

116TH CONGRESS
2D SESSION

S. 4521

To amend the Patient Protection and Affordable Care Act to reduce health care costs and expand health care coverage to more Americans.

IN THE SENATE OF THE UNITED STATES

AUGUST 11, 2020

Mr. WARNER introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Patient Protection and Affordable Care Act to reduce health care costs and expand health care coverage to more Americans.

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 “Health Care Improve-
5 ment Act of 2020”.

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—REDUCING HEALTH CARE COSTS AND PROTECTING
PEOPLE WITH PREEXISTING CONDITIONS

- Sec. 101. Improving affordability by expanding premium assistance for consumers.
- Sec. 102. Expanding affordability for working families to fix the family glitch.
- Sec. 103. Establishing a State Health Insurance Affordability and Innovation fund.
- Sec. 104. Rescinding the short-term limited duration insurance regulation.
- Sec. 105. Revoking section 1332 guidance.
- Sec. 106. Promoting consumer outreach and education.

TITLE II—ENCOURAGING MEDICAID EXPANSION AND STRENGTHENING THE MEDICAID PROGRAM

- Sec. 201. Incentivizing Medicaid expansion.
- Sec. 202. Reducing the administrative FMAP for nonexpansion States.
- Sec. 203. State option to provide 12 months of postpartum Medicaid eligibility.
- Sec. 204. Supporting State Medicaid programs through economic downturns.
- Sec. 205. State flexibility to use administrative simplification policies for enrollment.

TITLE III—ESTABLISHMENT OF A PUBLIC HEALTH CARE OPTION

- Sec. 301. Establishment of health plan.
- Sec. 302. Availability of plan.
- Sec. 303. Affordability.
- Sec. 304. Participating providers.
- Sec. 305. Provider payment rates.
- Sec. 306. No effect on Medicare benefits or Medicare trust funds.

TITLE IV—FAIR MEDICARE PAYMENTS TO RURAL PROVIDERS

- Sec. 401. Ensuring fairness in Medicare hospital payments.

TITLE V—COMMONSENSE COMPETITION AND ACCESS TO HEALTH INSURANCE

- Sec. 501. Providing small business health insurance across State lines.
- Sec. 502. Report and models.

TITLE VI—EMPOWERING MEDICARE SENIORS TO NEGOTIATE PRESCRIPTION DRUG PRICES

- Sec. 601. Authority to negotiate fair prices for Medicare prescription drugs.

TITLE VII—COMMONSENSE REPORTING FOR EMPLOYERS

- Sec. 701. Voluntary prospective reporting system.
- Sec. 702. Protection of dependent privacy.
- Sec. 703. Electronic statements.
- Sec. 704. GAO studies.
- Sec. 705. Tax Compliance.

TITLE VIII—FEDERAL BAN ON SURPRISE MEDICAL BILLING

- Sec. 801. Protection against surprise bills.

1 **TITLE I—REDUCING HEALTH**
 2 **CARE COSTS AND PRO-**
 3 **TECTING PEOPLE WITH PRE-**
 4 **EXISTING CONDITIONS**

5 **SEC. 101. IMPROVING AFFORDABILITY BY EXPANDING PRE-**
 6 **MIUM ASSISTANCE FOR CONSUMERS.**

7 (a) IN GENERAL.—Section 36B(b)(3)(A) of the In-
 8 ternal Revenue Code of 1986 is amended to read as fol-
 9 lows:

10 “(A) APPLICABLE PERCENTAGE.—The ap-
 11 plicable percentage for any taxable year shall be
 12 the percentage such that the applicable percent-
 13 age for any taxpayer whose household income is
 14 within an income tier specified in the following
 15 table shall increase, on a sliding scale in a lin-
 16 ear manner, from the initial premium percent-
 17 age to the final premium percentage specified in
 18 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—
Up to 150.0 percent	0.0	0.0
150.0 percent up to 200.0 percent	0.0	3.0
200.0 percent up to 250.0 percent	3.0	4.0
250.0 percent up to 300.0 percent	4.0	6.0
300.0 percent up to 400.0 percent	6.0	8.5
400.0 percent and higher	8.5	8.5”.

1 (b) CONFORMING AMENDMENT.—Section
 2 36B(c)(1)(A) of the Internal Revenue Code of 1986 is
 3 amended by striking “but does not exceed 400 percent”.

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

7 **SEC. 102. EXPANDING AFFORDABILITY FOR WORKING FAM-**
 8 **ILIES TO FIX THE FAMILY GLITCH.**

9 (a) IN GENERAL.—Clause (i) of section 36B(c)(2)(C)
 10 of the Internal Revenue Code of 1986 is amended to read
 11 as follows:

12 “(i) COVERAGE MUST BE AFFORD-
 13 ABLE.—

14 “(I) EMPLOYEES.—An employee
 15 shall not be treated as eligible for
 16 minimum essential coverage if such
 17 coverage consists of an eligible em-
 18 ployer-sponsored plan (as defined in
 19 section 5000A(f)(2)) and the employ-
 20 ee’s required contribution (within the
 21 meaning of section 5000A(e)(1)(B))
 22 with respect to the plan exceeds 9.5
 23 percent of the employee’s household
 24 income.

1 “(II) FAMILY MEMBERS.—An in-
 2 dividual who is eligible to enroll in an
 3 eligible employer-sponsored plan (as
 4 defined in section 5000A(f)(2)) by
 5 reason of a relationship the individual
 6 bears to the employee shall not be
 7 treated as eligible for minimum essen-
 8 tial coverage by reason of such eligi-
 9 bility to enroll if the employee’s re-
 10 quired contribution (within the mean-
 11 ing of section 5000A(e)(1)(B), deter-
 12 mined by substituting ‘family’ for
 13 ‘self-only’) with respect to the plan ex-
 14 ceeds 9.5 percent of the employee’s
 15 household income.”.

16 (b) CONFORMING AMENDMENTS.—

17 (1) Clause (ii) of section 36B(c)(2)(C) of the
 18 Internal Revenue Code of 1986 is amended by strik-
 19 ing “Except as provided in clause (iii), an employee”
 20 and inserting “An individual”.

21 (2) Clause (iii) of section 36B(c)(2)(C) of such
 22 Code is amended by striking “the last sentence of
 23 clause (i)” and inserting “clause (i)(II)”.

24 (3) Clause (iv) of section 36B(c)(2)(C) of such
 25 Code is amended by striking “the 9.5 percent under

1 clause (i)(II)” and inserting “the 9.5 percent under
 2 clauses (i)(I) and (i)(II)”.

3 (c) EFFECTIVE DATE.—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 2021.

6 **SEC. 103. ESTABLISHING A STATE HEALTH INSURANCE AF-**
 7 **FORDABILITY AND INNOVATION FUND.**

8 Subtitle D of title I of the Patient Protection and
 9 Affordable Care Act (42 U.S.C. 18021 et seq.) is amended
 10 by adding at the end the following:

11 **“PART 6—STATE HEALTH INSURANCE**
 12 **AFFORDABILITY AND INNOVATION FUND**

13 **“SEC. 1351. ESTABLISHMENT OF PROGRAM.**

14 “There is hereby established the ‘State Health Insur-
 15 ance Affordability and Innovation Fund’ to be adminis-
 16 tered by the Secretary of Health and Human Services, act-
 17 ing through the Administrator of the Centers for Medicare
 18 & Medicaid Services (referred to in this section as the ‘Ad-
 19 ministrator’), to provide funding, in accordance with this
 20 part, to each of the 50 States and the District of Columbia
 21 (each referred to in this section as a ‘State’) beginning
 22 on January 1, 2022, for the purposes described in section
 23 1352.

1 **“SEC. 1352. USE OF FUNDS.**

2 “(a) IN GENERAL.—A State shall use the funds allo-
3 cated to the State under this part for one of the following
4 purposes:

5 “(1) To provide reinsurance payments to health
6 insurance issuers with respect to individuals enrolled
7 under individual health insurance coverage (other
8 than through a plan described in subsection (b)) of-
9 fered by such issuers.

10 “(2) To provide assistance (other than through
11 payments described in paragraph (1)) to reduce out-
12 of-pocket costs, such as copayments, coinsurance,
13 premiums, and deductibles, of individuals enrolled
14 under qualified health plans offered on the indi-
15 vidual market through an Exchange.

16 “(3) State efforts to streamline health insur-
17 ance enrollment procedures in order to reduce bur-
18 dens on consumers and facilitate greater enrollment
19 in health insurance coverage in the individual and
20 small group markets, including automatic enrollment
21 and reenrollment of, or pre-populated applications
22 for, individuals without health insurance who are eli-
23 gible for tax credits under section 36B of the Inter-
24 nal Revenue Code of 1986, with the ability to opt
25 out of such enrollment.

1 “(4) State investment in technology to improve
2 data sharing and collection for the purposes of facili-
3 tating greater enrollment in health insurance cov-
4 erage in such markets.

5 “(5) Feasibility studies to develop comprehen-
6 sive and coherent State plan for increasing enroll-
7 ment in the individual and small group market.

8 “(b) EXCLUSION OF CERTAIN GRANDFATHERED AND
9 TRANSITIONAL PLANS.—For purposes of subsection (a),
10 a plan described in this subsection is the following:

11 “(1) A grandfathered health plan (as defined in
12 section 1251).

13 “(2) A plan (commonly referred to as a ‘transi-
14 tional plan’) continued under the letter issued by the
15 Centers for Medicare & Medicaid Services on No-
16 vember 14, 2013, to the State Insurance Commis-
17 sioners outlining a transitional policy for coverage in
18 the individual and small group markets to which sec-
19 tion 1251 does not apply, and under the extension
20 of the transitional policy for such coverage set forth
21 in the Insurance Standards Bulletin Series guidance
22 issued by the Centers for Medicare & Medicaid Serv-
23 ices on March 5, 2014, February 29, 2016, Feb-
24 ruary 13, 2017, April 9, 2018, March 25, 2019, and

1 January 31, 2020, or under any subsequent exten-
2 sions thereof.

3 “(3) Student health insurance coverage (as de-
4 fined in section 147.145 of title 45, Code of Federal
5 Regulations).

6 **“SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT**
7 **SAFEGUARD.**

8 “(a) ENCOURAGING STATE OPTIONS FOR ALLOCA-
9 TIONS.—

10 “(1) IN GENERAL.—To be eligible for an alloca-
11 tion of funds under this part for a year (beginning
12 with 2022), a State shall submit to the Adminis-
13 trator an application at such time (but, in the case
14 of allocations for 2022, not later than 90 days after
15 the date of the enactment of this part and, in the
16 case of allocations for a subsequent year, not later
17 than March 1 of the previous year) and in such form
18 and manner as specified by the Administrator con-
19 taining—

20 “(A) a description of how the funds will be
21 used; and

22 “(B) such other information as the Admin-
23 istrator may require.

24 “(2) AUTOMATIC APPROVAL.—An application so
25 submitted is approved unless the Administrator noti-

1 fies the State submitting the application, not later
2 than 60 days after the date of the submission of
3 such application, that the application has been de-
4 nied for not being in compliance with any require-
5 ment of this part and of the reason for such denial.

6 “(3) 5-YEAR APPLICATION APPROVAL.—If an
7 application of a State is approved for a purpose de-
8 scribed in section 1352 for a year, such application
9 shall be treated as approved for such purpose for
10 each of the subsequent 4 years.

11 “(4) REVOCATION OF APPROVAL.—The ap-
12 proval of an application of a State, with respect to
13 a purpose described in section 1352, may be revoked
14 if the State fails to use funds provided to the State
15 under this section for such purpose or otherwise fails
16 to comply with the requirements of this section.

17 “(b) DEFAULT FEDERAL SAFEGUARD.—

18 “(1) 2022.—For 2022, in the case of a State
19 that does not submit an application under subsection
20 (a) by the 90-day submission date applicable to such
21 year under subsection (a)(1) and in the case of a
22 State that does submit such an application by such
23 date that is not approved, the Administrator, in con-
24 sultation with the State insurance commissioner,
25 shall, from the amount calculated under paragraph

1 (4) for such year, carry out the purpose described in
2 paragraph (3) in such State for such year.

