

116TH CONGRESS
1ST SESSION

S. 1213

To provide health insurance reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 11, 2019

Ms. WARREN (for herself, Mrs. GILLIBRAND, Ms. HARRIS, Ms. BALDWIN, Ms. KLOBUCHAR, Mr. BOOKER, and Mr. BLUMENTHAL) 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 2019”.

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. Deductible-exempt services for group health plans and group health insurance coverage.

Sec. 206. 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 and coverage of pediatric services.

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”.

1 **SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR**
 2 **THEIR DOLLARS.**

3 The first section 2794 of the Public Health Service
 4 Act (42 U.S.C. 300gg-94), added by section 1003 of the
 5 Patient Protection and Affordable Care Act (Public Law
 6 111-148), is amended—

7 (1) in subsection (a)—

8 (A) in paragraph (1), by striking “sub-
 9 section (b)(2)(A)” and inserting “subsections
 10 (b)(2)(A) and (b)(3)”; and

11 (B) in paragraph (2), by adding at the end
 12 the following: “Notwithstanding any other pro-
 13 vision of law, a health insurance issuer may not
 14 exclude from such disclosure information that is
 15 a trade secret or commercial or financial infor-
 16 mation described in section 552(b)(4) of title 5,
 17 United States Code.”;

18 (2) in subsection (b)—

19 (A) in paragraph (2)(A), by inserting “and
 20 paragraph (3)” after “subsection (a)(2)”; and

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

22 “(3) PROHIBITING UNREASONABLE PREMIUM
 23 INCREASES.—

24 “(A) IN GENERAL.—Beginning with plan
 25 years beginning in 2021, the Secretary, or a
 26 State pursuant to an effective rate review pro-

1 gram meeting the requirements under para-
2 graph (4)—

3 “(i) shall, consistent with subsection
4 (a)(2) and paragraph (2), review increases
5 in premiums for health insurance coverage
6 that are subject to review pursuant to sec-
7 tion 154.200 of title 45, Code of Federal
8 Regulations (or any successor regulation),
9 and determine whether such increases are
10 unreasonable; and

11 “(ii) may prohibit a health insurance
12 issuer from implementing such an increase
13 that is unreasonable.

14 “(B) UNREASONABLE INCREASES.—In de-
15 termining whether an increase in premiums for
16 health insurance coverage is unreasonable
17 under subparagraph (A)(i)—

18 “(i) the Secretary shall consider
19 whether the increase is excessive, unjusti-
20 fied, discriminatory, or inadequate; and

21 “(ii) the State, pursuant to an effec-
22 tive rate review program meeting the re-
23 quirements under paragraph (4), shall
24 apply applicable State law for making such
25 determination.

1 “(4) STATE EFFECTIVE RATE REVIEW PRO-
2 GRAMS.—A State effective rate review program
3 meets the requirements under this paragraph if—

4 “(A) the program carries out the reviews
5 described in paragraph (3)(A)(i) and ensures
6 that such reviews are meaningful, effective, and
7 timely reviews of the data and documentation
8 (including any contracts or documents described
9 in subparagraph (E)) submitted by health in-
10 surance issuers in support of proposed increases
11 in premiums for health insurance coverage;

12 “(B) such reviews include an examination
13 of—

14 “(i) the affordability of proposed in-
15 creases in premiums for health insurance
16 coverage;

17 “(ii) the quality improvement activi-
18 ties carried out by health insurance issuers
19 proposing the increases;

20 “(iii) the cost containment activities
21 of health insurance issuers proposing the
22 increases; and

23 “(iv) the solvency of the health insur-
24 ance coverage;

1 “(C) the program establishes a mechanism
2 for receiving public comments on proposed in-
3 creases in premiums for health insurance cov-
4 erage reviewed by the State;

5 “(D) such reviews include a review of all
6 public comments received under subparagraph
7 (C);

8 “(E) the program requires each health in-
9 surance issuer proposing an increase in pre-
10 miums for health insurance coverage to submit
11 to the State any provider contracts that may be
12 affected, including any documents incorporated
13 by reference into such contracts; and

14 “(F) the program requires the State to
15 provide the Secretary its determination of
16 whether each increase reviewed is unreasonable,
17 in a form and manner prescribed by the Sec-
18 retary.”; and

19 (3) in subsection (c)—

20 (A) in paragraph (1)—

21 (i) in the heading, by striking “2010
22 THROUGH 2014” and inserting “2021
23 THROUGH 2025”; and

1 (ii) in the matter preceding subpara-
 2 graph (A), by striking “2010” and insert-
 3 ing “2021”; and

4 (B) in paragraph (2)(B), by striking
 5 “2014” and inserting “2025”.

6 **SEC. 103. EFFECTIVE DATE.**

7 The amendments made by this title shall apply to
 8 plan years beginning after December 31, 2020.

9 **TITLE II—MAKING HEALTH IN-**
 10 **SURANCE COVERAGE AF-**
 11 **FORDABLE**

12 **SEC. 201. ENHANCEMENT OF PREMIUM ASSISTANCE CRED-**
 13 **IT.**

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

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

20 (2) CONFORMING AMENDMENT RELATED TO
 21 AFFORDABILITY.—Section 36B(c)(4)(C)(i)(I) of
 22 such Code is amended by striking “second lowest
 23 cost silver plan” and inserting “second lowest cost
 24 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 “but does not exceed 400 percent”.

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

16 (A) by striking “In the case of” and all
17 that follows through “the amount of” and in-
18 serting “The amount of”, and

19 (B) by striking “but less than 400%” in
20 the table therein.

21 (c) DETERMINATION OF APPLICABLE PERCENT-
22 AGE.—

23 (1) IN GENERAL.—Subparagraph (A) of section
24 36B(b)(3) of the Internal Revenue Code of 1986 is
25 amended to read as follows:

1 “(A) APPLICABLE PERCENTAGE.—The ap-
 2 plicable percentage for any taxable year shall be
 3 the percentage such that the applicable percent-
 4 age for any taxpayer whose household income is
 5 within an income tier specified in the following
 6 table shall increase, on a sliding scale in a lin-
 7 ear manner, from the initial premium percent-
 8 age to the final premium percentage specified in
 9 such table for such income tier:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
100% through 133%	0%	1.0%
133% through 150%	1.0%	2.0%
150% through 200%	2.0%	4.0%
200% through 250%	4.0%	6.0%
250% through 300%	6.0%	7.0%
300% through 400%	7.0%	8.5%
Over 400%	8.5%	8.5%”.

