

116TH CONGRESS  
1ST SESSION

# H. R. 2463

To provide for the establishment of Medicare part E public health plans,  
and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 1, 2019

Mr. RICHMOND (for himself, Mr. HUFFMAN, and Ms. NORTON) 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 Labor, 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

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## A BILL

To provide for the establishment of Medicare part E public  
health plans, 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 “Choose Medicare Act”.

5 **SEC. 2. PUBLIC HEALTH PLAN.**

6 The Social Security Act is amended by adding at the  
7 end the following:

1 “TITLE XXII—MEDICARE PART E PUBLIC HEALTH PLANS

2 “SEC. 2201. PUBLIC HEALTH PLANS.—

3 “(a) ESTABLISHMENT.—The Secretary shall estab-  
4 lish public health plans (to be known as ‘Medicare part  
5 E plans’) that are available in the individual market, small  
6 group market, and large group market.

7 “(b) BENEFITS.—

8 “(1) IN GENERAL.—Each Medicare part E  
9 plan, regardless of whether the plan is offered in the  
10 individual market, small group market, or large  
11 group market, shall be a qualified health plan within  
12 the meaning of section 1301(a) of the Patient Pro-  
13 tection and Affordable Care Act (42 U.S.C.  
14 18021(a)) that—

15 “(A) meets all requirements applicable to  
16 qualified health plans under subtitle D of title  
17 I of the Patient Protection and Affordable Care  
18 Act (42 U.S.C. 18021 et seq.) (other than the  
19 requirement under section 1301(a)(1)(C)(ii) of  
20 such Act) and title XXVII of the Public Health  
21 Service Act (42 U.S.C. 300gg et seq.);

22 “(B) provides coverage of—

23 “(i) the essential health benefits de-  
24 scribed in section 1302(b) of the Patient

1 Protection and Affordable Care Act (42  
2 U.S.C. 18022(b)); and

3 “(ii) all items and services for which  
4 benefits are available under title XVIII;

5 “(C) provides gold-level coverage described  
6 in section 1302(d)(1)(C) of the Patient Protec-  
7 tion and Affordable Care Act (42 U.S.C.  
8 18022(d)(1)(C)); and

9 “(D) provides coverage of abortions and all  
10 other reproductive services.

11 “(2) PREEMPTION.—Notwithstanding section  
12 1303(a)(1) of the Patient Protection and Affordable  
13 Care Act (42 U.S.C. 18023(a)(1))—

14 “(A) a State may not prohibit a Medicare  
15 part E plan from offering the coverage de-  
16 scribed in paragraph (1)(D); and

17 “(B) no State law that would prohibit such  
18 a plan from offering such coverage shall apply  
19 to such plan.

20 “(c) ELIGIBILITY; ENROLLMENT.—

21 “(1) AVAILABILITY ON THE EXCHANGES.—The  
22 Medicare part E plans offered in the individual and  
23 small group markets shall be offered through the  
24 Federal and State Exchanges, including the Small

1 Business Health Options Program Exchanges (com-  
2 monly referred to as the ‘SHOP Exchanges’).

3 “(2) ELIGIBILITY.—

4 “(A) IN GENERAL.—Any individual who is  
5 a resident of the United States, as determined  
6 by the Secretary under subparagraph (C), and  
7 who is not an individual described in subpara-  
8 graph (B), is eligible to enroll in a Medicare  
9 part E plan.

10 “(B) EXCLUSIONS.—An individual de-  
11 scribed in this subparagraph is any individual  
12 who is—

13 “(i) entitled to, or enrolled for, bene-  
14 fits under title XVIII;

15 “(ii) eligible for medical assistance  
16 under a State plan under title XIX; or

17 “(iii) enrolled for child health assist-  
18 ance or pregnancy-related assistance under  
19 a State plan under title XXI.

20 “(C) REGULATIONS.—The Secretary shall  
21 promulgate a rule for determining residency for  
22 purposes of subparagraph (A).

23 “(3) EMPLOYER-SPONSORED PLANS.—

24 “(A) EMPLOYER ENROLLMENT.—Effective  
25 with respect to the first plan year that begins

1           1 year after the date of enactment of the  
2           Choose Medicare Act and each plan year there-  
3           after, the Secretary shall provide options for  
4           Medicare part E plans in the small group mar-  
5           ket and large group market that are voluntary,  
6           and available to all employers.

7           “(B) GROUP HEALTH PLANS.—The Sec-  
8           retary, acting through the Administrator for the  
9           Centers for Medicare & Medicaid Services, at  
10          the request of a plan sponsor, shall serve as a  
11          third party administrator of a group health  
12          plan that is a Medicare part E plan offered by  
13          such sponsor.

