

117TH CONGRESS
1ST SESSION

H. R. 2881

To amend title XVIII of the Social Security Act to provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2021

Mr. HIGGINS of New York (for himself, Mr. LARSON of Connecticut, Mr. COURTNEY, and Mr. WELCH) 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 amend title XVIII of the Social Security Act to provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization, and for other purposes.

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 Buy-In and
5 Health Care Stabilization Act of 2021”.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) Medicare has coverage gaps and should pro-
4 vide more comprehensive coverage, including increas-
5 ing coverage for the medical needs of beneficiaries
6 relating to hearing, dental, and vision care.

7 (2) Special needs populations face financial
8 challenges to secure coverage for Medicare’s out of
9 pocket costs and other hurdles.

10 (3) Medicare Buy-In is a step in the right di-
11 rection as Congress considers additional needed leg-
12 islation to address these and other coverage issues
13 and beneficiary financial challenges in Medicare and
14 Medicare Buy-In.

15 **SEC. 3. MEDICARE BUY-IN OPTION.**

16 (a) IN GENERAL.—Title XVIII of the Social Security
17 Act (42 U.S.C. 1395c et seq.) is amended by adding at
18 the end the following new section:

19 “MEDICARE BUY-IN OPTION

20 “SEC. 1899C. (a) OPTION.—

21 “(1) IN GENERAL.—Every individual who meets
22 the requirements described in paragraph (2) shall be
23 eligible to enroll under this section.

24 “(2) ELIGIBILITY.—An individual who meets
25 the following requirements is eligible to enroll under
26 this section:

1 “(A) AGE.—The individual has attained 50
2 years of age, but has not attained 65 years of
3 age.

4 “(B) MEDICARE ELIGIBILITY (BUT FOR
5 AGE).—The individual is not otherwise entitled
6 to benefits under part A or eligible to enroll
7 under part A or part B but would be eligible for
8 benefits under part A or part B if the indi-
9 vidual were 65 years of age.

10 “(3) PART A, B, AND D BENEFITS AND PROTEC-
11 TIONS.—An individual enrolled under this section is
12 entitled to the same benefits (and shall receive the
13 same protections) under this title as an individual
14 who is entitled to benefits under part A and enrolled
15 under parts B and D, including the ability to enroll
16 in a Medicare Advantage plan that provides qualified
17 prescription drug coverage (an MA–PD plan) and
18 including access to the Medicare Beneficiary Om-
19 budsman under section 1808(c).

20 “(b) ENROLLMENT AND COVERAGE PERIODS.—The
21 Secretary shall establish enrollment and coverage periods
22 for individuals who enroll under this section. Such periods
23 shall be established in coordination with the enrollment
24 and coverage periods for plans offered under an Exchange
25 established under title I of the Patient Protection and Af-

1 fordable Care Act. The Secretary shall establish such peri-
2 ods so that coverage under this section shall first begin
3 on January 1 of the first year beginning at least one year
4 after the date of the enactment of this section and shall
5 include special enrollment periods, in accordance with sec-
6 tion 155.420 of title 45 of the Code of Federal Regula-
7 tions, that are applicable to qualified health plans offered
8 through an Exchange.

9 “(c) BUY-IN PREMIUM.—

10 “(1) AMOUNT OF MONTHLY PREMIUMS.—The
11 Secretary shall (beginning for the first year that be-
12 gins more than 1 year after the date of the enact-
13 ment of this section), during September of the pre-
14 ceding year, determine a monthly premium for indi-
15 viduals enrolled under this section. Such monthly
16 premium shall be equal to $\frac{1}{12}$ of the annual pre-
17 mium computed under paragraph (2)(B), which
18 shall apply with respect to coverage provided under
19 this section for any month in such year.

20 “(2) ANNUAL PREMIUM.—

21 “(A) COMBINED NATIONAL, PER CAPITA
22 AVERAGE FOR PARTS A, B, AND D BENEFITS.—
23 The Secretary shall estimate the average, an-
24 nual per capita amount for benefits and admin-
25 istrative expenses that will be payable under

1 parts A, B, and D in the year for all individuals
2 enrolled under this section.

3 “(B) ANNUAL PREMIUM.—Subject to sub-
4 paragraphs (C) and (D), the annual premium
5 under this subsection for months in a year is
6 equal to the average, annual per capita amount
7 estimated under subparagraph (A) for the year.

8 “(C) ADJUSTMENTS.—The Secretary shall
9 adjust the annual premium under this sub-
10 section as necessary—

11 “(i) to ensure that expenditures under
12 this title for any year are not increased by
13 reason of this section; and

14 “(ii) by a geographic adjustment fac-
15 tor to address regional affordability con-
16 cerns.

