May 15, 2020

116th Congress Healthcare Reform Legislation Tracker

Newly Included Legislative Updates

- May 5: Sen. Rand Paul (R-KY) and Rep. John Curtis (R-UT) introduced the American Healthshare Plans Act of 2020 (S. 3610/H.R. 6712), which allows any membership organization to offer group insurance coverage or group health plans, among other things.

I. Single-Issue Legislation (116th Congress) (*all legislation has been introduced; no further action has been taken, unless noted)*

Broker-Specific Issues
Cadillac Tax Repeal (and Other ACA Taxes and Fees)
Wellness
Health Savings Accounts
Mandate Reform/Alternatives
Antitrust
Interstate Sales
Stop-Loss
Essential Health Benefits
ACA Market Reforms
Short-Term, Limited-Duration Insurance
Association Health Plans
Balance Billing
Healthcare Transparency
Multi-Issue Bills
Section 1332 Waivers
Blanket Repeal
Miscellaneous

Broker-Specific Issues

Lower Health Care Costs Act of 2019 S. 1895 Sen. Lamar Alexander (R-TN)	Expands current broker compensation disclosures by requiring providers of brokerage or consulting services ("covered service providers" – broadly defined) to group health plans who reasonably expect $1,000 or more in compensation, direct or indirect, in return for such services, to disclose to the plan fiduciary in writing: • A description of services to be provided; • If applicable, a statement that the service provider will provide, or reasonably expects to provide, services as a fiduciary; • A description of all direct (in aggregate or by service) and indirect compensation the provider reasonably expects to receive; • Descriptions of arrangements between covered service providers and payers of indirect compensation and identification of services for which the indirect compensation will be received; • A description of any transaction-based compensation that will be paid to the provider (e.g., commissions, finder's fees, incentive comp, etc.), along with the payers and the services for which the compensation is being paid; • A description of any compensation the provider expects to receive for termination of the contract/arrangement and how prepaid amounts will be calculated and refunded; • A description of the manner in which any of the above-referenced compensation will be received; and • Upon the plan fiduciary's request, any other information related to compensation. Incorporates various other provisions, including: • Requires disclosures be made no later than the date that "is reasonable in advance of" execution of a contract/arrangement, extension, or renewal; • Requires notification of changes to the information within 60 days; • Waives penalties for good faith errors if the provider promptly corrects any misinformation; • Requires that plan fiduciaries who discover that providers have not provided the above disclosures (if the error is left uncured) terminate the contract; • Does not preempt state laws governing broker/consultant disclosures. *June 18 – A hearing was held on the legislation.* *June 26 – Approved by the Senate Committee on Health, Education, Labor and Pensions, as amended, by a vote of 20-3.*

Cadillac Tax Repeal (and Other ACA Taxes and Fees)

Jobs and Premium Protection Act S. 80/H.R. 2447 Sen. John Barrasso (R-WY)/Rep. Anthony Brindisi (D-NY)	Repeals the ACA's health insurance tax.
Health Insurance Tax Relief Act S. 172/H.R. 1398 Sen. Cory Gardner (R-CO)/Rep. Ami Bera (D-CA)	Delays the implementation of the ACA's health insurance tax until 2022.
Middle Class Health Benefits Tax Repeal Act of 2019 S. 684/H.R. 748 Sen. Martin Heinrich (D-NM)/Rep. Joe Courtney (D-CT)	Repeals the Cadillac tax. *July 17 – H.R. 748 was approved by the House by a vote of 419-6.*
First Responder Medical Device Tax Relief Act H.R. 1290 Rep. Michael Turner (R-OH)	Exempts certain emergency medical devices from the medical device tax.
Protect Medical Innovation Act of 2019 S. 692/H.R. 2207 Sen. Pat Toomey (R-PA)/Rep. Ron Kind (D-WI)	Repeals the medical device tax.
Territory Health Insurance Tax Relief Act of 2019 H.R. 2243 Rep. Jenniffer Gonzalez-Colon (R-PR)	Exempts residents of U.S. territories from the ACA's health insurance tax.
Patient-Centered Outcomes Research Extension Act of 2019/PATIENT Act (*similar though not identical*) H.R. 3030/H.R. 3439 Rep. Diana DeGette (D-CO)/Rep. Don Beyer (D-VA)	Extends appropriations and transfers to the Patient-Centered Outcomes Research Trust Fund and extends insured and self-insured health plan fees for such transfers from 2019 to 2029 (2026 for H.R. 3439 version). *June 26 – H.R. 3439, as amended, was approved by the Ways and Means Committee by a vote of 26-15.*
S. 2414 Sen. Rob Portman (R-OH)	Extends the Health Coverage Tax Credit from 2020 to 2025.

Dependent Income Exclusion Act of 2019 S. 2497/H.R. 4417 Sen. Catherine Cortez Masto (D-NV)/Rep. Steven Horsford (D-NV)	Excludes wages and self-employment earnings of a dependent when determining a taxpayer's eligibility to receive tax credits for coverage under a qualified health plan if (1) the taxpayer resides in a Medicaid non-expansion state, or (2) the dependent of the individual is: • Under 18; or • Under 24 while (1) working full-time, (2) attending a for-profit educational institution, (3) participating in a job-training program, or (4) participating in an apprenticeship program.

Wellness

Health Savings Accounts

Health Savings Act of 2019 S. 12 Sen. Marco Rubio (R-FL)	***On-Site Clinics* –** Creates a special rule for individuals eligible for on-site medical clinic coverage (eligibility to receive health care benefits from an on-site medical clinic of an employer does not qualify as coverage under a health plan if such health care benefits are not significant benefits). Examples of such benefits include: • Physicals and immunizations • Injecting antigens provided by employees • Medications available without a prescription (pain relievers, antihistamines, etc.) • Treatment for injuries occurring at the employer's place of employment or otherwise in the course of employment • Tests for infectious diseases and conditions • Monitoring of chronic conditions • Drug testing • Hearing or vision screenings and related services • Other services and treatments of a similar nature ***OTC Medications* –** Includes an amount paid for any prescription or OTC medicine or drug within the definition of a "qualified medical expense;" includes within the definition of "preventive care" prescription and OTC drugs. ***Contribution Amount* –** Increases maximum contribution limit. ***Medicare Enrollment* –** Allows Medicare beneficiaries enrolled only in Part A to continue to contribute to HSAs after turning 65 if otherwise eligible. ***Other* –** Renames HDHP as "HSA-qualified health plan;" allows both spouses to make catch up contributions to the same HSA account; simplifies limitations on FSA and HSA rollovers; eliminates tax for failure to maintain HDHP coverage.

