

115TH CONGRESS  
2D SESSION

# S. 2582

To provide health insurance reform, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MARCH 21, 2018

Ms. WARREN (for herself, Ms. HASSAN, Mr. SANDERS, Ms. HARRIS, Ms. BALDWIN, and Mrs. GILLIBRAND) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide health insurance reform, 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 “Consumer Health In-  
5 surance Protection Act of 2018”.

6 **SEC. 2. TABLE OF CONTENTS.**

7 The table of contents for this Act is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

TITLE I—LIMITING INSURER PROFITS AND PREVENTING  
UNREASONABLE PREMIUM INCREASES

Sec. 101. Medical loss ratio.

Sec. 102. Ensuring that consumers get value for their dollars.

Sec. 103. Effective date.

## TITLE II—MAKING HEALTH INSURANCE COVERAGE AFFORDABLE

- Sec. 201. Enhancement of premium assistance credit.
- Sec. 202. Enhancements for reduced cost-sharing.
- Sec. 203. Cap on prescription drug cost-sharing.
- Sec. 204. Standardized options in the bronze, silver, and gold levels of coverage.
- Sec. 205. Clarification regarding determination of affordability of employer-sponsored minimum essential coverage.

## TITLE III—ENSURING ACCESS TO CARE

- Sec. 301. Network adequacy requirements.
- Sec. 302. Ensuring adequate coverage in areas with fewer than 3 health insurance issuers offering qualified health plans on the State Exchange.
- Sec. 303. Enrollment in Exchanges.
- Sec. 304. Marketing and outreach for Exchanges operated by the Secretary.
- Sec. 305. Navigator program.

## TITLE IV—STRENGTHENING CONSUMER HEALTH INSURANCE PROTECTIONS

- Sec. 401. Prohibiting discriminatory premiums based on tobacco use.
- Sec. 402. Health insurance consumer information.
- Sec. 403. Patient protections.
- Sec. 404. Limitation on balance billing for emergency services.
- Sec. 405. Notification of provider terminations.
- Sec. 406. Short-term limited duration health insurance coverage.
- Sec. 407. Protecting essential health benefits.
- Sec. 408. Association health plans.

1 **TITLE I—LIMITING INSURER**  
 2 **PROFITS AND PREVENTING**  
 3 **UNREASONABLE PREMIUM**  
 4 **INCREASES**

5 **SEC. 101. MEDICAL LOSS RATIO.**

6 Section 2718(b)(1)(A)(ii) of the Public Health Serv-  
 7 ice Act (42 U.S.C. 300gg–18(b)(1)(A)(ii)) is amended by  
 8 striking “80” each place it appears and inserting “85”.

9 **SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR**  
 10 **THEIR DOLLARS.**

11 Section 2794 of the Public Health Service Act (42  
 12 U.S.C. 300gg–94) is amended—

1 (1) in subsection (a)—

2 (A) in paragraph (1), by striking “sub-  
3 section (b)(2)(A)” and inserting “subsections  
4 (b)(2)(A) and (b)(3)”; and

5 (B) in paragraph (2), by adding at the end  
6 the following: “Notwithstanding any other pro-  
7 vision of law, a health insurance issuer may not  
8 exclude from such disclosure information that is  
9 a trade secret or commercial or financial infor-  
10 mation described in section 552(b)(4) of title 5,  
11 United States Code.”;

12 (2) in subsection (b)—

13 (A) in paragraph (2)(A), by inserting “and  
14 paragraph (3)” after “subsection (a)(2)”; and

15 (B) by adding at the end the following:

16 “(3) PROHIBITING UNREASONABLE IN-  
17 CREASES.—

18 “(A) IN GENERAL.—Beginning with plan  
19 years beginning in 2020, the Secretary, or a  
20 State pursuant to an effective rate review pro-  
21 gram meeting the requirements under para-  
22 graph (4)—

23 “(i) shall, consistent with subsection  
24 (a)(2) and paragraph (2), review increases  
25 in health insurance premiums that are sub-

1           ject to review pursuant to section 154.200  
 2           of title 45, Code of Federal Regulations (or  
 3           any successor regulation), and determine  
 4           whether such increases are unreasonable;  
 5           and

6                   “(ii) may prohibit a health insurance  
 7           issuer from implementing such an increase  
 8           that is unreasonable.

9                   “(B) UNREASONABLE INCREASES.—In de-  
 10          termining whether an increase in health insur-  
 11          ance premiums is unreasonable under subpara-  
 12          graph (A)(i)—

13                   “(i) the Secretary shall consider  
 14          whether the increase is excessive, unjusti-  
 15          fied, discriminatory, or inadequate; and

16                   “(ii) the State, pursuant to an effec-  
 17          tive rate review program meeting the re-  
 18          quirements under paragraph (4), shall  
 19          apply applicable State law for making such  
 20          determination.

21                   “(4) STATE EFFECTIVE RATE REVIEW PRO-  
 22          GRAMS.—A State effective rate review program  
 23          meets the requirements under this paragraph if—

24                   “(A) the program carries out the reviews  
 25          described in paragraph (3)(A)(i) and ensures

1 that such reviews are a meaningful, effective,  
2 and timely review of the data and documenta-  
3 tion (including any contracts or documents de-  
4 scribed in subparagraph (E)) submitted by  
5 health insurance issuers in support of proposed  
6 increases in health insurance premiums;

7 “(B) such reviews include an examination  
8 of—

9 “(i) the affordability of proposed in-  
10 creases in health insurance premiums;

11 “(ii) the quality improvement activi-  
12 ties carried out by health insurance issuers  
13 proposing the increases; and

14 “(iii) the cost containment activities  
15 of health insurance issuers proposing the  
16 increases;

17 “(C) the program establishes a mechanism  
18 for receiving public comments on proposed in-  
19 creases in health insurance premiums reviewed  
20 by the State;

21 “(D) such reviews include a review of all  
22 public comments received under subparagraph  
23 (C);

24 “(E) the program requires each health in-  
25 surance issuer proposing an increase in health

1 insurance premiums to submit to the State any  
 2 provider contracts that may be affected, includ-  
 3 ing any documents incorporated by reference  
 4 into such contracts; and

5 “(F) the program requires the State to  
 6 provide the Secretary its determination of  
 7 whether each increase reviewed is unreasonable,  
 8 in a form and manner prescribed by the Sec-  
 9 retary.”; and

10 (3) in subsection (c)—

11 (A) in paragraph (1)—

12 (i) in the heading, by striking “2010  
 13 THROUGH 2014” and inserting “2020  
 14 THROUGH 2024”; and

15 (ii) in the matter preceding subpara-  
 16 graph (A), by striking “2010” and insert-  
 17 ing “2020”; and

18 (B) in paragraph (2)(B), by striking  
 19 “2014” and inserting “2024”.

20 **SEC. 103. EFFECTIVE DATE.**

21 The amendments made by this title shall apply to  
 22 plan years beginning after December 31, 2019.

1 **TITLE II—MAKING HEALTH IN-**  
 2 **SURANCE COVERAGE AF-**  
 3 **FORDABLE**

4 **SEC. 201. ENHANCEMENT OF PREMIUM ASSISTANCE CRED-**  
 5 **IT.**

6 (a) USE OF GOLD LEVEL PLAN FOR BENCHMARK.—

7 (1) IN GENERAL.—Clause (i) of section  
 8 36B(b)(2)(B) of the Internal Revenue Code of 1986  
 9 is amended by striking “applicable second lowest  
 10 cost silver plan” and inserting “applicable second  
 11 lowest cost gold plan”.