17 “(D) AUTHORITY TO CALCULATE
18 AMOUNTS OF MONTHLY PREMIUMS SEPARATELY
19 FOR DIFFERENT AGES.—In determining the an-
20 nual premium amount under this paragraph for
21 months in a year, the Secretary may make sep-
22 arate determinations of such amount for indi-
23 viduals by age, if the Secretary determines that
24 making such separate determinations would in-

1 crease enrollment under this section and reduce
2 the risk of adverse selection.

3 “(3) ADDITIONAL PREMIUM FOR CERTAIN PART
4 D PLANS.—Nothing in this section shall preclude an
5 individual from choosing a prescription drug plan
6 which requires the individual to pay an additional
7 amount (because of the inclusion of supplemental
8 prescription drug benefits or because the plan is a
9 more expensive plan, pursuant to section 1860D–
10 13(a)(1)). In such case, the monthly premium under
11 paragraph (1) shall be increased with respect to
12 such individual.

13 “(d) PAYMENT OF PREMIUMS.—

14 “(1) PAYMENT.—Premiums for enrollment
15 under this section shall be paid to the Secretary at
16 such times, and in such manner, as the Secretary
17 determines appropriate.

18 “(2) DEPOSIT.—Amounts collected by the Sec-
19 retary under this section shall be deposited in the
20 Medicare Buy-In Trust Fund established under sub-
21 section (e).

22 “(e) MEDICARE BUY-IN TRUST FUND.—

23 “(1) IN GENERAL.—There is hereby created on
24 the books of the Treasury of the United States a
25 trust fund to be known as the ‘Medicare Buy-In

1 Trust Fund’ (in this subsection referred to as the
2 ‘Trust Fund’). The Trust Fund shall consist of such
3 gifts and bequests as may be made as provided in
4 section 201(i)(1) and such amounts as may be de-
5 posited in, or appropriated to, such fund as provided
6 in this title.

7 “(2) PREMIUMS.—Premiums collected under
8 subsection (d) shall be transferred to the Trust
9 Fund.

10 “(3) INCORPORATION OF PROVISIONS.—Sub-
11 sections (b) through (i) of section 1841 shall apply
12 with respect to the Trust Fund and this title in the
13 same manner as they apply with respect to the Fed-
14 eral Supplementary Medical Insurance Trust Fund
15 and part B, respectively, except that in applying
16 such section 1841, any reference in such section to
17 ‘this part’ shall be construed to be a reference to
18 this section and any reference in section 1841(h) to
19 section 1840(d) and in section 1841(i) to sections
20 1840(b)(1) and 1842(g) are deemed to be references
21 to comparable authority exercised under this section.

22 “(f) CLARIFICATION.—Nothing in this section shall
23 affect the benefits or eligibility under this title of individ-
24 uals who would otherwise be entitled to or eligible for ben-
25 efits under this title or title XIX, or both.

1 “(g) ELIGIBILITY FOR FINANCIAL ASSISTANCE.—

2 “(1) IN GENERAL.—Individuals enrolled in cov-
3 erage under this section shall, from amounts trans-
4 ferred under paragraph (2), receive financial assist-
5 ance for such coverage that is substantially similar
6 to the assistance the individual would have received
7 if the individual were enrolled in a qualified health
8 plan through an Exchange.

9 “(2) TRANSFER OF FUNDS TO MEDICARE BUY-
10 IN TRUST FUND.—

11 “(A) IN GENERAL.—The Secretary shall
12 transfer to the Medicare Buy-In Trust Fund
13 under subsection (d) for each plan year the
14 amount determined under paragraph (C) for
15 such year.

16 “(B) USE OF FUNDS.—The amounts
17 transferred to the Medicare Buy-In Trust Fund
18 under subparagraph (A) shall only be used to
19 reduce the premiums and cost-sharing for cov-
20 erage under this section of individuals enrolled
21 under such coverage who would be eligible for
22 cost-sharing reductions under section 1402 of
23 the Patient Protection and Affordable Care Act
24 and premium assistance under section 36B of

1 the Internal Revenue Code of 1986 if such indi-
2 vidual were enrolled in a qualified health plan.

3 “(C) AMOUNT OF TRANSFER.—

4 “(i) IN GENERAL.—The amount de-
5 termined under this subparagraph for any
6 plan year is the aggregate amount the Sec-
7 retary determines is equal to 100 percent
8 of the premium tax credits under section
9 36B of the Internal Revenue Code of
10 1986, and 100 percent of the cost-sharing
11 reductions under section 1402 of the Pa-
12 tient Protection and Affordable Care Act,
13 that would have been provided for the plan
14 year to eligible individuals who meet speci-
15 fied income criteria and are enrolled for
16 such plan year in coverage provided
17 through enrollment under this section if
18 such individuals were enrolled for such
19 year in a qualified health plan through an
20 Exchange.

