115TH CONGRESS 1ST SESSION	S.
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To provide health insurance reform, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Ms. Warren (for herself, Ms. Hassan, Mr. Sanders, Ms. Harris, Ms. Baldwin, and Mrs. Gillibrand) introduced the following bill; which was read twice and referred to the Committee on

A BILL

To provide health insurance reform, and for other purposes.

- 1 Be it enacted by the Senate and House of Representa-
- 2 tives of the United States of America in Congress assembled,
- 3 SECTION 1. SHORT TITLE.
- 4 This Act may be cited as the "Consumer Health In-
- 5 surance Protection Act of 2018".
- 6 SEC. 2. TABLE OF CONTENTS.
- 7 The table of contents for this Act is as follows:
 - Sec. 1. Short title.
 - Sec. 2. Table of contents.

TITLE I—LIMITING INSURER PROFITS AND PREVENTING UNREASONABLE PREMIUM INCREASES

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

TITLE II—MAKING HEALTH INSURANCE COVERAGE AFFORDABLE

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

TITLE III—ENSURING ACCESS TO CARE

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

TITLE IV—STRENGTHENING CONSUMER HEALTH INSURANCE PROTECTIONS

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

1 TITLE I—LIMITING INSURER

- 2 PROFITS AND PREVENTING
- 3 UNREASONABLE PREMIUM
- 4 INCREASES
- 5 SEC. 101. MEDICAL LOSS RATIO.
- 6 Section 2718(b)(1)(A)(ii) of the Public Health Serv-
- 7 ice Act (42 U.S.C. 300gg–18(b)(1)(A)(ii)) is amended by
- 8 striking "80" each place it appears and inserting "85".
- 9 SEC. 102. ENSURING THAT CONSUMERS GET VALUE FOR
- 10 THEIR DOLLARS.
- 11 Section 2794 of the Public Health Service Act (42
- 12 U.S.C. 300gg-94) is amended—

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

1	ject to review pursuant to section 154.200
2	of title 45, Code of Federal Regulations (or
3	any successor regulation), and determine
4	whether such increases are unreasonable;
5	and
6	"(ii) may prohibit a health insurance
7	issuer from implementing such an increase
8	that is unreasonable.
9	"(B) Unreasonable increases.—In de-
10	termining whether an increase in health insur-
11	ance premiums is unreasonable under subpara-
12	graph (A)(i)—
13	"(i) the Secretary shall consider
14	whether the increase is excessive, unjusti-
15	fied, discriminatory, or inadequate; and
16	"(ii) the State, pursuant to an effec-
17	tive rate review program meeting the re-
18	quirements under paragraph (4), shall
19	apply applicable State law for making such
20	determination.
21	"(4) State effective rate review pro-
22	GRAMS.—A State effective rate review program
23	meets the requirements under this paragraph if—
24	"(A) the program carries out the reviews
25	described in paragraph (3)(A)(i) and ensures

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

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

1	TITLE	II–	-MAKING	HEALTH	IN-
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2	SURANCE	COVERAGE	AF-
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4	SEC.	201.	ENHANCEMENT	OF	PREMIUM	ASSISTANCE	CRED.
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- 6 (a) Use of Gold Level Plan for Benchmark.—
- 7 (1) IN GENERAL.—Clause (i) of section 8 36B(b)(2)(B) of the Internal Revenue Code of 1986 9 is amended by striking "applicable second lowest 10 cost silver plan" and inserting "applicable second
- lowest cost gold plan".
- 12 (2) Conforming amendment related to
 13 Affordability.—Section 36B(c)(4)(C)(i)(I) of
 14 such Code is amended by striking "second lowest
 15 cost silver plan" and inserting "second lowest cost
- gold plan".
- 17 (3) OTHER CONFORMING AMENDMENTS.—Sub-
- paragraphs (B) and (C) of section 36B(b)(3) of such
- 19 Code are each amended by striking "silver plan"
- each place it appears in the text and the heading
- and inserting "gold plan".
- (b) Expansion of Eligibility for Refundable
- 23 Credits for Coverage Under Qualified Health
- 24 Plans.—

