115TH CONGRESS
1ST SESSION

S. 1354

To establish an Individual Market Reinsurance fund to provide funding for State individual market stabilization reinsurance programs.

IN THE SENATE OF THE UNITED STATES

JUNE 14, 2017

Mr. CARPER (for himself, Mr. KAINE, Mrs. SHAHEEN, Mr. NELSON, Ms. HASSAN, and Mr. CARDIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To establish an Individual Market Reinsurance fund to provide funding for State individual market stabilization reinsurance programs.

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 ''Individual Health Insurance Marketplace Improvement Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 114–148)

in 2010, Americans with pre-existing conditions faced unfair barriers to accessing health insurance coverage and health care costs had risen rapidly for decades.

(2) Since 2010, the rate of uninsured Americans has declined to a historic low, with more than 20,000,000 Americans gaining access to health insurance coverage.

(3) Since 2010, America has experienced the slowest growth in the price of health care in over five decades.

(4) Thanks to the Patient Protection and Affordable Care Act (Public Law 114–148), Americans can no longer be denied insurance or charged more on the basis of their health status, more Americans than ever have insurance, and the health care they receive is continually improving.

(5) Starting in 2016, independent, non-partisan organizations, including the Congressional Budget Office, have determined that the individual health insurance markets have stabilized and improved.

(6) The cost-sharing reduction payments in the Patient Protection and Affordable Care Act provide stability in the individual health insurance market, lower insurance premiums by nearly 20 percent, and

encourage competition among health insurers. The payments reduce costs for approximately 6,000,000 people with incomes below 250 percent of the poverty line by an average of about $1,100 per person and should be increased to help more Americans.

(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability to the health insurance markets, restrained premium growth, and lowered taxpayer costs by helping health insurers predict and bear risk associated with managing health care costs for a population.

(8) From 2014 to 2016, the temporary reinsurance program established under the Affordable Care Act helped to stabilize the new insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

(9) Throughout his Presidential campaign, the President of the United States repeatedly promised the American people that his health care plan will result in reduced rates of uninsured, lower costs, and higher quality care, stating on January 14, 2017, that ''We're going to have insurance for every-

body. There was a philosophy in some circles that if you can't pay for it, you don't get it. That's not going to happen with us''; and on January 25, 2017, that ''I can assure you, we are going to have a better plan, much better health care, much better service treatment, a plan where you can have access to the doctor that you want and the plan that you want. We're gonna have a much better health care plan at much less money''.

(10) The goal of any health care legislation should be to build on the Affordable Care Act to continue expanding coverage and make health care more affordable for Americans. Improving affordability and expanding coverage will also broaden the individual market risk pool, contributing to lower premiums and strengthening market stability.

SEC. 3. INDIVIDUAL MARKET REINSURANCE FUND.

(a) ESTABLISHMENT OF FUND.—

(1) IN GENERAL.—There is established the ''Individual Market Reinsurance Fund'' to be administered by the Secretary to provide funding for an individual market stabilization reinsurance program in each State that complies with the requirements of this section.

(2) FUNDING.—There is appropriated to the Fund, out of any moneys in the Treasury not otherwise appropriated, such sums as are necessary to carry out this section (other than subsection (c)) for each calendar year beginning with 2018. Amounts appropriated to the Fund shall remain available without fiscal or calendar year limitation to carry out this section.

(b) INDIVIDUAL MARKET REINSURANCE PROGRAM.—

(1) USE OF FUNDS.—The Secretary shall use amounts in the Fund to establish a reinsurance program under which the Secretary shall make reinsurance payments to health insurance issuers with respect to high-cost individuals enrolled in qualified health plans offered by such issuers that are not grandfathered health plans or transitional health plans for any plan year beginning with the 2018 plan year. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide payments from the Fund in accordance with this subsection.

(2) AMOUNT OF PAYMENT.—The payment made to a health insurance issuer under subsection

(a) with respect to each high-cost individual enrolled in a qualified health plan issued by the issuer that is not a grandfathered health plan or a transitional health plan shall equal 80 percent of the lesser of—

(A) the amount (if any) by which the individual's claims incurred during the plan year exceeds—

(i) in the case of the 2018, 2019, or 2020 plan year, $50,000; and

(ii) in the case of any other plan year, $100,000; or

(B) for plan years described in—

(i) subparagraph (A)(i), $450,000; and

(ii) subparagraph (A)(ii), $400,000.