21 “(ii) SPECIFIC REQUIREMENTS.—The
22 Secretary shall make the determination
23 under clause (i) on a per enrollee basis and
24 shall take into account all relevant factors
25 necessary to determine the value of the

1 premium tax credits and cost-sharing re-
2 ductions that would have been provided to
3 eligible individuals described in section
4 1331 of the Patient Protection and Afford-
5 able Care Act, including the age and in-
6 come of the enrollee, geographic differences
7 in average spending for health care across
8 rating areas, the health status of the en-
9 rollee for purposes of determining risk ad-
10 justment payments and reinsurance pay-
11 ments that would have been made if the
12 enrollee had enrolled in a qualified health
13 plan through an Exchange, and whether
14 any reconciliation of the credit or cost-
15 sharing reductions would have occurred if
16 the enrollee had been so enrolled. This de-
17 termination shall take into consideration
18 the experience of other States with respect
19 to participation in an Exchange and such
20 credits and reductions provided to resi-
21 dents of the other States, with a special
22 focus on enrollees with income below 200
23 percent of poverty.

24 “(D) CERTIFICATION.—

1 “(i) IN GENERAL.—The Chief Actuary
2 of the Centers for Medicare & Medicaid
3 Services, in consultation with the Office of
4 Tax Analysis of the Department of the
5 Treasury, shall certify whether the method-
6 ology used to make determinations under
7 subparagraph (C), and such determina-
8 tions, meet the requirements of this para-
9 graph. Such certifications shall be based
10 on sufficient data from the federal ex-
11 change and from comparable States about
12 their experience with programs created by
13 the Basic Health Plan.

14 “(ii) CORRECTIONS.—The Secretary
15 shall adjust the payment to the Trust
16 Fund for any plan year to reflect any error
17 in the determinations under subparagraph
18 (C) for any preceding plan year.

19 “(iii) APPLICATION.—Coverage pro-
20 vided through enrollment under this part
21 and parts B and D pursuant to this sec-
22 tion shall be treated as coverage under a
23 qualified health plan in the silver level of
24 coverage in the individual market offered

1 through an Exchange and the Secretary
2 shall be treated as the issuer of such plan.

3 “(h) TREATMENT IN RELATION TO THE AFFORD-
4 ABLE CARE ACT.—

5 “(1) TREATMENT AS MINIMUM ESSENTIAL COV-
6 ERAGE.—For purposes of applying section 5000A of
7 the Internal Revenue Code of 1986, the coverage
8 provided through enrollment under this section con-
9 stitutes minimum essential coverage under sub-
10 section (f)(1)(A)(i) of such section.

11 “(2) USE OF EXCHANGES.—Coverage provided
12 through enrollment under this section shall be
13 deemed to be coverage under a qualified health plan
14 for purposes of section 1311(d)(4)(C) of the Patient
15 Protection and Affordable Care Act and shall be
16 made available for enrollment, information compari-
17 son, and otherwise as such a plan through any inter-
18 net website maintained by an Exchange established
19 under title I of such Act (as described in such sec-
20 tion).

21 “(3) MEDICAID MANAGED CARE.—States are
22 prohibited from buying their Medicaid beneficiaries
23 ages 50 to 64 into Medicare under this section, and
24 individuals otherwise eligible for enrollment under a
25 State plan under title XIX are prohibited from cov-

1 erage under this title pursuant to enrollment under
2 this section. The preceding sentence shall not apply
3 to Medicaid beneficiaries whose Medicaid coverage or
4 eligibility does not meet the definition of minimum
5 essential coverage under a government-sponsored
6 program under section 1.5000A–2 of title 26, Code
7 of Federal Regulations (or any successor regulation).

8 “(4) ACCESS TO MEDIGAP.—Coverage provided
9 through medicare supplemental policies certified
10 under section 1882 shall be made available to indi-
11 viduals eligible for enrollment pursuant to this sec-
12 tion for enrollment, information, comparison, and
13 otherwise as such a policy through any internet
14 website described in paragraph (2).

15 “(i) OVERSIGHT.—There is established an advisory
16 committee to be known as the ‘Medicare Buy In Oversight
17 Board’ to monitor and oversee the implementation of this
18 section, including the experience of the individuals enroll-
19 ing under this section. The Medicare Buy In Oversight
20 Board shall make periodic recommendations for the con-
21 tinual improvement of the implementation of this section
22 as well as the relationship of enrollment under this section
23 to other health care programs.