14          “(C) PORTABILITY FOR EMPLOYER-SPON-  
15          SORED PLANS.—The Secretary shall develop a  
16          process for allowing individuals enrolled in a  
17          Medicare part E plan offered in the small group  
18          market or large group market to maintain  
19          health insurance coverage through a Medicare  
20          part E plan if the individual subsequently loses  
21          eligibility for enrollment in such a plan based  
22          on termination of the employment relationship.  
23          The ability to maintain such coverage shall  
24          exist regardless of whether the individual has  
25          the option to enroll in other health insurance

1 coverage, including coverage offered in the indi-  
2 vidual market or through a subsequent em-  
3 ployer.

4 “(d) PREMIUMS.—The Secretary shall establish pre-  
5 mium rates for the Medicare part E plans that—

6 “(1) are adjusted based on—

7 “(A) whether the plan is offered in the in-  
8 dividual market, small group market, or large  
9 group market; and

10 “(B) the applicable rating area;

11 “(2) are at a level sufficient to fully finance—

12 “(A) the costs of health benefits provided  
13 by such plans; and

14 “(B) administrative costs related to oper-  
15 ating the plans; and

16 “(3) comply with the requirements under sec-  
17 tion 2701 of the Public Health Service Act, includ-  
18 ing for such plans that are offered in the large  
19 group market.

20 “(e) PROVIDERS AND REIMBURSEMENT RATES.—

21 “(1) IN GENERAL.—The Secretary shall estab-  
22 lish a rate schedule for reimbursing types of health  
23 care providers furnishing items and services under  
24 the Medicare part E plans at rates that are con-

1       sistent with the negotiations described in paragraph  
2       (2) and are necessary to maintain network adequacy.

3           “(2) MANNER OF NEGOTIATION.—The Sec-  
4       retary shall negotiate the rates described in para-  
5       graph (1) in a manner that results in payment rates  
6       that are not lower, in the aggregate, than rates  
7       under title XVIII, and not higher, in the aggregate,  
8       than the average rates paid by other health insur-  
9       ance issuers offering health insurance coverage  
10      through an Exchange.

11           “(3) PARTICIPATING PROVIDERS.—

12           “(A) IN GENERAL.—A health care provider  
13       that is a participating provider of services or  
14       supplier under the Medicare program under  
15       title XVIII on the date of enactment of Choose  
16       Medicare Act shall be a participating provider  
17       for Medicare part E plans.

18           “(B) ADDITIONAL PROVIDERS.—The Sec-  
19       retary shall establish a process to allow health  
20       care providers not described in subparagraph  
21       (A) to become participating providers for Medi-  
22       care part E plans.

23           “(4) LIMITATIONS ON BALANCE BILLING.—The  
24       limitations on balance billing pursuant to the provi-  
25       sions of section 1866(a)(1)(A) of the Social Security

1 Act (42 U.S.C. 1395cc(a)(1)(A)) shall apply to par-  
2 ticipating providers for Medicare part E plans in the  
3 same manner as such provisions apply to partici-  
4 pating providers under the Medicare program.

5 “(f) ENCOURAGING USE OF ALTERNATIVE PAYMENT  
6 MODELS.—The Secretary shall, as applicable, utilize alter-  
7 native payment models, including those described in sec-  
8 tion 1833(z)(3)(C), as added by section 101(e)(2) of the  
9 Medicare Access and CHIP Reauthorization Act of 2015  
10 (Public Law 114–10), in making payments for items and  
11 services (including prescription drugs) furnished under  
12 Medicare part E plans. The payment rates under such al-  
13 ternative payment models shall comply with the require-  
14 ment for negotiated rates under subsection (e)(2).

15 “(g) PRESCRIPTION DRUGS.—The Secretary shall  
16 apply the provisions of section 1860D–11(i) to prescrip-  
17 tion drugs under Medicare part E plans in the same man-  
18 ner as such provisions apply with respect to applicable cov-  
19 ered part D drugs under such section.

20 “(h) APPROPRIATIONS.—

21 “(1) START UP FUNDING.—For purposes of es-  
22 tablishing the Medicare part E plans, there is appro-  
23 priated to the Secretary, out of any funds in the  
24 Treasury not otherwise obligated, \$2,000,000,000,  
25 for fiscal year 2020.



1           “(2) INITIAL RESERVES.—There is appro-  
 2           priated to the Secretary, out of any funds in the  
 3           Treasury not otherwise obligated, such sums as may  
 4           be necessary, based on projected enrollment in the  
 5           Medicare part E plans in the first plan year in  
 6           which such plans are offered, to provide reserves for  
 7           the purpose of paying claims filed during the initial  
 8           90-day period of such plan year.

