

117TH CONGRESS
1ST SESSION

H. R. 1227

To establish a public health plan.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 23, 2021

Mr. DELGADO (for himself, Mr. HIGGINS of New York, and Mr. LARSON of Connecticut) 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 2021”.

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 2022 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 2025 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 during the period of fiscal years 2021 through
2 2030.

3 “(B) APPROPRIATION.—There is appro-
4 priated \$1,000,000,000, out of monies in the
5 Treasury not otherwise obligated, to the Plan
6 Reserve Fund for fiscal year 2021, to remain
7 available until expended.

8 “(2) DATA AND TECHNOLOGY FUND.—

9 “(A) IN GENERAL.—There is established in
10 the Treasury of the United States a ‘Data and
11 Technology Fund’, to be administered by the
12 Secretary of Health and Human Services, act-
13 ing through the Chief Actuary of the Centers
14 for Medicare & Medicaid Services, for purposes
15 of updating technology and performing data
16 collection under section 2205 in order to estab-
17 lish appropriate premiums for all geographic re-
18 gions of the United States, consisting of
19 amounts appropriated to such fund during the
20 period of fiscal years 2021 through 2030.

21 “(B) APPROPRIATION.—There is appro-
22 priated \$1,000,000,000, out of amounts in the
23 Treasury not otherwise appropriated, to the
24 Data and Technology Fund for fiscal year
25 2021, to remain available until expended.

1 “(c) RULEMAKING.—Not later than 180 days after
2 the date of enactment of this Act, the Secretary shall pro-
3 mulgate such regulations as may be necessary to carry out
4 this title. Rules promulgated under this subsection shall
5 be finalized not later than 270 days after the date of en-
6 actment of this Act.

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

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

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

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

16 “(b) EXCHANGES.—In accordance with the time-
17 frame under section 2201(a)(2), the health plan shall be
18 made available through the American Health Benefit Ex-
19 changes described in sections 1311 and 1321 of the Pa-
20 tient Protection and Affordable Care Act (42 U.S.C.
21 18031, 18041), including the Small Business Health Op-
22 tions Program Exchange.

23 **“SEC. 2203. PLAN REQUIREMENTS.**

24 “(a) GENERAL REQUIREMENTS.—The health plan
25 shall comply with all requirements, as applicable, of sub-

1 title D of title I of the Patient Protection and Affordable
 2 Care Act (42 U.S.C. 18021 et seq.) and title XXVII of
 3 the Public Health Service Act (42 U.S.C. 300gg et seq.)
 4 applicable to qualified health plans, and such health plan
 5 shall be a qualified health plan, including for purposes of
 6 the Internal Revenue Code of 1986.

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

8 “(1) shall make available a silver level and gold
 9 level version of the plan, in accordance with section
 10 1301(a)(1)(C)(ii); and

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

16 “(c) PRIMARY CARE SERVICES.—The health plan
 17 shall provide coverage for primary care services, and shall
 18 not impose any cost-sharing requirements for such serv-
 19 ices.

20 **“SEC. 2204. ADMINISTRATIVE CONTRACTING.**

21 “(a) IN GENERAL.—The Secretary may enter into
 22 contracts for the purpose of performing administrative
 23 functions (including functions described in subsection
 24 (a)(4) of section 1874A) with respect to the health plan
 25 in the same manner as the Secretary may enter into con-

1 tracts under subsection (a)(1) of such section. The Sec-
 2 retary shall have the same authority with respect to the
 3 public health insurance option as the Secretary has under
 4 such subsection (a)(1) and subsection (b) of section 1874A
 5 with respect to title XVIII.

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

11 **“SEC. 2205. DATA COLLECTION.**

12 “Subject to all applicable privacy requirements, in-
 13 cluding the requirements under the regulations promul-
 14 gated pursuant to section 264(c) of the Health Insurance
 15 Portability and Accountability Act of 1996 (42 U.S.C.
 16 1320d–2 note), the Secretary may collect data from State
 17 insurance commissioners and other relevant entities to es-
 18 tablish rates for premiums and for other purposes includ-
 19 ing to improve quality, and reduce racial, ethnic, socio-
 20 economic, geographic, gender, sexual identity, and other
 21 health disparities, including such disparities experienced
 22 by people with disabilities and older adults, with respect
 23 to the health plan.

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

25 “(a) SETTING PREMIUMS.—

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

14 “(2) INITIAL PLAN YEAR.—For plan year 2022,
15 the Secretary shall set premiums for the health plan
16 for each rating area in which the health plan is
17 available for such plan year, taking into consider-
18 ation the premium rates for plans offered in each
19 such rating area for plan year 2021.