3 “(2) 2023 AND SUBSEQUENT YEARS.—For
4 2023 or a subsequent year, in the case of a State
5 that does not have in effect an approved application
6 under this section for such year, the Administrator,
7 in consultation with the State insurance commis-
8 sioner, shall, from the amount calculated under
9 paragraph (4) for such year, carry out the purpose
10 described in paragraph (3) in such State for such
11 year.

12 “(3) SPECIFIED USE.—The amount described
13 in paragraph (4), with respect to 2022 or a subse-
14 quent year, shall be used to carry out the purpose
15 described in section 1352(a)(1) in each State de-
16 scribed in paragraph (1) or (2) for such year, as ap-
17 plicable, by providing reinsurance payments to
18 health insurance issuers with respect to attachment
19 range claims (as defined in section 1354(b)(2)),
20 using the dollar amounts specified in subparagraph
21 (B) of such section for such year in an amount equal
22 to, subject to paragraph (5), the percentage (speci-
23 fied for such year by the Secretary under such sub-
24 paragraph) of the amount of such claims.

1 “(4) AMOUNT DESCRIBED.—The amount de-
 2 scribed in this paragraph, with respect to 2022 or
 3 a subsequent year, is the amount equal to the total
 4 sum of amounts that the Secretary would otherwise
 5 estimate under section 1354(b)(2)(A)(i) for such
 6 year for each State described in paragraph (1) or
 7 (2) for such year, as applicable, if each such State
 8 were not so described for such year.

9 “(5) ADJUSTMENT.—For purposes of this sub-
 10 section, the Secretary may apply a percentage under
 11 paragraph (3) with respect to a year that is less
 12 than the percentage otherwise specified in section
 13 1354(b)(2)(B) for such year, if the cost of paying
 14 the total eligible attachment range claims for States
 15 described in this subsection for such year at such
 16 percentage otherwise specified would exceed the
 17 amount calculated under paragraph (4) for such
 18 year.

19 **“SEC. 1354. ALLOCATIONS.**

20 “(a) APPROPRIATION.—For the purpose of providing
 21 allocations for States under subsection (b) and payments
 22 under section 1353(b) there is appropriated, out of any
 23 money in the Treasury not otherwise appropriated,
 24 \$10,000,000,000 for 2022 and each subsequent year.

25 “(b) ALLOCATIONS.—

1 “(1) PAYMENT.—

2 “(A) IN GENERAL.—From amounts appro-
3 priated under subsection (a) for a year, the
4 Secretary shall, with respect to a State not de-
5 scribed in section 1353(b) for such year and
6 not later than the date specified under subpara-
7 graph (B) for such year, allocate for such State
8 the amount determined for such State and year
9 under paragraph (2).

10 “(B) SPECIFIED DATE.—For purposes of
11 subparagraph (A), the date specified in this
12 subparagraph is—

13 “(i) for 2022, the date that is 45 days
14 after the date of the enactment of this
15 part; and

16 “(ii) for 2023 or a subsequent year,
17 January 1 of the respective year.

18 “(C) NOTIFICATIONS OF ALLOCATION
19 AMOUNTS.—For 2023 and each subsequent
20 year, the Secretary shall notify each State of
21 the amount determined for such State under
22 paragraph (2) for such year by not later than
23 January 1 of the previous year.

24 “(2) ALLOCATION AMOUNT DETERMINA-
25 TIONS.—

1 “(A) IN GENERAL.—For purposes of para-
2 graph (1), the amount determined under this
3 paragraph for a year for a State described in
4 paragraph (1)(A) for such year is the amount
5 equal to—

6 “(i) the amount that the Secretary es-
7 timates would be expended under this part
8 for such year on attachment range claims
9 of individuals residing in such State if such
10 State used such funds only for the purpose
11 described in paragraph (1) of section
12 1352(a) at the dollar amounts and per-
13 centage specified under subparagraph (B)
14 for such year; minus

15 “(ii) the amount, if any, by which the
16 Secretary determines—

17 “(I) the estimated amount of
18 premium tax credits under section
19 36B of the Internal Revenue Code of
20 1986 that would be attributable to in-
21 dividuals residing in such State for
22 such year without application of this
23 part; exceeds

24 “(II) the estimated amount of
25 premium tax credits under section

1 36B of the Internal Revenue Code of
2 1986 that would be attributable to in-
3 dividuals residing in such State for
4 such year if such State were a State
5 described in section 1353(b) for such
6 year.

7 For purposes of the previous sentence and sec-
8 tion 1353(b)(3), the term ‘attachment range
9 claims’ means, with respect to an individual, the
10 claims for such individual that exceed a dollar
11 amount specified by the Secretary for a year,
12 but do not exceed a ceiling dollar amount speci-
13 fied by the Secretary for such year, under sub-
14 paragraph (B).

15 “(B) SPECIFICATIONS.—For purposes of
16 subparagraph (A) and section 1353(b)(3), the
17 Secretary shall determine the dollar amounts
18 and the percentage to be specified under this
19 subparagraph for a year in a manner to ensure
20 that the total amount of expenditures under
21 this part for such year is estimated to equal the
22 total amount appropriated for such year under
23 subsection (a) if such expenditures were used
24 solely for the purpose described in paragraph
25 (1) of section 1352(a) for attachment range

1 claims at the dollar amounts and percentage so
2 specified for such year.

3 “(3) AVAILABILITY.—Funds allocated to a
4 State under this subsection for a year shall remain
5 available through the end of the subsequent year.”.

6 **SEC. 104. RESCINDING THE SHORT-TERM LIMITED DURA-**
7 **TION INSURANCE REGULATION.**

8 (a) PROHIBITION.—The Secretary of Health and
9 Human Services, the Secretary of the Treasury, and the
10 Secretary of Labor—

11 (1) may not take any action to implement, en-
12 force, or otherwise give effect to the rule entitled
13 “Short-Term, Limited Duration Insurance” (83
14 Fed. Reg. 38212 (August 3, 2018));

15 (2) shall apply any regulation revised by such
16 rule as if such rule had not been issued; and

17 (3) may not promulgate any substantially simi-
18 lar rule.

19 **SEC. 105. REVOKING SECTION 1332 GUIDANCE.**

20 (a) PROVIDING THAT CERTAIN GUIDANCE RELATED
21 TO WAIVERS FOR STATE INNOVATION UNDER THE PA-
22 TIENT PROTECTION AND AFFORDABLE CARE ACT SHALL
23 HAVE NO FORCE OR EFFECT.—Beginning July 1, 2020,
24 the Secretary of Health and Human Services and the Sec-
25 retary of the Treasury may not take any action to imple-

1 ment, enforce, or otherwise give effect to the guidance en-
2 titled “State Relief and Empowerment Waivers” (83 Fed.
3 Reg. 53575 (October 24, 2018)), including any such ac-
4 tion that would—

5 (1) result in individuals losing health insurance
6 coverage that includes the essential health benefits
7 package (as defined in subsection (a) of section
8 1302 of the Patient Protection and Affordable Care
9 Act (42 U.S.C. 18022(a)) without regard to any
10 waiver of any provision of such package under a
11 waiver under such section 1332), including the ma-
12 ternity and newborn care essential health benefit de-
13 scribed in subsection (b)(1)(D) of such section;

14 (2) result in a decrease in the number of such
15 individuals enrolled in coverage that is at least as
16 comprehensive as the coverage defined in section
17 1302(a) of the Patient Protection and Affordable
18 Care Act (42 U.S.C. 18022(a)) compared to the
19 number of such individuals who would have been so
20 enrolled in such coverage had such action not been
21 taken;

22 (3) with respect to individuals with substance
23 use disorders, including opioid use disorders, reduce
24 the availability or affordability of coverage that is at
25 least as comprehensive as the coverage defined in

1 section 1302(a) of the Patient Protection and Af-
2 fordable Care Act (42 U.S.C. 18022(a)) compared to
3 the availability or affordability, respectively, of such
4 coverage had such action not been taken;

5 (4) result, with respect to vulnerable popu-
6 lations (including low-income individuals, elderly in-
7 dividuals, and individuals with serious health issues
8 or who have a greater risk of developing serious
9 health issues), in a decrease in the availability of
10 coverage that is at least as comprehensive as the
11 coverage defined in section 1302(a) of the Patient
12 Protection and Affordable Care Act (42 U.S.C.
13 18022(a)) with coverage and cost-sharing protec-
14 tions required under section 1332(b)(1)(B) of such
15 Act (42 U.S.C. 18052(b)(1)(B));

16 (5) with respect to individuals with preexisting
17 conditions, reduce the affordability of coverage that
18 is at least as comprehensive as the coverage defined
19 in section 1302(a) of the Patient Protection and Af-
20 fordable Care Act (42 U.S.C. 18022(a)) compared to
21 the affordability of such coverage had such action
22 not been taken; or

23 (6) result in higher health insurance premiums
24 for individuals enrolled in health insurance coverage
25 that is at least as comprehensive as the coverage de-

1 fined in section 1302(b) of such Act (42 U.S.C.
 2 18022(b)), and the Secretaries may not promulgate
 3 any substantially similar guidance or rule.

4 (b) RULE OF CONSTRUCTION.—Nothing in sub-
 5 section (a) shall be construed to affect the approval of
 6 waivers under section 1332 of the Patient Protection and
 7 Affordable Care Act (42 U.S.C. 18052) that establish re-
 8 insurance programs that are consistent with the require-
 9 ments under subsection (b)(1) of such section (42 U.S.C.
 10 18052(b)(1)), lower health insurance premiums, and pro-
 11 tect health insurance coverage for people with preexisting
 12 conditions.

13 **SEC. 106. PROMOTING CONSUMER OUTREACH AND EDU-**
 14 **CATION.**

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

18 (1) in paragraph (2), by adding at the end the
 19 following new subparagraph:

20 “(C) SELECTION OF RECIPIENTS.—In the
 21 case of an Exchange established and operated
 22 by the Secretary within a State pursuant to sec-
 23 tion 1321(c), in awarding grants under para-
 24 graph (1), the Exchange shall—

1 “(i) select entities to receive such
2 grants based on an entity’s demonstrated
3 capacity to carry out each of the duties
4 specified in paragraph (3);

5 “(ii) not take into account whether or
6 not the entity has demonstrated how the
7 entity will provide information to individ-
8 uals relating to group health plans offered
9 by a group or association of employers de-
10 scribed in section 2510.3–5(b) of title 29,
11 Code of Federal Regulations (or any suc-
12 cessor regulation), or short-term limited
13 duration insurance (as defined by the Sec-
14 retary for purposes of section 2791(b)(5)
15 of the Public Health Service Act); and

16 “(iii) ensure that, each year, the Ex-
17 change awards such a grant to—

18 “(I) at least one entity described
19 in this paragraph that is a community
20 and consumer-focused nonprofit
21 group; and

22 “(II) at least one entity described
23 in subparagraph (B), which may in-
24 clude another community and con-
25 sumer-focused nonprofit group in ad-

1 dition to any such group awarded a
2 grant pursuant to subclause (I).

