To amend the Patient Protection and Affordable Care Act to improve affordability of, undo sabotage with respect to, and increase access to health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. PALLONE introduced the following bill; which was referred to the Committee on ____________________________

A BILL

To amend the Patient Protection and Affordable Care Act to improve affordability of, undo sabotage with respect to, and increase access to health insurance coverage, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
4 (a) Short Title.—This Act may be cited as the "Undo Sabotage and Expand Affordability of Health In-
5 surance Act of 2018".
(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—EXPANDING AFFORDABILITY

Sec. 101. Improve affordability and reduce premium costs for consumers.
Sec. 102. Lower out-of-pocket costs for consumers.
Sec. 103. Expand affordability for working families.

TITLE II—UNDOING SABOTAGE

Sec. 201. Protect comprehensive coverage for small businesses and workers.
Sec. 202. Prevent junk plans and continue protections for consumers with pre-existing conditions.
Sec. 203. Ensure plans provide comprehensive benefits.
Sec. 204. Undo Administration sabotage by requiring open enrollment outreach, education, and funding for navigators.
Sec. 205. Improve Marketplace stability to prevent sabotage from raising premiums.

TITLE III—STATE INNOVATION AND TRANSPARENCY

Sec. 301. Fund State health insurance education programs for consumers.
Sec. 302. Fund State innovations to expand coverage.
Sec. 303. Preserve State option to implement health care Marketplaces.
Sec. 304. Promote transparency and accountability in the Administration's expenditures of Exchange user fees.

TITLE I—EXPANDING AFFORDABILITY

SEC. 101. IMPROVE AFFORDABILITY AND REDUCE PREMIUM COSTS FOR CONSUMERS.

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

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

<table>
<thead>
<tr>
<th>Over 100% up to 133%</th>
<th>0%</th>
<th>1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>133% up to 150%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>150% up to 200%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>200% up to 250%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>250% up to 300%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>300% up to 400%</td>
<td>7%</td>
<td>8.5%</td>
</tr>
<tr>
<td>400% and higher</td>
<td>8.5%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

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

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

SEC. 102. LOWER OUT-OF-POCKET COSTS FOR CONSUMERS.

(a) EXPANSION OF ELIGIBILITY.—

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

(A) by striking paragraphs (1) and (2) and inserting the following:

“(1) IN GENERAL.—The reduction in cost-sharing under this subsection shall be achieved, with respect to an issuer of a qualified health plan to which
this section applies, by reducing cost-sharing under
the plan (and the applicable out-of-pocket limit
under section 1302(c)(1)) in a manner and amount
sufficient to—

“(A) in the case of an eligible insured
whose household income is not less than 100
percent but not more than 250 percent of the
poverty line for a family of the size involved, in-
crease the plan’s share of the total allowed
costs of benefits provided under the plan to 94
percent of such costs; and

“(B) in the case of an eligible insured
whose household income is more than 250 per-
cent but not more than 400 percent of the pov-
erty line for a family of the size involved, in-
crease the plan’s share of the total allowed
costs of benefits provided under the plan to 87
percent of such costs.”; and

(B) by redesignating paragraphs (3), (4),
and (5) as paragraphs (2), (3), and (4), respec-
tively.

(2) EFFECTIVE DATE.—The amendments made
by paragraph (1) shall apply with respect to plan
years beginning after December 31, 2019.
(b) FUNDING COST SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

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

SEC. 103. EXPAND AFFORDABILITY FOR WORKING FAMILIES.

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

“(i) COVERAGE MUST BE AFFORDABLE.—

“(I) EMPLOYEES.—An employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the employer’s required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5
percent of the employee’s household income.

“(II) FAMILY MEMBERS.—An individual who is eligible to enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) by reason of a relationship the individual bears to the employee shall not be treated as eligible for minimum essential coverage by reason of such eligibility to enroll if the employee’s required contribution (within the meaning of section 5000A(e)(1)(B), determined by substituting ‘family’ for ‘self-only’) with respect to the plan exceeds 9.5 percent of the employee’s household income.”.

