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(Original Signature of Member)

115TH CONGRESS
1ST SESSION

H. R. _____

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

Mr. HIGGINS of New York introduced the following bill; which was referred to the Committee on _____

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 2017”.

1 **SEC. 2. MEDICARE BUY-IN OPTION.**

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

5 “MEDICARE BUY-IN OPTION

6 “SEC. 1899C. (a) OPTION.—

7 “(1) ELIGIBILITY.—Every individual who meets
8 the requirements described in paragraph (3) shall be
9 eligible to enroll under this section.

10 “(2) IN GENERAL.—An individual who meets
11 the following requirements is eligible to enroll under
12 this section:

13 “(A) AGE.—The individual has attained 50
14 years of age, but has not attained 65 years of
15 age.

16 “(B) MEDICARE ELIGIBILITY (BUT FOR
17 AGE).—The individual is not otherwise entitled
18 to benefits under part A or eligible to enroll
19 under part A or part B but would be eligible for
20 benefits under part A or part B if the indi-
21 vidual were 65 years of age.

22 “(3) BENEFITS.—An individual enrolled under
23 this section is entitled to the same benefits under
24 this title as an individual who is entitled to benefits
25 under part A and enrolled under parts B and D.

1 “(b) ENROLLMENT AND COVERAGE PERIODS.—The
2 Secretary shall establish enrollment and coverage periods
3 for individuals who enroll under this section. Such periods
4 shall be established in coordination with the enrollment
5 and coverage periods for plans offered under an Exchange
6 established under title I of the Patient Protection and Af-
7 fordable Care Act. The Secretary shall establish such peri-
8 ods so that coverage under this section shall first begin
9 on January 1 of the first year beginning at least one year
10 after the date of the enactment of this section.

11 “(c) BUY-IN PREMIUM.—

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

22 “(2) ANNUAL PREMIUM.—

23 “(A) COMBINED NATIONAL, PER CAPITA
24 AVERAGE FOR PART A, B, AND D BENEFITS.—
25 The Secretary shall estimate the average, an-

1 nual per capita amount for benefits and admin-
2 istrative expenses that will be payable under
3 parts A, B, and D in the year for all individuals
4 enrolled under this section).

5 “(B) ANNUAL PREMIUM.—The annual pre-
6 mium under this subsection for months in a
7 year is equal to the average, annual per capita
8 amount estimated under subparagraph (A) for
9 the year.

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

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

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

19 “(3) ADDITIONAL PREMIUM FOR CERTAIN D
20 PLANS.—Nothing in this section shall preclude an
21 individual from choosing a prescription drug plan
22 which requires the individual to pay an additional
23 amount (because of the inclusion of supplemental
24 prescription drug benefits or because the plan is a
25 more expensive plan, pursuant to section 1860D–

1 13(a)(1)). In such case, the monthly premium under
2 paragraph (1) shall be increased with respect to
3 such individual.

4 “(d) PAYMENT OF PREMIUMS.—

5 “(1) PAYMENT.—

6 “(A) IN GENERAL.—Premiums for enroll-
7 ment under this section shall be paid to the
8 Secretary at such times, and in such manner,
9 as the Secretary determines appropriate.

10 “(B) PAYMENT OF PREMIUMS BY EMPLOY-
11 ERS ON BEHALF OF EMPLOYEES.—An employer
12 of an individual who enrolls under this section
13 may make payments for the premiums for such
14 enrollment on behalf of such individual pursu-
15 ant to a process established by the Secretary.
16 Such process shall ensure that enrollment under
17 this section is the choice of the individual and
18 not the employer.

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

23 “(e) MEDICARE BUY-IN TRUST FUND.—

24 “(1) IN GENERAL.—There is hereby created on
25 the books of the Treasury of the United States a

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

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

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

23 “(f) CLARIFICATION.—Nothing in this section shall
24 affect the benefits or eligibility under this title of individ-

1 uals who would otherwise be entitled to or eligible for ben-
2 efits under this title or title XIX, or both.