10 (2) CONFORMING AMENDMENTS.—Subsections
 11 (c)(2)(C)(iv) and (c)(4)(F) of section 36B of the In-
 12 ternal Revenue Code of 1986 are each amended by
 13 inserting “(as in effect before the date of the enact-
 14 ment of the Consumer Health Insurance Protection
 15 Act of 2019)” after “subsection (b)(3)(A)(ii)”.

16 (d) RECONCILIATION OF PREMIUM ASSISTANCE
 17 CREDIT AND ADVANCE CREDIT FOR SINGLE-PARENT
 18 HOUSEHOLDS.—

19 (1) IN GENERAL.—Clause (i) of section
 20 36B(f)(2)(B) of the Internal Revenue Code of 1986

1 is amended by striking “section 1(c)” and inserting
2 “subsection (b) or (c) of section 1”.

3 (2) EFFECTIVE DATE.—The amendment made
4 by this subsection shall apply to taxable years begin-
5 ning after December 31, 2019.

6 (e) DETERMINATION OF PREMIUM ASSISTANCE
7 CREDIT FOR DISABLED WORKERS.—

8 (1) IN GENERAL.—Section 36B(d)(2) of the In-
9 ternal Revenue Code of 1986 is amended by insert-
10 ing at the end the following new subparagraph:

11 “(C) EXCLUSION OF CERTAIN AMOUNTS
12 RECEIVED AS LUMP-SUM PAYMENT.—For pur-
13 poses of subparagraph (B), such amount shall
14 not include any portion of a lump-sum payment
15 of disability insurance benefits under section
16 223 of the Social Security Act (42 U.S.C. 423)
17 which is—

18 “(i) received during the taxable year,
19 and
20 “(ii) attributable to prior taxable
21 years.”.

22 (2) EFFECTIVE DATE.—The amendment made
23 by this subsection shall apply to taxable years begin-
24 ning after December 31, 2019.

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2020.

4 **SEC. 202. ENHANCEMENTS FOR REDUCED COST-SHARING.**

5 (a) MODIFICATION OF AMOUNT.—

6 (1) IN GENERAL.—Section 1402 of the Patient
7 Protection and Affordable Care Act (42 U.S.C.
8 18071) is amended—

9 (A) in subsection (b)(1), by striking “sil-
10 ver” and inserting “gold”;

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

13 “(B) COORDINATION WITH ACTUARIAL
14 LIMITS.—The Secretary shall ensure the reduc-
15 tion under this paragraph shall not result in the
16 plan’s share of the total allowed costs of bene-
17 fits provided under the plan becoming less
18 than—

19 “(i) 95 percent in the case of an eligi-
20 ble insured described in paragraph (2)(A);

21 “(ii) 90 percent in the case of an eli-
22 gible insured described in paragraph
23 (2)(B); and

1 “(iii) 85 percent in the case of an eli-
2 gible insured described in paragraph
3 (2)(C).”; and

4 (C) by amending subsection (e)(2) to read
5 as follows:

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

11 “(A) in the case of an eligible insured
12 whose household income is not less than 100
13 percent but not more than 200 percent of the
14 poverty 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 95
17 percent of such costs;

18 “(B) in the case of an eligible insured
19 whose household income is more than 200 per-
20 cent but not more than 300 percent of the pov-
21 erty line for a family of the size involved, in-
22 crease the plan’s share of the total allowed
23 costs of benefits provided under the plan to 90
24 percent of such costs; and

1 “(C) in the case of an eligible insured
2 whose household income is more than 300 per-
3 cent but not more than 400 percent of the pov-
4 erty line for a family of the size involved, in-
5 crease the plan’s share of the total allowed
6 costs of benefits provided under the plan to 85
7 percent of such costs.”.

8 (2) EFFECTIVE DATE.—The amendments made
9 by this subsection shall apply to plan years begin-
10 ning after December 31, 2020.

11 (b) FUNDING.—Section 1402 of the Patient Protec-
12 tion and Affordable Care Act (42 U.S.C. 18071) is amend-
13 ed by adding at the end the following new subsection:

14 “(g) FUNDING.—Out of any funds in the Treasury
15 not otherwise appropriated, there are appropriated to the
16 Secretary such sums as may be necessary for payments
17 under this section.”.

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

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

22 (1) in paragraph (3)(A)(i), by inserting “, in-
23 cluding cost-sharing with respect to prescription
24 drugs covered by the plan” after “charges”; and

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

1 “(5) PRESCRIPTION DRUG COST-SHARING.—

2 “(A) 2021.—For plan years beginning in
3 2021, the cost-sharing incurred under a health
4 plan with respect to prescription drugs covered
5 by the plan shall not exceed \$250 per month for
6 each enrolled individual, or \$500 for each fam-
7 ily.

8 “(B) 2022 AND LATER.—

9 “(i) IN GENERAL.—In the case of any
10 plan year beginning in a calendar year
11 after 2021, the limitation under this para-
12 graph shall be equal to the applicable dol-
13 lar amount under subparagraph (A) for
14 plan years beginning in 2021, increased by
15 an amount equal to the product of that
16 amount and the medical care component of
17 the consumer price index for all urban con-
18 sumers (as published by the Bureau of
19 Labor Statistics) for that year.

20 “(ii) ADJUSTMENT TO AMOUNT.—If
21 the amount of any increase under clause
22 (i) is not a multiple of \$5, such increase
23 shall be rounded to the next lowest mul-
24 tiple of \$5.”.

1 (b) GROUP HEALTH PLANS.—Section 2707(b) of the
 2 Public Health Service Act (42 U.S.C. 300gg–6(b)) is
 3 amended—

4 (1) by striking “annual”; and

5 (2) by striking “paragraph (1) of section
 6 1302(c)” and inserting “paragraphs (1) and (5) of
 7 section 1302(c) of the Patient Protection and Af-
 8 fordable Care Act”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 subsections (a) and (b) shall take effect with respect to
 11 plans beginning after December 31, 2020.

