

115TH CONGRESS
2D SESSION

S. 2708

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

IN THE SENATE OF THE UNITED STATES

APRIL 18, 2018

Mr. MERKLEY (for himself, Mr. MURPHY, Ms. HARRIS, Mr. BOOKER, Ms. BALDWIN, Mrs. GILLIBRAND, Mr. SCHATZ, Mrs. SHAHEEN, Mr. HEINRICH, Mr. BLUMENTHAL, and Mr. UDALL) 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.

“(f) ENCOURAGING USE OF ALTERNATIVE PAYMENT MODELS.—The Secretary shall, as applicable, utilize alternative payment models, including those described in section 1833(z)(3)(C), as added by section 101(e)(2) of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), in making payments for items and services (including prescription drugs) furnished under

1 Medicare part E plans. The payment rates under such al-
 2 ternative payment models shall comply with the require-
 3 ment for negotiated rates under subsection (e)(2).

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

9 “(h) APPROPRIATIONS.—

10 “(1) START UP FUNDING.—For purposes of es-
 11 tablishing the Medicare part E plans, there is appro-
 12 priated to the Secretary, out of any funds in the
 13 Treasury not otherwise obligated, \$2,000,000,000,
 14 for fiscal year 2019.

15 “(2) INITIAL RESERVES.—There is appro-
 16 priated to the Secretary, out of any funds in the
 17 Treasury not otherwise obligated, such sums as may
 18 be necessary, based on projected enrollment in the
 19 Medicare part E plans in the first plan year in
 20 which such plans are offered, to provide reserves for
 21 the purpose of paying claims filed during the initial
 22 90-day period of such plan year.

23 “(3) CLARIFICATION.—Any provision of law re-
 24 stricting the use of Federal funds with respect to

1 any reproductive health service shall not apply to
 2 funds appropriated under paragraph (1) or (2).

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

7 **SEC. 3. NOTICE AND NAVIGATOR REFERRAL FOR EMPLOY-**
 8 **EES UNDER THE FAIR LABOR STANDARDS**
 9 **ACT OF 1938.**

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

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

14 (2) by redesignating subsection (b) as sub-
 15 section (c);

16 (3) by inserting after subsection (a) the fol-
 17 lowing:

18 “(b) NAVIGATOR REFERRAL.—

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

23 “(A) an entity that serves as a navigator
 24 under section 1311(i) of the Patient Protection
 25 and Affordable Care Act (42 U.S.C. 18031(i))

1 for the Exchange operating in the State of the
2 employer; or

3 “(B) if the Exchange operating in the
4 State of the employer does not have an entity
5 serving as such a navigator, another entity that
6 shall carry out equivalent activities as such a
7 navigator.

8 “(2) REFERRAL.—The referral described in
9 paragraph (1) shall occur—

10 “(A) at the time the employer hires the
11 employee; or

12 “(B) on the effective date described in sub-
13 section (c)(2) with respect to an employee who
14 is currently employed by the employer on such
15 date.

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

18 “(A) does not provide an eligible employer-
19 sponsored plan as defined in section
20 5000A(f)(2) of the Internal Revenue Code of
21 1986; or

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

1 “(i) to be unaffordable to the em-
 2 ployee; or

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

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

6 (A) in the heading, by striking “EFFECTIVE
 7 DATE” and inserting “EFFECTIVE
 8 DATES”;

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

11 “(1) NOTICE.—Subsection (a);” and

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

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

17 (b) STUDY.—Not later than January 1, 2023, the
 18 Comptroller General of the United States shall conduct
 19 a study on the impact of the requirements under section
 20 18B of the Fair Labor Standards Act of 1938 (29 U.S.C.
 21 218b), including the amendments made by subsection (a),
 22 on the rate of individuals without minimum essential cov-
 23 erage as defined in section 5000A of the Internal Revenue
 24 Code of 1986 in the United States and in each State.

1 (c) FUNDING FOR NAVIGATOR PROGRAM.—Section
 2 1311(i)(6) of the Patient Protection and Affordable Care
 3 Act (42 U.S.C. 18031(i)(6)) is amended—

4 (1) by striking “Grants” and inserting the fol-
 5 lowing:

6 “(A) IN GENERAL.—Grants”; and

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

8 “(B) AUTHORIZATION OF APPROPRIA-
 9 TIONS.—There is authorized to be appropriated
 10 such sums as may be necessary to address ca-
 11 pacity limitations of entities serving as naviga-
 12 tors through a grant under this subsection.”.