3 In awarding such grants, an Exchange may
4 consider an entity's record with respect to
5 waste, fraud, and abuse for purposes of main-
6 taining the integrity of such Exchange.”;

7 (2) in paragraph (3)—

8 (A) by amending subparagraph (C) to read
9 as follows:

10 “(C) facilitate enrollment, including with
11 respect to individuals with limited English pro-
12 ficiency and individuals with chronic illnesses,
13 in qualified health plans, State Medicaid plans
14 under title XIX of the Social Security Act, and
15 State child health plans under title XXI of such
16 Act;”;

17 (B) in subparagraph (D), by striking
18 “and” at the end;

19 (C) in subparagraph (E), by striking the
20 period at the end and inserting “; and”;

21 (D) by inserting after subparagraph (E)
22 the following new subparagraph:

23 “(F) provide referrals to community-based
24 organizations that address social needs related
25 to health outcomes.”; and

1 (E) by adding at the end the following
 2 flush text:

3 “The duties specified in the preceding sentence may
 4 be carried out by such a navigator at any time dur-
 5 ing a year.”;

6 (3) in paragraph (4)(A)—

7 (A) in the matter preceding clause (i), by
 8 striking “not”;

9 (B) in clause (i)—

10 (i) by inserting “not” before “be”;

11 and

12 (ii) by striking “; or” and inserting a
 13 semicolon;

14 (C) in clause (ii)—

15 (i) by inserting “not” before “re-
 16 ceive”; and

17 (ii) by striking the period and insert-
 18 ing a semicolon; and

19 (D) by adding at the end the following new
 20 clauses:

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

24 “(iv) receive opioid specific education
 25 and training that ensures the navigator

1 can best educate individuals on qualified
2 health plans offered through an Exchange,
3 specifically coverage under such plans for
4 opioid health care treatment.”; and

5 (4) in paragraph (6)—

6 (A) by striking “Grants under” and insert-
7 ing the following:

8 “(A) STATE EXCHANGES.—Grants under”;
9 and

10 (B) by adding at the end the following new
11 subparagraph:

12 “(B) FEDERAL EXCHANGES.—For pur-
13 poses of carrying out this subsection, with re-
14 spect to an Exchange established and operated
15 by the Secretary within a State pursuant to sec-
16 tion 1321(c), the Secretary shall obligate
17 \$100,000,000 out of amounts collected through
18 the user fees on participating health insurance
19 issuers pursuant to section 156.50 of title 45,
20 Code of Federal Regulations (or any successor
21 regulations), for fiscal year 2022 and each sub-
22 sequent fiscal year. Such amount for a fiscal
23 year shall remain available until expended.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply with respect to plan years begin-
 3 ning on or after January 1, 2021.

4 **TITLE II—ENCOURAGING MED-**
 5 **ICAID EXPANSION AND**
 6 **STRENGTHENING THE MED-**
 7 **ICAID PROGRAM**

8 **SEC. 201. INCENTIVIZING MEDICAID EXPANSION.**

9 (a) IN GENERAL.—Section 1905 of the Social Secu-
 10 rity Act (42 U.S.C. 1396d(y)(1)) is amended—

11 (1) in subsection (y)(1)—

12 (A) in subparagraph (A), by striking
 13 “2014, 2015, and 2016” and inserting “each of
 14 the first 3 consecutive 12-month periods in
 15 which the State provides medical assistance to
 16 newly eligible individuals”;

17 (B) in subparagraph (B), by striking
 18 “2017” and inserting “the fourth consecutive
 19 12-month period in which the State provides
 20 medical assistance to newly eligible individuals”;

21 (C) in subparagraph (C), by striking
 22 “2018” and inserting “the fifth consecutive 12-
 23 month period in which the State provides med-
 24 ical assistance to newly eligible individuals”;

1 (D) in subparagraph (D), by striking
 2 “2019” and inserting “the sixth consecutive 12-
 3 month period in which the State provides med-
 4 ical assistance to newly eligible individuals”;
 5 and

6 (E) in subparagraph (E), by striking
 7 “2020 and each year thereafter” and inserting
 8 “the seventh consecutive 12-month period in
 9 which the State provides medical assistance to
 10 newly eligible individuals and each such period
 11 thereafter”; and

12 (2) in subsection (z)(2)(B)(i)(II), by inserting
 13 “(as in effect on the day before the date of enact-
 14 ment of the Health Care Improvement Act of
 15 2020)” after “subsection (y)(1)”.

16 (b) EFFECTIVE DATE.—Beginning on January 1,
 17 2022, the amendments made by subsection (a) shall take
 18 effect as if included in the enactment of the Patient Pro-
 19 tection and Affordable Care Act (Public Law 111–148).

20 **SEC. 202. REDUCING THE ADMINISTRATIVE FMAP FOR**
 21 **NONEXPANSION STATES.**

22 Section 1903 of the Social Security Act (42 U.S.C.
 23 1396b) is amended—

1 (1) in subsection (a)(7), by inserting “sub-
 2 section (bb) and” before “section 1919(g)(3)(B)”;
 3 and

4 (2) by adding at the end the following new sub-
 5 section:

6 “(bb) REDUCTION OF FEDERAL PAYMENTS FOR
 7 CERTAIN ADMINISTRATIVE COSTS OF NONEXPANSION
 8 STATES.—

9 “(1) IN GENERAL.—In the case of a State that
 10 does not provide under the State plan of such State
 11 (or waiver of such plan) for making medical assist-
 12 ance available in accordance with section 1902(k)(1)
 13 to all individuals described in section
 14 1902(a)(10)(i)(VIII) for a calendar quarter begin-
 15 ning on or after October 1, 2022, the Secretary may
 16 reduce the percentage specified in subsection (a)(7)
 17 for amounts described in such subsection expended
 18 during such quarter by such State by the number of
 19 percentage points specified in paragraph (2) for such
 20 quarter.

21 “(2) AMOUNT OF REDUCTION.—For purposes
 22 of paragraph (1), the number of percentage points
 23 specified in this paragraph for a calendar quarter is
 24 the following:

1 “(A) For the calendar quarter beginning
2 on October 1, 2022, 0.5.

3 “(B) For a calendar quarter beginning on
4 or after January 1, 2023, and ending before
5 July 1, 2027, the number of percentage points
6 specified under this paragraph for the previous
7 quarter, plus 0.5.

8 “(C) For a calendar quarter beginning on
9 or after July 1, 2027, 10.

10 “(3) DEFINITION.—For purposes of this sub-
11 section, the term ‘State’ means a State that is one
12 of the 50 States or the District of Columbia.”.

13 **SEC. 203. STATE OPTION TO PROVIDE 12 MONTHS OF**
14 **POSTPARTUM MEDICAID ELIGIBILITY.**

15 (a) OPTION TO PROVIDE CONTINUOUS MEDICAID
16 AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM
17 WOMEN.—

18 (1) MEDICAID.—Title XIX of the Social Secu-
19 rity Act (42 U.S.C. 1396 et seq.) is amended—

20 (A) in section 1902(l)(1)(A), by inserting
21 “(or, at the option of the State, 365-day pe-
22 riod)” after “60-day period”;

23 (B) in section 1902(e)(6), by inserting
24 “(or, at the option of the State, 365-day pe-
25 riod)” after “60-day period”;

1 (C) in section 1903(v)(4)(A)(i), by insert-
 2 ing “(or, at the option of the State, 365-day pe-
 3 riod)” after “60-day period”; and

4 (D) in section 1905(a), in the 4th sentence
 5 in the matter following paragraph (30), by in-
 6 serting “(or, at the option of the State, 365-day
 7 period)” after “60-day period”.

8 (2) CHIP.—Section 2112 of the Social Security
 9 Act (42 U.S.C. 1397ll) is amended by inserting “(or,
 10 at the option of the State, 365-day period)” after
 11 “60-day period” each place it appears.

12 (b) REQUIRING FULL BENEFITS FOR PREGNANT
 13 AND POSTPARTUM WOMEN.—

14 (1) MEDICAID.—

15 (A) IN GENERAL.—Paragraph (5) of sec-
 16 tion 1902(e) of the Social Security Act (24
 17 U.S.C. 1396a(e)) is amended to read as follows:

18 “(5) Any woman who is eligible for medical as-
 19 sistance under the State plan or a waiver of such
 20 plan and who is, or who while so eligible becomes,
 21 pregnant, shall continue to be eligible under the plan
 22 or waiver for medical assistance through the end of
 23 the month in which the 60-day period (or, at the op-
 24 tion of the State, 365-day period) (beginning on the
 25 last day of her pregnancy) ends, regardless of the

1 basis for the woman’s eligibility for medical assist-
 2 ance, including if the woman’s eligibility for medical
 3 assistance is on the basis of being pregnant.”.

4 (B) CONFORMING AMENDMENT.—Section
 5 1902(a)(10) of the Social Security Act (42
 6 U.S.C. 1396a(a)(10)) is amended in the matter
 7 following subparagraph (G) by striking “(VII)
 8 the medical assistance” and all that follows
 9 through “complicate pregnancy,”.

10 (2) CHIP.—Section 2107(e)(1) of the Social
 11 Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

12 (A) by redesignating subparagraphs (H)
 13 through (S) as subparagraphs (I) through (T),
 14 respectively; and

15 (B) by inserting after subparagraph (G),
 16 the following:

17 “(H) Section 1902(e)(5) (requiring 60-day
 18 (or, at the option of the State, 365-day) contin-
 19 uous coverage for pregnant and postpartum
 20 women).”.

21 (c) MAINTENANCE OF EFFORT.—

22 (1) MEDICAID.—Section 1902 of the Social Se-
 23 curity Act (42 U.S.C. 1396a) is amended—

1 (A) in paragraph (74), by striking “sub-
 2 section (gg); and” and inserting “subsections
 3 (gg) and (qq);”; and

4 (B) by adding at the end the following new
 5 subsection:

6 “(qq) MAINTENANCE OF EFFORT RELATED TO LOW-
 7 INCOME PREGNANT WOMEN.—For calendar quarters be-
 8 ginning on or after the effective date described in section
 9 204(d) of the Health Care Improvement Act of 2020, and
 10 before January 1, 2023, no Federal payment shall be
 11 made to a State under section 1903(a) for amounts ex-
 12 pended under a State plan under this title or a waiver
 13 of such plan if the State—

14 “(1) has in effect under such plan eligibility
 15 standards, methodologies, or procedures for individ-
 16 uals described in subsection (l)(1) who are eligible
 17 for medical assistance under the State plan or waiv-
 18 er under subsection (a)(10)(A)(ii)(IX) that are more
 19 restrictive than the eligibility standards, methodolo-
 20 gies, or procedures, respectively, for such individuals
 21 under such plan or waiver that are in effect on the
 22 date of the enactment of this subsection; or

23 “(2) provides medical assistance to individuals
 24 described in subsection (l)(1) who are eligible for
 25 medical assistance under such plan or waiver under

1 subsection (a)(10)(A)(ii)(IX) at a level that is less
 2 than the level at which the State provides such as-
 3 sistance to such individuals under such plan or waiv-
 4 er on the date of the enactment of this subsection.”.

5 (2) CHIP.—Section 2112 of the Social Security
 6 Act (42 U.S.C. 1397ll), as amended by subsection
 7 (b), is further amended by adding at the end the fol-
 8 lowing subsection:

9 “(g) MAINTENANCE OF EFFORT.—For calendar
 10 quarters beginning on or after the effective date described
 11 in section 204(d) of the Health Care Improvement Act of
 12 2020, and before January 1, 2023, no payment may be
 13 made under section 2105(a) with respect to a State child
 14 health plan if the State—

15 “(1) has in effect under such plan eligibility
 16 standards, methodologies, or procedures for targeted
 17 low-income pregnant women that are more restric-
 18 tive than the eligibility standards, methodologies, or
 19 procedures, respectively, under such plan that are in
 20 effect on the date of the enactment of this sub-
 21 section; or

22 “(2) provides pregnancy-related assistance to
 23 targeted low-income pregnant women under such
 24 plan at a level that is less than the level at which
 25 the State provides such assistance to such women

1 under such plan on the date of the enactment of this
2 subsection.”.

3 (d) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided under
5 paragraph (2), the amendments made by subsections
6 (a) and (b) shall take effect on (and the effective
7 date described in this subsection shall be) the first
8 day of the calendar quarter during which the last
9 day of the emergency period described in section
10 1135(g)(1)(B) of the Social Security Act (42 U.S.C.
11 1320b–5(g)(1)(B)) occurs.

12 (2) EXTENSION OF EFFECTIVE DATE FOR
13 STATE LAW AMENDMENT.—In the case of a State
14 plan under title XIX or State child health plan
15 under title XXI of the Social Security Act (42
16 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.)
17 which the Secretary of Health and Human Services
18 determines requires State legislation (other than leg-
19 islation appropriating funds) in order for the respec-
20 tive plan to meet the additional requirement imposed
21 by the amendments made by subsection (a) or (b),
22 respectively, the respective plan shall not be re-
23 garded as failing to comply with the requirements of
24 such title solely on the basis of its failure to meet
25 such applicable additional requirement before the

1 first day of the first calendar quarter beginning
 2 after the close of the first regular session of the
 3 State legislature that begins after the date of enact-
 4 ment of this Act. For purposes of the previous sen-
 5 tence, in the case of a State that has a 2-year legis-
 6 lative session, each year of the session is considered
 7 to be a separate regular session of the State legisla-
 8 ture.

