115TH CONGRESS
2D SESSION

S. 2582

To provide health insurance reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 21, 2018

Ms. WARREN (for herself, Ms. HASSAN, Mr. SANDERS, Ms. HARRIS, Ms. BALDWIN, and Mrs. GILLIBRAND) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide health insurance reform, 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 ''Consumer Health In-
5 surance Protection Act of 2018''.

6 **SEC. 2. TABLE OF CONTENTS.**

7 The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—LIMITING INSURER PROFITS AND PREVENTING UNREASONABLE PREMIUM INCREASES

Sec. 101. Medical loss ratio.
Sec. 102. Ensuring that consumers get value for their dollars.
Sec. 103. Effective date.

TITLE II—MAKING HEALTH INSURANCE COVERAGE AFFORDABLE

Sec. 201. Enhancement of premium assistance credit.
Sec. 202. Enhancements for reduced cost-sharing.
Sec. 203. Cap on prescription drug cost-sharing.
Sec. 204. Standardized options in the bronze, silver, and gold levels of coverage.
Sec. 205. Clarification regarding determination of affordability of employer-sponsored minimum essential coverage.

TITLE III—ENSURING ACCESS TO CARE

Sec. 301. Network adequacy requirements.
Sec. 302. Ensuring adequate coverage in areas with fewer than 3 health insurance issuers offering qualified health plans on the State Exchange.
Sec. 303. Enrollment in Exchanges.
Sec. 304. Marketing and outreach for Exchanges operated by the Secretary.
Sec. 305. Navigator program.

TITLE IV—STRENGTHENING CONSUMER HEALTH INSURANCE PROTECTIONS

Sec. 401. Prohibiting discriminatory premiums based on tobacco use.
Sec. 402. Health insurance consumer information.
Sec. 403. Patient protections.
Sec. 404. Limitation on balance billing for emergency services.
Sec. 405. Notification of provider terminations.
Sec. 406. Short-term limited duration health insurance coverage.
Sec. 407. Protecting essential health benefits.
Sec. 408. Association health plans.

1 # TITLE I—LIMITING INSURER
2 # PROFITS AND PREVENTING
3 # UNREASONABLE PREMIUM
4 # INCREASES

5 **SEC. 101. MEDICAL LOSS RATIO.**

6 Section 2718(b)(1)(A)(ii) of the Public Health Serv-
7 ice Act (42 U.S.C. 300gg–18(b)(1)(A)(ii)) is amended by
8 striking ‘‘80’’ each place it appears and inserting ‘‘85’’.

9 **SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR**
10 **THEIR DOLLARS.**

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

1 (1) in subsection (a)—
2 (A) in paragraph (1), by striking "sub-
3 section (b)(2)(A)" and inserting "subsections
4 (b)(2)(A) and (b)(3)"; and
5 (B) in paragraph (2), by adding at the end
6 the following: "Notwithstanding any other pro-
7 vision of law, a health insurance issuer may not
8 exclude from such disclosure information that is
9 a trade secret or commercial or financial infor-
10 mation described in section 552(b)(4) of title 5,
11 United States Code.";
12 (2) in subsection (b)—
13 (A) in paragraph (2)(A), by inserting "and
14 paragraph (3)" after "subsection (a)(2)"; and
15 (B) by adding at the end the following:
16 "(3) PROHIBITING UNREASONABLE IN-
17 CREASES.—
18 "(A) IN GENERAL.—Beginning with plan
19 years beginning in 2020, the Secretary, or a
20 State pursuant to an effective rate review pro-
21 gram meeting the requirements under para-
22 graph (4)—
23 "(i) shall, consistent with subsection
24 (a)(2) and paragraph (2), review increases
25 in health insurance premiums that are sub-

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

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

9 ''(B) UNREASONABLE INCREASES.—In de-
10 termining whether an increase in health insur-
11 ance premiums is unreasonable under subpara-
12 graph (A)(i)—

13 ''(i) the Secretary shall consider
14 whether the increase is excessive, unjusti-
15 fied, discriminatory, or inadequate; and

16 ''(ii) the State, pursuant to an effec-
17 tive rate review program meeting the re-
18 quirements under paragraph (4), shall
19 apply applicable State law for making such
20 determination.

21 ''(4) STATE EFFECTIVE RATE REVIEW PRO-
22 GRAMS.—A State effective rate review program
23 meets the requirements under this paragraph if—

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

1 that such reviews are a meaningful, effective,
2 and timely review of the data and documenta-
3 tion (including any contracts or documents de-
4 scribed in subparagraph (E)) submitted by
5 health insurance issuers in support of proposed
6 increases in health insurance premiums;
7 "(B) such reviews include an examination
8 of—
9 "(i) the affordability of proposed in-
10 creases in health insurance premiums;
11 "(ii) the quality improvement activi-
12 ties carried out by health insurance issuers
13 proposing the increases; and
14 "(iii) the cost containment activities
15 of health insurance issuers proposing the
16 increases;
17 "(C) the program establishes a mechanism
18 for receiving public comments on proposed in-
19 creases in health insurance premiums reviewed
20 by the State;
21 "(D) such reviews include a review of all
22 public comments received under subparagraph
23 (C);
24 "(E) the program requires each health in-
25 surance issuer proposing an increase in health

1 insurance premiums to submit to the State any
2 provider contracts that may be affected, includ-
3 ing any documents incorporated by reference
4 into such contracts; and
5 "(F) the program requires the State to
6 provide the Secretary its determination of
7 whether each increase reviewed is unreasonable,
8 in a form and manner prescribed by the Sec-
9 retary."; and
10 (3) in subsection (c)—
11 (A) in paragraph (1)—
12 (i) in the heading, by striking "2010
13 THROUGH 2014" and inserting "2020
14 THROUGH 2024"; and
15 (ii) in the matter preceding subpara-
16 graph (A), by striking "2010" and insert-
17 ing "2020"; and
18 (B) in paragraph (2)(B), by striking
19 "2014" and inserting "2024".
20 **SEC. 103. EFFECTIVE DATE.**
21 The amendments made by this title shall apply to
22 plan years beginning after December 31, 2019.

