S.

To stabilize individual market premiums for the 2018 and 2019 plan years and provide meaningful State flexibility.

IN THE SENATE OF THE UNITED STATES

introduced the following bill; which was read twice and referred to the Committee on

A BILL

To stabilize individual market premiums for the 2018 and 2019 plan years and provide meaningful State flexibility.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the [xxx].

SEC. 2. WAIVERS FOR STATE INNOVATION.

(a) STREAMLINING THE STATE APPLICATION PROCESS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—
(1) in subsection (a)(1)(C), by striking “the law” and inserting “a law or has in effect a certification”; and

(2) in subsection (b)(2)—

(A) in the paragraph heading, by inserting “OR CERTIFY” after “LAW”;

(B) in subparagraph (A)—

(i) by striking “A law” and inserting the following:

“(i) LAWS.—A law”; and

(ii) by adding at the end the following:

“(ii) CERTIFICATIONS.—A certification described in this paragraph is a document, signed by the Governor of the State, that certifies that such Governor has the authority under existing Federal and State law to take action under this section, including implementation of the State plan under subsection (a)(1)(B).”; and

(C) in subparagraph (B)—

(i) in the subparagraph heading, by striking “OF OPT OUT”; and
(ii) by striking “may repeal a law” and all that follows through the period at the end and inserting the following: “may terminate the authority provided under the waiver with respect to the State by—

“(i) repealing a law described in subparagraph (A)(i); or

“(ii) terminating a certification described in subparagraph (A)(ii), through a certification for such termination signed by the Governor of the State.”.

(b) GIVING STATES MORE FUNDING FLEXIBILITY, TO ESTABLISH REINSURANCE, HIGH RISK POOLS, INVISIBLE HIGH RISK POOLS, INSURANCE STABILITY FUNDS AND OTHER PROGRAMS.—Section 1332(a)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)(3)) is amended—

(1) in the first sentence—

(A) by inserting “or would qualify for a reduced portion of” after “would not qualify for”; 

(B) by inserting “, or the State would not qualify for or would qualify for a reduced portion of basic health program funds under section 1331,” after “subtitle E”;
(C) by inserting “, or basic health program funds the State would have received,” after “this title”; and

(D) by inserting “or for implementing the basic health program established under section 1331” before the period;

(2) in the second sentence, by inserting before the period, “, and with respect to participation in the basic health program and funds provided to such other States under section 1331”; and

(3) by adding after the second sentence the following: “A State may request that all of, or any portion of, such aggregate amount of such credits, reductions, or funds be paid to the State as described in the first sentence.”.

(e) Ensuring Patient Access to More Flexible Health Plans.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (B), by striking “at least as affordable” and inserting “of comparable affordability, including for low-income individuals, individuals with serious
health needs, and other vulnerable populations,”; and

(ii) by amending subparagraph (D) to read as follows:

“(D)(i) will not increase the Federal deficit over the term of the waiver; and

“(ii) will not increase the Federal deficit over the term of the 10-year budget plan submitted under subsection (a)(1)(B)(ii).”;

(B) by redesignating paragraph (2) (as amended by subsection (a)) as paragraph (3); and

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

“(2) BUDGETARY EFFECT.—

“(A) IN GENERAL.—In determining whether a State plan submitted under subsection (a) meets the budget neutrality requirements of paragraph (1)(D), the Secretary may take into consideration the direct budgetary effect of the provisions of such plan on sources of Federal funding other than the funding described in subsection (a)(3).

“(B) LIMITATION.—A determination made by the Secretary under subparagraph (A)—
“(i) shall not be construed to affect any waiver process or standards in effect on the date of enactment of the [short title] under title XVIII, XIX, or XXI of the Social Security Act, or any other Federal law relating to the provision of health care items or services; and

“(ii) shall be made without regard to any changes in policy with respect to any waiver process or provision of health care items or services described in clause (i).”;

and

(2) in subsection (a)(1)(C), by striking “subsection (b)(2)” and inserting “subsection (b)(3)”.

(d) PROVIDING EXPEDITED APPROVAL OF STATE WAIVERS.—Section 1332(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(d)) is amended—

(1) in paragraph (1) by striking “180” and inserting “90”; and

(2) by adding at the end the following:

“(3) EXPEDITED DETERMINATION.—

“(A) IN GENERAL.—With respect to any application under subsection (a)(1) submitted on or after the date of enactment of the [short title] or any such application submitted prior to
such date of enactment and under review by the Secretary on such date of enactment, the Secretary shall make a determination on such application, using the criteria for approval otherwise applicable under this section, not later than 45 days after the receipt of such application, and shall allow the public notice and comment at the State and Federal levels described under subsection (a)(4) to occur concurrently if such State application—

“(i) is submitted in response to an urgent situation, with respect to areas in the State that the Secretary determines are at risk for excessive premium increases or having no health plans offered in the applicable health insurance market for the current or following plan year; or

“(ii) is for a waiver that is the same or substantially similar to a waiver that the Secretary already has approved for another State.