Health Savings Account Expansion Act H.R. 603 Rep. Mike Gallagher (R-WI)	***OTC Medications* –** Repeals the restriction on using HSAs for OTC medications. ***Contribution Amount* –** Increases maximum contribution limit. ***Other* –** Permits the use of HSAs to pay health insurance premiums and direct primary care expenses; eliminates the requirement that a participant in an HSA be enrolled in an HDHP; decreases the additional tax for HSA distributions not used for qualified medical expenses.
Health Savings Account Act H.R. 457 Rep. Jeff Fortenberry (R-NE)	***Contribution Amount* –** Increases maximum contribution limit. ***Other* –** Allows HSAs to be used for fitness center memberships; allows individuals who receive direct primary care services in exchange for a fixed periodic fee or payment to participate in an HSA, among other things.
Personal Health Investment Today Act of 2019 S. 680 Sen. John Thune (R-SD)	***Other*** – Allows taxpayers to use HSAs or other pre-tax health accounts to pay for sports equipment and other fitness expenses.
Restoring Access to Medication Act S. 1089/H.R. 1922 Sen. Pat Roberts (R-KS)/Rep. Ron Kind (D-WI) (***similar***)	***OTC Medications*** – Allows HSAs and FSAs to purchase OTC medications and menstrual care products (***Senate bill does not extend the protections to the purchase of menstrual care products***). *October 23 – H.R. 1922 was approved by the House Ways and Means Committee, as amended, by voice vote.*
Allowing Greater Access to Safe and Effective Contraception Act S. 930 Sen. Joni Ernst (R-IA)	***OTC Medications*** – Repeals the tax on OTC medications for HSAs, Archer MSAs, and HRAs; and repeals the cap on contributions for FSAs, among other things.
Faith in Health Savings Accounts Act of 2019 H.R. 2177 Rep. Mike Kelly (R-PA)	***Other* –** Treats membership in a health care sharing ministry as coverage under a HDHP for purposes of contributing to an HSA.
Freedom for Families Act	***Contribution Amount*** – Increases maximum contribution limit.

H.R. 2163 Rep. Andy Biggs (R-AZ)	***Other –*** Permits use of HSA funds during specific periods of "qualified caregiving" (e.g., the birth or adoption of a child/a family illness) in certain circumstances, among other things.
Homecare for Seniors Act H.R. 2878 Rep. Katie Porter (D-CA)	***Other –*** Permits use of HSA funds for certain in-home services for senior citizens (e.g., assistance with daily tasks such as eating, bathing, dressing, etc.).
Chronic Disease Management Act of 2019 S. 1948 Sen. John Thune (R-SD)	***Other –*** Permits high deductible plans required for a HSA to provide chronic disease prevention and treatment with no deductible.
Healthcare Freedom Act of 2019 H.R. 3594 Rep. Chip Roy (R-TX)	Renames HSAs to Health Freedom Accounts (HFAs); allows all individuals to contribute to HFAs; permits the purchasing of health insurance coverage with HFAs; allows individuals to use HFAs for additional medical expenses (e.g., costs associated with direct primary care, health care sharing ministries, and medical cost sharing organizations); permits amounts paid or distributed from a HFA to rollover into another HFA. ***Contribution Amount*** – Increases maximum contribution limit. ***Employer Contribution Exclusion*** – Clarifies that gross income of an employee does not include amounts contributed by an employer to a HFA.
Veterans Health Savings Account Act H.R. 3565 Rep. Paul Gosar (R-AZ)	***Eligibility*** – Requires that eligibility to contribute to HSAs not be affected by receipt of, or payment for, hospital care or medical services under any law administered by the Secretary of Veterans Affairs, including hospital care, medical services, and extended care services.
Primary Care Enhancement Act of 2019 S. 2999/H.R. 3708 Sen. Bill Cassidy (R-LA)/Rep. Earl Blumenauer (D-OR)	***Eligibility*** – Allows individuals with direct primary care service arrangements to remain eligible individuals for HSAs. *October 23 – House version was approved by the House Ways and Means Committee, as amended, by voice vote.*

Health Savings for Seniors Act H.R. 3796 Rep. Ami Bera (D-CA)	***Eligibility*** – Permits seniors enrolled in Medicare to continue using or create new HSAs; repeals the additional tax on distributions for Medicare beneficiaries; and repeals the Medicare limitation on deductions for contributions.
Keeping HSAs Accessible Act of 2019 H.R. 4130 Rep. Kenny Marchant (R-TX)	***Eligibility*** – Repeals the maximum deductible and out-of-pocket expense requirements for HSAs under high deductible health plans.
Health Savings Account Expansion Act of 2019 S. 2441 Sen. Ben Sasse (R-NE)	***Eligibility*** – Permits individuals enrolled in qualified health plans (e.g., including plans with coverage of benefits for no more than 80% of the full actuarial value of the benefits, and plans without deductibles for coverage such as preventive care, primary care, or prescription drug coverage) ***Contribution Amount*** – Increases maximum contribution limit.
Qualified Health Savings Account Distribution Act of 2019 S. 2440 Sen. Ben Sasse (R-NE)	***Other –*** Specifies certain conditions for the distribution of funds from HRAs and FSAs to HSAs; expands the allowable amount of such distributions.
Health Savings for Families Act of 2019 H.R. 4576 Rep. Jennifer Wexton (D-VA)	***Other*** – Permits HSA contributions from individuals with spouses who have FSAs if the aggregate reimbursements under such FSAs do not exceed the aggregate expenses which would be eligible for reimbursement under the FSA for that spouse.
American Future Healthcare Act of 2019 H.R. 4651 Rep. Steve King (R-IA**)**	***Eligibility*** – Repeals the requirement for an individual to be covered by a HDHP for HSA contributions. ***Contribution Amount*** – Increases the maximum contribution limit. ***Medicare Enrollment*** – Permits Medicare eligible individuals to contribute to an HSA and permits rollover of HSA amounts to a Medicare Advantage Medical Savings Account (MSA). ***Other*** – Allows individuals to use HSAs to purchase health insurance and allows certain primary care service fees to be treated as deductible medical expenses, among other things.

Primary Care Patient Protection Act S. 2793 Sen. Angus King (I-ME)	Allows high deductible health plan holders to have two deductible-free primary care visits each year.
Personalized Care Act of 2019 S. 3112/H.R. 5596 Sen. Ted Cruz (R-TX)/Rep. Chip Roy (R-TX)	***Eligibility*** – Allows individuals covered by group or individual health plans; other health insurance coverage (including STLDI and medical indemnity plans); government programs (i.e., Medicare, Medicaid, CHIP, etc.); and healthcare sharing ministries to remain eligible for HSAs. ***Contribution Amount* –** Increases maximum contribution limit. ***OTC Medications* –** Allows HSAs to cover OTC medications. ***Other* –** Permits the use of HSAs to pay health plan and insurance premiums, direct primary care expenses, certain medical care service arrangements, etc.; eliminates the requirement that a participant in an HSA be enrolled in an HDHP; and decreases the additional tax for HSA distributions not used for qualified medical expenses.
Patient Fairness Act of 2020 H.R. 5566 Rep. Warren Davidson (R-OH)	***Eligibility* –** Repeals the requirement for an individual to be covered by a HDHP for HSA contributions. ***Contribution Amount* –** Increases maximum contribution limits. ***OTC Medications*** – Allows HSAs to purchase OTC medications. ***Other*** – Allows individuals to use HSAs to purchase health insurance; establishes an exception for relatives acquiring an HSA after the beneficiary is deceased; and codifies HHS' hospital price transparency final rule.
Veteran Access to Direct Primary Care Act H.R. 6259 Rep. Chip Roy (R-TX)	***Other*** – Allows veterans to use HSAs for primary care services and any associated costs (e.g., physician fees, amounts paid/prepaid for certain medical services for wellness, and prescription or non-prescription drugs).
Health Savings Act of 2020 H.R. 6286 Rep. Michael Burgess (R-TX)	***Eligibility* –** Allows catastrophic and bronze plans to qualify for HSA contributions. ***Contribution Amount* –** Increases maximum contribution limits.

	Other – Permits a deduction for amounts paid to a designated child's HSA and simplifies HSA rollovers to children, parents, and surviving spouses.
Lower Health Insurance Deductibles Act S. 3439 Sen. Rick Scott (R-FL)	Allows high deductible health plan holders to divide annual deductibles between medical and drug costs in order to qualify for HSA contributions.