9 **SEC. 204. SUPPORTING STATE MEDICAID PROGRAMS**
 10 **THROUGH ECONOMIC DOWNTURNS.**

11 (a) IN GENERAL.—Section 1905 of the Social Secu-
 12 rity Act (42 U.S.C. 1396d) is amended—

13 (1) in subsection (b), by striking “and (ff)” and
 14 inserting “(ff), and (gg)”; and

15 (2) by adding at the end the following new sub-
 16 section:

17 “(gg) INCREASED FMAP DURING ECONOMIC
 18 DOWNTURNS.—

19 “(1) IN GENERAL.—If a fiscal quarter that be-
 20 gins on or after January 1, 2020, is an economic
 21 downturn quarter (as defined in paragraph (2)) with
 22 respect to a State, then the Federal medical assist-
 23 ance percentage determined for each State for such
 24 quarter under subsection (b) shall be equal to the

percentage determined for the State and quarter
under paragraph (3).

“(2) ECONOMIC DOWNTURN QUARTER.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—In this subsection,
the term ‘economic downturn quarter’
means, with respect to a State, a fiscal
quarter during which the State’s unem-
ployment rate for the quarter exceeds the
percentage determined for the State and
quarter under clause (ii).

“(ii) THRESHOLD PERCENTAGE.—The
percentage determined under this clause
for a State and fiscal quarter is the per-
centage equal to the lower of—

“(I) the State unemployment
rate at the 20th percentile of the dis-
tribution of the State’s quarterly un-
employment rates for the 60-quarter
period preceding the quarter involved,
increased by 1 percentage point; and

“(II) the State’s average quar-
terly unemployment rate for the 12-
quarter period preceding the quarter

1 involved, increased by 1 percentage
2 point.

3 “(B) UNEMPLOYMENT DATA.—

4 “(i) IN GENERAL.—Except as pro-
5 vided in clause (ii), for purposes of deter-
6 mining unemployment rates for a State
7 and a quarter under this paragraph, the
8 Secretary shall use data from the Local
9 Area Unemployment Statistics from the
10 Bureau of Labor Statistics.

11 “(ii) APPLICATION TO CERTAIN TER-
12 RITORIES.—In the case of the Virgin Is-
13 lands, Guam, the Northern Mariana Is-
14 lands, American Samoa, or any other juris-
15 diction for which suitable data from the
16 Local Area Unemployment Statistics from
17 the Bureau of Labor Statistics are unavail-
18 able, the Secretary shall use data from the
19 U–3 unemployment measure of the Bureau
20 of Labor Statistics to make any necessary
21 determinations under subparagraph (A).

22 “(3) INCREASED FMAP DURING ECONOMIC
23 DOWNTURN QUARTER.—

24 “(A) IN GENERAL.—During a fiscal quar-
25 ter that is an economic downturn quarter with

1 respect to a State, the Federal medical assist-
 2 ance percentage for the State and quarter de-
 3 termined under subsection (b) shall be equal
 4 to—

5 “(i) the Federal medical assistance
 6 percentage determined for the State and
 7 quarter under subsection (b) without re-
 8 gard to this subsection (but including any
 9 increase to such percentage for such quar-
 10 ter made pursuant to section 6008(a) of
 11 the Families First Coronavirus Response
 12 Act); increased by

13 “(ii) the number of percentage points
 14 (rounded to the nearest tenth of a percent-
 15 age point) equal to the product of—

16 “(I) the number of percentage
 17 points (rounded to the nearest tenth
 18 of a percentage point) by which the
 19 unemployment rate for the State and
 20 quarter exceeds the percentage deter-
 21 mined for the State and quarter
 22 under paragraph (2)(A)(ii); and

23 “(II) 4.8.

24 “(B) RULES OF APPLICATION.—The fol-
 25 lowing rules shall apply with respect to the Fed-

1 eral medical assistance percentage determined
2 for a State and an economic downturn quarter
3 under this subsection:

4 “(i) SCOPE OF APPLICATION.—Such
5 Federal medical assistance percentage shall
6 not apply for purposes of—

7 “(I) disproportionate share hos-
8 pital payments described in section
9 1923;

10 “(II) payments under part D of
11 title IV; or

12 “(III) any payments under this
13 title that are based on a Federal med-
14 ical assistance percentage determined
15 for a State under subsection (aa) (but
16 only to the extent that such Federal
17 medical assistance percentage is high-
18 er than the economic recovery
19 FMAP).

20 “(ii) LIMITATION.—In no case shall—

21 “(I) the Federal medical assist-
22 ance percentage determined for a
23 State and quarter pursuant to this
24 subsection exceed 95 percent; or

1 “(II) any increase to the Federal
 2 medical assistance percentage deter-
 3 mined for a State and quarter pursu-
 4 ant to this subsection result in the ap-
 5 plication of a Federal medical assist-
 6 ance percentage that exceeds 95 per-
 7 cent.

8 “(iii) APPLICATION TO CHIP.—Not-
 9 withstanding the first sentence of section
 10 2105(b), the application of this subsection
 11 may result in the enhanced FMAP of a
 12 State for a fiscal year under such section
 13 exceeding 85 percent, but in no case may
 14 the application of this subsection before
 15 application of the second sentence of such
 16 section result in the enhanced FMAP of
 17 the State exceeding 95 percent.

18 “(4) ADVANCE PAYMENT; RETROSPECTIVE AD-
 19 JUSTMENT.—

20 “(A) IN GENERAL.—Prior to the beginning
 21 of each fiscal quarter that begins on or after
 22 July 1, 2020, the Secretary shall, with respect
 23 to each State—

24 “(i) make an initial determination,
 25 based on the projections made for the

1 State and quarter under subparagraph
2 (B), as to—

3 “(I) whether the application of
4 this subsection is expected to result in
5 the application of a higher Federal
6 medical assistance percentage for the
7 State and quarter than the percentage
8 that would otherwise apply without re-
9 gard to this subsection; and—

10 “(II) if the application of this
11 subsection is expected to result in
12 such a higher Federal medical assist-
13 ance percentage for the State and
14 quarter, what such higher percentage
15 is expected to be; and

16 “(ii) if the Secretary determines under
17 clause (i) that the application of this sub-
18 section is expected to result in the applica-
19 tion of a higher Federal medical assistance
20 percentage for the State and quarter than
21 the percentage that would otherwise apply
22 without regard to this subsection—

23 “(I) apply such higher Federal
24 medical assistance percentage of the
25 State for purposes of making pay-

ments to the State for amounts expended during such quarter as medical assistance under the State plan; and

“(II) take into account such higher Federal medical assistance percentage of the State for purposes of calculating the enhanced FMAP for the State and quarter under section 2105(b).

“(B) PROJECTION OF STATE UNEMPLOYMENT RATES.—Prior to the beginning of each fiscal quarter that begins on or after July 1, 2020, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall, using the most recently available data described in paragraph (2)(B), make projections with respect to—

“(i) the unemployment rates for each State for such quarter;

“(ii) the threshold percentages described in paragraph (2)(A)(ii) for each State for such quarter; and

“(iii) the national unemployment rate for such quarter.

1 “(C) RETROSPECTIVE ADJUSTMENT.—As
2 soon as practicable after final unemployment
3 data becomes available for a fiscal quarter that
4 begins on or after July 1, 2020, the Secretary
5 shall, with respect to each State—

6 “(i) make a final determination with
7 respect to the application of this subsection
8 for purposes of determining the Federal
9 medical assistance percentage and en-
10 hanced FMAP of the State for the quarter;
11 and

12 “(ii) in accordance with section
13 1903(d)(2) and section 2105(e), reduce or
14 increase the amount payable to the State
15 under section 1903(a) or section 2105 for
16 a subsequent fiscal quarter to the extent of
17 any overpayment or underpayment under
18 either such section which the Secretary de-
19 termines was made as a result of an incor-
20 rect initial determination under subpara-
21 graph (A)(i) with respect to the application
22 of this subsection for purposes of deter-
23 mining the Federal medical assistance per-
24 centage and enhanced FMAP of the State
25 for such prior fiscal quarter.

1 “(5) RETROSPECTIVE APPLICATION OF OVER-
2 THE-LIMIT FMAP INCREASES.—

3 “(A) IN GENERAL.—If a State has excess
4 percentage points with respect to an economic
5 downturn quarter and an applicable FMAP (as
6 determined under subparagraph (B)), the State
7 may elect to apply such excess percentage
8 points to increase such applicable FMAP for
9 one or more quarters during the look-back pe-
10 riod for the State and economic downturn quar-
11 ter in accordance with this paragraph.

12 “(B) EXCESS PERCENTAGE POINTS.—For
13 purposes of this paragraph, the number of ex-
14 cess percentage points for a State, economic
15 downturn quarter, and an applicable FMAP
16 shall be equal to the number of percentage
17 points by which—

18 “(i) the applicable FMAP for the
19 State and quarter (after application of
20 paragraph (3) but without regard to sub-
21 paragraph (B)(ii) of such paragraph); ex-
22 ceeds

23 “(ii) 95 percent.

24 “(C) EFFECT OF APPLICATION OF EXCESS
25 PERCENTAGE POINTS.—If a State elects to

1 apply excess percentage points to an applicable
 2 FMAP to a quarter during a look-back period
 3 under this paragraph, the Secretary shall deter-
 4 mine the additional amount of payment under
 5 section 1903(a) to which the State would have
 6 been entitled for such quarter if the applicable
 7 FMAP (as so increased) had been in effect for
 8 such quarter, and shall treat such additional
 9 amount as an underpayment for such quarter.

10 “(D) DISTRIBUTION OF EXCESS PERCENT-
 11 AGE POINTS.—A State that has excess percent-
 12 age points with respect to an economic down-
 13 turn quarter and applicable FMAP may elect to
 14 divide such points among more than 1 quarter
 15 during the look-back period for such State and
 16 quarter provided that no excess percentage
 17 point (or fraction of an excess percentage point)
 18 is applied to the applicable FMAP of more than
 19 1 quarter.

20 “(E) LIMITATIONS.—

21 “(i) NO INCREASES OVER 100 PER-
 22 CENT.—A State may not increase an appli-
 23 cable FMAP for any quarter during a look-
 24 back period under this paragraph if such
 25 increase would result in the applicable

1 FMAP for such quarter exceeding 100 per-
 2 cent.

3 “(ii) SCOPE OF APPLICATION.—Any
 4 increase to an applicable FMAP of a State
 5 for a fiscal quarter under this paragraph—

6 “(I) shall only apply with respect
 7 to payments for amounts expended by
 8 the State for medical assistance for
 9 services furnished during such quarter
 10 to which such applicable FMAP is ap-
 11 plicable; and

12 “(II) shall not apply with respect
 13 to payments described in paragraph
 14 (3)(B)(i).

15 “(F) DEFINITIONS.—In this paragraph:

16 “(i) APPLICABLE FMAP.—The term
 17 ‘applicable FMAP’ means, with respect to
 18 a State and fiscal quarter—

19 “(I) the Federal medical assist-
 20 ance percentage determined for the
 21 State and quarter under subsection
 22 (b);

23 “(II) the Federal medical assist-
 24 ance percentage applicable under sub-
 25 section (y);

1 “(III) the Federal medical assist-
 2 ance percentage applicable under sub-
 3 section (z)(2);

4 “(IV) the Federal medical assist-
 5 ance percentage determined for the
 6 State and quarter under subsection
 7 (ff); or

8 “(V) the enhanced FMAP deter-
 9 mined for the State and quarter
 10 under section 2105(b).