12 (2) CONFORMING AMENDMENT RELATED TO  
 13 AFFORDABILITY.—Section 36B(c)(4)(C)(i)(I) of  
 14 such Code is amended by striking “second lowest  
 15 cost silver plan” and inserting “second lowest cost  
 16 gold plan”.

17 (3) OTHER CONFORMING AMENDMENTS.—Sub-  
 18 paragraphs (B) and (C) of section 36B(b)(3) of such  
 19 Code are each amended by striking “silver plan”  
 20 each place it appears in the text and the heading  
 21 and inserting “gold plan”.

22 (b) EXPANSION OF ELIGIBILITY FOR REFUNDABLE  
 23 CREDITS FOR COVERAGE UNDER QUALIFIED HEALTH  
 24 PLANS.—

1           (1) IN GENERAL.—Section 36B(e)(1)(A) of the  
2 Internal Revenue Code of 1986 is amended by strik-  
3 ing “but does not exceed 400 percent”.

4           (2) CONFORMING AMENDMENTS RELATING TO  
5 RECAPTURE OF EXCESS ADVANCED PAYMENTS.—  
6 Clause (i) of section 36B(f)(2)(B) of such Code is  
7 amended—

8                   (A) by striking “In the case of” and all  
9 that follows through “the amount of” and in-  
10 sserting “The amount of”; and

11                   (B) by striking “but less than 400%” in  
12 the table therein.

13           (c) DETERMINATION OF APPLICABLE PERCENT-  
14 AGE.—

15           (1) IN GENERAL.—Subparagraph (A) of section  
16 36B(b)(3) of the Internal Revenue Code of 1986 is  
17 amended to read as follows:

18                   “(A) APPLICABLE PERCENTAGE.—The ap-  
19 plicable percentage for any taxable year shall be  
20 the percentage such that the applicable percent-  
21 age for any taxpayer whose household income is  
22 within an income tier specified in the following  
23 table shall increase, on a sliding scale in a lin-  
24 ear manner, from the initial premium percent-



1                   age to the final premium percentage specified in  
 2                   such table for such income tier:

| “In the case of household<br>income (expressed as a<br>percent of poverty line) within<br>the following income tier: | The initial<br>premium<br>percentage is— | The final<br>premium<br>percentage is— |
|--|--|--|
| 100% through 133% .....  | 0.0%                                     | 1.0%                                   |
| 133% through 150% .....  | 1.0%                                     | 2.0%                                   |
| 150% through 200% .....  | 2.0%                                     | 4.0%                                   |
| 200% through 250% .....  | 4.0%                                     | 6.0%                                   |
| 250% through 300% .....  | 6.0%                                     | 7.0%                                   |
| 300% through 400% .....  | 7.0%                                     | 8.5%                                   |
| Over 400% .....  | 8.5%                                     | 8.5%”.                                 |

3                   (2) CONFORMING AMENDMENTS.—Subsections  
 4                   (c)(2)(C)(iv) and (c)(4)(F) of section 36B of the In-  
 5                   ternal Revenue Code of 1986 are each amended by  
 6                   inserting “(as in effect before the date of the enact-  
 7                   ment of the Consumer Health Insurance Protection  
 8                   Act of 2018)” after “subsection (b)(3)(A)(ii)”.

9                   (d) EFFECTIVE DATE.—The amendments made by  
 10                  this section shall apply to taxable years beginning after  
 11                  December 31, 2019.

12                  **SEC. 202. ENHANCEMENTS FOR REDUCED COST-SHARING.**

13                  (a) MODIFICATION OF AMOUNT.—

14                   (1) IN GENERAL.—Section 1402 of the Patient  
 15                  Protection and Affordable Care Act (42 U.S.C.  
 16                  18071) is amended—

17                   (A) in subsection (b)(1), by striking “sil-  
 18                  ver” and inserting “gold”;

19                   (B) by amending subsection (c)(1)(B) to  
 20                  read as follows:

1           “(B) COORDINATION WITH ACTUARIAL  
2           LIMITS.—The Secretary shall ensure the reduc-  
3           tion under this paragraph shall not result in the  
4           plan’s share of the total allowed costs of bene-  
5           fits provided under the plan becoming less  
6           than—

7                   “(i) 95 percent in the case of an eligi-  
8                   ble insured described in paragraph (2)(A);

9                   “(ii) 90 percent in the case of an eli-  
10                  gible insured described in paragraph  
11                  (2)(B); and

12                  “(iii) 85 percent in the case of an eli-  
13                  gible insured described in paragraph  
14                  (2)(C).”; and

15                  (C) by amending subsection (c)(2) to read  
16                  as follows:

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

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

1           crease the plan’s share of the total allowed  
2           costs of benefits provided under the plan to 95  
3           percent of such costs;

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

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

18          (2) EFFECTIVE DATE.—The amendments made  
19          by this subsection shall apply to plan years begin-  
20          ning after December 31, 2019.

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

24          “(g) FUNDING.—Out of any funds in the Treasury  
25          not otherwise appropriated, there are appropriated to the

1 Secretary such sums as may be necessary for payments  
2 under this section.”.

3 **SEC. 203. CAP ON PRESCRIPTION DRUG COST-SHARING.**

4 (a) QUALIFIED HEALTH PLANS.—Section 1302(c) of  
5 the Patient Protection and Affordable Care Act (42  
6 U.S.C. 18022(c)) is amended—

7 (1) in paragraph (3)(A)(i), by inserting “(in-  
8 cluding cost-sharing with respect to prescription  
9 drugs covered by the plan)” after “copayments”;  
10 and

11 (2) by adding at the end the following:

12 “(5) PRESCRIPTION DRUG COST-SHARING.—

13 “(A) 2020.—For plan years beginning in  
14 2020, the cost-sharing incurred under a health  
15 plan with respect to prescription drugs covered  
16 by the plan shall not exceed \$250 per month for  
17 each enrolled individual, or \$500 for each fam-  
18 ily.

19 “(B) 2021 AND LATER.—

20 “(i) IN GENERAL.—In the case of any  
21 plan year beginning in a calendar year  
22 after 2020, the limitation under this para-  
23 graph shall be equal to the applicable dol-  
24 lar amount under subparagraph (A) for  
25 plan years beginning in 2020, increased by

1 an amount equal to the product of that  
 2 amount and the medical care component of  
 3 the consumer price index for all urban con-  
 4 sumers (as published by the Bureau of  
 5 Labor Statistics) for that year.

6 “(ii) ADJUSTMENT TO AMOUNT.—If  
 7 the amount of any increase under clause  
 8 (i) is not a multiple of \$5, such increase  
 9 shall be rounded to the next lowest mul-  
 10 tiple of \$5.”.

11 (b) GROUP HEALTH PLANS.—Section 2707(b) of the  
 12 Public Health Service Act (42 U.S.C. 300gg–6(b)) is  
 13 amended by striking “paragraph (1) of section 1302(c)”  
 14 and inserting “paragraphs (1) and (5) of section 1302(c)  
 15 of the Patient Protection and Affordable Care Act”.

16 (c) EFFECTIVE DATE.—The amendments made by  
 17 subsections (a) and (b) shall take effect with respect to  
 18 plans beginning after December 31, 2019.