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

5 “(1) SATISFACTION OF INDIVIDUAL MAN-
6 DATE.—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) ELIGIBILITY FOR PREMIUM ASSISTANCE.—
12 Coverage provided through enrollment under this
13 section—

14 “(A) shall be treated as coverage under a
15 qualified health plan in the individual market
16 enrolled in through the Exchange where the in-
17 dividual resides for all purposes of section 36B
18 of the Internal Revenue Code of 1986 other
19 than subsection (c)(2)(B) thereof; and

20 “(B) shall not be treated as eligibility for
21 other minimum essential coverage for purposes
22 of subsection (c)(2)(B) of such section 36B.

23 The Secretary shall determine the applicable second
24 lowest cost silver plan which shall apply to coverage

1 provided through enrollment under this section for
2 purposes of section 36B of such Code.

3 “(3) ELIGIBILITY FOR COST-SHARING SUB-
4 SIDIES.—For purposes of applying section 1402 of
5 the Patient Protection and Affordable Care Act—

6 “(A) coverage provided through enrollment
7 under this part and parts B and D pursuant to
8 this section shall be treated as coverage under
9 a qualified health plan in the silver level of cov-
10 erage in the individual market offered through
11 an Exchange; and

12 “(B) the Secretary shall be treated as the
13 issuer of such plan.

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

24 “(5) ACCESS TO MEDIGAP.—Coverage provided
25 through medicare supplemental policies certified

1 under section 1882 shall be made available to indi-
2 viduals eligible for enrollment pursuant to this sec-
3 tion for enrollment, information, comparison, and
4 otherwise as such a policy through any Internet
5 website described in paragraph (4).

6 “(h) OVERSIGHT.—There is established an advisory
7 committee to be known as the ‘Medicare Buy In Oversight
8 Board’ to monitor and oversee the implementation of this
9 section, including the experience of the individuals enroll-
10 ing under this section. The Medicare Buy In Oversight
11 Board shall make periodic recommendations for the con-
12 tinual improvement of the implementation of this section
13 as well as the relationship of enrollment under this section
14 to other health care programs.

15 “(i) OUTREACH AND ENROLLMENT.—

16 “(1) IN GENERAL.—During the period that be-
17 gins on January 1, 2018, and ends on December 31,
18 2020, the Secretary shall award grants to eligible
19 entities for the following purposes:

20 “(A) OUTREACH AND ENROLLMENT.—To
21 carry out outreach, public education activities,
22 and enrollment activities to raise awareness of
23 the availability of, and encourage, enrollment
24 under this section.

1 “(B) ASSISTING INDIVIDUALS TRANSITION
2 UNDER THIS SECTION.—To provide assistance
3 to individuals to enroll under this section.

4 “(C) RAISING AWARENESS OF PREMIUM
5 ASSISTANCE AND COST-SHARING REDUC-
6 TIONS.—To distribute fair and impartial infor-
7 mation concerning enrollment under this section
8 and the availability of premium assistance tax
9 credits under section 36B of the Internal Rev-
10 enue Code of 1986 and cost-sharing reductions
11 under section 1402 of the Patient Protection
12 and Affordable Care Act, and to assist eligible
13 individuals in applying for such tax credits and
14 cost-sharing reductions.

15 “(2) ELIGIBLE ENTITIES.—

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

18 “(i) a State; or

19 “(ii) a nonprofit community-based or-
20 ganization.

21 “(B) ENROLLMENT AGENTS.—Such term
22 includes a licensed independent insurance agent
23 or broker that has an arrangement with a State
24 or nonprofit community-based organization to
25 enroll eligible individuals under this section.

1 “(C) EXCLUSIONS.—Such term does not
2 include an entity that—

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

4 “(ii) receives any consideration, either
5 directly or indirectly, from any health in-
6 surance issuer in connection with the en-
7 rollment of any individuals under this sec-
8 tion.

9 “(3) PRIORITY.—In awarding grants under this
10 subsection, the Secretary shall give priority to
11 awarding grants to States or eligible entities in
12 States that have geographic rating areas at risk of
13 having no qualified health plans in the individual
14 market.

15 “(4) FUNDING.—Out of any moneys in the
16 Treasury not otherwise appropriated, \$500,000,000
17 is appropriated to the Secretary for each of calendar
18 years 2018 through 2020, to carry out this sub-
19 section.