11 “(ii) LOOK-BACK PERIOD.—The term
 12 ‘look-back period’ means, with respect to a
 13 State and a fiscal quarter that is an eco-
 14 nomic downturn quarter for the State, the
 15 period of 4 fiscal quarters that ends with
 16 the fourth quarter which precedes the most
 17 recent fiscal quarters that was not an eco-
 18 nomic downturn quarter for the State.

19 “(6) REQUIREMENT FOR ALL STATES.—This
 20 subsection shall not apply to a State with respect to
 21 a fiscal quarter, if—

22 “(A) eligibility standards, methodologies,
 23 or procedures under the State plan or a waiver
 24 of such plan are more restrictive during such
 25 quarter than the eligibility standards, meth-

1 odologies, or procedures, respectively, under
2 such plan (or waiver) as in effect on the last
3 day of the most recent fiscal quarter that was
4 not an economic downturn quarter for the
5 State;

6 “(B) the amount of any premium imposed
7 by the State pursuant to section 1916 or 1916A
8 during such quarter, with respect to an indi-
9 vidual enrolled under such plan (or waiver), ex-
10 ceeds the amount of such premium as of the
11 date described in subparagraph (A); or

12 “(C) the State fails to provide that an in-
13 dividual who is enrolled for benefits under such
14 plan (or waiver) as of the date described in sub-
15 paragraph (A) or enrolls for benefits under
16 such plan (or waiver) during the period begin-
17 ning with such date and ending with the day
18 before the first day of the next quarter that is
19 not an economic downturn quarter for the State
20 shall be treated as eligible for such benefits for
21 not less than 12 months after such date or (if
22 later) the date that such individual so enrolls
23 unless the individual requests a voluntary ter-
24 mination of eligibility or the individual ceases to
25 be a resident of the State.”.

1 (b) EXCLUSION OF ECONOMIC DOWNTURN FMAP
 2 INCREASES FROM TERRITORIAL CAPS; SPECIAL RULE
 3 FOR CHIP ALLOTMENTS.—

4 (1) EXCLUSION FROM TERRITORIAL CAPS.—
 5 Section 1108 of the Social Security Act (42 U.S.C.
 6 1308) is amended—

7 (A) in subsection (f), in the matter pre-
 8 ceding paragraph (1), by striking “subsection
 9 (g) and section 1935(e)(1)(B)” and inserting
 10 “subsections (g) and (h) and section
 11 1935(e)(1)(B)”; and

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

13 “(h) EXCLUSION FROM CAPS OF AMOUNTS ATTRIB-
 14 UTABLE TO ECONOMIC DOWNTURN FMAP.—Any pay-
 15 ment made to a territory for a fiscal year in which the
 16 Federal medical assistance percentage for the territory is
 17 determined under section 1905(gg) shall not be taken into
 18 account for purposes of applying payment limits under
 19 subsections (f) and (g) to the extent that such payment
 20 exceeds the amount of the payment that would have been
 21 made to the territory for the year if the Federal medical
 22 assistance percentage for the territory had been deter-
 23 mined without regard to such section.”.

1 (2) CHIP ALLOTMENTS.—Section 2104(m) of
 2 the Social Security Act (42 U.S.C. 1397dd(m)) is
 3 amended—

4 (A) in paragraph (2)(B), in the matter
 5 preceding clause (i), by striking “paragraphs
 6 (5) and (7)” and inserting “paragraphs (5),
 7 (7), and (12)”; and

8 (B) by adding at the end the following new
 9 paragraph:

10 “(12) SPECIAL RULE FOR ADJUSTING ALLOT-
 11 MENTS DURING FISCAL YEARS WITH ECONOMIC
 12 DOWNTURN QUARTERS.—

13 “(A) IN GENERAL.—If a fiscal quarter oc-
 14 curring during fiscal year 2020 or any suc-
 15 ceeding fiscal year is determined to be an eco-
 16 nomic downturn quarter with respect to a State
 17 (as determined under section 1905(gg)) then,
 18 as soon as practicable after such determination,
 19 the Secretary shall increase the allotment for
 20 the State and fiscal year in accordance with
 21 subparagraph (B).

22 “(B) AMOUNT OF INCREASE.—

23 “(i) IN GENERAL.—The amount of an
 24 increase to the allotment of a State de-
 25 scribed in subparagraph (A) for a fiscal

1 year shall be equal to the amount by which
2 Federal payments made to the State for
3 the preceding fiscal year under this title
4 would have been increased (without regard
5 to whether such payments would exceed
6 the amount of the State's allotment for
7 such preceding fiscal year) if the enhanced
8 FMAP determined for the State for such
9 preceding fiscal year had been increased to
10 the same extent that the State's enhanced
11 FMAP for the fiscal year involved is ex-
12 pected to be increased as a result of the
13 application of section 1905(gg) relative to
14 the enhanced FMAP that would apply to
15 the State for the fiscal year involved with-
16 out the application of such section.

17 “(ii) INCLUSION OF PROJECTED IN-
18 CREASES.—In increasing the allotment of a
19 State for a fiscal year under this para-
20 graph, the Secretary may base the calcula-
21 tion of such increase on projections made
22 by the Secretary with respect to—

23 “(I) the number of fiscal quar-
24 ters during such fiscal year that will
25 be economic downturn quarters; and

1 “(II) the effect that the applica-
 2 tion of section 1905(gg) is expected to
 3 have on the enhanced FMAP of the
 4 State for such fiscal year.

5 “(C) DISREGARD OF INCREASED PAY-
 6 MENTS FOR PURPOSES OF FUTURE ALLOT-
 7 MENTS.—Any Federal payment made to a State
 8 under this title for a fiscal year in which the
 9 Federal medical assistance percentage for the
 10 State is determined under section 1905(gg)
 11 shall be disregarded when determining the allot-
 12 ment of the State for any subsequent year, in-
 13 cluding for purposes of applying this paragraph,
 14 to the extent that such payment exceeds the
 15 amount of the payment that would have been
 16 made to the State for the year if the Federal
 17 medical assistance percentage for the State and
 18 year had been determined without regard to
 19 such section.”.

20 **SEC. 205. STATE FLEXIBILITY TO USE ADMINISTRATIVE**
 21 **SIMPLIFICATION POLICIES FOR ENROLL-**
 22 **MENT.**

23 (a) PERMANENT EXTENSION OF MEDICAID AND
 24 CHIP EXPRESS LANE OPTION.—Section 1902(e)(13) of

1 the Social Security Act (42 U.S.C. 1396a(e)(13)) is
 2 amended by striking subparagraph (I).

3 (b) EXTENDING EXPRESS LANE ELIGIBILITY TO
 4 ADULTS.—Section 1902(e)(13)(A) of the Social Security
 5 Act (42 U.S.C. 1396a(e)(13)(A)) is amended by adding
 6 at the end the following new clause:

7 “(iii) STATE OPTION TO EXTEND EX-
 8 PRESS LANE ELIGIBILITY TO ADULTS.—

9 “(I) IN GENERAL.—At the option
 10 of the State, the State may apply the
 11 provisions of this paragraph with re-
 12 spect to determining eligibility under
 13 this title for an eligible individual (as
 14 defined in subclause (II)). In applying
 15 this paragraph in the case of a State
 16 making such an option, any reference
 17 in this paragraph to a child with re-
 18 spect to this title (other than a ref-
 19 erence to child health assistance) shall
 20 be deemed to be a reference to an eli-
 21 gible individual.

22 “(II) ELIGIBLE INDIVIDUAL DE-
 23 FINED.—In this clause, the term ‘eli-
 24 gible individual’ means—

1 “(aa) any individual (other
 2 than a child) whose income eligi-
 3 bility under the State plan or
 4 under a waiver of the plan for
 5 medical assistance is determined
 6 under paragraph (14); and

7 “(bb) an individual included
 8 in any other group of individuals
 9 the Secretary determines appro-
 10 priate.”.

11 (c) CONSENT BY BENEFIT UTILIZATION.—Section
 12 1902(e)(13)(D)(i) of the Social Security Act (42 U.S.C.
 13 1396a(e)(13)(D)(i)) is amended by inserting “by using
 14 medical assistance to access care,” after “through elec-
 15 tronic signature,”.

16 (d) STUDY AND REPORT ON OPTIONS FOR AUTO-
 17 MATIC ENROLLMENT IN MEDICAID AND CHIP.—

18 (1) STUDY.—The Secretary of Health and
 19 Human Services, by grant, contract, or interagency
 20 agency, shall conduct a study to identify options for,
 21 and barriers to, States automatically enrolling indi-
 22 viduals who, on the basis of data and information
 23 from income tax returns and other sources, are like-
 24 ly to be eligible for medical assistance under the
 25 State Medicaid plan established under title XIX of

1 the Social Security Act (42 U.S.C. 1396 et seq.) (or
 2 a waiver of such plan) or for child health assistance
 3 (or, if applicable, pregnancy-related assistance)
 4 under the State child health plan established under
 5 title XXI of the Social Security Act (42 U.S.C.
 6 1397aa et seq.) (or a waiver of such plan), and
 7 would not be required to pay a premium for enroll-
 8 ment in such a plan or waiver.

9 (2) REPORT.—Not later than 1 year after the
 10 date of enactment of this Act, the Secretary of
 11 Health and Human Services shall submit a report to
 12 Congress on the results of the study conducted
 13 under subsection (a). The report shall include the
 14 following:

15 (A) An analysis of the financial, regu-
 16 latory, and legislative barriers that limit the
 17 ability of States to implement automatic enroll-
 18 ment for individuals described in subsection (a).

19 (B) An analysis of the extent to which
 20 State implementation of automatic enrollment
 21 for such individuals would reduce the number of
 22 uninsured individuals in each State.

23 (C) Recommendations for administrative
 24 and legislative actions that, if taken, would
 25 eliminate the barriers identified under subpara-

1 graph (A) and allow States to elect to automati-
 2 cally enroll individuals described in subsection
 3 (a) in the State Medicaid plan established
 4 under title XIX of the Social Security Act (42
 5 U.S.C. 1396 et seq.) (or a waiver of such plan)
 6 or for child health assistance (or, if applicable,
 7 pregnancy-related assistance) under the State
 8 child health plan established under title XXI of
 9 the Social Security Act (42 U.S.C. 1397aa et
 10 seq.) (or a waiver of such plan).

11 **TITLE III—ESTABLISHMENT OF** 12 **A PUBLIC HEALTH CARE OPTION**

13 **SEC. 301. ESTABLISHMENT OF HEALTH PLAN.**

14 (a) IN GENERAL.—The Secretary shall establish a co-
 15 ordinated and low-cost health plan (referred to in this sec-
 16 tion as the “health plan”) to provide access to quality
 17 health care for enrollees.

18 (b) INDIVIDUAL MARKET AVAILABILITY.—The Sec-
 19 retary shall make the health plan available in the indi-
 20 vidual market for plan year 2022 and each subsequent
 21 plan year.

22 (c) RULEMAKING.—The Secretary may promulgate
 23 such regulations as may be necessary to carry out this
 24 title.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this title.

4 **SEC. 302. AVAILABILITY OF PLAN.**

5 (a) ELIGIBILITY.—An individual shall be eligible to
6 enroll in the health plan if such individual, for the entire
7 period for which enrollment is sought—

8 (1) is a qualified individual within the meaning
9 of section 1312 of the Patient Protection and Af-
10 fordable Care Act (42 U.S.C. 18032);

11 (2) is not eligible for benefits under the Medi-
12 care program under title XVIII of the Social Secu-
13 rity Act (42 U.S.C. 1395 et seq.); and

14 (3) is not otherwise eligible for, or has been
15 otherwise offered, employer-sponsored health care
16 coverage.

17 (b) EXCHANGES.—The health plan shall be made
18 available through the Exchanges, including the Small
19 Business Health Options Program Exchange.

20 **SEC. 303. AFFORDABILITY.**

21 The Secretary shall ensure that coverage options for
22 the health plan are not more costly than comparable op-
23 tions offered on the Exchange in the applicable market.

1 **SEC. 304. PARTICIPATING PROVIDERS.**

2 (a) REQUIREMENT TO PARTICIPATE IN ORDER TO
 3 BE ENROLLED UNDER MEDICARE.—Beginning January
 4 1, 2021, the Secretary may require a health care provider
 5 enrolled under the Medicare program under section
 6 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j))
 7 to be a participating provider under the health plan.

