

## **SEC. 132. PATIENT AND STATE STABILITY FUND.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

### **“TITLE XXII—PATIENT AND STATE STABILITY FUND**

#### **“SEC. 2201. ESTABLISHMENT OF PROGRAM.**

“There is hereby established the ‘Patient and State Stability Fund’ to be administered by the 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’) during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

#### **“SEC. 2202. USE OF FUNDS.**

“(a) IN GENERAL.—Subject to subsections (b) and (c), a State may use the funds allocated to the State under this title for any of the following purposes:

“(1) Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).

“(2) Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual market, as such markets are defined by the State.

“(3) Reducing the cost for providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) and to individuals who have high costs of health insurance coverage due to the low density population of the State in which they reside.

“(4) Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

“(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.

“(6) Maternity coverage and newborn care.

“(7) Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following:

“(A) Direct inpatient or outpatient clinical care for treatment of addiction and mental illness.  
“(B) Early identification and intervention for children and young adults with serious mental illness.

“(8) Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.

“(9) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

“(b) REQUIRED USE OF INCREASE IN ALLOTMENT.—

A State shall use the additional allocation provided to the State from the funds appropriated under the second sentence of section ~~2204(b)~~ 2204(a) for each year only for the purposes described in paragraphs (6) and (7) of subsection (a).

“(c) REQUIRED USE OF ADDITIONAL INCREASE TO CERTAIN WAIVER STATES TO PROVIDE FINANCIAL HARDSHIP ASSISTANCE.—A State shall use the additional allocation provided to the State from the funds appropriated under the last sentence of section 2204(a) only in accordance with such last sentence.

“**SEC. 2203. 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 title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 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 and containing—

“(A) a description of how the funds will be used for such purposes;

“(B) a certification that the State will make, from non-Federal funds, expenditures for such purposes in an amount that is not less than the State percentage required for the year under section 2204(e)(1); and

“(C) 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 title and of the reason for such denial.

“(3) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 2202, such application shall be treated as approved, with respect to such purpose, for each subsequent year through 2026.

“(4) TREATMENT AS A STATE HEALTH CARE PROGRAM.—Any program receiving funds from an allocation for a State under this title, including pursuant to subsection (b), shall be considered to be a ‘State health care program’ for purposes of sections 1128, 1128A, and 1128B.

“(b) DEFAULT FEDERAL SAFEGUARD.—

“(1) IN GENERAL.—

“(A) 2018.—For allocations made under this title for 2018, in the case of a State that does not submit an application under subsection (a) by the 45-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, subject to section 2204(e), the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such year, in accordance with paragraph (2), for such State.

“(B) 2019 THROUGH 2026.—In the case of a State that does not have in effect an approved application under this section for 2019 or a subsequent year beginning during the period described in section 2201, subject to section 2204(e), the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such year, in accordance with paragraph (2), for such State.

“(2) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—

Subject to section 2204(a), an allocation for a State made pursuant to paragraph (1) for a year shall be used to carry out the purpose described in section 2202(2) in such State by providing payments to appropriate entities described in such section with respect to claims that exceed \$50,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during the period specified in section 2201, such dollar amount specified by the Administrator), but do not exceed \$350,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such dollar amount specified by the Administrator), in an amount equal to 75 percent (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such percentage specified by the Administrator) of the amount of such claims.

#### “SEC. 2204. ALLOCATIONS.

“(a) APPROPRIATION.—For the purpose of providing allocations for States (including pursuant to section 2203(b)) under this title there is appropriated, out of any money in the Treasury not otherwise appropriated—

“(1) for 2018, \$15,000,000,000;

“(2) for 2019, \$15,000,000,000;

“(3) for 2020, \$10,000,000,000;

“(4) for 2021, \$10,000,000,000;

“(5) for 2022, \$10,000,000,000;

“(6) for 2023, \$10,000,000,000;

“(7) for 2024, \$10,000,000,000;

“(8) for 2025, \$10,000,000,000; and

“(9) for 2026, \$10,000,000,000.

The amount otherwise appropriated under the previous sentence for 2020 shall be increased by \$15,000,000,000, to be used and available under subsection (d) only for the purposes described in paragraphs (6) and (7) of section 2202(a).