TITLE II—MAKING HEALTH INSURANCE COVERAGE AFFORDABLE

SEC. 201. ENHANCEMENT OF PREMIUM ASSISTANCE CREDIT.

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

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

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

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

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

1 (1) IN GENERAL.—Section 36B(c)(1)(A) of the
2 Internal Revenue Code of 1986 is amended by strik-
3 ing ‘‘but does not exceed 400 percent’’.
4 (2) CONFORMING AMENDMENTS RELATING TO
5 RECAPTURE OF EXCESS ADVANCED PAYMENTS.—
6 Clause (i) of section 36B(f)(2)(B) of such Code is
7 amended—
8 (A) by striking ‘‘In the case of’’ and all
9 that follows through ‘‘the amount of’’ and in-
10 serting ‘‘The amount of’’; and
11 (B) by striking ‘‘but less than 400%’’ in
12 the table therein.
13 (c) DETERMINATION OF APPLICABLE PERCENT-
14 AGE.—
15 (1) IN GENERAL.—Subparagraph (A) of section
16 36B(b)(3) of the Internal Revenue Code of 1986 is
17 amended to read as follows:
18 ‘‘(A) APPLICABLE PERCENTAGE.—The ap-
19 plicable percentage for any taxable year shall be
20 the percentage such that the applicable percent-
21 age for any taxpayer whose household income is
22 within an income tier specified in the following
23 table shall increase, on a sliding scale in a lin-
24 ear manner, from the initial premium percent-

1 age to the final premium percentage specified in
2 such table for such income tier:

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
100% through 133%	0.0%	1.0%
133% through 150%	1.0%	2.0%
150% through 200%	2.0%	4.0%
200% through 250%	4.0%	6.0%
250% through 300%	6.0%	7.0%
300% through 400%	7.0%	8.5%
Over 400%	8.5%	8.5%".

3 (2) CONFORMING AMENDMENTS.—Subsections
4 (c)(2)(C)(iv) and (c)(4)(F) of section 36B of the In-
5 ternal Revenue Code of 1986 are each amended by
6 inserting "(as in effect before the date of the enact-
7 ment of the Consumer Health Insurance Protection
8 Act of 2018)" after "subsection (b)(3)(A)(ii)".
9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 December 31, 2019.
12 **SEC. 202. ENHANCEMENTS FOR REDUCED COST-SHARING.**
13 (a) MODIFICATION OF AMOUNT.—
14 (1) IN GENERAL.—Section 1402 of the Patient
15 Protection and Affordable Care Act (42 U.S.C.
16 18071) is amended—
17 (A) in subsection (b)(1), by striking "sil-
18 ver" and inserting "gold";
19 (B) by amending subsection (c)(1)(B) to
20 read as follows:

1 "(B) COORDINATION WITH ACTUARIAL
2 LIMITS.—The Secretary shall ensure the reduc-
3 tion under this paragraph shall not result in the
4 plan's share of the total allowed costs of bene-
5 fits provided under the plan becoming less
6 than—
7 "(i) 95 percent in the case of an eligi-
8 ble insured described in paragraph (2)(A);
9 "(ii) 90 percent in the case of an eli-
10 gible insured described in paragraph
11 (2)(B); and
12 "(iii) 85 percent in the case of an eli-
13 gible insured described in paragraph
14 (2)(C)."; and
15 (C) by amending subsection (c)(2) to read
16 as follows:
17 "(2) ADDITIONAL REDUCTION.—The Secretary
18 shall establish procedures under which the issuer of
19 a qualified health plan to which this section applies
20 shall further reduce cost-sharing under the plan in
21 a manner sufficient to—
22 "(A) in the case of an eligible insured
23 whose household income is not less than 100
24 percent but not more than 200 percent of the
25 poverty line for a family of the size involved, in-

1 crease the plan's share of the total allowed
2 costs of benefits provided under the plan to 95
3 percent of such costs;
4 "(B) in the case of an eligible insured
5 whose household income is more than 200 per-
6 cent but not more than 300 percent of the pov-
7 erty line for a family of the size involved, in-
8 crease the plan's share of the total allowed
9 costs of benefits provided under the plan to 90
10 percent of such costs; and
11 "(C) in the case of an eligible insured
12 whose household income is more than 300 per-
13 cent but not more than 400 percent of the pov-
14 erty line for a family of the size involved, in-
15 crease the plan's share of the total allowed
16 costs of benefits provided under the plan to 85
17 percent of such costs.".
18 (2) EFFECTIVE DATE.—The amendments made
19 by this subsection shall apply to plan years begin-
20 ning after December 31, 2019.
21 (b) FUNDING.—Section 1402 of the Patient Protec-
22 tion and Affordable Care Act (42 U.S.C. 18071) is amend-
23 ed by adding at the end the following new subsection:
24 "(g) FUNDING.—Out of any funds in the Treasury
25 not otherwise appropriated, there are appropriated to the

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

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

4 (a) QUALIFIED HEALTH PLANS.—Section 1302(c) of
5 the Patient Protection and Affordable Care Act (42
6 U.S.C. 18022(c)) is amended—
7 (1) in paragraph (3)(A)(i), by inserting ''(in-
8 cluding cost-sharing with respect to prescription
9 drugs covered by the plan)'' after ''copayments'';
10 and
11 (2) by adding at the end the following:
12 ''(5) PRESCRIPTION DRUG COST-SHARING.—
13 ''(A) 2020.—For plan years beginning in
14 2020, the cost-sharing incurred under a health
15 plan with respect to prescription drugs covered
16 by the plan shall not exceed $250 per month for
17 each enrolled individual, or $500 for each fam-
18 ily.
19 ''(B) 2021 AND LATER.—
20 ''(i) IN GENERAL.—In the case of any
21 plan year beginning in a calendar year
22 after 2020, the limitation under this para-
23 graph shall be equal to the applicable dol-
24 lar amount under subparagraph (A) for
25 plan years beginning in 2020, increased by

1 an amount equal to the product of that
2 amount and the medical care component of
3 the consumer price index for all urban con-
4 sumers (as published by the Bureau of
5 Labor Statistics) for that year.