19 **SEC. 204. STANDARDIZED OPTIONS IN THE BRONZE, SIL-**  
 20 **VER, AND GOLD LEVELS OF COVERAGE.**

21 (a) IN GENERAL.—Section 1301(a) of the Patient  
 22 Protection and Affordable Care Act (42 U.S.C. 18021(a))  
 23 is amended—

24 (1) in paragraph (1)(C)—

1 (A) in clause (iii), by striking “; and” and  
2 inserting “;”;

3 (B) by redesignating clause (iv) as clause  
4 (v); and

5 (C) by inserting after clause (iii) the fol-  
6 lowing:

7 “(iv)(I) agrees to offer the standard-  
8 ized option established for the State under  
9 paragraph (5) for each level of coverage of-  
10 fered by the issuer that is the bronze, sil-  
11 ver, or gold level of coverage; and

12 “(II) with respect to offering coverage  
13 that is the bronze, silver, or gold level of  
14 coverage on an Exchange that is operated  
15 by the Secretary, agrees to offer only  
16 standardized options established for the  
17 State under paragraph (5) and not any  
18 other plan for such levels of coverage;  
19 and”;

20 (2) by adding at the end the following:

21 “(5) STANDARDIZED OPTIONS.—

22 “(A) DEFINITION OF STANDARDIZED OP-  
23 TION.—In this section, the term ‘standardized  
24 option’ means a qualified health plan—

1           “(i) with a standardized cost-sharing  
2 structure established by the applicable  
3 State, or the Secretary, in accordance with  
4 this paragraph; and

5           “(ii) that is offered on an Exchange.

6           “(B) ESTABLISHMENT.—

7           “(i) STATE.—Each State may estab-  
8 lish a standardized option for the bronze,  
9 silver, and gold levels of coverage.

10           “(ii) SECRETARY.—The Secretary  
11 shall establish a standardized option in a  
12 State for any level of coverage described in  
13 clause (i) for which the State has not es-  
14 tablished a standardized option.

15           “(iii) UPDATES.—The Secretary shall  
16 annually update any standardized option  
17 established by the Secretary under clause  
18 (ii).

19           “(C) DEDUCTIBLE-EXEMPT SERVICES.—

20           “(i) IN GENERAL.—Except as pro-  
21 vided in clause (ii), each standardized op-  
22 tion established by the Secretary under  
23 subparagraph (B)(ii) shall include coverage  
24 of each of the following as deductible-ex-  
25 empt services:

1 “(I) All primary care visits and  
2 specialist visits.

3 “(II) All mental health and sub-  
4 stance use disorder outpatient serv-  
5 ices.

6 “(III) All drugs approved under  
7 section 505(j) of the Federal Food,  
8 Drug, and Cosmetic Act and biological  
9 products licensed under section  
10 351(k) of the Public Health Service  
11 Act.

12 “(IV) All urgent care services.

13 “(ii) BRONZE AND SILVER LEVELS OF  
14 COVERAGE.—The Secretary may alter the  
15 services that shall be covered as deductible-  
16 exempt services under clause (i) for stand-  
17 ardized options in the bronze and silver  
18 levels of coverage.

19 “(D) DISPLAY.—Each Exchange operated  
20 by a State shall preferentially display the stand-  
21 ardized options offered in such State on the  
22 website of the Exchange.”.

23 (b) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to plans beginning after December  
25 31, 2019.



1 **SEC. 205. CLARIFICATION REGARDING DETERMINATION OF**  
2 **AFFORDABILITY OF EMPLOYER-SPONSORED**  
3 **MINIMUM ESSENTIAL COVERAGE.**

4 (a) SPECIAL RULE FOR EMPLOYER-SPONSORED  
5 MINIMUM ESSENTIAL COVERAGE.—Clause (i) of section  
6 36B(c)(2)(C) of the Internal Revenue Code of 1986 is  
7 amended to read as follows:

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

10 “(I) IN GENERAL.—Except as  
11 provided in clause (iii), an individual  
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 required  
17 contribution with respect to the plan  
18 exceeds 8.5 percent of the applicable  
19 taxpayer’s household income.

20 “(II) REQUIRED CONTRIBUTION  
21 WITH RESPECT TO EMPLOYEE.—In  
22 the case of the employee eligible to en-  
23 roll in the plan, the required contribu-  
24 tion for purposes of subclause (I) is  
25 the employee’s required contribution  
26 (within the meaning of section

1 5000A(e)(1)(B)(i) with respect to the  
2 plan.

3 “(III) REQUIRED CONTRIBUTION  
4 WITH RESPECT TO FAMILY MEM-  
5 BERS.—In the case of an individual  
6 who is eligible to enroll in the plan by  
7 reason of a relationship the individual  
8 bears to the employee, the required  
9 contribution for purposes of subclause  
10 (I) is the employee’s required con-  
11 tribution (within the meaning of sec-  
12 tion 5000A(e)(1)(B)(i), determined by  
13 substituting ‘family’ for ‘self-only’)  
14 with respect to the plan.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) Clause (ii) of section 36B(c)(2)(C) of the  
17 Internal Revenue Code of 1986 is amended by add-  
18 ing at the end the following: “This clause shall also  
19 apply to an individual who is eligible to enroll in the  
20 plan by reason of a relationship the individual bears  
21 to the employee.”.

22 (2) Clause (iii) of section 36B(c)(2)(C) of such  
23 Code is amended by striking “the last sentence of  
24 clause (i)” and inserting “clause (i)(III)”.

1           (3) Clause (iv) of section 36B(c)(2)(C) of such  
 2           Code is amended by striking “clause (i)(II)” and in-  
 3           serting “clause (i)(I)”.

4           (c) EFFECTIVE DATE.—The amendments made by  
 5           this section shall apply to taxable years beginning after  
 6           December 31, 2019.

7           **TITLE III—ENSURING ACCESS**  
 8           **TO CARE**

9           **SEC. 301. NETWORK ADEQUACY REQUIREMENTS.**

10          (a) IN GENERAL.—Section 1311(c) of the Patient  
 11          Protection and Affordable Care Act (42 U.S.C. 18031(c))  
 12          is amended—

13                 (1) in paragraph (1)(B), by inserting “and  
 14                 paragraph (7) and in accordance with paragraph  
 15                 (8)” after “Public Health Service Act”; and

16                 (2) by adding at the end the following:

17                         “(7) NETWORK ADEQUACY REQUIREMENTS.—

18                                 “(A) IN GENERAL.—A qualified health  
 19                                 plan shall meet the network adequacy standards  
 20                                 established by the Secretary under subpara-  
 21                                 graph (B), except as provided in subparagraphs  
 22                                 (B)(ii) and (C).

23                                 “(B) FEDERAL STANDARDS AND RE-  
 24                                 VIEW.—

25   “(i) STANDARD.—

1                   “(I) ESTABLISHMENT.—The Sec-  
2                   retary shall establish a network ade-  
3                   quacy standard based on access to in-  
4                   network providers for qualified health  
5                   plans, except for those plans described  
6                   in subparagraph (C). Such standard  
7                   shall include requirements for the  
8                   minimum number and type of in-net-  
9                   work providers available, the geo-  
10                  graphical location of such providers,  
11                  the average distance and travel time  
12                  required for patients to visit such pro-  
13                  viders, and the average appointment  
14                  wait times for services covered by the  
15                  plan.

