

116TH CONGRESS
1ST SESSION

S. 1261

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

IN THE SENATE OF THE UNITED STATES

MAY 1, 2019

Mr. MERKLEY (for himself, Mr. MURPHY, Mrs. FEINSTEIN, Ms. HARRIS, Mr. BLUMENTHAL, Mr. SCHATZ, Ms. BALDWIN, Mr. DURBIN, Mr. REED, Ms. SMITH, Mrs. SHAHEEN, Ms. DUCKWORTH, Mr. BOOKER, Mrs. GILLIBRAND, and Mr. HEINRICH) introduced the following bill; which was read twice and referred to the Committee on Finance

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:

8 “TITLE XXII—MEDICARE PART E PUBLIC HEALTH PLANS

9 “SEC. 2201. PUBLIC HEALTH PLANS.—

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

5 “(b) BENEFITS.—

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

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

20 “(B) provides coverage of—

21 “(i) the essential health benefits de-
 22 scribed in section 1302(b) of the Patient
 23 Protection and Affordable Care Act (42
 24 U.S.C. 18022(b)); and

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

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

7 “(D) provides coverage of abortions and all
8 other reproductive services.

9 “(2) PREEMPTION.—Notwithstanding section
10 1303(a)(1) of the Patient Protection and Affordable
11 Care Act (42 U.S.C. 18023(a)(1))—

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

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

18 “(c) ELIGIBILITY; ENROLLMENT.—

19 “(1) AVAILABILITY ON THE EXCHANGES.—The
20 Medicare part E plans offered in the individual and
21 small group markets shall be offered through the
22 Federal and State Exchanges, including the Small
23 Business Health Options Program Exchanges (com-
24 monly referred to as the ‘SHOP Exchanges’).

25 “(2) ELIGIBILITY.—

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

“(B) EXCLUSIONS.—An individual described in this subparagraph is any individual who is—

“(i) entitled to, or enrolled for, benefits under title XVIII;

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

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

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

“(3) EMPLOYER-SPONSORED PLANS.—

“(A) EMPLOYER ENROLLMENT.—Effective with respect to the first plan year that begins 1 year after the date of enactment of the Choose Medicare Act and each plan year thereafter, the Secretary shall provide options for

1 Medicare part E plans in the small group mar-
2 ket and large group market that are voluntary,
3 and available to all employers.

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

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

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

3 “(1) are adjusted based on—

4 “(A) whether the plan is offered in the in-
5 dividual market, small group market, or large
6 group market; and

7 “(B) the applicable rating area;

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

9 “(A) the costs of health benefits provided
10 by such plans; and

11 “(B) administrative costs related to oper-
12 ating the plans; and

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

17 “(e) PROVIDERS AND REIMBURSEMENT RATES.—

18 “(1) IN GENERAL.—The Secretary shall estab-
19 lish a rate schedule for reimbursing types of health
20 care providers furnishing items and services under
21 the Medicare part E plans at rates that are con-
22 sistent with the negotiations described in paragraph
23 (2) and are necessary to maintain network adequacy.

24 “(2) MANNER OF NEGOTIATION.—The Sec-
25 retary shall negotiate the rates described in para-

graph (1) in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII, and not higher, in the aggregate, than the average rates paid by other health insurance issuers offering health insurance coverage through an Exchange.

“(3) PARTICIPATING PROVIDERS.—

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

“(B) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers for Medicare part E plans.

“(4) LIMITATIONS ON BALANCE BILLING.—The limitations on balance billing pursuant to the provisions of section 1866(a)(1)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(A)) shall apply to participating providers for Medicare part E plans in the same manner as such provisions apply to participating providers under the Medicare program.

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

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

16 “(h) APPROPRIATIONS.—

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

22 “(2) INITIAL RESERVES.—There is appro-
 23 priated to the Secretary, out of any funds in the
 24 Treasury not otherwise obligated, such sums as may
 25 be necessary, based on projected enrollment in the

1 Medicare part E plans in the first plan year in
 2 which such plans are offered, to provide reserves for
 3 the purpose of paying claims filed during the initial
 4 90-day period of such plan year.

