115TH CONGRESS
1ST SESSION

S. _____

To provide health insurance reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

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 _____

A BILL

To provide health insurance reform, 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 ''Consumer Health Insurance Protection Act of 2018''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—LIMITING INSURER PROFITS AND PREVENTING UNREASONABLE PREMIUM INCREASES

SEC. 101. MEDICAL LOSS RATIO.

Section 2718(b)(1)(A)(ii) of the Public Health Service Act (42 U.S.C. 300gg–18(b)(1)(A)(ii)) is amended by striking ''80'' each place it appears and inserting ''85''.

SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

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

(1) in subsection (a)—

(A) in paragraph (1), by striking ''subsection (b)(2)(A)'' and inserting ''subsections (b)(2)(A) and (b)(3)''; and

(B) in paragraph (2), by adding at the end the following: ''Notwithstanding any other provision of law, a health insurance issuer may not exclude from such disclosure information that is a trade secret or commercial or financial information described in section 552(b)(4) of title 5, United States Code.'';

(2) in subsection (b)—

(A) in paragraph (2)(A), by inserting ''and paragraph (3)'' after ''subsection (a)(2)''; and

(B) by adding at the end the following:

''(3) PROHIBITING UNREASONABLE INCREASES.—

''(A) IN GENERAL.—Beginning with plan years beginning in 2020, the Secretary, or a State pursuant to an effective rate review program meeting the requirements under paragraph (4)—

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

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

''(ii) may prohibit a health insurance issuer from implementing such an increase that is unreasonable.

''(B) UNREASONABLE INCREASES.—In determining whether an increase in health insurance premiums is unreasonable under subparagraph (A)(i)—

''(i) the Secretary shall consider whether the increase is excessive, unjustified, discriminatory, or inadequate; and

''(ii) the State, pursuant to an effective rate review program meeting the requirements under paragraph (4), shall apply applicable State law for making such determination.

''(4) STATE EFFECTIVE RATE REVIEW PROGRAMS.—A State effective rate review program meets the requirements under this paragraph if—

''(A) the program carries out the reviews described in paragraph (3)(A)(i) and ensures

that such reviews are a meaningful, effective, and timely review of the data and documentation (including any contracts or documents described in subparagraph (E)) submitted by health insurance issuers in support of proposed increases in health insurance premiums;

''(B) such reviews include an examination of—

''(i) the affordability of proposed increases in health insurance premiums;

''(ii) the quality improvement activities carried out by health insurance issuers proposing the increases; and

''(iii) the cost containment activities of health insurance issuers proposing the increases;

''(C) the program establishes a mechanism for receiving public comments on proposed increases in health insurance premiums reviewed by the State;

''(D) such reviews include a review of all public comments received under subparagraph (C);

''(E) the program requires each health insurance issuer proposing an increase in health

insurance premiums to submit to the State any provider contracts that may be affected, including any documents incorporated by reference into such contracts; and

''(F) the program requires the State to provide the Secretary its determination of whether each increase reviewed is unreasonable, in a form and manner prescribed by the Secretary.''; and

(3) in subsection (c)—

(A) in paragraph (1)—

(i) in the heading, by striking ''2010 THROUGH 2014'' and inserting ''2020 THROUGH 2024''; and

(ii) in the matter preceding subparagraph (A), by striking ''2010'' and inserting ''2020''; and

(B) in paragraph (2)(B), by striking ''2014'' and inserting ''2024''.

SEC. 103. EFFECTIVE DATE.

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

TITLE II—MAKING HEALTH INSURANCE COVERAGE AFFORDABLE

SEC. 201. ENHANCEMENT OF PREMIUM ASSISTANCE CREDIT.

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

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

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

(3) OTHER CONFORMING AMENDMENTS.—Subparagraphs (B) and (C) of section 36B(b)(3) of such Code are each amended by striking ''silver plan'' each place it appears in the text and the heading and inserting ''gold plan''.

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

(1) IN GENERAL.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''but does not exceed 400 percent''.

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

(A) by striking ''In the case of'' and all that follows through ''the amount of'' and inserting ''The amount of'', and

(B) by striking ''but less than 400%'' in the table therein.

(c) DETERMINATION OF APPLICABLE PERCENTAGE.—

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

''(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percent-

age to the final premium percentage specified in 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—
100% through 133%	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%".