6 "(ii) ADJUSTMENT TO AMOUNT.—If
7 the amount of any increase under clause
8 (i) is not a multiple of $5, such increase
9 shall be rounded to the next lowest mul-
10 tiple of $5.".

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

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

19 **SEC. 204. STANDARDIZED OPTIONS IN THE BRONZE, SIL-**
20 **VER, AND GOLD LEVELS OF COVERAGE.**

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

24 (1) in paragraph (1)(C)—

1 (A) in clause (iii), by striking "; and" and
2 inserting ";";
3 (B) by redesignating clause (iv) as clause
4 (v); and
5 (C) by inserting after clause (iii) the fol-
6 lowing:
7 "(iv)(I) agrees to offer the standard-
8 ized option established for the State under
9 paragraph (5) for each level of coverage of-
10 fered by the issuer that is the bronze, sil-
11 ver, or gold level of coverage; and
12 "(II) with respect to offering coverage
13 that is the bronze, silver, or gold level of
14 coverage on an Exchange that is operated
15 by the Secretary, agrees to offer only
16 standardized options established for the
17 State under paragraph (5) and not any
18 other plan for such levels of coverage;
19 and"; and
20 (2) by adding at the end the following:
21 "(5) STANDARDIZED OPTIONS.—
22 "(A) DEFINITION OF STANDARDIZED OP-
23 TION.—In this section, the term 'standardized
24 option' means a qualified health plan—

1 "(i) with a standardized cost-sharing
2 structure established by the applicable
3 State, or the Secretary, in accordance with
4 this paragraph; and
5 "(ii) that is offered on an Exchange.
6 "(B) ESTABLISHMENT.—
7 "(i) STATE.—Each State may estab-
8 lish a standardized option for the bronze,
9 silver, and gold levels of coverage.
10 "(ii) SECRETARY.—The Secretary
11 shall establish a standardized option in a
12 State for any level of coverage described in
13 clause (i) for which the State has not es-
14 tablished a standardized option.
15 "(iii) UPDATES.—The Secretary shall
16 annually update any standardized option
17 established by the Secretary under clause
18 (ii).
19 "(C) DEDUCTIBLE-EXEMPT SERVICES.—
20 "(i) IN GENERAL.—Except as pro-
21 vided in clause (ii), each standardized op-
22 tion established by the Secretary under
23 subparagraph (B)(ii) shall include coverage
24 of each of the following as deductible-ex-
25 empt services:

1 "(I) All primary care visits and
2 specialist visits.
3 "(II) All mental health and sub-
4 stance use disorder outpatient serv-
5 ices.
6 "(III) All drugs approved under
7 section 505(j) of the Federal Food,
8 Drug, and Cosmetic Act and biological
9 products licensed under section
10 351(k) of the Public Health Service
11 Act.
12 "(IV) All urgent care services.
13 "(ii) BRONZE AND SILVER LEVELS OF
14 COVERAGE.—The Secretary may alter the
15 services that shall be covered as deductible-
16 exempt services under clause (i) for stand-
17 ardized options in the bronze and silver
18 levels of coverage.
19 "(D) DISPLAY.—Each Exchange operated
20 by a State shall preferentially display the stand-
21 ardized options offered in such State on the
22 website of the Exchange.".
23 (b) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to plans beginning after December
25 31, 2019.

1 **SEC. 205. CLARIFICATION REGARDING DETERMINATION OF**
2 **AFFORDABILITY OF EMPLOYER-SPONSORED**
3 **MINIMUM ESSENTIAL COVERAGE.**

4 (a) SPECIAL RULE FOR EMPLOYER-SPONSORED
5 MINIMUM ESSENTIAL COVERAGE.—Clause (i) of section
6 36B(c)(2)(C) of the Internal Revenue Code of 1986 is
7 amended to read as follows:

8 "(i) COVERAGE MUST BE AFFORD-
9 ABLE.—

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

20 "(II) REQUIRED CONTRIBUTION
21 WITH RESPECT TO EMPLOYEE.—In
22 the case of the employee eligible to en-
23 roll in the plan, the required contribu-
24 tion for purposes of subclause (I) is
25 the employee's required contribution
26 (within the meaning of section

1 5000A(e)(1)(B)(i)) with respect to the
2 plan.
3 "(III) REQUIRED CONTRIBUTION
4 WITH RESPECT TO FAMILY MEM-
5 BERS.—In the case of an individual
6 who is eligible to enroll in the plan by
7 reason of a relationship the individual
8 bears to the employee, the required
9 contribution for purposes of subclause
10 (I) is the employee's required con-
11 tribution (within the meaning of sec-
12 tion 5000A(e)(1)(B)(i), determined by
13 substituting 'family' for 'self-only')
14 with respect to the plan.".
15 (b) CONFORMING AMENDMENTS.—
16 (1) Clause (ii) of section 36B(c)(2)(C) of the
17 Internal Revenue Code of 1986 is amended by add-
18 ing at the end the following: "This clause shall also
19 apply to an individual who is eligible to enroll in the
20 plan by reason of a relationship the individual bears
21 to the employee.".
22 (2) Clause (iii) of section 36B(c)(2)(C) of such
23 Code is amended by striking "the last sentence of
24 clause (i)" and inserting "clause (i)(III)".

