H. R. 11

To amend the Patient Protection and Affordable Care Act to improve affordability of, undo sabotage with respect to, and increase access to health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. Pallone introduced the following bill; which was referred to the Committee on _____________________

A BILL

To amend the Patient Protection and Affordable Care Act to improve affordability of, undo sabotage with respect to, and increase access to health insurance coverage, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Protecting Pre-Existing Conditions and Making Health Care More Affordable Act of 2019”.
(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—EXPANDING AFFORDABILITY
Sec. 101. Improve affordability and reduce premium costs for consumers.
Sec. 102. Expand affordability for working families.

TITLE II—UNDOING SABOTAGE
Sec. 201. Protect comprehensive coverage for small businesses and workers.
Sec. 202. Short-term limited duration insurance rule prohibition.
Sec. 203. Ensure plans provide comprehensive benefits.
Sec. 204. Providing for additional requirements with respect to the navigator program.
Sec. 205. Federal Exchange outreach and educational activities.
Sec. 206. Improve Health Insurance Affordability Fund.
Sec. 207. Providing that certain guidance related to waivers for State innovation under the Patient Protection and Affordable Care Act shall have no force or effect.

TITLE III—STATE INNOVATION AND TRANSPARENCY
Sec. 301. Fund State health insurance education programs for consumers.
Sec. 302. Fund State innovations to expand coverage.
Sec. 303. Preserving State option to implement health care marketplaces.
Sec. 304. Promote transparency and accountability in the Administration’s expenditures of Exchange user fees.

TITLE I—EXPANDING AFFORDABILITY

SEC. 101. IMPROVE AFFORDABILITY AND REDUCE PREMIUM COSTS FOR CONSUMERS.

(a) IN GENERAL.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended to read as follows:

“(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is
within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

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<table>
<thead>
<tr>
<th>Over 100.0% up to 133.0%</th>
<th>0.0%</th>
<th>1.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>133.0% up to 150.0%</td>
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<td>2.0%</td>
</tr>
<tr>
<td>150.0% up to 200.0%</td>
<td>2.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>200.0% up to 250.0%</td>
<td>4.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>250.0% up to 300.0%</td>
<td>6.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>300.0% up to 400.0%</td>
<td>7.0%</td>
<td>8.5%</td>
</tr>
<tr>
<td>400.0% and higher</td>
<td>8.5%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>
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(b) Conforming Amendment.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking “but does not exceed 400 percent”.

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2020.

SEC. 102. EXPAND AFFORDABILITY FOR WORKING FAMILIES.

(a) In General.—Clause (i) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended to read as follows:

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“(i) Coverage must be affordable.—

“(I) Employees.—An employee shall not be treated as eligible for
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minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the employee’s required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the employee’s household income.

“(II) FAMILY MEMBERS.—An individual who is eligible to enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) by reason of a relationship the individual bears to the employee shall not be treated as eligible for minimum essential coverage by reason of such eligibility to enroll if the employee’s required contribution (within the meaning of section 5000A(e)(1)(B), determined by substituting ‘family’ for ‘self-only’) with respect to the plan exceeds 9.5 percent of the employee’s household income.”.

(b) CONFORMING AMENDMENTS.—
(1) Clause (ii) of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by striking “Except as provided in clause (iii), an employee” and inserting “An individual”.

(2) Clause (iii) of section 36B(c)(2)(C) of such Code is amended by striking “the last sentence of clause (i)” and inserting “clause (i)(II)”.

(3) Clause (iv) of section 36B(c)(2)(C) of such Code is amended by striking “the 9.5 percent under clause (i)(II)” and inserting “the 9.5 percent under clauses (i)(I) and (i)(II)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2020.

TITLE II—UNDOING SABOTAGE

SEC. 201. PROTECT COMPREHENSIVE COVERAGE FOR SMALL BUSINESSES AND WORKERS.

The Secretary of Labor may not take any action to implement, enforce, or otherwise give effect to the rule entitled “Definition of ‘Employer’ Under Section 3(5) of ERISA–Association Health Plans” (83 Fed. Reg. 28912 (June 21, 2018)), and the Secretary may not promulgate any substantially similar rule.
SEC. 202. SHORT-TERM LIMITED DURATION INSURANCE RULE PROHIBITION.