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

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

13 **SEC. 3. NOTICE AND NAVIGATOR REFERRAL FOR EMPLOY-**
 14 **EES UNDER THE FAIR LABOR STANDARDS**
 15 **ACT OF 1938.**

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

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

20 (2) by redesignating subsection (b) as sub-
 21 section (c);

22 (3) by inserting after subsection (a) the fol-
 23 lowing:

24 “(b) NAVIGATOR REFERRAL.—

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

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

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

15 “(2) REFERRAL.—The referral described in
16 paragraph (1) shall occur—

17 “(A) at the time the employer hires the
18 employee; or

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

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

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

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

8 “(i) to be unaffordable to the em-
 9 ployee; or

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

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

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

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

18 “(1) NOTICE.—Subsection (a);”; and

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

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

24 (b) STUDY.—Not later than January 1, 2024, the
 25 Comptroller General of the United States shall conduct

1 a study on the impact of the requirements under section
 2 18B of the Fair Labor Standards Act of 1938 (29 U.S.C.
 3 218b), including the amendments made by subsection (a),
 4 on the rate of individuals without minimum essential cov-
 5 erage as defined in section 5000A of the Internal Revenue
 6 Code of 1986 in the United States and in each State.

7 (c) FUNDING FOR NAVIGATOR PROGRAM.—Section
 8 1311(i)(6) of the Patient Protection and Affordable Care
 9 Act (42 U.S.C. 18031(i)(6)) is amended—

10 (1) by striking “Grants” and inserting the fol-
 11 lowing:

12 “(A) IN GENERAL.—Grants”; and

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

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

19 **SEC. 4. PROTECTING AGAINST HIGH OUT-OF-POCKET EX-**
 20 **PENDITURES FOR MEDICARE FEE-FOR-SERV-**
 21 **ICE BENEFITS.**

22 Title XVIII of the Social Security Act (42 U.S.C.
 23 1395 et seq.) is amended by adding at the end the fol-
 24 lowing new section:

12 “(b) ANNUAL OUT-OF-POCKET LIMIT.—

15 “(A) for 2021, \$6,700; or

23 “(2) ROUNDING.—If any amount determined
24 under paragraph (1)(B) is not a multiple of \$5, such

1 amount shall be rounded to the nearest multiple of
2 \$5.

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

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

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

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

14 “(2) CERTAIN COSTS NOT INCLUDED.—

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

21 “(B) ITEMS AND SERVICES NOT FUR-
22 NISHED ON AN ASSIGNMENT-RELATED BASIS.—
23 If an item or service is furnished to an indi-
24 vidual under this title and is not furnished on
25 an assignment-related basis, any additional ex-

penses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

“(3) SOURCE OF PAYMENT.—For purposes of paragraph (1), the Secretary shall consider expenses to be incurred by the individual without regard to whether the individual or another person, including a State program, an employer, a Medicare supplemental policy, or other third-party coverage, has paid for such expenses.

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

SEC. 5. NEGOTIATING FAIR PRICES FOR MEDICARE PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and by inserting the following:

1 “(i) NEGOTIATING FAIR PRICES WITH DRUG MANU-
2 FACTURERS.—

3 “(1) IN GENERAL.—Notwithstanding any other
4 provision of law, in furtherance of the goals of pro-
5 viding quality care and containing costs under this
6 part, the Secretary shall, with respect to applicable
7 covered part D drugs, and may, with respect to
8 other covered part D drugs, negotiate, using the ne-
9 gotiation technique or techniques that the Secretary
10 determines will maximize savings and value to the
11 government for prescription drug plans and MA–PD
12 plans and for plan enrollees (in a manner that may
13 be similar to Federal entities and that may include,
14 but is not limited to, formularies, reference pricing,
15 discounts, rebates, other price concessions, and cov-
16 erage determinations), with drug manufacturers the
17 prices that may be charged to PDP sponsors and
18 MA organizations for such drugs for part D eligible
19 individuals who are enrolled in a prescription drug
20 plan or in an MA–PD plan. In conducting such ne-
21 gotiations, the Secretary shall consider the drug’s
22 current price, initial launch price, prevalence of dis-
23 ease and usage, and approved indications, the num-
24 ber of similarly effective alternative treatments for
25 each approved use of the drug, the budgetary impact

1 of providing coverage under this part for such drug
2 for all individuals who would likely benefit from the
3 drug, evidence on the drug's effectiveness and safety
4 compared to similar drugs, and the quality and
5 quantity of clinical data and rigor of the applicable
6 process of approval of a drug under section 505 of
7 the Federal Food, Drug, and Cosmetic Act or a bio-
8 logical product under section 351 of the Public
9 Health Service Act.

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

22 “(A) the price paid by the Secretary of
23 Veterans Affairs to procure the drug under the
24 laws administered by the Secretary of Veterans
25 Affairs; or

1 “(B) the price paid to procure the drug
2 under section 8126 of title 38, United States
3 Code.

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

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

12 “(B) The proportion of total spending
13 under this title.

14 “(C) Unit price increases over the pre-
15 ceding 5 years.

16 “(D) Initial launch price.

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

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

21 “(G) Any other criteria determined by the
22 Secretary.