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

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

17 (1) in paragraph (1)(C)—

18 (A) in clause (iii), by striking “; and” and
 19 inserting “;”;

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

22 (C) by inserting after clause (iii) the fol-
 23 lowing:

24 “(iv)(I) agrees to offer the applicable
 25 standardized option under paragraph (5)

1 for each level of coverage offered by the
2 issuer that is the bronze, silver, or gold
3 level of coverage; and

4 “(II) with respect to offering coverage
5 that is the bronze, silver, or gold level of
6 coverage through an Exchange that is op-
7 erated by the Secretary, agrees to offer
8 only the applicable standardized option
9 under paragraph (5) and not any other
10 plan for such levels of coverage; and”;

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

12 “(5) STANDARDIZED OPTIONS.—

13 “(A) DEFINITION OF STANDARDIZED OP-
14 TION.—In this section, the term ‘standardized
15 option’ means a qualified health plan—

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

20 “(ii) that is offered through an Ex-
21 change.

22 “(B) ESTABLISHMENT.—

23 “(i) STATE.—Each State may estab-
24 lish a standardized option for the bronze,
25 silver, and gold levels of coverage.

1 “(ii) SECRETARY.—The Secretary
2 shall establish a standardized option in a
3 State for any level of coverage described in
4 clause (i) for which the State has not es-
5 tablished a standardized option.

6 “(iii) UPDATES.—The Secretary shall
7 annually update any standardized option
8 established by the Secretary under clause
9 (ii).

10 “(C) DEDUCTIBLE-EXEMPT SERVICES.—

11 “(i) IN GENERAL.—Except as pro-
12 vided in clause (ii), each standardized op-
13 tion established by the Secretary under
14 subparagraph (B)(ii) shall provide coverage
15 for and waive the application of a deduct-
16 ible for—

17 “(I) all primary care visits and
18 specialist visits;

19 “(II) all mental health and sub-
20 stance use disorder outpatient serv-
21 ices;

22 “(III) all drugs approved under
23 section 505(j) of the Federal Food,
24 Drug, and Cosmetic Act and biological
25 products licensed under section

1 351(k) of the Public Health Service
2 Act; and

3 “(IV) all urgent care services.

4 “(ii) BRONZE AND SILVER LEVELS OF
5 COVERAGE.—The Secretary may alter the
6 services that shall be covered as deductible-
7 exempt services under clause (i) for stand-
8 ardized options in the bronze and silver
9 levels of coverage.

10 “(D) DISPLAY.—Each Exchange operated
11 by a State shall preferentially display the stand-
12 ardized options offered in such State on the
13 website of the Exchange.”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to plans beginning after December
16 31, 2020.

17 **SEC. 205. DEDUCTIBLE-EXEMPT SERVICES FOR GROUP**
18 **HEALTH PLANS AND GROUP HEALTH INSUR-**
19 **ANCE COVERAGE.**

20 (a) IN GENERAL.—Section 2713 of the Public Health
21 Service Act (42 U.S.C. 300gg–13) is amended by adding
22 at the end the following:

23 “(d) DEDUCTIBLE-EXEMPT SERVICES FOR GROUP
24 HEALTH PLANS AND GROUP HEALTH INSURANCE COV-
25 ERAGE.—

1 “(1) IN GENERAL.—Subject to paragraph (2), a
2 group health plan and a health insurance issuer of-
3 fering group health insurance coverage shall, in ad-
4 dition to the requirement under subsection (a), at a
5 minimum provide coverage for and waive the appli-
6 cation of a deductible for—

7 “(A) all primary care visits and specialist
8 visits;

9 “(B) all mental health and substance use
10 disorder outpatient services;

11 “(C) all drugs approved under section
12 505(j) of the Federal Food, Drug, and Cos-
13 metic Act and biological products licensed
14 under section 351(k) of the Public Health Serv-
15 ice Act; and

16 “(D) all urgent care services.

17 “(2) REGULATIONS.—The Secretary may issue
18 regulations to—

19 “(A) assist group health plans and health
20 insurance issuers offering group health insur-
21 ance coverage in complying with paragraph (1);
22 and

23 “(B) alter the services that shall be cov-
24 ered as deductible-exempt services under para-
25 graph (1) for group health plans and group

1 health insurance coverage with levels of cov-
2 erage that are designed to provide benefits that
3 are actuarially equivalent to 60 or 70 percent of
4 the full actuarial value of the benefits provided
5 under the plan or coverage.”.

6 (b) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to plans beginning after December
8 31, 2020.

9 **SEC. 206. CLARIFICATION REGARDING DETERMINATION OF**
10 **AFFORDABILITY OF EMPLOYER-SPONSORED**
11 **MINIMUM ESSENTIAL COVERAGE.**

12 (a) SPECIAL RULE FOR EMPLOYER-SPONSORED
13 MINIMUM ESSENTIAL COVERAGE.—Clause (i) of section
14 36B(c)(2)(C) of the Internal Revenue Code of 1986 is
15 amended to read as follows:

16 “(i) COVERAGE MUST BE AFFORD-
17 ABLE.—

18 “(I) IN GENERAL.—Except as
19 provided in clause (iii), an individual
20 shall not be treated as eligible for
21 minimum essential coverage if such
22 coverage consists of an eligible em-
23 ployer-sponsored plan (as defined in
24 section 5000A(f)(2)) and the required
25 contribution with respect to the plan

1 exceeds 8.5 percent of the applicable
2 taxpayer's household income.

3 “(II) REQUIRED CONTRIBUTION
4 WITH RESPECT TO EMPLOYEE.—In
5 the case of the employee eligible to en-
6 roll in the plan, the required contribu-
7 tion for purposes of subclause (I) is
8 the employee's required contribution
9 (within the meaning of section
10 5000A(e)(1)(B)(i)) with respect to the
11 plan.

12 “(III) REQUIRED CONTRIBUTION
13 WITH RESPECT TO FAMILY MEM-
14 BERS.—In the case of an individual
15 who is eligible to enroll in the plan by
16 reason of a relationship the individual
17 bears to the employee, the required
18 contribution for purposes of subclause
19 (I) is the employee's required con-
20 tribution (within the meaning of sec-
21 tion 5000A(e)(1)(B)(i), determined by
22 substituting ‘family’ for ‘self-only’)
23 with respect to the plan.”.

24 (b) CONFORMING AMENDMENTS.—

1 “(7) NETWORK ADEQUACY REQUIREMENTS.—

2 “(A) IN GENERAL.—A qualified health
3 plan shall, to be certified under this subsection,
4 meet the network adequacy standards estab-
5 lished by the Secretary under subparagraph
6 (B), except as provided in subparagraphs
7 (B)(ii) and (C).