(3) INDEXING.—In the case of plan years beginning after 2018, the dollar amounts that appear in subparagraphs (A) and (B) of paragraph (2) shall each be increased by an amount equal to—

(A) such amount; multiplied by

(B) the premium adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting ''2018'' for ''2013''.

(4) PAYMENT METHODS.—

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

(B) REQUIREMENT FOR PROVISION OF INFORMATION.—

(i) REQUIREMENT.—Payments under this subsection to a health insurance issuer are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this subsection.

(ii) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to clause (i) is subject to the HIPAA privacy and security law, as defined in section 3009(a) of the Public Health Service Act (42 U.S.C. 300jj–19(a)).

(5) SECRETARY FLEXIBILITY FOR BUDGET NEUTRAL REVISIONS TO REINSURANCE PAYMENT SPECIFICATIONS.—If the Secretary determines appropriate, the Secretary may substitute higher dollar amounts for the dollar amounts specified under subparagraphs (A) and (B) of paragraph (2) (and adjusted under paragraph (3), if applicable) if the Secretary certifies that such substitutions, considered together, neither increase nor decease the total projected payments under this subsection.

(c) OUTREACH AND ENROLLMENT.—

(1) IN GENERAL.—During the period that begins on January 1, 2018, and ends on December 31, 2020, the Secretary shall award grants to eligible entities for the following purposes:

(A) OUTREACH AND ENROLLMENT.—To carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage enrollment in, qualified health plans.

(B) ASSISTING INDIVIDUALS TRANSITION TO QUALIFIED HEALTH PLANS.—To provide assistance to individuals who are enrolled in health insurance coverage that is not a qualified health plan enroll in a qualified health plan.

(C) ASSISTING ENROLLMENT IN PUBLIC HEALTH PROGRAMS.—To facilitate the enrollment of eligible individuals in the Medicare program or in a State Medicaid program, as appropriate.

(D) RAISING AWARENESS OF PREMIUM ASSISTANCE AND COST-SHARING REDUCTIONS.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

(2) ELIGIBLE ENTITIES DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''eligible entity'' means—

(i) a State; or

(ii) a nonprofit community-based organization.

(B) ENROLLMENT AGENTS.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State

or nonprofit community-based organization to enroll eligible individuals in qualified health plans.

(C) EXCLUSIONS.—Such term does not include an entity that—

(i) is a health insurance issuer; or

(ii) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to awarding grants to States or eligible entities in States that have geographic rating areas at risk of having no qualified health plans in the individual market.

(4) FUNDING.—Out of any moneys in the Treasury not otherwise appropriated, $500,000,000 is appropriated to the Secretary for each of calendar years 2018 through 2020, to carry out this subsection.

(d) REPORTS TO CONGRESS.—

(1) ANNUAL REPORT.—The Secretary shall submit a report to Congress, not later than January 21, 2019, and each year thereafter, that contains the following information for the most recently ended year:

(A) The number and types of plans in each State's individual market, specifying the number that are qualified health plans, grandfathered health plans, or health insurance coverage that is not a qualified health plan.

(B) The impact of the reinsurance payments provided under this section on the availability of coverage, cost of coverage, and coverage options in each State.

(C) The amount of premiums paid by individuals in each State by age, family size, geographic area in the State's individual market, and category of health plan (as described in subparagraph (A)).

(D) The process used to award funds for outreach and enrollment activities awarded to eligible entities under subsection (c), the amount of such funds awarded, and the activities carried out with such funds.

(E) Such other information as the Secretary deems relevant.

(2) EVALUATION REPORT.—Not later than January 31, 2022, the Secretary shall submit to Congress a report that—

(A) analyzes the impact of the funds provided under this section on premiums and enrollment in the individual market in all States; and

(B) contains a State-by-State comparison of the design of the programs carried out by States with funds provided under this section.

(e) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

(2) FUND.—The term ''Fund'' means the Individual Market Reinsurance Fund established under subsection (a).

(3) GRANDFATHERED HEALTH PLAN.—The term ''grandfathered health plan'' has the meaning given that term in section 1251(e) of the Patient Protection and Affordable Care Act.

(4) HIGH-COST INDIVIDUAL.—The term ''high-cost individual'' means an individual enrolled in a

qualified health plan (other than a grandfathered health plan or a transitional health plan) who incurs claims in excess of $50,000 during a plan year.

(5) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(6) TRANSITIONAL HEALTH PLAN.—The term ''transitional health plan'' means a plan continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 of the Patient Protection and Affordable Care Act does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, and February 13, 2017.

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