16                  “(II) MEDICARE ADVANTAGE OR-  
17                  GANIZATIONS.—The network ade-  
18                  quacy standard established under sub-  
19                  clause (I) shall, at a minimum, be  
20                  equivalent to the requirements for ac-  
21                  cess to services applicable to Medicare  
22                  Advantage organizations offering  
23                  Medicare Advantage plans under part  
24                  C of title XVIII of the Social Security  
25                  Act.

1           “(ii) JUSTIFICATION.—A qualified  
2 health plan that fails to meet the standard  
3 established under clause (i) may satisfy the  
4 requirement under subparagraph (A) by  
5 providing the Secretary with a reasonable  
6 justification for the variance from such  
7 standard, based on factors such as the  
8 availability of providers and variables re-  
9 flected in local patterns of health care.

10           “(iii) REVIEW.—The Secretary shall  
11 establish a process for reviewing the net-  
12 work adequacy of qualified health plans,  
13 except for those plans reviewed by the  
14 State in accordance with subparagraph  
15 (C)(ii).

16           “(C) STATE STANDARD.—

17           “(i) IN GENERAL.—In the case of a  
18 qualified health plan offered in a State  
19 that has implemented a quantifiable net-  
20 work adequacy metric that the Secretary  
21 determines is an acceptable metric com-  
22 monly used in the health insurance indus-  
23 try to measure network adequacy, such  
24 qualified health plan may satisfy the re-  
25 quirement under subparagraph (A) by

1 meeting the network adequacy standards  
2 of such State based on such metric.

3 “(ii) REVIEW.—A State with an ac-  
4 ceptable metric described in clause (i) may  
5 review the network adequacy of qualified  
6 health plans offered in such State in a  
7 process established by the State.

8 “(8) COVERAGE OF OUT-OF-NETWORK ESSEN-  
9 TIAL HEALTH BENEFITS.—

10 “(A) IN GENERAL.—A qualified health  
11 plan shall provide, to an individual enrolled in  
12 such plan, coverage of any service provided by  
13 an out-of-network provider if—

14 “(i) coverage of such service would  
15 otherwise be provided by the plan if the  
16 service was provided by an in-network pro-  
17 vider;

18 “(ii) the service is included in the es-  
19 sential health benefits package described in  
20 section 1302(a); and

21 “(iii) the service cannot be provided to  
22 the individual by an in-network provider  
23 within a reasonable timeframe or within a  
24 reasonable distance and travel time.

1           “(B) COST-SHARING.—A qualified health  
2           plan that provides coverage of a service pro-  
3           vided by an out-of-network provider under sub-  
4           paragraph (A) shall provide such coverage with  
5           the same cost-sharing requirements as if the  
6           service was provided by an in-network pro-  
7           vider.”.

8           (b) EFFECTIVE DATE.—The amendments made by  
9           subsection (a) shall apply to plans beginning after Decem-  
10          ber 31, 2019.

11          (c) GRANTS FOR STATE NETWORK ADEQUACY RE-  
12          VIEWS.—

13           (1) IN GENERAL.—The Secretary of Health and  
14          Human Services shall carry out a program to award  
15          grants to States during the 5-year period beginning  
16          with fiscal year 2020 to assist such States in devel-  
17          oping a metric to measure network adequacy as de-  
18          scribed in subparagraph (C)(i) of section 1311(c)(7)  
19          of the Patient Protection and Affordable Care Act  
20          (42 U.S.C. 18031(c)(7)) and to carry out the re-  
21          views described in subparagraph (C)(ii) of such sec-  
22          tion.

23           (2) AUTHORIZATION OF APPROPRIATIONS.—  
24          There are authorized to be appropriated for fiscal  
25          years 2020 through 2024 such sums as may be nec-

1        essary to carry out the grant program under this  
2        subsection.

3        **SEC. 302. ENSURING ADEQUATE COVERAGE IN AREAS WITH**  
4                               **FEWER THAN 3 HEALTH INSURANCE ISSUERS**  
5                               **OFFERING QUALIFIED HEALTH PLANS ON**  
6                               **THE STATE EXCHANGE.**

7        (a) REQUIREMENTS FOR MEDICARE ADVANTAGE OR-  
8        GANIZATIONS.—

9                (1) IN GENERAL.—Section 1857(e) of the So-  
10        cial Security Act (42 U.S.C. 1395w–27(e)) is  
11        amended by adding at the end the following new  
12        paragraph:

13                       “(5) REQUIREMENT FOR CERTAIN MEDICARE  
14        ADVANTAGE ORGANIZATIONS THAT OFFER AN MA  
15        PLAN IN AN APPLICABLE AREA TO ALSO OFFER  
16        QUALIFIED HEALTH PLANS IN THE APPLICABLE  
17        AREA.—

18                       “(A) IN GENERAL.—A contract under this  
19        section with an MA organization described in  
20        subparagraph (B) shall require the organization  
21        to, in each applicable area in which the organi-  
22        zation offers an MA plan, also offer, through  
23        the individual market in the Exchange oper-  
24        ating in the State, at least one qualified health  
25        plan in the silver level of coverage and at least



1 one qualified health plan in the gold level of  
2 coverage, as described in section 1302(d) of the  
3 Patient Protection and Affordable Care Act.

4 “(B) MA ORGANIZATIONS DESCRIBED.—  
5 An MA organization described in this subpara-  
6 graph is an MA organization that, in addition  
7 to offering an MA plan in an applicable area,  
8 offers health insurance coverage in the group  
9 market or individual market in the State but  
10 does not offer such coverage through the Ex-  
11 change operating in the State.

12 “(C) NOTIFICATION.—The Secretary, or  
13 the State in the case of an MA organization of-  
14 fering an MA plan in an applicable area in a  
15 State with an Exchange operated by the State,  
16 shall notify each MA organization that is re-  
17 quired to offer a qualified health plan under  
18 subparagraph (A) for a plan year of such re-  
19 quirement. Such notification shall be provided  
20 each year—

21 “(i) beginning with respect to the re-  
22 quirement for plan years beginning after  
23 December 31, 2019; and

24 “(ii) not less than 1 year prior to the  
25 rate filing deadline for the plan year for

1 the Exchange operating in the State in  
2 which the MA organization will be required  
3 to offer such plan.

4 “(D) WAIVER.—The Secretary, or the  
5 State in the case of an MA organization offer-  
6 ing an MA plan in an applicable area in a State  
7 with an Exchange operated by the State, may  
8 waive the requirement under subparagraph (A)  
9 if—

10 “(i) by the first day of the plan year,  
11 the number of health insurance issuers of-  
12 fering a qualified health plan through the  
13 individual market in the Exchange has in-  
14 creased such that the applicable area no  
15 longer has fewer than 3 health insurance  
16 issuers offering a qualified health plan  
17 through the individual market in the Ex-  
18 change operating in the State; or

19 “(ii) the Secretary, or the State in  
20 such a case, determines that the require-  
21 ment under subparagraph (A) would cause  
22 the MA organization to become insolvent.

23 “(E) DEFINITIONS.—In this paragraph:

24 “(i) APPLICABLE AREA.—The term  
25 ‘applicable area’ means an area in which,

1 at the time the Secretary or the State  
2 sends the notification under subparagraph  
3 (C), fewer than 3 health insurance issuers  
4 offer a qualified health plan through the  
5 individual market in the Exchange oper-  
6 ating in the State.