(2) CONFORMING AMENDMENTS.—Subsections (c)(2)(C)(iv) and (c)(4)(F) of section 36B of the Internal Revenue Code of 1986 are each amended by inserting "(as in effect before the date of the enactment of the Consumer Health Insurance Protection Act of 2018)" after "subsection (b)(3)(A)(ii)".

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

SEC. 202. ENHANCEMENTS FOR REDUCED COST-SHARING.

(a) MODIFICATION OF AMOUNT.—

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

(A) in subsection (b)(1), by striking "silver" and inserting "gold";

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

"(B) COORDINATION WITH ACTUARIAL LIMITS.—The Secretary shall ensure the reduction under this paragraph shall not result in the plan's share of the total allowed costs of benefits provided under the plan becoming less than—

"(i) 95 percent in the case of an eligible insured described in paragraph (2)(A);

"(ii) 90 percent in the case of an eligible insured described in paragraph (2)(B); and

"(iii) 85 percent in the case of an eligible insured described in paragraph (2)(C)."; and

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

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

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

crease the plan's share of the total allowed costs of benefits provided under the plan to 95 percent of such costs;

''(B) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

''(C) in the case of an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2019.

(b) FUNDING.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

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

Secretary such sums as may be necessary for payments under this section.''.

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

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

(1) in paragraph (3)(A)(i), by inserting ''(including cost-sharing with respect to prescription drugs covered by the plan)'' after ''copayments''; and

(2) by adding at the end the following:

''(5) PRESCRIPTION DRUG COST-SHARING.—

''(A) 2020.—For plan years beginning in 2020, the cost-sharing incurred under a health plan with respect to prescription drugs covered by the plan shall not exceed $250 per month for each enrolled individual, or $500 for each family.

''(B) 2021 AND LATER.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2020, the limitation under this paragraph shall be equal to the applicable dollar amount under subparagraph (A) for plan years beginning in 2020, increased by

an amount equal to the product of that amount and the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for that year.

''(ii) ADJUSTMENT TO AMOUNT.—If the amount of any increase under clause (i) is not a multiple of $5, such increase shall be rounded to the next lowest multiple of $5.''.

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

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

SEC. 204. STANDARDIZED OPTIONS IN THE BRONZE, SILVER, AND GOLD LEVELS OF COVERAGE.

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

(1) in paragraph (1)(C)—

(A) in clause (iii), by striking ''; and'' and inserting '';'';

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

(C) by inserting after clause (iii) the following:

''(iv)(I) agrees to offer the standardized option established for the State under paragraph (5) for each level of coverage offered by the issuer that is the bronze, silver, or gold level of coverage; and

''(II) with respect to offering coverage that is the bronze, silver, or gold level of coverage on an Exchange that is operated by the Secretary, agrees to offer only standardized options established for the State under paragraph (5) and not any other plan for such levels of coverage; and''; and

(2) by adding at the end the following:

''(5) STANDARDIZED OPTIONS.—

''(A) DEFINITION OF STANDARDIZED OPTION.—In this section, the term 'standardized option' means a qualified health plan—

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

"(ii) that is offered on an Exchange.

"(B) ESTABLISHMENT.—

"(i) STATE.—Each State may establish a standardized option for the bronze, silver, and gold levels of coverage.

"(ii) SECRETARY.—The Secretary shall establish a standardized option in a State for any level of coverage described in clause (i) for which the State has not established a standardized option.

"(iii) UPDATES.—The Secretary shall annually update any standardized option established by the Secretary under clause (ii).

"(C) DEDUCTIBLE-EXEMPT SERVICES.—

"(i) IN GENERAL.—Except as provided in clause (ii), each standardized option established by the Secretary under subparagraph (B)(ii) shall include coverage of each of the following as deductible-exempt services:

"(I) All primary care visits and specialist visits.

"(II) All mental health and substance use disorder outpatient services.

"(III) All drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act and biological products licensed under section 351(k) of the Public Health Service Act.

"(IV) All urgent care services.

"(ii) BRONZE AND SILVER LEVELS OF COVERAGE.—The Secretary may alter the services that shall be covered as deductible-exempt services under clause (i) for standardized options in the bronze and silver levels of coverage.

"(D) DISPLAY.—Each Exchange operated by a State shall preferentially display the standardized options offered in such State on the website of the Exchange.".

