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

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A BILL

To provide health insurance reform, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Consumer Health Insurance Protection Act of 2019''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—LIMITING INSURER PROFITS AND PREVENTING UNREASONABLE PREMIUM INCREASES

SEC. 101. MEDICAL LOSS RATIO.

Section 2718(b)(1)(A)(ii) of the Public Health Service Act (42 U.S.C. 300gg–18(b)(1)(A)(ii)) is amended by striking ''80'' each place it appears and inserting ''85''.

SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

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

(1) in subsection (a)—

(A) in paragraph (1), by striking ''subsection (b)(2)(A)'' and inserting ''subsections (b)(2)(A) and (b)(3)''; and

(B) in paragraph (2), by adding at the end the following: ''Notwithstanding any other provision of law, a health insurance issuer may not exclude from such disclosure information that is a trade secret or commercial or financial information described in section 552(b)(4) of title 5, United States Code.'';

(2) in subsection (b)—

(A) in paragraph (2)(A), by inserting ''and paragraph (3)'' after ''subsection (a)(2)''; and

(B) by adding at the end the following:

''(3) PROHIBITING UNREASONABLE PREMIUM INCREASES.—

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

gram meeting the requirements under paragraph (4)—

"(i) shall, consistent with subsection (a)(2) and paragraph (2), review increases in premiums for health insurance coverage that are subject to review pursuant to section 154.200 of title 45, Code of Federal Regulations (or any successor regulation), and determine whether such increases are unreasonable; and

"(ii) may prohibit a health insurance issuer from implementing such an increase that is unreasonable.

"(B) UNREASONABLE INCREASES.—In determining whether an increase in premiums for health insurance coverage is unreasonable under subparagraph (A)(i)—

"(i) the Secretary shall consider whether the increase is excessive, unjustified, discriminatory, or inadequate; and

"(ii) the State, pursuant to an effective rate review program meeting the requirements under paragraph (4), shall apply applicable State law for making such determination.

''(4) STATE EFFECTIVE RATE REVIEW PROGRAMS.—A State effective rate review program meets the requirements under this paragraph if—

''(A) the program carries out the reviews described in paragraph (3)(A)(i) and ensures that such reviews are meaningful, effective, and timely reviews of the data and documentation (including any contracts or documents described in subparagraph (E)) submitted by health insurance issuers in support of proposed increases in premiums for health insurance coverage;

''(B) such reviews include an examination of—

''(i) the affordability of proposed increases in premiums for health insurance coverage;

''(ii) the quality improvement activities carried out by health insurance issuers proposing the increases;

''(iii) the cost containment activities of health insurance issuers proposing the increases; and

''(iv) the solvency of the health insurance coverage;

''(C) the program establishes a mechanism for receiving public comments on proposed increases in premiums for health insurance coverage reviewed by the State;

''(D) such reviews include a review of all public comments received under subparagraph (C);

''(E) the program requires each health insurance issuer proposing an increase in premiums for health insurance coverage to submit to the State any provider contracts that may be affected, including any documents incorporated by reference into such contracts; and

''(F) the program requires the State to provide the Secretary its determination of whether each increase reviewed is unreasonable, in a form and manner prescribed by the Secretary.''; and

(3) in subsection (c)—

(A) in paragraph (1)—

(i) in the heading, by striking ''2010 THROUGH 2014'' and inserting ''2021 THROUGH 2025''; and

(ii) in the matter preceding subparagraph (A), by striking ''2010'' and inserting ''2021''; and

(B) in paragraph (2)(B), by striking ''2014'' and inserting ''2025''.

SEC. 103. EFFECTIVE DATE.

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

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) IN GENERAL.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''but does not exceed 400 percent''.

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

(A) by striking ''In the case of'' and all that follows through ''the amount of'' and inserting ''The amount of'', and

(B) by striking ''but less than 400%'' in the table therein.

(c) DETERMINATION OF APPLICABLE PERCENTAGE.—

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

''(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in 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%''.