(b) CONFORMING AMENDMENTS.—

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

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

(3) Clause (iv) of section 36B(c)(2)(C) of such Code is amended by striking “9.5 percent under clause (i)(II)” and inserting “the 9.5 percent under clauses (i)(I) and (i)(II)”.

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

TITLE II—UNDOING SABOTAGE

SEC. 201. PROTECT COMPREHENSIVE COVERAGE FOR SMALL BUSINESSES AND WORKERS.

Notwithstanding any other provision of law, the Secretary of Labor may not take any action to implement, finalize, or enforce the proposed rule published on January 5, 2018, on pages 614 through 636 of volume 83 of the Federal Register, or any substantially similar proposed rule.

SEC. 202. PREVENT JUNK PLANS AND CONTINUE PROTECTIONS FOR CONSUMERS WITH PREEXISTING CONDITIONS.

(a) INCLUDING SHORT-TERM LIMITED DURATION INSURANCE AS INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300g–91(b)(5)) is amended by striking “but does not include short-term limited duration insur-
ance” and inserting “, including short-term limited dura-
tion insurance”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years begin-
ning after December 31, 2018.

SEC. 203. ENSURE PLANS PROVIDE COMPREHENSIVE BENEFITS.

(a) ESSENTIAL HEALTH BENEFITS.—Section 1302(b)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)(4)) is amended—

(1) in subparagraph (A), by inserting “and so that benefits are included within each of such cat-
egories”;

(2) in subparagraph (G), by striking at the end “and”;

(3) in subparagraph (H), by striking the period at the end and inserting “; and”; and

(4) by adding at the end the following new sub-
paragraph:

“(I) ensure that, beginning January 1, 2019—

“(i) in the case of health benefits that are established as essential health benefits, there shall not be substitution of such ben-
efits across benefit categories;
“(ii) a qualified health plan shall not be treated as providing coverage for the essential health benefits unless under such plan—

“(I) coverage of prescription drugs provides for access to a wide variety of classes of drugs within the prescription drug formulary of such plan; and

“(II) in the case that a drug that is medically necessary for an enrollee under such plan is not included within such formulary, such individual has access to such drug through an exceptions process established by the plan; and

“(iii) habilitative services are covered at parity with rehabilitative services.”.

(b) STANDARD BENEFIT PLANS.—Section 1302(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(d)) is amended by adding at the end the following new paragraph:

“(5) STANDARD BENEFIT PLANS.—

“(A) IN GENERAL.—For purposes of providing individuals with the opportunity to make
simpler comparisons of health plans offered by different health insurance issuers and simplify the selection process, the Secretary shall, for each plan year beginning with plan year 2020, through rulemaking, specify a structure described in subparagraph (B)(i) for a standard benefit plan for such plan year for each of the bronze, silver, and gold levels of coverage and for each actuarial value variation of a silver plan resulting from the application of section 1402(c). A standard benefit plan for a plan year for a level of coverage or actuarial value variation of a silver plan shall be modeled on the most commonly purchased plans (determined by enrollments in such plans) during the previous 2 plan years offered in the federally-facilitated Exchange operated pursuant to section 1321(c) in such level or variation and shall include coverage of deductible-exempt services consistent with actual purchasing patterns of consumers in the previous two plan years.

“(B) STANDARD BENEFIT PLAN.—For purposes of this paragraph, the term ‘standard benefit plan’ means a qualified health plan to
be offered through an Exchange on the individual market that has either—

“(i) a standardized cost-sharing structure specified by the Secretary pursuant to rulemaking; or

“(ii) a standardized cost-sharing structure specified by the Secretary pursuant to rulemaking that is modified by the health insurance issuer of such plan only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986 or the applicable annual limitation on cost sharing under subsection (c) and actuarial value requirements specified by the Secretary.”.