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

SEC. 205. CLARIFICATION REGARDING DETERMINATION OF AFFORDABILITY OF EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.

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

"(i) COVERAGE MUST BE AFFORDABLE.—

"(I) IN GENERAL.—Except as provided in clause (iii), an individual shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the required contribution with respect to the plan exceeds 8.5 percent of the applicable taxpayer's household income.

"(II) REQUIRED CONTRIBUTION WITH RESPECT TO EMPLOYEE.—In the case of the employee eligible to enroll in the plan, the required contribution for purposes of subclause (I) is the employee's required contribution (within the meaning of section

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

''(III) REQUIRED CONTRIBUTION WITH RESPECT TO FAMILY MEMBERS.—In the case of an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee, the required contribution for purposes of subclause (I) is the employee's required contribution (within the meaning of section 5000A(e)(1)(B)(i), determined by substituting 'family' for 'self-only') with respect to the plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Clause (ii) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.''.

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

(3) Clause (iv) of section 36B(c)(2)(C) of such Code is amended by striking ''clause (i)(II)'' and inserting ''clause (i)(I)''.

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

TITLE III—ENSURING ACCESS TO CARE

SEC. 301. NETWORK ADEQUACY REQUIREMENTS.

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

(1) in paragraph (1)(B), by inserting ''and paragraph (7) and in accordance with paragraph (8)'' after ''Public Health Service Act''; and

(2) by adding at the end the following:

''(7) NETWORK ADEQUACY REQUIREMENTS.—

''(A) IN GENERAL.—A qualified health plan shall meet the network adequacy standards established by the Secretary under subparagraph (B), except as provided in subparagraphs (B)(ii) and (C).

''(B) FEDERAL STANDARDS AND REVIEW.—

''(i) STANDARD.—

''(I) ESTABLISHMENT.—The Secretary shall establish a network adequacy standard based on access to in-network providers for qualified health plans, except for those plans described in subparagraph (C). Such standard shall include requirements for the minimum number and type of in-network providers available, the geographical location of such providers, the average distance and travel time required for patients to visit such providers, and the average appointment wait times for services covered by the plan.

''(II) MEDICARE ADVANTAGE ORGANIZATIONS.—The network adequacy standard established under subclause (I) shall, at a minimum, be equivalent to the requirements for access to services applicable to Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII of the Social Security Act.

"(ii) JUSTIFICATION.—A qualified health plan that fails to meet the standard established under clause (i) may satisfy the requirement under subparagraph (A) by providing the Secretary with a reasonable justification for the variance from such standard, based on factors such as the availability of providers and variables reflected in local patterns of health care.

"(iii) REVIEW.—The Secretary shall establish a process for reviewing the network adequacy of qualified health plans, except for those plans reviewed by the State in accordance with subparagraph (C)(ii).

"(C) STATE STANDARD.—

"(i) IN GENERAL.—In the case of a qualified health plan offered in a State that has implemented a quantifiable network adequacy metric that the Secretary determines is an acceptable metric commonly used in the health insurance industry to measure network adequacy, such qualified health plan may satisfy the requirement under subparagraph (A) by

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

''(ii) REVIEW.—A State with an acceptable metric described in clause (i) may review the network adequacy of qualified health plans offered in such State in a process established by the State.

''(8) COVERAGE OF OUT-OF-NETWORK ESSENTIAL HEALTH BENEFITS.—

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

''(i) coverage of such service would otherwise be provided by the plan if the service was provided by an in-network provider;

''(ii) the service is included in the essential health benefits package described in section 1302(a); and

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

"(B) COST-SHARING.—A qualified health plan that provides coverage of a service provided by an out-of-network provider under subparagraph (A) shall provide such coverage with the same cost-sharing requirements as if the service was provided by an in-network provider.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to plans beginning after December 31, 2019.

(c) GRANTS FOR STATE NETWORK ADEQUACY REVIEWS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2020 to assist such States in developing a metric to measure network adequacy as described in subparagraph (C)(i) of section 1311(c)(7) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(7)) and to carry out the reviews described in subparagraph (C)(ii) of such section.

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

essary to carry out the grant program under this subsection.