7 “(ii) EXCHANGE.—The term ‘Ex-  
8 change’ means an American Health Ben-  
9 efit Exchange established under section  
10 1311 or section 1321 of the Patient Pro-  
11 tection and Affordable Care Act.

12 “(iii) GROUP MARKET.—The term  
13 ‘group market’ has the meaning given such  
14 term in section 1304 of the Patient Protec-  
15 tion and Affordable Care Act.

16 “(iv) HEALTH INSURANCE COV-  
17 ERAGE.—The term ‘health insurance cov-  
18 erage’ has the meaning given the term in  
19 section 2791(b) of the Public Health Serv-  
20 ice Act.

21 “(v) INDIVIDUAL MARKET.—The term  
22 ‘individual market’ has the meaning given  
23 such term in section 1304 of the Patient  
24 Protection and Affordable Care Act.

1                   “(vi) QUALIFIED HEALTH PLAN.—  
 2                   The term ‘qualified health plan’ has the  
 3                   meaning given that term in section  
 4                   1301(a) of the Patient Protection and Af-  
 5                   fordable Care Act.”.

6                   (2) EFFECTIVE DATE.—The amendment made  
 7                   by this subsection shall apply to contracts entered  
 8                   into or renewed after December 31, 2019.

9                   (b) REQUIREMENTS FOR MEDICAID MANAGED CARE  
 10 ORGANIZATIONS.—

11                   (1) IN GENERAL.—Section 1903(m)(2)(A) of  
 12                   the Social Security Act (42 U.S.C. 1396b(m)(2)(A))  
 13                   is amended—

14                   (A) in clause (xii), by striking “; and” and  
 15                   inserting a semicolon;

16                   (B) by realigning the left margin of clause  
 17                   (xiii) to align with the left margin of clause  
 18                   (xii);

19                   (C) in clause (xiii), by striking the period  
 20                   at the end and inserting “; and”; and

21                   (D) by inserting after clause (xiii) the fol-  
 22                   lowing:

23                   “(xiv) such contract requires that the enti-  
 24                   ty meets the requirements described in section

1           1857(e)(5) in the same manner as such require-  
2           ments apply to an MA organization.”.

3           (2) EFFECTIVE DATE.—The amendments made  
4           by this subsection shall apply to contracts entered  
5           into or renewed after December 31, 2019.

6 **SEC. 303. ENROLLMENT IN EXCHANGES.**

7           (a) OPEN ENROLLMENT AND SPECIAL ENROLLMENT  
8 PERIODS.—Section 1311(c)(6) of the Patient Protection  
9 and Affordable Care Act (42 U.S.C. 18031(c)(6)) is  
10 amended—

11           (1) in subparagraph (B), by inserting “that are  
12           not less than 8 weeks” after “open enrollment peri-  
13           ods”;

14           (2) in subparagraph (C), by striking “; and”  
15           and inserting “;”;

16           (3) in subparagraph (D), by striking the period  
17           and inserting “; and”; and

18           (4) by adding at the end the following:

19           “(E) a special enrollment period for indi-  
20           viduals enrolled in a plan that makes significant  
21           provider terminations during the plan year, as  
22           determined in accordance with regulations pro-  
23           mulgated by the Secretary.”.

24           (b) CONSUMER PROTECTIONS REGARDING AUTO-  
25           MATIC RE-ENROLLMENT.—Part 2 of subtitle D of title I

1 of the Patient Protection and Affordable Care Act (42  
2 U.S.C. 18031 et seq.) is amended by adding at the end  
3 the following:

4 **“SEC. 1314. CONSUMER PROTECTIONS REGARDING AUTO-**  
5 **MATIC RE-ENROLLMENT.**

6 “(a) CONSENT TO AVOID AUTOMATIC RE-ENROLL-  
7 MENT FOR INDIVIDUALS LOSING ELIGIBILITY FOR PRE-  
8 MIUM TAX CREDITS.—The Secretary shall establish a  
9 process to allow an individual, who is enrolling in a quali-  
10 fied health plan through an Exchange and whom the Ex-  
11 change estimates is eligible to receive a premium tax credit  
12 under section 36B of the Internal Revenue Code of 1986,  
13 to provide consent to the Exchange to not automatically  
14 re-enroll the individual in such qualified health plan (or  
15 a comparable qualified health plan in a case described in  
16 subsection (b)) for the following plan year if during the  
17 plan year the Exchange estimates that the individual has  
18 become no longer eligible to receive such credit.

19 “(b) NOTICE REGARDING DISCONTINUED PLANS.—  
20 In the case of an individual who is enrolled in a qualified  
21 health plan through an Exchange for a plan year that will  
22 not be offered through such Exchange for the following  
23 plan year, the Exchange through which such plan is of-  
24 fered shall, prior to the open enrollment period for the  
25 following plan year, send the individual a notice stating—

1           “(1) that the qualified health plan in which the  
2 individual is enrolled will not be offered through  
3 such Exchange for the following plan year;

4           “(2) that unless the individual takes action, the  
5 individual will be enrolled in a comparable qualified  
6 health plan for the following plan year;

7           “(3) the estimated amount of premiums for  
8 such comparable qualified health plan; and

9           “(4) clear information on the eligibility of the  
10 individual for a special enrollment period.

11       “(c) NOTICE REGARDING AUTOMATIC RE-ENROLL-  
12 MENT.—Any notice regarding automatic re-enrollment  
13 sent by an Exchange to an individual enrolled in a quali-  
14 fied health plan shall be provided to the individual in the  
15 language that the individual has indicated to the Ex-  
16 change as the preferred language of the individual.”.

17       “(c) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to plan years beginning after the  
19 date of enactment of this Act.

20       “(d) STUDY.—The Secretary shall conduct a study  
21 that examines the practices used by the Exchanges for no-  
22 tifying consumers of automatic re-enrollment in qualified  
23 health plans and identifies strategies for—

24           (1) improving automatic re-enrollment and re-  
25 newal notifications;

1           (2) improving the ability to reach consumers in  
2           providing such notices;

3           (3) increasing consumer comprehension of such  
4           notices; and

5           (4) encouraging consumers to—

6                   (A) update information that will affect eli-  
7                   gibility for premium tax credits under section  
8                   36B of the Internal Revenue Code of 1986 and  
9                   the amount of such credits; and

10                   (B) shop for qualified health plans that  
11                   will best meet their needs through the Ex-  
12                   change operating in their State.

13 **SEC. 304. MARKETING AND OUTREACH FOR EXCHANGES**  
14 **OPERATED BY THE SECRETARY.**

15           Part 2 of subtitle D of title I of the Patient Protec-  
16           tion and Affordable Care Act (42 U.S.C. 18031 et seq.),  
17           as amended by section 303(b), is further amended by add-  
18           ing at the end the following:

19 **“SEC. 1315. MARKETING AND OUTREACH FOR EXCHANGES**  
20 **OPERATED BY THE SECRETARY.**

21           “(a) IN GENERAL.—Out of the funds appropriated  
22           under subsection (b), the Secretary shall conduct a mar-  
23           keting and outreach program with respect to qualified  
24           health plans offered in Exchanges operated by the Sec-  
25           retary in order to encourage enrollment in such plans.



