the Sec-
18 retary shall promulgate regulations on—

19 “(A) the evaluation of applications for
20 grants under the program; and

21 “(B) administration of the program.

22 “(g) TELEHEALTH.—The Secretary shall ensure the
23 integration of telehealth tools that increase patient access
24 to medical care, particularly in remote or underserved

1 areas, if the Secretary determines that such integration
2 is expected to—

3 “(1) reduce spending without reducing the qual-
4 ity of patient care; or

5 “(2) improve the quality of patient care without
6 increasing spending.

7 “(h) ALTERNATIVE PAYMENT MODEL.—

8 “(1) IN GENERAL.—The Secretary shall evalu-
9 ate the possibility of providing incentives, and, if ap-
10 propriate, apply incentives, for enrollees in the
11 health plan who receive services from providers who
12 are participating in an alternative payment model
13 (as defined in section 1833(z)(3)(C)).

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

19 **“SEC. 2210. NO EFFECT ON MEDICARE BENEFITS OR MEDI-**
20 **CARE TRUST FUNDS.**

21 “Nothing in this title shall—

22 “(1) affect the benefits available under title
23 XVIII; or

24 “(2) impact the Federal Hospital Insurance
25 Trust Fund under section 1817 or the Federal Sup-

1 plementary Medical Insurance Trust Fund under
2 section 1841 (including the Medicare Prescription
3 Drug Account within such Trust Fund).”.

4 **SEC. 3. REINSURANCE.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services shall establish a mechanism to pool, on
7 a nationwide basis, the costs of the highest-cost patients
8 enrolled in individual health insurance coverage (as de-
9 fined in section 2791 of the Public Health Service Act (42
10 U.S.C. 300gg–91)) offered on or off the Exchanges, to the
11 extent such costs are not already pooled pursuant to sec-
12 tion 1343 of the Patient Protection and Affordable Care
13 Act (42 U.S.C. 18063), for the purpose of reducing pre-
14 miums for such individual health insurance coverage.

15 (b) AUTHORIZATION OF APPROPRIATIONS.—For pur-
16 poses of carrying out paragraph (1), there is authorized
17 to be appropriated \$10,000,000,000 for each of fiscal
18 years 2021, 2022, and 2023.

19 **SEC. 4. EXPANSION OF TAX CREDIT.**

20 (a) IN GENERAL.—Subparagraph (A) of section
21 36B(c)(1) of the Internal Revenue Code of 1986 is amend-
22 ed by striking “but does not exceed 400 percent”.

23 (b) APPLICABLE PERCENTAGES.—Clause (i) of sec-
24 tion 36B(b)(3)(A) of the Internal Revenue Code of 1986
25 is amended to read as follows:

1 “(i) IN GENERAL.—The applicable
2 percentage for any taxable year shall be
3 the percentage such that the applicable
4 percentage for any taxpayer whose house-
5 hold income is within an income tier speci-
6 fied in the following table shall increase, on
7 a sliding scale in a linear manner, from the
8 initial premium percentage to the final pre-
9 mium percentage specified in such table
10 for such income tier:

“In the case of household income (expressed as a percent of poverty line) within the following in- come tier:	The initial premium percentage is—	The final premium percentage is—
Up to 138 percent	1.5	1.5
138 percent up to 150 percent	2.5	3.5
150 percent up to 200 percent	3.5	5.8
200 percent up to 250 percent	5.8	7.55
250 percent up to 300 percent	7.55	9.0
300 percent up to 400 percent	9.0	9.0
400 percent up to 600 percent	9.0	13.0
600 percent and up	13.0	13.0.”.

11 (c) LIMITATION ON RECAPTURE.—Clause (i) of sec-
12 tion 36B(f)(2)(B) of the Internal Revenue Code of 1986
13 is amended—

14 (1) by striking “In the case of a taxpayer” and
15 all that follows through “the amount of the in-
16 crease” and inserting “The amount of the increase”;
17 (2) by striking the period at the end of the last
18 row of the table; and

1 (3) by adding at the end of the table the fol-
 2 lowing new row:

“400 percent and up	\$5,000.”.
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3 (d) **EFFECTIVE DATE.**—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 2019.

6 **SEC. 5. AUTHORITY TO NEGOTIATE FAIR PRICES FOR MEDI-**
 7 **CARE PRESCRIPTION DRUGS.**

8 (a) **IN GENERAL.**—Section 1860D–11 of the Social
 9 Security Act (42 U.S.C. 1395w–111) is amended by strik-
 10 ing subsection (i).

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

○