Mandate Reform/Alternatives

Family Health Care Affordability Act H.R. 1870 Rep. Susan Wild (D-PA)	Amends the ACA's affordability determinations to allow individuals with employer-sponsored health plans to receive ACA subsidies based on the affordability of family coverage, rather than self-only coverage, among other things.
Health Care Affordability Act H.R. 1868 Rep. Lauren Underwood (D-IL)	Expands eligibility for premium tax credits beyond 400% of the federal poverty line and increases the tax credit for all income brackets.
Employee Flexibility Act of 2019 S. 1510/H.R. 2782 Sen. Todd Young (R-IN)/Rep. Jackie Walorski (R-IN)	Amends the ACA's definition of a "full-time employee" to 40 hours per week, as opposed to 30 hours.
Family Coverage Act S.1935 Sen. Sherrod Brown (D-OH)	Amends eligibility requirements for minimum essential health coverage under eligible employer-sponsored health plans by preventing such coverage if the required contribution to the plan exceeds 9.86% (as opposed to 9.5%) of the applicable taxpayer's household income; defines the employee's required contribution as the portion of the annual premium (without regard to whether paid through salary reduction or otherwise) for self and family coverage (i.e., the contribution amount for families is determined by self-only coverage).
Commonsense Reporting Act of 2019 S. 2366/H.R. 4070 Sen. Mark Warner (D-VA)/Rep. Mike Thompson (D-CA)	Amends sections 6055 and 6056 of the Internal Revenue Code to streamline current employer requirements by establishing a voluntary prospective reporting system to report general employee information in forms 1094-C and 1095-C.

Fair Indexing for Health Care Affordability Act S. 2785/H.R. 5291 Sen. Jeanne Shaheen (D-NH)/Rep. Cynthia Axne (D-IA)	Shifts the indexing factor used to determine eligibility for the ACA's premium tax credits back to premium growth from employer-sponsored plans (as opposed to premium growth across all private plans, as was finalized under the recent Trump Administration rule).
Advancing Youth Enrollment Act S. 2735/H.R. 4927 Sen. Tammy Baldwin (D-WI)/Rep. Donald McEachin (D-VA)	Increases premium tax credits that are available to taxpayers with household members who are 18-34 years old.
American Healthshare Plans Act of 2020 S. 3610/H.R. 6712 Sen. Rand Paul (R-KY)/Rep. John Curtis (R-UT)	Amends the ERISA definition of employers to allow any membership organization to offer group insurance coverage or group health plans to its members (i.e., allowing smaller employers to enter the large group market) subject to employer-sponsored coverage requirements.

Antitrust

Competitive Health Insurance Reform Act of 2019 S. 350/H.R. 1418 Sen. Steve Daines (R-MT)/Rep. Peter DeFazio (D-OR)	Amends McCarran-Ferguson to clarify that it does not modify or supersede any antitrust laws with respect to health insurance.

Interstate Sales

Stop-Loss

Essential Health Benefits

No Health Care, No Raise Act H.R. 3271 Rep. Josh Harder (D-CA)	Annually prohibits pay raises for Members of Congress unless HHS certifies that all U.S. citizens for the previous year were enrolled in health insurance coverage that minimally provided ACA essential health benefits.

ACA Market Reforms

Continuing Coverage for Preexisting Conditions Act S. 3383/H.R. 383 Sen. John Kennedy (R-LA)/Rep. David Joyce (R-OH)	Ensures that the ACA's prohibition against preexisting condition exclusions is protected if the ACA is found to be unconstitutional or otherwise invalid.
Preexisting Conditions Protection Act H.R. 692 Rep. Greg Walden (R-OR)	Maintains the ACA's consumer protections (e.g., preexisting condition coverage, non-discrimination requirements, genetic information collection prohibitions, wellness provisions), if the ACA is repealed.
Protect Act S. 1125 Sen. Thom Tillis (R-NC)	Guarantees the availability of coverage in the individual or group market, regardless of preexisting conditions (i.e., requires insurers offering coverage in the individual or group markets—subject to limited exceptions—to accept all individuals/employers who apply during the enrollment period); prohibits discrimination against patients based on health status, among other things.
Affordability is Access Act S. 1847/H.R. 3296 Sen. Patty Murray (D-WA)/Rep. Ayanna Pressley (D-MA)	Expands group and individual health plan coverage of preventative services to over-the-counter contraceptives, among other things.
Maintaining Protections for Patients with Preexisting Conditions Act of 2019 H.R. 4159 Rep. Denver Riggleman (R-VA)	If the ACA is rendered unconstitutional in Texas v. United States, ensures that certain pre-existing condition protections will be maintained for health insurance market participants. (i.e., retains prohibitions on denying coverage or restricting eligibility on the basis of status-related health factors like medical conditions, claims experience, medical history, genetic information, etc.); and ensures enforcement of such protections.
No More Narrow Networks Act of 2020 H.R. 6135 Rep. Jan Schakowsky (D-IL)	Requires HHS to establish network adequacy standards for qualified health plans offered through exchanges.

Short-Term, Limited-Duration Insurance

H.R. 1010 Rep. Kathy Castor (D-FL)	Prevents the Departments of Health and Human Services, Treasury, and Labor from implementing, enforcing, or giving effect to the Administration's final rule on STLDI plans and from promulgating any substantially similar rule. *February 13 – A hearing was held on the legislation.* *March 27 – Approved by the Energy and Commerce Subcommittee on Health by a vote of 19-13.* *April 3 – Approved by the Energy and Commerce Committee by a vote of 30-22.* *April 9 – Approved by the Education and Labor Committee by a vote of 26-19.*
Educating Consumers on the Risks of Short-Term Plans Act of 2019 H.R. 1143 Rep. Anna Eshoo (D-CA)	Preempts state laws governing STLDI plans; requires health insurance issuers offering STLDI plans to disclose certain information to consumers (e.g., such plans may not cover preexisting conditions or the cost of medical services, coverage may be rescinded if the consumer seeks treatment for a preexisting condition, etc.); prevents a health insurance issuer from enrolling any individual in an STLDI plan during any ACA-qualifying open enrollment period, among other things. *February 13 – A hearing was held on the legislation.*
Affordable Limited Health Coverage Act H.R. 458 Rep. Jeff Fortenberry (R-NE)	Prohibits the Departments of Health and Human Services, Treasury, and Labor from implementing the Obama Administration's final rule on the definition of STLDI; requires the Departments to use the definition of STLDI in use immediately prior to publication of the rule.
No Junk Plans Act S. 1556 Sen. Tammy Baldwin (D-WI)	Prevents the Departments of Health and Human Services, Treasury, and Labor from implementing, enforcing, or giving effect to the Administration's final rule on STLDI plans and from promulgating any substantially similar rule.

Association Health Plans

Association Health Plans Act of 2019 S. 1170/H.R. 2294	Codifies DOL's AHP rule and further clarifies that participating in an AHP does not establish a joint employer relationship under federal or state law—a topic that was discussed in the final rule, but not formally incorporated into the DOL's regulations.