“The amount otherwise appropriated under this subsection shall be increased by \$8,000,000,000 for the period beginning with 2018 and ending with 2023, to be allocated to States with a waiver in effect under section 2701(b) of the Public Health Service Act with respect to the purpose described in paragraph (1)(C) of such section, in accordance with an allocation methodology specified by the Secretary that takes into account the relative allocation of other amounts appropriated under this subsection among such States, and to be used by (and made available under subsection (d), for any year during such period that such waiver is in effect, to) such States for the purpose of providing assistance to reduce premiums or other out-of-pocket costs of individuals who are subject to an increase in the monthly premium rate for health insurance coverage as a result of such waiver.

“(b) ALLOCATIONS.—

“(1) PAYMENT.—

“(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Administrator shall, with respect to a State and not later than the date specified under subparagraph (B) for such year, allocate, subject to subsection (e), for such State (including pursuant to section 2203(b)) 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 2018, the date that is 45 days after the date of the enactment of this title; and

“(ii) for 2019 and subsequent years, January 1 of the respective year.

“(2) ALLOCATION AMOUNT DETERMINATIONS.—

“(A) FOR 2018 AND 2019.—

“(i) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for 2018 and 2019 for a State is an amount equal to the sum of—

“(I) the relative incurred claims amount described in clause (ii) for such State and year; and

“(II) the relative uninsured and issuer participation amount described in clause (iv) for such State and year.

“(ii) RELATIVE INCURRED CLAIMS AMOUNT.—For purposes of clause (i), the relative incurred claims amount described in this clause for a State for 2018 and 2019 is the product of—

“(I) 85 percent of the amount appropriated under subsection (a) for the year; and

“(II) the relative State incurred claims proportion described in clause (iii) for such State and year.

“(iii) RELATIVE STATE INCURRED CLAIMS PROPORTION.—The relative State incurred claims proportion described in this clause for a State and year is the amount equal to the ratio of—

“(I) the adjusted incurred claims by the State, as reported through the medical loss ratio annual reporting under section 2718 of the Public Health Service Act for the third previous year; to

“(II) the sum of such adjusted incurred claims for all States, as so reported, for such third previous year.

“(iv) RELATIVE UNINSURED AND ISSUER PARTICIPATION AMOUNT.—For purposes of clause (i), the relative uninsured and issuer participation amount described in this clause for a State for 2018 and 2019 is the product of—

“(I) 15 percent of the amount appropriated under subsection (a) for the year; and

“(II) the relative State uninsured and issuer participation proportion described in clause (v) for such State and year.

“(v) RELATIVE STATE UNINSURED AND ISSUER PARTICIPATION PROPORTION.—The relative State uninsured and issuer participation proportion described in this clause for a State and year is—

“(I) in the case of a State not described in clause (vi) for such year, 0; and

“(II) in the case of a State described in clause (vi) for such year, the amount equal to the ratio of—

“(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

“(bb) the sum of the number of such individuals for all States described in clause (vi) for the third preceding year.

“(vi) STATES DESCRIBED.—For purposes of clause (v), a State is described in this clause, with respect to 2018 and 2019, if the State satisfies either of the following criterion:

“(I) The ratio described in subclause (II) of clause (v) that would be determined for such State by substituting ‘2015’ for each reference in such subclause to ‘the third preceding year’ and by substituting ‘all such States’ for the reference in item (bb) of such subclause to ‘all States described in clause (vi)’ is greater than the ratio described in such subclause that would be determined for such State by substituting ‘2013’ for each reference in such subclause to ‘the third preceding year’ and by substituting ‘all such States’ for the reference in item (bb) of such subclause to ‘all States described in clause (vi)’.

“(II) The State has fewer than three health insurance issuers offering qualified health plans through the Exchange for 2017.

“(B) FOR 2020 THROUGH 2026.—For purposes of paragraph (1), the amount determined under this paragraph for a year (beginning with 2020) during the period described in section 2201 for a State is an amount determined in accordance with an allocation methodology specified by the Administrator which—

“(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

“(ii) is established after consultation with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional

cost and risk factors that may inhibit health care consumer and health insurance issuer participation; and

“(iii) reflects the goals of improving the health insurance risk pool, promoting a more competitive health insurance market, and increasing choice for health care consumers.

“(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR’S REMAINING FUNDS.— In carrying out subsection (b), the Administrator shall, with respect to a year (beginning with 2020 and ending with 2027), not later than March 31 of such year—

“(1) 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

“(2) if the Administrator determines that any funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to subsection (b)(2)(B)—

“(A) to States that have submitted an application approved under section 2203(a) for such previous year for any purpose for which such an application was approved; and

“(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, ~~to carry out the purpose described in section 2202(2) in such States by providing payments to appropriate entities described in such section with respect to claims that exceed \$1,000,000~~ to carry out the Federal Invisible Risk Sharing Program in such States under section 2205;

with, respect to a year before 2027, any remaining funds being made available for allocations to States for the subsequent year.