SEC. 204. UNDO ADMINISTRATION SABOTAGE BY REQUIRING OPEN ENROLLMENT OUTREACH, EDUCATION, AND FUNDING FOR NAVIGATORS.

Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) is amended by adding at the end the following new paragraph:

“(3) NAVIGATOR PROGRAM AND OUTREACH AND ENROLLMENT ACTIVITIES.—

“(A) NAVIGATOR PROGRAM.—
“(i) IN GENERAL.—In the case of an Exchange established or operated by the Secretary pursuant to this subsection, the Secretary shall establish a program under which it awards grants to entities that would be described in paragraph (2) of section 1311(i) to carry out the duties that would be described in paragraph (3) of such section if the references in such section 1311(i) to ‘this subsection’ and ‘paragraph (1)’ were each instead a reference to ‘paragraph (3)(A) of section 1321(c)’.

“(ii) APPLICATION OF STATE EXCHANGE NAVIGATOR PROVISIONS.—For purposes of carrying out this subparagraph, the provisions of paragraphs (2) through (5) of section 1311(i) shall apply to the Secretary with respect to an Exchange described in clause (i) and the program under this subparagraph in the same manner as such provisions apply to a State with respect to an Exchange described in section 1311(i) and the program established under such section.
“(iii) FUNDING.—For purposes of carrying out this subparagraph, the Secretary shall obligate $100,000,000 out of amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations) for each of fiscal years 2019 through 2021. Such amount shall remain available without fiscal year limitation until expended.

“(B) OUTREACH AND EDUCATIONAL ACTIVITIES.—

“(i) IN GENERAL.—In the case of an Exchange established or operated by the Secretary pursuant to this subsection, the Secretary shall carry out outreach and educational activities for purposes of informing potential enrollees in qualified health plans offered through the Exchange of the availability of coverage under such plans and financial assistance for coverage under such plans.

“(ii) FUNDING.—For purposes of carrying out this subparagraph, the Secretary
shall obligate $100,000,000 out of the amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations) for each of fiscal years 2019 through 2021. Such amount shall remain available without fiscal year limitation until expended.’’.

SEC. 205. IMPROVE MARKETPLACE STABILITY TO PREVENT SABOTAGE FROM RAISING PREMIUMS.

(a) Fund.—

(1) In general.—There is hereby established the National Reinsurance Program Fund to be administered by the Secretary of Health and Human Services for purposes of carrying out a national reinsurance program to make reinsurance payments, in accordance with this section.

(2) Appropriation.—There is hereby appropriated to the Fund established under paragraph (1), out of any funds in the Treasury not otherwise appropriated, such sums as are necessary for carrying out the purpose described in such paragraph.

(b) Payments.—
(1) IN GENERAL.—The Secretary of Health and Human Services shall use amounts available in the Fund to establish a national reinsurance program under which the Secretary makes reinsurance payments to health insurance issuers with respect to claims for individuals enrolled under qualifying reinsurance plans offered by such issuers for plan year 2019 or a subsequent plan year that exceed, subject to paragraph (2), $50,000 in an amount equal to 75 percent of the amount of such claims, but not to exceed $1,000,000.

(2) INDEXING.—For plan year 2020 or subsequent plan year, in lieu of each dollar amount specified in paragraph (1), each such dollar amount applied under this subsection for such plan year shall be the dollar amount applied under this subsection for the previous year, increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year).

(3) METHODS.—Payments under this subsection shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this subsection are made during a
plan year based on the Secretary’s best estimate of amounts that will be payable after obtaining all of necessary information.

(c) QUALIFYING REINSURANCE PLAN.—

(1) IN GENERAL.—For purposes of this section, the term “qualifying reinsurance plan” means, with respect to a health insurance issuer a qualified health plan (as defined in section 1301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18021)) offered by such issuer on the individual market. Such term does not include a grandfathered health plan (as defined in section 1251 of such Act (42 U.S.C. 18011)), transitional health plan, or a standard health plan offered in connection with a basic health program established under section 1331 of such Act (42 U.S.C. 18051).