(2) CONFORMING AMENDMENTS.—Subsections (c)(2)(C)(iv) and (c)(4)(F) of section 36B of the Internal Revenue Code of 1986 are each amended by inserting ''(as in effect before the date of the enactment of the Consumer Health Insurance Protection Act of 2019)'' after ''subsection (b)(3)(A)(ii)''.

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

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

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

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

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

(1) IN GENERAL.—Section 36B(d)(2) of the Internal Revenue Code of 1986 is amended by inserting at the end the following new subparagraph:

''(C) EXCLUSION OF CERTAIN AMOUNTS RECEIVED AS LUMP-SUM PAYMENT.—For purposes of subparagraph (B), such amount shall not include any portion of a lump-sum payment of disability insurance benefits under section 223 of the Social Security Act (42 U.S.C. 423) which is—

''(i) received during the taxable year, and

''(ii) attributable to prior taxable years.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

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

SEC. 202. ENHANCEMENTS FOR REDUCED COST-SHARING.

(a) MODIFICATION OF AMOUNT.—

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

(A) in subsection (b)(1), by striking ''silver'' and inserting ''gold'';

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

''(B) COORDINATION WITH ACTUARIAL LIMITS.—The Secretary shall ensure the reduction under this paragraph shall not result in the plan's share of the total allowed costs of benefits provided under the plan becoming less than—

''(i) 95 percent in the case of an eligible insured described in paragraph (2)(A);

''(ii) 90 percent in the case of an eligible insured described in paragraph (2)(B); and

"(iii) 85 percent in the case of an eligible insured described in paragraph (2)(C)."; and

(C) by amending subsection (c)(2) to read as follows:

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

"(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 95 percent of such costs;

"(B) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

''(C) in the case of an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2020.

(b) FUNDING.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

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

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

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

(1) in paragraph (3)(A)(i), by inserting '', including cost-sharing with respect to prescription drugs covered by the plan'' after ''charges''; and

(2) by adding at the end the following:

''(5) PRESCRIPTION DRUG COST-SHARING.—

''(A) 2021.—For plan years beginning in 2021, the cost-sharing incurred under a health plan with respect to prescription drugs covered by the plan shall not exceed $250 per month for each enrolled individual, or $500 for each family.

''(B) 2022 AND LATER.—

''(i) IN GENERAL.—In the case of any plan year beginning in a calendar year after 2021, the limitation under this paragraph shall be equal to the applicable dollar amount under subparagraph (A) for plan years beginning in 2021, increased by an amount equal to the product of that amount and the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for that year.

''(ii) ADJUSTMENT TO AMOUNT.—If the amount of any increase under clause (i) is not a multiple of $5, such increase shall be rounded to the next lowest multiple of $5.''.

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

(1) by striking ''annual''; and

(2) by striking ''paragraph (1) of section 1302(c)'' and inserting ''paragraphs (1) and (5) of section 1302(c) of the Patient Protection and Affordable Care Act''.

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

SEC. 204. STANDARDIZED OPTIONS IN THE BRONZE, SILVER, AND GOLD LEVELS OF COVERAGE.

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

(1) in paragraph (1)(C)—

(A) in clause (iii), by striking ''; and'' and inserting '';'';

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

(C) by inserting after clause (iii) the following:

''(iv)(I) agrees to offer the applicable standardized option under paragraph (5)

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

''(II) with respect to offering coverage that is the bronze, silver, or gold level of coverage through an Exchange that is operated by the Secretary, agrees to offer only the applicable standardized option under paragraph (5) and not any other plan for such levels of coverage; and''; and

(2) by adding at the end the following:

''(5) STANDARDIZED OPTIONS.—

''(A) DEFINITION OF STANDARDIZED OPTION.—In this section, the term 'standardized option' means a qualified health plan—

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

''(ii) that is offered through an Exchange.