24 “(j) OUTREACH AND ENROLLMENT.—

1 “(1) IN GENERAL.—During the period that be-
2 gins on January 1, 2021, and ends on December 31,
3 2023, the Secretary shall award grants to eligible
4 entities for the following purposes:

5 “(A) OUTREACH AND ENROLLMENT.—To
6 carry out outreach, public education activities,
7 and enrollment activities to raise awareness of
8 the availability of, and encourage, enrollment
9 under this section.

10 “(B) ASSISTING INDIVIDUALS TRANSITION
11 UNDER THIS SECTION.—To provide assistance
12 to individuals to enroll under this section.

13 “(C) RAISING AWARENESS OF PREMIUM
14 ASSISTANCE AND COST-SHARING REDUC-
15 TIONS.—To distribute fair and impartial infor-
16 mation concerning enrollment under this section
17 and the availability of premium assistance tax
18 credits under section 36B of the Internal Rev-
19 enue Code of 1986 and cost-sharing reductions
20 under section 1402 of the Patient Protection
21 and Affordable Care Act, and to assist eligible
22 individuals in applying for such tax credits and
23 cost-sharing reductions.

24 “(2) ELIGIBLE ENTITIES.—

1 “(A) IN GENERAL.—In this subsection, the
2 term ‘eligible entity’ means—

3 “(i) a State; or

4 “(ii) a nonprofit community-based or-
5 ganization.

6 “(B) ENROLLMENT AGENTS.—Such term
7 includes a licensed independent insurance agent
8 or broker that has an arrangement with a State
9 or nonprofit community-based organization to
10 enroll eligible individuals under this section.

11 “(C) EXCLUSIONS.—Such term does not
12 include an entity that—

13 “(i) is a health insurance issuer; or

14 “(ii) receives any consideration, either
15 directly or indirectly, from any health in-
16 surance issuer in connection with the en-
17 rollment of any individuals under this sec-
18 tion.

19 “(3) PRIORITY.—In awarding grants under this
20 subsection, the Secretary shall give priority to
21 awarding grants to States or eligible entities in
22 States that have geographic rating areas at risk of
23 having no qualified health plans in the individual
24 market.

1 “(4) FUNDING.—Out of any moneys in the
2 Treasury not otherwise appropriated, \$500,000,000
3 is appropriated to the Secretary for each of calendar
4 years 2021 through 2023, to carry out this sub-
5 section.

6 “(k) IMPLEMENTATION.—

7 “(1) CONSULTATION.—In carrying out this sec-
8 tion, the Secretary shall—

9 “(A) consult with other Federal agencies,
10 including the Department of the Treasury, the
11 Department of Labor, the Department of Vet-
12 erans Affairs, the Department of Defense, and
13 the Office of Personnel Management; and

14 “(B) incorporate significant public con-
15 sultation and feedback, through public forums,
16 notice and comment rulemaking, and any other
17 appropriate mediums.

18 “(2) REPORT.—No later than one year after
19 the date of the enactment of this section, the Sec-
20 retary shall submit to Congress a report establishing
21 the administrative parameters for the implementa-
22 tion of this section.

23 “(l) FEASIBILITY STUDY.—The Secretary shall con-
24 duct a study on the feasibility of applying this section with

1 respect to individuals residing in States that are not with-
2 in the 50 States or the District of Columbia.”.

3 (b) MEDIGAP.—Section 1882 of the Social Security
4 Act is amended by adding at the end the following new
5 subsection:

6 “(aa) DEVELOPMENT OF NEW STANDARDS FOR CER-
7 TAIN MEDICARE SUPPLEMENTAL POLICIES RELATING TO
8 BUY-IN OPTION.—The Secretary shall request the Na-
9 tional Association of Insurance Commissioners to review
10 and revise the standards for benefit packages described
11 in subsection (p)(1), to otherwise update standards to in-
12 clude requirements for each medicare supplemental policy
13 that offers such a policy in a State, with respect to each
14 year, to accept every individual in the State who is eligible
15 for enrollment pursuant to section 1899C and who applies
16 for such coverage for such year if the individual applies
17 for enrollment in such policy during the 30-day period fol-
18 lowing the date of enrollment pursuant to section 1899C
19 and to accept every such individual during a period of
20 transition from enrollment pursuant to such section to en-
21 rollment under this title pursuant to eligibility other than
22 under such section. Such revisions shall be made con-
23 sistent with the rules applicable under subsection
24 (p)(1)(E) with the reference to the ‘1991 NAIC Model
25 Regulation’ deemed a reference to the NAIC Model Regu-

1 lation as published in the Federal Register on December
2 4, 1998, and as subsequently updated by the National As-
3 sociation of Insurance Commissioners to reflect previous
4 changes in law and the reference to ‘date of enactment
5 of this subsection’ deemed a reference to the date of enact-
6 ment of this subsection (aa).”.