Sen. Mike Enzi (R-WY)/Rep. Tim Walberg (R-MI)	

Balance Billing

End Surprise Billing Act of 2019 H.R. 861 Rep. Lloyd Doggett (D-TX)	***Covered Plans*** – Individual and group plans. ***Emergency Services*** – Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility when there is not at least 24 hours' notice (describing OON services and out-of-pocket costs) and the patient's consent, or if the patient receives same-day emergency services. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for in-network cost-sharing amount.
No Surprises Act H.R. 3630 Rep. Frank Pallone (D-NJ)	***Covered Plans*** – Individual and group plans. ***Emergency Services*** – Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. ***Non-Emergency Services*** – For plan years beginning Jan. 1, 2021, prohibits balance billing for OON provider services performed at an in-network facility. ***Exceptions*** – Beginning in 2021, subjects providers who seek to balance bill patients in the above scenarios to civil monetary penalties, except in non-emergency circumstances when the patient's treatment is scheduled in advance if: • The provider furnishes and the patient receives advance oral and written notice of the provider's OON status and the estimated amount the patient will be charged for the item/service involved; and • The patient consents in writing at least 24 hours prior to the treatment by the OON provider and acknowledges that receipt of such services may result in charges greater than if the services were furnished by an in-network provider. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for in-network cost-sharing amount. ***Minimum Payment by Carrier/Plan*** – OON provider automatically gets paid the plan's median in-network rate, less the patient's cost-sharing amount. ***Dispute Resolution*** – No specific process established. ***Transparency*** – Provides $50 million in state grants to develop/maintain all-payer claims databases. ***Preemption/Role of States*** – Permits states to set a different minimum carrier payment/methodology for plans they regulate.

	June 12 – A hearing was held on the legislation. *July 11 – Approved by the House Energy and Commerce Subcommittee on Health by voice vote.*
Lower Health Care Costs Act of 2019 S. 1895 Sen. Lamar Alexander (R-TN)	***Covered Plans*** – Individual and group plans. ***Emergency Services***. Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. For patients initially admitted for emergency services or for maternal care for labor, prohibits balance billing for follow-up, non-emergency care unless, post-stabilization, the patient receives notice that the hospital/provider is OON and the patient consents the post-stabilization services. ***Non-Emergency Services***. Prohibits balance billing for OON services at an in-network facility. Prohibits balance billing for OON "ancillary, non-emergency services" (e.g., services provided by intensivists, radiologists, neonatologists, etc.) performed at in-network facilities, unless, within 48 hours, notice is provided to the patient that the service will be provided OON and the patient consents to receive the service. ***Air ambulance Services –*** Prohibits balance billing for OON air ambulance services.. ***Cost Sharing*** – In situations when balance billing is prohibited, limits the consumer's responsibility/liability to the in-network cost-sharing amount. (provides for penalties up to $10,000 for each time a provider/facility sends an enrollee a bill for more than this amount -- safe harbor for unknowing violations with cure within 30 days). ***Payment Processes*** – Beginning in the second plan year that begins after the date of enactment, in situations where balance billing is prohibited, requires plans to automatically pay to the OON provider or facility the median in-network rate, using a methodology to be prescribed by HHS, based on the same or similar services offered by the group health plan or health insurance issuer in that geographic region; or, for plans/issuers without sufficient data to determine an in-network median rate, a regional database-based rate. Note that the "geographic area" used to establish the benchmark rate for air ambulance services may be different than the geographic area used for in-facility services. ***Preemption/Role of States*** – For insured plans, states may establish or continue in effect alternate methods for determining compensation for OON services described in the bill (e.g., arbitration processes and/or benchmark minimum payments). For self-insured plans not subject to state regulation, the bill's approach applies. ***Transparency*** – Incorporates various plan transparency requirements (e.g., providing plan participants with "good faith" estimates of cost-sharing

	responsibility, verifying and updating provider directory information at least every 90 days, etc.) With respect to the directory, requires providers to have in place business processes to ensure the timely provision of provider directory information to plans to support maintenance of the provider directories. *June 18 – A hearing was held on the legislation.* *June 26 – Approved by the Senate Committee on Health, Education, Labor and Pensions, as amended, by a vote of 20-3.*
STOP Surprise Medical Bills Act S. 1531 Sen. Bill Cassidy (R-LA)	***Covered Plans*** – Individual and group plans. ***Emergency Services*** – Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. ***Non-Emergency Services*** – Prohibits balance billing for procedures/services at in-network facilities performed by OON providers. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for in-network cost-sharing amount. ***Minimum Automatic Payment by Carrier/Plan*** – OON provider automatically gets paid the plan's median in-network rate, less the patient's cost-sharing amount. ***Dispute Resolution*** – Creates an independent dispute resolution process. If a provider challenges the automatic carrier payment, it has 30 days to initiate arbitration proceedings with the carrier (patient does not participate). Parties submit final offers to arbitrator; arbitrator decides "the more reasonable amount" between offers based on "commercially reasonable rates" (based on in-network rates) within that area. For group plans, costs of arbitration count toward medical care costs for MLR. ***Transparency*** – Requires plans/issuers to put in-network and OON deductibles and out-of-pocket maximums on insurance cards and by 2021, include price and benefits information on their website for services at all in-network sites of care; requires all group health plans report annually to HHS and DOL on in-network and OON claims, out-of-pocket costs for OON claims, and number of OON claims reported for emergency services and at in-network facilities; requires plans/issuers and providers provide to enrollees/patients estimated cost-sharing amounts for elective services within 48 hours of enrollee/patient request (or for providers, at the time of scheduling); and requires hospitals disclose on its websites, in materials for any profit-sharing arrangements with physician groups, and include in bills to patients ancillary services provided (e.g., lab technicians). ***Preemption/Role of States*** – Does not prohibit states from enacting protections "greater than" those in the bill. For insured plans, states may create their own minimum payment/dispute resolution processes (if they do not, the bill's processes apply), but these states must still rely on the bill's general balance billing prohibitions.

	Miscellaneous – Requires HHS study the impact of the legislation.
Medical Billing Fairness Act of 2019 S. 1607 Sen. John Kennedy (R-LA)	Requires hospitals to give patients the opportunity to opt for in-network care when scheduling non-emergency treatment; and requires hospitals pay any additional cost to the patient, group health plan, or group or individual health insurer if the scheduled treatment resulted in OON charges.
Protecting People From Surprise Medical Bills H.R. 3502 Rep. Raul Ruiz (D-CA)	***Covered Plans*** – Self-funded, FEHBPs, and all fully-insured plans in states that do not have balance billing protection laws/regulations. ***Emergency Services*** – Prohibits balance billing for emergency services performed at both an in-network and OON provider/facility. ***Non-Emergency Services*** – Prohibits balance billing for scheduled anticipated procedures/services performed by unanticipated OON providers; OON after-emergency services when a patient can't travel without medical transport; OON imaging or lab services when ordered by an in-network provider. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for the in-network cost-sharing amount and deductible. ***Minimum Payment by Carrier/Plan*** – Requires the plan/issuer pay the provider a commercially reasonable rate within 30 days. ***Direct Negotiation*** – If the provider or insurer is dissatisfied with the commercially reasonable rate, they have 30 days to privately settle on a payment amount. ***Dispute Resolution*** – Establishes an Independent Dispute Resolution Process (IDR); requires the IDR be completed within 60 days (including 30 days for both parties to submit supporting documents, and 30 days for the arbiter to render a decision); if the parties reach a settlement prior to completion of the IDR, they must split the costs associated with the IDR; requires any payment owed by one party to the other be made within 15 calendar days; and requires the final judgment of the arbitrator on the reasonable amount be binding and enforceable in any court with subject matter jurisdiction, and not subject to appeal unless it is determined that fraudulent or corrupt actions have been taken by any of the parties involved in the IDR process. ***Transparency*** – Requires group health plans to clearly print in-network and OON deductible amounts on insurance cards; requires HHS establish transparency standards (e.g., a requirement that plans offer provider directories online and in print; annual audits of provider directories; monthly updates of the online directory; and disclosures on accuracy of the print directories). ***Reporting Requirements*** – Requires group health plans and issuers annually report the following information to HHS and DOL: • The number of claims submitted by in-network and OON providers, including how many of those claims were paid and how many were denied; • Total amount of patient out-of-pocket costs for OON services; and