“(d) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.

“(e) CONDITIONS FOR AND LIMITATIONS ON RECEIPT OF FUNDS.—The Secretary may not make an allocation under this title for a State, with respect to a purpose described in section 2202—

“(1) in the case of an allocation that would be made to a State pursuant to section 2203(a), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

“(A) for 2020, 7 percent of the amount allocated under this subsection to such State for such year and purpose;

“(B) for 2021, 14 percent of the amount allocated under this subsection to such State for such year and purpose;

“(C) for 2022, 21 percent of the amount allocated under this subsection to such State for such year and purpose;

“(D) for 2023, 28 percent of the amount allocated under this subsection to such State for such year and purpose;

“(E) for 2024, 35 percent of the amount allocated under this subsection to such State for such year and purpose;

“(F) for 2025, 42 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

“(2) in the case of an allocation that would be made for a State pursuant to section 2203(b), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

“(A) for 2020, 10 percent of the amount allocated under this subsection to such State for such year and purpose;

“(B) for 2021, 20 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(C) for 2022, 30 percent of the amount allocated under this subsection to such State for such year and purpose;

“(D) for 2023, 40 percent of the amount allocated under this subsection to such State for such year and purpose;

“(E) for 2024, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

“(F) for 2025, 50 percent of the amount allocated under this subsection to such State for such year and purpose; and

“(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose; or

“(3) if such an allocation for such purpose would not be permitted under subsection (c)(7) of section 2105 if such allocation were payment made under such section.”.

#### **“SEC. 2205. FEDERAL INVISIBLE RISK SHARING PROGRAM.**

“(a) **IN GENERAL.**—There is established within the Patient and State Stability Fund a Federal Invisible Risk Sharing Program (in this section referred to as the ‘Program’), to be administered by the 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 payments to health insurance issuers with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market.

“(b) **FUNDING.**—

“(1) **APPROPRIATION.**—For the purpose of providing funding for the Program there is appropriated, out of any money in the Treasury not otherwise appropriated, \$15,000,000,000 for the period beginning on January 1, 2018, and ending on December 31, 2026.

“(2) USE OF UNALLOCATED FUNDS.—Funds provided under section 2204(c)(2)(B) to carry out this section are in addition to the amount appropriated under paragraph (1).

“(c) OPERATION OF PROGRAM.—

“(1) IN GENERAL.—The Administrator shall establish, after consultation with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration high cost health conditions and other health trends that generate high cost, parameters for the operation of the Program consistent with this section and consistent with the same limitation on payment with respect to health insurance coverage that applies to payment with respect health benefits coverage under section 2105(c)(7).

“(2) DEADLINE FOR INITIAL OPERATION.—Not later than 60 days after the date of the enactment of this title, the Administrator shall establish sufficient parameters to specify how the Program will operate for plan year 2018.

“(3) STATE OPERATION OF PROGRAM.—The Administrator shall establish a process for a State to operate the Program in such State beginning with plan year 2020.

“(d) DETAILS OF PROGRAM.—The parameters for the Program shall include the following:

“(1) ELIGIBLE INDIVIDUALS.—A definition for eligible individuals.

“(2) HEALTH STATUS STATEMENTS.—The development and use of health status statements with respect to such individuals.

“(3) STANDARDS FOR QUALIFICATION.—

“(A) AUTOMATIC QUALIFICATION.—The identification of health conditions that automatically qualify individuals as eligible individuals at the time of application for health insurance coverage.

“(B) VOLUNTARY QUALIFICATION.—A process under which health insurance issuers may voluntarily qualify individuals, who do not automatically qualify under subparagraph (A), as eligible individuals at the time of application for such coverage.



“(4) PERCENTAGE OF INSURANCE PREMIUMS TO BE APPLIED.—The percentage of the premiums paid, to health insurance issuers for health insurance coverage by eligible individuals, that shall be collected and deposited to the credit (and available for the use) of the Program.

“(5) ATTACHMENT DOLLAR AMOUNT AND PAYMENT PROPORTION.—The dollar amount of claims for eligible individuals after which the Program will provide payments to health insurance issuers and the proportion of such claims above such dollar amount that the Program will pay.”.