7 **SEC. 4. MEDICARE DIRECT SUPPLEMENTAL INSURANCE**
8 **OPTION.**

9 (a) IN GENERAL.—Title XVIII of the Social Security
10 Act is amended by inserting after section 1882 (42 U.S.C.
11 1395ss) the following new section:

12 **“SEC. 1882A. MEDICARE DIRECT SUPPLEMENTAL INSUR-**
13 **ANCE OPTION.**

14 “(a) IN GENERAL.—The Secretary shall provide for
15 the offering under this section of a voluntary program to
16 supplement the benefits provided to individuals under
17 parts A and B of this title.

18 “(b) ELIGIBILITY; ENROLLMENT.—The Secretary
19 shall provide procedures for the enrollment under the pro-
20 gram under this section of individuals who are entitled to
21 benefits under part A and enrolled under part B, but who
22 are not enrolled in a Medicare Advantage plan (or in a
23 plan under section 1876). Such procedures shall be con-
24 sistent with the following:

1 “(1) There shall be an initial enrollment period
2 during the last calendar quarter of 2022 that per-
3 mits all individuals who are eligible to enroll at that
4 time under this subsection to enroll and obtain bene-
5 fits effective on January 1, 2023.

6 “(2) For individuals who are not eligible to en-
7 roll at such time but who subsequently become eligi-
8 ble, there shall be an individual enrollment period
9 which is the 6-month period described in section
10 1882(s)(2)(A).

11 “(3) The Secretary shall permit eligible individ-
12 uals to enroll at other times (and not less frequently
13 than annually) in a uniform manner, but such en-
14 rollment shall be subject to a late enrollment penalty
15 under subsection (d)(2)(B).

16 “(c) BENEFITS.—

17 “(1) IN GENERAL.—The benefits provided
18 under the program under this section shall consist of
19 payment of the cost of deductibles, copayments, and
20 other cost-sharing amounts (including amounts at-
21 tributable to and permitted as balance billing) other-
22 wise imposed or permitted under this title, subject to
23 an annual deductible of \$100.

24 “(2) ADMINISTRATION.—The Secretary shall
25 coordinate payment of benefits under this part with

1 those under parts A and B and may, for such pur-
2 pose, enter into appropriate arrangements with
3 qualified entities (which may include fiscal inter-
4 mediaries and carriers).

5 “(3) NO PRE-EXISTING CONDITION LIMITA-
6 TIONS.—The benefits under this section shall not be
7 subject to any pre-existing condition or similar un-
8 derwriting limitation.

9 “(d) PREMIUMS.—

10 “(1) ACTUARIAL COST.—The Secretary shall,
11 during September of each year beginning with 2022,
12 determine a monthly actuarial rate for all enrollees
13 under this section, which rate shall be applicable for
14 months in the succeeding calendar year. Such actu-
15 arial rate shall be the amount the Secretary esti-
16 mates to be necessary so that the aggregate amount
17 for such calendar year with respect to those enrollees
18 will equal the total amount which the Secretary esti-
19 mates will be payable under this section for benefits
20 accrued (including services performed and related
21 administrative costs incurred) in such calendar year
22 under the program under this section. In calculating
23 the monthly actuarial rate, the Secretary shall make
24 adjustments to take into account errors in esti-
25 mations under this paragraph for previous years and

1 shall include an appropriate amount for a contin-
2 gency margin.

3 “(2) PREMIUM.—

4 “(A) IN GENERAL.—The monthly premium
5 of each individual enrolled under this section
6 for a month in a year shall be the monthly ac-
7 tuarial rate determined under paragraph (1) for
8 months in such year. Such premium shall be
9 community-rated and shall not vary among en-
10 rollees based upon the age, place of residence,
11 or any other factors, except as provided under
12 subparagraph (B).

13 “(B) PENALTY FOR LATE ENROLLMENT.—

14 In the case of an individual who does not enroll
15 under this section in a period provided under
16 paragraph (1) or (2) of subsection (b), the Sec-
17 retary shall increase the monthly premium (in
18 a manner similar to that applied under part B
19 pursuant to section 1839(b)) of 10 percent for
20 each full 12 months in which the individual
21 could have been but was not so enrolled. In ap-
22 plying such an increase—

23 “(i) the aggregate percentage increase
24 may not exceed 100 percent; and

1 “(ii) periods of time in which an indi-
2 vidual is enrolled under an employee wel-
3 fare benefit plan described in section
4 1882(s)(3)(B)(i), under a Medicare Advan-
5 tage plan, with an organization described
6 in section 1882(s)(3)(B)(iii), or under a
7 PACE program under section 1894 shall
8 not be taken into account.