8 (b) REQUIREMENT TO PARTICIPATE IN ORDER TO
 9 PARTICIPATE IN MEDICAID.—Beginning January 1, 2021,
 10 the Secretary may require a health care provider under
 11 a State Medicaid plan under title XIX of the Social Secu-
 12 rity Act (42 U.S.C. 1396 et seq.) to also be a participating
 13 provider under the health plan.

14 **SEC. 305. PROVIDER PAYMENT RATES.**

15 The Secretary shall set competitive provider payment
 16 rates under the health plan using the best information
 17 publically available and data otherwise accessible to the
 18 Secretary. The Secretary shall give consideration to exist-
 19 ing provider payment rates for commercial health plans
 20 and provider costs to deliver care, giving special consider-
 21 ation to increased costs for providers to deliver care in
 22 rural and medically underserved areas.

23 **SEC. 306. NO EFFECT ON MEDICARE BENEFITS OR MEDI-**
 24 **CARE TRUST FUNDS.**

25 Nothing in this title shall—

1 (1) affect the benefits available under title
2 XVIII of the Social Security Act (42 U.S.C. 1395 et
3 seq.); or

4 (2) impact the Federal Hospital Insurance
5 Trust Fund under section 1817 of the Social Secu-
6 rity Act (42 U.S.C. 1395i) or the Federal Supple-
7 mentary Medical Insurance Trust Fund under sec-
8 tion 1841 of the Social Security Act (42 U.S.C.
9 1395t) (including the Medicare Prescription Drug
10 Account within such Trust Fund).

11 **TITLE IV—FAIR MEDICARE PAY-** 12 **MENTS TO RURAL PRO-** 13 **VIDERS**

14 **SEC. 401. ENSURING FAIRNESS IN MEDICARE HOSPITAL** 15 **PAYMENTS.**

16 (a) HOSPITAL INPATIENT SERVICES.—

17 (1) IN GENERAL.—Section 1886(d)(3)(E)(i) of
18 the Social Security Act (42 U.S.C.
19 1395www(d)(3)(E)) is amended—

20 (A) in clause (i), in the first sentence, by
21 striking “or (iii)” and inserting “, (iii), or (iv)”;
22 and

23 (B) by adding at the end the following new
24 clause:

25 “(iv) AREA WAGE INDEX FLOOR.—

“(I) IN GENERAL.—For discharges occurring on or after October 1, 2020, the area wage index applicable under this subparagraph to any hospital which is not located in a frontier State (as defined in clause (iii)(II)) may not be less than 0.85.

“(II) WAIVING BUDGET NEUTRALITY.—Pursuant to the fifth sentence of clause (i), this clause shall not be applied in a budget neutral manner.”.

(2) WAIVING BUDGET NEUTRALITY.—

(A) TECHNICAL AMENDATORY CORRECTION.—Section 10324(a)(2) of Public Law 111–148 is amended by striking “third sentence” and inserting “fifth sentence”.

(B) WAIVER.—Section 1886(d)(3)(E)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)(i)) is amended, in the fifth sentence—

(i) by striking “and the amendments” and inserting “, the amendments”; and

(ii) by inserting “, and the amendments made by section 401(a)(1) of the

1 Health Care Improvement Act of 2020”
2 after “Care Act”.

3 (b) HOSPITAL OUTPATIENT DEPARTMENT SERV-
4 ICES.—Section 1833(t) of the Social Security Act (42
5 U.S.C. 1395l(t)), is amended—

6 (1) in paragraph (2)(D), by striking “(19), the
7 Secretary” and inserting “(19) and paragraph (23),
8 the Secretary”; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(23) FLOOR ON AREA WAGE ADJUSTMENT
12 FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT
13 SERVICES.—With respect to covered OPD services
14 furnished on or after January 1, 2021, the area
15 wage adjustment factor applicable under the pay-
16 ment system established under this subsection to
17 any hospital outpatient department which is not lo-
18 cated in a frontier State (as defined in section
19 1886(d)(3)(E)(iii)(II)) may not be less than 0.85.
20 The preceding sentence shall not be implemented in
21 a budget neutral manner.”.

1 **TITLE V—COMMONSENSE COM-**
 2 **PETITION AND ACCESS TO**
 3 **HEALTH INSURANCE**

4 **SEC. 501. PROVIDING SMALL BUSINESS HEALTH INSUR-**
 5 **ANCE ACROSS STATE LINES.**

6 Section 1333(a)(1)(A) of the Patient Protection and
 7 Affordable Care Act (42 U.S.C. 18053(a)(1)(A)) is
 8 amended by inserting “and small group markets” after
 9 “individual markets”.

10 **SEC. 502. REPORT AND MODELS.**

11 Section 1333 of the Patient Protection and Afford-
 12 able Care Act (42 U.S.C. 18053) is amended by adding
 13 at the end the following:

14 “(b) NAIC REPORT AND MODELS.—

15 “(1) IN GENERAL.—Not later than December
 16 31, 2021, the Secretary shall request that the Na-
 17 tional Association of Insurance Commissioners sub-
 18 mit to the Secretary a report concerning health
 19 plans provided for under this section. Such report
 20 shall include—

21 “(A) a description of the challenges that
 22 States would face by permitting issuers of
 23 qualified health plans to offer such plans in
 24 States other than those States where such plan
 25 was originally written or issued;

1 “(B) an assessment of how an out-of-State
2 insurer would go about building an adequate
3 provider network;

4 “(C) a description of how such challenges
5 could be lessened without weakening the en-
6 forcement of laws and regulations described in
7 subsection (a)(1)(B)(i) in any State that is in-
8 cluded in a compact under this section;

9 “(D) a description of the commonalities
10 that exist in State laws and opportunities to
11 allow issuers of qualified health plans to offer
12 such plans in States other than those States
13 where such plan was originally written or
14 issued; and

15 “(E) models to be used by States to estab-
16 lish and enter into interstate health care choice
17 compacts under this section, which—

18 “(i) may include model legislation for
19 use by States to enact laws to enter into
20 such compacts;

21 “(ii) shall identify how States would
22 continue to enforce, and not weaken, the
23 laws and regulations described in sub-
24 section (a)(1)(B)(i) in any State that is in-
25 cluded in such compact; and

1 “(iii) shall identify how such models
 2 would ensure that there is no violation of
 3 the conditions for Secretarial approval
 4 under subsection (a)(3).

5 “(2) OTHER ORGANIZATIONS AND ENTITIES.—
 6 In making the request under paragraph (1), the Sec-
 7 retary may also request that the National Associa-
 8 tion of Insurance Commissioners gather concepts for
 9 inclusion in the report under such paragraph from
 10 organizations and entities that have experience in of-
 11 fering qualified health plans in States in which such
 12 plans were not originally issued.”.

13 **TITLE VI—EMPOWERING MEDI-**
 14 **CARE SENIORS TO NEGOTIATE**
 15 **PRESCRIPTION DRUG**
 16 **PRICES**

17 **SEC. 601. AUTHORITY TO NEGOTIATE FAIR PRICES FOR**
 18 **MEDICARE PRESCRIPTION DRUGS.**

19 (a) IN GENERAL.—Section 1860D–11 of the Social
 20 Security Act (42 U.S.C. 1395w–111) is amended by strik-
 21 ing subsection (i).

22 (b) EFFECTIVE DATE.—The amendment made by
 23 this section shall take effect on the date of the enactment
 24 of this Act.

1 **TITLE VII—COMMONSENSE**
2 **REPORTING FOR EMPLOYERS**

3 **SEC. 701. VOLUNTARY PROSPECTIVE REPORTING SYSTEM.**

4 (a) IN GENERAL.—Not later than 1 year after the
5 date of the enactment of this Act, the Secretary of the
6 Treasury, in consultation with the Secretary of Health and
7 Human Services, the Secretary of Labor, and the Admin-
8 istrator of the Small Business Administration, shall de-
9 velop and implement guidance providing for a prospective
10 reporting system meeting the requirements of subsection
11 (b). Such system shall be available for use by employers
12 on a voluntary basis beginning not later than January 1,
13 2021.

14 (b) REQUIREMENTS.—The system created under sub-
15 section (a) shall include—

16 (1) voluntary reporting by each participating
17 employer that offers minimum essential coverage to
18 its full-time employees and their dependents under
19 an eligible employer-sponsored plan, not later than
20 45 days before the first day of the annual open en-
21 rollment period under section 1311(c)(6)(B) of the
22 Patient Protection and Affordable Care Act (42
23 U.S.C. 18031(c)(6)(B)) for each calendar year, of—

1 (A) the name and employer identification
2 number for purposes of section 6056 of the In-
3 ternal Revenue Code of 1986 of the employer;

4 (B) a certification of—

5 (i) whether coverage meeting the defi-
6 nition of minimum essential coverage in
7 section 5000A(f) of the Internal Revenue
8 Code of 1986 is offered to the full-time
9 employees (within the meaning of section
10 4980H of such Code) of the employer;

11 (ii) whether such coverage is offered
12 to part-time employees of the employer;

13 (iii) whether such coverage is offered
14 to dependents of employees;

15 (iv) whether such coverage is offered
16 to spouses of employees;

17 (v) whether such coverage meets the
18 minimum value requirement of section
19 36B(c)(2)(C)(ii) of such Code;

20 (vi) whether such coverage satisfies
21 the requirements to qualify for one of the
22 affordability safe harbors promulgated by
23 the Secretary of the Treasury for purposes
24 of section 4980H of such Code; and

1 (vii) whether the employer reasonably
2 expects to be liable for any shared respon-
3 sibility payment under section 4980H of
4 such Code for such year;

5 (C) the months during the prospective re-
6 porting period that such coverage is available to
7 individuals described in clauses (i) through (iv)
8 of subparagraph (B);

9 (D) what waiting periods, if any, apply
10 with respect to such coverage; and

11 (E) a list of all employer identification
12 numbers of the employer for entities that em-
13 ploy employees within the employers control
14 group under subsection (b), (c), (m), or (o) of
15 section 414 of the Internal Revenue Code for
16 1986;

17 (2) processes necessary to ensure that Ex-
18 changes, the Federal Marketplace Data Services
19 Hub, and the Internal Revenue Service can securely
20 and confidentially access the information described
21 in paragraph (1) as necessary to carry out their re-
22 spective missions, and to provide to the Secretary of
23 Health and Human Services additional information
24 relating to eligibility determinations for advance pay-
25 ment of the premium tax credits under section 36B

1 of such Code and the cost-sharing subsidies under
 2 section 1402 of the Patient Protection and Afford-
 3 able Care Act (42 U.S.C. 18071);

4 (3) a process to allow Exchanges to follow up
 5 with employers in order to obtain additional reason-
 6 ably necessary information relating to an employee’s
 7 eligibility for such advance payment or such cost-
 8 sharing subsidies, and to allow an employee to re-
 9 ceive notification of any problem in verifying such
 10 eligibility; and

11 (4) a process to allow employers using the sys-
 12 tem to provide timely updates to the Federal Mar-
 13 ketplace Data Services Hub regarding any cancella-
 14 tion of coverage or significant change in coverage for
 15 participating employees that would change the infor-
 16 mation reported under paragraph (1).

17 (c) EMPLOYER NOTIFICATION OF EMPLOYEE EN-
 18 ROLLMENT IN EXCHANGE PLANS.—Subparagraph (J) of
 19 section 1311(d)(4) of the Patient Protection and Afford-
 20 able Care Act (42 U.S.C. 18031(d)(4)(J)) is amended by
 21 striking “to each employer” and all that follows through
 22 “(and the effective date of such cessation); and” and in-
 23 serting “to each employer—

24 “(i) the name of each employee of the
 25 employer who enrolls in a qualified health

1 plan for a plan year, or whose dependents
 2 enroll in such a plan, at the time of such
 3 enrollment; or

4 “(ii) the name of each employee of the
 5 employer described in subparagraph (I)(ii)
 6 who ceases coverage under a qualified
 7 health plan during a plan year (and the ef-
 8 fective date of such cessation); and”.