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

(a) REQUIREMENTS FOR MEDICARE ADVANTAGE ORGANIZATIONS.—

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

''(5) REQUIREMENT FOR CERTAIN MEDICARE ADVANTAGE ORGANIZATIONS THAT OFFER AN MA PLAN IN AN APPLICABLE AREA TO ALSO OFFER QUALIFIED HEALTH PLANS IN THE APPLICABLE AREA.—

''(A) IN GENERAL.—A contract under this section with an MA organization described in subparagraph (B) shall require the organization to, in each applicable area in which the organization offers an MA plan, also offer, through the individual market in the Exchange operating in the State, at least one qualified health plan in the silver level of coverage and at least

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

''(B) MA ORGANIZATIONS DESCRIBED.—An MA organization described in this subparagraph is an MA organization that, in addition to offering an MA plan in an applicable area, offers health insurance coverage in the group market or individual market in the State but does not offer such coverage through the Exchange operating in the State.

''(C) NOTIFICATION.—The Secretary, or the State in the case of an MA organization offering an MA plan in an applicable area in a State with an Exchange operated by the State, shall notify each MA organization that is required to offer a qualified health plan under subparagraph (A) for a plan year of such requirement. Such notification shall be provided each year—

''(i) beginning with respect to the requirement for plan years beginning after December 31, 2019; and

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

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

''(D) WAIVER.—The Secretary, or the State in the case of an MA organization offering an MA plan in an applicable area in a State with an Exchange operated by the State, may waive the requirement under subparagraph (A) if—

''(i) by the first day of the plan year, the number of health insurance issuers offering a qualified health plan through the individual market in the Exchange has increased such that the applicable area no longer has fewer than 3 health insurance issuers offering a qualified health plan through the individual market in the Exchange operating in the State; or

''(ii) the Secretary, or the State in such a case, determines that the requirement under subparagraph (A) would cause the MA organization to become insolvent.

''(E) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE AREA.—The term 'applicable area' means an area in which,

at the time the Secretary or the State sends the notification under subparagraph (C), fewer than 3 health insurance issuers offer a qualified health plan through the individual market in the Exchange operating in the State.

''(ii) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 or section 1321 of the Patient Protection and Affordable Care Act.

''(iii) GROUP MARKET.—The term 'group market' has the meaning given such term in section 1304 of the Patient Protection and Affordable Care Act.

''(iv) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given the term in section 2791(b) of the Public Health Service Act.

''(v) INDIVIDUAL MARKET.—The term 'individual market' has the meaning given such term in section 1304 of the Patient Protection and Affordable Care Act.

"(vi) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given that term in section 1301(a) of the Patient Protection and Affordable Care Act.".

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

(b) REQUIREMENTS FOR MEDICAID MANAGED CARE ORGANIZATIONS.—

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

(A) in clause (xii), by striking "; and" and inserting a semicolon;

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

(C) in clause (xiii), by striking the period at the end and inserting "; and"; and

(D) by inserting after clause (xiii) the following:

"(xiv) such contract requires that the entity meets the requirements described in section

1857(e)(5) in the same manner as such requirements apply to an MA organization.''.

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

SEC. 303. ENROLLMENT IN EXCHANGES.

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

(1) in subparagraph (B), by inserting ''that are not less than 8 weeks'' after ''open enrollment periods'';

(2) in subparagraph (C), by striking ''; and'' and inserting '';'';

(3) in subparagraph (D), by striking the period and inserting ''; and''; and

(4) by adding at the end the following:

''(E) a special enrollment period for individuals enrolled in a plan that makes significant provider terminations during the plan year, as determined in accordance with regulations promulgated by the Secretary.''.

(b) CONSUMER PROTECTIONS REGARDING AUTOMATIC RE-ENROLLMENT.—Part 2 of subtitle D of title I

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

"SEC. 1314. CONSUMER PROTECTIONS REGARDING AUTOMATIC RE-ENROLLMENT.

''(a) CONSENT TO AVOID AUTOMATIC RE-ENROLLMENT FOR INDIVIDUALS LOSING ELIGIBILITY FOR PREMIUM TAX CREDITS.—The Secretary shall establish a process to allow an individual, who is enrolling in a qualified health plan through an Exchange and whom the Exchange estimates is eligible to receive a premium tax credit under section 36B of the Internal Revenue Code of 1986, to provide consent to the Exchange to not automatically re-enroll the individual in such qualified health plan (or a comparable qualified health plan in a case described in subsection (b)) for the following plan year if during the plan year the Exchange estimates that the individual has become no longer eligible to receive such credit.

