

115TH CONGRESS
1ST SESSION

S. 1354

To establish an Individual Market Reinsurance fund to provide funding for
State individual market stabilization reinsurance programs.

IN THE SENATE OF THE UNITED STATES

JUNE 14, 2017

Mr. CARPER (for himself, Mr. KAINE, Mrs. SHAHEEN, Mr. NELSON, Ms. HAS-
SAN, and Mr. CARDIN) introduced the following bill; which was read twice
and referred to the Committee on Health, Education, Labor, and Pen-
sions

A BILL

To establish an Individual Market Reinsurance fund to pro-
vide funding for State individual market stabilization
reinsurance programs.

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 “Individual Health In-
5 surance Marketplace Improvement Act”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

8 (1) Before the passage of the Patient Protec-
9 tion and Affordable Care Act (Public Law 114–148)

1 in 2010, Americans with pre-existing conditions
2 faced unfair barriers to accessing health insurance
3 coverage and health care costs had risen rapidly for
4 decades.

5 (2) Since 2010, the rate of uninsured Ameri-
6 cans has declined to a historic low, with more than
7 20,000,000 Americans gaining access to health in-
8 surance coverage.

9 (3) Since 2010, America has experienced the
10 slowest growth in the price of health care in over
11 five decades.

12 (4) Thanks to the Patient Protection and Af-
13 fordable Care Act (Public Law 114–148), Americans
14 can no longer be denied insurance or charged more
15 on the basis of their health status, more Americans
16 than ever have insurance, and the health care they
17 receive is continually improving.

18 (5) Starting in 2016, independent, non-partisan
19 organizations, including the Congressional Budget
20 Office, have determined that the individual health
21 insurance markets have stabilized and improved.

22 (6) The cost-sharing reduction payments in the
23 Patient Protection and Affordable Care Act provide
24 stability in the individual health insurance market,
25 lower insurance premiums by nearly 20 percent, and

1 encourage competition among health insurers. The
2 payments reduce costs for approximately 6,000,000
3 people with incomes below 250 percent of the pov-
4 erty line by an average of about \$1,100 per person
5 and should be increased to help more Americans.

6 (7) Risk mitigation programs, such as the rein-
7 surance program for the Medicare Part D prescrip-
8 tion drug benefit program, have provided additional
9 stability to the health insurance markets, restrained
10 premium growth, and lowered taxpayer costs by
11 helping health insurers predict and bear risk associ-
12 ated with managing health care costs for a popu-
13 lation.

14 (8) From 2014 to 2016, the temporary reinsur-
15 ance program established under the Affordable Care
16 Act helped to stabilize the new insurance market-
17 places and reduced insurance premiums in the indi-
18 vidual health insurance market by as much as 10
19 percent.

20 (9) Throughout his Presidential campaign, the
21 President of the United States repeatedly promised
22 the American people that his health care plan will
23 result in reduced rates of uninsured, lower costs,
24 and higher quality care, stating on January 14,
25 2017, that “We’re going to have insurance for every-

1 body. There was a philosophy in some circles that if
 2 you can't pay for it, you don't get it. That's not
 3 going to happen with us"; and on January 25, 2017,
 4 that "I can assure you, we are going to have a bet-
 5 ter plan, much better health care, much better serv-
 6 ice treatment, a plan where you can have access to
 7 the doctor that you want and the plan that you
 8 want. We're gonna have a much better health care
 9 plan at much less money".

10 (10) The goal of any health care legislation
 11 should be to build on the Affordable Care Act to
 12 continue expanding coverage and make health care
 13 more affordable for Americans. Improving afford-
 14 ability and expanding coverage will also broaden the
 15 individual market risk pool, contributing to lower
 16 premiums and strengthening market stability.

