

The Patient Protection and Affordable Care Enhancement Act

Section by Section Summary

Title I: Lowering Health Care Costs and Protecting People with Preexisting Conditions

Sec. 101. Improving affordability by expanding premium assistance for consumers.

Expands eligibility for premium tax credits beyond 400 percent of the federal poverty line (FPL), and increases the size of the tax credits for individuals and families.

Sec. 102. Improving affordability by reducing out-of-pocket and premium costs for consumers.

Reverses the Trump Administration's changes for determining annual updates to premium tax credit eligibility and maximum out-of-pocket limits, thereby lowering consumers' out-of-pocket costs and premiums.

Sec. 103. Expanding affordability for working families to fix the family glitch.

Fixes the "family glitch," thereby expanding access to tax credits for working families. Currently, an individual who has an offer of coverage through his or her employer can receive subsidized coverage in the Marketplaces if the cost of self-only coverage is unaffordable (e.g., the employee's financial contribution exceeds 9.5 percent of the employee's household income). However, some low-to-moderate-income families are locked out of receiving financial assistance because affordability is based on the cost of self-only coverage, rather than family coverage (which is significantly more expensive).

Section 104. Tax credit reconciliation protections for individuals receiving social security lump-sum payments.

Limits advanced premium tax credit reconciliation payments for Americans with disabilities, widows, new retirees, and others receiving Social Security Income (SSI) lump sum payments.

Sec. 105. Preserving State option to implement health care Marketplaces.

Provides states with \$200 million in federal funds to establish State-based Marketplaces.

Sec. 106. Establishing a Health Insurance Affordability Fund.

Provides \$10 billion annually to states, providing the option for states to establish a state reinsurance program or use the funds to provide financial assistance to reduce out-of-pocket costs for individuals enrolled in qualified health plans. Requires the Centers for Medicare and Medicaid Services (CMS) to establish and implement a reinsurance program in states that do not apply for federal funding.

Sec. 107. Rescinding the short-term limited duration insurance (STLDI) regulation.

Reverses the Trump Administration's final rule expanding short-term, limited-duration health plans, which are not required to comply with any of the ACA's consumer protections (protections for preexisting conditions, guaranteed issue, community rating, essential health benefits, and many others). These junk plans discriminate against people with preexisting conditions and expanding them raises premiums and undermines the individual insurance market.

Sec. 108. Revoking Section 1332 guidance.

Rescinds the Trump Administration's Section 1332 guidance released in October 2018 and prevents the Secretaries of the Departments of Health and Human Services (HHS) and the Treasury from promulgating any substantially similar guidance or rule. Section 1332 (State Innovation Waivers) of the ACA authorizes states to waive certain requirements of the law and experiment with health insurance reforms that could improve the well-being and health of their residents. The law has a clear statutory directive that states must maintain the level of benefits, affordability, and coverage provided to state residents by the ACA. The 2018 guidance weakens states standards for approval and also allows states to receive waiver approval for proposals that direct the ACA's tax credit subsidies towards junk plans.

Sec. 109. Requiring Marketplace outreach and educational activities and annual enrollment targets.

Requires HHS to conduct consumer outreach and enrollment educational activities for the ACA Marketplaces – which the Trump Administration has gutted – and funds these activities at \$100 million per year. It requires these activities be culturally and linguistically appropriate to the needs of the populations being served as well as be provided to populations residing in high health disparity areas. It also prohibits HHS from using the funds to promote plans that do not provide comprehensive consumer protections, including junk plans and association health plans. Lastly, this section requires the Secretary of HHS to set annual enrollment targets for the Federally-Facilitated Marketplace (FFM).

Sec. 110. Report on effects of website maintenance during open enrollment.

Requires a GAO report examining whether HHS has been conducting maintenance of www.healthcare.gov during annual open enrollment in order to minimize any disruptions to the use of the website.

Sec. 111. Promoting consumer outreach and education.

Funds the Navigator program for the FFM at \$100 million per year and imposes additional requirements on navigators. Directs that funding be given to community, non-profit organizations.

Sec. 112. Improving transparency and accountability in the Marketplace.

Requires HHS to be transparent in the Administration's use of the FFM user fee. Requires HHS to report on the FFM enrollment metrics and submit open enrollment after action reports.

Sec. 113. Improving awareness of health coverage options.

Improves the information provided to workers so that they are aware of all affordable coverage options, including coverage through the Marketplaces.

Sec. 114. Promoting state innovations to expand coverage.

Provides \$200 million a year for two years in funding for states to conduct feasibility studies, pilot programs, technology upgrades, and other efforts to encourage enrollment in the individual and small group markets.

Sec. 115. Strengthening network adequacy.

Requires CMS to promulgate quantitative network adequacy standards for qualified health plans on the FFM.

Sec. 116. Protecting consumers from unreasonable rate hikes.

Requires HHS or the state regulatory authority to ensure that any excessive, unjustified, or unfairly discriminatory rates on the Marketplaces are corrected before, or as soon as possible after, implementation, including through mechanisms such as denying rates, modifying rates, or requiring rebates to consumers. HHS may apply civil monetary penalties to health insurers that fail to comply with a corrective action taken by HHS and may make the plan involved ineligible for classification as a qualified health plan.