23 “(4) PDP SPONSORS AND MA ORGANIZATION
24 MAY NEGOTIATE LOWER PRICES.—Nothing in this
25 subsection shall be construed as preventing the spon-

1 sor of a prescription drug plan, or an organization
 2 offering an MA–PD plan, from obtaining a discount
 3 or reduction of the price for a covered part D drug
 4 below the price negotiated under paragraph (1) or
 5 the price established under paragraph (2).

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

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

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

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

16 (1) IN GENERAL.—Clause (i) of section
 17 36B(b)(2)(B) of the Internal Revenue Code of 1986
 18 is amended by striking “applicable second lowest
 19 cost silver plan” and inserting “applicable second
 20 lowest cost gold plan”.

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

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

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

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

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

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

20 (A) by striking “400 percent” and insert-
 21 ing “600 percent”; and

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

1 (c) ELIMINATION OF FAILSAFE.—Section
 2 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986 is
 3 amended by striking subclause (III).

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

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

8 (a) DEFINITION OF ELIGIBLE INDIVIDUAL.—Section
 9 1402(b)(1) of the Patient Protection and Affordable Care
 10 Act (42 U.S.C. 1807(b)(1)) is amended by striking “silver
 11 level” and inserting “gold level”.

12 (b) MODIFICATION OF AMOUNT.—

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

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

21 “(A) in the case of an eligible insured
 22 whose household income is not less than 100
 23 percent but not more than 133 percent of the
 24 poverty line for a family of the size involved, in-
 25 crease the plan’s share of the total allowed

1 costs of benefits provided under the plan to 94
2 percent of such costs;

3 “(B) in the case of an eligible insured
4 whose household income is more than 133 per-
5 cent but not more than 150 percent of the pov-
6 erty 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 92
9 percent of such costs;

10 “(C) in the case of an eligible insured
11 whose household income is more than 150 per-
12 cent but not more than 200 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 90
16 percent of such costs;

17 “(D) in the case of an eligible insured
18 whose household income is more than 200 per-
19 cent but not more than 300 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 85
23 percent of such costs; and

24 “(E) in the case of an eligible insured
25 whose household income is more than 300 per-

cent 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);

“(II) 92 percent in the case of an eligible insured described in paragraph (2)(B);

“(III) 90 percent in the case of an eligible insured described in paragraph (2)(C);

“(IV) 85 percent in the case of an eligible insured described in paragraph (2)(D); and

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

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

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

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

11 **“SEC. 1341A. REINSURANCE AND AFFORDABILITY FUND**
 12 **FOR THE INDIVIDUAL MARKET IN EACH**
 13 **STATE.**

14 “(a) IN GENERAL.—The Secretary, in consultation
 15 with the National Association of Insurance Commis-
 16 sioners, shall establish a program to enable each State,
 17 for any plan year beginning in the 3-year period beginning
 18 January 1, 2020, to—

19 “(1) provide reinsurance payments to health in-
 20 surance issuers with respect to individuals enrolled
 21 under individual health insurance coverage offered
 22 by such issuers; or

23 “(2) provide assistance (other than through
 24 payments described in paragraph (1)) to reduce out-
 25 of-pocket costs, such as copayments, coinsurance,

1 premiums, and deductibles, of individuals enrolled
 2 under qualified health plans offered in the individual
 3 market through an Exchange.

4 “(b) APPROPRIATIONS.—There is appropriated, out
 5 of any money in the Treasury not otherwise appropriated,
 6 \$30,000,000,000 for the period of fiscal years 2020
 7 through 2022 for purposes of establishing and admin-
 8 istering the program established under this section. Such
 9 amount shall remain available until expended.”.

10 **SEC. 9. EXPANDING RATING RULES TO LARGE GROUP MAR-**
 11 **KET.**

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

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

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

20 **SEC. 10. PROTECTION OF CONSUMERS FROM EXCESSIVE,**
 21 **UNJUSTIFIED, OR UNFAIRLY DISCRIMINA-**
 22 **TORY RATES.**

23 (a) PROTECTION FROM EXCESSIVE, UNJUSTIFIED,
 24 OR UNFAIRLY DISCRIMINATORY RATES.—The first sec-
 25 tion 2794 of the Public Health Service Act (42 U.S.C.

1 300gg–94), as added by section 1003 of the Patient Pro-
 2 tection and Affordable Care Act (Public Law 111–148),
 3 is amended by adding at the end the following new sub-
 4 section:

5 “(e) PROTECTION FROM EXCESSIVE, UNJUSTIFIED,
 6 OR UNFAIRLY DISCRIMINATORY RATES.—

7 “(1) AUTHORITY OF STATES.—Nothing in this
 8 section shall be construed to prohibit a State from
 9 imposing requirements (including requirements re-
 10 lating to rate review standards and procedures and
 11 information reporting) on health insurance issuers
 12 with respect to rates that are in addition to the re-
 13 quirements of this section and are more protective of
 14 consumers than such requirements.

