

Choose Medicare Act

This legislation would create a new Medicare plan that would be available to individuals of all ages in every part of the country, using the infrastructure established by the Affordable Care Act. Unless already enrolled in Medicaid or traditional Medicare, an individual will be able to choose the new Medicare plan on all State and Federal exchanges, and use ACA subsidies to help pay for it. The new Medicare plan (Part E) would cover the same benefits as traditional Medicare, as well as additional benefits to meet the needs of the nonelderly. The Medicare Part E plan would leverage the existing exchange networks and low administrative costs of the Medicare program, while achieving additional savings by allowing Medicare to negotiate drug prices with manufacturers. It further allows the Secretary of the Department of Health and Human Services to block or modify excessive private insurance rates.

Medicare Part E also would open Medicare to employers of all sizes and allow them to purchase high quality, affordable health care for their employees. Medicare Part E addresses the discrepancy between consumer protections in the individual and group markets by extending the Affordable Care Act's (ACA's) rating requirements to all markets, to end discrimination based on pre-existing conditions once and for all.

Medicare Part E also strengthens traditional Medicare for seniors by establishing an out-of-pocket maximum, and improves affordability across all insurance plans in the marketplace by increasing the generosity of premium tax credits and extending eligibility to middle-income earners.

Medicare Part E opens up Medicare to everyone while building on the system we have today, while preserving the existing Medicare program for seniors. By creating a strong public health plan that can compete with private health insurance, Medicare Part E puts consumers and businesses in the driver's seat on the road to universal health coverage.

Section 1 – Short Title

Section 2 – Public Health Plan

Sec. 2201 Public Health Plans

Establishment – The Secretary will establish public health plans that are available in the individual market, small group market, and large group market.

Benefits – Each Medicare Part E plan, regardless of whether the plan is offered in the individual market, small group market, or large group market, will be a qualified health plan and,

- provide coverage of essential health benefits and all items and services covered by Medicare;
- cover abortions and all reproductive care;
- provide gold-level coverage; and

- meet all other requirements applicable to qualified health plans, other than the requirement to offer silver and gold plans.

Availability on the Exchanges – The Medicare Part E plans offered in the individual and small group markets will be offered through the Federal and State Exchanges, including the Small Business Health Options Program Exchanges (commonly referred to as the ‘SHOP Exchanges’).

Eligibility – Any individual who is a resident of the United States, who is not eligible for Medicaid, CHIP, or traditional Medicare, is eligible to enroll in a Medicare Part E plan offered in the individual market or offered by the individual’s employer. The Secretary shall establish residency requirements.

Employer-Sponsored Plans – The Secretary will provide options for Medicare Part E plans in the small group market and large group market that are voluntary, and available to all employers, effective one year after the date of enactment.

- At the request of a plan sponsor, the Centers for Medicare and Medicaid may serve as a third party administrator of a group health plan that is a Medicare Part E plan offered by such sponsor.
- The Secretary will develop a process for allowing individuals enrolled in a Medicare Part E plan offered in the small group market or large group market to maintain health insurance coverage through such plan if the individual subsequently loses eligibility for enrollment in such plan based on termination of the employment relationship.

Premiums – The Secretary will establish premium rates for the Medicare Part E plans that are adjusted based on—

- whether the plan is offered in the individual market, small group market, or large group market; and
- applicable rating area;
- are at a level sufficient to fully finance the costs of health benefits provided by the plans and administrative costs related to operating the plans; and
- comply with all rating reform requirements under the ACA, including for plans offered in the large group market.

Providers and Reimbursement Rates – The Secretary will establish a rate schedule for reimbursing health care providers under the Medicare Part E plans by negotiating rates that are not lower, in the aggregate, than Medicare Fee for Service rates, and not higher, in the aggregate, than average rates paid by private plans offered on the exchanges.

Participating Providers – A health care provider that is a participating provider of services or supplier under traditional Medicare will be a participating provider for Medicare Part E plans. The Secretary will also establish a process to allow additional health care providers to become participating providers for Medicare Part E plans.

Limitations on Balance Billing – The limitations on balance billing in traditional Medicare also apply to participating providers in Medicare Part E plans.

Encouraging Use of Alternative Payment Models – The Secretary shall utilize alternative payment models, including those in the Medicare Access and CHIP Reauthorization Act of 2015.

Start Up Funding and Initial Reserves – For purposes of establishing the Medicare Part E plans, \$2,000,000,000 is appropriated for fiscal year 2022. The Secretary will also appropriate such sums as may be necessary, based on projected enrollment in the Medicare Part E plans in the first plan year, to provide sufficient reserves for paying claims filed during the first 90-days.

Section 3 – Notice and Navigator Referral for Employees Under the Fair Labor Standards Act of 1938

- The Fair Labor Standards Act of 1938 is amended by adding the requirement that employers who do not provide health insurance to their employees must refer full time employees at the time of hire to a health care navigator, as defined under the ACA, beginning two years after the date of enactment.
- The Government Accountability Office will conduct a study of the efficacy of the ACA’s requirement on employers to notify new workers of their health care coverage options.
- Authorizes such sums as may be necessary to be appropriated to address capacity limitations of entities serving as navigators.

Section 4 – Protecting Against High Out of Pocket Expenditures for Medicare Fee-for-Service Benefits — The annual out-of-pocket limit for seniors enrolled in traditional Medicare will be \$6,700 for 2023 and adjusted in subsequent years according to the medical care component of the Consumer Price Index for All Urban Consumers.

Section 5 – Negotiating Fair Prices for Medicare Prescription Drugs — The Secretary is granted the authority to negotiate drug prices under Medicare Part D.

- If, after a year, the Secretary and drug manufacturers fail to successfully negotiate a fair price, the Secretary will use the price that the Department of Veterans Affairs or other federal agencies that purchase prescription drugs use.
- The Secretary will prioritize negotiations on specialty and other high-priced drugs.

Section 6 – Enhancement of Premium Assistance Credit

- The benchmark plan is changed from the applicable second lowest cost silver plan to the applicable second lowest cost gold plan.
- Eligibility for refundable tax credits for coverage under Qualified Health Plans is increased to allow individuals and families earning up to 600% of the Federal Poverty Level to receive assistance.
- The household income in regard to the repaying of excess advance credit payments is changed from 400% to 600%.

Section 7 – Enhancement for Reduced Cost Sharing – Cost-sharing reduction payments for low-income individuals are enhanced by increasing the actuarial value of the plan provided to eligible enrollees.

Section 8 – Reinsurance and Affordability Fund – The Secretary will establish a program to enable each State to carry out a reinsurance program or provide assistance to reduce out-of-

pocket costs, such as copayments, coinsurance, premiums, or deductibles, and will provide funding of \$30 billion for fiscal years 2022 through 2024.

Section 9 – Expanding Rating Rules to Large Group Market – This section expands the individual market rating rules to the large group market.

Section 10 – Protection of Consumers from Excessive, Unjustified, or Unfairly Discriminatory Rates – The Secretary is granted the authority to deny, modify or require consumer rebates for excessive private insurance rates in States where the State insurance commissioner or relevant State regulator does not correct excessive rates.

Section 11 – Sense of Congress on Reproductive Services – This section states that the Federal Government, acting in its capacity as an insurer, employer, or health care provider, should serve as a model for the nation to ensure coverage of all reproductive services, and further that all restrictions on coverage of reproductive services in the private insurance market should end.