“(B) APPROVAL.—

“(i) URGENT SITUATIONS.—

“(I) PROVISIONAL APPROVAL.—A waiver approved under the expedited
determination process under subparagraph (A)(i) shall be in effect for a period of 3 years, unless the State requests a shorter duration.

“(II) Full Approval.—Subject to the requirements for approval otherwise applicable under this section, not later than 1 year before the expiration of a provisional waiver period described in subclause (I) with respect to an application described in subparagraph (A)(i), the Secretary shall make a determination on whether to extend the approval of such waiver for the full term of the waiver requested by the State, for a total approval period not to exceed 6 years. The Secretary may request additional information as the Secretary determines appropriate to make such determination.

“(ii) Approval of Same or Similar Applications.—An approval of a waiver under subparagraph (A)(ii) shall be subject to the terms of subsection (e).
“(C) GAO Study.—Not later than 5 years after the date of enactment of the short title, the Comptroller General of the United States shall conduct a review of all waivers approved pursuant to an application under subparagraph (A)(ii) to evaluate whether such waivers met the requirements of subsection (b)(1) and whether the applications should have qualified for such expedited process.”.

(e) Providing Certainty for State-based Reforms.—Section 1332(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(e)) is amended by striking “No waiver” and all that follows through the period at the end and inserting the following: “A waiver under this section—

“(1) shall be in effect for a period of 6 years unless the State requests a shorter duration;

“(2) may be renewed, subject to the State meeting the criteria for approval otherwise applicable under this section, for unlimited additional 6-year periods upon application by the State; and

“(3) may not be suspended or terminated, in whole or in part, by the Secretary at any time before the date of expiration of the waiver period (including any renewal period under paragraph (2)), unless the
Secretary determines that the State materially failed
to comply with the terms and conditions of the waiv-
er.”.
(f) GUIDANCE AND REGULATIONS.—Section 1332 of
the Patient Protection and Affordable Care Act (42
U.S.C. 18052) is amended—
(1) by adding at the end the following:
“(f) GUIDANCE AND REGULATIONS.—
“(1) IN GENERAL.—With respect to carrying
out this section, the Secretary shall—
“(A) issue guidance, not later than 30
days after the date of enactment of the [short
title], that includes initial examples of model
State plans that meet the requirements for ap-
proval under this section; and
“(B) periodically review the guidance
issued under subparagraph (A) and when ap-
propriate, issue additional examples of model
State plans that meet the requirements for ap-
proval under this section, which may include—
“(i) State plans establishing reinsur-
ance or invisible high-risk pool arrange-
ments for purposes of covering the cost of
high-risk individuals;
“(ii) State plans expanding insurer participation, access to affordable health plans, network adequacy, and health plan options over the entire applicable health insurance market in the State;

“(iii) waivers encouraging or requiring health plans in such State to deploy value-based insurance designs which structure enrollee cost-sharing and other health plan design elements to encourage enrollees to consume high-value clinical services;

“(iv) State plans allowing for significant variation in health plan benefit design; or

“(v) any other State plan as the Secretary determines appropriate.

“(2) Rescission of previous regulations and guidance.—Beginning on the date of enactment of the [short title], the regulations promulgated, and the guidance issued, under this section prior to the date of enactment of the [short title] shall have no force or effect.”; and

(2) in subsection (b)(4)—

(A) in subparagraph (A), by inserting “, as applicable” before the semicolon; and
(B) in subparagraph (B), by striking “Not later than 180 days after the date of enactment of this Act, the Secretary shall” and inserting “The Secretary may”.

(g) APPLICABILITY.—The amendments made by this Act to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052)—

(1) with respect to applications for waivers under such section 1332 submitted after the date of enactment of this Act and applications for such waivers submitted prior to such date of enactment and under review by the Secretary on the date of enactment, shall take effect on the date of enactment of this Act; and

(2) with respect to applications for waivers approved under such section 1332 before the date of enactment of this Act, shall not require reconsideration of whether such applications meet the requirements of such section 1332, except that, at the request of a State, the Secretary shall recalculate the amount of funding provided under subsection (a)(3) of such section.

(h) CLARIFYING BUDGET NEUTRALITY.—Section 1332(a)(1)(B)(ii) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)(1)(B)(ii)) is amended by
inserting “over both the term of the proposed waiver and the term of the 10-year budget plan” after “Government”.

SEC. 3. COST-SHARING PAYMENTS.

(a) In General.—There is appropriated to the Secretary of Health and Human Services (referred to in this section as the “Secretary”), out of any funds in the Treasury not otherwise obligated, such sums as may be necessary for payments for cost-sharing reductions authorized by section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) for the portion of plan year 2017 that begins on the date of enactment of this Act and ends on December 31, 2017, and for plan years 2018 and 2019.

