116TH CONGRESS
2D SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

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

A BILL

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

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 ''Health Care Improvement Act of 2020''.

SEC. 2. TABLE OF CONTENTS.

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TITLE I—REDUCING HEALTH CARE COSTS AND PROTECTING PEOPLE WITH PREEXISTING CONDITIONS

SEC. 101. IMPROVING AFFORDABILITY BY EXPANDING PREMIUM ASSISTANCE 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:

''In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150.0 percent	0.0	0.0
150.0 percent up to 200.0 percent	0.0	3.0
200.0 percent up to 250.0 percent	3.0	4.0
250.0 percent up to 300.0 percent	4.0	6.0
300.0 percent up to 400.0 percent	6.0	8.5
400.0 percent and higher	8.5	8.5''.

(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. EXPANDING AFFORDABILITY FOR WORKING FAMILIES TO FIX THE FAMILY GLITCH.

(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 employee'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 ''the 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, 2021.

SEC. 103. ESTABLISHING A STATE HEALTH INSURANCE AFFORDABILITY AND INNOVATION FUND.

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

''PART 6—STATE HEALTH INSURANCE AFFORDABILITY AND INNOVATION FUND

''SEC. 1351. ESTABLISHMENT OF PROGRAM.

''There is hereby established the 'State Health Insurance Affordability and Innovation Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (referred to in this section as the 'Administrator'), to provide funding, in accordance with this part, to each of the 50 States and the District of Columbia (each referred to in this section as a 'State') beginning on January 1, 2022, for the purposes described in section 1352.

"SEC. 1352. USE OF FUNDS.

"(a) IN GENERAL.—A State shall use the funds allocated to the State under this part for one of the following purposes:

"(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

"(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

"(3) 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 reenrollment 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.

''(4) State investment in technology to improve data sharing and collection for the purposes of facilitating greater enrollment in health insurance coverage in such markets.

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

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

''(1) A grandfathered health plan (as defined in section 1251).

''(2) A plan (commonly referred to as a 'transitional 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 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, February 13, 2017, April 9, 2018, March 25, 2019, and

January 31, 2020, or under any subsequent extensions thereof.

''(3) Student health insurance coverage (as defined in section 147.145 of title 45, Code of Federal Regulations).

''SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

''(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

''(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2022), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2022, not later than 90 days after the date of the enactment of this part and, in the case of allocations for a subsequent year, not later than March 1 of the previous year) and in such form and manner as specified by the Administrator containing—

''(A) a description of how the funds will be used; and

''(B) such other information as the Administrator may require.

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

fies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

''(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

''(4) REVOCATION OF APPROVAL.—The approval of an application of a State, with respect to a purpose described in section 1352, may be revoked if the State fails to use funds provided to the State under this section for such purpose or otherwise fails to comply with the requirements of this section.

''(b) DEFAULT FEDERAL SAFEGUARD.—

''(1) 2022.—For 2022, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph

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

''(2) 2023 AND SUBSEQUENT YEARS.—For 2023 or a subsequent year, in the case of a State that does not have in effect an approved application under this section for such year, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

''(3) SPECIFIED USE.—The amount described in paragraph (4), with respect to 2022 or a subsequent year, shall be used to carry out the purpose described in section 1352(a)(1) in each State described in paragraph (1) or (2) for such year, as applicable, by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2)), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to, subject to paragraph (5), the percentage (specified for such year by the Secretary under such subparagraph) of the amount of such claims.

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

''(5) ADJUSTMENT.—For purposes of this subsection, the Secretary may apply a percentage under paragraph (3) with respect to a year that is less than the percentage otherwise specified in section 1354(b)(2)(B) for such year, if the cost of paying the total eligible attachment range claims for States described in this subsection for such year at such percentage otherwise specified would exceed the amount calculated under paragraph (4) for such year.

''SEC. 1354. ALLOCATIONS.

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

''(b) ALLOCATIONS.—

"(1) PAYMENT.—

"(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Secretary shall, with respect to a State not described in section 1353(b) for such year and not later than the date specified under subparagraph (B) for such year, allocate for such State the amount determined for such State and year under paragraph (2).

"(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

"(i) for 2022, the date that is 45 days after the date of the enactment of this part; and

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

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

"(2) ALLOCATION AMOUNT DETERMINATIONS.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State described in paragraph (1)(A) for such year is the amount equal to—

"(i) the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if such State used such funds only for the purpose described in paragraph (1) of section 1352(a) at the dollar amounts and percentage specified under subparagraph (B) for such year; minus

"(ii) the amount, if any, by which the Secretary determines—

"(I) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year without application of this part; exceeds

"(II) the estimated amount of premium tax credits under section

36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year if such State were a State described in section 1353(b) for such year.

For purposes of the previous sentence and section 1353(b)(3), the term 'attachment range claims' means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount specified by the Secretary for such year, under subparagraph (B).

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

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

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

SEC. 104. RESCINDING THE SHORT-TERM LIMITED DURATION INSURANCE REGULATION.

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

(1) may not take any action to implement, enforce, or otherwise give effect to the rule entitled ''Short-Term, Limited Duration Insurance'' (83 Fed. Reg. 38212 (August 3, 2018));

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

(3) may not promulgate any substantially similar rule.

SEC. 105. REVOKING SECTION 1332 GUIDANCE.