8 “(B) FEDERAL STANDARDS AND RE-
9 VIEW.—

10 “(i) STANDARD.—

11 “(I) ESTABLISHMENT.—The Sec-
12 retary shall, in consultation with
13 stakeholders including pediatric-spe-
14 cific stakeholders, establish a network
15 adequacy standard based on access to
16 in-network providers for qualified
17 health plans, except for those plans
18 described in subparagraph (C). Such
19 standard shall—

20 “(aa) include requirements
21 for the minimum number and
22 type of in-network providers
23 available, the geographical loca-
24 tion of such providers, the aver-
25 age distance and travel time re-

1 required for patients to visit such
2 providers, and the average ap-
3 pointment wait times for services
4 covered by the plan; and

5 “(bb) account for differences
6 in the needs of children and
7 adults.

8 “(II) MEDICARE ADVANTAGE OR-
9 GANIZATIONS.—The network ade-
10 quacy standard established under sub-
11 clause (I) shall, at a minimum, be
12 equivalent to the requirements for ac-
13 cess to services applicable to Medicare
14 Advantage organizations offering
15 Medicare Advantage plans under part
16 C of title XVIII of the Social Security
17 Act.

18 “(ii) JUSTIFICATION.—A qualified
19 health plan that fails to meet the standard
20 established under clause (i) may satisfy the
21 requirement under subparagraph (A) by
22 providing the Secretary with a reasonable
23 justification for the variance from such
24 standard, based on factors such as the

1 availability of providers and variables re-
2 flected in local patterns of health care.

3 “(iii) REVIEW.—The Secretary shall
4 establish a process for reviewing the net-
5 work adequacy of qualified health plans,
6 except for those plans reviewed by the
7 State in accordance with subparagraph
8 (C)(ii).

9 “(C) STATE STANDARD.—

10 “(i) IN GENERAL.—In the case of a
11 qualified health plan offered in a State
12 that has implemented a quantifiable net-
13 work adequacy metric that the Secretary
14 determines is an acceptable metric com-
15 monly used in the health insurance indus-
16 try to measure network adequacy, such
17 qualified health plan may, to be certified
18 under this subsection, satisfy the require-
19 ment under subparagraph (A) by meeting
20 the network adequacy standards of such
21 State based on such metric.

22 “(ii) REVIEW.—A State with an ac-
23 ceptable metric described in clause (i) may
24 review the network adequacy of qualified

1 health plans offered in such State in a
2 process established by the State.

3 “(8) COVERAGE OF OUT-OF-NETWORK ESSEN-
4 TIAL HEALTH BENEFITS.—

5 “(A) IN GENERAL.—A qualified health
6 plan shall, to be certified under this subsection,
7 provide to individuals enrolled in such plan cov-
8 erage of any service provided by an out-of-net-
9 work provider if—

10 “(i) coverage of such service would
11 otherwise be provided by the plan if the
12 service was provided by an in-network pro-
13 vider;

14 “(ii) the service is included in the es-
15 sential health benefits package described in
16 section 1302(a); and

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

21 “(B) COST-SHARING.—A qualified health
22 plan that provides coverage of a service pro-
23 vided by an out-of-network provider under sub-
24 paragraph (A) shall provide such coverage with
25 the same cost-sharing requirements as if the

1 service was provided by an in-network pro-
2 vider.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply to plans beginning after Decem-
5 ber 31, 2020.

6 (c) GRANTS FOR STATE NETWORK ADEQUACY RE-
7 VIEWS.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall carry out a program to award
10 grants to States during the 5-year period beginning
11 with fiscal year 2021 to assist such States in devel-
12 oping a metric to measure network adequacy as de-
13 scribed in subparagraph (C)(i) of section 1311(c)(7)
14 of the Patient Protection and Affordable Care Act
15 (42 U.S.C. 18031(c)(7)) and to carry out the re-
16 views described in subparagraph (C)(ii) of such sec-
17 tion.

18 (2) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated for each of
20 fiscal years 2021 through 2025 such sums as may
21 be necessary to carry out the grant program under
22 this subsection.

23 (d) REPORT.—

24 (1) IN GENERAL.—Not later than December 31,
25 2022, the Secretary shall prepare, and submit to

1 Congress, a report containing the analysis and rec-
 2 ommendations described in paragraph (2).

3 (2) ANALYSIS AND RECOMMENDATIONS.—The
 4 report under this subsection shall—

5 (A) analyze how network adequacy and ac-
 6 cess to care has changed since the implementa-
 7 tion of this section, including the amendments
 8 made by this section, including for children;

9 (B) include information on the availability
 10 of providers that are essential community pro-
 11 viders as described in section 1311(e)(1)(C) of
 12 the Patient Protection and Affordable Care Act
 13 (42 U.S.C. 18031(e)(1)(C)); and

14 (C) provide recommendations for such leg-
 15 islation and administrative actions as the Sec-
 16 retary considers appropriate to improve network
 17 adequacy, including with respect to access to
 18 pediatric services and essential community pro-
 19 viders.

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

24 (a) REQUIREMENTS FOR MEDICARE ADVANTAGE OR-
 25 GANIZATIONS.—

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

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

10 “(A) IN GENERAL.—A contract under this
11 section with an MA organization described in
12 subparagraph (B) shall require the organization
13 to, in each applicable area in which the organi-
14 zation offers an MA plan, also offer, through
15 the individual market in the Exchange oper-
16 ating in the State, at least one qualified health
17 plan in the silver level of coverage and at least
18 one qualified health plan in the gold level of
19 coverage, as described in section 1302(d) of the
20 Patient Protection and Affordable Care Act.

21 “(B) MA ORGANIZATIONS DESCRIBED.—
22 An MA organization described in this subpara-
23 graph is an MA organization that, in addition
24 to offering an MA plan in an applicable area,
25 offers health insurance coverage in the group

1 market or individual market in the State but
2 does not offer such coverage through the Ex-
3 change operating in the State.