9 “(3) COLLECTION.—The Secretary shall pro-
10 vide for the collection of premiums for enrollees
11 under this part in the same manner as premiums
12 under part B are collected under section 1840, ex-
13 cept that any reference in such section to the Fed-
14 eral Supplementary Medical Insurance Trust Fund
15 shall be deemed a reference to an account (to be
16 known as the ‘Direct Medicare Supplemental Insur-
17 ance Account’) to be established in the Treasury by
18 the Secretary to carry out the program under this
19 section. Amounts in such account may be invested
20 and draw interest in the same manner as such Trust
21 Fund under section 1840(c).

22 “(4) USE OF FUNDS.—Premium amounts de-
23 posited into the account established under paragraph
24 (3) shall be available without regard to appropria-
25 tions to the Secretary to make payment for benefits

1 and administrative costs incurred in carrying out
2 this section.

3 “(e) NONDUPLICATION OF COVERAGE.—For pur-
4 poses of applying section 1882(d)(3)(A), coverage under
5 this section shall be treated as coverage under a Medicare
6 supplemental policy.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall take effect on the date of the enact-
9 ment of this Act and shall apply to benefits for months
10 beginning with January 2022.

11 **SEC. 5. NEGOTIATION OF LOWER COVERED PART D DRUG**
12 **PRICES ON BEHALF OF MEDICARE BENE-**
13 **FICIARIES.**

14 (a) NEGOTIATION BY SECRETARY.—Section 1860D–
15 11 of the Social Security Act (42 U.S.C. 1395w–111) is
16 amended by striking subsection (i) (relating to noninter-
17 ference) and inserting the following:

18 “(i) NEGOTIATION OF LOWER DRUG PRICES.—

19 “(1) IN GENERAL.—Notwithstanding any other
20 provision of law, the Secretary shall negotiate with
21 pharmaceutical manufacturers the prices (including
22 discounts, rebates, and other price concessions) that
23 may be charged to PDP sponsors and MA organiza-
24 tions for covered part D drugs for part D eligible in-

1 individuals who are enrolled under a prescription drug
2 plan or under an MA–PD plan.

3 “(2) NO CHANGE IN RULES FOR
4 FORMULARIES.—

5 “(A) IN GENERAL.—Nothing in paragraph
6 (1) shall be construed to authorize the Sec-
7 retary to establish or require a particular for-
8 mulary.

9 “(B) CONSTRUCTION.—Subparagraph (A)
10 shall not be construed as affecting the Sec-
11 retary’s authority to ensure appropriate and
12 adequate access to covered part D drugs under
13 prescription drug plans and under MA–PD
14 plans, including compliance of such plans with
15 formulary requirements under section 1860D–
16 4(b)(3).

17 “(3) CONSTRUCTION.—Nothing in this sub-
18 section shall be construed as preventing the sponsor
19 of a prescription drug plan, or an organization offer-
20 ing an MA–PD plan, from obtaining a discount or
21 reduction of the price for a covered part D drug
22 below the price negotiated under paragraph (1).

23 “(4) SEMI-ANNUAL REPORTS TO CONGRESS.—
24 Not later than June 1, 2024, and every 6 months
25 thereafter, the Secretary shall submit to the Com-

1 mittees on Ways and Means, Energy and Commerce,
2 and Oversight and Reform of the House of Rep-
3 resentatives and the Committee on Finance of the
4 Senate a report on negotiations conducted by the
5 Secretary to achieve lower prices for Medicare bene-
6 ficiaries, and the prices and price discounts achieved
7 by the Secretary as a result of such negotiations.”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) shall take effect on the date of the enact-
10 ment of this Act and shall first apply to negotiations and
11 prices for plan years beginning on January 1, 2024.

12 **SEC. 6. INDIVIDUAL MARKET REINSURANCE FUND.**

13 (a) ESTABLISHMENT OF FUND.—

14 (1) IN GENERAL.—There is established the “In-
15 dividual Market Reinsurance Fund” (in this section
16 referred to as the “Fund”) to be administered by
17 the Secretary to provide funding for an individual
18 market stabilization reinsurance program in each
19 State that complies with the requirements of this
20 section.