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

ment, enforce, or otherwise give effect to the guidance entitled ''State Relief and Empowerment Waivers'' (83 Fed. Reg. 53575 (October 24, 2018)), including any such action that would—

(1) result in individuals losing health insurance coverage that includes the essential health benefits package (as defined in subsection (a) of section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) without regard to any waiver of any provision of such package under a waiver under such section 1332), including the maternity and newborn care essential health benefit described in subsection (b)(1)(D) of such section;

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

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

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

(4) result, with respect to vulnerable populations (including low-income individuals, elderly individuals, and individuals with serious health issues or who have a greater risk of developing serious health issues), in a decrease in the availability of coverage that is at least as comprehensive as the coverage defined in section 1302(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)) with coverage and cost-sharing protections required under section 1332(b)(1)(B) of such Act (42 U.S.C. 18052(b)(1)(B));

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

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

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

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed to affect the approval of waivers under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) that establish reinsurance programs that are consistent with the requirements under subsection (b)(1) of such section (42 U.S.C. 18052(b)(1)), lower health insurance premiums, and protect health insurance coverage for people with preexisting conditions.

SEC. 106. PROMOTING CONSUMER OUTREACH AND EDUCATION.

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

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

"(C) SELECTION OF RECIPIENTS.—In the case of an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), in awarding grants under paragraph (1), the Exchange shall—

"(i) select entities to receive such grants based on an entity's demonstrated capacity to carry out each of the duties specified in paragraph (3);

"(ii) not take into account whether or not the entity has demonstrated how the entity will provide information to individuals relating to group health plans offered by a group or association of employers described in section 2510.3–5(b) of title 29, Code of Federal Regulations (or any successor regulation), or short-term limited duration insurance (as defined by the Secretary for purposes of section 2791(b)(5) of the Public Health Service Act); and

"(iii) ensure that, each year, the Exchange awards such a grant to—

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

"(II) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group in ad-

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

In awarding such grants, an Exchange may consider an entity's record with respect to waste, fraud, and abuse for purposes of maintaining the integrity of such Exchange.'';

(2) in paragraph (3)—

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

''(C) facilitate enrollment, including with respect to individuals with limited English proficiency and individuals with chronic illnesses, in qualified health plans, State Medicaid plans under title XIX of the Social Security Act, and State child health plans under title XXI of such Act;'';

(B) in subparagraph (D), by striking ''and'' at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and'';

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

''(F) provide referrals to community-based organizations that address social needs related to health outcomes.''; and

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

''The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.'';

(3) in paragraph (4)(A)—

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

(B) in clause (i)—

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

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

(C) in clause (ii)—

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

(ii) by striking the period and inserting a semicolon; and

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

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

''(iv) receive opioid specific education and training that ensures the navigator

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

(4) in paragraph (6)—

(A) by striking ''Grants under'' and inserting the following:

''(A) STATE EXCHANGES.—Grants under''; and

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

''(B) FEDERAL EXCHANGES.—For purposes of carrying out this subsection, with respect to an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), 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 fiscal year 2022 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.''.

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

TITLE II—ENCOURAGING MEDICAID EXPANSION AND STRENGTHENING THE MEDICAID PROGRAM

SEC. 201. INCENTIVIZING MEDICAID EXPANSION.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d(y)(1)) is amended—

(1) in subsection (y)(1)—

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

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

(C) in subparagraph (C), by striking ''2018'' and inserting ''the fifth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals'';

(D) in subparagraph (D), by striking ''2019'' and inserting ''the sixth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals''; and

(E) in subparagraph (E), by striking ''2020 and each year thereafter'' and inserting ''the seventh consecutive 12-month period in which the State provides medical assistance to newly eligible individuals and each such period thereafter''; and

(2) in subsection (z)(2)(B)(i)(II), by inserting ''(as in effect on the day before the date of enactment of the Health Care Improvement Act of 2020)'' after ''subsection (y)(1)''.

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

SEC. 202. REDUCING THE ADMINISTRATIVE FMAP FOR NONEXPANSION STATES.

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

(1) in subsection (a)(7), by inserting ''subsection (bb) and'' before ''section 1919(g)(3)(B)''; and

(2) by adding at the end the following new subsection:

''(bb) REDUCTION OF FEDERAL PAYMENTS FOR CERTAIN ADMINISTRATIVE COSTS OF NONEXPANSION STATES.—

''(1) IN GENERAL.—In the case of a State that does not provide under the State plan of such State (or waiver of such plan) for making medical assistance available in accordance with section 1902(k)(1) to all individuals described in section 1902(a)(10)(i)(VIII) for a calendar quarter beginning on or after October 1, 2022, the Secretary may reduce the percentage specified in subsection (a)(7) for amounts described in such subsection expended during such quarter by such State by the number of percentage points specified in paragraph (2) for such quarter.

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

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

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

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

''(3) DEFINITION.—For purposes of this subsection, the term 'State' means a State that is one of the 50 States or the District of Columbia.''.

SEC. 203. STATE OPTION TO PROVIDE 12-MONTHS OF POSTPARTUM MEDICAID ELIGIBILITY.

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

(1) MEDICAID.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) in section 1902(l)(1)(A), by inserting ''(or, at the option of the State, 365-day period)'' after ''60-day period'';

(B) in section 1902(e)(6), by inserting ''(or, at the option of the State, 365-day period)'' after ''60-day period'';

(C) in section 1903(v)(4)(A)(i), by inserting ''(or, at the option of the State, 365-day period)'' after ''60-day period''; and

(D) in section 1905(a), in the 4th sentence in the matter following paragraph (30), by inserting ''(or, at the option of the State, 365-day period)'' after ''60-day period''.