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

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

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

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

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

''(c) NOTICE REGARDING AUTOMATIC RE-ENROLLMENT.—Any notice regarding automatic re-enrollment sent by an Exchange to an individual enrolled in a qualified health plan shall be provided to the individual in the language that the individual has indicated to the Exchange as the preferred language of the individual.''.

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

(d) STUDY.—The Secretary shall conduct a study that examines the practices used by the Exchanges for notifying consumers of automatic re-enrollment in qualified health plans and identifies strategies for—

(1) improving automatic re-enrollment and renewal notifications;

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

(3) increasing consumer comprehension of such notices; and

(4) encouraging consumers to—

(A) update information that will affect eligibility for premium tax credits under section 36B of the Internal Revenue Code of 1986 and the amount of such credits; and

(B) shop for qualified health plans that will best meet their needs through the Exchange operating in their State.

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

Part 2 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18031 et seq.), as amended by section 303(b), is further amended by adding at the end the following:

"SEC. 1315. MARKETING AND OUTREACH FOR EXCHANGES OPERATED BY THE SECRETARY.

''(a) IN GENERAL.—Out of the funds appropriated under subsection (b), the Secretary shall conduct a marketing and outreach program with respect to qualified health plans offered in Exchanges operated by the Secretary in order to encourage enrollment in such plans.

''(b) APPROPRIATION.—

''(1) ENCOURAGING ENROLLMENT FOR PLAN YEAR 2019.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $480,000,000 to carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in calendar year 2019.

''(2) ENCOURAGING ENROLLMENT FOR SUBSEQUENT PLAN YEARS.—To carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in each of calendar years 2020 through 2024, there is appropriated to the Secretary prior to each such calendar year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount appropriated under this subsection for the prior calendar year increased by 4 percent for each such calendar year.

''(3) AVAILABILITY.—The amounts appropriated under paragraphs (1) and (2) shall remain available until expended.''.

SEC. 305. NAVIGATOR PROGRAM.

Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (B), by striking ''and other entities'' and inserting ''and other entities (such as Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies)''; and

(B) by adding at the end the following:

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

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

''(ii) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group.'';

(2) in paragraph (3)—

(A) in subparagraph (D), by striking ''; and'' and inserting ''; '';

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

(C) by adding at the end the following:

''(F) provide targeted assistance to individuals likely to qualify for a special enrollment

period under subparagraph (C), (D), or (E) of subsection (c)(6).'';

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking ''not'';

(B) in clause (i)—

(i) by inserting ''not'' before ''be''; and

(ii) by striking ''; or'' and inserting ''; '';

(C) in clause (ii)—

(i) by inserting ''not'' before ''receive''; and

(ii) by striking the period and inserting ''; ''; and

(D) by adding at the end the following:

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

''(iv) not provide compensation to an employee employed by the navigator based on the number of individuals the employee assists in enrolling in qualified health plans.''.

TITLE IV—STRENGTHENING CONSUMER HEALTH INSURANCE PROTECTIONS

SEC. 401. PROHIBITING DISCRIMINATORY PREMIUMS BASED ON TOBACCO USE.

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

(1) in clause (ii), by inserting ''and'' after the semicolon; and

(2) by striking clause (iv).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2019.

SEC. 402. HEALTH INSURANCE CONSUMER INFORMATION.

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

(1) in subsection (d)—

(A) in the second sentence, by striking ''and shall share'' and inserting '', shall share''; and

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

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

(2) in subsection (e)—

(A) in paragraph (1), by striking ''$30,000,000 for the first fiscal year for which this section applies'' and inserting ''$50,000,000 for each of fiscal years 2020 through 2024''; and

(B) in paragraph (2), by striking ''each fiscal year following the fiscal year described in paragraph (1)'' and inserting ''fiscal year 2025 and each fiscal year thereafter''.

SEC. 403. PATIENT PROTECTIONS.

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

(1) in subsection (b)—

(A) in paragraph (1), by striking ''paragraph (2)(B)'' and inserting ''paragraph (3)(B)'';

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

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

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

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

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

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

(2) by adding at the end the following:

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

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

"(A) the plan or issuer would have provided coverage for the service if the service was provided by an in-network provider; and

"(B) in choosing such provider, the individual reasonably relied on a materially inaccurate, incomplete, or misleading statement of information contained in a directory, compiled by the plan or issuer, of in-network providers.