4 “(C) NOTIFICATION.—The Secretary, or
5 the State in the case of an MA organization of-
6 fering an MA plan in an applicable area in a
7 State with an Exchange operated by the State,
8 shall notify each MA organization that is re-
9 quired to offer a qualified health plan under
10 subparagraph (A) for a plan year of such re-
11 quirement. Such notification shall be provided
12 each year—

13 “(i) beginning with respect to the re-
14 quirement for plan years beginning after
15 December 31, 2020; and

16 “(ii) not less than 1 year prior to the
17 rate filing deadline for the plan year for
18 the Exchange operating in the State in
19 which the MA organization will be required
20 to offer such plan.

21 “(D) WAIVER.—The Secretary, or the
22 State in the case of an MA organization offer-
23 ing an MA plan in an applicable area in a State
24 with an Exchange operated by the State, may

1 waive the requirement under subparagraph (A)
2 if—

3 “(i) by the first day of the plan year
4 following the determination, the number of
5 health insurance issuers offering a quali-
6 fied health plan through the individual
7 market in the Exchange has increased
8 such that the applicable area no longer has
9 fewer than 3 health insurance issuers of-
10 fering a qualified health plan through the
11 individual market in the Exchange oper-
12 ating in the State; or

13 “(ii) the Secretary, or the State in
14 such a case, determines that the require-
15 ment under subparagraph (A) would cause
16 the MA organization to become insolvent.

17 “(E) DEFINITIONS.—In this paragraph:

18 “(i) APPLICABLE AREA.—The term
19 ‘applicable area’ means an area in which,
20 at the time the Secretary or the State
21 sends the notification under subparagraph
22 (C), fewer than 3 health insurance issuers
23 offer a qualified health plan through the
24 individual market in the Exchange oper-
25 ating in the State.

1 “(ii) EXCHANGE.—The term ‘Ex-
2 change’ means an American Health Ben-
3 efit Exchange established under section
4 1311 or section 1321 of the Patient Pro-
5 tection and Affordable Care Act.

6 “(iii) GROUP MARKET.—The term
7 ‘group market’ has the meaning given such
8 term in section 1304 of the Patient Protec-
9 tion and Affordable Care Act.

10 “(iv) HEALTH INSURANCE COV-
11 ERAGE.—The term ‘health insurance cov-
12 erage’ has the meaning given the term in
13 section 2791(b) of the Public Health Serv-
14 ice Act.

15 “(v) INDIVIDUAL MARKET.—The term
16 ‘individual market’ has the meaning given
17 such term in section 1304 of the Patient
18 Protection and Affordable Care Act.

19 “(vi) QUALIFIED HEALTH PLAN.—
20 The term ‘qualified health plan’ has the
21 meaning given that term in section
22 1301(a) of the Patient Protection and Af-
23 fordable Care Act.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by this subsection shall apply to contracts entered
3 into or renewed after December 31, 2020.

4 (b) REQUIREMENTS FOR MEDICAID MANAGED CARE
5 ORGANIZATIONS.—

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

9 (A) in clause (xii), by striking “; and” and
10 inserting a semicolon;

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

14 (C) in clause (xiii), by striking the period
15 at the end and inserting “; and”; and

16 (D) by inserting after clause (xiii) the fol-
17 lowing:

18 “(xiv) such contract requires that the enti-
19 ty meets the requirements described in section
20 1857(e)(6) in the same manner as such require-
21 ments apply to an MA organization.”.

22 (2) EFFECTIVE DATE.—The amendments made
23 by this subsection shall apply to contracts entered
24 into or renewed after December 31, 2020.

1 **SEC. 303. ENROLLMENT IN EXCHANGES.**

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

6 (1) in subparagraph (B), by inserting “that are
7 not less than 8 weeks” after “open enrollment peri-
8 ods”;

9 (2) in subparagraph (C), by striking “; and”
10 and inserting “;”;

11 (3) in subparagraph (D), by striking the period
12 and inserting “;”;

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

14 “(E) a special enrollment period for quali-
15 fied individuals enrolled in a plan that makes
16 significant provider terminations during the
17 plan year, as determined in accordance with
18 regulations promulgated by the Secretary; and

19 “(F) a special enrollment period—

20 “(i) for each qualified individual
21 who—

22 “(I) is determined by the Ex-
23 change to be eligible for a premium
24 assistance credit under section 36B of
25 the Internal Revenue Code of 1986;
26 and

1 a case described in subsection (b)) for the following plan
2 year if during the plan year the Exchange estimates that
3 the individual has become no longer eligible to receive such
4 credit.

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

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

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

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

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

22 “(c) NOTICE REGARDING AUTOMATIC RE-ENROLL-
23 MENT.—Any notice regarding automatic re-enrollment
24 sent by an Exchange to an individual enrolled in a quali-
25 fied health plan shall be provided to the individual in the

1 language that the individual has indicated to the Ex-
2 change as the preferred language of the individual.

3 “(d) RETROACTIVE TERMINATION.—

4 “(1) IN GENERAL.—The Secretary shall estab-
5 lish a process to allow an individual who is automati-
6 cally re-enrolled in a qualified health plan for a plan
7 year and who has enrolled in other creditable cov-
8 erage for that plan year to retroactively terminate
9 such qualified health plan for such plan year.

10 “(2) CREDITABLE COVERAGE.—In this sub-
11 section, the term ‘creditable coverage’ has the mean-
12 ing given the term in section 2704(c)(1) of the Pub-
13 lic Health Service Act.”.

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

17 (d) STUDY.—The Secretary shall conduct a study
18 that examines the practices used by the Exchanges for no-
19 tifying consumers of automatic re-enrollment in qualified
20 health plans and identifies strategies for—

21 (1) improving automatic re-enrollment and re-
22 newal notifications;

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

1 (3) increasing consumer comprehension of such
2 notices; and

3 (4) encouraging consumers to—

4 (A) update information that will affect eli-
5 gibility for premium assistance credits under
6 section 36B of the Internal Revenue Code of
7 1986 and the amount of such credits; and

8 (B) shop for qualified health plans that
9 will best meet their needs through the Ex-
10 change operating in their State.

11 **SEC. 304. MARKETING AND OUTREACH FOR EXCHANGES**

12 **OPERATED BY THE SECRETARY.**

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

17 **“SEC. 1315. MARKETING AND OUTREACH FOR EXCHANGES**

18 **OPERATED BY THE SECRETARY.**

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

24 “(b) APPROPRIATIONS.—

1 “(1) ENCOURAGING ENROLLMENT FOR PLAN
2 YEAR 2020.—There is appropriated to the Secretary,
3 out of any moneys in the Treasury not otherwise ap-
4 propriated, \$480,000,000 to carry out the marketing
5 and outreach program under subsection (a) with re-
6 spect to encouraging enrollment for qualified health
7 plans that begin in calendar year 2020.