9           “(3) CLARIFICATION.—Any provision of law re-  
 10          stricting the use of Federal funds with respect to  
 11          any reproductive health service shall not apply to  
 12          funds appropriated under paragraph (1) or (2).

13          “(i) HEALTH INSURANCE ISSUER.—With respect to  
 14          any Medicare part E plan, the Secretary shall be consid-  
 15          ered a health insurance issuer, within the meaning of sec-  
 16          tion 2791(b) of the Public Health Service Act.”.

17       **SEC. 3. NOTICE AND NAVIGATOR REFERRAL FOR EMPLOY-**  
 18                               **EES UNDER THE FAIR LABOR STANDARDS**  
 19                               **ACT OF 1938.**

20          (a) IN GENERAL.—Section 18B of the Fair Labor  
 21          Standards Act of 1938 (29 U.S.C. 218b) is amended—

22               (1) in the heading, by striking “**TO**” and insert-  
 23               ing “**AND NAVIGATOR REFERRAL FOR**”;

24               (2) by redesignating subsection (b) as sub-  
 25               section (c);

1           (3) by inserting after subsection (a) the fol-  
2       lowing:

3       “(b) NAVIGATOR REFERRAL.—

4           “(1) IN GENERAL.—An employer described in  
5       paragraph (3) shall refer each full-time employee (as  
6       defined in section 4980H of the Internal Revenue  
7       Code of 1986) to—

8           “(A) an entity that serves as a navigator  
9       under section 1311(i) of the Patient Protection  
10      and Affordable Care Act (42 U.S.C. 18031(i))  
11      for the Exchange operating in the State of the  
12      employer; or

13          “(B) if the Exchange operating in the  
14      State of the employer does not have an entity  
15      serving as such a navigator, another entity that  
16      shall carry out equivalent activities as such a  
17      navigator.

18          “(2) REFERRAL.—The referral described in  
19      paragraph (1) shall occur—

20          “(A) at the time the employer hires the  
21      employee; or

22          “(B) on the effective date described in sub-  
23      section (c)(2) with respect to an employee who  
24      is currently employed by the employer on such  
25      date.

1           “(3) EMPLOYER.—An employer described in  
2       this paragraph is any employer that—

3           “(A) does not provide an eligible employer-  
4       sponsored plan as defined in section  
5       5000A(f)(2) of the Internal Revenue Code of  
6       1986; or

7           “(B) provides such an eligible employer-  
8       sponsored plan, but the plan is determined  
9       under section 36B(c)(2)(C) of such Code—

10           “(i) to be unaffordable to the em-  
11       ployee; or

12           “(ii) to not provide the required min-  
13       imum actuarial value.”; and

14       (4) in subsection (c), as so redesignated—

15           (A) in the heading, by striking “EFFECTIVE  
16       DATE” and inserting “EFFECTIVE  
17       DATES”;

18           (B) by striking “Subsection (a)” and in-  
19       serting the following:

20           “(1) NOTICE.—Subsection (a);”; and

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

22           “(2) NAVIGATOR REFERRAL.—Subsection (b)  
23       shall take effect with respect to employers in a State  
24       beginning on the date that is 2 years after the date  
25       of enactment of the Choose Medicare Act.”.

1       (b) STUDY.—Not later than January 1, 2024, the  
2 Comptroller General of the United States shall conduct  
3 a study on the impact of the requirements under section  
4 18B of the Fair Labor Standards Act of 1938 (29 U.S.C.  
5 218b), including the amendments made by subsection (a),  
6 on the rate of individuals without minimum essential cov-  
7 erage as defined in section 5000A of the Internal Revenue  
8 Code of 1986 in the United States and in each State.

9       (c) FUNDING FOR NAVIGATOR PROGRAM.—Section  
10 1311(i)(6) of the Patient Protection and Affordable Care  
11 Act (42 U.S.C. 18031(i)(6)) is amended—

12               (1) by striking “Grants” and inserting the fol-  
13       lowing:

14                       “(A) IN GENERAL.—Grants”; and

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

16                       “(B) AUTHORIZATION OF APPROPRIA-  
17       TIONS.—There is authorized to be appropriated  
18       such sums as may be necessary to address ca-  
19       pacity limitations of entities serving as naviga-  
20       tors through a grant under this subsection.”.