The Secretary of Health and Human Services, the Secretary of the Treasury, and the Secretary of Labor may not take any action to implement, enforce, or otherwise give effect to the rule entitled “Short-Term, Limited Duration Insurance” (83 Fed. Reg. 38212 (August 3, 2018)), and the Secretaries may not promulgate any substantially similar rule.

SEC. 203. ENSURE PLANS PROVIDE COMPREHENSIVE BENEFITS.

(a) ESSENTIAL HEALTH BENEFITS.—Section 1302(b)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)(4)) is amended—

(1) in subparagraph (A), by inserting “and so that benefits are included within each of such categories” before the semicolon;

(2) in subparagraph (G), by striking at the end “and”;

(3) in subparagraph (H), by striking the period at the end and inserting “; and”; and

(4) by adding at the end the following new sub-
paragraph:

“(I) ensure that, beginning January 1, 2020—
“(i) in the case of health benefits that are established as essential health benefits, there shall not be substitution of such benefits across benefit categories;

“(ii) a qualified health plan shall not be treated as providing coverage for the essential health benefits unless under such plan—

“(I) coverage of prescription drugs provides for access to a wide variety of classes of drugs within the prescription drug formulary of such plan; and

“(II) in the case that a drug that is medically necessary for an enrollee under such plan is not included within such formulary, such individual has access to such drug through an exceptions process established by the plan; and

“(iii) habilitative services are covered at parity with rehabilitative services.”.

(b) STANDARD BENEFIT PLANS.—Section 1302(d) of the Patient Protection and Affordable Care Act (42
U.S.C. 18022(d)) is amended by adding at the end the following new paragraph:

“(5) STANDARD BENEFIT PLANS.—

“(A) IN GENERAL.—For purposes of providing individuals with the opportunity to make simpler comparisons of health plans offered by different health insurance issuers and simplify the selection process, the Secretary shall, for each plan year beginning with plan year 2020, through rulemaking, specify a structure described in subparagraph (B)(i) for a standard benefit plan for such plan year for each of the bronze, silver, and gold levels of coverage and for each actuarial value variation of a silver plan resulting from the application of section 1402(c). A standard benefit plan for a plan year for a level of coverage or actuarial value variation of a silver plan shall be modeled on the most commonly purchased plans (determined by enrollments in such plans) during the previous 2 plan years offered in the federally facilitated Exchange operated pursuant to section 1321(c) in such level or variation and shall include coverage of deductible-exempt services
consistent with actual purchasing patterns of consumers in the previous two plan years.

“(B) STANDARD BENEFIT PLAN.—For purposes of this paragraph, the term ‘standard benefit plan’ means a qualified health plan to be offered through an Exchange on the individual market that has either—

“(i) a standardized cost-sharing structure specified by the Secretary pursuant to rulemaking; or

“(ii) a standardized cost-sharing structure specified by the Secretary pursuant to rulemaking that is modified by the health insurance issuer of such plan only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986 or the applicable annual limitation on cost sharing under subsection (c) and actuarial value requirements specified by the Secretary.”.
SEC. 204. PROVIDING FOR ADDITIONAL REQUIREMENTS WITH RESPECT TO THE NAVIGATOR PROGRAM.

(a) In General.—Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

“(C) Selection of Recipients.—In the case of an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), in awarding grants under paragraph (1), the Exchange shall—

“(i) select entities to receive such grants based solely on an entity’s demonstrated capacity to carry out each of the duties specified in paragraph (3);

“(ii) not take into account whether or not the entity has demonstrated how the entity will provide information to individuals relating to group health plans offered by a group or association of employers described in section 2510.3–5(b) of title 29, Code of Federal Regulations (or any successor regulation), or short-term limited duration insurance (as defined by the Sec-
retary for purposes of section 2791(b)(5) of the Public Health Service Act); and

“(iii) ensure that, each year, the Exchange awards such a grant to—

“(I) at least one entity described in this paragraph that is a community and consumer-focused nonprofit group; and

“(II) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group in addition to any such group awarded a grant pursuant to subclause (I).”;

