116TH CONGRESS
1ST SESSION

S. _____

To provide for the establishment of Medicare part E public health plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. MERKLEY (for himself, Mr. MURPHY, Mrs. FEINSTEIN, Ms. HARRIS, Mr. BLUMENTHAL, Mr. SCHATZ, Ms. BALDWIN, Mr. DURBIN, Mr. REED, Ms. SMITH, Mrs. SHAHEEN, Ms. DUCKWORTH, Mr. BOOKER, Mrs. GILLIBRAND, and Mr. HEINRICH) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide for the establishment of Medicare part E public health plans, and for other purposes.

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 ''Choose Medicare Act''.

SEC. 2. PUBLIC HEALTH PLAN.

The Social Security Act is amended by adding at the end the following:

''TITLE XXII—MEDICARE PART E PUBLIC HEALTH PLANS

''SEC. 2201. PUBLIC HEALTH PLANS.—

"(a) ESTABLISHMENT.—The Secretary shall establish public health plans (to be known as 'Medicare part E plans') that are available in the individual market, small group market, and large group market.

"(b) BENEFITS.—

"(1) IN GENERAL.—Each Medicare part E plan, regardless of whether the plan is offered in the individual market, small group market, or large group market, shall be a qualified health plan within the meaning of section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)) that—

"(A) meets all requirements applicable to qualified health plans under subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.) (other than the requirement under section 1301(a)(1)(C)(ii) of such Act) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.);

"(B) provides coverage of—

"(i) the essential health benefits described in section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)); and

"(ii) all items and services for which benefits are available under title XVIII;

"(C) provides gold-level coverage described in section 1302(d)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(d)(1)(C)); and

"(D) provides coverage of abortions and all other reproductive services.

"(2) PREEMPTION.—Notwithstanding section 1303(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18023(a)(1))—

"(A) a State may not prohibit a Medicare part E plan from offering the coverage described in paragraph (1)(D); and

"(B) no State law that would prohibit such a plan from offering such coverage shall apply to such plan.

"(c) ELIGIBILITY; ENROLLMENT.—

"(1) AVAILABILITY ON THE EXCHANGES.—The Medicare part E plans offered in the individual and small group markets shall be offered through the Federal and State Exchanges, including the Small Business Health Options Program Exchanges (commonly referred to as the 'SHOP Exchanges').

"(2) ELIGIBILITY.—

''(A) IN GENERAL.—Any individual who is a resident of the United States, as determined by the Secretary under subparagraph (C), and who is not an individual described in subparagraph (B), is eligible to enroll in a Medicare part E plan.

''(B) EXCLUSIONS.—An individual described in this subparagraph is any individual who is—

''(i) entitled to, or enrolled for, benefits under title XVIII;

''(ii) eligible for medical assistance under a State plan under title XIX; or

''(iii) enrolled for child health assistance or pregnancy-related assistance under a State plan under title XXI.

''(C) REGULATIONS.—The Secretary shall promulgate a rule for determining residency for purposes of subparagraph (A).

''(3) EMPLOYER-SPONSORED PLANS.—

''(A) EMPLOYER ENROLLMENT.—Effective with respect to the first plan year that begins 1 year after the date of enactment of the Choose Medicare Act and each plan year thereafter, the Secretary shall provide options for

Medicare part E plans in the small group market and large group market that are voluntary, and available to all employers.

''(B) GROUP HEALTH PLANS.—The Secretary, acting through the Administrator for the Centers for Medicare & Medicaid Services, at the request of a plan sponsor, shall serve as a third party administrator of a group health plan that is a Medicare part E plan offered by such sponsor.

''(C) PORTABILITY FOR EMPLOYER-SPONSORED PLANS.—The Secretary shall develop a process for allowing individuals enrolled in a Medicare part E plan offered in the small group market or large group market to maintain health insurance coverage through a Medicare part E plan if the individual subsequently loses eligibility for enrollment in such a plan based on termination of the employment relationship. The ability to maintain such coverage shall exist regardless of whether the individual has the option to enroll in other health insurance coverage, including coverage offered in the individual market or through a subsequent employer.