	• The number of unanticipated care out-of-pockets claims for OON and in-network care. ***Hold Harmless*** – A patient cannot be held responsible for OON costs if the patient could not have reasonably known they were OON because insurers are not compliant (i.e., if a patient checks the website and verifies with the plan that they are in-network, they cannot be balance billed if that turns out not to be true) ***Preemption/Role of States*** – The bill does not apply to states that have laws or regulations that prohibit balance billing or otherwise provide an alternate method for resolving a dispute between a health plan and provider, as long as the state law does not require an individual to pay more in cost-sharing than the amount required for such individual under this bill. ***Penalties*** – Subjects providers and insurers to a civil monetary penalty if the patient has not been reimbursed the amount they were balance billed within 30 days of the provider or insurer being made aware of the error. ***Billing Statute of Limitation*** – Prohibits a provider from billing a patient for any services more than one year after such date of service; subjects providers to a civil monetary penalty for violating the statute of limitation.
Air Ambulance Affordability Act of 2019 H.R. 3784 Rep. Joe Neguse (D-CO)	***Covered Plans*** – Individual and group plans. ***Emergency Air Ambulance Services*** – Prohibits balance billing for air ambulance services provided to a beneficiary with an emergency medical condition. ***Non-Emergency Air Ambulance Services*** – Permits plans to balance bill for non-emergency air ambulance services if the plan provides to the beneficiary, by the date of the services, the following information: • An oral explanation of the services and charges; • A written notice stating the provider is a non-participating provider for air ambulance services, which must be signed by the beneficiary or by a representative of the beneficiary no less than 24 hours prior to the services being provided; • The estimated charges the beneficiary will need to pay for those services; and • Any other appropriate documentation as determined by HHS. ***Dispute Resolution*** – Establishes an Independent Dispute Resolution Process (IDR); requires an arbiter to determine the amount the health plan is required to pay a nonparticipating provider or facility no later than 30 days after receiving an IDR request from a provider or health plan; if the parties reach a settlement prior to completion of the IDR, the arbiter is permitted to direct the parties to attempt a good faith negotiation within 10 days, which accrues toward the 30-day period; requires any payment owed by one party to the other be made within 30 days; and requires the final judgment of the arbitrator on the reasonable amount be binding and enforceable in any court with subject matter jurisdiction, and not subject to appeal unless it is determined that fraudulent or corrupt actions have been taken by any of the parties involved in the IDR process.

	Cost Sharing – For emergency air ambulance services, a patient is responsible for the in-network cost-sharing amount and requires plans to calculate such cost-sharing amount as if the negotiated rate that would have been charged by a participating provider, or were equal to the amount determined through the IDR. ***Preemption/Role of States*** – Preempts state laws if the state law requires the beneficiary to pay more than the cost-sharing amount. ***Penalties*** – Subjects providers and insurers to a civil monetary penalty if they hold an individual liable for a payment amount that is more than the cost-sharing amount for air-ambulance services.
Protecting Patients from Surprise Medical Bills Act H.R. 4223 Rep. Ross Spano (R-FL)	***Covered Plans*** – Self-insured group health plans. ***Emergency Services*** – Prohibits balance billing for emergency services performed by an OON provider and/or at an OON facility. ***Non-Emergency Services*** – Prohibits balance billing for non-emergency services at an in-network facility provided by any physicians or professionals within that facility (i.e., OON physicians at in-network facilities) if the beneficiary did not have the ability or opportunity to go elsewhere. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for in-network cost-sharing amount. ***Payments*** – A self-insured group health plan must reimburse a provider of OON emergency and non-emergency services based on the following payment methods: • The amount of the claim made by the provider; • The usual and customary amount charged by the provider for similar services in the community where the services were provided; and • The amount mutually agreed to by the plan and the provider during the 60-day period after the claim is submitted. ***Voluntary Binding Arbitration*** – If a self-insured group health plan and provider are unable to resolve a dispute, the provider may voluntarily initiate binding arbitration if the claim involves health care services over $3,000 and/or professional services over $500; permits the plan or provider to make an offer to settle the claim; requires a plan or provider to respond within 15 days after receipt of a settlement offer; permits parties to settle a claim at any time, for any amount, regardless of whether an offer to settle was made or rejected; if the party receiving a settlement offer does not accept such offer, and the arbitrator issues a final order that is more than 90% or less than 110% of the offer amount, the party receiving the offer must pay the arbitration costs; and subjects parties to a monetary penalty each day the final amount is not paid. ***Transparency*** – Requires self-insured group health plans to publish on their website a monthly updated list of network providers; and requires self-insured group health plans provide an annual notification to beneficiaries on balance billing when using OON providers.

Consumer Protections Against Surprise Medical Bills Act of 2020 H.R. 5826 Rep. Richard Neal (D-MA)	***Covered Plans*** – Individual and group plans. ***Emergency Services*** – Prohibits balance billing for services performed by an OON provider and/or at an OON facility. ***Non-Emergency Services*** – Prohibits balance billing for non-emergency services from an OON provider and/or at an OON facility. ***Cost-Sharing*** – In situations when balance billing is prohibited, limits the consumer's responsibility/liability to the in-network cost-sharing amount and requires plans to pay those providers the difference between the patient's in-network rate and a benchmark minimum rate (established by the state, based on the median contracted rate, approved by the state, or—for self-insured group plans with agreements with the state—the amount payable as determined by the agreement). ***Dispute Resolution*** – Establishes a two-step dispute resolution process which: (1) allows either party to initiate a 30-day "open" negotiation during which the plan and provider will exchange information (e.g., the median in-network rate, the median reimbursement amount, etc.); and (2) if the open negotiations fail, allows either party to initiate the mediated dispute process to resolve the dispute within 30 days. Though some details are left to HHS (e.g., batching of similar claims, creating a process to transition from the open negotiation to mediation, establishing a process to certify the third-party mediators, etc.), broadly requires selection of and administration by an unbiased third party (i.e., a "selected independent entity"); each party—within 10 days of initiating the mediation—to put forth their "best and final" offer and supporting information to substantiate it; and the "selected independent entity" to select/approve one of the offers following consideration of the median contracted rate and the supporting information provided by the parties. ***Transparency*** – Incorporates various plan transparency requirements (e.g., maintaining a price comparison tool for consumers, etc.). *February 12 – Approved by the House Ways & Means Committee, as amended, by a unanimous voice vote.*
Ban Surprise Billing Act H.R. 5800 Rep. Bobby Scott (D-VA)	***Covered Plans*** – Individual and group plans. ***Emergency Services*** – Prohibits balance billing for emergency services provided by an OON provider and/or at an OON facility. ***Non-Emergency Services*** – Prohibits balance billing for certain ancillary services (e.g., services related to pathology, radiology, anesthesiology, and neonatology) provided by an OON provider and/or at an OON facility. ***Air Ambulance Services*** – For plan years beginning Jan. 1, 2022, prohibits balance billing for air ambulance services provided by an OON provider.