(2) in paragraph (3)—

(A) in subparagraph (C), by inserting after “qualified health plans” the following: “, State Medicaid plans under title XIX of the Social Security Act, and State Children’s Health Insurance Programs under title XXI of such Act”; and

(B) by adding at the end the following flush left sentence:
“The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.”;

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking “not”;

(B) in clause (i)—

(i) by inserting “not” before “be”;

and

(ii) by striking “; or” and inserting “;”;

(C) in clause (ii)—

(i) by inserting “not” before “receive”; and

(ii) by striking the period and inserting “;”; and

(D) by adding at the end the following new clause:

“(iii) maintain physical presence in the State of the Exchange so as to allow in-person assistance to consumers.”; and

(4) in paragraph (6)—

(A) by striking “FUNDING.—Grants under” and inserting “FUNDING.—
“(A) STATE EXCHANGES.—Grants under”; and

(B) by adding at the end the following new subparagraph:

“(B) FEDERAL EXCHANGES.—For purposes of carrying out this subsection, with respect to an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), the Secretary shall obligate $100,000,000 out of amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations) for fiscal year 2020 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2020.

SEC. 205. FEDERAL EXCHANGE OUTREACH AND EDUCATIONAL ACTIVITIES.

Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) is amended by adding at the end the following new paragraph:
“(3) Outreach and educational activities.—

“(A) In general.—In the case of an Exchange established or operated by the Secretary within a State pursuant to this subsection, the Secretary shall carry out outreach and educational activities for purposes of informing potential enrollees in qualified health plans offered through the Exchange of the availability of coverage under such plans and financial assistance for coverage under such plans. Such outreach and educational activities shall be provided in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the Exchange (including hard-to-reach populations, such as racial and sexual minorities, limited English proficient populations, and young adults).

“(B) Limitation on use of funds.—No funds appropriated under this paragraph shall be used for expenditures for promoting non-ACA compliant health insurance coverage.

“(C) Non-ACA compliant health insurance coverage.—For purposes of this subparagraph (B):
“(i) The term ‘non-ACA compliant health insurance coverage’ means health insurance coverage, or a group health plan, that is not a qualified health plan.

“(ii) Such term includes the following:

“(I) An association health plan.

“(II) Short-term limited duration insurance.

“(D) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are hereby appropriated for fiscal year 2020 and each subsequent fiscal year, $100,000,000 to carry out this paragraph. Funds appropriated under this subparagraph shall remain available until expended.”.

SEC. 206. IMPROVE HEALTH INSURANCE AFFORDABILITY FUND.

Subtitle D of title I of the Patient Protection and Affordable Care Act is amended by inserting after part 5 (42 U.S.C. 18061 et seq.) the following new part:

“PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

“SEC. 1351. ESTABLISHMENT OF PROGRAM.

“There is hereby established the ‘Improve Health Insurance Affordability Fund’ to be administered by the Sec-
Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the ‘Administrator’), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a ‘State’) beginning on January 1, 2020, for the purposes described in section 1352.

“SEC. 1352. USE OF FUNDS.

“(a) In General.—A State shall use the funds allocated to the State under this part for one of the following purposes:

“(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

“(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

“(b) Exclusion of Certain Grandfathered and Transitional Plans.—For purposes of subsection (a), a plan described in this subsection is the following:
“(1) A grandfathered health plan (as defined in section 1251).

“(2) A plan (commonly referred to as a ‘transitional plan’) continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, February 13, 2017, and April 9, 2018, or under any subsequent extensions thereof.

“SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

“(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

“(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2020), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2020, not later than 90 days after the date of the enactment of this title and, in the
case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator containing—

“(A) a description of how the funds will be used; and

“(B) such other information as the Administrator may require.

“(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

“(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

“(b) DEFAULT FEDERAL SAFEGUARD.—

“(1) 2020.—For allocations made under this part for 2020, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year
under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall use, in accordance with paragraph (3), the allocation that would otherwise be provided to the State under this part for such year for such State.

“(2) 2021 AND SUBSEQUENT YEARS.—In the case of a State that does not have in effect an approved application under this section for 2021 or a subsequent year, the Administrator, in consultation with the State insurance commissioner, shall use, in accordance with paragraph (3), the allocation that would otherwise be provided to the State under this part for such year for such State.