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

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

(1) MEDICAID.—

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

''(5) Any woman who is eligible for medical assistance under the State plan or a waiver of such plan and who is, or who while so eligible becomes, pregnant, shall continue to be eligible under the plan or waiver for medical assistance through the end of the month in which the 60-day period (or, at the option of the State, 365-day period) (beginning on the last day of her pregnancy) ends, regardless of the

basis for the woman's eligibility for medical assistance, including if the woman's eligibility for medical assistance is on the basis of being pregnant.''.

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

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

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

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

''(H) Section 1902(e)(5) (requiring 60-day (or, at the option of the State, 365-day) continuous coverage for pregnant and postpartum women).''.

(c) MAINTENANCE OF EFFORT.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in paragraph (74), by striking ''subsection (gg); and'' and inserting ''subsections (gg) and (qq);''; and

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

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

''(1) has in effect under such plan eligibility standards, methodologies, or procedures for individuals described in subsection (l)(1) who are eligible for medical assistance under the State plan or waiver under subsection (a)(10)(A)(ii)(IX) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, for such individuals under such plan or waiver that are in effect on the date of the enactment of this subsection; or

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

subsection (a)(10)(A)(ii)(IX) at a level that is less than the level at which the State provides such assistance to such individuals under such plan or waiver on the date of the enactment of this subsection.''.

(2) CHIP.—Section 2112 of the Social Security Act (42 U.S.C. 1397ll), as amended by subsection (b), is further amended by adding at the end the following subsection:

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

''(1) has in effect under such plan eligibility standards, methodologies, or procedures for targeted low-income pregnant women that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan that are in effect on the date of the enactment of this subsection; or

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

under such plan on the date of the enactment of this subsection.''.

(d) EFFECTIVE DATE.—

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

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX or State child health plan under title XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the respective plan to meet the additional requirement imposed by the amendments made by subsection (a) or (b), respectively, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such applicable additional requirement before the

first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 204. SUPPORTING STATE MEDICAID PROGRAMS THROUGH ECONOMIC DOWNTURNS.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (b), by striking ''and (ff)'' and inserting ''(ff), and (gg)''; and

(2) by adding at the end the following new subsection:

''(gg) INCREASED FMAP DURING ECONOMIC DOWNTURNS.—

''(1) IN GENERAL.—If a fiscal quarter that begins on or after January 1, 2020, is an economic downturn quarter (as defined in paragraph (2)) with respect to a State, then the Federal medical assistance percentage determined for each State for such quarter under subsection (b) shall be equal to the

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

''(2) ECONOMIC DOWNTURN QUARTER.—

''(A) IN GENERAL.—

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

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

''(I) the State unemployment rate at the 20th percentile of the distribution of the State's quarterly unemployment rates for the 60-quarter period preceding the quarter involved, increased by 1 percentage point; and

''(II) the State's average quarterly unemployment rate for the 12-quarter period preceding the quarter

involved, increased by 1 percentage point.

''(B) UNEMPLOYMENT DATA.—

''(i) IN GENERAL.—Except as provided in clause (ii), for purposes of determining unemployment rates for a State and a quarter under this paragraph, the Secretary shall use data from the Local Area Unemployment Statistics from the Bureau of Labor Statistics.

''(ii) APPLICATION TO CERTAIN TERRITORIES.—In the case of the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, or any other jurisdiction for which suitable data from the Local Area Unemployment Statistics from the Bureau of Labor Statistics are unavailable, the Secretary shall use data from the U–3 unemployment measure of the Bureau of Labor Statistics to make any necessary determinations under subparagraph (A).

''(3) INCREASED FMAP DURING ECONOMIC DOWNTURN QUARTER.—

''(A) IN GENERAL.—During a fiscal quarter that is an economic downturn quarter with

respect to a State, the Federal medical assistance percentage for the State and quarter determined under subsection (b) shall be equal to—

"(i) the Federal medical assistance percentage determined for the State and quarter under subsection (b) without regard to this subsection (but including any increase to such percentage for such quarter made pursuant to section 6008(a) of the Families First Coronavirus Response Act); increased by

"(ii) the number of percentage points (rounded to the nearest tenth of a percentage point) equal to the product of—

"(I) the number of percentage points (rounded to the nearest tenth of a percentage point) by which the unemployment rate for the State and quarter exceeds the percentage determined for the State and quarter under paragraph (2)(A)(ii); and

"(II) 4.8.

"(B) RULES OF APPLICATION.—The following rules shall apply with respect to the Fed-

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

"(i) SCOPE OF APPLICATION.—Such Federal medical assistance percentage shall not apply for purposes of—

"(I) disproportionate share hospital payments described in section 1923;

"(II) payments under part D of title IV; or

"(III) any payments under this title that are based on a Federal medical assistance percentage determined for a State under subsection (aa) (but only to the extent that such Federal medical assistance percentage is higher than the economic recovery FMAP).

"(ii) LIMITATION.—In no case shall—

"(I) the Federal medical assistance percentage determined for a State and quarter pursuant to this subsection exceed 95 percent; or

"(II) any increase to the Federal medical assistance percentage determined for a State and quarter pursuant to this subsection result in the application of a Federal medical assistance percentage that exceeds 95 percent.

"(iii) APPLICATION TO CHIP.—Notwithstanding the first sentence of section 2105(b), the application of this subsection may result in the enhanced FMAP of a State for a fiscal year under such section exceeding 85 percent, but in no case may the application of this subsection before application of the second sentence of such section result in the enhanced FMAP of the State exceeding 95 percent.