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

"(f) COVERAGE FOR ENROLLEES IN ACTIVE COURSE OF TREATMENT.—

"(1) IN GENERAL.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall, at the request of an individual enrolled in such plan or coverage and subject to paragraph (3), provide covered services (as defined in paragraph (4)) by an out-of-network provider for such individual in accordance with paragraph (2) if—

''(A) the individual is receiving an active course of treatment from such out-of-network provider that was occurring while the individual was enrolled in a different health plan offered by such plan or issuer for the prior plan year that has been discontinued by such plan or issuer, including a case where such plan is withdrawn from the market, and such provider was an in-network provider under such different health plan; or

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

''(2) DURATION AND RATES OF COVERAGE.—

''(A) DURATION.—The coverage for an active course of treatment described in paragraph (1) shall be continued until the earlier of—

''(i) the date on which the treatment is complete; or

''(ii) the date that is 180 days following the date on which—

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

"(II) in the case of an individual described in subparagraph (B) of paragraph (1), the contract of the terminated provider with the group health plan or health insurance issuer is no longer in effect.

"(B) COST-SHARING.—The coverage for an active course of treatment provided by an out-of-network provider as described in paragraph (1) shall be provided with cost-sharing requirements that are the same as if such coverage was provided by an in-network provider.

"(3) REQUEST FOR CONTINUITY OF CARE.—Any request made under paragraph (1) shall be subject to any internal or external grievance or appeals process of the plan or issuer, in accordance with any applicable State or Federal law.

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) ACTIVE COURSE OF TREATMENT.—The term 'active course of treatment' means any of the following that is occurring on the first day on which, with respect to an individual described in paragraph (1)(A), the individual's prior health plan described in such paragraph has been discontinued by the plan or issuer or, with respect to an individual described in paragraph (1)(B), the provider providing the treatment becomes a terminated provider:

"(i) An ongoing course of treatment for a life-threatening condition, serious acute condition, or serious chronic condition.

"(ii) Services provided with respect to pregnancy, including until the completion of postpartum care directly related to the delivery.

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

"(iv) The performance of a surgery or other procedure that, prior to the applicable time described in this subparagraph, has been authorized by the plan or coverage as part of a documented course of

treatment for such individual and has been recommended and documented by the provider for such individual.

"(B) COVERED SERVICES.—The term 'covered services' means services that—

"(i) would be covered by the group health plan or health insurance issuer offering group or individual health insurance coverage if such services were provided by an in-network provider; and

"(ii) are for an active course of treatment.

"(C) TERMINATED PROVIDER.—The term 'terminated provider' means a provider that had a contract for participation with the plan or coverage during a plan year while the individual was enrolled in such plan or coverage and receiving covered services from such provider and, during such plan year, the plan or issuer terminates such contract or does not renew such contract for the remainder of the plan year. Such term does not include—

"(i) any provider that voluntarily terminates or does not renew such contract for the remainder of the plan year; and

"(ii) any provider whose contract with the plan or issuer has terminated, or was not renewed, for the remainder of the plan year for reasons relating to a medical disciplinary cause or fraud or other criminal activity.

"(g) LIMITATIONS ON CHANGES IN COVERAGE OF PRESCRIPTION DRUGS.—

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

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

"(B) Increasing the obligation of an enrollee with respect to cost-sharing, as defined in section 1302(c)(3) of the Patient Protection and Affordable Care Act, required for a prescription drug covered by such plan or issuer.

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

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

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

"(B) Adding a new prescription drug to a formulary of prescription drugs covered by such plan or issuer.

"(C) Removing a prescription drug from such a formulary due to patient safety concerns, a prescription drug recall, or the removal of a prescription drug from interstate commerce as determined necessary by the Secretary.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2019.

SEC. 404. LIMITATION ON BALANCE BILLING FOR EMERGENCY SERVICES.

(a) IN GENERAL.—A health care provider that provides any emergency service to an individual enrolled in a group health plan, group health insurance coverage, or individual health insurance coverage and that is not an in-network provider of such plan or coverage shall not impose a charge on such individual for such emergency serv-

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

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

(c) DEFINITIONS.—In this section:

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

(2) EMERGENCY SERVICE.—The term ''emergency service'' has the meaning given such term in section 2719A(b)(3)(B) of the Public Health Service Act (42 U.S.C. 300gg–19a(b)(3)(B)).