(2) TRANSITIONAL HEALTH PLAN.—For purposes of paragraph (1), the term “transitional health plan” means a plan continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 of the Patient Protection and Affordable Care Act (42 U.S.C. 18011) does not
apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, and February 13, 2017, or under any subsequent extensions thereof.

(d) COORDINATION WITH RISK ADJUSTMENT.—The Secretary shall make adjustments to the risk adjustment program operated under section 1343 of the Patient Protection and Affordable Care Act (42 U.S.C. 18063), as appropriate, to account for the effects of this section on the actuarial risk of enrollees.

TITLE III—STATE INNOVATION AND TRANSPARENCY

SEC. 301. FUND STATE HEALTH INSURANCE EDUCATION PROGRAMS FOR CONSUMERS.

Section 2793(e) of the Public Health Service Act (42 U.S.C. 300gg–93(e)) is amended by adding at the end the following new paragraph:

“(3) APPROPRIATIONS.—For purposes of carrying out this section, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $100,000,000 for each of the fiscal years 2019 through 2021. Such amount shall remain available until expended.”.
SEC. 302. FUND STATE INNOVATIONS TO EXPAND COVERAGE.

(a) In General.—Subject to subsection (d), the Secretary of Health and Human Services shall award grants to eligible State agencies to enable such States to explore innovative solutions to promote greater enrollment in health insurance coverage in the individual and small group markets, including activities described in subsection (c).

(b) Eligibility.—For purposes of subsection (a), eligible State agencies are Exchanges established by a State under title I of the Patient Protection and Affordable Care Act and State agencies with primary responsibility over health and human services for the State involved.

(c) Use of Funds.—For purposes of subsection (a), the activities described in this subsection are the following:

(1) State efforts to streamline health insurance enrollment procedures in order to reduce burdens on consumers and facilitate greater enrollment in health insurance coverage in the individual and small group markets, including automatic enrollment and re-enrollment of, or pre-populated applications for, individuals without health insurance who are eligible for tax credits under section 36B of the Internal Revenue Code of 1986, with the ability to opt out of such enrollment.
1. (2) State investment in technology to improve data sharing and collection for the purposes of facilitating greater enrollment in health insurance coverage in such markets.

2. (3) Implementation of a State version of an individual mandate to be enrolled in health insurance coverage.

3. (4) Feasibility studies to develop comprehensive and coherent State plan for increasing enrollment in the individual and small group market.

4. (d) FUNDING.—For purposes of carrying out this section, there is hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $200,000,000 for each of the fiscal years 2019 through 2021. Such amount shall remain available until expended.

SEC. 303. PRESERVE STATE OPTION TO IMPLEMENT HEALTH CARE MARKETPLACES.

Section 1311(a)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(a)(4)) is amended—

1. (1) by striking subparagraph (B);

2. (2) by striking “RENEWABILITY OF GRANT” and all that follows through “Subject to subsection (d)(4)” and inserting “RENEWABILITY OF GRANT.—Subject to subsection (d)(4)”; and
(3) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively, with appropriate indentation; and

(4) in subparagraph (A), as redesignated by paragraph (3), by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively, with appropriate indentation.

SEC. 304. PROMOTE TRANSPARENCY AND ACCOUNTABILITY IN THE ADMINISTRATION’S EXPENDITURES OF EXCHANGE USER FEES.

For each of plan years 2018, 2019, and 2020, not later than the date that is 3 months after the end of such fiscal year, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress and make available to the public an annual report on the expenditure by the Department of Health and Human Services of user fees collected pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations). Each such report for a plan year shall include a detailed accounting of the amount of such user fees collected during such plan year and of the amount of such expenditures used during such plan year for the federally-facilitated Exchange operated pursuant to section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) on outreach and en-
enrollment activities, navigators, maintenance of Healthcare.gov, and operation of call centers.