''(B) ESTABLISHMENT.—

''(i) STATE.—Each State may establish a standardized option for the bronze, silver, and gold levels of coverage.

''(ii) SECRETARY.—The Secretary shall establish a standardized option in a State for any level of coverage described in clause (i) for which the State has not established a standardized option.

''(iii) UPDATES.—The Secretary shall annually update any standardized option established by the Secretary under clause (ii).

''(C) DEDUCTIBLE-EXEMPT SERVICES.—

''(i) IN GENERAL.—Except as provided in clause (ii), each standardized option established by the Secretary under subparagraph (B)(ii) shall provide coverage for and waive the application of a deductible for—

''(I) all primary care visits and specialist visits;

''(II) all mental health and substance use disorder outpatient services;

''(III) all drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act and biological products licensed under section

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

''(IV) all urgent care services.

''(ii) BRONZE AND SILVER LEVELS OF COVERAGE.—The Secretary may alter the services that shall be covered as deductible-exempt services under clause (i) for standardized options in the bronze and silver levels of coverage.

''(D) DISPLAY.—Each Exchange operated by a State shall preferentially display the standardized options offered in such State on the website of the Exchange.''.

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

SEC. 205. DEDUCTIBLE-EXEMPT SERVICES FOR GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

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

''(d) DEDUCTIBLE-EXEMPT SERVICES FOR GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer offering group health insurance coverage shall, in addition to the requirement under subsection (a), at a minimum provide coverage for and waive the application of a deductible for—

''(A) all primary care visits and specialist visits;

''(B) all mental health and substance use disorder outpatient services;

''(C) all drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act and biological products licensed under section 351(k) of the Public Health Service Act; and

''(D) all urgent care services.

''(2) REGULATIONS.—The Secretary may issue regulations to—

''(A) assist group health plans and health insurance issuers offering group health insurance coverage in complying with paragraph (1); and

''(B) alter the services that shall be covered as deductible-exempt services under paragraph (1) for group health plans and group

health insurance coverage with levels of coverage that are designed to provide benefits that are actuarially equivalent to 60 or 70 percent of the full actuarial value of the benefits provided under the plan or coverage.''.

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

SEC. 206. CLARIFICATION REGARDING DETERMINATION OF AFFORDABILITY OF EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.

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

''(i) COVERAGE MUST BE AFFORDABLE.—

''(I) IN GENERAL.—Except as provided in clause (iii), an individual shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the required contribution with respect to the plan

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

"(II) REQUIRED CONTRIBUTION WITH RESPECT TO EMPLOYEE.—In the case of the employee eligible to enroll in the plan, the required contribution for purposes of subclause (I) is the employee's required contribution (within the meaning of section 5000A(e)(1)(B)(i)) with respect to the plan.

"(III) REQUIRED CONTRIBUTION WITH RESPECT TO FAMILY MEMBERS.—In the case of an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee, the required contribution for purposes of subclause (I) is the employee's required contribution (within the meaning of section 5000A(e)(1)(B)(i), determined by substituting 'family' for 'self-only') with respect to the plan.".

(b) CONFORMING AMENDMENTS.—

(1) Clause (ii) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.''.

(2) Clause (iii) of section 36B(c)(2)(C) of such Code is amended by striking ''the last sentence of clause (i)'' and inserting ''clause (i)(III)''.

(3) Clause (iv) of section 36B(c)(2)(C) of such Code is amended by striking ''clause (i)(II)'' and inserting ''clause (i)(I)''.

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

TITLE III—ENSURING ACCESS TO CARE

SEC. 301. NETWORK ADEQUACY REQUIREMENTS.

(a) IN GENERAL.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)) is amended—

(1) in paragraph (1)(B), by inserting ''and paragraph (7) and in accordance with paragraph (8)'' after ''Public Health Service Act''; and

(2) by adding at the end the following:

''(7) NETWORK ADEQUACY REQUIREMENTS.—

''(A) IN GENERAL.—A qualified health plan shall, to be certified under this subsection, meet the network adequacy standards established by the Secretary under subparagraph (B), except as provided in subparagraphs (B)(ii) and (C).