1 (3) Clause (iv) of section 36B(c)(2)(C) of such
2 Code is amended by striking ''clause (i)(II)'' and in-
3 serting ''clause (i)(I)''.
4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2019.

7 TITLE III—ENSURING ACCESS 8 TO CARE

9 **SEC. 301. NETWORK ADEQUACY REQUIREMENTS.**

10 (a) IN GENERAL.—Section 1311(c) of the Patient
11 Protection and Affordable Care Act (42 U.S.C. 18031(c))
12 is amended—
13 (1) in paragraph (1)(B), by inserting ''and
14 paragraph (7) and in accordance with paragraph
15 (8)'' after ''Public Health Service Act''; and
16 (2) by adding at the end the following:
17 ''(7) NETWORK ADEQUACY REQUIREMENTS.—
18 ''(A) IN GENERAL.—A qualified health
19 plan shall meet the network adequacy standards
20 established by the Secretary under subpara-
21 graph (B), except as provided in subparagraphs
22 (B)(ii) and (C).
23 ''(B) FEDERAL STANDARDS AND RE-
24 VIEW.—
25 ''(i) STANDARD.—

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

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

1 "(ii) JUSTIFICATION.—A qualified
2 health plan that fails to meet the standard
3 established under clause (i) may satisfy the
4 requirement under subparagraph (A) by
5 providing the Secretary with a reasonable
6 justification for the variance from such
7 standard, based on factors such as the
8 availability of providers and variables re-
9 flected in local patterns of health care.
10 "(iii) REVIEW.—The Secretary shall
11 establish a process for reviewing the net-
12 work adequacy of qualified health plans,
13 except for those plans reviewed by the
14 State in accordance with subparagraph
15 (C)(ii).
16 "(C) STATE STANDARD.—
17 "(i) IN GENERAL.—In the case of a
18 qualified health plan offered in a State
19 that has implemented a quantifiable net-
20 work adequacy metric that the Secretary
21 determines is an acceptable metric com-
22 monly used in the health insurance indus-
23 try to measure network adequacy, such
24 qualified health plan may satisfy the re-
25 quirement under subparagraph (A) by

1 meeting the network adequacy standards
2 of such State based on such metric.
3 "(ii) REVIEW.—A State with an ac-
4 ceptable metric described in clause (i) may
5 review the network adequacy of qualified
6 health plans offered in such State in a
7 process established by the State.
8 "(8) COVERAGE OF OUT-OF-NETWORK ESSEN-
9 TIAL HEALTH BENEFITS.—
10 "(A) IN GENERAL.—A qualified health
11 plan shall provide, to an individual enrolled in
12 such plan, coverage of any service provided by
13 an out-of-network provider if—
14 "(i) coverage of such service would
15 otherwise be provided by the plan if the
16 service was provided by an in-network pro-
17 vider;
18 "(ii) the service is included in the es-
19 sential health benefits package described in
20 section 1302(a); and
21 "(iii) the service cannot be provided to
22 the individual by an in-network provider
23 within a reasonable timeframe or within a
24 reasonable distance and travel time.

1 "(B) COST-SHARING.—A qualified health
2 plan that provides coverage of a service pro-
3 vided by an out-of-network provider under sub-
4 paragraph (A) shall provide such coverage with
5 the same cost-sharing requirements as if the
6 service was provided by an in-network pro-
7 vider.".

8 (b) EFFECTIVE DATE.—The amendments made by
9 subsection (a) shall apply to plans beginning after Decem-
10 ber 31, 2019.

11 (c) GRANTS FOR STATE NETWORK ADEQUACY RE-
12 VIEWS.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services shall carry out a program to award
15 grants to States during the 5-year period beginning
16 with fiscal year 2020 to assist such States in devel-
17 oping a metric to measure network adequacy as de-
18 scribed in subparagraph (C)(i) of section 1311(c)(7)
19 of the Patient Protection and Affordable Care Act
20 (42 U.S.C. 18031(c)(7)) and to carry out the re-
21 views described in subparagraph (C)(ii) of such sec-
22 tion.

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

1 essary to carry out the grant program under this
2 subsection.

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

7 (a) REQUIREMENTS FOR MEDICARE ADVANTAGE OR-
8 GANIZATIONS.—

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

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

18 ''(A) IN GENERAL.—A contract under this
19 section with an MA organization described in
20 subparagraph (B) shall require the organization
21 to, in each applicable area in which the organi-
22 zation offers an MA plan, also offer, through
23 the individual market in the Exchange oper-
24 ating in the State, at least one qualified health
25 plan in the silver level of coverage and at least

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

4 ''(B) MA ORGANIZATIONS DESCRIBED.—
5 An MA organization described in this subpara-
6 graph is an MA organization that, in addition
7 to offering an MA plan in an applicable area,
8 offers health insurance coverage in the group
9 market or individual market in the State but
10 does not offer such coverage through the Ex-
11 change operating in the State.