20 “(b) RISK POOL.—After plan year 2022, all enrollees
21 in the health plan within a State shall be members of a
22 single risk pool, except that the Secretary may establish
23 separate risk pools for the individual market and small
24 group market if the State has not exercised its authority

1 under section 1312(c)(3) of the Patient Protection and Af-
2 fordable Care Act.

3 **“SEC. 2207. REIMBURSEMENT RATES.**

4 “(a) MEDICARE RATES.—

5 “(1) IN GENERAL.—Except as provided in para-
6 graph (2) and subsections (b) and (c) and subject to
7 subsection (d), the Secretary shall reimburse health
8 care providers furnishing items and services under
9 the health plan at rates determined for equivalent
10 items and services under the original Medicare fee-
11 for-service program under parts A and B of title
12 XVIII.

13 “(2) AUTHORITY TO INCREASE PAYMENTS
14 RATES IN RURAL AREAS.—If the Secretary deter-
15 mines appropriate, the Secretary may increase the
16 reimbursements rates described in paragraph (1) by
17 up to 50 percent for items and services furnished in
18 rural areas (as defined in section 1886(d)(2)(D)).

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

24 “(c) ADDITIONAL ITEMS AND SERVICES.—Subject to
25 subsection (d), the Secretary shall establish reimburse-

1 ment rates for any items and services provided under the
2 health plan that are not items and services provided under
3 the original Medicare fee-for-service program under parts
4 A and B of title XVIII.

5 “(d) INNOVATIVE PAYMENT METHODS.—The Sec-
6 retary may utilize innovative payment methods, including
7 value-based payment arrangements, in making payments
8 for items and services (including prescription drugs) fur-
9 nished under the health plan.

10 “(e) COMPREHENSIVE STUDY ON COVERING ADDI-
11 TIONAL SERVICES.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Administrator of the Centers for Medi-
14 care & Medicaid Services, shall conduct a com-
15 prehensive study, in consultation with stakeholders,
16 and develop recommendations for Congress on the
17 need for, and cost of providing coverage for, addi-
18 tional services under the health plan.

19 “(2) CONTENT.—The study shall under para-
20 graph (1) shall include—

21 “(A) consideration of providing coverage
22 for long-term services and supports, home and
23 community based services, assistive and ena-
24 bling technologies, and vision, hearing, and den-
25 tal services;

1 “(B) consideration of providing coverage
2 for other services in addition to the services de-
3 scribed in subparagraph (A) that could most
4 benefit the health and financial well-being of
5 beneficiaries, including by reducing health dis-
6 parities, if included for coverage under the plan;

7 “(C) the costs associated with covering ad-
8 ditional services described in subparagraphs (A)
9 and (B), for beneficiaries through cost-sharing
10 and premiums, and for the Federal Govern-
11 ment; and

12 “(D) an assessment of the implications of
13 covering such additional services for the risk
14 pool of the health plan and for the individual
15 and small group markets.

16 “(3) SUBMISSION OF REPORT.—Not later than
17 2 years after the date of enactment of this title, the
18 Secretary shall submit to Congress a report on the
19 findings and recommendations of the study under
20 this subsection and shall make such report publicly
21 available on the website of the Department of
22 Health and Human Services.

23 **“SEC. 2208. PARTICIPATING PROVIDERS.**

24 “(a) REQUIREMENT TO PARTICIPATE IN ORDER TO
25 BE ENROLLED UNDER MEDICARE.—Subject to sub-

1 section (d), beginning January 1, 2022, a health care pro-
2 vider may not be enrolled under the Medicare program
3 under section 1866(j) unless the provider is also a partici-
4 pating provider under the health plan.

5 “(b) REQUIREMENT TO PARTICIPATE IN ORDER TO
6 PARTICIPATE IN MEDICAID.—Subject to subsection (d),
7 beginning January 1, 2022, a health care provider may
8 not be a participating provider under a State Medicaid
9 plan under title XIX unless the provider is also a partici-
10 pating provider under the health plan.

11 “(c) ADDITIONAL PROVIDERS.—The Secretary shall
12 establish a process to allow health care providers not de-
13 scribed in subsection (a) or (b) to become a participating
14 provider under the health plan.

15 “(d) OPT-OUT.—The Secretary shall establish a
16 process by which a health care provider described in sub-
17 section (a) or (b) may opt out of being a participating
18 provider under the health plan, under exceptional cir-
19 cumstances where participation in the health plan threat-
20 ens the provider’s ability to operate.