Title II: Encouraging Medicaid Expansion and Strengthening the Medicaid Program

Sec. 201. Incentivizing Medicaid expansion.

Provides 100 percent federal medical assistance percentage (FMAP) for Medicaid expansion beneficiaries for the first three years after a state expands Medicaid, and then scales down to 95 percent FMAP, 94 percent FMAP, and 93 percent FMAP, for, respectively, years four, five, and six. In year seven and beyond, the FMAP for the expansion population would be 90 percent. This enhanced FMAP schedule was available to states that expanded Medicaid beginning in 2014. The bill would provide parity to states that chose to expand Medicaid subsequent to 2014.

Sec. 202. Providing 12-months of continuous eligibility for Medicaid and CHIP.

Ensures that Medicaid and Children's Health Insurance Program (CHIP) beneficiaries do not lose Medicaid eligibility due to minor fluctuations in their income throughout the year. It would ensure that an individual determined to be eligible for Medicaid or CHIP would maintain that eligibility for 12 consecutive months.

Sec. 203. Mandatory 12-months of postpartum Medicaid eligibility.

Ensures that women remain eligible for Medicaid or CHIP for one year postpartum so that women with medical complications related to pregnancy can be prevented, detected, and treated.

Sec. 204. Reducing the administrative FMAP for non-expansion states.

Provides a 0.5 percent reduction to the administrative FMAP for each quarter for states that choose to not expand Medicaid, with a maximum reduction of 10 percent.

Sec. 205. Enhanced reporting requirements for non-expansion states.

Requires a state that chooses not to expand Medicaid to submit an annual report to HHS and Congress providing a detailed description of the state's Medicaid program and uninsured rates, including the number of uninsured individuals in the state at or below 138 percent of the federal poverty level (FPL), information on current state eligibility levels for different categories of beneficiaries, a description of hospital uncompensated care costs and the sources of those costs, and a detailed description of any efforts underway in the state to provide care to those without health insurance.

Sec. 206. Primary care pay increase.

Reauthorizes, for five years, the ACA's increased payments for primary care physicians who treat Medicaid beneficiaries to require that they are paid no less than the Medicare pay rate.

Sec. 207. Permanent funding for CHIP.

Permanently authorizes sufficient funding for CHIP. Funding for CHIP is currently set to expire at the end of fiscal year 2027.

Sec. 208. Permanent extension of CHIP enrollment and quality measures.

Permanently extends policies that facilitate enrollment in CHIP and monitor quality.

Sec. 209. State option to increase children's eligibility for Medicaid and CHIP.

Provides states the option to increase Medicaid and CHIP eligibility levels for children to up to 300 percent of FPL without receiving a waiver.

Section 210. Medicaid coverage for COFA migrants.

Addresses a Medicaid eligibility gap by which citizens of the Freely Associated States (Republic of Marshall Islands, Micronesia, Republic of Palau) are ineligible for Medicaid.

Sec. 211. Increased FMAP for Urban Indian Health Programs.

Increases the FMAP to 100 percent for Urban Indian Health Programs for services provided to American Indians and Alaska Natives (AI/AN). This would ensure that services furnished to AI/AN through Urban Indian Health Programs are matched at the same rate as services provided by Indian Health Service facilities. Also increases the FMAP to 100 percent for services furnished by the Native Hawaiian Health Care System.

Title III: Lowering Prices Through Fair Drug Price Negotiation

This title reflects Title I of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, as passed by the House on December 12, 2019.

Section 301. Establishing a Fair Drug Pricing Program.

Requires the Secretary of HHS to establish a Fair Price Negotiation Program to negotiate with drug manufacturers in order to obtain a maximum fair price (MFP) for certain selected drugs. When establishing this program, the Secretary must publish a list of 250 negotiation-eligible drugs, which encompass the 125 covered part D drugs with the greatest net spending, as well as 125 other drugs that represent the greatest net spending in the United States and the U.S. Territories that are branded, single-source drugs that lack generic or biosimilar competition. From this list, the Secretary shall select no fewer than 25 drugs to negotiate in each of the first year of the program, which increases to no fewer than 50 drugs each year beginning in 2024. In addition to the minimum number of selected drugs the Secretary is required to negotiate, the Secretary shall also negotiate with manufacturers of insulin products to establish an MFP for insulin.

Section 302. Drug manufacturer excise tax for noncompliance.

Amends the Internal Revenue Code to create an escalating penalty on manufacturers of selected drugs who are not in compliance with an agreement established under section 301. The tax is imposed on the sales by the manufacturer, producer, or importer of any selected drug, starting at 65 percent and increasing by 10 percentage points every quarter the manufacturer is out of compliance, to a maximum of 95 percent.

Section 303. Fair Price Negotiation Implementation Fund.

Establishes a \$3 billion implementation fund to carry out this title.

Prepared by the Committees on Energy and Commerce, Ways and Means, and Education and Labor