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

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

23 “(A) In which markets in each State the
 24 State insurance commissioner or relevant State
 25 regulator shall undertake the corrective actions

under paragraph (4), as a condition of the State receiving the grant in subsection (c), based on the Secretary's determination that the State insurance commissioner or relevant State regulator is adequately undertaking and utilizing such actions in that market.

“(B) In which markets in each State the Secretary shall undertake the corrective actions under paragraph (4), in cooperation with the relevant State insurance commissioner or State regulator, based on the Secretary's determination that the State is not adequately undertaking and utilizing such actions in that market.

“(4) CORRECTIVE ACTION FOR EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—In accordance with the process established under this section, the Secretary or the relevant State insurance commissioner or State regulator shall take corrective actions to ensure that any excessive, unjustified, or unfairly discriminatory rates are corrected prior to implementation, or as soon as possible thereafter, through mechanisms such as—

“(A) denying rates;

“(B) modifying rates; or

1 “(C) requiring rebates to consumers.

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

8 (b) CLARIFICATION OF REGULATORY AUTHORITY.—
9 Such section is further amended—

10 (1) in subsection (a)—

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

13 (B) in paragraph (1), by striking “unrea-
14 sonable increases in premiums” and inserting
15 “potentially excessive, unjustified, or unfairly
16 discriminatory rates, including premiums,”; and

17 (C) in paragraph (2)—

18 (i) by striking “an unreasonable pre-
19 mium increase” and inserting “a poten-
20 tially excessive, unjustified, or unfairly dis-
21 criminatory rate”;

22 (ii) by striking “the increase” and in-
23 serting “the rate”; and

24 (iii) by striking “such increases” and
25 inserting “such rates”;

1 (2) in subsection (b)—

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

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

6 (C) in paragraph (1), in the paragraph
7 heading, by striking “PREMIUM INCREASE” and
8 inserting “RATE”; and

9 (D) in paragraph (2)—

10 (i) in the paragraph heading, by strik-
11 ing “PREMIUM INCREASES” and inserting
12 “RATES”; and

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

15 (3) in subsection (c)(1)—

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

18 (B) by inserting “that satisfy the condition
19 under subsection (e)(3)(A)” after “award
20 grants to States”; and

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

23 (c) CONFORMING AMENDMENTS.—

1 (1) PUBLIC HEALTH SERVICE ACT.—Title
 2 XXVII of the Public Health Service Act (42 U.S.C.
 3 300gg et seq.) is amended—

4 (A) in section 2723 (42 U.S.C. 300gg–
 5 22)—

6 (i) in subsection (a)—

7 (I) in paragraph (1), by inserting
 8 “and section 2794 (relating to the
 9 reasonableness of rates with respect to
 10 health insurance coverage)” after
 11 “this part”; and

12 (II) in paragraph (2), by insert-
 13 ing “or such section 2794” after “this
 14 part”; and

15 (ii) in subsection (b)—

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)—

22 (aa) in subparagraph (A),
 23 by inserting “or such section
 24 2794 that is” after “this part”;
 25 and

1 (bb) in subparagraph (C)(ii),
 2 by inserting “or such section
 3 2794” after “this part”; and

4 (B) in section 2761 (42 U.S.C. 300gg–
 5 61)—

6 (i) in subsection (a)—

7 (I) in paragraph (1), by inserting
 8 “and section 2794 (relating to the
 9 reasonableness of rates with respect to
 10 health insurance coverage)” after
 11 “this part”; and

12 (II) in paragraph (2)—

13 (aa) by inserting “or such
 14 section 2794” after “set forth in
 15 this part”; and

16 (bb) by inserting “and such
 17 section 2794” after “the require-
 18 ments of this part”; and

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

21 (2) PATIENT PROTECTION AND AFFORDABLE
 22 CARE ACT.—Section 1311(e)(2) of the Patient Pro-
 23 tection and Affordable Care Act (42 U.S.C.
 24 18031(e)(2)) is amended by striking “unjustified

1 premium increases” and inserting “unjustified
2 rates”.

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

7 “(v) Section 2794 (relating to reason-
8 ableness of rates with respect to health in-
9 surance coverage).”.

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

14 **SEC. 11. SENSE OF CONGRESS.**

15 It is the sense of the Congress that—

16 (1) the Federal Government, acting in its ca-
17 pacity as an insurer, employer, or health care pro-
18 vider, should serve as a model for the Nation to en-
19 sure coverage of all reproductive services; and

20 (2) all restrictions on coverage of reproductive
21 services in the private insurance market should end.

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