21 (2) FUNDING.—Amounts made available to the
22 Fund shall consist of the funds deposited into the
23 Fund under paragraph (3) and shall be used to
24 carry out this section (other than subsection (c)) for
25 each calendar year beginning with 2023. Amounts

1 made available to the Fund shall remain available
2 without fiscal or calendar year limitation to carry
3 out this section.

4 (3) COST-SHARING IN COSTS OF PROGRAM.—

5 (A) IN GENERAL.—A qualified health plan
6 that participates in the reinsurance program es-
7 tablished under subsection (b) shall pay the fee
8 established under subparagraph (B).

9 (B) AUTHORIZATION.—The Secretary is
10 authorized to charge a fee to each qualified
11 health plan that participates in the reinsurance
12 program established under subsection (b). Any
13 amounts collected pursuant to this paragraph
14 shall be deposited into the Fund for purposes of
15 payments under subsection (b).

16 (C) REQUIREMENTS.—In establishing the
17 fee under subparagraph (B)—

18 (i) the Secretary shall consult with in-
19 terested parties; and

20 (ii) shall ensure that the amount of
21 such fee is not excessive so as to unduly
22 discourage qualified health plans from par-
23 ticipating in the reinsurance program.

24 (b) INDIVIDUAL MARKET REINSURANCE PRO-
25 GRAM.—

1 (1) USE OF FUNDS.—The Secretary shall use
2 amounts in the Fund to establish a reinsurance pro-
3 gram under which the Secretary shall make reinsur-
4 ance payments, subject to subsection (a)(3), to
5 health insurance issuers with respect to high-cost in-
6 dividuals enrolled in qualified health plans offered by
7 such issuers that are not grandfathered health plans
8 or transitional health plans for any plan year begin-
9 ning with the 2020 plan year. This subsection con-
10 stitutes budget authority in advance of appropria-
11 tions Acts and represents the obligation of the Sec-
12 retary to provide payments from the Fund in ac-
13 cordance with this subsection.

14 (2) AMOUNT OF PAYMENT.—The payment
15 made to a health insurance issuer under paragraph
16 (1) with respect to each high-cost individual enrolled
17 in a qualified health plan issued by the issuer that
18 is not a grandfathered health plan or a transitional
19 health plan shall equal 80 percent of the lesser of—

20 (A) the amount (if any) by which the indi-
21 vidual’s claims incurred during the plan year
22 exceeds—

23 (i) in the case of the 2021, 2022, or
24 2023 plan year, \$50,000; and

1 (ii) in the case of any other plan year,
2 \$100,000; or

3 (B) for plan years described in—

4 (i) subparagraph (A)(i), \$450,000;

5 and

6 (ii) subparagraph (A)(ii), \$400,000.

7 (3) INDEXING.—In the case of plan years be-
8 ginning after 2021, the dollar amounts that appear
9 in subparagraphs (A) and (B) of paragraph (2) shall
10 each be increased by an amount equal to—

11 (A) such amount; multiplied by

12 (B) the premium adjustment percentage
13 specified under section 1302(c)(4) of the Af-
14 fordable Care Act, but determined by sub-
15 stituting “2019” for “2013”.

16 (4) PAYMENT METHODS.—

17 (A) IN GENERAL.—Payments under this
18 subsection shall be based on such a method as
19 the Secretary determines. The Secretary may
20 establish a payment method by which interim
21 payments of amounts under this subsection are
22 made during a plan year based on the Sec-
23 retary’s best estimate of amounts that will be
24 payable after obtaining all of the information.

1 (B) REQUIREMENT FOR PROVISION OF IN-
2 FORMATION.—

3 (i) REQUIREMENT.—Payments under
4 this subsection to a health insurance issuer
5 are conditioned upon the furnishing to the
6 Secretary, in a form and manner specified
7 by the Secretary, of such information as
8 may be required to carry out this sub-
9 section.

10 (ii) RESTRICTION ON USE OF INFOR-
11 MATION.—Information disclosed or ob-
12 tained pursuant to clause (i) is subject to
13 the HIPAA privacy and security law, as
14 defined in section 3009(a) of the Public
15 Health Service Act (42 U.S.C. 300jj–
16 19(a)).

17 (5) SECRETARY FLEXIBILITY FOR BUDGET
18 NEUTRAL REVISIONS TO REINSURANCE PAYMENT
19 SPECIFICATIONS.—If the Secretary determines ap-
20 propriate, the Secretary may substitute higher dollar
21 amounts for the dollar amounts specified under sub-
22 paragraphs (A) and (B) of paragraph (2) (and ad-
23 justed under paragraph (3), if applicable) if the Sec-
24 retary certifies that such substitutions, considered

1 together, neither increase nor decrease the total pro-
2 jected payments under this subsection.