1	(1) In general.—Section $36B(c)(1)(A)$ of the
2	Internal Revenue Code of 1986 is amended by strik-
3	ing "but does not exceed 400 percent".
4	(2) Conforming amendments relating to
5	RECAPTURE OF EXCESS ADVANCED PAYMENTS.—
6	Clause (i) of section 36B(f)(2)(B) of such Code is
7	amended—
8	(A) by striking "In the case of" and all
9	that follows through "the amount of" and in-
10	serting "The amount of", and
11	(B) by striking "but less than 400%" in
12	the table therein.
13	(c) Determination of Applicable Percent-
13 14	(e) Determination of Applicable Percentage.—
14	AGE.—
14 15	AGE.— (1) In General.—Subparagraph (A) of section
141516	AGE.— (1) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is
14151617	AGE.— (1) In General.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended to read as follows:
1415161718	AGE.— (1) In General.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended to read as follows: "(A) Applicable percentage.—The ap-
141516171819	(1) In general.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended to read as follows: "(A) Applicable percentage.—The applicable percentage for any taxable year shall be
14151617181920	(1) In General.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended to read as follows: "(A) Applicable percentage.—The applicable percentage for any taxable year shall be the percentage such that the applicable percent-
14 15 16 17 18 19 20 21	(1) In General.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended to read as follows: "(A) Applicable percentage.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxable year shall be the percenta

1	age to the fina	l premium percen	tage specified in	
2	such table for such income tier:			
	"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	
	100% through 133% 133% through 150% 150% through 200% 200% through 250% 250% through 300% 300% through 400% Over 400%	0% $1.0%$ $2.0%$ $4.0%$ $6.0%$ $7.0%$ $8.5%$	1.0% 2.0% 4.0% 6.0% 7.0% 8.5%	
3	(2) Conform	ING AMENDMENT	s.—Subsections	
4	(e)(2)(C)(iv) and $(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)($	e)(4)(F) of section	36B of the In-	
5	ternal Revenue Cod	de of 1986 are ea	ach amended by	
6	inserting "(as in ef	fect before the da	ate of the enact-	
7	ment of the Consu	mer Health Insur	rance Protection	
8	Act of 2018)" after "subsection (b)(3)(A)(ii)".			
9	(d) Effective Da	The amend	ments made by	
10	this section shall apply	to taxable years	beginning after	
11	December 31, 2019.			
12	SEC. 202. ENHANCEMENT	S FOR REDUCED C	OST-SHARING.	
13	(a) Modification (OF AMOUNT.—		
14	(1) In General	AL.—Section 1402	2 of the Patient	
15	Protection and Af	ffordable Care A	Act (42 U.S.C.	
16	18071) is amended-	_		
17	(A) in su	bsection (b)(1), l	y striking "sil-	
18	ver" and insert	ting "gold";		
19	(B) by an	mending subsecti	on (e)(1)(B) to	
20	read as follows	:		

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

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

1	Secretary such sums as may be necessary for payments	
2	under this section.".	
3	SEC. 203. CAP ON PRESCRIPTION DRUG COST-SHARING.	
4	(a) Qualified Health Plans.—Section 1302(c) of	
5	the Patient Protection and Affordable Care Act (42	
6	U.S.C. 18022(c)) is amended—	
7	(1) in paragraph (3)(A)(i), by inserting "(in-	
8	cluding cost-sharing with respect to prescription	
9	drugs covered by the plan)" after "copayments"	
10	and	
11	(2) by adding at the end the following:	
12	"(5) Prescription drug cost-sharing.—	
13	"(A) 2020.—For plan years beginning in	
14	2020, the cost-sharing incurred under a health	
15	plan with respect to prescription drugs covered	
16	by the plan shall not exceed \$250 per month for	
17	each enrolled individual, or \$500 for each fam-	
18	ily.	
19	"(B) 2021 and later.—	
20	"(i) In general.—In the case of any	
21	plan year beginning in a calendar year	
22	after 2020, the limitation under this para-	
23	graph shall be equal to the applicable dol-	
24	lar amount under subparagraph (A) for	
25	plan years beginning in 2020, increased by	