''(B) FEDERAL STANDARDS AND REVIEW.—

''(i) STANDARD.—

''(I) ESTABLISHMENT.—The Secretary shall, in consultation with stakeholders including pediatric-specific stakeholders, 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—

''(aa) 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 re-

quired for patients to visit such providers, and the average appointment wait times for services covered by the plan; and

''(bb) account for differences in the needs of children and adults.

''(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.

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

availability of providers and variables reflected in local patterns of health care.

''(iii) REVIEW.—The Secretary shall establish a process for reviewing the network adequacy of qualified health plans, except for those plans reviewed by the State in accordance with subparagraph (C)(ii).

''(C) STATE STANDARD.—

''(i) IN GENERAL.—In the case of a qualified health plan offered in a State that has implemented a quantifiable network adequacy metric that the Secretary determines is an acceptable metric commonly used in the health insurance industry to measure network adequacy, such qualified health plan may, to be certified under this subsection, satisfy the requirement under subparagraph (A) by meeting the network adequacy standards of such State based on such metric.

''(ii) REVIEW.—A State with an acceptable metric described in clause (i) may review the network adequacy of qualified

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

''(8) COVERAGE OF OUT-OF-NETWORK ESSENTIAL HEALTH BENEFITS.—

''(A) IN GENERAL.—A qualified health plan shall, to be certified under this subsection, provide to individuals enrolled in such plan coverage of any service provided by an out-of-network provider if—

''(i) coverage of such service would otherwise be provided by the plan if the service was provided by an in-network provider;

''(ii) the service is included in the essential health benefits package described in section 1302(a); and

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

''(B) COST-SHARING.—A qualified health plan that provides coverage of a service provided by an out-of-network provider under subparagraph (A) shall provide such coverage with the same cost-sharing requirements as if the

service was provided by an in-network provider.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to plans beginning after December 31, 2020.

(c) GRANTS FOR STATE NETWORK ADEQUACY REVIEWS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2021 to assist such States in developing a metric to measure network adequacy as described in subparagraph (C)(i) of section 1311(c)(7) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(7)) and to carry out the reviews described in subparagraph (C)(ii) of such section.

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

(d) REPORT.—

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

Congress, a report containing the analysis and recommendations described in paragraph (2).

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

(A) analyze how network adequacy and access to care has changed since the implementation of this section, including the amendments made by this section, including for children;

(B) include information on the availability of providers that are essential community providers as described in section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(C)); and

(C) provide recommendations for such legislation and administrative actions as the Secretary considers appropriate to improve network adequacy, including with respect to access to pediatric services and essential community providers.

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

(a) REQUIREMENTS FOR MEDICARE ADVANTAGE ORGANIZATIONS.—

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

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

"(A) IN GENERAL.—A contract under this section with an MA organization described in subparagraph (B) shall require the organization to, in each applicable area in which the organization offers an MA plan, also offer, through the individual market in the Exchange operating in the State, at least one qualified health plan in the silver level of coverage and at least one qualified health plan in the gold level of coverage, as described in section 1302(d) of the Patient Protection and Affordable Care Act.

"(B) MA ORGANIZATIONS DESCRIBED.—An MA organization described in this subparagraph is an MA organization that, in addition to offering an MA plan in an applicable area, offers health insurance coverage in the group

market or individual market in the State but does not offer such coverage through the Exchange operating in the State.