9 (d) EXEMPTION FROM REPORTING REQUIREMENT
 10 UNDER INTERNAL REVENUE CODE OF 1986.—Section
 11 6056 of the Internal Revenue Code of 1986 is amended
 12 by redesignating subsection (f) as subsection (g) and by
 13 inserting after subsection (e) the following new subsection:
 14 “(f) EXEMPTION.—If, through the system created
 15 pursuant to section 701(a) of the Health Care Improve-
 16 ment Act of 2020, an employer provides prospective re-
 17 porting for any calendar year that meets the requirements
 18 of section 701(b)(1) of such Act—

19 “(1) such employer shall be treated as satis-
 20 fying the return requirements of subsections (a) and
 21 (b) for such year; and

22 “(2) such employer shall be treated as satis-
 23 fying the requirements of subsection (c) for such
 24 year if the employer—

1 “(A) furnishes the statement described in
2 such section to those employees of the employer
3 whose names have been provided to the em-
4 ployer by an Exchange under section
5 1311(d)(4)(J)(i) of the Patient Protection and
6 Affordable Care Act regarding enrollment of the
7 employee or a dependent in a qualified health
8 plan (as defined in section 1301 of such Act)
9 through the Exchange; and

10 “(B) furnishes a copy of such statement
11 with respect to such employees to the Sec-
12 retary.”.

13 (e) THIRD-PARTY FILING.—An employer may con-
14 tract with a third party to make the report under sub-
15 section (b)(1) without affecting the employer’s treatment
16 as having satisfied the return requirements of subsections
17 (a) and (b) of section 6056 of the Internal Revenue Code
18 of 1986.

19 (f) ACCESS TO THE NATIONAL DIRECTORY OF NEW
20 HIRES.—Subsection (i)(3) of section 453 of the Social Se-
21 curity Act (42 U.S.C. 653) is amended by adding at the
22 end the following new sentence: “The Secretary of the
23 Treasury and the Secretary of Health and Human Serv-
24 ices shall have access to the information in the National
25 Directory of New Hires for purposes of administering sec-

tion 36B and 4980H of the Internal Revenue Code of 1986 and section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071). Subsection (k)(3) shall not apply to information received for purposes of the administration of such sections 36B and 4980H of such Code and section 1402 of such Act.”.

(g) IMPROVING EMPLOYEE ACCESS TO ACCURATE EINS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of the Treasury shall develop and implement guidance for allowing any employee of an employer to receive, on request, the employer’s employer identification number for purposes of section 6056 of the Internal Revenue Code of 1986. Employers shall provide the employer’s employer identification number for purposes of section 6056 of the Internal Revenue Code of 1986 on one of the following documents of the employer’s election:

(1) Health Insurance Marketplace Coverage Options Notice required under section 18B of the Fair Labor Standards Act.

(2) Summary of Benefits and Coverage described in section 2715 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071).

(3) Marketplace Employer Coverage tool.

1 (4) Annual benefits enrollment materials dis-
 2 tributed to employees, including through an intranet
 3 or an online portal accessible by employees.

4 (5) Employee pay statements or Form W-2.

5 (h) FUNDING FOR VOLUNTARY PROSPECTIVE RE-
 6 PORTING SYSTEM.—It is the sense of Congress that build-
 7 ing and maintaining the voluntary prospective reporting
 8 system described in this section will require appropriations
 9 to the Secretary of the Treasury, the Secretary of Health
 10 and Human Services, the Secretary of Labor, and the Ad-
 11 ministrators of the Small Business Administration, and
 12 that necessary sums to carry out the requirements of this
 13 section should be appropriated for such purpose.

14 **SEC. 702. PROTECTION OF DEPENDENT PRIVACY.**

15 (a) IN GENERAL.—Paragraph (1) of section 6055(b)
 16 of the Internal Revenue Code of 1986 is amended by add-
 17 ing at the end the following flush sentence:

18 “For purposes of subparagraph (B)(i), in the case of
 19 an individual other than the primary insured, if the health
 20 insurance issuer or the employer is unable to collect or
 21 maintain information on the TINs of such individuals
 22 (other than for purposes of this section), the Secretary
 23 may allow the individual’s full name and date of birth to
 24 be substituted for the name and TIN. In the event the
 25 Secretary allows the use of the individual’s full name and

1 date of birth in lieu of the TIN, the Social Security Ad-
 2 ministration shall assist the Internal Revenue Service in
 3 providing data matches to determine the TIN associated
 4 with the name and date of birth provided by the Internal
 5 Revenue Service with respect to such individual.”.

6 (b) EFFECTIVE DATE.—The amendment made by
 7 this section shall apply to returns the due date for which
 8 is after the date that is 60 days after the date of the enact-
 9 ment of this Act.

10 **SEC. 703. ELECTRONIC STATEMENTS.**

11 (a) IN GENERAL.—Subsection (c) of section 6056 of
 12 the Internal Revenue Code of 1986 is amended by adding
 13 at the end the following new paragraph:

14 “(3) ELECTRONIC DELIVERY.—An individual
 15 shall be deemed to have consented to receive the
 16 statement under this subsection in electronic form if
 17 such individual has affirmatively consented at any
 18 prior time, to the person who is the employer of the
 19 individual during the calendar year to which the
 20 statement relates, to receive such statement in elec-
 21 tronic form. The preceding sentence shall not apply
 22 if the individual revokes consent in writing with re-
 23 spect to the statement under this subsection.”.

24 (b) STATEMENTS RELATING TO HEALTH INSURANCE
 25 COVERAGE.—Subsection (c) of section 6055 of the Inter-

1 nal Revenue Code of 1986 is amended by adding at the
2 end the following new paragraph:

3 “(3) ELECTRONIC DELIVERY.—An individual
4 shall be deemed to have consented to receive the
5 statement under this subsection in electronic form if
6 such individual has affirmatively consented at any
7 prior time, to the person required to make such
8 statement (such as the provider of the individual’s
9 health coverage), to receive in electronic form any
10 private health information (such as electronic health
11 records), unless the individual revokes such consent
12 in writing.”.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to statements the due date for
15 which is after December 31, 2019.

16 **SEC. 704. GAO STUDIES.**

17 (a) STUDY OF FIRST YEARS OF EMPLOYER REPORT-
18 ING.—

19 (1) IN GENERAL.—The Comptroller General of
20 the United States shall conduct a study that evalu-
21 ates, with respect to the period beginning on Janu-
22 ary 1, 2015, and ending on December 31, 2018—

23 (A) the notification of employers by Ex-
24 changes established under title I of the Patient
25 Protection and Affordable Care Act (Public

1 Law 111–148) that a full-time employee of the
2 employer has been determined eligible for ad-
3 vance payment of premium tax credits under
4 section 36B of the Internal Revenue Code of
5 1986 or cost-sharing subsidies under section
6 1402 of such Act (42 U.S.C. 18071), including
7 information regarding—

8 (i) the data elements included in the
9 employer notification;

10 (ii) the process by which the notifica-
11 tion forms were developed and sent to em-
12 ployers, including whether the process pro-
13 vided for a formal notice and comment pe-
14 riod;

15 (iii) whether employers report that
16 such notifications provided sufficient and
17 relevant information for them to make ap-
18 propriate decisions about whether to utilize
19 the appeals process;

20 (iv) the total number of notifications
21 sent to employers and the timeline of when
22 such notifications were sent;

23 (v) differences in the notification proc-
24 ess between the marketplace facilitated by

1 the Federal Government and the State-
2 Based Marketplaces; and

3 (vi) challenges that have arisen in the
4 notification process, and recommendations
5 to address these challenges; and

6 (B) the extent to which the Secretary of
7 Health and Human Services has established a
8 separate appeals process for employers who re-
9 ceived such a notification to challenge the eligi-
10 bility determination, as required by section
11 1411(f)(2) of the Patient Protection and Af-
12 fordable Care Act (42 U.S.C. 18081(f)(2)).

13 (2) REPORT.—Not later than 1 year after the
14 date of the enactment of this Act, the Comptroller
15 General shall submit to the Committees on Finance
16 and Health, Education, Labor, and Pensions of the
17 Senate and the Committees on Ways and Means,
18 Energy and Commerce, and Education and Labor of
19 the House of Representatives a report on the results
20 of the study conducted under paragraph (1).

21 (b) STUDY OF PROSPECTIVE REPORTING SYSTEM.—

22 (1) IN GENERAL.—The Comptroller General of
23 the United States shall conduct a study that evalu-
24 ates, with respect to the period beginning on Janu-
25 ary 1, 2020, and ending on December 31, 2020, the

1 functionality of the prospective reporting system es-
 2 tablished pursuant to section 701, including the ac-
 3 curacy of information collected, the number of em-
 4 ployers electing to report under such system, and
 5 any challenges that have arisen in implementing
 6 such system.

7 (2) REPORT.—Not later than July 1, 2021, the
 8 Comptroller General shall submit to the Committees
 9 on Finance and Health, Education, Labor, and Pen-
 10 sions of the Senate and the Committees on Ways
 11 and Means, Energy and Commerce, and Education
 12 and Labor of the House of Representatives a report
 13 on the results of the study conducted under para-
 14 graph (1).

15 **SEC. 705. TAX COMPLIANCE.**

16 (a) IN GENERAL.—Section 6724(d)(1)(B)(xxv) of the
 17 Internal Revenue Code of 1986 is amended by inserting
 18 “or, in the case of an employer to which section 6056(f)
 19 applies, section 701(b)(1) of the Health Care Improve-
 20 ment Act of 2020” before “, or”.

21 (b) EFFECTIVE DATE.—The amendment made by
 22 this section shall apply to returns required to be filed after
 23 the date of the enactment of this Act.

1 **TITLE VIII—FEDERAL BAN ON**
 2 **SURPRISE MEDICAL BILLING**

3 **SEC. 801. PROTECTION AGAINST SURPRISE BILLS.**

4 (a) PHSA.—Section 2719A of the Public Health
 5 Service Act (42 U.S.C. 300gg–19a) is amended by adding
 6 at the end the following:

7 “(e) OUT-OF-NETWORK ANCILLARY SERVICES.—

8 “(1) COVERAGE OF SERVICES.—Subject to sub-
 9 section (h), in the case of an enrollee in a group
 10 health plan or group or individual health insurance
 11 coverage who receives out-of-network ancillary serv-
 12 ices at an in-network facility, including any referrals
 13 for diagnostic services, and such services would be
 14 covered under such plan or coverage if provided in-
 15 network—

16 “(A) the cost-sharing requirement (ex-
 17 pressed as a copayment amount, coinsurance
 18 rate, or deductible) with respect to such services
 19 shall be the same requirement that would apply
 20 if such services were provided by an in-network
 21 practitioner, and any coinsurance or deductible
 22 shall be based on in-network rates; and

23 “(B) amounts paid toward such cost-shar-
 24 ing shall be counted towards the in-network de-
 25 ductible and in-network out-of-pocket maximum

1 amount, as applicable, under the plan or cov-
2 erage for the plan year.

3 “(2) NOTICE BEFORE PROVIDING NON-EMER-
4 GENCY SERVICES.—Subject to subsection (h), in the
5 case of an enrollee in a group health plan or group
6 or individual health insurance coverage who receives
7 out-of-network, non-emergency services that are not
8 ancillary services, from an out-of-network provider
9 at an in-network facility, and such services would be
10 covered under such plan or coverage if provided in-
11 network, the cost-sharing requirement (expressed as
12 a copayment amount, coinsurance rate, or deduct-
13 ible) with respect to such services shall be the same
14 requirement that would apply if such services were
15 provided by an in-network practitioner, and any co-
16 insurance or deductible shall be based on in-network
17 rates, unless, as soon as practicable, and in no case
18 later than 48 hours prior to providing non-emer-
19 gency services that are not ancillary services—

20 “(A) the in-network facility provides to the
21 enrollee who is scheduled to receive such serv-
22 ices notice that—

23 “(i) is provided in paper or electronic
24 form (and including electronic notification
25 whenever practicable);

1 “(ii) states that such service will be
2 provided out-of-network;

3 “(iii) includes the estimated amount
4 that such practitioner or facility may
5 charge the enrollee for such services; and

6 “(iv) provides the option to affirma-
7 tively consent to receiving such services
8 from such practitioner or facility;

9 “(B) such enrollee signs such notice con-
10 senting to receive such services from an out-of-
11 network provider at an in-network facility, and
12 acknowledging that the out-of-network services
13 may be covered at an out-of-network cost-shar-
14 ing amount, requiring higher cost-sharing obli-
15 gations of the enrollee than if the service were
16 provided by an in-network practitioner or facil-
17 ity; and

18 “(C) such facility maintains documentation
19 of the enrollee’s signature or confirmation of re-
20 ceipt of such information under subparagraph
21 (B) in the enrollee’s patient record for 2 years
22 after the date of services.