''(d) PREMIUMS.—The Secretary shall establish premium rates for the Medicare part E plans that—

''(1) are adjusted based on—

''(A) whether the plan is offered in the individual market, small group market, or large group market; and

''(B) the applicable rating area;

''(2) are at a level sufficient to fully finance—

''(A) the costs of health benefits provided by such plans; and

''(B) administrative costs related to operating the plans; and

''(3) comply with the requirements under section 2701 of the Public Health Service Act, including for such plans that are offered in the large group market.

''(e) PROVIDERS AND REIMBURSEMENT RATES.—

''(1) IN GENERAL.—The Secretary shall establish a rate schedule for reimbursing types of health care providers furnishing items and services under the Medicare part E plans at rates that are consistent with the negotiations described in paragraph (2) and are necessary to maintain network adequacy.

''(2) MANNER OF NEGOTIATION.—The Secretary shall negotiate the rates described in para-

graph (1) in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII, and not higher, in the aggregate, than the average rates paid by other health insurance issuers offering health insurance coverage through an Exchange.

''(3) PARTICIPATING PROVIDERS.—

''(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII on the date of enactment of Choose Medicare Act shall be a participating provider for Medicare part E plans.

''(B) ADDITIONAL PROVIDERS.—The Secretary shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers for Medicare part E plans.

''(4) LIMITATIONS ON BALANCE BILLING.—The limitations on balance billing pursuant to the provisions of section 1866(a)(1)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(A)) shall apply to participating providers for Medicare part E plans in the same manner as such provisions apply to participating providers under the Medicare program.

''(f) ENCOURAGING USE OF ALTERNATIVE PAYMENT MODELS.—The Secretary shall, as applicable, utilize alternative payment models, including those described in section 1833(z)(3)(C), as added by section 101(e)(2) of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), in making payments for items and services (including prescription drugs) furnished under Medicare part E plans. The payment rates under such alternative payment models shall comply with the requirement for negotiated rates under subsection (e)(2).

''(g) PRESCRIPTION DRUGS.—The Secretary shall apply the provisions of section 1860D–11(i) to prescription drugs under Medicare part E plans in the same manner as such provisions apply with respect to applicable covered part D drugs under such section.

''(h) APPROPRIATIONS.—

''(1) START UP FUNDING.—For purposes of establishing the Medicare part E plans, there is appropriated to the Secretary, out of any funds in the Treasury not otherwise obligated, $2,000,000,000, for fiscal year 2020.

''(2) INITIAL RESERVES.—There is appropriated to the Secretary, out of any funds in the Treasury not otherwise obligated, such sums as may be necessary, based on projected enrollment in the

Medicare part E plans in the first plan year in which such plans are offered, to provide reserves for the purpose of paying claims filed during the initial 90-day period of such plan year.

''(3) CLARIFICATION.—Any provision of law restricting the use of Federal funds with respect to any reproductive health service shall not apply to funds appropriated under paragraph (1) or (2).

''(i) HEALTH INSURANCE ISSUER.—With respect to any Medicare part E plan, the Secretary shall be considered a health insurance issuer, within the meaning of section 2791(b) of the Public Health Service Act.''.

SEC. 3. NOTICE AND NAVIGATOR REFERRAL FOR EMPLOYEES UNDER THE FAIR LABOR STANDARDS ACT OF 1938.

(a) IN GENERAL.—Section 18B of the Fair Labor Standards Act of 1938 (29 U.S.C. 218b) is amended—

(1) in the heading, by striking ''**TO**'' and inserting ''**AND NAVIGATOR REFERRAL FOR**'';

(2) by redesignating subsection (b) as subsection (c);

(3) by inserting after subsection (a) the following:

''(b) NAVIGATOR REFERRAL.—

''(1) IN GENERAL.—An employer described in paragraph (3) shall refer each full-time employee (as defined in section 4980H of the Internal Revenue Code of 1986) to—

''(A) an entity that serves as a navigator under section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) for the Exchange operating in the State of the employer; or

''(B) if the Exchange operating in the State of the employer does not have an entity serving as such a navigator, another entity that shall carry out equivalent activities as such a navigator.

''(2) REFERRAL.—The referral described in paragraph (1) shall occur—

''(A) at the time the employer hires the employee; or

''(B) on the effective date described in subsection (c)(2) with respect to an employee who is currently employed by the employer on such date.