(b) Ensuring Consumer Benefit in 2018.—

(1) Cost-sharing payments.—

(A) In general.—

(i) Availability of funds.—For plan year 2018, except with respect to issuers of qualified health plans in a State described in clause (ii)(I), amounts appropriated under subsection (a) shall be made available for payments for cost-sharing reductions under such section 1402 to issuers of qualified health plans.

(ii) State flexibility.—
14

[(I) State described.—A State described by this clause is a State in which the State insurance regulator, before the date of enactment of this Act, directed issuers of qualified health plans to decline cost-sharing reduction payments under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) for the 2018 plan year, through a formal notice or correspondence.]

[(II) State option to reverse directive.—Nothing in this clause shall prevent a State insurance regulator from reversing a directive described in subclause (I).]

[(B) State plan.—

[(i) In general.—Not later than 60 days after the date of enactment of this Act, each State insurance regulator not described in subparagraph (A)(ii)(I) shall submit to the Secretary of Health and Human Services a certification that, with respect to plan year 2018, the State will
ensure that each applicable issuer of a qualified health plan in the State provides a direct financial benefit to consumers and the Federal Government, as applicable, and a State plan for so ensuring such benefit. The Secretaries of the Treasury and of Health and Human Services shall assist the States in developing and implementing plans as needed, including by providing technical assistance.]

[(ii) CONTENT.—A State plan under clause (i) shall include, as applicable—]

[(I) providing monthly rebates to affected consumers and the Federal Government;]

[(II) one-time rebates for consumers to affected consumers and the Federal Government;]

[(III) after-the-year rebates for affected consumers and the Federal Government;]

[(IV) rebates paid through the process under section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), allowing for the appro-
appropriate portion of rebates to be provided to the Federal Government; and]

[(V) other means of providing a direct financial benefit to consumers and the Federal Government approved by the State insurance regulator, provided such means of providing a financial benefit does not result in increased costs for applicable taxpayers described in section 36B of the Internal Revenue Code of 1986 or the Federal Government.]

[(iii) CONSIDERATIONS.—Any rebate amount described in clause (ii)(I)—]

[(I) shall be treated as part of the premium, but the premium under section 36B(b)(2) of the Internal Revenue Code of 1986 or section 36B(f)(3)(B) of such Code shall not be affected by the rebate amount;]

[(II) shall be treated as if it were an expenditure described in paragraph (1) or (2) of section 2718(a) of the
Public Health Service Act (42 U.S.C. 300gg–18); and

[(III) shall be accounted for by the Secretary in calculating risk adjustment and reconciling any other relevant downstream financial calculations.]

[(iv) Notice requirements.—
States that adopt a State plan under this subparagraph shall prominently post a notice that enrollees may qualify for rebates or other means and explain how such rebates will be provided.]

[(2) Report.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall issue a report describing the activities taken by issuers of qualified health plans in States that submitted certifications and State plans under paragraph (1)(B) to provide a direct financial benefit to individuals enrolled in a qualified health plan and the Federal Government, as applicable, for the 2018 plan year.]
SEC. 4. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM COPPER PLAN.

(a) In General.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended—

(1) in paragraph (1)—

(A) by redesignating clauses (i) and (ii) of subparagraph (B) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly;

(B) by striking “plan year if—” and all that follows through “the plan provides—” and inserting “plan year if the plan provides—”;

and

(C) in subparagraph (A), as redesignated by paragraph (1), by striking “clause (ii)” and inserting “subparagraph (B)”;

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) Risk Pools.—Section 1312(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)) is amended by inserting “and including enrollees in cata-
1 strophic plans described in section 1302(e)” after “Ex-
2 change”.
3 (c) CONFORMING AMENDMENT.—Section
4 1312(d)(3)(C) of the Patient Protection and Affordable
5 Care Act (42 U.S.C. 18032(d)(3)(C)) is amended by strik-
6 ing “, except that in the case of a catastrophic plan de-
7 scribed in section 1302(e), a qualified individual may en-
8 roll in the plan only if the individual is eligible to enroll
9 in the plan under section 1302(e)(2)”.
10 (d) EFFECTIVE DATE.—The amendments made by
11 subsections (a), (b), and (c) shall apply with respect to
12 plan years beginning on or after January 1, 2019.
13 SEC. 5. CONSUMER OUTREACH, EDUCATION, AND ASSIST-
14 ANCE.
15 (a) OPEN ENROLLMENT REPORTS.—For plan years
16 2018 and 2019, the Secretary of Health and Human Serv-
17 ices (referred to in this section as the “Secretary”), in co-
18 ordination with the Secretary of the Treasury and the Sec-
19 retary of Labor, shall issue biweekly public reports during
20 the annual open enrollment period on the performance of
21 the Federal Exchange and the Small Business Health Op-
22 tions Program (SHOP) Marketplace. Each such report
23 shall include a summary, including information on a
24 State-by-State basis where available, of—
25 (1) the number of unique website visits;
(2) the number of individuals who create an account;

(3) the number of calls to the call center;

(4) the average wait time for callers contacting the call center;

(5) the number of individuals who enroll in a qualified health plan; and

(6) the percentage of individuals who enroll in a qualified health plan through each of the following channels—

(A) the website;

(B) the call center;

(C) navigators;

(D) agents and brokers;

(E) the enrollment assistant program;

(F) directly from issuers or web brokers;

or

(G) by other means.