1	an amount equal to the product of that
2	amount and the medical care component of
3	the consumer price index for all urban con
4	sumers (as published by the Bureau of
5	Labor Statistics) for that year.
6	"(ii) Adjustment to amount.—I
7	the amount of any increase under clause
8	(i) is not a multiple of \$5, such increase
9	shall be rounded to the next lowest mul
10	tiple of \$5.".
11	(b) Group Health Plans.—Section 2707(b) of the
12	Public Health Service Act (42 U.S.C. 300gg-6(b)) is
13	amended by striking "paragraph (1) of section 1302(c)"
14	and inserting "paragraphs (1) and (5) of section 1302(c
15	of the Patient Protection and Affordable Care Act".
16	(c) Effective Date.—The amendments made by
17	subsections (a) and (b) shall take effect with respect to
18	plans beginning after December 31, 2019.
19	SEC. 204. STANDARDIZED OPTIONS IN THE BRONZE, SIL
20	VER, AND GOLD LEVELS OF COVERAGE.
21	(a) In General.—Section 1301(a) of the Patient
22	Protection and Affordable Care Act (42 U.S.C. 18021(a))
23	is amended—
24	(1) in paragraph (1)(C)—

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

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

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

1	SEC. 205. CLARIFICATION REGARDING DETERMINATION OF
2	AFFORDABILITY OF EMPLOYER-SPONSORED
3	MINIMUM ESSENTIAL COVERAGE.
4	(a) Special Rule for Employer-sponsored Min-
5	IMUM ESSENTIAL COVERAGE.—Clause (i) of section
6	36B(c)(2)(C) of the Internal Revenue Code of 1986 is
7	amended to read as follows:
8	"(i) Coverage must be afford-
9	ABLE.—
10	"(I) IN GENERAL.—Except as
11	provided in clause (iii), an individual
12	shall not be treated as eligible for
13	minimum essential coverage if such
14	coverage consists of an eligible em-
15	ployer-sponsored plan (as defined in
16	section $5000A(f)(2)$) and the required
17	contribution with respect to the plan
18	exceeds 8.5 percent of the applicable
19	taxpayer's household income.
20	"(II) REQUIRED CONTRIBUTION
21	WITH RESPECT TO EMPLOYEE.—In
22	the case of the employee eligible to en-
23	roll in the plan, the required contribu-
24	tion for purposes of subclause (I) is
25	the employee's required contribution
26	(within the meaning of section

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

1	(3) Clause (iv) of section $36B(c)(2)(C)$ of such
2	Code is amended by striking "clause (i)(II)" and in-
3	serting "clause (i)(I)".
4	(c) Effective Date.—The amendments made by
5	this section shall apply to taxable years beginning after
6	December 31, 2019.
7	TITLE III—ENSURING ACCESS
8	TO CARE
9	SEC. 301. NETWORK ADEQUACY REQUIREMENTS.
10	(a) In General.—Section 1311(c) of the Patient
11	Protection and Affordable Care Act (42 U.S.C. 18031(c))
12	is amended—
13	(1) in paragraph (1)(B), by inserting "and
14	paragraph (7) and in accordance with paragraph
15	(8)" after "Public Health Service Act"; and
16	(2) by adding at the end the following:
17	"(7) Network adequacy requirements.—
18	"(A) IN GENERAL.—A qualified health
19	plan shall meet the network adequacy standards
20	established by the Secretary under subpara-
21	graph (B), except as provided in subparagraphs
22	(B)(ii) and (C).
23	"(B) Federal standards and re-
24	VIEW.—
25	"(i) Standard.—

20

1	(1) ESTABLISHMENT.—The Sec-
2	retary shall establish a network ade-
3	quacy standard based on access to in-
4	network providers for qualified health
5	plans, except for those plans described
6	in subparagraph (C). Such standard
7	shall include requirements for the
8	minimum number and type of in-net-
9	work providers available, the geo-
10	graphical location of such providers,
11	the average distance and travel time
12	required for patients to visit such pro-
13	viders, and the average appointment
14	wait times for services covered by the
15	plan.
16	"(II) MEDICARE ADVANTAGE OR-
17	GANIZATIONS.—The network ade-
18	quacy standard established under sub-
19	clause (I) shall, at a minimum, be
20	equivalent to the requirements for ac-
21	cess to services applicable to Medicare
22	Advantage organizations offering
23	Medicare Advantage plans under part
24	C of title XVIII of the Social Security
25	Act.