''(3) EMPLOYER.—An employer described in this paragraph is any employer that—

"(A) does not provide an eligible employer-sponsored plan as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986; or

"(B) provides such an eligible employer-sponsored plan, but the plan is determined under section 36B(c)(2)(C) of such Code—

"(i) to be unaffordable to the employee; or

"(ii) to not provide the required minimum actuarial value."; and

(4) in subsection (c), as so redesignated—

(A) in the heading, by striking "EFFECTIVE DATE" and inserting "EFFECTIVE DATES";

(B) by striking "Subsection (a)" and inserting the following:

"(1) NOTICE.—Subsection (a);"; and

(C) by adding at the end the following:

"(2) NAVIGATOR REFERRAL.—Subsection (b) shall take effect with respect to employers in a State beginning on the date that is 2 years after the date of enactment of the Choose Medicare Act.".

(b) STUDY.—Not later than January 1, 2024, the Comptroller General of the United States shall conduct

a study on the impact of the requirements under section 18B of the Fair Labor Standards Act of 1938 (29 U.S.C. 218b), including the amendments made by subsection (a), on the rate of individuals without minimum essential coverage as defined in section 5000A of the Internal Revenue Code of 1986 in the United States and in each State.

(c) FUNDING FOR NAVIGATOR PROGRAM.—Section 1311(i)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)(6)) is amended—

(1) by striking ''Grants'' and inserting the following:

''(A) IN GENERAL.—Grants''; and

(2) by adding at the end the following:

''(B) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to address capacity limitations of entities serving as navigators through a grant under this subsection.''.

SEC. 4. PROTECTING AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR MEDICARE FEE-FOR-SERVICE BENEFITS.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

''SEC. 1899C. (a) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (beginning with 2021) equals or exceeds the annual out-of-pocket limit under subsection (b) for that year, the individual shall not be responsible for additional out-of-pocket cost-sharing incurred during that year.

''(b) ANNUAL OUT-OF-POCKET LIMIT.—

''(1) IN GENERAL.—The amount of the annual out-of-pocket limit under this subsection shall be—

''(A) for 2021, $6,700; or

''(B) for a subsequent year, the amount specified in this subsection for the preceding year increased or decreased by the percentage change in the medical care component of the Consumer Price Index for All Urban Consumers for the 12-month period ending with June of such preceding year.

''(2) ROUNDING.—If any amount determined under paragraph (1)(B) is not a multiple of $5, such

amount shall be rounded to the nearest multiple of $5.

''(c) OUT-OF-POCKET COST-SHARING DEFINED.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), in this section, the term 'out-of-pocket cost-sharing' means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

''(A) deductibles, coinsurance, and copayments applicable under part A or B; or

''(B) for items and services that would have otherwise been covered under part A or B but for the exhaustion of those benefits.

''(2) CERTAIN COSTS NOT INCLUDED.—

''(A) NON-COVERED ITEMS AND SERVICES.—Expenses incurred for items and services which are not covered under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

''(B) ITEMS AND SERVICES NOT FURNISHED ON AN ASSIGNMENT-RELATED BASIS.—If an item or service is furnished to an individual under this title and is not furnished on an assignment-related basis, any additional ex-

penses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

''(3) SOURCE OF PAYMENT.—For purposes of paragraph (1), the Secretary shall consider expenses to be incurred by the individual without regard to whether the individual or another person, including a State program, an employer, a medicare supplemental policy, or other third-party coverage, has paid for such expenses.

''(d) ANNOUNCEMENT OF THE ANNUAL OUT-OF-POCKET LIMIT.—The Secretary shall (beginning in 2020) announce (in a manner intended to provide notice to all interested parties) the annual out-of-pocket limit under this section that will be applicable for the succeeding year.''.