13 **SEC. 4. PROTECTING AGAINST HIGH OUT-OF-POCKET EX-**
 14 **PENDITURES FOR MEDICARE FEE-FOR-SERV-**
 15 **ICE BENEFITS.**

16 Title XVIII of the Social Security Act (42 U.S.C.
 17 1395 et seq.) is amended by adding at the end the fol-
 18 lowing new section:

19 “PROTECTION AGAINST HIGH OUT-OF-POCKET
 20 EXPENDITURES

21 “SEC. 1899D. (a) IN GENERAL.—Notwithstanding
 22 any other provision of this title, in the case of an indi-
 23 vidual entitled to, or enrolled for, benefits under part A
 24 or enrolled in part B, if the amount of the out-of-pocket
 25 cost-sharing of such individual for a year (beginning with
 26 2020) equals or exceeds the annual out-of-pocket limit

1 under subsection (b) for that year, the individual shall not
 2 be responsible for additional out-of-pocket cost-sharing in-
 3 curred during that year.

4 “(b) ANNUAL OUT-OF-POCKET LIMIT.—

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

7 “(A) for 2020, \$6,700; or

8 “(B) for a subsequent year, the amount
 9 specified in this subsection for the preceding
 10 year increased or decreased by the percentage
 11 change in the medical care component of the
 12 Consumer Price Index for All Urban Con-
 13 sumers for the 12-month period ending with
 14 June of such preceding year.

15 “(2) ROUNDING.—If any amount determined
 16 under paragraph (1)(B) is not a multiple of \$5, such
 17 amount shall be rounded to the nearest multiple of
 18 \$5.

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

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

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

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

6 “(2) CERTAIN COSTS NOT INCLUDED.—

7 “(A) NON-COVERED ITEMS AND SERV-
8 ICES.—Expenses incurred for items and serv-
9 ices which are not covered under part A or B
10 shall not be considered incurred expenses for
11 purposes of determining out-of-pocket cost-
12 sharing under paragraph (1).

13 “(B) ITEMS AND SERVICES NOT FUR-
14 NISHED ON AN ASSIGNMENT-RELATED BASIS.—
15 If an item or service is furnished to an indi-
16 vidual under this title and is not furnished on
17 an assignment-related basis, any additional ex-
18 penses the individual incurs above the amount
19 the individual would have incurred if the item
20 or service was furnished on an assignment-re-
21 lated basis shall not be considered incurred ex-
22 penses for purposes of determining out-of-pock-
23 et cost-sharing under paragraph (1).

24 “(3) SOURCE OF PAYMENT.—For purposes of
25 paragraph (1), the Secretary shall consider expenses

1 to be incurred by the individual without regard to
 2 whether the individual or another person, including
 3 a State program, an employer, a medicare supple-
 4 mental policy, or other third-party coverage, has
 5 paid for such expenses.

6 “(d) ANNOUNCEMENT OF THE ANNUAL OUT-OF-
 7 POCKET LIMIT.—The Secretary shall (beginning in 2019)
 8 announce (in a manner intended to provide notice to all
 9 interested parties) the annual out-of-pocket limit under
 10 this section that will be applicable for the succeeding
 11 year.”.

12 **SEC. 5. NEGOTIATING FAIR PRICES FOR MEDICARE PRE-**
 13 **SCRIPTION DRUGS.**

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

18 “(i) NEGOTIATING FAIR PRICES WITH DRUG MANU-
 19 FACTURERS.—

20 “(1) IN GENERAL.—Notwithstanding any other
 21 provision of law, in furtherance of the goals of pro-
 22 viding quality care and containing costs under this
 23 part, the Secretary shall, with respect to applicable
 24 covered part D drugs, and may, with respect to
 25 other covered part D drugs, negotiate, using the ne-

1 gotiation technique or techniques that the Secretary
2 determines will maximize savings and value to the
3 government for prescription drug plans and MA–PD
4 plans and for plan enrollees (in a manner that may
5 be similar to Federal entities and that may include,
6 but is not limited to, formularies, reference pricing,
7 discounts, rebates, other price concessions, and cov-
8 erage determinations), with drug manufacturers the
9 prices that may be charged to PDP sponsors and
10 MA organizations for such drugs for part D eligible
11 individuals who are enrolled in a prescription drug
12 plan or in an MA–PD plan. In conducting such ne-
13 gotiations, the Secretary shall consider the drug’s
14 current price, initial launch price, prevalence of dis-
15 ease and usage, and approved indications, the num-
16 ber of similarly effective alternative treatments for
17 each approved use of the drug, the budgetary impact
18 of providing coverage under this part for such drug
19 for all individuals who would likely benefit from the
20 drug, evidence on the drug’s effectiveness and safety
21 compared to similar drugs, and the quality and
22 quantity of clinical data and rigor of the applicable
23 process of approval of a drug under section 505 of
24 the Federal Food, Drug, and Cosmetic Act or a bio-

1 logical product under section 351 of the Public
2 Health Service Act.

