I

119TH CONGRESS
1ST SESSION

H. R. 1776

To amend the Patient Protection and Affordable Care Act to establish a reinsurance program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 2025

Mr. PALMER introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Workforce, 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 amend the Patient Protection and Affordable Care Act to establish a reinsurance program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''New Health Options Act of 2025''.

SEC. 2. CREATION OF A REINSURANCE PROGRAM FOR A NEW HEALTH INSURANCE RISK POOL.

(a) IN GENERAL.—Part V of subtitle B of title I of the Patient Protection and Affordable Care Act (42

U.S.C. 18061 et seq.) is amended by adding at the end the following new section:

"SEC. 1344. REINSURANCE PROGRAM FOR CERTAIN OFF-EXCHANGE PLANS.

"(a) IN GENERAL.—There is established a Reinsurance Program, to be administered by the Secretary of Health and Human Services, to provide payments to health insurance issuers with respect to claims for eligible individuals for the purpose of lowering premiums for such individuals.

"(b) FUNDING.—

"(1) APPROPRIATION.—For the purpose of providing funding for the Reinsurance Program, for each year during the period beginning on January 1, 2026, and ending on December 31, 2030, there is appropriated out of any monies in the Treasury not otherwise obligated an amount equal to the product of $50 and the aggregate number of member months for all eligible individuals enrolled in a covered plan during such year.

"(2) LIMITATION ON APPROPRIATION.—In no year shall the appropriation for the Reinsurance Program authorized in paragraph (1) exceed $6,000,000,000.

''(3) USE OF UNEXPENDED FUNDS.—Appropriated amounts remaining unexpended at the end of any year may be used to make payments under the Reinsurance Program in any future year.

''(4) LIMITATION ON USE OF FUNDS.—No funds received under the Reinsurance Program may be used to pay for services described in section 1303(b)(1)(B)(i) (as in effect on the date of the enactment of this section).

''(c) OPERATION OF PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish parameters for the operation of the Reinsurance Program consistent with this section.

''(2) DEADLINE FOR INITIAL OPERATION.—Not later than 120 days after the date of the enactment, the Secretary shall establish sufficient parameters to specify how the Program will operate for 2026.

''(3) DEFINITIONS.—In this section:

''(A) COVERED PLAN.—The term 'covered plan' means individual health insurance coverage (as such term is defined in section 2791 of the Public Health Service Act)—

''(i) with respect to which the issuer of such coverage has made the election described in section 1312(c)(1)(A); and

''(ii) that does not provide coverage for services described in section 1303(b)(1)(B)(i) (as in effect on the date of the enactment of this section).

''(B) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual enrolled in a covered plan.

''(d) ATTACHMENT DOLLAR AMOUNT AND PAYMENT PROPORTION.—

''(1) IN GENERAL.—The Secretary shall annually establish an attachment point, payment proportion, and reinsurance cap with respect to claims for eligible individuals for payments under the Reinsurance Program, consistent with the following:

''(A) The attachment point for the period beginning January 1, 2026, and ending December 31, 2026, shall be $110,000.

''(B) The payment proportion for the period beginning January 1, 2026, and ending December 31, 2026, shall be 90 percent.

''(C) The reinsurance cap for the period beginning January 1, 2026 and ending December 31, 2026, shall be $300,000.

''(2) ADJUSTMENT AUTHORITY.—The Secretary may adjust any amounts described in paragraph (1)

as necessary to ensure the Reinsurance Program does not make payment for a year in excess of the amount available for such year under subsection (b).''.

(b) ELECTION TO OPT OUT OF SINGLE RISK POOL.—

(1) IN GENERAL.—Section 1312(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)(1)) is amended—

(A) by striking ''A health insurance issuer'' and inserting the following:

''(A) IN GENERAL.—A health insurance issuer'';

(B) in subparagraph (A), as inserted by paragraph (1), by inserting ''and other than any health plan with respect to which such issuer has elected for this subparagraph not to apply'' after ''grandfathered health plans''; and

(C) by adding at the end the following new subparagraph:

''(B) TREATMENT OF PLANS OPTING OUT OF SINGLE RISK POOL.—A health insurance issuer shall consider all enrollees in all health plans offered by such issuer in the individual market with respect to which such issuer has

made the election described in subparagraph (A) to be members of a single risk pool.''.

(2) PROHIBITING SINGLE RISK POOL OPT OUT FOR QUALIFIED HEALTH PLANS.—Section 1301(a)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(1)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(v) has not made the election described in section 1312(c)(1)(A) with respect to such plan.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2026.