1 **SEC. 4. PROTECTING AGAINST HIGH OUT-OF-POCKET EX-**  
 2 **PENDITURES FOR MEDICARE FEE-FOR-SERV-**  
 3 **ICE BENEFITS.**

4 Title XVIII of the Social Security Act (42 U.S.C.  
 5 1395 et seq.) is amended by adding at the end the fol-  
 6 lowing new section:

7 “PROTECTION AGAINST HIGH OUT-OF-POCKET  
 8 EXPENDITURES

9 “SEC. 1899C. (a) IN GENERAL.—Notwithstanding  
 10 any other provision of this title, in the case of an indi-  
 11 vidual entitled to, or enrolled for, benefits under part A  
 12 or enrolled in part B, if the amount of the out-of-pocket  
 13 cost-sharing of such individual for a year (beginning with  
 14 2021) equals or exceeds the annual out-of-pocket limit  
 15 under subsection (b) for that year, the individual shall not  
 16 be responsible for additional out-of-pocket cost-sharing in-  
 17 curred during that year.

18 “(b) ANNUAL OUT-OF-POCKET LIMIT.—

19 “(1) IN GENERAL.—The amount of the annual  
 20 out-of-pocket limit under this subsection shall be—

21 “(A) for 2021, \$6,700; or

22 “(B) for a subsequent year, the amount  
 23 specified in this subsection for the preceding  
 24 year increased or decreased by the percentage  
 25 change in the medical care component of the  
 26 Consumer Price Index for All Urban Con-

1           sumers for the 12-month period ending with  
2           June of such preceding year.

3           “(2) ROUNDING.—If any amount determined  
4           under paragraph (1)(B) is not a multiple of \$5, such  
5           amount shall be rounded to the nearest multiple of  
6           \$5.

7           “(c) OUT-OF-POCKET COST-SHARING DEFINED.—

8           “(1) IN GENERAL.—Subject to paragraphs (2)  
9           and (3), in this section, the term ‘out-of-pocket cost-  
10          sharing’ means, with respect to an individual, the  
11          amount of the expenses incurred by the individual  
12          that are attributable to—

13                  “(A) deductibles, coinsurance, and copay-  
14                  ments applicable under part A or B; or

15                  “(B) for items and services that would  
16                  have otherwise been covered under part A or B  
17                  but for the exhaustion of those benefits.

18          “(2) CERTAIN COSTS NOT INCLUDED.—

19                  “(A) NON-COVERED ITEMS AND SERV-  
20                  ICES.—Expenses incurred for items and serv-  
21                  ices which are not covered under part A or B  
22                  shall not be considered incurred expenses for  
23                  purposes of determining out-of-pocket cost-  
24                  sharing under paragraph (1).

1                   “(B) ITEMS AND SERVICES NOT FUR-  
2                   NISHED ON AN ASSIGNMENT-RELATED BASIS.—

3                   If an item or service is furnished to an indi-  
4                   vidual under this title and is not furnished on  
5                   an assignment-related basis, any additional ex-  
6                   penses the individual incurs above the amount  
7                   the individual would have incurred if the item  
8                   or service was furnished on an assignment-re-  
9                   lated basis shall not be considered incurred ex-  
10                  penses for purposes of determining out-of-pock-  
11                  et cost-sharing under paragraph (1).

12                  “(3) SOURCE OF PAYMENT.—For purposes of  
13                  paragraph (1), the Secretary shall consider expenses  
14                  to be incurred by the individual without regard to  
15                  whether the individual or another person, including  
16                  a State program, an employer, a medicare supple-  
17                  mental policy, or other third-party coverage, has  
18                  paid for such expenses.

19                  “(d) ANNOUNCEMENT OF THE ANNUAL OUT-OF-  
20                  POCKET LIMIT.—The Secretary shall (beginning in 2020)  
21                  announce (in a manner intended to provide notice to all  
22                  interested parties) the annual out-of-pocket limit under  
23                  this section that will be applicable for the succeeding  
24                  year.”.

1 **SEC. 5. NEGOTIATING FAIR PRICES FOR MEDICARE PRE-**  
2 **SCRIPTION DRUGS.**

3 (a) IN GENERAL.—Section 1860D–11 of the Social  
4 Security Act (42 U.S.C. 1395w–111) is amended by strik-  
5 ing subsection (i) (relating to noninterference) and by in-  
6 serting the following:

