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2019 Healthcare Reform Legislation Tracker

Newly Included Legislative and Procedural Updates

Legislative Updates

- May 15: Sen. Ron Wyden (D-OR) introduced the Health Care Price Check Act of 2019 (S. 1497), which aims to improve cost and quality transparency under private health insurance (e.g., toll-free information phone number, detailed website, etc.), among other things.
- May 15: Rep. Brad Schneider (D-IL) introduced the Primary Care Patient Protection Act of 2019 (H.R. 2774), which establishes a primary care benefit for all high-deductible health plan holders.
- May 16: Rep. David Schweikert (R-AZ) introduced H.R. 2789, which establishes a health insurance Federal Invisible Risk Sharing Program.
- May 21: Sen. Tammy Baldwin (D-WI) introduced the No Junk Plans Act (S. 1556), which prohibits the implementation or otherwise giving effect to the administration's rule on STLDI.
- May 21: Rep. Katie Porter (D-CA) introduced the Homecare for Seniors Act (H.R. 2878), which allows distributions from HSAs for certain homecare expenses.
- May 21: Sen. Bill Cassidy (R-LA) introduced the Know the Price Act of 2019 (S. 1577), which prohibits group and individual insurance plans or issuers from entering into contracts with providers that would restrict them from providing price or quality information, among other things.
- May 22: Sen. John Kennedy (R-LA) introduced the Medical Billing Fairness Act of 2019 (S. 1607), which requires hospitals to give patients the opportunity to opt for in-network services when scheduling appointments.
- May 28: Rep. Diana DeGette (D-CO) introduced the Patient-Centered Outcomes Research Extension Act of 2019 (H.R. 3030), which extends appropriations for the Patient-Centered Outcomes Research Trust Fund and extends the related insured and self-insured health plan fees.

I. Single-Issue Legislation (116th Congress - 2019) (*all legislation has been introduced; no further action has been taken, unless noted)*

Section 1332 Waivers
Blanket Repeal
Miscellaneous

Broker-Specific Issues

Lower Health Care Costs Act of 2019 (Discussion Draft) 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.

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.
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 H.R. 3030 Rep. Diana DeGette (D-CO)	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.

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***).
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 H.R. 2163 Rep. Andy Biggs (R-AZ)	***Contribution Amount*** – Increases maximum contribution limit. ***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.).

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.

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

ACA Market Reforms

Continuing Coverage for Preexisting Conditions Act H.R. 383 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.

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

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 (Discussion Draft) 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*.
Lower Health Care Costs Act of 2019 (Discussion Draft) 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, balance billing is prohibited for follow-up non-emergency care unless, post-stabilization, the patient receives notice that the hospital/provider is OON, a list of in-network providers/facilities that could provide the same services, and estimated OON amounts the patient will be charged, and the patient consents and assumes in writing full responsibility for OOP costs associated with the post-stabilization services. ***Non-Emergency Services*** – Prohibits balance billing for all services at in-network facilities performed by OON providers; prohibits balance billing for OON "ancillary, non-emergency services" (including referrals for diagnostic services) performed at in-network facilities. ***Cost Sharing*** – In situations when balance billing is prohibited, patient is responsible for 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*** – Provides three options for minimum payment structures: • In-Network Guarantee: Requires the plan-facility network contract guarantee that all providers/services at the facility will also be in-network (all lab or diagnostic services will be provided at the facility or referred to another in-network facility) and for OON emergency services, the plan and facility/provider have 30 days to negotiate a payment and if they do not reach an agreement, the plan pays the default minimum (median contracted rate for the same services in the region, or if unable to calculate median contract rate, using a regional database of OON service prices); • Independent Dispute Resolution: Requires HHS and DOL establish a process and list of certified IDR entities (arbitrators); claims must be above $750 (for lesser claims, plan must pay median contracted rate or a regional database-based amount); parties may settle on amount or the IDR entity chooses the more reasonable amount between the parties' final offers (determined based on median contract rates in the area); or

	• Benchmark for Payment: Requires plans automatically pay the median contracted rate or a regional database-based rate to the OON provider or facility. ***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). ***Miscellaneous*** – Requires emergency air medical service providers (air ambulances) to submit to plans in electronic claims transactions with respect to enrollees a description of charges for such services separated by (1) the cost of air travel, and (2) the cost of emergency medical services and supplies; calls for penalties up to $10,000 per incident for violations.
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*** – Plans/issuers must put in-network and OON deductibles and out-of-pocket maximums on insurance cards and by 2021, put price and benefits information on their website for services at all in-network sites of care; all group health plans must 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; plans/issuers and providers must 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); hospitals must disclose on websites and in materials 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.

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 Sen. Bill Cassidy (R-LA)	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.

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.

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.

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 H.R. 1386 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 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.