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

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

1	"(B) Cost-sharing.—A qualified health
2	plan that provides coverage of a service pro-
3	vided by an out-of-network provider under sub-
4	paragraph (A) shall provide such coverage with
5	the same cost-sharing requirements as if the
6	service was provided by an in-network pro-
7	vider.".
8	(b) Effective Date.—The amendments made by
9	subsection (a) shall apply to plans beginning after Decem-
10	ber 31, 2019.
11	(c) Grants for State Network Adequacy Re-
12	VIEWS.—
13	(1) IN GENERAL.—The Secretary of Health and
14	Human Services shall carry out a program to award
15	grants to States during the 5-year period beginning
16	with fiscal year 2020 to assist such States in devel-
17	oping a metric to measure network adequacy as de-
18	scribed in subparagraph (C)(i) of section 1311(c)(7)
19	of the Patient Protection and Affordable Care Act
20	(42 U.S.C. 18031(c)(7)) and to carry out the re-
21	views described in subparagraph (C)(ii) of such sec-
22	tion.
23	(2) Authorization of appropriations.—
24	There are authorized to be appropriated for fiscal
25	years 2020 through 2024 such sums as may be nec-

1	essary to carry out the grant program under this
2	subsection.
3	SEC. 302. ENSURING ADEQUATE COVERAGE IN AREAS WITH
4	FEWER THAN 3 HEALTH INSURANCE ISSUERS
5	OFFERING QUALIFIED HEALTH PLANS ON
6	THE STATE EXCHANGE.
7	(a) Requirements for Medicare Advantage Or-
8	GANIZATIONS.—
9	(1) In General.—Section 1857(e) of the So-
10	cial Security Act (42 U.S.C. 1395w-27(e)) is
11	amended by adding at the end the following new
12	paragraph:
13	"(5) Requirement for certain medicare
14	ADVANTAGE ORGANIZATIONS THAT OFFER AN MA
15	PLAN IN AN APPLICABLE AREA TO ALSO OFFER
16	QUALIFIED HEALTH PLANS IN THE APPLICABLE
17	AREA.—
18	"(A) IN GENERAL.—A contract under this
19	section with an MA organization described in
20	subparagraph (B) shall require the organization
21	to, in each applicable area in which the organi-
22	zation offers an MA plan, also offer, through
23	the individual market in the Exchange oper-
24	ating in the State, at least one qualified health
25	plan in the silver level of coverage and at least

1	one qualified health plan in the gold level of
2	coverage, as described in section 1302(d) of the
3	Patient Protection and Affordable Care Act.
4	"(B) MA ORGANIZATIONS DESCRIBED.—
5	An MA organization described in this subpara-
6	graph is an MA organization that, in addition
7	to offering an MA plan in an applicable area,
8	offers health insurance coverage in the group
9	market or individual market in the State but
10	does not offer such coverage through the Ex-
11	change operating in the State.
12	"(C) NOTIFICATION.—The Secretary, or
13	the State in the case of an MA organization of-
14	fering an MA plan in an applicable area in a
15	State with an Exchange operated by the State,
16	shall notify each MA organization that is re-
17	quired to offer a qualified health plan under
18	subparagraph (A) for a plan year of such re-
19	quirement. Such notification shall be provided
20	each year—
21	"(i) beginning with respect to the re-
22	quirement for plan years beginning after
23	December 31, 2019; and
24	"(ii) not less than 1 year prior to the
25	rate filing deadline for the plan year for

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

1	at the time the Secretary or the State
2	sends the notification under subparagraph
3	(C), fewer than 3 health insurance issuers
4	offer a qualified health plan through the
5	individual market in the Exchange oper-
6	ating in the State.
7	"(ii) Exchange.—The term 'Ex-
8	change' means an American Health Ben-
9	efit Exchange established under section
10	1311 or section 1321 of the Patient Pro-
11	tection and Affordable Care Act.
12	"(iii) Group market.—The term
13	'group market' has the meaning given such
14	term in section 1304 of the Patient Protec-
15	tion and Affordable Care Act.
16	"(iv) Health insurance cov-
17	ERAGE.—The term 'health insurance cov-
18	erage' has the meaning given the term in
19	section 2791(b) of the Public Health Serv-
20	ice Act.
21	"(v) Individual market.—The term
22	'individual market' has the meaning given
23	such term in section 1304 of the Patient
24	Protection and Affordable Care Act.