SEC. 5. NEGOTIATING 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) (relating to noninterference) and by inserting the following:

''(i) NEGOTIATING FAIR PRICES WITH DRUG MANUFACTURERS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, in furtherance of the goals of providing quality care and containing costs under this part, the Secretary shall, with respect to applicable covered part D drugs, and may, with respect to other covered part D drugs, negotiate, using the negotiation technique or techniques that the Secretary determines will maximize savings and value to the government for prescription drug plans and MA–PD plans and for plan enrollees (in a manner that may be similar to Federal entities and that may include, but is not limited to, formularies, reference pricing, discounts, rebates, other price concessions, and coverage determinations), with drug manufacturers the prices that may be charged to PDP sponsors and MA organizations for such drugs for part D eligible individuals who are enrolled in a prescription drug plan or in an MA–PD plan. In conducting such negotiations, the Secretary shall consider the drug's current price, initial launch price, prevalence of disease and usage, and approved indications, the number of similarly effective alternative treatments for each approved use of the drug, the budgetary impact

of providing coverage under this part for such drug for all individuals who would likely benefit from the drug, evidence on the drug's effectiveness and safety compared to similar drugs, and the quality and quantity of clinical data and rigor of the applicable process of approval of a drug under section 505 of the Federal Food, Drug, and Cosmetic Act or a biological product under section 351 of the Public Health Service Act.

''(2) USE OF LOWER OF VA OR BIG FOUR PRICE IF NEGOTIATIONS FAIL.—If, after attempting to negotiate for a price with respect to a covered part D drug under paragraph (1) for a period of 1 year, the Secretary is not successful in obtaining an appropriate price for the drug (as determined by the Secretary), the Secretary shall establish the price that may be charged to PDP sponsors and MA organizations for such drug for part D eligible individuals who are enrolled in a prescription drug plan or in an MA–PD plan at an amount equal to the lesser of—

''(A) the price paid by the Secretary of Veterans Affairs to procure the drug under the laws administered by the Secretary of Veterans Affairs; or

"(B) the price paid to procure the drug under section 8126 of title 38, United States Code.

"(3) APPLICABLE COVERED PART D DRUG DEFINED.—For purposes of this subsection, the term 'applicable covered part D drug' means a covered part D drug that the Secretary determines to be appropriate for negotiation under paragraph (1) based on one or more of the following factors as applied to such drug:

"(A) Spending on a per beneficiary basis.

"(B) The proportion of total spending under this title.

"(C) Unit price increases over the preceding 5 years.

"(D) Initial launch price.

"(E) Availability of less expensive, similarly effective alternative treatments.

"(F) Status of the drug as a follow-on to previously approved drugs.

"(G) Any other criteria determined by the Secretary.

"(4) PDP SPONSORS AND MA ORGANIZATION MAY NEGOTIATE LOWER PRICES.—Nothing in this subsection shall be construed as preventing the spon-

sor of a prescription drug plan, or an organization offering an MA–PD plan, from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated under paragraph (1) or the price established under paragraph (2).

''(5) NO EFFECT ON EXISTING APPEALS PROCESS.—Nothing in this subsection shall be construed to affect the appeals procedures under subsections (g) and (h) of section 1860D–4.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall first apply to negotiations and prices for plan years beginning on January 1, 2020.

SEC. 6. ENHANCEMENT OF PREMIUM ASSISTANCE CREDIT.

(a) USE OF GOLD LEVEL PLAN FOR BENCHMARK.—

(1) IN GENERAL.—Clause (i) of section 36B(b)(2)(B) of the Internal Revenue Code of 1986 is amended by striking ''applicable second lowest cost silver plan'' and inserting ''applicable second lowest cost gold plan''.

(2) CONFORMING AMENDMENT RELATED TO AFFORDABILITY.—Section 36B(c)(4)(C)(i)(I) of such Code is amended by striking ''second lowest cost silver plan'' and inserting ''second lowest cost gold plan''.

(3) OTHER CONFORMING AMENDMENTS.—Subparagraphs (B) and (C) of section 36B(b)(3) of such Code are each amended by striking ''silver plan'' each place it appears in the text and the heading and inserting ''gold plan''.

(b) EXPANSION OF ELIGIBILITY FOR REFUNDABLE CREDITS FOR COVERAGE UNDER QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''400 percent'' and inserting ''600 percent''.

(2) CONFORMING AMENDMENT.—The last line of the table contained in section 36B(b)(3)(A)(i) of such Code is amended by striking ''400%'' and inserting ''600%''.

(3) CONFORMING AMENDMENTS RELATING TO RECAPTURE OF EXCESS ADVANCED PAYMENTS.—Clause (i) of section 36B(f)(2)(B) of such Code is amended—

(A) by striking ''400 percent'' and inserting ''600 percent''; and

(B) by striking ''400%'' in the table therein and inserting ''600%''.