7 “(i) NEGOTIATING FAIR PRICES WITH DRUG MANU-  
8 FACTURERS.—

9 “(1) IN GENERAL.—Notwithstanding any other  
10 provision of law, in furtherance of the goals of pro-  
11 viding quality care and containing costs under this  
12 part, the Secretary shall, with respect to applicable  
13 covered part D drugs, and may, with respect to  
14 other covered part D drugs, negotiate, using the ne-  
15 gotiation technique or techniques that the Secretary  
16 determines will maximize savings and value to the  
17 government for prescription drug plans and MA–PD  
18 plans and for plan enrollees (in a manner that may  
19 be similar to Federal entities and that may include,  
20 but is not limited to, formularies, reference pricing,  
21 discounts, rebates, other price concessions, and cov-  
22 erage determinations), with drug manufacturers the  
23 prices that may be charged to PDP sponsors and  
24 MA organizations for such drugs for part D eligible  
25 individuals who are enrolled in a prescription drug  
26 plan or in an MA–PD plan. In conducting such ne-



1 negotiations, the Secretary shall consider the drug's  
2 current price, initial launch price, prevalence of dis-  
3 ease and usage, and approved indications, the num-  
4 ber of similarly effective alternative treatments for  
5 each approved use of the drug, the budgetary impact  
6 of providing coverage under this part for such drug  
7 for all individuals who would likely benefit from the  
8 drug, evidence on the drug's effectiveness and safety  
9 compared to similar drugs, and the quality and  
10 quantity of clinical data and rigor of the applicable  
11 process of approval of a drug under section 505 of  
12 the Federal Food, Drug, and Cosmetic Act or a bio-  
13 logical product under section 351 of the Public  
14 Health Service Act.

15 “(2) USE OF LOWER OF VA OR BIG FOUR PRICE  
16 IF NEGOTIATIONS FAIL.—If, after attempting to ne-  
17 gotiate for a price with respect to a covered part D  
18 drug under paragraph (1) for a period of 1 year, the  
19 Secretary is not successful in obtaining an appro-  
20 priate price for the drug (as determined by the Sec-  
21 retary), the Secretary shall establish the price that  
22 may be charged to PDP sponsors and MA organiza-  
23 tions for such drug for part D eligible individuals  
24 who are enrolled in a prescription drug plan or in

1 an MA–PD plan at an amount equal to the lesser  
2 of—

3 “(A) the price paid by the Secretary of  
4 Veterans Affairs to procure the drug under the  
5 laws administered by the Secretary of Veterans  
6 Affairs; or

7 “(B) the price paid to procure the drug  
8 under section 8126 of title 38, United States  
9 Code.

10 “(3) APPLICABLE COVERED PART D DRUG DE-  
11 FINED.—For purposes of this subsection, the term  
12 ‘applicable covered part D drug’ means a covered  
13 part D drug that the Secretary determines to be ap-  
14 propriate for negotiation under paragraph (1) based  
15 on one or more of the following factors as applied  
16 to such drug:

17 “(A) Spending on a per beneficiary basis.

18 “(B) The proportion of total spending  
19 under this title.

20 “(C) Unit price increases over the pre-  
21 ceding 5 years.

22 “(D) Initial launch price.

23 “(E) Availability of less expensive, simi-  
24 larly effective alternative treatments.

1           “(F) Status of the drug as a follow-on to  
2           previously approved drugs.

3           “(G) Any other criteria determined by the  
4           Secretary.

5           “(4) PDP SPONSORS AND MA ORGANIZATION  
6           MAY NEGOTIATE LOWER PRICES.—Nothing in this  
7           subsection shall be construed as preventing the spon-  
8           sor of a prescription drug plan, or an organization  
9           offering an MA–PD plan, from obtaining a discount  
10          or reduction of the price for a covered part D drug  
11          below the price negotiated under paragraph (1) or  
12          the price established under paragraph (2).

13          “(5) NO EFFECT ON EXISTING APPEALS PROC-  
14          ESS.—Nothing in this subsection shall be construed  
15          to affect the appeals procedures under subsections  
16          (g) and (h) of section 1860D–4.”.

17          (b) EFFECTIVE DATE.—The amendments made by  
18          this section shall take effect on the date of the enactment  
19          of this Act and shall first apply to negotiations and prices  
20          for plan years beginning on January 1, 2020.

21   **SEC. 6. ENHANCEMENT OF PREMIUM ASSISTANCE CREDIT.**

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

23                  (1) IN GENERAL.—Clause (i) of section  
24          36B(b)(2)(B) of the Internal Revenue Code of 1986  
25          is amended by striking “applicable second lowest

1 cost silver plan” and inserting “applicable second  
2 lowest cost gold plan”.

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

8 (3) OTHER CONFORMING AMENDMENTS.—Sub-  
9 paragraphs (B) and (C) of section 36B(b)(3) of such  
10 Code are each amended by striking “silver plan”  
11 each place it appears in the text and the heading  
12 and inserting “gold plan”.