12 ''(C) NOTIFICATION.—The Secretary, or
13 the State in the case of an MA organization of-
14 fering an MA plan in an applicable area in a
15 State with an Exchange operated by the State,
16 shall notify each MA organization that is re-
17 quired to offer a qualified health plan under
18 subparagraph (A) for a plan year of such re-
19 quirement. Such notification shall be provided
20 each year—

21 ''(i) beginning with respect to the re-
22 quirement for plan years beginning after
23 December 31, 2019; and

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

1 the Exchange operating in the State in
2 which the MA organization will be required
3 to offer such plan.
4 "(D) WAIVER.—The Secretary, or the
5 State in the case of an MA organization offer-
6 ing an MA plan in an applicable area in a State
7 with an Exchange operated by the State, may
8 waive the requirement under subparagraph (A)
9 if—
10 "(i) by the first day of the plan year,
11 the number of health insurance issuers of-
12 fering a qualified health plan through the
13 individual market in the Exchange has in-
14 creased such that the applicable area no
15 longer has fewer than 3 health insurance
16 issuers offering a qualified health plan
17 through the individual market in the Ex-
18 change operating in the State; or
19 "(ii) the Secretary, or the State in
20 such a case, determines that the require-
21 ment under subparagraph (A) would cause
22 the MA organization to become insolvent.
23 "(E) DEFINITIONS.—In this paragraph:
24 "(i) APPLICABLE AREA.—The term
25 'applicable area' means an area in which,

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

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

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

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

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

1 "(vi) QUALIFIED HEALTH PLAN.—
2 The term 'qualified health plan' has the
3 meaning given that term in section
4 1301(a) of the Patient Protection and Af-
5 fordable Care Act.".
6 (2) EFFECTIVE DATE.—The amendment made
7 by this subsection shall apply to contracts entered
8 into or renewed after December 31, 2019.
9 (b) REQUIREMENTS FOR MEDICAID MANAGED CARE
10 ORGANIZATIONS.—
11 (1) IN GENERAL.—Section 1903(m)(2)(A) of
12 the Social Security Act (42 U.S.C. 1396b(m)(2)(A))
13 is amended—
14 (A) in clause (xii), by striking "; and" and
15 inserting a semicolon;
16 (B) by realigning the left margin of clause
17 (xiii) to align with the left margin of clause
18 (xii);
19 (C) in clause (xiii), by striking the period
20 at the end and inserting "; and"; and
21 (D) by inserting after clause (xiii) the fol-
22 lowing:
23 "(xiv) such contract requires that the enti-
24 ty meets the requirements described in section

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

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

SEC. 303. ENROLLMENT IN EXCHANGES.

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

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

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

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

(4) by adding at the end the following:

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

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

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

4 **"SEC. 1314. CONSUMER PROTECTIONS REGARDING AUTO-**
5 **MATIC RE-ENROLLMENT.**

6 "(a) CONSENT TO AVOID AUTOMATIC RE-ENROLL-
7 MENT FOR INDIVIDUALS LOSING ELIGIBILITY FOR PRE-
8 MIUM TAX CREDITS.—The Secretary shall establish a
9 process to allow an individual, who is enrolling in a quali-
10 fied health plan through an Exchange and whom the Ex-
11 change estimates is eligible to receive a premium tax credit
12 under section 36B of the Internal Revenue Code of 1986,
13 to provide consent to the Exchange to not automatically
14 re-enroll the individual in such qualified health plan (or
15 a comparable qualified health plan in a case described in
16 subsection (b)) for the following plan year if during the
17 plan year the Exchange estimates that the individual has
18 become no longer eligible to receive such credit.

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

1 "(1) that the qualified health plan in which the
2 individual is enrolled will not be offered through
3 such Exchange for the following plan year;
4 "(2) that unless the individual takes action, the
5 individual will be enrolled in a comparable qualified
6 health plan for the following plan year;
7 "(3) the estimated amount of premiums for
8 such comparable qualified health plan; and
9 "(4) clear information on the eligibility of the
10 individual for a special enrollment period.
11 "(c) NOTICE REGARDING AUTOMATIC RE-ENROLL-
12 MENT.—Any notice regarding automatic re-enrollment
13 sent by an Exchange to an individual enrolled in a quali-
14 fied health plan shall be provided to the individual in the
15 language that the individual has indicated to the Ex-
16 change as the preferred language of the individual.".
17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to plan years beginning after the
19 date of enactment of this Act.
20 (d) STUDY.—The Secretary shall conduct a study
21 that examines the practices used by the Exchanges for no-
22 tifying consumers of automatic re-enrollment in qualified
23 health plans and identifies strategies for—
24 (1) improving automatic re-enrollment and re-
25 newal notifications;

1 (2) improving the ability to reach consumers in
2 providing such notices;
3 (3) increasing consumer comprehension of such
4 notices; and
5 (4) encouraging consumers to—
6 (A) update information that will affect eli-
7 gibility for premium tax credits under section
8 36B of the Internal Revenue Code of 1986 and
9 the amount of such credits; and
10 (B) shop for qualified health plans that
11 will best meet their needs through the Ex-
12 change operating in their State.

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

15 Part 2 of subtitle D of title I of the Patient Protec-
16 tion and Affordable Care Act (42 U.S.C. 18031 et seq.),
17 as amended by section 303(b), is further amended by add-
18 ing at the end the following:

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

21 "(a) IN GENERAL.—Out of the funds appropriated
22 under subsection (b), the Secretary shall conduct a mar-
23 keting and outreach program with respect to qualified
24 health plans offered in Exchanges operated by the Sec-
25 retary in order to encourage enrollment in such plans.

1 "(b) APPROPRIATION.—

2 "(1) ENCOURAGING ENROLLMENT FOR PLAN
3 YEAR 2019.—There is appropriated to the Secretary,
4 out of any moneys in the Treasury not otherwise ap-
5 propriated, $480,000,000 to carry out the marketing
6 and outreach program under subsection (a) with re-
7 spect to encouraging enrollment for qualified health
8 plans that begin in calendar year 2019.

9 "(2) ENCOURAGING ENROLLMENT FOR SUBSE-
10 QUENT PLAN YEARS.—To carry out the marketing
11 and outreach program under subsection (a) with re-
12 spect to encouraging enrollment for qualified health
13 plans that begin in each of calendar years 2020
14 through 2024, there is appropriated to the Secretary
15 prior to each such calendar year, out of any moneys
16 in the Treasury not otherwise appropriated, an
17 amount equal to the amount appropriated under this
18 subsection for the prior calendar year increased by
19 4 percent for each such calendar year.