"(4) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

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

"(i) make an initial determination, based on the projections made for the

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

"(I) whether the application of this subsection is expected to result in the application of a higher Federal medical assistance percentage for the State and quarter than the percentage that would otherwise apply without regard to this subsection; and—

"(II) if the application of this subsection is expected to result in such a higher Federal medical assistance percentage for the State and quarter, what such higher percentage is expected to be; and

"(ii) if the Secretary determines under clause (i) that the application of this subsection is expected to result in the application of a higher Federal medical assistance percentage for the State and quarter than the percentage that would otherwise apply without regard to this subsection—

"(I) apply such higher Federal medical assistance percentage of the State for purposes of making pay-

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

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

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

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

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

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

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

"(i) make a final determination with respect to the application of this subsection for purposes of determining the Federal medical assistance percentage and enhanced FMAP of the State for the quarter; and

"(ii) in accordance with section 1903(d)(2) and section 2105(e), reduce or increase the amount payable to the State under section 1903(a) or section 2105 for a subsequent fiscal quarter to the extent of any overpayment or underpayment under either such section which the Secretary determines was made as a result of an incorrect initial determination under subparagraph (A)(i) with respect to the application of this subsection for purposes of determining the Federal medical assistance percentage and enhanced FMAP of the State for such prior fiscal quarter.

''(5) RETROSPECTIVE APPLICATION OF OVER-THE-LIMIT FMAP INCREASES.—

''(A) IN GENERAL.—If a State has excess percentage points with respect to an economic downturn quarter and an applicable FMAP (as determined under subparagraph (B)), the State may elect to apply such excess percentage points to increase such applicable FMAP for one or more quarters during the look-back period for the State and economic downturn quarter in accordance with this paragraph.

''(B) EXCESS PERCENTAGE POINTS.—For purposes of this paragraph, the number of excess percentage points for a State, economic downturn quarter, and an applicable FMAP shall be equal to the number of percentage points by which—

''(i) the applicable FMAP for the State and quarter (after application of paragraph (3) but without regard to subparagraph (B)(ii) of such paragraph); exceeds

''(ii) 95 percent.

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

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

''(D) DISTRIBUTION OF EXCESS PERCENTAGE POINTS.—A State that has excess percentage points with respect to an economic downturn quarter and applicable FMAP may elect to divide such points among more than 1 quarter during the look-back period for such State and quarter provided that no excess percentage point (or fraction of an excess percentage point) is applied to the applicable FMAP of more than 1 quarter.

''(E) LIMITATIONS.—

''(i) NO INCREASES OVER 100 PERCENT.—A State may not increase an applicable FMAP for any quarter during a look-back period under this paragraph if such increase would result in the applicable

FMAP for such quarter exceeding 100 percent.

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

''(I) shall only apply with respect to payments for amounts expended by the State for medical assistance for services furnished during such quarter to which such applicable FMAP is applicable; and

''(II) shall not apply with respect to payments described in paragraph (3)(B)(i).

''(F) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE FMAP.—The term 'applicable FMAP' means, with respect to a State and fiscal quarter—

''(I) the Federal medical assistance percentage determined for the State and quarter under subsection (b);

''(II) the Federal medical assistance percentage applicable under subsection (y);

''(III) the Federal medical assistance percentage applicable under subsection (z)(2);

''(IV) the Federal medical assistance percentage determined for the State and quarter under subsection (ff); or

''(V) the enhanced FMAP determined for the State and quarter under section 2105(b).

''(ii) LOOK-BACK PERIOD.—The term 'look-back period' means, with respect to a State and a fiscal quarter that is an economic downturn quarter for the State, the period of 4 fiscal quarters that ends with the fourth quarter which precedes the most recent fiscal quarters that was not an economic downturn quarter for the State.

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

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

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

''(B) the amount of any premium imposed by the State pursuant to section 1916 or 1916A during such quarter, with respect to an individual enrolled under such plan (or waiver), exceeds the amount of such premium as of the date described in subparagraph (A); or

''(C) the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date described in subparagraph (A) or enrolls for benefits under such plan (or waiver) during the period beginning with such date and ending with the day before the first day of the next quarter that is not an economic downturn quarter for the State shall be treated as eligible for such benefits for not less than 12 months after such date or (if later) the date that such individual so enrolls unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State.''.

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

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

(A) in subsection (f), in the matter preceding paragraph (1), by striking ''subsection (g) and section 1935(e)(1)(B)'' and inserting ''subsections (g) and (h) and section 1935(e)(1)(B)''; and

(B) by adding at the end the following:

''(h) EXCLUSION FROM CAPS OF AMOUNTS ATTRIBUTABLE TO ECONOMIC DOWNTURN FMAP.—Any payment made to a territory for a fiscal year in which the Federal medical assistance percentage for the territory is determined under section 1905(gg) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) to the extent that such payment exceeds the amount of the payment that would have been made to the territory for the year if the Federal medical assistance percentage for the territory had been determined without regard to such section.''.

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

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

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

''(12) SPECIAL RULE FOR ADJUSTING ALLOTMENTS DURING FISCAL YEARS WITH ECONOMIC DOWNTURN QUARTERS.—

''(A) IN GENERAL.—If a fiscal quarter occurring during fiscal year 2020 or any succeeding fiscal year is determined to be an economic downturn quarter with respect to a State (as determined under section 1905(gg)) then, as soon as practicable after such determination, the Secretary shall increase the allotment for the State and fiscal year in accordance with subparagraph (B).