8 “(2) ENCOURAGING ENROLLMENT FOR SUBSE-
9 QUENT PLAN YEARS.—To carry out the marketing
10 and outreach program under subsection (a) with re-
11 spect to encouraging enrollment for qualified health
12 plans that begin in each of calendar years 2021
13 through 2025, there is appropriated to the Secretary
14 prior to each such calendar year, out of any moneys
15 in the Treasury not otherwise appropriated, an
16 amount equal to the amount appropriated under this
17 subsection for the prior calendar year increased by
18 4 percent for each such calendar year.

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

22 **SEC. 305. NAVIGATOR PROGRAM.**

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

25 (1) in paragraph (2)—

1 (A) in subparagraph (B), by striking “and
2 other entities” and inserting “and other entities
3 (such as Indian tribes, tribal organizations,
4 urban Indian organizations, and State or local
5 human service agencies)”; and

6 (B) by adding at the end the following:

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

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

13 “(ii) at least one entity described in
14 subparagraph (B), which may include an-
15 other community and consumer-focused
16 nonprofit group.”;

17 (2) in paragraph (3)—

18 (A) in subparagraph (D), by striking “;
19 and” and inserting “;”;

20 (B) in subparagraph (E), by striking the
21 period and inserting “; and”; and

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

23 “(F) provide targeted assistance to individ-
24 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.”.

1 **TITLE IV—STRENGTHENING**
2 **CONSUMER HEALTH INSUR-**
3 **ANCE PROTECTIONS**

4 **SEC. 401. PROHIBITING DISCRIMINATORY PREMIUMS**
5 **BASED ON TOBACCO USE.**

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

9 (1) in clause (ii), by inserting “and” after the
10 semicolon; and

11 (2) by striking clause (iv).

12 (b) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to plan years beginning after De-
14 cember 31, 2020.

15 **SEC. 402. HEALTH INSURANCE CONSUMER INFORMATION.**

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

18 (1) in subsection (d)—

19 (A) in the second sentence, by striking
20 “and shall share” and inserting “, shall share”;
21 and

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

1 2019) 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 2021
9 through 2025”; 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 2026
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), in the matter pre-
19 ceding subparagraph (A), by striking “para-
20 graph (2)(B)” and inserting “paragraph
21 (3)(B)”;

22 (B) by redesignating paragraph (2) as
23 paragraph (3);

24 (C) by inserting after paragraph (1) the
25 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 who is a participant, beneficiary, or
6 enrollee of such plan or coverage at an amount equal
7 to the greatest of—

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

10 “(B) the amount for the emergency service
11 calculated using the same method the plan or
12 issuer uses to determine payments for out-of-
13 network services that are not emergency serv-
14 ices; or

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

19 (D) in paragraph (3)(B), as so redesi-
20 gnated—

21 (i) clause (i), by inserting “, including
22 ambulance services provided by ground or
23 air transportation” before “, and” at the
24 end; and

1 (ii) in clause (ii), by striking the pe-
 2 riod at the end and inserting “, including
 3 ambulance services provided by ground or
 4 air transportation.”; and

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

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

8 “(1) IN GENERAL.—A group health plan or
 9 health insurance issuer offering group or individual
 10 health insurance coverage shall provide coverage of
 11 a service provided by an out-of-network provider to
 12 an individual who is a participant, beneficiary, or en-
 13 rollee of such plan or coverage if—

14 “(A) the plan or issuer would have pro-
 15 vided coverage of the service if the service was
 16 provided by an in-network provider; and

17 “(B) in choosing such provider, the indi-
 18 vidual reasonably relied on a materially inac-
 19 curate, incomplete, or misleading statement of
 20 information contained in a directory of in-net-
 21 work providers compiled by the plan or issuer.

22 “(2) COST-SHARING.—A group health plan or
 23 health insurance issuer that provides coverage of a
 24 service provided by an out-of-network provider under
 25 paragraph (1) shall provide such coverage with the

1 same cost-sharing requirement that would apply if
2 the services were provided in-network.

3 “(f) COVERAGE FOR ENROLLEES IN ACTIVE COURSE
4 OF TREATMENT.—

5 “(1) IN GENERAL.—A group health plan or
6 health insurance issuer offering group or individual
7 health insurance coverage shall, at the request of an
8 individual who is a participant, beneficiary, or en-
9 rollee of such plan or coverage and in accordance
10 with paragraphs (4) and (5), provide to such indi-
11 vidual coverage of services for an active course of
12 treatment provided by a provider that is an out-of-
13 network provider with respect to such plan or cov-
14 erage if—

15 “(A) coverage of such services would be
16 provided under the group health plan or health
17 insurance coverage if the services were provided
18 by an in-network provider; and

19 “(B) a circumstance described in para-
20 graph (3) applies.

21 “(2) COST-SHARING.—A group health plan or
22 health insurance issuer offering group or individual
23 health insurance coverage shall ensure that any cost-
24 sharing requirements for coverage of services for an
25 active course of treatment provided by an out-of-net-

1 work provider under paragraph (1) are the same re-
2 quirements as if such services were provided by an
3 in-network provider.

4 “(3) CIRCUMSTANCE.—A circumstance de-
5 scribed in this paragraph is a circumstance in
6 which—

7 “(A) with respect to a health insurance
8 issuer offering group or individual health insur-
9 ance coverage—

10 “(i) the individual was receiving serv-
11 ices for the active course of treatment de-
12 scribed in paragraph (1) from the out-of-
13 network provider described in such para-
14 graph during the prior plan year when—

15 “(I) the individual was a partici-
16 pant, beneficiary, or enrollee of a dif-
17 ferent health insurance coverage of-
18 fered by such health insurance issuer;
19 and

20 “(II) such provider was an in-
21 network provider with respect to such
22 different health insurance coverage;
23 and

24 “(ii) the health insurance issuer de-
25 cided to cancel or discontinue offering such

1 different health insurance coverage for the
2 plan year for which the individual makes
3 the request, including a case in which such
4 different health insurance coverage is with-
5 drawn from the market for such plan year;
6 and

7 “(B) the individual was receiving services
8 for the active course of treatment described in
9 paragraph (1) from the out-of-network provider
10 described in such paragraph while the provider
11 was an in-network provider for the group health
12 plan or health insurance coverage for the plan
13 year, and, during such plan year, the provider
14 became a terminated provider with respect to
15 such plan or coverage for the remainder of such
16 plan year.