20 "(3) AVAILABILITY.—The amounts appro-
21 priated under paragraphs (1) and (2) shall remain
22 available until expended.".

23 **SEC. 305. NAVIGATOR PROGRAM.**

24 Section 1311(i) of the Patient Protection and Afford-
25 able Care Act (42 U.S.C. 18031(i)) is amended—

1 (1) in paragraph (2)—
2 (A) in subparagraph (B), by striking "and
3 other entities" and inserting "and other entities
4 (such as Indian tribes, tribal organizations,
5 urban Indian organizations, and State or local
6 human service agencies)"; and
7 (B) by adding at the end the following:
8 "(C) PREFERENCE.—An Exchange shall
9 ensure that, each year, it awards a grant under
10 paragraph (1) to—
11 "(i) at least one entity described in
12 this paragraph that is a community and
13 consumer-focused nonprofit group; and
14 "(ii) at least one entity described in
15 subparagraph (B), which may include an-
16 other community and consumer-focused
17 nonprofit group.";
18 (2) in paragraph (3)—
19 (A) in subparagraph (D), by striking ";
20 and" and inserting ";";
21 (B) in subparagraph (E), by striking the
22 period and inserting "; and"; and
23 (C) by adding at the end the following:
24 "(F) provide targeted assistance to individ-
25 uals likely to qualify for a special enrollment

1 period under subparagraph (C), (D), or (E) of
2 subsection (c)(6).''; and
3 (3) in paragraph (4)(A)—
4 (A) in the matter preceding clause (i), by
5 striking ''not'';
6 (B) in clause (i)—
7 (i) by inserting ''not'' before ''be'';
8 and
9 (ii) by striking ''; or'' and inserting
10 '';'';
11 (C) in clause (ii)—
12 (i) by inserting ''not'' before ''re-
13 ceive''; and
14 (ii) by striking the period and insert-
15 ing '';''; and
16 (D) by adding at the end the following:
17 ''(iii) maintain physical presence in
18 the State of the Exchange so as to allow
19 in-person assistance to consumers; and
20 ''(iv) not provide compensation to an
21 employee employed by the navigator based
22 on the number of individuals the employee
23 assists in enrolling in qualified health
24 plans.''.

TITLE IV—STRENGTHENING CONSUMER HEALTH INSURANCE PROTECTIONS

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

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

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

(2) by striking clause (iv).

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

SEC. 402. HEALTH INSURANCE CONSUMER INFORMATION.

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

(1) in subsection (d)—

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

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

1 2018) shall make such data available to the
2 public in a searchable format on an internet
3 website established by the Secretary.''; and
4 (2) in subsection (e)—
5 (A) in paragraph (1), by striking
6 ''$30,000,000 for the first fiscal year for which
7 this section applies'' and inserting
8 ''$50,000,000 for each of fiscal years 2020
9 through 2024''; and
10 (B) in paragraph (2), by striking ''each
11 fiscal year following the fiscal year described in
12 paragraph (1)'' and inserting ''fiscal year 2025
13 and each fiscal year thereafter''.
14 **SEC. 403. PATIENT PROTECTIONS.**
15 (a) IN GENERAL.—Section 2719A of the Public
16 Health Service Act (42 U.S.C. 300gg–19a) is amended—
17 (1) in subsection (b)—
18 (A) in paragraph (1), by striking ''para-
19 graph (2)(B)'' and inserting ''paragraph
20 (3)(B)'';
21 (B) by redesignating paragraph (2) as
22 paragraph (3); and
23 (C) by inserting after paragraph (1) the
24 following:

1 "(2) REIMBURSEMENT.—A group health plan
2 or health insurance issuer offering group or indi-
3 vidual health insurance coverage shall reimburse an
4 out-of-network provider providing emergency services
5 to an individual enrolled in such plan or coverage at
6 an amount equal to the greatest of—
7 "(A) the median amount negotiated with
8 in-network providers for the emergency service;
9 "(B) the amount for the emergency service
10 calculated using the same method the plan or
11 issuer generally uses to determine payments for
12 out-of-network services; or
13 "(C) the amount that would be paid to a
14 provider of services or supplier with respect to
15 the furnishing of such service under title XVIII
16 of the Social Security Act."; and
17 (2) by adding at the end the following:
18 "(e) COVERAGE OF SERVICES BY OUT-OF-NETWORK
19 PROVIDERS BASED ON PLAN OR ISSUER ERROR.—
20 "(1) IN GENERAL.—A group health plan or
21 health insurance issuer offering group or individual
22 health insurance coverage shall provide coverage of
23 a service provided by an out-of-network provider to
24 an individual enrolled in such plan or coverage if—

1 ‘‘(A) the plan or issuer would have pro-
2 vided coverage for the service if the service was
3 provided by an in-network provider; and
4 ‘‘(B) in choosing such provider, the indi-
5 vidual reasonably relied on a materially inac-
6 curate, incomplete, or misleading statement of
7 information contained in a directory, compiled
8 by the plan or issuer, of in-network providers.
9 ‘‘(2) COST-SHARING.—A group health plan or
10 health insurance issuer that provides coverage of a
11 service provided by an out-of-network provider under
12 paragraph (1) shall provide such coverage with the
13 same cost-sharing requirements as if the service was
14 provided by an in-network provider.
15 ‘‘(f) COVERAGE FOR ENROLLEES IN ACTIVE COURSE
16 OF TREATMENT.—
17 ‘‘(1) IN GENERAL.—A group health plan or
18 health insurance issuer offering group or individual
19 health insurance coverage shall, at the request of an
20 individual enrolled in such plan or coverage and sub-
21 ject to paragraph (3), provide covered services (as
22 defined in paragraph (4)) by an out-of-network pro-
23 vider for such individual in accordance with para-
24 graph (2) if—