“(3) SPECIFIED USE.—An allocation for a State made pursuant to paragraph (1) or (2) for a year shall be used to carry out the purpose described in section 1352(a)(1) in such State by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to the percentage (speci-
fied for such year by the Secretary under such sub-
paragraph) of the amount of such claims.

“SEC. 1354. ALLOCATIONS.

“(a) APPROPRIATION.—For the purpose of providing
allocations for States under this part there is appro-
priated, out of any money in the Treasury not otherwise
appropriated $10,000,000,000 for 2020 and each subse-
quent year.

“(b) ALLOCATIONS.—

“(1) PAYMENT.—

“(A) IN GENERAL.—From amounts appro-
priated under subsection (a) for a year, the
Secretary shall, with respect to a State and not
later than the date specified under subpara-
graph (B) for such year, allocate for such State
the amount determined for such State and year
under paragraph (2).

“(B) SPECIFIED DATE.—For purposes of
subparagraph (A), the date specified in this
subparagraph is—

“(i) for 2020, the date that is 45 days
after the date of the enactment of this
title; and

“(ii) for 2021 or a subsequent year,

January 1 of the respective year.
“(C) Notifications of Allocation Amounts.—For 2021 and each subsequent year, the Secretary shall notify each State of the amount determined for such State under paragraph (2) for such year by not later than January 1 of the previous year.

“(2) Allocation Amount Determinations.—

“(A) In general.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State is the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if all States used such funds only for the purpose described in paragraph (1) of section 1352 at the dollar amounts and percentage specified under subparagraph (B) for such year. For purposes of the previous sentence and section 1353(b)(3), the term ‘attachment range claims’ means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount speci-
fied by the Secretary for such year, under sub-
paragraph (B).

“(B) SPECIFICATIONS.—For purposes of
subparagraph (A) and section 1353(b)(3), the
Secretary shall determine the dollar amounts
and the percentage to be specified under sub-
paragraph (A) for a year in a manner to ensure
that the total amount of expenditures under
this part for such year is estimated to equal the
total amount appropriated for such year under
subsection (a) if such expenditures were used
solely for the purpose described in paragraph
(1) of section 1352(a) for attachment range
claims at the dollar amounts and percentage so
specified for such year.

“(3) AVAILABILITY.—Funds allocated to a
State under this subsection for a year shall remain
available through the end of the subsequent year.

“(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR’S
REMAINING FUNDS.—

“(1) IN GENERAL.—In carrying out subsection
(b), the Secretary shall, with respect to a year (be-
ginning with 2021), not later than March 31 of such
year—
“(A) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

“(B) if the Secretary determines that any funds were not so allocated for such previous year, allocate such remaining funds to States for such year, in accordance with paragraph (2).

“(2) ALLOCATION METHODOLOGY.—For purposes of paragraph (1), of the total remaining funds to be allocated for a year pursuant to such paragraph, the Secretary shall allocate to each State an amount that bears the same ratio to such total remaining funds as the amount allocated pursuant to subsection (b) to such State for such year bears to the total allocations made under such subsection for such year.”.

SEC. 207. PROVIDING THAT CERTAIN GUIDANCE RELATED TO WAIVERS FOR STATE INNOVATION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT SHALL HAVE NO FORCE OR EFFECT.

Beginning April 1, 2019, the Secretary of Health and Human Services and the Secretary of the Treasury may
not take any action to implement, enforce, or otherwise
give effect to the guidance entitled “State Relief and Em-
powerment Waivers” (83 Fed. Reg. 53575 (October 24,
2018)), and the Secretaries may not promulgate any sub-
stantially similar guidance or rule.

TITLE III—STATE INNOVATION
AND TRANSPARENCY

SEC. 301. FUND STATE HEALTH INSURANCE EDUCATION
PROGRAMS FOR CONSUMERS.