20 “(c) IMPLEMENTATION.—

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

23 “(A) consult with other federal agencies,
24 including the Department of the Treasury, De-
25 partment of Labor, Department of Veterans Af-

1 fairs, the Department of Defense, and the Of-
2 fice of Personnel Management; and

3 “(B) incorporate significant public con-
4 sultation and feedback, through public forums,
5 notice and comment rulemaking, and any other
6 appropriate mediums.

7 “(2) REPORT.—No later than one year after
8 the date of the enactment of this section, the Sec-
9 retary shall submit to Congress a report establishing
10 the administrative parameters for the implementa-
11 tion of this section.

12 “(d) FEASIBILITY STUDY.—The Secretary shall con-
13 duct a study on the feasibility of applying this section with
14 respect to individuals residing in States that are not with-
15 in the 50 States or the District of Columbia.”.

16 (b) MEDIGAP.—Section 1882 of the Social Security
17 Act is amended by adding at the end the following new
18 subsection:

19 “(aa) DEVELOPMENT OF NEW STANDARDS FOR CER-
20 TAIN MEDICARE SUPPLEMENTAL POLICIES RELATING TO
21 BUY-IN OPTION.—The Secretary shall request the Na-
22 tional Association of Insurance Commissioners to review
23 and revise the standards for benefit packages described
24 in subsection (p)(1), to otherwise update standards to in-
25 clude requirements for each medicare supplemental policy

1 that offers such a policy in a State, with respect to each
2 year, to accept every individual in the State who is eligible
3 for enrollment pursuant to section 1899C and who applies
4 for such coverage for such year if the individual applies
5 for enrollment in such policy during the 30-day period fol-
6 lowing the date of enrollment pursuant to section 1899C
7 and to accept every such individual during a period of
8 transition from enrollment pursuant to such section to en-
9 rollment under this title pursuant to eligibility other than
10 under such section. Such revisions shall be made con-
11 sistent with the rules applicable under subsection
12 (p)(1)(E) with the reference to the ‘1991 NAIC Model
13 Regulation’ deemed a reference to the NAIC Model Regu-
14 lation as published in the Federal Register on December
15 4, 1998, and as subsequently updated by the National As-
16 sociation of Insurance Commissioners to reflect previous
17 changes in law and the reference to ‘date of enactment
18 of this subsection’ deemed a reference to the date of enact-
19 ment of this subsection (aa).”.

20 **SEC. 3. NEGOTIATION OF LOWER COVERED PART D DRUG**
21 **PRICES ON BEHALF OF MEDICARE BENE-**
22 **FICIARIES.**

23 (a) NEGOTIATION BY SECRETARY.—Section 1860D–
24 11 of the Social Security Act (42 U.S.C. 1395w–111) is

1 amended by striking subsection (i) (relating to noninter-
2 ference) and inserting the following:

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

4 “(1) IN GENERAL.—Notwithstanding any other
5 provision of law, the Secretary shall negotiate with
6 pharmaceutical manufacturers the prices (including
7 discounts, rebates, and other price concessions) that
8 may be charged to PDP sponsors and MA organiza-
9 tions for covered part D drugs for part D eligible in-
10 dividuals who are enrolled under a prescription drug
11 plan or under an MA–PD plan.

12 “(2) NO CHANGE IN RULES FOR
13 FORMULARIES.—

14 “(A) IN GENERAL.—Nothing in paragraph
15 (1) shall be construed to authorize the Sec-
16 retary to establish or require a particular for-
17 mulary.

18 “(B) CONSTRUCTION.—Subparagraph (A)
19 shall not be construed as affecting the Sec-
20 retary’s authority to ensure appropriate and
21 adequate access to covered part D drugs under
22 prescription drug plans and under MA–PD
23 plans, including compliance of such plans with
24 formulary requirements under section 1860D–
25 4(b)(3).

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

7 “(4) SEMI-ANNUAL REPORTS TO CONGRESS.—
8 Not later than June 1, 2018, and every 6 months
9 thereafter, the Secretary shall submit to the Com-
10 mittees on Ways and Means, Energy and Commerce,
11 and Oversight and Government Reform of the House
12 of Representatives and the Committee on Finance of
13 the Senate a report on negotiations conducted by the
14 Secretary to achieve lower prices for Medicare bene-
15 ficiaries, and the prices and price discounts achieved
16 by the Secretary as a result of such negotiations.”.