(3) GROUP HEALTH PLAN, GROUP HEALTH INSURANCE COVERAGE, AND INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms ''group health plan'', ''group health insurance coverage'', and ''individual health insurance coverage'' have the mean-

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

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

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

SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.

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

''SEC. 2729. NOTIFICATION OF PROVIDER TERMINATIONS.

''(a) IN GENERAL.—Beginning January 1, 2019, a group health plan or health insurance issuer offering group or individual health insurance coverage shall inform individuals enrolled in such plan or coverage, who are described in subsection (b), of the termination of any provider as an in-network provider under the plan or coverage. Such notice shall be provided not later than 30 days prior to the termination.

''(b) INDIVIDUALS.—The individuals described in this subsection are any patients who have seen a provider described in subsection (a) on a regular basis or who have received primary care from the provider.''.

SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amended by striking ''but does not include'' and inserting ''including''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2019.

SEC. 407. PROTECTING ESSENTIAL HEALTH BENEFITS.

Section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)) is amended—

(1) in paragraph (2)(B) and paragraph (3), by striking ''(4)(H)'' each place it appears and inserting ''(4)(I)''; and

(2) in paragraph (4)—

(A) in subparagraph (A), by inserting ''and coverage in every category is included'' before the semicolon;

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

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

''(E) ensure that, to be treated as providing coverage for the essential health benefits

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

"(i) shall not substitute benefits across the various categories described in paragraph (1);

"(ii) shall provide a wide variety of classes of prescription drugs on the prescription drug formulary of such plan;

"(iii) shall, if a medically necessary drug is not on the prescription drug formulary of such plan, allow individuals enrolled in such plan to have access to the drug through an exceptions process established by the plan; and

"(iv) shall provide coverage of habilitative services at parity with rehabilitative services, in accordance with regulations promulgated by the Secretary.".

SEC. 408. ASSOCIATION HEALTH PLANS.

(a) TREATMENT OF ASSOCIATION HEALTH PLANS.—

(1) ASSOCIATION HEALTH PLAN DEFINED.—For purposes of this subsection, the term "association health plan" means any health insurance coverage that is provided to an association, but not re-

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

(2) TREATMENT AS INDIVIDUAL HEALTH INSURANCE COVERAGE.—For purposes of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), chapter 100 of the Internal Revenue Code of 1986, and title I of the Patient Protection and Affordable Care Act (Public Law 111–148), health insurance coverage offered through an association health plan shall be treated as individual health insurance coverage if—

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

(B) the coverage is offered to a member of the association that is an employer maintaining a group health plan that has fewer than 2 participants who are employees on the first day of the plan year.

(3) TREATMENT AS HEALTH INSURANCE COVERAGE IN THE SMALL GROUP MARKET.—For purposes of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B

of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), chapter 100 of the Internal Revenue Code of 1986, and title I of the Patient Protection and Affordable Care Act (Public Law 111–148), health insurance coverage offered through an association health plan shall, subject to paragraph (2)(B), be treated as health insurance coverage in the small group market if the coverage is offered to a member of the association in connection with a group health plan offered to employers that are small employers, as defined in such applicable Act or Code.

(4) PREEMPTION.—An association health plan shall be treated as individual health insurance coverage in accordance with paragraph (2) or health insurance coverage in the small group market in accordance with paragraph (3) notwithstanding any applicable State law.

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

(b) PROPOSED RULE REGARDING THE DEFINITION OF ''EMPLOYER'' UNDER ERISA.—

(1) DEFINITION OF ''JANUARY 5, 2018, PROPOSED RULE''.—In this subsection, the term ''Janu-

ary 5, 2018, proposed rule'' means the proposed rule of the Department of Labor entitled ''Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans'' (83 Fed. Reg. 614), or any final rule promulgated with respect to such proposed rule.

(2) ENFORCEMENT.—Beginning on the date of enactment of this Act, the January 5, 2018, proposed rule shall cease to have any force or effect. In the case that the January 5, 2018, proposed rule is a final rule on the date of enactment of this Act, the Secretary of Labor shall cease to enforce such final rule.