1 “(b) APPROPRIATION.—

2 “(1) ENCOURAGING ENROLLMENT FOR PLAN  
3 YEAR 2019.—There is appropriated to the Secretary,  
4 out of any moneys in the Treasury not otherwise ap-  
5 propriated, \$480,000,000 to carry out the marketing  
6 and outreach program under subsection (a) with re-  
7 spect to encouraging enrollment for qualified health  
8 plans that begin in calendar year 2019.

9 “(2) ENCOURAGING ENROLLMENT FOR SUBSE-  
10 QUENT PLAN YEARS.—To carry out the marketing  
11 and outreach program under subsection (a) with re-  
12 spect to encouraging enrollment for qualified health  
13 plans that begin in each of calendar years 2020  
14 through 2024, there is appropriated to the Secretary  
15 prior to each such calendar year, out of any moneys  
16 in the Treasury not otherwise appropriated, an  
17 amount equal to the amount appropriated under this  
18 subsection for the prior calendar year increased by  
19 4 percent for each such calendar year.

20 “(3) AVAILABILITY.—The amounts appro-  
21 priated under paragraphs (1) and (2) shall remain  
22 available until expended.”.

23 **SEC. 305. NAVIGATOR PROGRAM.**

24 Section 1311(i) of the Patient Protection and Afford-  
25 able Care Act (42 U.S.C. 18031(i)) is amended—

1 (1) in paragraph (2)—

2 (A) in subparagraph (B), by striking “and  
3 other entities” and inserting “and other entities  
4 (such as Indian tribes, tribal organizations,  
5 urban Indian organizations, and State or local  
6 human service agencies)”; and

7 (B) by adding at the end the following:

8 “(C) PREFERENCE.—An Exchange shall  
9 ensure that, each year, it awards a grant under  
10 paragraph (1) to—

11 “(i) at least one entity described in  
12 this paragraph that is a community and  
13 consumer-focused nonprofit group; and

14 “(ii) at least one entity described in  
15 subparagraph (B), which may include an-  
16 other community and consumer-focused  
17 nonprofit group.”;

18 (2) in paragraph (3)—

19 (A) in subparagraph (D), by striking “;  
20 and” and inserting “;”;

21 (B) in subparagraph (E), by striking the  
22 period and inserting “; and”; and

23 (C) by adding at the end the following:

24 “(F) provide targeted assistance to individ-  
25 uals likely to qualify for a special enrollment

1 period under subparagraph (C), (D), or (E) of  
2 subsection (c)(6).”; and

3 (3) in paragraph (4)(A)—

4 (A) in the matter preceding clause (i), by  
5 striking “not”;

6 (B) in clause (i)—

7 (i) by inserting “not” before “be”;

8 and

9 (ii) by striking “; or” and inserting  
10 “;”;

11 (C) in clause (ii)—

12 (i) by inserting “not” before “re-  
13 ceive”; and

14 (ii) by striking the period and insert-  
15 ing “;”; and

16 (D) by adding at the end the following:

17 “(iii) maintain physical presence in  
18 the State of the Exchange so as to allow  
19 in-person assistance to consumers; and

20 “(iv) not provide compensation to an  
21 employee employed by the navigator based  
22 on the number of individuals the employee  
23 assists in enrolling in qualified health  
24 plans.”.

1 **TITLE IV—STRENGTHENING**  
2 **CONSUMER HEALTH INSUR-**  
3 **ANCE PROTECTIONS**

4 **SEC. 401. PROHIBITING DISCRIMINATORY PREMIUMS**  
5 **BASED ON TOBACCO USE.**

6 (a) IN GENERAL.—Section 2701(a)(1)(A) of the  
7 Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is  
8 amended—

9 (1) in clause (ii), by inserting “and” after the  
10 semicolon; and

11 (2) by striking clause (iv).

12 (b) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to plan years beginning after De-  
14 cember 31, 2019.

15 **SEC. 402. HEALTH INSURANCE CONSUMER INFORMATION.**

16 Section 2793 of the Public Health Service Act (42  
17 U.S.C. 300gg–93) is amended—

18 (1) in subsection (d)—

19 (A) in the second sentence, by striking  
20 “and shall share” and inserting “, shall share”;  
21 and

22 (B) by striking the period at the end of  
23 second sentence and inserting “, and (not later  
24 than 2 years after the date of enactment of the  
25 Consumer Health Insurance Protection Act of

1           2018) shall make such data available to the  
2           public in a searchable format on an internet  
3           website established by the Secretary.”; and

4           (2) in subsection (e)—

5                 (A) in paragraph (1), by striking  
6                 “\$30,000,000 for the first fiscal year for which  
7                 this section applies” and inserting  
8                 “\$50,000,000 for each of fiscal years 2020  
9                 through 2024”; and

10                (B) in paragraph (2), by striking “each  
11                fiscal year following the fiscal year described in  
12                paragraph (1)” and inserting “fiscal year 2025  
13                and each fiscal year thereafter”.

14   **SEC. 403. PATIENT PROTECTIONS.**

15           (a) IN GENERAL.—Section 2719A of the Public  
16   Health Service Act (42 U.S.C. 300gg–19a) is amended—

17                (1) in subsection (b)—

18                   (A) in paragraph (1), by striking “para-  
19                   graph (2)(B)” and inserting “paragraph  
20                   (3)(B)”;

21                   (B) by redesignating paragraph (2) as  
22                   paragraph (3); and

23                   (C) by inserting after paragraph (1) the  
24                   following:

1           “(2) REIMBURSEMENT.—A group health plan  
2 or health insurance issuer offering group or indi-  
3 vidual health insurance coverage shall reimburse an  
4 out-of-network provider providing emergency services  
5 to an individual enrolled in such plan or coverage at  
6 an amount equal to the greatest of—

7           “(A) the median amount negotiated with  
8 in-network providers for the emergency service;

9           “(B) the amount for the emergency service  
10 calculated using the same method the plan or  
11 issuer generally uses to determine payments for  
12 out-of-network services; or

13           “(C) the amount that would be paid to a  
14 provider of services or supplier with respect to  
15 the furnishing of such service under title XVIII  
16 of the Social Security Act.”; and

17           (2) by adding at the end the following:

18           “(e) COVERAGE OF SERVICES BY OUT-OF-NETWORK  
19 PROVIDERS BASED ON PLAN OR ISSUER ERROR.—

20           “(1) IN GENERAL.—A group health plan or  
21 health insurance issuer offering group or individual  
22 health insurance coverage shall provide coverage of  
23 a service provided by an out-of-network provider to  
24 an individual enrolled in such plan or coverage if—

1           “(A) the plan or issuer would have pro-  
2           vided coverage for the service if the service was  
3           provided by an in-network provider; and

4           “(B) in choosing such provider, the indi-  
5           vidual reasonably relied on a materially inac-  
6           curate, incomplete, or misleading statement of  
7           information contained in a directory, compiled  
8           by the plan or issuer, of in-network providers.

9           “(2) COST-SHARING.—A group health plan or  
10          health insurance issuer that provides coverage of a  
11          service provided by an out-of-network provider under  
12          paragraph (1) shall provide such coverage with the  
13          same cost-sharing requirements as if the service was  
14          provided by an in-network provider.