21 **“SEC. 2209. DELIVERY SYSTEM REFORM FOR AN ENHANCED**
22 **HEALTH PLAN.**

23 “(a) IN GENERAL.—For plan years beginning with
24 plan year 2022, the Secretary may utilize innovative pay-
25 ment mechanisms and policies to determine payments for

1 items and services under the health plan. The payment
2 mechanisms and policies under this section may include
3 patient-centered medical home and other care manage-
4 ment payments, accountable care organizations, account-
5 able communities for health, value-based purchasing, bun-
6 dling of services, differential payment rates, performance
7 or utilization based payments, telehealth, remote patient
8 monitoring, partial capitation, and direct contracting with
9 providers.

10 “(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—
11 The Secretary shall design and implement the payment
12 mechanisms and policies under this section in a manner
13 that—

14 “(1) seeks to—

15 “(A) improve health outcomes;

16 “(B) reduce health disparities (including
17 racial, ethnic, socioeconomic, geographic, gen-
18 der, sexual identity, and other disparities, in-
19 cluding such disparities experienced by people
20 with disabilities and older adults);

21 “(C) improve coordination to provide more
22 efficient and affordable quality care;

23 “(D) address geographic variation in the
24 provision of health services; or

25 “(E) prevent or manage chronic illness;

1 “(2) promotes care that is integrated, patient-
2 centered, quality, and efficient;

3 “(3) implements patient feedback mechanisms,
4 including culturally- and disability-competent mecha-
5 nisms; and

6 “(4) uses person-reported experiences to im-
7 prove service delivery.

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

14 “(d) PROMOTION OF DELIVERY SYSTEM REFORM.—
15 The Secretary shall monitor and evaluate the progress of
16 payment and delivery system reforms under this section
17 and shall seek to implement such reforms subject to the
18 following:

19 “(1) To the extent that the Secretary finds a
20 payment and delivery system reform successful in
21 improving quality and reducing costs, the Secretary
22 shall implement such reform on as large a geo-
23 graphic scale as practical and economical.

24 “(2) The Secretary may delay the implementa-
25 tion of such a reform in geographic areas in which

1 such implementation would place the public health
2 insurance option at a competitive disadvantage.

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

7 “(4) The Secretary may prioritize implementa-
8 tion of such a reform to reduce racial, ethnic, socio-
9 economic, geographic, gender, sexual identity, or
10 other health disparities, including such disparities
11 experienced by people with disabilities or older
12 adults.

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

18 “(f) INTEGRATION WITH SOCIAL SERVICES.—

19 “(1) IN GENERAL.—The Secretary shall estab-
20 lish processes and, when appropriate, collaborate
21 with other agencies to integrate medical care under
22 the health plan with food, housing, transportation,
23 and income assistance if the Secretary determines
24 that such integration is expected to—

1 “(A) reduce spending without reducing the
2 quality of patient care;

3 “(B) improve the quality of patient care
4 without increasing spending; or

5 “(C) reduce racial, ethnic, socioeconomic,
6 geographic, gender, sexual identity, or other
7 health disparities, including any such disparities
8 experienced by people with disabilities or older
9 adults.

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

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

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

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

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

1 “(iii) a nonprofit entity that the Sec-
2 retary determines has a demonstrated his-
3 tory of community engagement; or

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

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

8 “(i) support community needs assess-
9 ment;

10 “(ii) establish social service partner-
11 ships; or

12 “(iii) establish interactive data sys-
13 tems across health and social service pro-
14 viders.

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

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

22 “(A) the evaluation of applications for
23 grants under the program; and

24 “(B) administration of the program.

1 “(g) TELEHEALTH.—The Secretary shall ensure the
2 integration of telehealth tools, including technology-en-
3 abled collaborative learning and capacity building models,
4 that increase patient access to medical care (including spe-
5 cialty care), particularly in remote or underserved areas,
6 if the Secretary determines that such integration is ex-
7 pected to—

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

10 “(2) improve the quality of patient care without
11 increasing spending.

12 “(h) ALTERNATIVE PAYMENT MODEL.—

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

19 “(2) AUTHORITY TO USE APMS IN USE UNDER
20 TRADITIONAL MEDICARE.—Nothing in this section
21 shall preclude the Secretary from using alternative
22 payment models (as so defined) under this title that
23 are in use under title XVIII.

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

3 “Nothing in this title shall—

4 “(1) affect the benefits available under title
 5 XVIII; or

6 “(2) impact the Federal Hospital Insurance
 7 Trust Fund under section 1817 or the Federal Sup-
 8plementary Medical Insurance Trust Fund under
 9 section 1841 (including the Medicare Prescription
 10 Drug Account within such Trust Fund).”.