### **SEC. 133. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.**

Subpart I of part A of title XXVII of the Public Health Service Act is amended—

(1) in section 2701(a)(1)(B), by striking “such rate” and inserting “subject to section 2710A, such rate”;

(2) by redesignating the second section 2709 as section 2710; and

(3) by adding at the end the following new section:

#### **“SEC. 2710A. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.**

“(a) PENALTY APPLIED.—

“(1) IN GENERAL.—~~Notwithstanding section 2701~~, Subject to the succeeding provisions of this section, a health insurance issuer offering health insurance coverage in the individual market shall, in the case of an individual who is an applicable policyholder of such coverage with respect to an enforcement period applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), increase the monthly premium rate otherwise applicable to such individual for such coverage during each month of such period, by an amount determined under paragraph (2).

“(2) AMOUNT OF PENALTY.—The amount determined under this paragraph for an applicable policyholder enrolling in health insurance coverage described in paragraph (1) for a plan year, with respect to each month during the enforcement period applicable to enrollments for such plan year, is the amount that is equal to 30 percent of the monthly premium rate otherwise applicable to such applicable policyholder for such coverage during such month.

“(b) DEFINITIONS.—For purposes of this section:

“(1) APPLICABLE POLICYHOLDER.—The term ‘applicable policyholder’ means, with respect to months of an enforcement period and health insurance coverage, an individual who—

“(A) is a policyholder of such coverage for such months;

“(B) cannot demonstrate that (through presentation of certifications described in section 2704(e) or in such other manner as may be specified in regulations, such as a return or statement made under section 6055(d) or 36B of the Internal Revenue Code of 1986), during the look-back

period that is with respect to such enforcement period, there was not a period of at least 63 continuous days during which the individual did not have creditable coverage (as defined in paragraph (1) of section 2704(c) and credited in accordance with paragraphs (2) and (3) of such section); and

“(C) in the case of an individual who had been enrolled under dependent coverage under a group health plan or health insurance coverage by reason of section 2714 and such dependent coverage of such individual ceased because of the age of such individual, is not enrolling during the first open enrollment period following the date on which such coverage so ceased.

“(2) LOOK-BACK PERIOD.—The term ‘lookback period’ means, with respect to an enforcement period applicable to an enrollment of an individual for a plan year beginning with plan year 2019 (or, in the case of an enrollment of an individual during a special enrollment period, beginning with plan year 2018) in health insurance coverage described in subsection (a)(1), the 12-month period ending on the date the individual enrolls in such coverage for such plan year.

“(3) ENFORCEMENT PERIOD.—The term ‘enforcement period’ means—

“(A) with respect to enrollments during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that begins subsequent to such date of enrollment, and ending with the last month of such plan year; and

“(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-month period beginning on the first day of the respective plan year.”.

#### **SEC. 134. INCREASING COVERAGE OPTIONS.**

Section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) is amended—

(1) in subsection (a)(3), by inserting “and with respect to a plan year before plan year 2020” after “subsection (e)”; and

(2) in subsection (d), by adding at the end the following:

“(5) SUNSET.—The provisions of this subsection shall not apply after December 31, 2019, and after such date any reference to this subsection or level of coverage or plan described in this subsection and any requirement under law applying such a level of coverage or plan shall have no force or effect (and such a requirement shall be applied as if this section had been repealed).”.

#### **SEC. 135. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.**

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of the Patient Protection and Affordable Care Act, is amended by inserting after “(consistent with section 2707(c))” the following:

“or, for plan years beginning on or after January 1, 2018, as the Secretary may implement through interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other

ratio for adults (consistent with section 2707(c)) as the State involved may provide (or, in the case of a State with a waiver under subsection (b) in effect for such a plan year, the ratio applied for such plan year in accordance with such waiver)”

**~~SEC. 136. ESSENTIAL HEALTH BENEFITS DEFINED BY THE STATES.~~**

~~Section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) is amended—~~

~~(1) in subsection (a)(1), by striking “by the Secretary”; and~~

~~(2) in subsection (b)—~~

~~(A) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (6)”; and~~

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

~~“(6) ESSENTIAL HEALTH BENEFITS FOR PLAN AND TAXABLE YEARS BEGINNING ON OR AFTER JANUARY 1, 2018.— For plan years and taxable years beginning on or after January 1, 2018, each State shall define the essential health benefits with respect to health plans offered in such State, for the purposes of section 36B of the Internal Revenue Code of 1986.”.~~