''(B) AMOUNT OF INCREASE.—

''(i) IN GENERAL.—The amount of an increase to the allotment of a State described in subparagraph (A) for a fiscal

year shall be equal to the amount by which Federal payments made to the State for the preceding fiscal year under this title would have been increased (without regard to whether such payments would exceed the amount of the State's allotment for such preceding fiscal year) if the enhanced FMAP determined for the State for such preceding fiscal year had been increased to the same extent that the State's enhanced FMAP for the fiscal year involved is expected to be increased as a result of the application of section 1905(gg) relative to the enhanced FMAP that would apply to the State for the fiscal year involved without the application of such section.

''(ii) INCLUSION OF PROJECTED INCREASES.—In increasing the allotment of a State for a fiscal year under this paragraph, the Secretary may base the calculation of such increase on projections made by the Secretary with respect to—

''(I) the number of fiscal quarters during such fiscal year that will be economic downturn quarters; and

"(II) the effect that the application of section 1905(gg) is expected to have on the enhanced FMAP of the State for such fiscal year.

"(C) DISREGARD OF INCREASED PAYMENTS FOR PURPOSES OF FUTURE ALLOTMENTS.—Any Federal payment made to a State under this title for a fiscal year in which the Federal medical assistance percentage for the State is determined under section 1905(gg) shall be disregarded when determining the allotment of the State for any subsequent year, including for purposes of applying this paragraph, to the extent that such payment exceeds the amount of the payment that would have been made to the State for the year if the Federal medical assistance percentage for the State and year had been determined without regard to such section.".

SEC. 205. STATE FLEXIBILITY TO USE ADMINISTRATIVE SIMPLIFICATION POLICIES FOR ENROLLMENT.

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

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

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

"(iii) STATE OPTION TO EXTEND EXPRESS LANE ELIGIBILITY TO ADULTS.—

"(I) IN GENERAL.—At the option of the State, the State may apply the provisions of this paragraph with respect to determining eligibility under this title for an eligible individual (as defined in subclause (II)). In applying this paragraph in the case of a State making such an option, any reference in this paragraph to a child with respect to this title (other than a reference to child health assistance) shall be deemed to be a reference to an eligible individual.

"(II) ELIGIBLE INDIVIDUAL DEFINED.—In this clause, the term 'eligible individual' means—

"(aa) any individual (other than a child) whose income eligibility under the State plan or under a waiver of the plan for medical assistance is determined under paragraph (14); and

"(bb) an individual included in any other group of individuals the Secretary determines appropriate.".

(c) CONSENT BY BENEFIT UTILIZATION.—Section 1902(e)(13)(D)(i) of the Social Security Act (42 U.S.C. 1396a(e)(13)(D)(i)) is amended by inserting "by using medical assistance to access care," after "through electronic signature,".

(d) STUDY AND REPORT ON OPTIONS FOR AUTOMATIC ENROLLMENT IN MEDICAID AND CHIP.—

(1) STUDY.—The Secretary of Health and Human Services, by grant, contract, or interagency agency, shall conduct a study to identify options for, and barriers to, States automatically enrolling individuals who, on the basis of data and information from income tax returns and other sources, are likely to be eligible for medical assistance under the State Medicaid plan established under title XIX of

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

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

(A) An analysis of the financial, regulatory, and legislative barriers that limit the ability of States to implement automatic enrollment for individuals described in subsection (a).

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

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

graph (A) and allow States to elect to automatically enroll individuals described in subsection (a) in the State Medicaid plan established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) or for child health assistance (or, if applicable, pregnancy-related assistance) under the State child health plan established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) (or a waiver of such plan).

TITLE III—ESTABLISHMENT OF A PUBLIC HEALTH CARE OPTION

SEC. 301. ESTABLISHMENT OF HEALTH PLAN.

(a) IN GENERAL.—The Secretary shall establish a coordinated and low-cost health plan (referred to in this section as the ''health plan'') to provide access to quality health care for enrollees.

(b) INDIVIDUAL MARKET AVAILABILITY.—The Secretary shall make the health plan available in the individual market for plan year 2022 and each subsequent plan year.

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

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

SEC. 302. AVAILABILITY OF PLAN.

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

(1) is a qualified individual within the meaning of section 1312 of the Patient Protection and Affordable Care Act (42 U.S.C. 18032);

(2) is not eligible for benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

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

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

SEC. 303. AFFORDABILITY.

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

SEC. 304. PARTICIPATING PROVIDERS.

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

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

SEC. 305. PROVIDER PAYMENT RATES.

The Secretary shall set competitive provider payment rates under the health plan using the best information publically available and data otherwise accessible to the Secretary. The Secretary shall give consideration to existing provider payment rates for commercial health plans and provider costs to deliver care, giving special consideration to increased costs for providers to deliver care in rural and medically underserved areas.

SEC. 306. NO EFFECT ON MEDICARE BENEFITS OR MEDICARE TRUST FUNDS.

Nothing in this title shall—

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

(2) impact the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) (including the Medicare Prescription Drug Account within such Trust Fund).

TITLE IV—FAIR MEDICARE PAYMENTS TO RURAL PROVIDERS

SEC. 401. ENSURING FAIRNESS IN MEDICARE HOSPITAL PAYMENTS.

(a) HOSPITAL INPATIENT SERVICES.—

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

(A) in clause (i), in the first sentence, by striking ''or (iii)'' and inserting '', (iii), or (iv)''; and

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

''(iv) AREA WAGE INDEX FLOOR.—

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

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

(2) WAIVING BUDGET NEUTRALITY.—

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

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

(i) by striking ''and the amendments'' and inserting '', the amendments''; and

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

Health Care Improvement Act of 2020'' after ''Care Act''.