1 “(A) the individual is receiving an active
2 course of treatment from such out-of-network
3 provider that was occurring while the individual
4 was enrolled in a different health plan offered
5 by such plan or issuer for the prior plan year
6 that has been discontinued by such plan or
7 issuer, including a case where such plan is with-
8 drawn from the market, and such provider was
9 an in-network provider under such different
10 health plan; or

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

17 “(2) DURATION AND RATES OF COVERAGE.—

18 “(A) DURATION.—The coverage for an ac-
19 tive course of treatment described in paragraph
20 (1) shall be continued until the earlier of—

21 “(i) the date on which the treatment
22 is complete; or

23 “(ii) the date that is 180 days fol-
24 lowing the date on which—

1 "(I) in the case of an individual
2 described in subparagraph (A) of
3 paragraph (1), the individual enrolls
4 in such group health plan or health
5 insurance coverage; or
6 "(II) in the case of an individual
7 described in subparagraph (B) of
8 paragraph (1), the contract of the ter-
9 minated provider with the group
10 health plan or health insurance issuer
11 is no longer in effect.
12 "(B) COST-SHARING.—The coverage for an
13 active course of treatment provided by an out-
14 of-network provider as described in paragraph
15 (1) shall be provided with cost-sharing require-
16 ments that are the same as if such coverage
17 was provided by an in-network provider.
18 "(3) REQUEST FOR CONTINUITY OF CARE.—
19 Any request made under paragraph (1) shall be sub-
20 ject to any internal or external grievance or appeals
21 process of the plan or issuer, in accordance with any
22 applicable State or Federal law.
23 "(4) DEFINITIONS.—For purposes of this sub-
24 section:

1 "(A) ACTIVE COURSE OF TREATMENT.—
2 The term 'active course of treatment' means
3 any of the following that is occurring on the
4 first day on which, with respect to an individual
5 described in paragraph (1)(A), the individual's
6 prior health plan described in such paragraph
7 has been discontinued by the plan or issuer or,
8 with respect to an individual described in para-
9 graph (1)(B), the provider providing the treat-
10 ment becomes a terminated provider:
11 "(i) An ongoing course of treatment
12 for a life-threatening condition, serious
13 acute condition, or serious chronic condi-
14 tion.
15 "(ii) Services provided with respect to
16 pregnancy, including until the completion
17 of postpartum care directly related to the
18 delivery.
19 "(iii) An ongoing course of treatment
20 for a child between birth and 36 months.
21 "(iv) The performance of a surgery or
22 other procedure that, prior to the applica-
23 ble time described in this subparagraph,
24 has been authorized by the plan or cov-
25 erage as part of a documented course of

1 treatment for such individual and has been
2 recommended and documented by the pro-
3 vider for such individual.

4 "(B) COVERED SERVICES.—The term 'cov-
5 ered services' means services that—

6 "(i) would be covered by the group
7 health plan or health insurance issuer of-
8 fering group or individual health insurance
9 coverage if such services were provided by
10 an in-network provider; and

11 "(ii) are for an active course of treat-
12 ment.

13 "(C) TERMINATED PROVIDER.—The term
14 'terminated provider' means a provider that had
15 a contract for participation with the plan or
16 coverage during a plan year while the individual
17 was enrolled in such plan or coverage and re-
18 ceiving covered services from such provider and,
19 during such plan year, the plan or issuer termi-
20 nates such contract or does not renew such con-
21 tract for the remainder of the plan year. Such
22 term does not include—

23 "(i) any provider that voluntarily ter-
24 minates or does not renew such contract
25 for the remainder of the plan year; and

1 "(ii) any provider whose contract with
2 the plan or issuer has terminated, or was
3 not renewed, for the remainder of the plan
4 year for reasons relating to a medical dis-
5 ciplinary cause or fraud or other criminal
6 activity.

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

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

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

18 "(B) Increasing the obligation of an en-
19 rollee with respect to cost-sharing, as defined in
20 section 1302(c)(3) of the Patient Protection
21 and Affordable Care Act, required for a pre-
22 scription drug covered by such plan or issuer.

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

1 health insurance coverage from, during a plan year,
2 taking any of the following actions with respect to
3 coverage for such plan year:
4 "(A) Changing the policy of the plan or
5 issuer to require an enrollee to use a generic
6 substitution for a branded prescription drug.
7 "(B) Adding a new prescription drug to a
8 formulary of prescription drugs covered by such
9 plan or issuer.
10 "(C) Removing a prescription drug from
11 such a formulary due to patient safety con-
12 cerns, a prescription drug recall, or the removal
13 of a prescription drug from interstate commerce
14 as determined necessary by the Secretary.".
15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to plan years beginning after De-
17 cember 31, 2019.
18 **SEC. 404. LIMITATION ON BALANCE BILLING FOR EMER-**
19 **GENCY SERVICES.**
20 (a) IN GENERAL.—A health care provider that pro-
21 vides any emergency service to an individual enrolled in
22 a group health plan, group health insurance coverage, or
23 individual health insurance coverage and that is not an
24 in-network provider of such plan or coverage shall not im-
25 pose a charge on such individual for such emergency serv-

1 ice, other than any cost-sharing that would otherwise be
2 applicable if the physician was an in-network provider of
3 such plan or coverage.
4 (b) ENFORCEMENT.—The Secretary may impose a
5 civil monetary penalty, in the same manner as such pen-
6 alties are authorized under section 1128A of the Social
7 Security Act (42 U.S.C. 1320a–7a) for violations of bal-
8 ance billing prohibitions under part B of title XVIII of
9 such Act (42 U.S.C. 1395j et seq.), on any provider that
10 violates the requirement under subsection (a).
11 (c) DEFINITIONS.—In this section:
12 (1) COST-SHARING.—The term ''cost-sharing''
13 has the meaning given the term in section
14 1302(c)(3) of the Patient Protection and Affordable
15 Care Act (42 U.S.C. 18022(c)(3)).
16 (2) EMERGENCY SERVICE.—The term ''emer-
17 gency service'' has the meaning given such term in
18 section 2719A(b)(3)(B) of the Public Health Service
19 Act (42 U.S.C. 300gg–19a(b)(3)(B)).
20 (3) GROUP HEALTH PLAN, GROUP HEALTH IN-
21 SURANCE COVERAGE, AND INDIVIDUAL HEALTH IN-
22 SURANCE COVERAGE.—The terms ''group health
23 plan'', ''group health insurance coverage'', and ''in-
24 dividual health insurance coverage'' have the mean-

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

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

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

SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.