(c) ELIMINATION OF FAILSAFE.—Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986 is amended by striking subclause (III).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2018.

SEC. 7. ENHANCEMENTS FOR REDUCED COST SHARING.

(a) DEFINITION OF ELIGIBLE INDIVIDUAL.—Section 1402(b)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 1807(b)(1)) is amended by striking ''silver level'' and inserting ''gold level''.

(b) MODIFICATION OF AMOUNT.—

(1) IN GENERAL.—Section 1402(c)(2) of the Patient Protection and Affordable Care Act is amended to read as follows:

''(2) ADDITIONAL REDUCTION.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

''(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 133 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed

costs of benefits provided under the plan to 94 percent of such costs;

"(B) in the case of an eligible insured whose household income is more than 133 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 92 percent of such costs;

"(C) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs;

"(D) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs; and

"(E) in the case of an eligible insured whose household income is more than 300 per-

cent but not more than 400 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.''.

(2) CONFORMING AMENDMENT.—Clause (i) of section 1402(c)(1)(B) of such Act is amended to read as follows:

''(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

''(I) 94 percent in the case of an eligible insured described in paragraph (2)(A);

''(II) 92 percent in the case of an eligible insured described in paragraph (2)(B);

''(III) 90 percent in the case of an eligible insured described in paragraph (2)(C);

''(IV) 85 percent in the case of an eligible insured described in paragraph (2)(D); and

''(V) 80 percent in the case of an eligible insured described in paragraph (2)(E).''.

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

SEC. 8. REINSURANCE AND AFFORDABILITY FUND.

Part 5 of subtitle D of title I of the Patient Protection and Affordable Care Act is amended by inserting after section 1341 (42 U.S.C. 18061) the following:

''SEC. 1341A. REINSURANCE AND AFFORDABILITY FUND FOR THE INDIVIDUAL MARKET IN EACH STATE.

''(a) IN GENERAL.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish a program to enable each State, for any plan year beginning in the 3-year period beginning January 1, 2020, to—

''(1) provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage offered by such issuers; or

''(2) 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 in the individual market through an Exchange.

''(b) APPROPRIATIONS.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $30,000,000,000 for the period of fiscal years 2020 through 2022 for purposes of establishing and administering the program established under this section. Such amount shall remain available until expended.''.

SEC. 9. EXPANDING RATING RULES TO LARGE GROUP MARKET.

(a) IN GENERAL.—Section 2701(a) of the Public Health Service Act (42 U.S.C. 300gg(a)) is amended—

(1) in paragraph (1), by striking ''small''; and

(2) by striking paragraph (5).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to plans offered in the first plan year beginning after the date of enactment of this Act and any plan year thereafter.

SEC. 10. PROTECTION OF CONSUMERS FROM EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.

(a) PROTECTION FROM EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—The first section 2794 of the Public Health Service Act (42 U.S.C.

300gg–94), as added by section 1003 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by adding at the end the following new subsection:

"(e) PROTECTION FROM EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—

"(1) AUTHORITY OF STATES.—Nothing in this section shall be construed to prohibit a State from imposing requirements (including requirements relating to rate review standards and procedures and information reporting) on health insurance issuers with respect to rates that are in addition to the requirements of this section and are more protective of consumers than such requirements.

"(2) CONSULTATION IN RATE REVIEW PROCESS.—In carrying out this section, the Secretary shall consult with the National Association of Insurance Commissioners and consumer groups.

"(3) DETERMINATION OF WHO CONDUCTS REVIEWS FOR EACH STATE.—The Secretary shall determine, after the date of enactment of this subsection and periodically thereafter, the following:

"(A) In which markets in each State the State insurance commissioner or relevant State regulator shall undertake the corrective actions

under paragraph (4), as a condition of the State receiving the grant in subsection (c), based on the Secretary's determination that the State insurance commissioner or relevant State regulator is adequately undertaking and utilizing such actions in that market.

''(B) In which markets in each State the Secretary shall undertake the corrective actions under paragraph (4), in cooperation with the relevant State insurance commissioner or State regulator, based on the Secretary's determination that the State is not adequately undertaking and utilizing such actions in that market.