	Dispute Resolution – Requires HHS (with DOL and Treasury) to establish by regulation an independent dispute resolution (IDR) process to determine payment amounts that uses the following framework: • Requires providers/facilities to exhaust internal dispute resolution mechanisms (i.e., the provider/facility must have filed an appeal with the plan's appeals process to dispute the payment) and requires plans to notify providers/facilities of their intent to dispute the payment. • Allows either entity to then request that the required payment amount be increased or decreased. • Selects/assigns an unbiased/unaffiliated third-party entity that is certified by HHS (i.e., a "certified IDR entity") to resolve the request. • If the certified IDR entity determines that a settlement is likely, allows the entity to direct the parties to attempt a good faith negotiation for settlement. • In the event that a settlement is not reached with respect to such request, requires both parties to submit a final offer to be considered. • Requires the certified IDR entity to determine an alternative payment following consideration of several factors (e.g., median contracted rates, level of training/experience of the provider, extenuating circumstances, demonstration of good faith efforts, etc.). Prohibits submission of a request under the IDR process, unless the median contract rate for the item/service is at least $750 (or, in the case of air ambulance services, $25,000) (adjusted for inflation). ***Transparency*** – Incorporates various plan transparency requirements, among other things (e.g., including on insurance identification cards the amount of the in-network and OON deductibles and out-of-pocket limitations under the plan. *February 11 – Approved by the House Education & Labor Committee, as amended, by a vote of 32-13.*
Continuing Care for Patients Act of 2020 H.R. 5816 Rep. Gwen Moore (D-WI)	If an individual is receiving continuous care from a provider/facility with a contractual relationship to their insurer—and if such relationship, benefits/coverage, or contract is terminated—requires the insurer to notify such individual regarding the termination and allows the patient to elect to continue their coverage/treatment under the same terms and conditions, among other things. ***Mirrors part of the Consumer Protections Against Surprise Medical Bills Act of 2020.***

Healthcare Transparency

Health Care Price Check Act of 2019 S. 1497 Sen. Ron Wyden (D-OR)	Requires group and individual health plan insurers to establish a toll-free telephone number for enrollees to directly receive information regarding the quality of in-network providers and facilities, and the following information regarding out-of-pocket costs, among other things: • The out-of-pocket costs for a specific covered benefit provided by an in-network provider or facility and other covered benefits; and • An explanation of the cost-sharing components (e.g., deductibles, copayments, and coinsurance).

Know the Price Act of 2019 S. 1577/H.R. 6005 Sen. Bill Cassidy (R-LA)/Rep. Tom Malinowski (D-NJ)	Prohibits group and individual insurance plans or issuers from entering into contracts with providers that would restrict the plan or issuer from providing price or quality information and restricts issuers from sharing data with a third party for plan management purposes.
Healthcare Cost Transparency Act H.R. 5121 Rep. Don Beyer (D-VA)	Requires all health insurers to maintain a price comparison tool for enrollees to compare cost-sharing information.
Insurance Accountability and Transparency Act H.R. 5144 Rep. Sharice Davids (D-KS)	Requires group health plans and insurers to update their publicly available provider directories at least once every six months.
Know Where To Go In An Emergency Act H.R. 5192 Rep. Don Beyer (D-VA)	Requires group health plans and insurers to include information about the nearest in-network hospital or urgent care facility on enrollee's insurance cards.
Know Your Provider Act of 2020 H.R. 5807 Rep. John Larson (D-CT)	Requires insurers to: • Establish business processes to ensure that all enrollees receive proof of a provider's network status upon request (including a real-time, online provider directory search tool maintained by the plan); • Establish business processes to verify and update—at least every 90 days—the provider directory information; • Provide plan participants with a "good faith" estimate of their cost-sharing responsibility for a specific service/item within 2 days of a request; and • Include on insurance identification cards the amount of the in-network and OON deductibles and out-of-pocket limitations under the plan. ***Mirrors part of the Consumer Protections Against Surprise Medical Bills Act of 2020.***
Transparent Health Care Pricing Act of 2020 S. 3318/H.R. 5916 Sen. Bill Cassidy (R-LA)/Rep. Mike Gallagher (R-WI)	Requires healthcare providers and insurers publicly disclose on the internet the point-of-sale cash prices for items, products, services, and procedures.
Transparency and Accountability in Health Care Costs and Prices Act of 2020 H.R. 6004 Rep. Dan Lipinski (D-IL)	Appropriates $100 million to HHS to establish a grant program for the purposes of facilitating state efforts to create, maintain, or expand all-payer claims databases.

Multi-Issue Bills

Keeping Health Insurance Affordable Act of 2019 S. 3 Sen. Ben Cardin (D-MD)	Appropriates $2 billion to HHS for the purposes of establishing a public health insurance option that offers bronze, silver, and gold ACA-compliant plans on the exchanges alongside private health plans; establishes a permanent Individual Market Reinsurance program; and permanently appropriates funds for cost-sharing reductions, among other things.
Fair Care Act of 2019 H.R. 1332 Rep. Bruce Westerman (R-AR)	Implements several private-sector health insurance reforms, including, among other things: • Appropriates $200 billion over 10 years to establish an invisible high risk pool reinsurance program; • Increases the baseline age band rating ratio from 3:1 to 5:1; • Repeals the employer mandate; • Requires employers with 100+ employees to provide certain information to those beneficiaries annually; • Amends 1332 waiver requirements to streamline the application process, facilitate expedited determinations, increase the waiver's duration etc.; • Codifies existing regulations related to STLDI plans (i.e., setting a maximum duration of 12 months, guaranteed renewability, etc.); • Appropriates $10 million to fund research/pilot programs focused on promoting interstate health insurance sales; • Amends McCarran-Ferguson to clarify that it does not exempt the business of health insurance from federal antitrust laws; • Reinstates CSR payments and authorizes HHS to approve 1332 waivers to provide funds equivalent in amount to those that would be distributed; through CSRs for the sole purpose of redistributing them to HSAs of individuals/families with incomes below 250% of the federal poverty line; • Permits all policyholders (i.e., even those without HDHPs) to contribute to/qualify for HSAs; • Codifies existing regulations related to AHPs; and • Repeals certain ACA taxes (e.g., Cadillac tax, health insurance tax, medical device tax, etc.).
Protecting Pre-Existing Conditions and Making Health Care More Affordable Act of 2019 H.R. 1884 Rep. Frank Pallone (D-NJ)	Implements several private-sector health insurance reforms, including, among other things: • Expands eligibility for premium tax credits beyond 400% of the federal poverty line/eliminates the income cap and increases the tax credit for all income brackets; • Bases affordability determinations for families on the amount they would pay for family coverage, rather than self-only coverage; • Reverses the Administration's expansion of AHPs and STLDI plans and prevents issuance of any "substantially similar rule"; • Stalls the Administration's efforts to allow substitution of benefits across benefit categories (along with other EHB reforms) in the 2019 Benefit and Payment Parameters proposed rule and requires HHS to—by rule—establish standard benefit plans for each level of coverage; • Along with imposing other requirements on navigators (e.g., requiring them to maintain a physical presence in the state in which the contract is awarded), requires HHS to implement a navigator program for the federally-facilitated exchange and funds it at $100 million/year; • Appropriates $100 million for ACA-related education and outreach efforts on the federally-facilitated exchange and prohibits the funds from being used to promote non-ACA compliant health insurance plans (e.g., AHPs and STLDI plans);