17 (b) EFFECTIVE DATE.—The amendment made by
18 subsection (a) shall take effect on the date of the enact-
19 ment of this Act and shall first apply to negotiations and
20 prices for plan years beginning on January 1, 2018.

21 **SEC. 4. INDIVIDUAL MARKET REINSURANCE FUND.**

22 (a) ESTABLISHMENT OF FUND.—

23 (1) IN GENERAL.—There is established the “In-
24 dividual Market Reinsurance Fund” (in this section
25 referred to as the “Fund”) to be administered by

1 the Secretary to provide funding for an individual
2 market stabilization reinsurance program in each
3 State that complies with the requirements of this
4 section.

5 (2) FUNDING.—Amounts made available to the
6 Fund shall consist of the funds deposited into the
7 Fund under paragraph (3) and shall be used to
8 carry out this section (other than subsection (c)) for
9 each calendar year beginning with 2018. Amounts
10 made available to the Fund shall remain available
11 without fiscal or calendar year limitation to carry
12 out this section.

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

14 (A) IN GENERAL.—A qualified health plan
15 that participates in the reinsurance program es-
16 tablished under subsection (b) shall pay the fee
17 established under subparagraph (B).

18 (B) AUTHORIZATION.—The Secretary is
19 authorized to charge a fee to each qualified
20 health plan that participates in the reinsurance
21 program established under subsection (b). Any
22 amounts collected pursuant to this paragraph
23 shall be deposited into the Fund for purposes of
24 payments under subsection (b).

1 (C) REQUIREMENTS.—In establishing the
2 fee under subparagraph (B)—

3 (i) the Secretary shall consult with in-
4 terested parties; and

5 (ii) shall ensure that the amount of
6 such fee is not excessive so as to unduly
7 discourage qualified health plans from par-
8 ticipating in the reinsurance program.

9 (b) INDIVIDUAL MARKET REINSURANCE PRO-
10 GRAM.—

11 (1) USE OF FUNDS.—The Secretary shall use
12 amounts in the Fund to establish a reinsurance pro-
13 gram under which the Secretary shall make reinsur-
14 ance payments, subject to subsection (a)(3), to
15 health insurance issuers with respect to high-cost in-
16 dividuals enrolled in qualified health plans offered by
17 such issuers that are not grandfathered health plans
18 or transitional health plans for any plan year begin-
19 ning with the 2018 plan year. This subsection con-
20 stitutes budget authority in advance of appropria-
21 tions Acts and represents the obligation of the Sec-
22 retary to provide payments from the Fund in ac-
23 cordance with this subsection.

24 (2) AMOUNT OF PAYMENT.—The payment
25 made to a health insurance issuer under paragraph

1 (1) with respect to each high-cost individual enrolled
2 in a qualified health plan issued by the issuer that
3 is not a grandfathered health plan or a transitional
4 health plan shall equal 80 percent of the lesser of—

5 (A) the amount (if any) by which the indi-
6 vidual’s claims incurred during the plan year
7 exceeds—

8 (i) in the case of the 2018, 2019, or
9 2020 plan year, \$50,000; and

10 (ii) in the case of any other plan year,
11 \$100,000; or

12 (B) for plan years described in—

13 (i) subparagraph (A)(i), \$450,000;
14 and

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

16 (3) INDEXING.—In the case of plan years be-
17 ginning after 2018, the dollar amounts that appear
18 in subparagraphs (A) and (B) of paragraph (2) shall
19 each be increased by an amount equal to—

20 (A) such amount; multiplied by

21 (B) the premium adjustment percentage
22 specified under section 1302(c)(4) of the Af-
23 fordable Care Act, but determined by sub-
24 stituting “2018” for “2013”.

25 (4) PAYMENT METHODS.—

1 (A) IN GENERAL.—Payments under this
2 subsection shall be based on such a method as
3 the Secretary determines. The Secretary may
4 establish a payment method by which interim
5 payments of amounts under this subsection are
6 made during a plan year based on the Sec-
7 retary's best estimate of amounts that will be
8 payable after obtaining all of the information.