11 **SEC. 3. EXCLUSION OF PROVIDERS THAT PLACE ADDI-**
 12 **TIONAL RESTRICTIONS ON MEDICARE EX-**
 13 **CHANGE HEALTH PLAN PATIENTS FROM FED-**
 14 **ERAL HEALTH CARE PROGRAMS.**

15 Section 1128(b) of the Social Security Act (42 U.S.C.
 16 1320a–7(b)) is amended by adding at the end the fol-
 17 lowing new paragraph:

18 “(18) PLACEMENT OF RESTRICTIONS ON MEDI-
 19 CARE EXCHANGE HEALTH PLAN PATIENTS.—Any in-
 20 dividual or entity that places restrictions on the indi-
 21 viduals the individual or provider will accept for
 22 treatment and fails to either—

23 “(A) exempt enrollees in the Medicare Ex-
 24 change health plan established under title XXII
 25 from such restrictions; or

1 “(B) apply such restrictions to enrollees in
2 the Medicare Exchange health plan in the same
3 manner and to the same extent the restrictions
4 are applied to all other individuals seeking
5 care.”.

6 **SEC. 4. REINSURANCE.**

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

17 (b) AUTHORIZATION OF APPROPRIATIONS.—For pur-
18 poses of carrying out paragraph (1), there is authorized
19 to be appropriated \$10,000,000,000 for each of fiscal
20 years 2022, 2023, and 2024.

21 **SEC. 5. EXPANSION OF TAX CREDIT.**

22 (a) IN GENERAL.—Subparagraph (A) of section
23 36B(c)(1) of the Internal Revenue Code of 1986 is amend-
24 ed by striking “but does not exceed 400 percent”.

1 (b) APPLICABLE PERCENTAGES.—Section
 2 36B(b)(3)(A) of the Internal Revenue Code of 1986 is
 3 amended to read as follows:

4 “(A) APPLICABLE PERCENTAGE.—The ap-
 5 plicable percentage for any taxable year shall be
 6 the percentage such that the applicable percent-
 7 age for any taxpayer whose household income is
 8 within an income tier specified in the following
 9 table shall increase, on a sliding scale in a lin-
 10 ear manner, from the initial premium percent-
 11 age to the final premium percentage specified in
 12 such table for such income tier:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150 percent	0	0
150 percent up to 200 percent	0	2.0
200 percent up to 250 percent	2.0	4.0
250 percent up to 300 percent	4.0	6.0
300 percent up to 400 percent	6.0	8.5
400 percent and up	8.5	8.5.”.

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

16 (1) by striking “In the case of a taxpayer” and
 17 all that follows through “the amount of the in-
 18 crease” and inserting “The amount of the increase”;

1 (2) by striking the period at the end of the last
2 row of the table; and

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

“400 percent and up	\$5,000.”.
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5 (d) FIXING THE FAMILY GLITCH.—

6 (1) IN GENERAL.—Clause (i) of section
7 36B(c)(2)(C) of the Internal Revenue Code of 1986
8 is amended to read as follows:

9 “(i) COVERAGE MUST BE AFFORD-
10 ABLE.—

11 “(I) EMPLOYEES.—An employee
12 shall not be treated as eligible for
13 minimum essential coverage if such
14 coverage consists of an eligible em-
15 ployer-sponsored plan (as defined in
16 section 5000A(f)(2)) and the employ-
17 ee’s required contribution (within the
18 meaning of section 5000A(e)(1)(B))
19 with respect to the plan exceeds 9.5
20 percent of the employee’s household
21 income.

22 “(II) FAMILY MEMBERS.—An in-
23 dividual who is eligible to enroll in an
24 eligible employer-sponsored plan (as

1 defined in section 5000A(f)(2)) by
 2 reason of a relationship the individual
 3 bears to the employee shall not be
 4 treated as eligible for minimum essen-
 5 tial coverage by reason of such eligi-
 6 bility to enroll if the employee’s re-
 7 quired contribution (within the mean-
 8 ing of section 5000A(e)(1)(B), deter-
 9 mined by substituting ‘family’ for
 10 ‘self-only’) with respect to the plan ex-
 11 ceeds 9.5 percent of the employee’s
 12 household income.”.

13 (2) CONFORMING AMENDMENTS.—

14 (A) Clause (ii) of section 36B(c)(2)(C) of
 15 the Internal Revenue Code of 1986 is amended
 16 by striking “Except as provided in clause (iii),
 17 an employee” and inserting “An individual”.

18 (B) Clause (iii) of section 36B(c)(2)(C) of
 19 such Code is amended by striking “the last sen-
 20 tence of clause (i)” and inserting “clause
 21 (i)(II)”.

22 (C) Clause (iv) of section 36B(c)(2)(C) of
 23 such Code is amended by striking “the 9.5 per-
 24 cent under clause (i)(II)” and inserting “the
 25 9.5 percent under clauses (i)(I) and (i)(II)”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2021.

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

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

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

○