''(C) NOTIFICATION.—The Secretary, or the State in the case of an MA organization offering an MA plan in an applicable area in a State with an Exchange operated by the State, shall notify each MA organization that is required to offer a qualified health plan under subparagraph (A) for a plan year of such requirement. Such notification shall be provided each year—

''(i) beginning with respect to the requirement for plan years beginning after December 31, 2020; and

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

''(D) WAIVER.—The Secretary, or the State in the case of an MA organization offering an MA plan in an applicable area in a State with an Exchange operated by the State, may

waive the requirement under subparagraph (A) if—

''(i) by the first day of the plan year following the determination, the number of health insurance issuers offering a qualified health plan through the individual market in the Exchange has increased such that the applicable area no longer has fewer than 3 health insurance issuers offering a qualified health plan through the individual market in the Exchange operating in the State; or

''(ii) the Secretary, or the State in such a case, determines that the requirement under subparagraph (A) would cause the MA organization to become insolvent.

''(E) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE AREA.—The term '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.

"(vi) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given that term in section 1301(a) of the Patient Protection and Affordable Care Act.".

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

(b) REQUIREMENTS FOR MEDICAID MANAGED CARE ORGANIZATIONS.—

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

(A) in clause (xii), by striking ''; and'' and inserting a semicolon;

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

(C) in clause (xiii), by striking the period at the end and inserting ''; and''; and

(D) by inserting after clause (xiii) the following:

''(xiv) such contract requires that the entity meets the requirements described in section 1857(e)(6) 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, 2020.

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

(4) by adding at the end the following:

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

''(F) a special enrollment period—

''(i) for each qualified individual who—

''(I) is determined by the Exchange to be eligible for a premium assistance credit under section 36B of the Internal Revenue Code of 1986; and

''(II) has a household income not in excess of 300 percent of the poverty line for the size of the family involved; and

''(ii) which shall begin on the date on which the individual is determined by the Exchange to be eligible for a premium assistance credit under such section 36B.''.

(b) CONSUMER PROTECTIONS REGARDING AUTOMATIC RE-ENROLLMENT.—Part 2 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18031 et seq.) is amended by adding at the end the following:

''SEC. 1314. CONSUMER PROTECTIONS REGARDING AUTOMATIC RE-ENROLLMENT.

''(a) CONSENT TO AVOID AUTOMATIC RE-ENROLLMENT FOR INDIVIDUALS LOSING ELIGIBILITY FOR PREMIUM ASSISTANCE CREDITS.—The Secretary shall establish a process to allow an individual, who is enrolling in a qualified health plan through an Exchange and whom the Exchange estimates is eligible to receive a premium assistance credit under section 36B of the Internal Revenue Code of 1986, to provide consent to the Exchange to not automatically re-enroll the individual in such qualified health plan (or a comparable qualified health plan in

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

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

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

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

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

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

''(c) NOTICE REGARDING AUTOMATIC RE-ENROLLMENT.—Any notice regarding automatic re-enrollment sent by an Exchange to an individual enrolled in a qualified health plan shall be provided to the individual in the

language that the individual has indicated to the Exchange as the preferred language of the individual.

''(d) RETROACTIVE TERMINATION.—

''(1) IN GENERAL.—The Secretary shall establish a process to allow an individual who is automatically re-enrolled in a qualified health plan for a plan year and who has enrolled in other creditable coverage for that plan year to retroactively terminate such qualified health plan for such plan year.

''(2) CREDITABLE COVERAGE.—In this subsection, the term 'creditable coverage' has the meaning given the term in section 2704(c)(1) of the Public Health Service Act.''.

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

(d) STUDY.—The Secretary shall conduct a study that examines the practices used by the Exchanges for notifying consumers of automatic re-enrollment in qualified health plans and identifies strategies for—

(1) improving automatic re-enrollment and renewal notifications;

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

(3) increasing consumer comprehension of such notices; and

(4) encouraging consumers to—

(A) update information that will affect eligibility for premium assistance credits under section 36B of the Internal Revenue Code of 1986 and the amount of such credits; and

(B) shop for qualified health plans that will best meet their needs through the Exchange operating in their State.