9 (B) REQUIREMENT FOR PROVISION OF IN-
10 FORMATION.—

11 (i) REQUIREMENT.—Payments under
12 this subsection to a health insurance issuer
13 are conditioned upon the furnishing to the
14 Secretary, in a form and manner specified
15 by the Secretary, of such information as
16 may be required to carry out this sub-
17 section.

18 (ii) RESTRICTION ON USE OF INFOR-
19 MATION.—Information disclosed or ob-
20 tained pursuant to clause (i) is subject to
21 the HIPAA privacy and security law, as
22 defined in section 3009(a) of the Public
23 Health Service Act (42 U.S.C. 300jj-
24 19(a)).

1 (5) SECRETARY FLEXIBILITY FOR BUDGET
2 NEUTRAL REVISIONS TO REINSURANCE PAYMENT
3 SPECIFICATIONS.—If the Secretary determines ap-
4 propriate, the Secretary may substitute higher dollar
5 amounts for the dollar amounts specified under sub-
6 paragraphs (A) and (B) of paragraph (2) (and ad-
7 justed under paragraph (3), if applicable) if the Sec-
8 retary certifies that such substitutions, considered
9 together, neither increase nor decrease the total pro-
10 jected payments under this subsection.

11 (c) REPORTS TO CONGRESS.—

12 (1) ANNUAL REPORT.—The Secretary shall
13 submit a report to Congress, not later than January
14 21, 2019, and each year thereafter, that contains
15 the following information for the most recently
16 ended year:

17 (A) The number and types of plans in each
18 State’s individual market, specifying the num-
19 ber that are qualified health plans, grand-
20 fathered health plans, or health insurance cov-
21 erage that is not a qualified health plan.

22 (B) The impact of the reinsurance pay-
23 ments provided under this section on the avail-
24 ability of coverage, cost of coverage, and cov-
25 erage options in each State.

1 (C) The amount of premiums paid by indi-
2 viduals in each State by age, family size, geo-
3 graphic area in the State's individual market,
4 and category of health plan (as described in
5 subparagraph (A)).

6 (D) The process used to award funds for
7 outreach and enrollment activities awarded to
8 eligible entities under subsection (e), the
9 amount of such funds awarded, and the activi-
10 ties carried out with such funds.

11 (E) Such other information as the Sec-
12 retary deems relevant.

13 (2) EVALUATION REPORT.—Not later than Jan-
14 uary 31, 2022, the Secretary shall submit to Con-
15 gress a report that—

16 (A) analyzes the impact of the funds pro-
17 vided under this section on premiums and en-
18 rollment in the individual market in all States;
19 and

20 (B) contains a State-by-State comparison
21 of the design of the programs carried out by
22 States with funds provided under this section.

23 (d) DEFINITIONS.—In this section:

1 (1) SECRETARY.—The term “Secretary” means
2 the Secretary of the Department of Health and
3 Human Services.

4 (2) FUND.—The term “Fund” means the Indi-
5 vidual Market Reinsurance Fund established under
6 subsection (a).

7 (3) GRANDFATHERED HEALTH PLAN.—The
8 term “grandfathered health plan” has the meaning
9 given that term in section 1251(e) of the Patient
10 Protection and Affordable Care Act.

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

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

18 (6) TRANSITIONAL HEALTH PLAN.—The term
19 “transitional health plan” means a plan continued
20 under the letter issued by the Centers for Medicare
21 & Medicaid Services on November 14, 2013, to the
22 State Insurance Commissioners outlining a transi-
23 tional policy for coverage in the individual and small
24 group markets to which section 1251 of the Patient
25 Protection and Affordable Care Act does not apply,

1 and under the extension of the transitional policy for
2 such coverage set forth in the Insurance Standards
3 Bulletin Series guidance issued by the Centers for
4 Medicare & Medicaid Services on March 5, 2014,
5 February 29, 2016, and February 13, 2017.

6 **SEC. 5. REAUTHORIZATION OF RISK CORRIDORS.**

7 Section 1342(a) of the Patient Protection and Af-
8 fordable Care Act (42 U.S.C. 18062(a)) is amended by
9 inserting “and calendar years 2018 through 2020” after
10 “2016”.