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

1	1857(e)(5) in the same manner as such require-
2	ments apply to an MA organization.".
3	(2) Effective date.—The amendments made
4	by this subsection shall apply to contracts entered
5	into or renewed after December 31, 2019.
6	SEC. 303. ENROLLMENT IN EXCHANGES.
7	(a) Open Enrollment and Special Enrollment
8	Periods.—Section 1311(c)(6) of the Patient Protection
9	and Affordable Care Act (42 U.S.C. 18031(e)(6)) is
10	amended—
11	(1) in subparagraph (B), by inserting "that are
12	not less than 8 weeks" after "open enrollment peri-
13	ods'';
14	(2) in subparagraph (C), by striking "; and"
15	and inserting ";";
16	(3) in subparagraph (D), by striking the period
17	and inserting "; and; and
18	(4) by adding at the end the following:
19	"(E) a special enrollment period for indi-
20	viduals enrolled in a plan that makes significant
21	provider terminations during the plan year, as
22	determined in accordance with regulations pro-
23	mulgated by the Secretary.".
24	(b) Consumer Protections Regarding Auto-
25	MATIC RE-ENROLLMENT.—Part 2 of subtitle D of title I

- 1 of the Patient Protection and Affordable Care Act (42
- 2 U.S.C. 18031 et seq.) is amended by adding at the end
- 3 the following:
- 4 "SEC. 1314. CONSUMER PROTECTIONS REGARDING AUTO-
- 5 MATIC RE-ENROLLMENT.
- 6 "(a) Consent to Avoid Automatic Re-enroll-
- 7 MENT FOR INDIVIDUALS LOSING ELIGIBILITY FOR PRE-
- 8 MIUM TAX CREDITS.—The Secretary shall establish a
- 9 process to allow an individual, who is enrolling in a quali-
- 10 field health plan through an Exchange and whom the Ex-
- 11 change estimates is eligible to receive a premium tax credit
- 12 under section 36B of the Internal Revenue Code of 1986,
- 13 to provide consent to the Exchange to not automatically
- 14 re-enroll the individual in such qualified health plan (or
- 15 a comparable qualified health plan in a case described in
- 16 subsection (b)) for the following plan year if during the
- 17 plan year the Exchange estimates that the individual has
- 18 become no longer eligible to receive such credit.
- 19 "(b) Notice Regarding Discontinued Plans.—
- 20 In the case of an individual who is enrolled in a qualified
- 21 health plan through an Exchange for a plan year that will
- 22 not be offered through such Exchange for the following
- 23 plan year, the Exchange through which such plan is of-
- 24 fered shall, prior to the open enrollment period for the
- 25 following plan year, send the individual a notice stating—

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

1	(2) improving the ability to reach consumers in
2	providing such notices;
3	(3) increasing consumer comprehension of such
4	notices; and
5	(4) encouraging consumers to—
6	(A) update information that will affect eli-
7	gibility for premium tax credits under section
8	36B of the Internal Revenue Code of 1986 and
9	the amount of such credits; and
10	(B) shop for qualified health plans that
11	will best meet their needs through the Ex-
12	change operating in their State.
13	SEC. 304. MARKETING AND OUTREACH FOR EXCHANGES
14	OPERATED BY THE SECRETARY.
15	Part 2 of subtitle D of title I of the Patient Protec-
16	tion and Affordable Care Act (42 U.S.C. 18031 et seq.),
17	as amended by section 303(b), is further amended by add-
18	ing at the end the following:
19	"SEC. 1315. MARKETING AND OUTREACH FOR EXCHANGES
20	OPERATED BY THE SECRETARY.
21	"(a) In General.—Out of the funds appropriated
22	under subsection (b), the Secretary shall conduct a mar-
23	keting and outreach program with respect to qualified
24	health plans offered in Exchanges operated by the Sec-
25	retary in order to encourage enrollment in such plans.

1 "(b) Appropriation.—

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"(1) Encouraging enrollment for plan YEAR 2019.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$480,000,000 to carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in calendar year 2019.