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

16 (1) IN GENERAL.—Section 36B(c)(1)(A) of the  
17 Internal Revenue Code of 1986 is amended by strik-  
18 ing “400 percent” and inserting “600 percent”.

19 (2) CONFORMING AMENDMENT.—The last line  
20 of the table contained in section 36B(b)(3)(A)(i) of  
21 such Code is amended by striking “400%” and in-  
22 serting “600%”.

23 (3) CONFORMING AMENDMENTS RELATING TO  
24 RECAPTURE OF EXCESS ADVANCED PAYMENTS.—

1 Clause (i) of section 36B(f)(2)(B) of such Code is  
2 amended—

3 (A) by striking “400 percent” and insert-  
4 ing “600 percent”; and

5 (B) by striking “400%” in the table there-  
6 in and inserting “600%”.

7 (c) ELIMINATION OF FAILSAFE.—Section  
8 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986 is  
9 amended by striking subclause (III).

10 (d) EFFECTIVE DATE.—The amendments made by  
11 this section shall apply to taxable years beginning after  
12 December 31, 2018.

13 **SEC. 7. ENHANCEMENTS FOR REDUCED COST SHARING.**

14 (a) DEFINITION OF ELIGIBLE INDIVIDUAL.—Section  
15 1402(b)(1) of the Patient Protection and Affordable Care  
16 Act (42 U.S.C. 1807(b)(1)) is amended by striking “silver  
17 level” and inserting “gold level”.

18 (b) MODIFICATION OF AMOUNT.—

19 (1) IN GENERAL.—Section 1402(c)(2) of the  
20 Patient Protection and Affordable Care Act is  
21 amended to read as follows:

22 “(2) ADDITIONAL REDUCTION.—The Secretary  
23 shall establish procedures under which the issuer of  
24 a qualified health plan to which this section applies

1 shall further reduce cost-sharing under the plan in  
2 a manner sufficient to—

3 “(A) in the case of an eligible insured  
4 whose household income is not less than 100  
5 percent but not more than 133 percent of the  
6 poverty line for a family of the size involved, in-  
7 crease the plan’s share of the total allowed  
8 costs of benefits provided under the plan to 94  
9 percent of such costs;

10 “(B) in the case of an eligible insured  
11 whose household income is more than 133 per-  
12 cent but not more than 150 percent of the pov-  
13 erty line for a family of the size involved, in-  
14 crease the plan’s share of the total allowed  
15 costs of benefits provided under the plan to 92  
16 percent of such costs;

17 “(C) in the case of an eligible insured  
18 whose household income is more than 150 per-  
19 cent but not more than 200 percent of the pov-  
20 erty line for a family of the size involved, in-  
21 crease the plan’s share of the total allowed  
22 costs of benefits provided under the plan to 90  
23 percent of such costs;

24 “(D) in the case of an eligible insured  
25 whose household income is more than 200 per-

cent 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 85 percent of such costs; and

“(E) 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 80 percent of such costs.”.

(2) CONFORMING AMENDMENT.—Clause (i) of section 1402(c)(1)(B) of such Act is amended to read as follows:

“(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

“(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

1 “(II) 92 percent in the case of an  
 2 eligible insured described in para-  
 3 graph (2)(B);

4 “(III) 90 percent in the case of  
 5 an eligible insured described in para-  
 6 graph (2)(C);

7 “(IV) 85 percent in the case of  
 8 an eligible insured described in para-  
 9 graph (2)(D); and

10 “(V) 80 percent in the case of an  
 11 eligible insured described in para-  
 12 graph (2)(E).”.

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

16 **SEC. 8. REINSURANCE AND AFFORDABILITY FUND.**

17 Part 5 of subtitle D of title I of the Patient Protec-  
 18 tion and Affordable Care Act is amended by inserting  
 19 after section 1341 (42 U.S.C. 18061) the following:

20 **“SEC. 1341A. REINSURANCE AND AFFORDABILITY FUND**  
 21 **FOR THE INDIVIDUAL MARKET IN EACH**  
 22 **STATE.**

23 “(a) IN GENERAL.—The Secretary, in consultation  
 24 with the National Association of Insurance Commis-  
 25 sioners, shall establish a program to enable each State,



1 for any plan year beginning in the 3-year period beginning  
 2 January 1, 2020, to—

3 “(1) provide reinsurance payments to health in-  
 4 surance issuers with respect to individuals enrolled  
 5 under individual health insurance coverage offered  
 6 by such issuers; or

7 “(2) provide assistance (other than through  
 8 payments described in paragraph (1)) to reduce out-  
 9 of-pocket costs, such as copayments, coinsurance,  
 10 premiums, and deductibles, of individuals enrolled  
 11 under qualified health plans offered in the individual  
 12 market through an Exchange.