23 “(f) COVERAGE OF OUT-OF-NETWORK SERVICES FOR
24 ENROLLEES ADMITTED AFTER EMERGENCY SERVICES.—

1 “(1) PROTECTION FOR ENROLLEES ADMITTED
 2 TO THE HOSPITAL FOR EMERGENCY SERVICES PRIOR
 3 TO STABILIZATION.—In the case of an enrollee in a
 4 group health plan or group or individual health in-
 5 surance coverage who receives emergency services, or
 6 maternal care for a woman in labor, in the emer-
 7 gency department of an out-of-network facility and
 8 has not been stabilized (within the meaning of sub-
 9 section (b)(2)(C)), if the patient is subsequently ad-
 10 mitted to the out-of-network facility for care, the
 11 cost-sharing requirement (expressed as a copayment
 12 amount, coinsurance rate, or deductible) with re-
 13 spect to any out-of-network services provided to the
 14 enrollee prior to being stable and in a condition to
 15 receive information under (2), is the same require-
 16 ment that would apply as under subsection
 17 (b)(2)(C)(ii)(II).

18 “(2) NOTICE AND CONSENT.—

19 “(A) IN GENERAL.—Subject to subsection
 20 (h), in the case of an enrollee in a group health
 21 plan or group or individual health insurance
 22 coverage who receives emergency services, or
 23 maternal care for a woman in labor, in the
 24 emergency department of an out-of-network fa-
 25 cility and has been stabilized (within the mean-

ing of subsection (b)(2)(C)), if the patient is subsequently admitted to the out-of-network facility for care, the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to any out-of-network services is the same requirement that would apply if such services were provided by an in-network provider, unless the enrollee, once stable and in a condition to receive such information, including having sufficient mental capacity—

“(i) has been provided by the facility, prior to the provision of any post-stabilization, out-of-network service at such facility, with—

“(I) paper or electronic notification that the practitioner or facility is an out-of-network health care provider and the out-of-network rate of the provider, as applicable, and the option to affirmatively consent to receiving services from such practitioner or facility; and

“(II) the estimated amount that such provider may charge the partici-

1 pant, beneficiary, or enrollee for such
2 services involved;

3 “(ii) has been provided by the plan or
4 coverage, prior to the provision of any
5 post-stabilization, out-of-network service at
6 such facility, with—

7 “(I) paper or electronic notifica-
8 tion (and including electronic notifica-
9 tion whenever practicable) that the
10 practitioner or facility is an out-of-
11 network health care provider, and the
12 option to affirmatively consent to re-
13 ceiving services from such practitioner
14 or facility;

15 “(II) a list of in-network practi-
16 tioners or facilities in the relevant ge-
17 ographic area that could provide the
18 same services, and an option for a re-
19 ferral to such providers; and

20 “(III) information about whether
21 prior authorization or other care man-
22 agement limitations may be required
23 in advance of receiving in-network
24 services at the facility; and

“(iii) has acknowledged, in writing, that the out-of-network services provided after the individual has been stabilized may not be covered or may be covered at an out-of-network cost-sharing amount, requiring higher cost-sharing obligations of the enrollee than if the service were provided at an in-network facility.

“(B) REQUIREMENTS OF NOTICE.—The notice under subparagraph (A) shall be in a format determined by the Secretary to give a reasonable layperson clear comprehension of the terms of the agreement, including all possible financial responsibilities, including the requirements that the notice—

“(i) does not exceed one page in length;

“(ii) is readily identifiable for its purpose and as a contract of consent;

“(iii) clearly states that consent to potential out-of-network charges is optional and that the enrollee has the choice to transfer to an in-network facility;

“(iv) includes an estimate of the amount that such provider will charge the

1 participant, beneficiary, or enrollee for
 2 such services involved; and

3 “(v) be available in the 15 most com-
 4 mon languages in the facility’s geographic
 5 area, with the facility making a good faith
 6 effort to provide oral notice in the enroll-
 7 ee’s primary language if it is not one of
 8 such 15 languages.

9 “(C) MAINTENANCE OF RECORDS.—A fa-
 10 cility shall maintain documentation of notice
 11 given to an enrollee pursuant to this subsection
 12 and the enrollee’s confirmation of receipt of
 13 such information in the enrollee’s patient record
 14 for 2 years after the date of services.

15 “(3) RULEMAKING.—Not later than 6 months
 16 after the date of enactment of this subsection, the
 17 Secretary shall issue regulations to carry out this
 18 subsection, which shall include clarification on how
 19 to determine whether an individual is stabilized and
 20 the timing of the notice required under this para-
 21 graph.

22 “(g) PROHIBITION ON BILLING MORE THAN AN IN-
 23 NETWORK RATE UNDER CERTAIN CIRCUMSTANCES.—

24 “(1) IN GENERAL.—A facility or practitioner
 25 furnishing—

1 “(A) emergency services, as defined in sub-
2 section (b)(2), regardless of the State in which
3 the patient resides;

4 “(B) out-of-network services at an in-net-
5 work facility described in subsection (e)(1);

6 “(C) out-of-network services at an in-net-
7 work facility described in subsection (e)(2),
8 where the notice and consent for receiving such
9 services out-of-network did not meet the re-
10 quirement of such subsection;

11 “(D) services furnished by an out-of-net-
12 work provider after an enrollee has been admit-
13 ted to the hospital for emergency services but
14 prior to stabilization, as described in subsection
15 (f)(1); or

16 “(E) out-of-network services furnished
17 after the enrollee has been stabilized (within the
18 meaning of subsection (b)(2)(C)), where the no-
19 tice and option for receiving care at an alter-
20 nate facility required under subsection (f)(2)
21 have not been provided to the enrollee and the
22 enrollee did not give consent under subsection
23 (f)(3),

24 may not bill an enrollee in a group health plan or
25 group or individual health insurance coverage for

1 amounts beyond the cost-sharing amount that would
2 apply under subsection (b)(1)(C)(ii)(II), (e)(1),
3 (e)(2), or (f), as applicable.

4 “(2) NOTICE.—A facility furnishing services de-
5 scribed in paragraph (1) shall provide enrollees in a
6 group health plan or group or individual health in-
7 surance coverage with a one-page notice, in 16-point
8 font, upon intake at the emergency room or being
9 admitted at the facility of the prohibition on balance
10 billing under paragraph (1) and who to contact for
11 recourse if they are sent a balance bill in violation
12 of such paragraph. The facility shall be responsible
13 for obtaining the signature from the enrollee on such
14 notice. The Secretary shall issue regulations within
15 6 months of the date of enactment of this subsection
16 on the requirements for the notice under this para-
17 graph.

18 “(h) MAINTAINING STATE SURPRISE BILLING PRO-
19 TECTIONS.—

20 “(1) IN GENERAL.—Nothing in this section
21 shall prevent a State from establishing or continuing
22 in effect, with respect to health insurance issuers,
23 facilities, or practitioners, an alternate method under
24 State law for determining the appropriate compensa-

tion for services described in subsection (b), (e), or (f).

“(2) ADDITIONAL APPLICATION.—In the case of group health plans or group or individual health insurance coverage offered in a State that has not established an alternate method described in paragraph (1), such as arbitration or a benchmark, or for services described in subsection (b), (e), or (f) that are not covered by such State’s alternate method described in paragraph (1), the provisions of this section shall apply.

“(3) SELF-INSURED PLANS.—Subsections (b), (e), and (f) shall apply to a self-insured group health plan that is not subject to State insurance regulation.

“(i) DEFINITIONS.—In this section:

“(1) IN-NETWORK.—The term ‘in-network’, with respect to a group health plan or health insurance coverage means a provider that has a contractual relationship with the plan.

“(2) ENROLLEE.—The term ‘enrollee’, with respect to health insurance coverage or a group health plan, includes a participant, dependent, or beneficiary.

“(A) provided by anesthesiologists, pathologists, emergency medicine providers, intensivists, radiologists, neonatologists, hospitalists, and assistant surgeons, whether the care is provided by a physician or non-physician practitioner;

9 “(B) a diagnostic service (including radi-
10 ology and lab services); or

“(C) provided by such other specialty practitioner not typically selected by the patients receiving the care, which the Secretary may add periodically to such definition through rule-making.”.

(b) ENFORCEMENT OF BALANCE BILLING PROHIBITIONS.—Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

20 “SEC. 2795. ENFORCEMENT OF BALANCE BILLING PROHIBI-
21 TIONS.

22 “(a) IN GENERAL.—Subject to subsection (b), a facil-
23 ity or practitioner that violates a requirement under sec-
24 tion 2719A(g)(1) or fails to provide notice or obtain con-
25 sent as required under subsection (e)(2) or (f)(2) shall be

1 subject to a civil monetary penalty of not more than
2 \$10,000 for each act constituting such violation.

3 “(b) PROCEDURE.—The provisions of section 1128A
4 of the Social Security Act, other than subsections (a) and
5 (b) and the first sentence of subsection (c)(1) of such sec-
6 tion, shall apply to civil money penalties under this sub-
7 section in the same manner as such provisions apply to
8 a penalty or proceeding under section 1128A of the Social
9 Security Act.

10 “(c) SAFE HARBOR.—

11 “(1) IN GENERAL.—The Secretary shall waive
12 the penalties described under subsection (a) with re-
13 spect to a facility or, practitioner who does not
14 knowingly violate, and should not have reasonably
15 known it violated, section 2719A(g)(1) with respect
16 to an enrollee, if such facility or practitioner, within
17 30 days of the violation, withdraws the bill that was
18 in violation of section 2719A(g)(1), and, as applica-
19 ble, reimburses the group health plan, health insur-
20 ance issuer, or enrollee, in an amount equal to the
21 difference between the amount billed and the
22 amount allowed to be billed under section
23 2719A(g)(1), plus interest, at an interest rate deter-
24 mined by the Secretary.

1 “(2) HARDSHIP EXEMPTION.—The Secretary
2 may establish a hardship exemption to the penalties
3 under this section.

4 “(3) STATE ENFORCEMENT.—The Secretary
5 shall waive penalties under this section with respect
6 to a facility or practitioner that has already been
7 subject to enforcement action under State law for a
8 violation described in subsection (a).”.

9 (c) APPLICATION TO GRANDFATHERED PLANS.—
10 Section 1251(a) of the Patient Protection and Affordable
11 Care Act (42 U.S.C. 18011(a)) is amended by adding at
12 the end the following:

13 “(5) APPLICATION OF ADDITIONAL PROVI-
14 SIONS.—Subsections (b) through (h) of section
15 2719A of the Public Health Service Act (42 U.S.C.
16 300gg–19a) shall apply to grandfathered health
17 plans for plan years beginning with the second plan
18 year that begins after the date of enactment of this
19 paragraph.”.

20 (d) COVERAGE UNDER FEDERAL EMPLOYEES
21 HEALTH BENEFITS PROGRAM.—Section 8904 of title 5,
22 United States Code, is amended by adding at the end the
23 following:

24 “(c) Any health benefits plan offered under this chap-
25 ter shall be treated as a group health plan or group or

1 individual health insurance coverage for purposes of sub-
2 sections (e) through (g) of section 2719A of the Public
3 Health Service Act (42 U.S.C. 300gg-19a) (except for
4 paragraph (3) of such subsection (g)).”.

○