(b) Open Enrollment After Action Report.—For plan years 2018 and 2019, the Secretary, in coordination with the Secretary of the Treasury and the Secretary of Labor, shall publish an after action report not later than 3 months after the completion of the annual open enrollment period regarding the performance of the Federal Exchange and the Small Business Health Options
Program (SHOP) Marketplace for the applicable plan year. Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the open enrollment data reported under subsection (a) for the entirety of the enrollment period; and

(2) activities related to patient navigators described in section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)), including—

(A) the performance objectives established by the Secretary for such patient navigators;

(B) the number of consumers enrolled by such a patient navigator;

(C) an assessment of how such patient navigators have met established performance metrics, including a detailed list of all patient navigators, funding received by patient navigators, and whether established performance objectives of patient navigators were met; and

(D) with respect to the performance objectives described in subparagraph (A)—

(i) whether such objectives assess the full scope of patient navigator responsibil-
ities, including general education, plan selec-
tion, and determination of eligibility for
tax credits, cost-sharing reductions, or
other coverage;

(ii) how the Secretary worked with pa-
tient navigators to establish such objec-
tives; and

(iii) how the Secretary adjusted such
objectives for case complexity and other
contextual factors.

(c) REPORT ON ADVERTISING AND CONSUMER OUT-
REACH.—Not later than 3 months after the completion of
the annual open enrollment period for the 2018 plan year,
the Secretary shall issue a report on advertising and out-
reach to consumers for the open enrollment period for the
2018 plan year. Such report shall include a description
of—

(1) the division of spending on individual adver-
tising platforms, including television and radio ad-
vertisements and digital media, to raise consumer
awareness of open enrollment;

(2) the division of spending on individual out-
reach platforms, including email and text messages,
to raise consumer awareness of open enrollment; and
whether the Secretary conducted targeted outreach to specific demographic groups and geographic areas.

(d) Outreach and Enrollment Activities.—

(1) Open Enrollment.—Of the amounts collected through the user fees on participating health insurance issuers pursuant to section 156.60 of title 45, Code of Federal Regulations (or any successor regulations), the Secretary shall obligate $105,800,000 for outreach and enrollment activities for each of the open enrollment periods for plan years 2018 and 2019.

(2) Outreach and Enrollment Activities.—

(A) In General.—For purposes of this subsection, the term “outreach and enrollment activities” means—

(i) activities to educate consumers about coverage options or to encourage consumers to enroll in or maintain health insurance coverage (excluding allocations to the call center for the Federal or State Exchanges); or

(ii) activities conducted by an in-person consumer assistance program that does
not have a conflict of interest and that, among other activities, facilitates enrollment of individuals through the Federal Exchange or State Exchanges, and distributes fair and impartial information concerning enrollment through such Exchanges and the availability of tax credits and cost-sharing reductions.

(B) CONNECTION WITH FEDERAL EXCHANGE.—Activities conducted under this section shall be in connection with the operation of the Federal Exchange, to provide special benefits to health insurance issuers participating in the Federal Exchange.

(3) CONTRACT AUTHORITY.—The Secretary may contract with a State to conduct outreach and enrollment activities for plan years 2018 and 2019. Any outreach and enrollment activities conducted by a State or other entity at the direction of the State, in accordance with such a contract, shall be treated as Federal activities to provide special benefits to participating health insurance issuers consistent with OMB Circular No. A–25R.

(4) CLARIFICATIONS.—
(A) PRIOR FUNDING.—Nothing in this subsection should be construed as rescinding or cancelling any funds already obligated on the date of enactment of this Act for outreach and enrollment activities for plan year 2018.

(B) AVAILABILITY OF FUNDING.—The Secretary shall ensure that outreach and enrollment activities are conducted in all applicable States, including, as necessary, by providing for such activities through contracts described in paragraph (3).

SEC. 6. OFFERING HEALTH PLANS IN MORE THAN ONE STATE.

Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the National Association of Insurance Commissioners, shall issue regulations for the implementation of health care choice compacts established under section 1333 of the Patient Protection and Affordable Care Act (42 U.S.C. 18053) to allow for the offering of health plans in more than one State.