(b) HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), is amended—

(1) in paragraph (2)(D), by striking ''(19), the Secretary''and inserting ''(19) and paragraph (23), the Secretary''; and

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

''(23) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—With respect to covered OPD services furnished on or after January 1, 2021, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is not located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 0.85. The preceding sentence shall not be implemented in a budget neutral manner.''.

TITLE V—COMMONSENSE COMPETITION AND ACCESS TO HEALTH INSURANCE

SEC. 501. PROVIDING SMALL BUSINESS HEALTH INSURANCE ACROSS STATE LINES.

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

SEC. 502. REPORT AND MODELS.

Section 1333 of the Patient Protection and Affordable Care Act (42 U.S.C. 18053) is amended by adding at the end the following:

''(b) NAIC REPORT AND MODELS.—

''(1) IN GENERAL.—Not later than December 31, 2021, the Secretary shall request that the National Association of Insurance Commissioners submit to the Secretary a report concerning health plans provided for under this section. Such report shall include—

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

"(B) an assessment of how an out-of-State insurer would go about building an adequate provider network;

"(C) a description of how such challenges could be lessened without weakening the enforcement of laws and regulations described in subsection (a)(1)(B)(i) in any State that is included in a compact under this section;

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

"(E) models to be used by States to establish and enter into interstate health care choice compacts under this section, which—

"(i) may include model legislation for use by States to enact laws to enter into such compacts;

"(ii) shall identify how States would continue to enforce, and not weaken, the laws and regulations described in subsection (a)(1)(B)(i) in any State that is included in such compact; and

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

''(2) OTHER ORGANIZATIONS AND ENTITIES.—In making the request under paragraph (1), the Secretary may also request that the National Association of Insurance Commissioners gather concepts for inclusion in the report under such paragraph from organizations and entities that have experience in offering qualified health plans in States in which such plans were not originally issued.''.

TITLE VI—EMPOWERING MEDICARE SENIORS TO NEGOTIATE PRESCRIPTION DRUG PRICES

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

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

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

TITLE VII—COMMONSENSE REPORTING FOR EMPLOYERS

SEC. 701. VOLUNTARY PROSPECTIVE REPORTING SYSTEM.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the Secretary of Labor, and the Administrator of the Small Business Administration, shall develop and implement guidance providing for a prospective reporting system meeting the requirements of subsection (b). Such system shall be available for use by employers on a voluntary basis beginning not later than January 1, 2021.

(b) REQUIREMENTS.—The system created under subsection (a) shall include—

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

(A) the name and employer identification number for purposes of section 6056 of the Internal Revenue Code of 1986 of the employer;

(B) a certification of—

(i) whether coverage meeting the definition of minimum essential coverage in section 5000A(f) of the Internal Revenue Code of 1986 is offered to the full-time employees (within the meaning of section 4980H of such Code) of the employer;

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

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

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

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

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

(vii) whether the employer reasonably expects to be liable for any shared responsibility payment under section 4980H of such Code for such year;

(C) the months during the prospective reporting period that such coverage is available to individuals described in clauses (i) through (iv) of subparagraph (B);

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

(E) a list of all employer identification numbers of the employer for entities that employ employees within the employers control group under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code for 1986;

(2) processes necessary to ensure that Exchanges, the Federal Marketplace Data Services Hub, and the Internal Revenue Service can securely and confidentially access the information described in paragraph (1) as necessary to carry out their respective missions, and to provide to the Secretary of Health and Human Services additional information relating to eligibility determinations for advance payment of the premium tax credits under section 36B

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

(3) a process to allow Exchanges to follow up with employers in order to obtain additional reasonably necessary information relating to an employee's eligibility for such advance payment or such cost-sharing subsidies, and to allow an employee to receive notification of any problem in verifying such eligibility; and

(4) a process to allow employers using the system to provide timely updates to the Federal Marketplace Data Services Hub regarding any cancellation of coverage or significant change in coverage for participating employees that would change the information reported under paragraph (1).

(c) EMPLOYER NOTIFICATION OF EMPLOYEE ENROLLMENT IN EXCHANGE PLANS.—Subparagraph (J) of section 1311(d)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(d)(4)(J)) is amended by striking ''to each employer'' and all that follows through ''(and the effective date of such cessation); and'' and inserting ''to each employer—

''(i) the name of each employee of the employer who enrolls in a qualified health

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

''(ii) the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and''.

(d) EXEMPTION FROM REPORTING REQUIREMENT UNDER INTERNAL REVENUE CODE OF 1986.—Section 6056 of the Internal Revenue Code of 1986 is amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

''(f) EXEMPTION.—If, through the system created pursuant to section 701(a) of the Health Care Improvement Act of 2020, an employer provides prospective reporting for any calendar year that meets the requirements of section 701(b)(1) of such Act—

''(1) such employer shall be treated as satisfying the return requirements of subsections (a) and (b) for such year; and

''(2) such employer shall be treated as satisfying the requirements of subsection (c) for such year if the employer—

"(A) furnishes the statement described in such section to those employees of the employer whose names have been provided to the employer by an Exchange under section 1311(d)(4)(J)(i) of the Patient Protection and Affordable Care Act regarding enrollment of the employee or a dependent in a qualified health plan (as defined in section 1301 of such Act) through the Exchange; and

"(B) furnishes a copy of such statement with respect to such employees to the Secretary.".

(e) THIRD-PARTY FILING.—An employer may contract with a third party to make the report under subsection (b)(1) without affecting the employer's treatment as having satisfied the return requirements of subsections (a) and (b) of section 6056 of the Internal Revenue Code of 1986.