17 **SEC. 3. INDIVIDUAL MARKET REINSURANCE FUND.**

18 (a) ESTABLISHMENT OF FUND.—

19 (1) IN GENERAL.—There is established the "In-
 20 dividual Market Reinsurance Fund" to be adminis-
 21 tered by the Secretary to provide funding for an in-
 22 dividual market stabilization reinsurance program in
 23 each State that complies with the requirements of
 24 this section.

1 (2) FUNDING.—There is appropriated to the
2 Fund, out of any moneys in the Treasury not other-
3 wise appropriated, such sums as are necessary to
4 carry out this section (other than subsection (c)) for
5 each calendar year beginning with 2018. Amounts
6 appropriated to the Fund shall remain available
7 without fiscal or calendar year limitation to carry
8 out this section.

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 to health insurance issuers with re-
15 spect to high-cost individuals enrolled in qualified
16 health plans offered by such issuers that are not
17 grandfathered health plans or transitional health
18 plans for any plan year beginning with the 2018
19 plan year. This subsection constitutes budget au-
20 thority in advance of appropriations Acts and rep-
21 resents the obligation of the Secretary to provide
22 payments from the Fund in accordance with this
23 subsection.

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

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

(A) the amount (if any) by which the individual’s claims incurred during the plan year exceeds—

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

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

(B) for plan years described in—

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

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

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

(A) such amount; multiplied by

(B) the premium adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting “2018” for “2013”.

(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) OUTREACH AND ENROLLMENT.—

12 (1) IN GENERAL.—During the period that be-
 13 gins on January 1, 2018, and ends on December 31,
 14 2020, the Secretary shall award grants to eligible
 15 entities for the following purposes:

16 (A) OUTREACH AND ENROLLMENT.—To
 17 carry out outreach, public education activities,
 18 and enrollment activities to raise awareness of
 19 the availability of, and encourage enrollment in,
 20 qualified health plans.

21 (B) ASSISTING INDIVIDUALS TRANSITION
 22 TO QUALIFIED HEALTH PLANS.—To provide as-
 23 sistance to individuals who are enrolled in
 24 health insurance coverage that is not a qualified
 25 health plan enroll in a qualified health plan.

(C) ASSISTING ENROLLMENT IN PUBLIC HEALTH PROGRAMS.—To facilitate the enrollment of eligible individuals in the Medicare program or in a State Medicaid program, as appropriate.

(D) RAISING AWARENESS OF PREMIUM ASSISTANCE AND COST-SHARING REDUCTIONS.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

(2) ELIGIBLE ENTITIES DEFINED.—

(A) IN GENERAL.—In this subsection, the term “eligible entity” means—

- (i) a State; or
- (ii) a nonprofit community-based organization.

(B) ENROLLMENT AGENTS.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State

1 or nonprofit community-based organization to
2 enroll eligible individuals in qualified health
3 plans.

4 (C) EXCLUSIONS.—Such term does not in-
5 clude an entity that—

6 (i) is a health insurance issuer; or

7 (ii) receives any consideration, either
8 directly or indirectly, from any health in-
9 surance issuer in connection with the en-
10 rollment of any qualified individuals or em-
11 ployees of a qualified employer in a quali-
12 fied health plan.

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

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

24 (d) REPORTS TO CONGRESS.—

1 (1) ANNUAL REPORT.—The Secretary shall
2 submit a report to Congress, not later than January
3 21, 2019, and each year thereafter, that contains
4 the following information for the most recently
5 ended year:

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

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

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

20 (D) The process used to award funds for
21 outreach and enrollment activities awarded to
22 eligible entities under subsection (c), the
23 amount of such funds awarded, and the activi-
24 ties carried out with such funds.

1 (E) Such other information as the Sec-
 2 retary deems relevant.

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

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

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

13 (e) DEFINITIONS.—In this section:

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

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

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

24 (4) HIGH-COST INDIVIDUAL.—The term “high-
 25 cost individual” means an individual enrolled in a

1 qualified health plan (other than a grandfathered
2 health plan or a transitional health plan) who incurs
3 claims in excess of \$50,000 during a plan year.

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

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

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