13 “(b) APPROPRIATIONS.—There is appropriated, out  
 14 of any money in the Treasury not otherwise appropriated,  
 15 \$30,000,000,000 for the period of fiscal years 2020  
 16 through 2022 for purposes of establishing and admin-  
 17 istering the program established under this section. Such  
 18 amount shall remain available until expended.”.

19 **SEC. 9. EXPANDING RATING RULES TO LARGE GROUP MAR-**  
 20 **KET.**

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

- 23 (1) in paragraph (1), by striking “small”; and  
 24 (2) by striking paragraph (5).

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 subsection (a) shall apply to plans offered in the first plan  
 3 year beginning after the date of enactment of this Act and  
 4 any plan year thereafter.

5 **SEC. 10. PROTECTION OF CONSUMERS FROM EXCESSIVE,**  
 6 **UNJUSTIFIED, OR UNFAIRLY DISCRIMINA-**  
 7 **TORY RATES.**

8 (a) PROTECTION FROM EXCESSIVE, UNJUSTIFIED,  
 9 OR UNFAIRLY DISCRIMINATORY RATES.—The first sec-  
 10 tion 2794 of the Public Health Service Act (42 U.S.C.  
 11 300gg–94), as added by section 1003 of the Patient Pro-  
 12 tection and Affordable Care Act (Public Law 111–148),  
 13 is amended by adding at the end the following new sub-  
 14 section:

15 “(e) PROTECTION FROM EXCESSIVE, UNJUSTIFIED,  
 16 OR UNFAIRLY DISCRIMINATORY RATES.—

17 “(1) AUTHORITY OF STATES.—Nothing in this  
 18 section shall be construed to prohibit a State from  
 19 imposing requirements (including requirements re-  
 20 lating to rate review standards and procedures and  
 21 information reporting) on health insurance issuers  
 22 with respect to rates that are in addition to the re-  
 23 quirements of this section and are more protective of  
 24 consumers than such requirements.

1           “(2) CONSULTATION IN RATE REVIEW PROC-  
2           ESS.—In carrying out this section, the Secretary  
3           shall consult with the National Association of Insur-  
4           ance Commissioners and consumer groups.

5           “(3) DETERMINATION OF WHO CONDUCTS RE-  
6           VIEWS FOR EACH STATE.—The Secretary shall de-  
7           termine, after the date of enactment of this sub-  
8           section and periodically thereafter, the following:

9                   “(A) In which markets in each State the  
10                  State insurance commissioner or relevant State  
11                  regulator shall undertake the corrective actions  
12                  under paragraph (4), as a condition of the  
13                  State receiving the grant in subsection (c),  
14                  based on the Secretary’s determination that the  
15                  State insurance commissioner or relevant State  
16                  regulator is adequately undertaking and uti-  
17                  lizing such actions in that market.

18                  “(B) In which markets in each State the  
19                  Secretary shall undertake the corrective actions  
20                  under paragraph (4), in cooperation with the  
21                  relevant State insurance commissioner or State  
22                  regulator, based on the Secretary’s determina-  
23                  tion that the State is not adequately under-  
24                  taking and utilizing such actions in that mar-  
25                  ket.

1           “(4) CORRECTIVE ACTION FOR EXCESSIVE, UN-  
 2 JUSTIFIED, OR UNFAIRLY DISCRIMINATORY  
 3 RATES.—In accordance with the process established  
 4 under this section, the Secretary or the relevant  
 5 State insurance commissioner or State regulator  
 6 shall take corrective actions to ensure that any ex-  
 7 cessive, unjustified, or unfairly discriminatory rates  
 8 are corrected prior to implementation, or as soon as  
 9 possible thereafter, through mechanisms such as—

10                   “(A) denying rates;

11                   “(B) modifying rates; or

12                   “(C) requiring rebates to consumers.

13           “(5) NONCOMPLIANCE.—Failure to comply with  
 14 any corrective action taken by the Secretary under  
 15 this subsection may result in the application of civil  
 16 monetary penalties and, if the Secretary determines  
 17 appropriate, make the plan involved ineligible for  
 18 classification as a qualified health plan.”.