- "(2) Encouraging enrollment for subse-QUENT PLAN YEARS.—To carry out the marketing and outreach program under subsection (a) with respect to encouraging enrollment for qualified health plans that begin in each of calendar years 2020 through 2024, there is appropriated to the Secretary prior to each such calendar year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount appropriated under this subsection for the prior calendar year increased by 4 percent for each such calendar year.
- 20 AVAILABILITY.—The amounts appropriated under paragraphs (1) and (2) shall remain 22 available until expended.".

23 SEC. 305. NAVIGATOR PROGRAM.

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

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

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

1	TITLE IV—STRENGTHENING
2	CONSUMER HEALTH INSUR-
3	ANCE PROTECTIONS
4	SEC. 401. PROHIBITING DISCRIMINATORY PREMIUMS
5	BASED ON TOBACCO USE.
6	(a) In General.—Section 2701(a)(1)(A) of the
7	Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is
8	amended—
9	(1) in clause (ii), by inserting "and" after the
10	semicolon; and
11	(2) by striking clause (iv).
12	(b) Effective Date.—The amendments made by
13	this section shall apply to plan years beginning after De-
14	cember 31, 2019.
15	SEC. 402. HEALTH INSURANCE CONSUMER INFORMATION.
16	Section 2793 of the Public Health Service Act (42
17	U.S.C. 300gg-93) is amended—
18	(1) in subsection (d)—
19	(A) in the second sentence, by striking
20	"and shall share" and inserting ", shall share";
21	and
22	(B) by striking the period at the end of
23	second sentence and inserting ", and (not later
24	than 2 years after the date of enactment of the
25	Consumer Health Insurance Protection Act of

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

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

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

1	(A) the individual is receiving an active
2	course of treatment from such out-of-network
3	provider that was occurring while the individual
4	was enrolled in a different health plan offered
5	by such plan or issuer for the prior plan year
6	that has been discontinued by such plan or
7	issuer, including a case where such plan is with-
8	drawn from the market, and such provider was
9	an in-network provider under such different
10	health plan; or
11	"(B) the individual is receiving an active
12	course of treatment from such out-of-network
13	provider for a plan year in which the provider
14	was an in-network provider of the plan or issuer
15	but became a terminated provider with respect
16	to such plan or issuer for such plan year.
17	"(2) Duration and rates of coverage.—
18	"(A) DURATION.—The coverage for an ac-
19	tive course of treatment described in paragraph
20	(1) shall be continued until the earlier of—
21	"(i) the date on which the treatment
22	is complete; or
23	"(ii) the date that is 180 days fol-
24	lowing the date on which—

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

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

1	treatment for such individual and has been
2	recommended and documented by the pro-
3	vider for such individual.
4	"(B) COVERED SERVICES.—The term 'cov-
5	ered services' means services that—
6	"(i) would be covered by the group
7	health plan or health insurance issuer of-
8	fering group or individual health insurance
9	coverage if such services were provided by
10	an in-network provider; and
11	"(ii) are for an active course of treat-
12	ment.
13	"(C) TERMINATED PROVIDER.—The term
14	'terminated provider' means a provider that had
15	a contract for participation with the plan or
16	coverage during a plan year while the individual
17	was enrolled in such plan or coverage and re-
18	ceiving covered services from such provider and,
19	during such plan year, the plan or issuer termi-
20	nates such contract or does not renew such con-
21	tract for the remainder of the plan year. Such
22	term does not include—
23	"(i) any provider that voluntarily ter-
24	minates or does not renew such contract
25	for the remainder of the plan year; and

1	"(ii) any provider whose contract with
2	the plan or issuer has terminated, or was
3	not renewed, for the remainder of the plan
4	year for reasons relating to a medical dis-
5	ciplinary cause or fraud or other criminal
6	activity.
7	"(g) Limitations on Changes in Coverage of
8	Prescription Drugs.—
9	"(1) IN GENERAL.—A group health plan or
10	health insurance issuer offering group or individual
11	health insurance coverage shall not, during a plan
12	year, take any of the following actions with respect
13	to coverage for such plan year:
14	"(A) Removing a prescription drug from a
15	formulary of prescription drugs covered by such
16	plan or issuer, except as provided in paragraph
17	(2)(C).
18	"(B) Increasing the obligation of an en-
19	rollee with respect to cost-sharing, as defined in
20	section 1302(c)(3) of the Patient Protection
21	and Affordable Care Act, required for a pre-
22	scription drug covered by such plan or issuer.
23	"(2) Rule of Construction.—Nothing in
24	this subsection shall prohibit a group health plan or
25	health insurance issuer offering group or individual

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

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

- 1 ings given such terms in section 2791 of the Public
- 2 Health Service Act (42 U.S.C. 300gg-91).
- 3 (4) Secretary.—The term "Secretary" means
- 4 the Secretary of Health and Human Services.
- 5 (d) Effective Date.—This section shall apply to
- 6 plan years beginning after December 31, 2019.