11 **SEC. 6. ENHANCEMENTS FOR REDUCED COST SHARING.**

12 (a) MODIFICATION OF AMOUNT.—

13 (1) IN GENERAL.—Section 1402(c)(2) of the
14 Patient Protection and Affordable Care Act (42
15 U.S.C. 18071(c)(2)) is amended to read as follows:

16 “(2) ADDITIONAL REDUCTION.—The Secretary
17 shall establish procedures under which the issuer of
18 a qualified health plan to which this section applies
19 shall further reduce cost-sharing under the plan in
20 a manner sufficient to—

21 “(A) in the case of an eligible insured
22 whose household income is not less than 100
23 percent but not more than 200 percent of the
24 poverty line for a family of the size involved, in-
25 crease the plan’s share of the total allowed

1 costs of benefits provided under the plan to 95
2 percent of such costs;

3 “(B) in the case of an eligible insured
4 whose household income is more than 200 per-
5 cent but not more than 300 percent of the pov-
6 erty line for a family of the size involved, in-
7 crease the plan’s share of the total allowed
8 costs of benefits provided under the plan to 90
9 percent of such costs; and

10 “(C) in the case of an eligible insured
11 whose household income is more than 300 per-
12 cent but not more than 400 percent of the pov-
13 erty line for a family of the size involved, in-
14 crease the plan’s share of the total allowed
15 costs of bene- fits provided under the plan to 85
16 percent of such costs.”.

17 (2) CONFORMING AMENDMENT.—Clause (i) of
18 section 1402(c)(1)(B) of such Act (42 U.S.C.
19 18071(c)(1)(B)) is amended to read as follows:

20 “(i) IN GENERAL.—The Secretary
21 shall ensure the reduction under this para-
22 graph shall not result in an increase in the
23 plan’s share of the total allowed costs of
24 benefits provided under the plan above—

1 “(I) 95 percent in the case of an
2 eligible insured described in para-
3 graph (2)(A);

4 “(II) 90 percent in the case of an
5 eligible insured described in para-
6 graph (2)(B); and

7 “(III) 85 percent in the case of
8 an eligible insured described in para-
9 graph (2)(C).”.

10 (3) EFFECTIVE DATE.—The amendments made
11 by this subsection shall apply to plan years begin-
12 ning after December 31, 2017.

13 (b) FUNDING.—Section 1402 of the Patient Protec-
14 tion and Affordable Care Act (42 U.S.C. 18071) is amend-
15 ed by adding at the end the following new subsection:

16 “(g) FUNDING.—Out of any funds in the Treasury
17 not otherwise appropriated, there are appropriated to the
18 Secretary such sums as may be necessary for payments
19 under this section.”.

20 **SEC. 7. TECHNICAL ADVISORY COMMITTEE ON HEALTH**
21 **CARE DELIVERY SYSTEM REFORM AND PRO-**
22 **GRAM INTEGRITY.**

23 (a) ESTABLISHMENT.—There is established a com-
24 mittee to be known as the Committee on Delivery System
25 Reform and Program Integrity.

1 (b) MEMBERSHIP.—The Committee shall be com-
2 posed of 11 members appointed by the Comptroller Gen-
3 eral of the United States. Such members shall include in-
4 dividuals with national recognition for their expertise in
5 health care delivery system reform and the related delivery
6 of health care. Health care providers and patient advo-
7 cates shall have adequate representation on the Com-
8 mittee.

9 (c) DUTIES.—The Committee shall periodically sub-
10 mit to the Secretary of Health and Human Services and
11 the Congress written recommendations, provided in a com-
12 prehensive report format, to further the goals of health
13 care delivery system reform that generally aim to improve
14 the quality of patient care, improve the health of popu-
15 lations, and reduce the cost of care. The origin of these
16 proposals can be derived from any initiative underway be-
17 tween the Department of Health and Human Services and
18 any party, or other initiatives, national or regional in
19 scope, that offer promise to accelerate the goals of delivery
20 system reform or improve program integrity toward the
21 goal of providing further stability to the appropriate Trust
22 Funds under title XVIII of the Social Security Act.