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

''SEC. 2729. NOTIFICATION OF PROVIDER TERMINATIONS.

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

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

1 **SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSUR-**
2 **ANCE COVERAGE.**

3 (a) IN GENERAL.—Section 2791(b)(5) of the Public
4 Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amend-
5 ed by striking ''but does not include'' and inserting ''in-
6 cluding''.

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall apply to plan years beginning after De-
9 cember 31, 2019.

10 **SEC. 407. PROTECTING ESSENTIAL HEALTH BENEFITS.**

11 Section 1302(b) of the Patient Protection and Af-
12 fordable Care Act (42 U.S.C. 18022(b)) is amended—

13 (1) in paragraph (2)(B) and paragraph (3), by
14 striking ''(4)(H)'' each place it appears and insert-
15 ing ''(4)(I)''; and

16 (2) in paragraph (4)—

17 (A) in subparagraph (A), by inserting
18 ''and coverage in every category is included'' be-
19 fore the semicolon;

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

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

25 ''(E) ensure that, to be treated as pro-
26 viding coverage for the essential health benefits

1 described in paragraph (1), a qualified health
2 plan—
3 "(i) shall not substitute benefits
4 across the various categories described in
5 paragraph (1);
6 "(ii) shall provide a wide variety of
7 classes of prescription drugs on the pre-
8 scription drug formulary of such plan;
9 "(iii) shall, if a medically necessary
10 drug is not on the prescription drug for-
11 mulary of such plan, allow individuals en-
12 rolled in such plan to have access to the
13 drug through an exceptions process estab-
14 lished by the plan; and
15 "(iv) shall provide coverage of
16 habilitative services at parity with rehabili-
17 tative services, in accordance with regula-
18 tions promulgated by the Secretary.".

19 **SEC. 408. ASSOCIATION HEALTH PLANS.**

20 (a) TREATMENT OF ASSOCIATION HEALTH PLANS.—
21 (1) ASSOCIATION HEALTH PLAN DEFINED.—
22 For purposes of this subsection, the term "associa-
23 tion health plan" means any health insurance cov-
24 erage that is provided to an association, but not re-

1 lated to employment, and sold to individuals through
2 such association.
3 (2) TREATMENT AS INDIVIDUAL HEALTH IN-
4 SURANCE COVERAGE.—For purposes of title XXVII
5 of the Public Health Service Act (42 U.S.C. 300gg
6 et seq.), part 7 of subtitle B of title I of the Em-
7 ployee Retirement Income Security Act of 1974 (29
8 U.S.C. 1181 et seq.), chapter 100 of the Internal
9 Revenue Code of 1986, and title I of the Patient
10 Protection and Affordable Care Act (Public Law
11 111–148), health insurance coverage offered through
12 an association health plan shall be treated as indi-
13 vidual health insurance coverage if—
14 (A) the coverage is offered to a member of
15 the association other than in connection with a
16 group health plan; or
17 (B) the coverage is offered to a member of
18 the association that is an employer maintaining
19 a group health plan that has fewer than 2 par-
20 ticipants who are employees on the first day of
21 the plan year.
22 (3) TREATMENT AS HEALTH INSURANCE COV-
23 ERAGE IN THE SMALL GROUP MARKET.—For pur-
24 poses of title XXVII of the Public Health Service
25 Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B

1 of title I of the Employee Retirement Income Secu-
2 rity Act of 1974 (29 U.S.C. 1181 et seq.), chapter
3 100 of the Internal Revenue Code of 1986, and title
4 I of the Patient Protection and Affordable Care Act
5 (Public Law 111–148), health insurance coverage of-
6 fered through an association health plan shall, sub-
7 ject to paragraph (2)(B), be treated as health insur-
8 ance coverage in the small group market if the cov-
9 erage is offered to a member of the association in
10 connection with a group health plan offered to em-
11 ployers that are small employers, as defined in such
12 applicable Act or Code.
13 (4) PREEMPTION.—An association health plan
14 shall be treated as individual health insurance cov-
15 erage in accordance with paragraph (2) or health in-
16 surance coverage in the small group market in ac-
17 cordance with paragraph (3) notwithstanding any
18 applicable State law.
19 (5) EFFECTIVE DATE.—This subsection shall
20 apply to plan years beginning after December 31,
21 2019.
22 (b) PROPOSED RULE REGARDING THE DEFINITION
23 OF "EMPLOYER" UNDER ERISA.—
24 (1) DEFINITION OF "JANUARY 5, 2018, PRO-
25 POSED RULE".—In this subsection, the term "Janu-

1 ary 5, 2018, proposed rule'' means the proposed rule
2 of the Department of Labor entitled ''Definition of
3 'Employer' Under Section 3(5) of ERISA—Associa-
4 tion Health Plans'' (83 Fed. Reg. 614), or any final
5 rule promulgated with respect to such proposed rule.
6 (2) ENFORCEMENT.—Beginning on the date of
7 enactment of this Act, the January 5, 2018, pro-
8 posed rule shall cease to have any force or effect. In
9 the case that the January 5, 2018, proposed rule is
10 a final rule on the date of enactment of this Act, the
11 Secretary of Labor shall cease to enforce such final
12 rule.

○