7 SEC. 405. NOTIFICATION OF PROVIDER TERMINATIONS.

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

11 "SEC. 2729. NOTIFICATION OF PROVIDER TERMINATIONS.

- 12 "(a) IN GENERAL.—Beginning January 1, 2019, a
- 13 group health plan or health insurance issuer offering
- 14 group or individual health insurance coverage shall inform
- 15 individuals enrolled in such plan or coverage, who are de-
- 16 scribed in subsection (b), of the termination of any pro-
- 17 vider as an in-network provider under the plan or cov-
- 18 erage. Such notice shall be provided not later than 30 days
- 19 prior to the termination.
- 20 "(b) Individuals.—The individuals described in this
- 21 subsection are any patients who have seen a provider de-
- 22 scribed in subsection (a) on a regular basis or who have
- 23 received primary care from the provider.".

1	SEC. 406. SHORT-TERM LIMITED DURATION HEALTH INSUR-
2	ANCE COVERAGE.
3	(a) In General.—Section 2791(b)(5) of the Public
4	Health Service Act (42 U.S.C. 300gg-91(b)(5)) is amend-
5	ed by striking "but does not include" and inserting "in-
6	cluding".
7	(b) Effective Date.—The amendment made by
8	this section shall apply to plan years beginning after De-
9	cember 31, 2019.
10	SEC. 407. PROTECTING ESSENTIAL HEALTH BENEFITS.
11	Section 1302(b) of the Patient Protection and Af-
12	fordable Care Act (42 U.S.C. 18022(b)) is amended—
13	(1) in paragraph (2)(B) and paragraph (3), by
14	striking "(4)(H)" each place it appears and insert-
15	ing " $(4)(I)$ "; and
16	(2) in paragraph (4)—
17	(A) in subparagraph (A), by inserting
18	"and coverage in every category is included" be-
19	fore the semicolon;
20	(B) by redesignating subparagraphs (E)
21	through (H) as subparagraphs (F) through (I),
22	respectively; and
23	(C) by inserting after subparagraph (D)
24	the following:
25	"(E) ensure that, to be treated as pro-
26	viding coverage for the essential health benefits

1	described in paragraph (1), a qualified health
2	plan—
3	"(i) shall not substitute benefits
4	across the various categories described in
5	paragraph (1);
6	"(ii) shall provide a wide variety of
7	classes of prescription drugs on the pre-
8	scription drug formulary of such plan;
9	"(iii) shall, if a medically necessary
10	drug is not on the prescription drug for-
11	mulary of such plan, allow individuals en-
12	rolled in such plan to have access to the
13	drug through an exceptions process estab-
14	lished by the plan; and
15	"(iv) shall provide coverage of
16	habilitative services at parity with rehabili-
17	tative services, in accordance with regula-
18	tions promulgated by the Secretary.".
19	SEC. 408. ASSOCIATION HEALTH PLANS.
20	(a) Treatment of Association Health Plans.—
21	(1) Association health plan defined.—
22	For purposes of this subsection, the term "associa-
23	tion health plan" means any health insurance cov-
24	erage that is provided to an association, but not re-

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

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

POSED RULE".—In this subsection, the term "Janu-

25

rule.

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ary 5, 2018, proposed rule" means the proposed rule of the Department of Labor entitled "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans" (83 Fed. Reg. 614), or any final rule promulgated with respect to such proposed rule.

(2) Enforcement.—Beginning on the date of enactment of this Act, the January 5, 2018, proposed rule shall cease to have any force or effect. In the case that the January 5, 2018, proposed rule is a final rule on the date of enactment of this Act, the Secretary of Labor shall cease to enforce such final