(f) ACCESS TO THE NATIONAL DIRECTORY OF NEW HIRES.—Subsection (i)(3) of section 453 of the Social Security Act (42 U.S.C. 653) is amended by adding at the end the following new sentence: "The Secretary of the Treasury and the Secretary of Health and Human Services shall have access to the information in the National Directory of New Hires for purposes of administering sec-

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

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

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

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

(3) Marketplace Employer Coverage tool.

(4) Annual benefits enrollment materials distributed to employees, including through an intranet or an online portal accessible by employees.

(5) Employee pay statements or Form W–2.

(h) FUNDING FOR VOLUNTARY PROSPECTIVE REPORTING SYSTEM.—It is the sense of Congress that building and maintaining the voluntary prospective reporting system described in this section will require appropriations to the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, and the Administrator of the Small Business Administration, and that necessary sums to carry out the requirements of this section should be appropriated for such purpose.

SEC. 702. PROTECTION OF DEPENDENT PRIVACY.

(a) IN GENERAL.—Paragraph (1) of section 6055(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

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

date of birth in lieu of the TIN, the Social Security Administration shall assist the Internal Revenue Service in providing data matches to determine the TIN associated with the name and date of birth provided by the Internal Revenue Service with respect to such individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to returns the due date for which is after the date that is 60 days after the date of the enactment of this Act.

SEC. 703. ELECTRONIC STATEMENTS.

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

''(3) ELECTRONIC DELIVERY.—An individual shall be deemed to have consented to receive the statement under this subsection in electronic form if such individual has affirmatively consented at any prior time, to the person who is the employer of the individual during the calendar year to which the statement relates, to receive such statement in electronic form. The preceding sentence shall not apply if the individual revokes consent in writing with respect to the statement under this subsection.''.

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

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

"(3) ELECTRONIC DELIVERY.—An individual shall be deemed to have consented to receive the statement under this subsection in electronic form if such individual has affirmatively consented at any prior time, to the person required to make such statement (such as the provider of the individual's health coverage), to receive in electronic form any private health information (such as electronic health records), unless the individual revokes such consent in writing.".

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

SEC. 704. GAO STUDIES.

(a) STUDY OF FIRST YEARS OF EMPLOYER REPORTING.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that evaluates, with respect to the period beginning on January 1, 2015, and ending on December 31, 2018—

(A) the notification of employers by Exchanges established under title I of the Patient Protection and Affordable Care Act (Public

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

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

(ii) the process by which the notification forms were developed and sent to employers, including whether the process provided for a formal notice and comment period;

(iii) whether employers report that such notifications provided sufficient and relevant information for them to make appropriate decisions about whether to utilize the appeals process;

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

(v) differences in the notification process between the marketplace facilitated by

the Federal Government and the State-Based Marketplaces; and

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

(B) the extent to which the Secretary of Health and Human Services has established a separate appeals process for employers who received such a notification to challenge the eligibility determination, as required by section 1411(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f)(2)).

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

(b) STUDY OF PROSPECTIVE REPORTING SYSTEM.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that evaluates, with respect to the period beginning on January 1, 2020, and ending on December 31, 2020, the

functionality of the prospective reporting system established pursuant to section 701, including the accuracy of information collected, the number of employers electing to report under such system, and any challenges that have arisen in implementing such system.

(2) REPORT.—Not later than July 1, 2021, the Comptroller General shall submit to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate and the Committees on Ways and Means, Energy and Commerce, and Education and Labor of the House of Representatives a report on the results of the study conducted under paragraph (1).

SEC. 705. TAX COMPLIANCE.

(a) IN GENERAL.—Section 6724(d)(1)(B)(xxv) of the Internal Revenue Code of 1986 is amended by inserting ''or, in the case of an employer to which section 6056(f) applies, section 701(b)(1) of the Health Care Improvement Act of 2020'' before '', or''.

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

TITLE VIII—FEDERAL BAN ON SURPRISE MEDICAL BILLING

SEC. 801. PROTECTION AGAINST SURPRISE BILLS.

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

''(e) OUT-OF-NETWORK ANCILLARY SERVICES.—

''(1) COVERAGE OF SERVICES.—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who receives out-of-network ancillary services at an in-network facility, including any referrals for diagnostic services, and such services would be covered under such plan or coverage if provided in-network—

''(A) the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by an in-network practitioner, and any coinsurance or deductible shall be based on in-network rates; and

''(B) amounts paid toward such cost-sharing shall be counted towards the in-network deductible and in-network out-of-pocket maximum

amount, as applicable, under the plan or coverage for the plan year.

''(2) NOTICE BEFORE PROVIDING NON-EMERGENCY SERVICES.—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who receives out-of-network, non-emergency services that are not ancillary services, from an out-of-network provider at an in-network facility, and such services would be covered under such plan or coverage if provided in-network, the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to such services shall be the same requirement that would apply if such services were provided by an in-network practitioner, and any coinsurance or deductible shall be based on in-network rates, unless, as soon as practicable, and in no case later than 48 hours prior to providing non-emergency services that are not ancillary services—

''(A) the in-network facility provides to the enrollee who is scheduled to receive such services notice that—

''(i) is provided in paper or electronic form (and including electronic notification whenever practicable);

"(ii) states that such service will be provided out-of-network;

"(iii) includes the estimated amount that such practitioner or facility may charge the enrollee for such services; and

"(iv) provides the option to affirmatively consent to receiving such services from such practitioner or facility;

"(B) such enrollee signs such notice consenting to receive such services from an out-of-network provider at an in-network facility, and acknowledging that the out-of-network services may be covered at an out-of-network cost-sharing amount, requiring higher cost-sharing obligations of the enrollee than if the service were provided by an in-network practitioner or facility; and

"(C) such facility maintains documentation of the enrollee's signature or confirmation of receipt of such information under subparagraph (B) in the enrollee's patient record for 2 years after the date of services.