17 “(4) DURATION.—A group health plan or
18 health insurance issuer offering group or individual
19 health insurance coverage shall provide coverage of
20 services for an active course of treatment under
21 paragraph (1) until the earlier of—

22 “(A) the date on which the treatment is
23 complete; or

24 “(B) the date that is 180 days following
25 the first date on which the provider described in

1 paragraph (1) is no longer an in-network pro-
2 vider of the plan or coverage in providing such
3 services to the individual.

4 “(5) REQUEST FOR CONTINUITY OF CARE.—A
5 request made under paragraph (1) shall be subject
6 to any internal or external grievance or appeals
7 process of the group health plan or health insurance
8 issuer, in accordance with any applicable State or
9 Federal law.

10 “(6) DEFINITIONS.—For purposes of this sub-
11 section:

12 “(A) ACTIVE COURSE OF TREATMENT.—
13 The term ‘active course of treatment’ means
14 any of the following:

15 “(i) An ongoing course of treatment
16 for—

17 “(I) a life-threatening condition;

18 “(II) a serious, acute condition;

19 or

20 “(III) a serious, chronic condi-
21 tion.

22 “(ii) Care provided with respect to
23 pregnancy, including until the completion
24 of postpartum care directly related to the
25 delivery.

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

3 “(iv) The performance of a surgery or
4 other procedure that, as documented prior
5 to the time the provider became an out-of-
6 network provider with respect to the group
7 health plan or health insurance coverage—

8 “(I) the plan or issuer offering
9 such coverage authorized as part of a
10 course of treatment for the individual;
11 and

12 “(II) the provider recommended
13 for such individual.

14 “(B) TERMINATED PROVIDER.—The term
15 ‘terminated provider’—

16 “(i) means a provider that had a con-
17 tract with a group health plan or health in-
18 surance issuer offering group or individual
19 health insurance coverage to provide serv-
20 ices as an in-network provider with respect
21 to such plan or coverage for a plan year,
22 and, during such plan year, the plan or
23 issuer terminated such contract or did not
24 renew such contract for the remainder of
25 the plan year; and

1 “(ii) does not include—

2 “(I) any provider that voluntarily
3 terminated or did not renew such con-
4 tract for the remainder of the plan
5 year; and

6 “(II) any provider whose contract
7 with the plan or issuer terminated, or
8 was not renewed, for the remainder of
9 the plan year for reasons relating to a
10 medical disciplinary cause, fraud, or
11 other criminal activity.

12 “(g) LIMITATIONS ON CHANGES IN COVERAGE OF
13 PRESCRIPTION DRUGS.—

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

19 “(A) Remove a prescription drug from a
20 formulary of prescription drugs covered by such
21 plan or coverage, except as provided in para-
22 graph (2)(C).

23 “(B) Increase the obligation of a partici-
24 pant, beneficiary, or enrollee with respect to
25 cost-sharing, as defined in section 1302(c)(3) of

1 the Patient Protection and Affordable Care Act,
2 for a prescription drug covered under such plan
3 or coverage.

4 “(2) RULE OF CONSTRUCTION.—Nothing in
5 this subsection shall prohibit a group health plan or
6 health insurance issuer offering group or individual
7 health insurance coverage from, during a plan year,
8 taking any of the following actions with respect to
9 coverage under the plan or health insurance cov-
10 erage for such plan year:

11 “(A) Changing the policy of the plan or
12 health insurance coverage to require a partici-
13 pant, beneficiary, or enrollee to use a generic
14 substitution for a branded prescription drug.

15 “(B) Adding a new prescription drug to a
16 formulary of prescription drugs covered by such
17 plan or health insurance coverage.

18 “(C) Removing a prescription drug from
19 such a formulary due to patient safety con-
20 cerns, or a prescription drug recall, or removing
21 a prescription drug from interstate commerce
22 as determined necessary by the Secretary.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to plan years beginning after De-
25 cember 31, 2020.

1 **SEC. 404. LIMITATION ON BALANCE BILLING FOR EMER-**
2 **GENCY SERVICES.**

3 (a) **IN GENERAL.**—A health care provider that pro-
4 vides any emergency service to an individual that is a par-
5 ticipant, beneficiary, or enrollee of a group health plan,
6 group health insurance coverage, or individual health in-
7 surance coverage and that is not an in-network provider
8 of such plan or coverage shall not impose a charge on such
9 individual for such emergency service, other than any cost-
10 sharing that would otherwise be applicable if the health
11 care provider was an in-network provider of such plan or
12 health insurance coverage.

13 (b) **ENFORCEMENT.**—The Secretary may impose a
14 civil monetary penalty, in the same manner as such pen-
15 alties are authorized under section 1128A of the Social
16 Security Act (42 U.S.C. 1320a–7a) for violations of bal-
17 ance billing prohibitions under part B of title XVIII of
18 such Act (42 U.S.C. 1395j et seq.), on any provider that
19 violates the requirement under subsection (a).

20 (c) **DEFINITIONS.**—In this section:

21 (1) **COST-SHARING.**—The term “cost-sharing”
22 has the meaning given the term in section
23 1302(c)(3) of the Patient Protection and Affordable
24 Care Act (42 U.S.C. 18022(c)(3)).

25 (2) **EMERGENCY SERVICE.**—The term “emer-
26 gency service” has the meaning given such term in

1 paragraph (3)(B) of section 2719A(b) of the Public
 2 Health Service Act (42 U.S.C. 300gg–19a(b)), as
 3 amended by section 403(a).

4 (3) GROUP HEALTH PLAN, GROUP HEALTH IN-
 5 SURANCE COVERAGE, AND INDIVIDUAL HEALTH IN-
 6 SURANCE COVERAGE.—The terms “group health
 7 plan”, “group health insurance coverage”, and “in-
 8 dividual health insurance coverage” have the mean-
 9 ings given such terms in section 2791 of the Public
 10 Health Service Act (42 U.S.C. 300gg–91).

11 (4) SECRETARY.—The term “Secretary” means
 12 the Secretary of Health and Human Services.