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

Part 2 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18031 et seq.), as amended by section 303(b), is further amended by adding at the end the following:

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

"(a) IN GENERAL.—Out of the funds appropriated under subsection (b), the Secretary shall conduct a marketing and outreach program with respect to qualified health plans offered through Exchanges operated by the Secretary in order to encourage enrollment in such plans.

"(b) APPROPRIATIONS.—

''(1) ENCOURAGING ENROLLMENT FOR PLAN YEAR 2020.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $480,000,000 to carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in calendar year 2020.

''(2) ENCOURAGING ENROLLMENT FOR SUBSEQUENT PLAN YEARS.—To carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in each of calendar years 2021 through 2025, there is appropriated to the Secretary prior to each such calendar year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount appropriated under this subsection for the prior calendar year increased by 4 percent for each such calendar year.

''(3) AVAILABILITY.—The amounts appropriated under paragraphs (1) and (2) shall remain available until expended.''.

SEC. 305. NAVIGATOR PROGRAM.

Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (B), by striking ''and other entities'' and inserting ''and other entities (such as Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies)''; and

(B) by adding at the end the following:

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

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

''(ii) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group.'';

(2) in paragraph (3)—

(A) in subparagraph (D), by striking ''; and'' and inserting ''; '';

(B) in subparagraph (E), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(F) provide targeted assistance to individuals likely to qualify for a special enrollment

period under subparagraph (C), (D), or (E) of subsection (c)(6).''; and

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking ''not'';

(B) in clause (i)—

(i) by inserting ''not'' before ''be''; and

(ii) by striking ''; or'' and inserting ''; '';

(C) in clause (ii)—

(i) by inserting ''not'' before ''receive''; and

(ii) by striking the period and inserting ''; ''; and

(D) by adding at the end the following:

''(iii) maintain physical presence in the State of the Exchange so as to allow in-person assistance to consumers; and

''(iv) not provide compensation to an employee employed by the navigator based on the number of individuals the employee assists in enrolling in qualified health 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, 2020.

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

2019) shall make such data available to the public in a searchable format on an internet website established by the Secretary.''; and

(2) in subsection (e)—

(A) in paragraph (1), by striking ''$30,000,000 for the first fiscal year for which this section applies'' and inserting ''$50,000,000 for each of fiscal years 2021 through 2025''; and

(B) in paragraph (2), by striking ''each fiscal year following the fiscal year described in paragraph (1)'' and inserting ''fiscal year 2026 and each fiscal year thereafter''.

SEC. 403. PATIENT PROTECTIONS.

(a) IN GENERAL.—Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended—

(1) in subsection (b)—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (2)(B)'' and inserting ''paragraph (3)(B)'';

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

(C) by inserting after paragraph (1) the following:

''(2) REIMBURSEMENT.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall reimburse an out-of-network provider providing emergency services to an individual who is a participant, beneficiary, or enrollee of such plan or coverage at an amount equal to the greatest of—

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

''(B) the amount for the emergency service calculated using the same method the plan or issuer uses to determine payments for out-of-network services that are not emergency services; or

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

(D) in paragraph (3)(B), as so redesignated—

(i) clause (i), by inserting '', including ambulance services provided by ground or air transportation'' before '', and'' at the end; and

(ii) in clause (ii), by striking the period at the end and inserting ", including ambulance services provided by ground or air transportation."; and

(2) by adding at the end the following:

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

"(1) IN GENERAL.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall provide coverage of a service provided by an out-of-network provider to an individual who is a participant, beneficiary, or enrollee of such plan or coverage if—

"(A) the plan or issuer would have provided coverage of the service if the service was provided by an in-network provider; and

"(B) in choosing such provider, the individual reasonably relied on a materially inaccurate, incomplete, or misleading statement of information contained in a directory of in-network providers compiled by the plan or issuer.