''(4) CORRECTIVE ACTION FOR EXCESSIVE, UNJUSTIFIED, OR UNFAIRLY DISCRIMINATORY RATES.—In accordance with the process established under this section, the Secretary or the relevant State insurance commissioner or State regulator shall take corrective actions to ensure that any excessive, unjustified, or unfairly discriminatory rates are corrected prior to implementation, or as soon as possible thereafter, through mechanisms such as—

''(A) denying rates;

''(B) modifying rates; or

''(C) requiring rebates to consumers.

''(5) NONCOMPLIANCE.—Failure to comply with any corrective action taken by the Secretary under this subsection may result in the application of civil monetary penalties and, if the Secretary determines appropriate, make the plan involved ineligible for classification as a qualified health plan.''.

(b) CLARIFICATION OF REGULATORY AUTHORITY.—Such section is further amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''PREMIUM'' and inserting ''RATE'';

(B) in paragraph (1), by striking ''unreasonable increases in premiums'' and inserting ''potentially excessive, unjustified, or unfairly discriminatory rates, including premiums,''; and

(C) in paragraph (2)—

(i) by striking ''an unreasonable premium increase'' and inserting ''a potentially excessive, unjustified, or unfairly discriminatory rate'';

(ii) by striking ''the increase'' and inserting ''the rate''; and

(iii) by striking ''such increases'' and inserting ''such rates'';

(2) in subsection (b)—

(A) in the subsection heading, by striking ''PREMIUM'' and inserting ''RATE'';

(B) by striking ''premium increases'' each place it appears and inserting ''rates'';

(C) in paragraph (1), in the paragraph heading, by striking ''PREMIUM INCREASE'' and inserting ''RATE''; and

(D) in paragraph (2)—

(i) in the paragraph heading, by striking ''PREMIUM INCREASES'' and inserting ''RATES''; and

(ii) in subparagraph (B), by striking ''premium'' and inserting ''rate''; and

(3) in subsection (c)(1)—

(A) in the heading, by striking ''PREMIUM'' and inserting ''RATE'';

(B) by inserting ''that satisfy the condition under subsection (e)(3)(A)'' after ''award grants to States''; and

(C) in subparagraph (A), by striking ''premium increases'' and inserting ''rates''.

(c) CONFORMING AMENDMENTS.—

(1) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(A) in section 2723 (42 U.S.C. 300gg–22)—

(i) in subsection (a)—

(I) in paragraph (1), by inserting ''and section 2794 (relating to the reasonableness of rates with respect to health insurance coverage)'' after ''this part''; and

(II) in paragraph (2), by inserting ''or such section 2794'' after ''this part''; and

(ii) in subsection (b)—

(I) in paragraph (1), by inserting ''and section 2794 (relating to the reasonableness of rates with respect to health insurance coverage)'' after ''this part''; and

(II) in paragraph (2)—

(aa) in subparagraph (A), by inserting ''or such section 2794 that is'' after ''this part''; and

(bb) in subparagraph (C)(ii), by inserting ''or such section 2794'' after ''this part''; and

(B) in section 2761 (42 U.S.C. 300gg–61)—

(i) in subsection (a)—

(I) in paragraph (1), by inserting ''and section 2794 (relating to the reasonableness of rates with respect to health insurance coverage)'' after ''this part''; and

(II) in paragraph (2)—

(aa) by inserting ''or such section 2794'' after ''set forth in this part''; and

(bb) by inserting ''and such section 2794'' after ''the requirements of this part''; and

(ii) in subsection (b), by inserting ''and such section 2794'' after ''this part''.

(2) PATIENT PROTECTION AND AFFORDABLE CARE ACT.—Section 1311(e)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(2)) is amended by striking ''unjustified

premium increases'' and inserting ''unjustified rates''.

(d) APPLICABILITY TO GRANDFATHERED PLANS.—Section 1251(a)(4)(A) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(a)(4)(A)) is amended by adding at the end the following:

''(v) Section 2794 (relating to reasonableness of rates with respect to health insurance coverage).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall be implemented with respect to health plans beginning not later than January 1, 2020.

SEC. 11. SENSE OF CONGRESS.

It is the sense of the Congress that—

(1) the Federal Government, acting in its capacity as an insurer, employer, or health care provider, should serve as a model for the Nation to ensure coverage of all reproductive services; and

(2) all restrictions on coverage of reproductive services in the private insurance market should end.