15          “(f) COVERAGE FOR ENROLLEES IN ACTIVE COURSE  
16          OF TREATMENT.—

17                 “(1) IN GENERAL.—A group health plan or  
18          health insurance issuer offering group or individual  
19          health insurance coverage shall, at the request of an  
20          individual enrolled in such plan or coverage and sub-  
21          ject to paragraph (3), provide covered services (as  
22          defined in paragraph (4)) by an out-of-network pro-  
23          vider for such individual in accordance with para-  
24          graph (2) if—

1           “(A) the individual is receiving an active  
2 course of treatment from such out-of-network  
3 provider that was occurring while the individual  
4 was enrolled in a different health plan offered  
5 by such plan or issuer for the prior plan year  
6 that has been discontinued by such plan or  
7 issuer, including a case where such plan is with-  
8 drawn from the market, and such provider was  
9 an in-network provider under such different  
10 health plan; or

11           “(B) the individual is receiving an active  
12 course of treatment from such out-of-network  
13 provider for a plan year in which the provider  
14 was an in-network provider of the plan or issuer  
15 but became a terminated provider with respect  
16 to such plan or issuer for such plan year.

17           “(2) DURATION AND RATES OF COVERAGE.—

18           “(A) DURATION.—The coverage for an ac-  
19 tive course of treatment described in paragraph  
20 (1) shall be continued until the earlier of—

21                   “(i) the date on which the treatment  
22 is complete; or

23                   “(ii) the date that is 180 days fol-  
24 lowing the date on which—



1           “(I) in the case of an individual  
2           described in subparagraph (A) of  
3           paragraph (1), the individual enrolls  
4           in such group health plan or health  
5           insurance coverage; or

6           “(II) in the case of an individual  
7           described in subparagraph (B) of  
8           paragraph (1), the contract of the ter-  
9           minated provider with the group  
10          health plan or health insurance issuer  
11          is no longer in effect.

12          “(B) COST-SHARING.—The coverage for an  
13          active course of treatment provided by an out-  
14          of-network provider as described in paragraph  
15          (1) shall be provided with cost-sharing require-  
16          ments that are the same as if such coverage  
17          was provided by an in-network provider.

18          “(3) REQUEST FOR CONTINUITY OF CARE.—  
19          Any request made under paragraph (1) shall be sub-  
20          ject to any internal or external grievance or appeals  
21          process of the plan or issuer, in accordance with any  
22          applicable State or Federal law.

23          “(4) DEFINITIONS.—For purposes of this sub-  
24          section:

1           “(A) ACTIVE COURSE OF TREATMENT.—

2           The term ‘active course of treatment’ means  
3           any of the following that is occurring on the  
4           first day on which, with respect to an individual  
5           described in paragraph (1)(A), the individual’s  
6           prior health plan described in such paragraph  
7           has been discontinued by the plan or issuer or,  
8           with respect to an individual described in para-  
9           graph (1)(B), the provider providing the treat-  
10          ment becomes a terminated provider:

11                   “(i) An ongoing course of treatment  
12                   for a life-threatening condition, serious  
13                   acute condition, or serious chronic condi-  
14                   tion.

15                   “(ii) Services provided with respect to  
16                   pregnancy, including until the completion  
17                   of postpartum care directly related to the  
18                   delivery.

19                   “(iii) An ongoing course of treatment  
20                   for a child between birth and 36 months.

21                   “(iv) The performance of a surgery or  
22                   other procedure that, prior to the applica-  
23                   ble time described in this subparagraph,  
24                   has been authorized by the plan or cov-  
25                   erage as part of a documented course of

1 treatment for such individual and has been  
2 recommended and documented by the pro-  
3 vider for such individual.

4 “(B) COVERED SERVICES.—The term ‘cov-  
5 ered services’ means services that—

6 “(i) would be covered by the group  
7 health plan or health insurance issuer of-  
8 fering group or individual health insurance  
9 coverage if such services were provided by  
10 an in-network provider; and

11 “(ii) are for an active course of treat-  
12 ment.

13 “(C) TERMINATED PROVIDER.—The term  
14 ‘terminated provider’ means a provider that had  
15 a contract for participation with the plan or  
16 coverage during a plan year while the individual  
17 was enrolled in such plan or coverage and re-  
18 ceiving covered services from such provider and,  
19 during such plan year, the plan or issuer termi-  
20 nates such contract or does not renew such con-  
21 tract for the remainder of the plan year. Such  
22 term does not include—

23 “(i) any provider that voluntarily ter-  
24 minates or does not renew such contract  
25 for the remainder of the plan year; and

1           “(ii) any provider whose contract with  
2           the plan or issuer has terminated, or was  
3           not renewed, for the remainder of the plan  
4           year for reasons relating to a medical dis-  
5           ciplinary cause or fraud or other criminal  
6           activity.

7           “(g) LIMITATIONS ON CHANGES IN COVERAGE OF  
8           PRESCRIPTION DRUGS.—

9           “(1) IN GENERAL.—A group health plan or  
10          health insurance issuer offering group or individual  
11          health insurance coverage shall not, during a plan  
12          year, take any of the following actions with respect  
13          to coverage for such plan year:

14               “(A) Removing a prescription drug from a  
15               formulary of prescription drugs covered by such  
16               plan or issuer, except as provided in paragraph  
17               (2)(C).

18               “(B) Increasing the obligation of an en-  
19               rollee with respect to cost-sharing, as defined in  
20               section 1302(c)(3) of the Patient Protection  
21               and Affordable Care Act, required for a pre-  
22               scription drug covered by such plan or issuer.

23           “(2) RULE OF CONSTRUCTION.—Nothing in  
24          this subsection shall prohibit a group health plan or  
25          health insurance issuer offering group or individual

1 health insurance coverage from, during a plan year,  
2 taking any of the following actions with respect to  
3 coverage for such plan year:

4 “(A) Changing the policy of the plan or  
5 issuer to require an enrollee to use a generic  
6 substitution for a branded prescription drug.

7 “(B) Adding a new prescription drug to a  
8 formulary of prescription drugs covered by such  
9 plan or issuer.

10 “(C) Removing a prescription drug from  
11 such a formulary due to patient safety con-  
12 cerns, a prescription drug recall, or the removal  
13 of a prescription drug from interstate commerce  
14 as determined necessary by the Secretary.”.

15 (b) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to plan years beginning after De-  
17 cember 31, 2019.

18 **SEC. 404. LIMITATION ON BALANCE BILLING FOR EMER-**  
19 **GENCY SERVICES.**

20 (a) IN GENERAL.—A health care provider that pro-  
21 vides any emergency service to an individual enrolled in  
22 a group health plan, group health insurance coverage, or  
23 individual health insurance coverage and that is not an  
24 in-network provider of such plan or coverage shall not im-  
25 pose a charge on such individual for such emergency serv-

1 ice, other than any cost-sharing that would otherwise be  
2 applicable if the physician was an in-network provider of  
3 such plan or coverage.

4 (b) ENFORCEMENT.—The Secretary may impose a  
5 civil monetary penalty, in the same manner as such pen-  
6 alties are authorized under section 1128A of the Social  
7 Security Act (42 U.S.C. 1320a–7a) for violations of bal-  
8 ance billing prohibitions under part B of title XVIII of  
9 such Act (42 U.S.C. 1395j et seq.), on any provider that  
10 violates the requirement under subsection (a).

11 (c) DEFINITIONS.—In this section:

12 (1) COST-SHARING.—The term “cost-sharing”  
13 has the meaning given the term in section  
14 1302(c)(3) of the Patient Protection and Affordable  
15 Care Act (42 U.S.C. 18022(c)(3)).