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

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

''(f) COVERAGE FOR ENROLLEES IN ACTIVE COURSE OF TREATMENT.—

''(1) IN GENERAL.—A group health plan or health insurance issuer offering group or individual health insurance coverage shall, at the request of an individual who is a participant, beneficiary, or enrollee of such plan or coverage and in accordance with paragraphs (4) and (5), provide to such individual coverage of services for an active course of treatment provided by a provider that is an out-of-network provider with respect to such plan or coverage if—

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

''(B) a circumstance described in paragraph (3) applies.

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

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

''(3) CIRCUMSTANCE.—A circumstance described in this paragraph is a circumstance in which—

''(A) with respect to a health insurance issuer offering group or individual health insurance coverage—

''(i) the individual was receiving services for the active course of treatment described in paragraph (1) from the out-of-network provider described in such paragraph during the prior plan year when—

''(I) the individual was a participant, beneficiary, or enrollee of a different health insurance coverage offered by such health insurance issuer; and

''(II) such provider was an in-network provider with respect to such different health insurance coverage; and

''(ii) the health insurance issuer decided to cancel or discontinue offering such

different health insurance coverage for the plan year for which the individual makes the request, including a case in which such different health insurance coverage is withdrawn from the market for such plan year; and

''(B) the individual was receiving services for the active course of treatment described in paragraph (1) from the out-of-network provider described in such paragraph while the provider was an in-network provider for the group health plan or health insurance coverage for the plan year, and, during such plan year, the provider became a terminated provider with respect to such plan or coverage for the remainder of such plan year.

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

''(A) the date on which the treatment is complete; or

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

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

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

''(6) DEFINITIONS.—For purposes of this subsection:

''(A) ACTIVE COURSE OF TREATMENT.—The term 'active course of treatment' means any of the following:

''(i) An ongoing course of treatment for—

''(I) a life-threatening condition;

''(II) a serious, acute condition; or

''(III) a serious, chronic condition.

''(ii) Care provided with respect to pregnancy, including until the completion of postpartum care directly related to the delivery.

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

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

''(I) the plan or issuer offering such coverage authorized as part of a course of treatment for the individual; and

''(II) the provider recommended for such individual.

''(B) TERMINATED PROVIDER.—The term 'terminated provider'—

''(i) means a provider that had a contract with a group health plan or health insurance issuer offering group or individual health insurance coverage to provide services as an in-network provider with respect to such plan or coverage for a plan year, and, during such plan year, the plan or issuer terminated such contract or did not renew such contract for the remainder of the plan year; and

"(ii) does not include—

"(I) any provider that voluntarily terminated or did not renew such contract for the remainder of the plan year; and

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

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

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

"(A) Remove a prescription drug from a formulary of prescription drugs covered by such plan or coverage, except as provided in paragraph (2)(C).

"(B) Increase the obligation of a participant, beneficiary, or enrollee with respect to cost-sharing, as defined in section 1302(c)(3) of

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

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall prohibit a group health plan or health insurance issuer offering group or individual health insurance coverage from, during a plan year, taking any of the following actions with respect to coverage under the plan or health insurance coverage for such plan year:

''(A) Changing the policy of the plan or health insurance coverage to require a participant, beneficiary, or enrollee to use a generic substitution for a branded prescription drug.

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

''(C) Removing a prescription drug from such a formulary due to patient safety concerns, or a prescription drug recall, or removing a prescription drug from interstate commerce as determined necessary by the Secretary.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2020.

SEC. 404. LIMITATION ON BALANCE BILLING FOR EMERGENCY SERVICES.

(a) IN GENERAL.—A health care provider that provides any emergency service to an individual that is a participant, beneficiary, or enrollee of a group health plan, group health insurance coverage, or individual health insurance coverage and that is not an in-network provider of such plan or coverage shall not impose a charge on such individual for such emergency service, other than any cost-sharing that would otherwise be applicable if the health care provider was an in-network provider of such plan or health insurance coverage.

(b) ENFORCEMENT.—The Secretary may impose a civil monetary penalty, in the same manner as such penalties are authorized under section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) for violations of balance billing prohibitions under part B of title XVIII of such Act (42 U.S.C. 1395j et seq.), on any provider that violates the requirement under subsection (a).