13 (d) EFFECTIVE DATE.—This section shall apply to
 14 plan years beginning after December 31, 2020.

15 **SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.**

16 Subpart II of part A of title XXVII of the Public
 17 Health Service Act (42 U.S.C. 300gg–11 et seq.) is
 18 amended by adding at the end the following:

19 **“SEC. 2730. NOTIFICATION OF PROVIDER TERMINATIONS.**

20 “(a) IN GENERAL.—Beginning January 1, 2020, a
 21 group health plan or health insurance issuer offering
 22 group or individual health insurance coverage shall inform
 23 individuals described in subsection (b) of the termination
 24 of any provider as an in-network provider under the plan

1 or health insurance coverage. Such notice shall be provided
2 not later than 30 days prior to the termination.

3 “(b) INDIVIDUALS.—The individuals described in this
4 subsection are any individuals enrolled in the group health
5 plan or health insurance coverage described in subsection
6 (a) who have seen the provider described in such sub-
7 section on a regular basis or who have received primary
8 care from such provider.”.

9 **SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSUR-**
10 **ANCE COVERAGE.**

11 (a) IN GENERAL.—Section 2791(b)(5) of the Public
12 Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amend-
13 ed by striking “but does not include” and inserting “in-
14 cluding”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 this section shall apply to plan years beginning after De-
17 cember 31, 2020.

18 **SEC. 407. PROTECTING ESSENTIAL HEALTH BENEFITS AND**
19 **COVERAGE OF PEDIATRIC SERVICES.**

20 (a) PROTECTING ESSENTIAL HEALTH BENEFITS.—
21 Section 1302(b) of the Patient Protection and Affordable
22 Care Act (42 U.S.C. 18022(b)) is amended—

23 (1) in paragraph (2)(B) and paragraph (3), by
24 striking “(4)(H)” each place it appears and insert-
25 ing “(4)(I)”; and

1 (2) in paragraph (4)—

2 (A) in subparagraph (A)—

3 (i) by striking “such subsection” and
4 inserting “such paragraph”; and

5 (ii) by inserting “and coverage in
6 every category is included” before the
7 semicolon;

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

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

13 “(E) ensure that, to be treated as pro-
14 viding coverage for the essential health benefits
15 described in paragraph (1), a qualified health
16 plan—

17 “(i) shall not substitute benefits be-
18 tween categories described such paragraph,
19 as described in section 156.115(b)(2)(ii) of
20 title 45, Code of Federal Regulations, as in
21 effect on the day before the date of enact-
22 ment of the Consumer Health Insurance
23 Protection Act of 2019;

1 “(ii) shall provide a wide variety of
2 classes of prescription drugs on the pre-
3 scription drug formulary of such plan;

4 “(iii) shall, if a medically necessary
5 drug is not on the prescription drug for-
6 mulary of such plan, allow individuals en-
7 rolled in such plan to have access to the
8 drug through an exceptions process estab-
9 lished by the plan; and

10 “(iv) shall not impose limits on cov-
11 erage of habilitative services and devices
12 that are less favorable than any such limits
13 imposed on coverage of rehabilitative serv-
14 ices and devices.”.

15 (b) **COVERAGE OF PEDIATRIC SERVICES.**—The Sec-
16 retary of Health and Human Services, in consultation with
17 pediatric service providers, shall promulgate a series of
18 recommendations for group health plans and health insur-
19 ance issuers offering group or individual health insurance
20 coverage to improve coverage of pediatric services.

21 **SEC. 408. ASSOCIATION HEALTH PLANS.**

22 (a) **TREATMENT OF ASSOCIATION HEALTH PLANS.**—

23 (1) **ASSOCIATION HEALTH PLAN DEFINED.**—

24 For purposes of this subsection, the term “associa-
25 tion health plan” means any health insurance cov-

1 erage that is provided to an association, but not re-
 2 lated to employment, and sold to individuals through
 3 such association.

4 (2) TREATMENT AS INDIVIDUAL HEALTH IN-
 5 SURANCE COVERAGE.—For purposes of title XXVII
 6 of the Public Health Service Act (42 U.S.C. 300gg
 7 et seq.), part 7 of subtitle B of title I of the Em-
 8 ployee Retirement Income Security Act of 1974 (29
 9 U.S.C. 1181 et seq.), chapter 100 of the Internal
 10 Revenue Code of 1986, and title I of the Patient
 11 Protection and Affordable Care Act (Public Law
 12 111–148), health insurance coverage offered through
 13 an association health plan shall be treated as indi-
 14 vidual health insurance coverage if—

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

18 (B) the coverage is offered to a member of
 19 the association that is an employer maintaining
 20 a group health plan that has fewer than 2 par-
 21 ticipants who are employees on the first day of
 22 the plan year.

23 (3) TREATMENT AS HEALTH INSURANCE COV-
 24 ERAGE IN THE SMALL GROUP MARKET.—For pur-
 25 poses of title XXVII of the Public Health Service

1 Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B
2 of title I of the Employee Retirement Income Secu-
3 rity Act of 1974 (29 U.S.C. 1181 et seq.), chapter
4 100 of the Internal Revenue Code of 1986, and title
5 I of the Patient Protection and Affordable Care Act
6 (Public Law 111–148), health insurance coverage of-
7 fered through an association health plan shall, sub-
8 ject to paragraph (2)(B), be treated as health insur-
9 ance coverage in the small group market if the cov-
10 erage is offered to a member of the association in
11 connection with a group health plan offered to em-
12 ployers that are small employers, as defined in such
13 applicable Act or Code.

14 (4) PREEMPTION.—An association health plan
15 shall be treated as individual health insurance cov-
16 erage in accordance with paragraph (2) or health in-
17 surance coverage in the small group market in ac-
18 cordance with paragraph (3) notwithstanding any
19 applicable State law.

20 (5) EFFECTIVE DATE.—This subsection shall
21 apply to plan years beginning after December 31,
22 2020.

23 (b) DEPARTMENT OF LABOR RULE REGARDING THE
24 DEFINITION OF “EMPLOYER” UNDER ERISA.—Begin-
25 ning with respect to plan years beginning after December

1 31, 2020, the final rule of the Department of Labor enti-
2 tled “Definition of ‘Employer’ Under Section 3(5) of
3 ERISA—Association Health Plans” (83 Fed. Reg. 28912
4 (June 21, 2018)) shall have no force or effect.

○