16 (2) EMERGENCY SERVICE.—The term “emer-  
17 gency service” has the meaning given such term in  
18 section 2719A(b)(3)(B) of the Public Health Service  
19 Act (42 U.S.C. 300gg–19a(b)(3)(B)).

20 (3) GROUP HEALTH PLAN, GROUP HEALTH IN-  
21 SURANCE COVERAGE, AND INDIVIDUAL HEALTH IN-  
22 SURANCE COVERAGE.—The terms “group health  
23 plan”, “group health insurance coverage”, and “in-  
24 dividual health insurance coverage” have the mean-

1       ings given such terms in section 2791 of the Public  
2       Health Service Act (42 U.S.C. 300gg–91).

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

5       (d) EFFECTIVE DATE.—This section shall apply to  
6       plan years beginning after December 31, 2019.

7       **SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.**

8       Title XXVII of the Public Health Service Act (42  
9       U.S.C. 300gg et seq.) is amended by inserting after sec-  
10      tion 2728 (42 U.S.C. 300gg–28) the following:

11      **“SEC. 2729. NOTIFICATION OF PROVIDER TERMINATIONS.**

12              “(a) IN GENERAL.—Beginning January 1, 2019, a  
13      group health plan or health insurance issuer offering  
14      group or individual health insurance coverage shall inform  
15      individuals enrolled in such plan or coverage, who are de-  
16      scribed in subsection (b), of the termination of any pro-  
17      vider as an in-network provider under the plan or cov-  
18      erage. Such notice shall be provided not later than 30 days  
19      prior to the termination.

20              “(b) INDIVIDUALS.—The individuals described in this  
21      subsection are any patients who have seen a provider de-  
22      scribed in subsection (a) on a regular basis or who have  
23      received primary care from the provider.”.

1 **SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSUR-**  
 2 **ANCE COVERAGE.**

3 (a) IN GENERAL.—Section 2791(b)(5) of the Public  
 4 Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amend-  
 5 ed by striking “but does not include” and inserting “in-  
 6 cluding”.

7 (b) EFFECTIVE DATE.—The amendment made by  
 8 this section shall apply to plan years beginning after De-  
 9 cember 31, 2019.

10 **SEC. 407. PROTECTING ESSENTIAL HEALTH BENEFITS.**

11 Section 1302(b) of the Patient Protection and Af-  
 12 fordable Care Act (42 U.S.C. 18022(b)) is amended—

13 (1) in paragraph (2)(B) and paragraph (3), by  
 14 striking “(4)(H)” each place it appears and insert-  
 15 ing “(4)(I)”; and

16 (2) in paragraph (4)—

17 (A) in subparagraph (A), by inserting  
 18 “and coverage in every category is included” be-  
 19 fore the semicolon;

20 (B) by redesignating subparagraphs (E)  
 21 through (H) as subparagraphs (F) through (I),  
 22 respectively; and

23 (C) by inserting after subparagraph (D)  
 24 the following:

25 “(E) ensure that, to be treated as pro-  
 26 viding coverage for the essential health benefits



1 described in paragraph (1), a qualified health  
2 plan—

3 “(i) shall not substitute benefits  
4 across the various categories described in  
5 paragraph (1);

6 “(ii) shall provide a wide variety of  
7 classes of prescription drugs on the pre-  
8 scription drug formulary of such plan;

9 “(iii) shall, if a medically necessary  
10 drug is not on the prescription drug for-  
11 mulary of such plan, allow individuals en-  
12 rolled in such plan to have access to the  
13 drug through an exceptions process estab-  
14 lished by the plan; and

15 “(iv) shall provide coverage of  
16 habilitative services at parity with rehabili-  
17 tative services, in accordance with regula-  
18 tions promulgated by the Secretary.”.

19 **SEC. 408. ASSOCIATION HEALTH PLANS.**

20 (a) TREATMENT OF ASSOCIATION HEALTH PLANS.—

21 (1) ASSOCIATION HEALTH PLAN DEFINED.—

22 For purposes of this subsection, the term “associa-  
23 tion health plan” means any health insurance cov-  
24 erage that is provided to an association, but not re-

1       lated to employment, and sold to individuals through  
2       such association.

3           (2) TREATMENT AS INDIVIDUAL HEALTH IN-  
4       SURANCE COVERAGE.—For purposes of title XXVII  
5       of the Public Health Service Act (42 U.S.C. 300gg  
6       et seq.), part 7 of subtitle B of title I of the Em-  
7       ployee Retirement Income Security Act of 1974 (29  
8       U.S.C. 1181 et seq.), chapter 100 of the Internal  
9       Revenue Code of 1986, and title I of the Patient  
10      Protection and Affordable Care Act (Public Law  
11      111–148), health insurance coverage offered through  
12      an association health plan shall be treated as indi-  
13      vidual health insurance coverage if—

14           (A) the coverage is offered to a member of  
15           the association other than in connection with a  
16           group health plan; or

17           (B) the coverage is offered to a member of  
18           the association that is an employer maintaining  
19           a group health plan that has fewer than 2 par-  
20           ticipants who are employees on the first day of  
21           the plan year.

22           (3) TREATMENT AS HEALTH INSURANCE COV-  
23       ERAGE IN THE SMALL GROUP MARKET.—For pur-  
24       poses of title XXVII of the Public Health Service  
25       Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B

1 of title I of the Employee Retirement Income Secu-  
2 rity Act of 1974 (29 U.S.C. 1181 et seq.), chapter  
3 100 of the Internal Revenue Code of 1986, and title  
4 I of the Patient Protection and Affordable Care Act  
5 (Public Law 111–148), health insurance coverage of-  
6 fered through an association health plan shall, sub-  
7 ject to paragraph (2)(B), be treated as health insur-  
8 ance coverage in the small group market if the cov-  
9 erage is offered to a member of the association in  
10 connection with a group health plan offered to em-  
11 ployers that are small employers, as defined in such  
12 applicable Act or Code.

13 (4) PREEMPTION.—An association health plan  
14 shall be treated as individual health insurance cov-  
15 erage in accordance with paragraph (2) or health in-  
16 surance coverage in the small group market in ac-  
17 cordance with paragraph (3) notwithstanding any  
18 applicable State law.

19 (5) EFFECTIVE DATE.—This subsection shall  
20 apply to plan years beginning after December 31,  
21 2019.

22 (b) PROPOSED RULE REGARDING THE DEFINITION  
23 OF “EMPLOYER” UNDER ERISA.—

24 (1) DEFINITION OF “JANUARY 5, 2018, PRO-  
25 POSED RULE”.—In this subsection, the term “Janu-

1       ary 5, 2018, proposed rule” means the proposed rule  
2       of the Department of Labor entitled “Definition of  
3       ‘Employer’ Under Section 3(5) of ERISA—Associa-  
4       tion Health Plans” (83 Fed. Reg. 614), or any final  
5       rule promulgated with respect to such proposed rule.

6           (2) ENFORCEMENT.—Beginning on the date of  
7       enactment of this Act, the January 5, 2018, pro-  
8       posed rule shall cease to have any force or effect. In  
9       the case that the January 5, 2018, proposed rule is  
10      a final rule on the date of enactment of this Act, the  
11      Secretary of Labor shall cease to enforce such final  
12      rule.

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