Section 2793(e) of the Public Health Service Act (42
U.S.C. 300gg–93(e)) is amended by adding at the end the
following new paragraph:

“(3) APPROPRIATIONS.—For purposes of car-
rying out this section, there is hereby appropriated
to the Secretary, out of any funds in the Treasury
not otherwise appropriated, $100,000,000 for each
of the fiscal years 2020 through 2022. Such amount
shall remain available until expended.”.

SEC. 302. FUND STATE INNOVATIONS TO EXPAND COV-
ERAGE.

(a) IN GENERAL.—Subject to subsection (d), the Sec-
retary of Health and Human Services shall award grants
to eligible State agencies to enable such States to explore
innovative solutions to promote greater enrollment in
health insurance coverage in the individual and small
group markets, including activities described in subsection (c).

(b) **ELIGIBILITY.**—For purposes of subsection (a), eligible State agencies are Exchanges established by a State under title I of the Patient Protection and Affordable Care Act and State agencies with primary responsibility over health and human services for the State involved.

(c) **USE OF FUNDS.**—For purposes of subsection (a), the activities described in this subsection are the following:

1. State efforts to streamline health insurance enrollment procedures in order to reduce burdens on consumers and facilitate greater enrollment in health insurance coverage in the individual and small group markets, including automatic enrollment and re-enrollment of, or pre-populated applications for, individuals without health insurance who are eligible for tax credits under section 36B of the Internal Revenue Code of 1986, with the ability to opt out of such enrollment.

2. State investment in technology to improve data sharing and collection for the purposes of facilitating greater enrollment in health insurance coverage in such markets.
(3) Implementation of a State version of an individual mandate to be enrolled in health insurance coverage.

(4) Feasibility studies to develop comprehensive and coherent State plan for increasing enrollment in the individual and small group market.

(d) FUNDING.—For purposes of carrying out this section, there is hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $200,000,000 for each of the fiscal years 2020 through 2022. Such amount shall remain available until expended.

SEC. 303. PRESERVING STATE OPTION TO IMPLEMENT HEALTH CARE MARKETPLACES.

(a) IN GENERAL.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended—

(1) in subsection (a)—

(A) in paragraph (4)(B), by striking “under this subsection” and inserting “under this paragraph or paragraph (1)”; and

(B) by adding at the end the following new paragraph:

“(6) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—
“(A) IN GENERAL.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $200,000,000 to award grants to eligible States for the uses described in paragraph (3).

“(B) DURATION AND RENEWABILITY.—A grant awarded under subparagraph (A) shall be for a period of two years and may not be renewed.

“(C) LIMITATION.—A grant may not be awarded under subparagraph (A) after December 31, 2022.

“(D) ELIGIBLE STATE DEFINED.—For purposes of this paragraph, the term ‘eligible State’ means a State that, as of the date of the enactment of this paragraph, is not operating an Exchange.”; and

(2) in subsection (d)(5)(A)—

(A) by striking “In establishing an Exchange under this section” and inserting “(I) IN GENERAL.—In establishing an Exchange under this section (other than in establishing an Exchange pursuant to subsection (a)(6))”; and

(B) by adding at the end the following:
“(ii) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—In establishing an Exchange pursuant to subsection (a)(6), the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2024, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.”.

(b) CLARIFICATION REGARDING FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)), as amended by section 205, is further amended—

(1) in paragraph (1), by striking “If” and inserting “Subject to paragraph (4), if”; and

(2) by adding at the end the following new paragraph:

“(4) CLARIFICATION.—This subsection shall not apply in the case of a State that elects to apply the requirements described in subsection (a) and satisfies the requirement described in subsection (b) on or after January 1, 2014.”.
SEC. 304. PROMOTE TRANSPARENCY AND ACCOUNTABILITY IN THE ADMINISTRATION'S EXPENDITURES OF EXCHANGE USER FEES.

For each of plan years 2018, 2019, and 2020, not later than the date that is 3 months after the end of such plan year, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress and make available to the public an annual report on the expenditure by the Department of Health and Human Services of user fees collected pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations). Each such report for a plan year shall include a detailed accounting of the amount of such user fees collected during such plan year and of the amount of such expenditures used during such plan year for the federally facilitated Exchange operated pursuant to section 1321(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(e)) on outreach and enrollment activities, navigators, maintenance of Healthcare.gov, and operation of call centers.