	• Appropriates $10 billion in annual funding to be allocated to states for one of two purposes: (1) establish a reinsurance program; or (2) provide financial assistance to reduce out-of-pocket costs for participants enrolled in QHPs offered on the individual market through an exchange; • Renders ineffective the Administration's guidance related to 1332 waivers and prevents issuance of any "substantially similar guidance or rule;" • Appropriates $100 million in Consumer Assistance Program grants to support educational activities regarding health insurance; • Establishes a grant program to enable states to explore innovative solutions to promote greater enrollment in the individual and small group markets and appropriates $200 million for such grants; • Appropriates $200 million to award grants to states that are currently participating on the federally-facilitated exchanges that want to transition to a state-based marketplace; and • Requires HHS to report to Congress on how it is spending the funds raised from user fees levied on "participating issuers."
Consumer Health Insurance Protection Act S. 1213 Sen. Elizabeth Warren (D-MA)	Implements several private-sector health insurance reforms, including, among other things: • Increases the medical loss ratio offered by a health insurer in the individual/small group markets to 85% (from 80%); • Funds CSRs (among other changes to the eligibility for/operation of CSRs); • Implements a framework requiring states and HHS to develop a "standardized option" for bronze, silver, and gold levels of coverage; • Amends the affordability determination for employer-sponsored coverage (i.e., lowers the maximum required contribution from 9.5% of taxable income to 8.5%); • Establishes a network adequacy standard for QHPs; requires QHPs to cover out-of-network EHB services, provided certain circumstances are present; qualifies STLDI plans as individual health insurance coverage; • Requires employer plans to cover certain services before the deductible is met, including primary care and specialist visits; • Prohibits substitution of EHBs across benefit categories; qualifies AHPs as individual/small group market coverage (notwithstanding state law) if (1) coverage is offered to an AHP member other than in connection with a group health plan, and (2) coverage is offered to an AHP member that has fewer than 2 participants who are employees on the first day of the plan year; prevents the DOL from enforcing its final rule on AHPs; • Other market reforms addressing affordability (e.g., preventing "unreasonable increases" in premiums, expanding eligibility for premium tax credits, capping prescription drug cost-sharing), access (e.g., setting minimum duration of annual open enrollment periods, encouraging enrollment through marketing/outreach programs, ensuring adequate coverage in areas with fewer than 3 carriers); and consumer protection (e.g., addressing consumer data, treatment of emergency services, and provider terminations), among other things.
Flexibility Through Lower Expenses Health Care (FLEX) Act H.R. 4484 Rep. Ted Budd (R-NC)	Codifies the Administration's final rules on STLDI plans and AHPs.

Section 1332 Waivers

Protecting Americans with Preexisting Conditions Act S. 466/H.R. 986 Sen. Mark Warner (D-VA)/Rep. Ann Kuster (D-NH)	Prohibits HHS and Treasury from implementing, enforcing, or giving effect to the agencies' 2018 "State Relief and Empowerment Waivers" guidance; prevents the agencies from promulgating any similar guidance or rule, among other things. *February 13 – A hearing was held on H.R. 986.* *March 27 – H.R. 986 approved by the Energy and Commerce Subcommittee on Health by a vote of 19-13.* *April 3 – H.R. 986 approved by the Energy and Commerce Committee by voice vote.* *May 9 – H.R. 986 was approved by the House—as amended—by a vote of 230-183.*
State Flexibility and Patient Choice Act of 2019 H.R. 2183 Rep. Roger Marshall (R-KS)	Amends Section 1332 of the ACA by creating an expedited process for states applying for state innovation waivers (i.e., requires HHS to make a determination in 90 days instead of 180 days, or within 60 days if the waiver is submitted in response to an urgent situation/is similar to that of a state that has already been approved by HHS), among other things.
Premium Reduction Act of 2019 S. 1868 Sen. Susan Collins (R-ME)	Amends Section 1332 of the ACA by requiring HHS to allocate grants to states that have received a Section 1332 waiver to establish an invisible high-risk pool or reinsurance program; appropriates $500 million in fiscal year 2020 and $5 billion annually for fiscal years 2021 – 2023 for such grants; allows states without approved Section 1332 waivers to receive grants and pass through funding in 2021; expedites the approval process (i.e., requires HHS to make a determination in 90 days instead of 180 days) for state pools based on the Maine and Alaska invisible high-risk insurance pool model, a traditional reinsurance model, or other model for which a Section 1332 waiver has been approved, among other things.
State-Based Universal Health Care Act of 2019 H.R. 5010 Rep. Ro Khanna (D-CA)	Establishes an ACA waiver program for certain states (e.g., states that have not applied for a 1332 waiver) to create state-based universal health care plans.

Blanket Repeal

Responsible Path to Full Obamacare Repeal Act H.R. 83 Rep. Andy Biggs (R-AZ)	Repeals the ACA in its entirety.
ObamaCare Repeal Act H.R. 185 Rep. Steve King (R-IA)	Repeals the ACA in its entirety.
H.R. 2536 Rep. Bill Flores (R-TX)	Repeals the ACA in its entirety.

Miscellaneous

Transparency and Accountability of Failed Exchanges Act H.R. 59 Rep. Rick Allen (R-GA)	In the event a state-awarded exchange fails/is terminated, requires the state to (1) provide audits of the use of grant funds and (2) return unused funds to the federal government.
Protection from Obamacare Mandates and Congressional Equity Act H.R. 90 Rep. Andy Biggs (R-AZ)	Provides an exemption to the ACA's individual mandate for individuals residing in counties with fewer than two health insurance issuers offering plans on an exchange; expands the requirement that members of Congress and certain congressional staff purchase coverage on the exchange to include committee staffers, political appointees, the President and Vice President, and others.
Care for All Act H.R. 456 Rep. Jeff Fortenberry (R-NE)	Allows catastrophic health plans to be offered as QHPs to any individual in the individual or group market.

Holding Health Insurers Harmless Act H.R. 352 Rep. Ted Yoho (R-FL)	Provides a safe harbor from the ACA's penalties to health insurers that offer plans that are not ACA-compliant.
H.R. 518 Rep. Steve King (R-IA)	Bans the Supreme Court from citing certain ACA-related cases (e.g., *NFIB v. Sebelius*, *King v. Burwell*, and *Burwell v. Hobby Lobby*) in future decisions.
Marketing and Outreach Restoration to Empower (MORE) Health Education Act of 2019 S. 455/H.R. 987 Sen. Jeanne Shaheen (D-NH)/Rep. Lisa Blunt Rochester (D-DE)	Appropriates $100 million in annual funding for ACA-related education, marketing, and outreach efforts; prohibits the funds from being used for non-ACA compliant health insurance plans (e.g., AHPs and STLDI plans), among other things. *March 27 – H.R. 987 approved by the Energy and Commerce Subcommittee on Health by voice vote.* *April 3 – H.R. 987 approved by the Energy and Commerce Committee—as amended—by a vote of 30-22.* *May 16 – H.R. 987 was approved by the House—as amended—by a vote of 234-183.*
Responsible Additions and Increases to Sustain Employee (RAISE) Health Benefits Act of 2019 S. 503/H.R. 1366 Sen. Roy Blunt (R-MO)/Rep. Steve Stivers (R-OH)	Increases the annual cap for contributions to FSAs and allows participants to rollover any unused balance in perpetuity.
Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act S. 1905/H.R. 1386 Sen. Tammy Baldwin (D-WI)/Rep. Kathy Castor (D-FL)	Requires Navigators to meet certain additional requirements to receive state funding (e.g., Navigators must demonstrate how they will provide individuals with information on STLDI plans and AHPs); requires Navigators to maintain a physical presence in the state in which the contract is awarded; and restores funding for the Navigator program and for consumer outreach/advertising to ACA-mandated levels. *March 6 – A hearing was held on the legislation.* *March 27 – Approved by the Energy and Commerce Subcommittee on Health by voice vote.* *April 3 – Approved by the Energy and Commerce Committee—as amended—by a vote of 30-22.*