3 (c) REPORTS TO CONGRESS.—

4 (1) ANNUAL REPORT.—The Secretary shall
5 submit a report to Congress, not later than January
6 21, 2021, and each year thereafter, that contains
7 the following information for the most recently
8 ended year:

9 (A) The number and types of plans in each
10 State’s individual market, specifying the num-
11 ber that are qualified health plans, grand-
12 fathered health plans, or health insurance cov-
13 erage that is not a qualified health plan.

14 (B) The impact of the reinsurance pay-
15 ments provided under this section on the avail-
16 ability of coverage, cost of coverage, and cov-
17 erage options in each State.

18 (C) The amount of premiums paid by indi-
19 viduals in each State by age, family size, geo-
20 graphic area in the State’s individual market,
21 and category of health plan (as described in
22 subparagraph (A)).

23 (D) The process used to award funds for
24 outreach and enrollment activities awarded to
25 eligible entities under subsection (c), the

1 amount of such funds awarded, and the activi-
2 ties carried out with such funds.

3 (E) Such other information as the Sec-
4 retary deems relevant.

5 (2) EVALUATION REPORT.—Not later than Jan-
6 uary 31, 2024, the Secretary shall submit to Con-
7 gress a report that—

8 (A) analyzes the impact of the funds pro-
9 vided under this section on premiums and en-
10 rollment in the individual market in all States;
11 and

12 (B) contains a State-by-State comparison
13 of the design of the programs carried out by
14 States with funds provided under this section.

15 (d) DEFINITIONS.—In this section:

16 (1) SECRETARY.—The term “Secretary” means
17 the Secretary of the Department of Health and
18 Human Services.

19 (2) FUND.—The term “Fund” means the Indi-
20 vidual Market Reinsurance Fund established under
21 subsection (a).

22 (3) GRANDFATHERED HEALTH PLAN.—The
23 term “grandfathered health plan” has the meaning
24 given that term in section 1251(e) of the Patient
25 Protection and Affordable Care Act.

1 (4) HIGH-COST INDIVIDUAL.—The term “high-
2 cost individual” means an individual enrolled in a
3 qualified health plan (other than a grandfathered
4 health plan or a transitional health plan) who incurs
5 claims in excess of \$50,000 during a plan year.

6 (5) STATE.—The term “State” means each of
7 the 50 States and the District of Columbia.

8 (6) TRANSITIONAL HEALTH PLAN.—The term
9 “transitional health plan” means a plan continued
10 under the letter issued by the Centers for Medicare
11 & Medicaid Services on November 14, 2013, to the
12 State Insurance Commissioners outlining a transi-
13 tional policy for coverage in the individual and small
14 group markets to which section 1251 of the Patient
15 Protection and Affordable Care Act does not apply,
16 and under the extension of the transitional policy for
17 such coverage set forth in the Insurance Standards
18 Bulletin Series guidance issued by the Centers for
19 Medicare & Medicaid Services on March 5, 2014,
20 February 29, 2016, and February 13, 2017.

21 **SEC. 7. REAUTHORIZATION OF RISK CORRIDORS.**

22 Section 1342(a) of the Patient Protection and Af-
23 fordable Care Act (42 U.S.C. 18062(a)) is amended by
24 inserting “and calendar years 2023 through 2026” after
25 “2016”.

1 **SEC. 8. INTEGRATION OF INDIVIDUALS AGED 50 TO 64 INTO**
2 **HEALTH DEMONSTRATIONS.**

3 The Center for Medicare and Medicaid Innovation
4 under section 1115A of the Social Security Act (42 U.S.C.
5 1315a) is authorized to include the individuals enrolled
6 under title XVIII of the Social Security Act pursuant to
7 section 1899C of such Act, as added by section 3, into
8 existing and future demonstrations conducted by such
9 Center.

10 **SEC. 9. QUALIFIED HEALTH PLAN TAX CREDIT EXPANSION**
11 **MADE PERMANENT.**

12 (a) IN GENERAL.—Section 36B of the Internal Rev-
13 enue Code of 1986 is amended—

14 (1) in subsection (b)(3)(A)(iii)—

15 (A) by striking the header and inserting
16 “PERCENTAGES FOR TAXABLE YEARS BEGIN-
17 NING AFTER 2020”, and

18 (B) by striking “beginning in 2021 or
19 2022” and inserting “beginning after 2020”,
20 and

21 (2) in subsection (c)(1)(E)—

22 (A) by striking the header and inserting
23 “RULE FOR TAXABLE YEARS AFTER 2020”, and

24 (B) by striking “beginning in 2021 or
25 2022” and inserting “beginning after 2020”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2020.

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