(c) DEFINITIONS.—In this section:

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

(2) EMERGENCY SERVICE.—The term ''emergency service'' has the meaning given such term in

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

(3) GROUP HEALTH PLAN, GROUP HEALTH INSURANCE COVERAGE, AND INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms ''group health plan'', ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings 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, 2020.

SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.

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

''SEC. 2730. NOTIFICATION OF PROVIDER TERMINATIONS.

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

or health insurance 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 individuals enrolled in the group health plan or health insurance coverage described in subsection (a) who have seen the provider described in such subsection on a regular basis or who have received primary care from such provider.''.

SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amended by striking ''but does not include'' and inserting ''including''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2020.

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

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

(1) in paragraph (2)(B) and paragraph (3), by striking ''(4)(H)'' each place it appears and inserting ''(4)(I)''; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) by striking ''such subsection'' and inserting ''such paragraph''; and

(ii) by inserting ''and coverage in every category is included'' before the semicolon;

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

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

''(E) ensure that, to be treated as providing coverage for the essential health benefits described in paragraph (1), a qualified health plan—

''(i) shall not substitute benefits between categories described such paragraph, as described in section 156.115(b)(2)(ii) of title 45, Code of Federal Regulations, as in effect on the day before the date of enactment of the Consumer Health Insurance Protection Act of 2019;

''(ii) shall provide a wide variety of classes of prescription drugs on the prescription drug formulary of such plan;

''(iii) shall, if a medically necessary drug is not on the prescription drug formulary of such plan, allow individuals enrolled in such plan to have access to the drug through an exceptions process established by the plan; and

''(iv) shall not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices.''.

(b) COVERAGE OF PEDIATRIC SERVICES.—The Secretary of Health and Human Services, in consultation with pediatric service providers, shall promulgate a series of recommendations for group health plans and health insurance issuers offering group or individual health insurance coverage to improve coverage of pediatric services.

SEC. 408. ASSOCIATION HEALTH PLANS.

(a) TREATMENT OF ASSOCIATION HEALTH PLANS.—

(1) ASSOCIATION HEALTH PLAN DEFINED.—For purposes of this subsection, the term ''association health plan'' means any health insurance cov-

erage that is provided to an association, but not related to employment, and sold to individuals through such association.

(2) TREATMENT AS INDIVIDUAL HEALTH INSURANCE COVERAGE.—For purposes of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), chapter 100 of the Internal Revenue Code of 1986, and title I of the Patient Protection and Affordable Care Act (Public Law 111–148), health insurance coverage offered through an association health plan shall be treated as individual health insurance coverage if—

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

(B) the coverage is offered to a member of the association that is an employer maintaining a group health plan that has fewer than 2 participants who are employees on the first day of the plan year.

(3) TREATMENT AS HEALTH INSURANCE COVERAGE IN THE SMALL GROUP MARKET.—For purposes of title XXVII of the Public Health Service

Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), chapter 100 of the Internal Revenue Code of 1986, and title I of the Patient Protection and Affordable Care Act (Public Law 111–148), health insurance coverage offered through an association health plan shall, subject to paragraph (2)(B), be treated as health insurance coverage in the small group market if the coverage is offered to a member of the association in connection with a group health plan offered to employers that are small employers, as defined in such applicable Act or Code.

(4) PREEMPTION.—An association health plan shall be treated as individual health insurance coverage in accordance with paragraph (2) or health insurance coverage in the small group market in accordance with paragraph (3) notwithstanding any applicable State law.

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

(b) DEPARTMENT OF LABOR RULE REGARDING THE DEFINITION OF ''EMPLOYER'' UNDER ERISA.—Beginning with respect to plan years beginning after December

31, 2020, the final rule of the Department of Labor entitled ''Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans'' (83 Fed. Reg. 28912 (June 21, 2018)) shall have no force or effect.

○