19           (b) CLARIFICATION OF REGULATORY AUTHORITY.—  
 20 Such section is further amended—

21                   (1) in subsection (a)—

22                           (A) in the subsection heading, by striking  
 23 “PREMIUM” and inserting “RATE”;

24                           (B) in paragraph (1), by striking “unrea-  
 25 sonable increases in premiums” and inserting

1 “potentially excessive, unjustified, or unfairly  
2 discriminatory rates, including premiums,”; and

3 (C) in paragraph (2)—

4 (i) by striking “an unreasonable pre-  
5 mium increase” and inserting “a poten-  
6 tially excessive, unjustified, or unfairly dis-  
7 criminatory rate”;

8 (ii) by striking “the increase” and in-  
9 serting “the rate”; and

10 (iii) by striking “such increases” and  
11 inserting “such rates”;

12 (2) in subsection (b)—

13 (A) in the subsection heading, by striking  
14 “PREMIUM” and inserting “RATE”;

15 (B) by striking “premium increases” each  
16 place it appears and inserting “rates”;

17 (C) in paragraph (1), in the paragraph  
18 heading, by striking “PREMIUM INCREASE” and  
19 inserting “RATE”; and

20 (D) in paragraph (2)—

21 (i) in the paragraph heading, by strik-  
22 ing “PREMIUM INCREASES” and inserting  
23 “RATES”; and

24 (ii) in subparagraph (B), by striking  
25 “premium” and inserting “rate”; and

1 (3) in subsection (c)(1)—

2 (A) in the heading, by striking “PRE-  
3 MIUM” and inserting “RATE”;

4 (B) by inserting “that satisfy the condition  
5 under subsection (e)(3)(A)” after “award  
6 grants to States”; and

7 (C) in subparagraph (A), by striking “pre-  
8 mium increases” and inserting “rates”.

9 (c) CONFORMING AMENDMENTS.—

10 (1) PUBLIC HEALTH SERVICE ACT.—Title  
11 XXVII of the Public Health Service Act (42 U.S.C.  
12 300gg et seq.) is amended—

13 (A) in section 2723 (42 U.S.C. 300gg–  
14 22)—

15 (i) in subsection (a)—

16 (I) in paragraph (1), by inserting  
17 “and section 2794 (relating to the  
18 reasonableness of rates with respect to  
19 health insurance coverage)” after  
20 “this part”; and

21 (II) in paragraph (2), by insert-  
22 ing “or such section 2794” after “this  
23 part”; and

24 (ii) in subsection (b)—

1 (I) in paragraph (1), by inserting  
2 “and section 2794 (relating to the  
3 reasonableness of rates with respect to  
4 health insurance coverage)” after  
5 “this part”; and

6 (II) in paragraph (2)—

7 (aa) in subparagraph (A),  
8 by inserting “or such section  
9 2794 that is” after “this part”;  
10 and

11 (bb) in subparagraph (C)(ii),  
12 by inserting “or such section  
13 2794” after “this part”; and

14 (B) in section 2761 (42 U.S.C. 300gg–  
15 61)—

16 (i) in subsection (a)—

17 (I) in paragraph (1), by inserting  
18 “and section 2794 (relating to the  
19 reasonableness of rates with respect to  
20 health insurance coverage)” after  
21 “this part”; and

22 (II) in paragraph (2)—

23 (aa) by inserting “or such  
24 section 2794” after “set forth in  
25 this part”; and

1 (bb) by inserting “and such  
 2 section 2794” after “the require-  
 3 ments of this part”; and

4 (ii) in subsection (b), by inserting  
 5 “and such section 2794” after “this part”.

6 (2) PATIENT PROTECTION AND AFFORDABLE  
 7 CARE ACT.—Section 1311(e)(2) of the Patient Pro-  
 8 tection and Affordable Care Act (42 U.S.C.  
 9 18031(e)(2)) is amended by striking “unjustified  
 10 premium increases” and inserting “unjustified  
 11 rates”.

12 (d) APPLICABILITY TO GRANDFATHERED PLANS.—  
 13 Section 1251(a)(4)(A) of the Patient Protection and Af-  
 14 fordable Care Act (42 U.S.C. 18011(a)(4)(A)) is amended  
 15 by adding at the end the following:

16 “(v) Section 2794 (relating to reason-  
 17 ableness of rates with respect to health in-  
 18 surance coverage).”.

19 (e) EFFECTIVE DATE.—The amendments made by  
 20 this section shall take effect on the date of enactment of  
 21 this Act and shall be implemented with respect to health  
 22 plans beginning not later than January 1, 2020.

23 **SEC. 11. SENSE OF CONGRESS.**

24 It is the sense of the Congress that—



- 1           (1) the Federal Government, acting in its ca-  
2           pacity as an insurer, employer, or health care pro-  
3           vider, should serve as a model for the Nation to en-  
4           sure coverage of all reproductive services; and
- 5           (2) all restrictions on coverage of reproductive  
6           services in the private insurance market should end.

○