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

15 “(A) the price paid by the Secretary of
16 Veterans Affairs to procure the drug under the
17 laws administered by the Secretary of Veterans
18 Affairs; or

19 “(B) the price paid to procure the drug
20 under section 8126 of title 38, United States
21 Code.

22 “(3) APPLICABLE COVERED PART D DRUG DE-
23 FINED.—For purposes of this subsection, the term
24 ‘applicable covered part D drug’ means a covered
25 part D drug that the Secretary determines to be ap-

1 appropriate for negotiation under paragraph (1) based
 2 on one or more of the following factors as applied
 3 to such drug:

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

5 “(B) The proportion of total spending
 6 under this title.

7 “(C) Unit price increases over the pre-
 8 ceding 5 years.

9 “(D) Initial launch price.

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

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

14 “(G) Any other criteria determined by the
 15 Secretary.

16 “(4) PDP SPONSORS AND MA ORGANIZATION
 17 MAY NEGOTIATE LOWER PRICES.—Nothing in this
 18 subsection shall be construed as preventing the spon-
 19 sor of a prescription drug plan, or an organization
 20 offering an MA–PD plan, from obtaining a discount
 21 or reduction of the price for a covered part D drug
 22 below the price negotiated under paragraph (1) or
 23 the price established under paragraph (2).

24 “(5) NO EFFECT ON EXISTING APPEALS PROC-
 25 ESS.—Nothing in this subsection shall be construed

1 to affect the appeals procedures under subsections
 2 (g) and (h) of section 1860D–4.”.

3 (b) EFFECTIVE DATE.—The amendments made by
 4 this section shall take effect on the date of the enactment
 5 of this Act and shall first apply to negotiations and prices
 6 for plan years beginning on January 1, 2019.

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

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

9 (1) IN GENERAL.—Clause (i) of section
 10 36B(b)(2)(B) of the Internal Revenue Code of 1986
 11 is amended by striking “applicable second lowest
 12 cost silver plan” and inserting “applicable second
 13 lowest cost gold plan”.

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

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

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

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

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

11 (A) by striking “400 percent” and insert-
 12 ing “600 percent”; and

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

15 (c) ELIMINATION OF FAILSAFE.—Section
 16 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986 is
 17 amended by striking subclause (III).

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

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

22 (a) DEFINITION OF ELIGIBLE INDIVIDUAL.—Section
 23 1402(b)(1) of the Patient Protection and Affordable Care
 24 Act (42 U.S.C. 1807(b)(1)) is amended by striking “silver
 25 level” and inserting “gold level”.

1 (b) MODIFICATION OF AMOUNT.—

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

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

10 “(A) in the case of an eligible insured
11 whose household income is not less than 100
12 percent but not more than 133 percent of the
13 poverty 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 94
16 percent of such costs;

17 “(B) in the case of an eligible insured
18 whose household income is more than 133 per-
19 cent but not more than 150 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 92
23 percent of such costs;

24 “(C) in the case of an eligible insured
25 whose household income is more than 150 per-

cent but not more than 200 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;

“(D) 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 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

1 plan’s share of the total allowed costs of
 2 benefits provided under the plan above—

3 “(I) 94 percent in the case of an
 4 eligible insured described in para-
 5 graph (2)(A);

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

9 “(III) 90 percent in the case of
 10 an eligible insured described in para-
 11 graph (2)(C);

12 “(IV) 85 percent in the case of
 13 an eligible insured described in para-
 14 graph (2)(D); and

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

18 (c) EFFECTIVE DATE.—The amendments made by
 19 this section shall apply to plan years beginning after De-
 20 cember 31, 2018.

21 **SEC. 8. REINSURANCE PROGRAM.**

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

1 **“SEC. 1341A. REINSURANCE PROGRAM FOR INDIVIDUAL**
 2 **MARKET IN EACH STATE.**

3 “(a) IN GENERAL.—The Secretary, in consultation
 4 with the National Association of Insurance Commis-
 5 sioners, shall establish a program to enable each State to
 6 carry out a reinsurance program consistent with the provi-
 7 sions described in section 1341 for any plan year begin-
 8 ning in the 3-year period beginning January 1, 2019.

9 “(b) APPROPRIATIONS.—There is appropriated, out
 10 of any money in the Treasury not otherwise appropriated,
 11 \$10,000,000,000 for the period of fiscal years 2019
 12 through 2021 for purposes of establishing and admin-
 13 istering the program established under this section. Such
 14 amount shall remain available until expended.”.

15 **SEC. 9. EXPANDING RATING RULES TO LARGE GROUP MAR-**
 16 **KET.**

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

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

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

25 **SEC. 10. SENSE OF CONGRESS.**

26 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.

○