(c) REMOVING AGE PREMIUM VARIATION LIMITATION FOR CERTAIN PLANS.—

(1) IN GENERAL.—

(A) REMOVAL OF LIMITATION FOR CERTAIN PLANS.—Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C

300gg(a)(1)(A)(iii)) is amended by inserting ''or, in the case of such coverage with respect to which the issuer of such coverage has made the election described in section 1312(c)(1)(A) of the Patient Protection and Affordable Care Act, by more than an actuarially justified amount for adults'' before ''; and''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply with respect to plan years beginning on or after January 1, 2026.

(2) MAINTAINING AGE PREMIUM VARIATION LIMITATION FOR QUALIFIED HEALTH PLANS.—Section 1301(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(1)), as amended by subsection (b), is further amended—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C)(v), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) with respect to the premium rate charged by such plan, if such plan varies such rate by age, does not vary such rate by more

than 3 to 1 for adults (consistent with section 2707(c) of the Public Health Service Act).''.

(d) TREATMENT OF OPT OUT PLANS IN RELATION TO INDIVIDUAL HEALTH COVERAGE REIMBURSEMENT ARRANGEMENTS.—The Secretaries of Health and Human Services, Labor, and the Treasury shall not fail to treat any individual health insurance coverage (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) as eligible for integration with an individual health care reimbursement arrangement on the basis that the health insurance issuer (as so defined) of such coverage has made the election described in section 1312(c)(1)(A) of the Patient Protection and Affordable Care Act (as inserted by subsection (b)).

SEC. 3. PROMOTION OF HIGH-VALUE CARE.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following new section:

''SEC. 2730. APPLICATION OF CERTAIN OUT-OF-NETWORK COSTS TO DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS.

''(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, in the case that an individual

enrolled under such plan or coverage is furnished items or services by a health care provider or health care facility that does not have in effect a contractual relationship with such plan or issuer for the furnishing of such items or services and such individual incurs any out-of-pockets costs with respect to such items and services, at the option of such individual, apply such costs to any deductible or out-of-pocket maximum applicable to items and services furnished by health care providers or health care facilities with contracts in effect with such plan or issuer for the furnishing of such items or services, but only if the following requirements are met:

''(1) The item or service furnished by such provider or facility without a contract in effect with such plan or issuer is an item or service for which benefits are available under such plan or coverage.

''(2) The amount charged by such provider or facility for such item or service is equal to or less than—

''(A) the lowest amount recognized by the plan or coverage as payment for such item or service out of all health care providers and health care facilities with a contract in effect with such plan or issuer to furnish such item or service in the same rating area (as defined for

purposes of section 2701) in which the item or service described in paragraph (1) was furnished; or

"(B) the 25th percentile of charges for such item or service furnished in the same State in which the item or service described in paragraph (1) was furnished.

"(b) DISCLOSURE OF INFORMATION.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, with respect to each item or service for which benefits are available under such plan or coverage, make available the lowest amount described in subsection (a)(2)(A) and the 25th percentile described in subsection (a)(2)(B) to all individuals enrolled under such plan or coverage.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2026.

SEC. 4. DISCLOSURE OF LOWER PRICES.

Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–131) is amended by adding at the end the following new section:

"SEC. 2799B–10. DISCLOSURE OF LOWER PRICES.

"(a) IN GENERAL.—Beginning January 1, 2026, each health care provider and health care facility shall dis-

close to patients and prospective patients enrolled in a group health plan, group or individual health insurance coverage, or a Federal health care program (as defined in section 1128B but including the program established under chapter 89 of title 5, United States Code) being furnished or seeking to be furnished an item or service by such provider or facility for which benefits are available under such plan, coverage, or program, as applicable, whether the amount of cost sharing (including deductibles, copayments, and coinsurance) that would be incurred by such individual for such item or service under such plan, coverage, or program, as applicable, exceeds the charge that would apply for such item or service for an individual without benefits under any such plan, coverage, or program for such item or service.

''(b) ADDITIONAL ENFORCEMENT.—In addition to any other penalty applicable with respect to a violation of subsection (a), an individual who is harmed by a violation of this section by a health care provider or health care facility may bring an action against such provider or facility in an appropriate district court of the United States for—

''(1) appropriate injunctive relief; and

''(2) damages in an amount that is equal to the amount provided for such harm in a civil action

under the law of the State in which the provider or facility is located.''.

○