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

"(1) PROTECTION FOR ENROLLEES ADMITTED TO THE HOSPITAL FOR EMERGENCY SERVICES PRIOR TO STABILIZATION.—In the case of an enrollee in a group health plan or group or individual health insurance coverage who receives emergency services, or maternal care for a woman in labor, in the emergency department of an out-of-network facility and has not been stabilized (within the meaning of subsection (b)(2)(C)), if the patient is subsequently admitted to the out-of-network facility for care, the cost-sharing requirement (expressed as a copayment amount, coinsurance rate, or deductible) with respect to any out-of-network services provided to the enrollee prior to being stable and in a condition to receive information under (2), is the same requirement that would apply as under subsection (b)(2)(C)(ii)(II).

"(2) NOTICE AND CONSENT.—

"(A) IN GENERAL.—Subject to subsection (h), in the case of an enrollee in a group health plan or group or individual health insurance coverage who receives emergency services, or maternal care for a woman in labor, in the emergency department of an out-of-network facility and has been stabilized (within the mean-

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

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

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

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

pant, beneficiary, or enrollee for such services involved;

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

''(I) paper or electronic notification (and including electronic notification whenever practicable) that the practitioner or facility is an out-of-network health care provider, and the option to affirmatively consent to receiving services from such practitioner or facility;

''(II) a list of in-network practitioners or facilities in the relevant geographic area that could provide the same services, and an option for a referral to such providers; and

''(III) information about whether prior authorization or other care management limitations may be required in advance of receiving in-network services at the facility;

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

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

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

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

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

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

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

''(v) be available in the 15 most common languages in the facility's geographic area, with the facility making a good faith effort to provide oral notice in the enrollee's primary language if it is not one of such 15 languages.

''(C) MAINTENANCE OF RECORDS.—A facility shall maintain documentation of notice given to an enrollee pursuant to this subsection and the enrollee's confirmation of receipt of such information in the enrollee's patient record for 2 years after the date of services.

''(3) RULEMAKING.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall issue regulations to carry out this subsection, which shall include clarification on how to determine whether an individual is stabilized and the timing of the notice required under this paragraph.

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

''(1) IN GENERAL.—A facility or practitioner furnishing—

"(A) emergency services, as defined in subsection (b)(2), regardless of the State in which the patient resides;

"(B) out-of-network services at an in-network facility described in subsection (e)(1);

"(C) out-of-network services at an in-network facility described in subsection (e)(2), where the notice and consent for receiving such services out-of-network did not meet the requirement of such subsection;

"(D) services furnished by an out-of-network provider after an enrollee has been admitted to the hospital for emergency services but prior to stabilization, as described in subsection (f)(1); or

"(E) out-of-network services furnished after the enrollee has been stabilized (within the meaning of subsection (b)(2)(C)), where the notice and option for receiving care at an alternate facility required under subsection (f)(2) have not been provided to the enrollee and the enrollee did not give consent under subsection (f)(3),

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

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

''(2) NOTICE.—A facility furnishing services described in paragraph (1) shall provide enrollees in a group health plan or group or individual health insurance coverage with a one-page notice, in 16-point font, upon intake at the emergency room or being admitted at the facility of the prohibition on balance billing under paragraph (1) and who to contact for recourse if they are sent a balance bill in violation of such paragraph. The facility shall be responsible for obtaining the signature from the enrollee on such notice. The Secretary shall issue regulations within 6 months of the date of enactment of this subsection on the requirements for the notice under this paragraph.

''(h) MAINTAINING STATE SURPRISE BILLING PROTECTIONS.—

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

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

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

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

''(i) DEFINITIONS.—In this section:

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

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

''(3) ANCILLARY SERVICES.—The term 'ancillary services' means non-emergency care that is—

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

''(B) a diagnostic service (including radiology and lab services); or

''(C) provided by such other specialty practitioner not typically selected by the patients receiving the care, which the Secretary may add periodically to such definition through rulemaking.''.

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

''SEC. 2795. ENFORCEMENT OF BALANCE BILLING PROHIBITIONS.

''(a) IN GENERAL.—Subject to subsection (b), a facility or practitioner that violates a requirement under section 2719A(g)(1) or fails to provide notice or obtain consent as required under subsection (e)(2) or (f)(2) shall be

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

''(b) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section, shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(c) SAFE HARBOR.—

''(1) IN GENERAL.—The Secretary shall waive the penalties described under subsection (a) with respect to a facility or, practitioner who does not knowingly violate, and should not have reasonably known it violated, section 2719A(g)(1) with respect to an enrollee, if such facility or practitioner, within 30 days of the violation, withdraws the bill that was in violation of section 2719A(g)(1), and, as applicable, reimburses the group health plan, health insurance issuer, or enrollee, in an amount equal to the difference between the amount billed and the amount allowed to be billed under section 2719A(g)(1), plus interest, at an interest rate determined by the Secretary.

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

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

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

''(5) APPLICATION OF ADDITIONAL PROVISIONS.—Subsections (b) through (h) of section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) shall apply to grandfathered health plans for plan years beginning with the second plan year that begins after the date of enactment of this paragraph.''.

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

''(e) Any health benefits plan offered under this chapter shall be treated as a group health plan or group or

individual health insurance coverage for purposes of subsections (e) through (g) of section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) (except for paragraph (3) of such subsection (g)).''.