State Allowance for a Variety of Exchanges (SAVE) Act S. 1400/H.R. 1385 Sen. Bob Menendez (D-NJ)/Rep. Andy Kim (D-NJ)	Appropriates $200 million to award grants to states that are currently participating on the federally-facilitated exchanges that want to transition to a state-based marketplace. *March 6 – A hearing was held on the legislation.* *March 27 – Approved by the Energy and Commerce Subcommittee on Health by voice vote.* *April 3 – Approved by the Energy and Commerce Committee—as amended—by a vote of 29-22.*
State Health Care Premium Reduction Act H.R. 1425 Rep. Angie Craig (D-MN)	Appropriates $10 billion in annual funding to be allocated to states for one of two purposes: (1) establish a reinsurance program; or (2) provide financial assistance to reduce out-of-pocket costs for participants enrolled in QHPs offered on the individual market through an exchange. *March 6 – A hearing was held on the legislation.* *March 27 – Approved by the Energy and Commerce Subcommittee on Health—as amended—by a vote of 18-13.* *April 3 – Approved by the Energy and Commerce Committee—as amended—by a vote of 30-22.*
Ensuring Lasting Smiles Act S. 560/H.R. 1379 Sen. Tammy Baldwin (D-WI)/Rep. Collin Peterson (D-MN)	Requires group and individual health plans to provide coverage for medically necessary treatment of a congenital anomaly or birth defect.
Premium Relief Act of 2019 H.R. 1510 Rep. Michael Burgess (R-TX)	Establishes the Patient and State Stability Fund to provide states health benefits coverage funding (e.g., providing financial assistance for high-risk individuals, incentives for certain entities to work with states to stabilize premiums, etc.); requires states to submit applications for the funds; appropriates $2.5 billion annually from 2020-2022 for such funding, among other things.
Marketplace Certainty Act S. 961 Sen. Jeanne Shaheen (D-NH)	Permanently appropriates funding to restore CSR payments; expands cost-sharing reduction assistance to certain households, among other things.

Improving Health Insurance Affordability Act S. 964 Sen. Jeanne Shaheen (D-NH)	Expands eligibility for the ACA's premium tax credit to households that are 800% of the federal poverty level (previously capped at 400%), among other things.
Reducing Costs for Out-of-Network Services Act S. 967 Sen. Jeanne Shaheen (D-NH)	Caps the amount that hospitals/physicians can charge out-of-network patients who have coverage in the individual market and uninsured patients; authorizes HHS to award grants to states to study potential ways to limit charges on health care services, among other things.
True Price Act S. 913 Sen. Mike Braun (R-IN)	Requires group health plans and insurers to disclose on their website and provide a hard copy upon request of the negotiated rate for each health care service covered, including the amount paid by the plan or insurer and any cost-sharing amount charged to the enrollee, beginning in 2020.
Pathway to Universal Coverage Act H.R. 2061 Rep. Ami Bera (D-CA)	Directs HHS to award grants to eligible state agencies to explore innovative solutions (e.g., automatic enrollment and reenrollment; investment in technology; implementation of a state individual mandate; and feasibility studies to develop state plans for increasing enrollment) to promote/increase enrollment in the individual and small group markets, among other things.
ACA OUTREACH Act H.R. 2292 Rep. Maxine Waters (D-CA)	Appropriates $100 million annually to HHS from 2019-2022 for navigator programs; awards grants to states that have established exchanges to conduct outreach and promotional activities as necessary for the successful operation of the exchange (e.g., informing potential enrollees of the availability of coverage under QHPs offered through the exchange, financial assistance available, etc.), among other things.
Reducing Administrative Costs and Burdens in Health Care Act of 2019 S. 1260 Sen. Tina Smith (D-MN)	Requires HHS to develop strategies and recommendations to reduce unnecessary costs and administrative burdens across the health care system (including the private health insurance market) by at least half over a 10-year period; authorizes HHS to award grants to establish/administer "private-public multi-stakeholder commissions" to accelerate state innovation in reducing health care administrative costs and burdens on patients, among other things.

Medical Nutrition Equity Act of 2019 H.R. 2501 Rep. James McGovern (D-MA)	Requires the public and private insurance market to provide coverage for medically necessary foods (e.g., vitamins, amino acids, etc.) for digestive and inherited metabolic disorders, among other things.
Health Coverage State Flexibility Act of 2019 H.R. 2469 Rep. Bill Flores (R-TX)	Aligns the grace period required for non-payment of premiums under qualified health plans with state law grace periods.
Repeal Insurance Plans of the Multi-State Program (RIP MSP) Act S. 1313/S. 1378 Sen. Ron Johnson (R-WI)	Repeals the ACA's Multi-State Plan Program effective January 1, 2020.
Primary Care Patient Protection Act of 2019 H.R. 2774 Rep. Brad Schneider (D-IL)	Establishes a primary care benefit for all high-deductible health plans, allowing for up to two deductible-free primary care office visits each year.
H.R. 2789 Rep. David Schweikert (R-AZ)	Allocates $15 billion to create a Federal Invisible Risk Sharing Program to provide payments to health insurance issuers for the purpose of lowering premiums for coverage offered in the individual market; directs HHS to establish parameters for the operation of the Program; and allows states that established high risk sharing pool or reinsurance programs prior to March 1, 2020 to not have the Program administered therein.
Protecting Personal Health Data Act S. 1842 Sen. Amy Klobuchar (D-MN)	Requires HHS promulgate regulations for operators of consumer devices, services, applications, and software that collects health data, including regulations that consider, among other things: • Consent standard (e.g., permission to withdrawal consent) related to genetic data, biometric data, and personal health data; • Security standards (e.g., that may differ based on the nature and sensitivity of the data); • De-identification of personal health data; • Limitation on the collection, use, or disclosure of personal health data; and • Consumers' rights to access a copy, delete, and amend the personal health data.

	Establishes the National Task Force on Health Data Protection to study the long-term effectiveness of de-identification methodologies, evaluate security standards, and addressing cybersecurity risks, among other things.
Protect the Uninsured Act of 2019 H.R. 3386 Rep. Chris Collins (R-NY)	Requires hospitals to provide uninsured individuals with the lowest negotiated rate for services; subjects violators to a civil monetary penalty of an amount equal to the difference between the lowest negotiated price and the amount the hospital charged an individual.
Chronic Care Management Improvement Act H.R. 3436 Rep. Suzan DelBene (D-WA)	Removes cost-sharing responsibilities for chronic care management services under Medicare Part B.
Easy Enrollment Act of 2019 H.R. 4336 Rep. Ami Bera (D-CA)	Aligns open enrollment periods with the deadline for filing Federal income tax returns.
Chronic Condition Copay Elimination Act H.R. 4457 Rep. Lauren Underwood (D-IL)	Requires group health plans and group or individual health insurance issuers to provide coverage without imposing cost-sharing requirements for additional preventative care services for individuals with chronic conditions.
Individual Health Insurance Marketplace Improvement Act H.R. 4652 Rep. James Langevin (D-RI)	Establishes a permanent Individual Market Reinsurance program and appropriates $500 million for outreach and enrollment activities for such program, among other things.
Wraparound Health Coverage Protection Act H.R. 4763 Rep. Marcy Kaptur (D-OH)	Extends the limited wraparound coverage pilot program for group health plans—currently set to expire in December 2019—through 2024.
Increasing Health Coverage through HRAs Act H.R. 5224 Rep. Dan Bishop (R-NC)	Codifies the Departments of Treasury, Labor, and Health and Human Services final rule on ICHRAs.