**SEC. 136. PERMITTING STATES TO WAIVE CERTAIN ACA REQUIREMENTS TO ENCOURAGE FAIR HEALTH INSURANCE PREMIUMS.**

(a) IN GENERAL.—Section 2701 of the Public Health Service Act (42 U.S.C. 300gg) is amended by adding at the end the following new subsection:

“(b) PERMISSIBLE STATE WAIVER TO ENCOURAGE FAIR HEALTH INSURANCE PREMIUMS.—

“(1) IN GENERAL.—A State may submit an application to the Secretary for one or more of the following purposes:

“(A) In the case of plan years beginning on or after January 1, 2018, to apply, subject to paragraph (5), under subsection (a)(1)(A)(iii), instead of the ratio specified in such subsection, a higher ratio specified by the State (consistent with section 2707(c)).

“(B) In the case of plan years beginning on or after January 1, 2020, for health insurance coverage offered in the individual or small group market in such State, to apply, subject to paragraph (5), instead of the essential health benefits specified under subsection (b) of section 1302 of the Patient Protection and Affordable Care Act, essential health benefits as specified by the State.

“(C) In the case of a State that has in place a program that carries out the purpose described in paragraph (1) or (2) of section 13 2202(a) of the Social Security Act or

participates in the program established under section 2205 of such Act, for health insurance offered in the individual market in such State, with respect to an individual who is an applicable policyholder of such coverage with respect to an enforcement period (as defined in section 2710A(b)) applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), to—

“(i) subject to paragraph (5), not apply any increase to the monthly premium rate that would otherwise apply under section 2710A to such individual for such coverage; and

“(ii) instead, subject to paragraph (5)—

“(I) apply subsection (a)(1) as if health status were included as a factor described in subparagraph (A) of such subsection; and

“(II) not apply section 2705(b).

“(2) DEFAULT APPROVAL.—An application submitted under paragraph (1) is approved unless the Secretary 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 paragraph (3) and of the reason for such denial.

“(3) REQUIREMENTS.—The requirements of this paragraph, with respect to an application submitted under paragraph (1), are the following:

“(A) The application is submitted at such time, and in such manner, as the Secretary may require.

“(B) The application specifies how the approval of such application will provide for one or more of the following:

“(i) Reducing average premiums for health insurance coverage in the State.

“(ii) Increasing enrollment in health insurance coverage in the State.

“(iii) Stabilizing the market for health insurance coverage in the State.

“(iv) Stabilizing premiums for individuals with pre-existing conditions.

“(v) Increasing the choice of health plans in the State.

“(C) The application specifies the period for which the waiver is to be effective, consistent with paragraph (4).

“(D) In the case of an application for purposes of paragraph (1)(A), the application specifies the higher ratio to be applied pursuant to such paragraph.

“(E) In the case of an application for purposes of paragraph (1)(B), the application specifies the essential health benefits to be applied pursuant to such paragraph.

“(F) In the case of an application for purposes of paragraph (1)(C), the application demonstrates that the State has in place a program that carries out the purpose described in paragraph (1) or (2) of section 2202(a) of the Social Security Act or participates in the program established under section 2205 of such Act.

“(4) TERM OF WAIVER.—

“(A) IN GENERAL.—No waiver for a State under this subsection may extend over a period of longer than 10 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

“(B) SPECIAL RULE.—A waiver applied for by a State under paragraph (1)(C) may only be effective for a period during which the State—

“(i) has in place a program that carries out the purpose described in paragraph (1) or (2) of section 2202(a) of the Social Security Act; or

“(ii) participates in the program established under section 2205 of such Act.

“(5) NON-APPLICATION RULES.—

“(A) SPECIFIED NON-APPLICATION PROVISIONS.—In no case may a waiver for purposes of paragraph (1) apply with respect to any of the following provisions:

“(i) Section 1301 of the Patient Protection and Affordable Care Act, to the extent that such section applies to qualified health plans offered through the CO-OP program under section 1322 of such Act or multi-State plans under section 1334 of such Act.

“(ii) Sections ~~1312(d)(3)(D)~~, 1331, 1332, 1333, and 1334 of such Act.

“(B) HOLD HARMLESS.—Any standard or requirement adopted by a State pursuant to the terms of a waiver approved under this subsection shall be deemed to comply with section 1252 of the Patient Protection and Affordable Care Act and subsection (a) of section 1324 of such Act, insofar as such standard or requirement relates to a Federal or State law described in subsection (b)(2) of such section (relating to rating).”.

(b) APPLICATION TO ESSENTIAL HEALTH BENEFITS.—Section 1302(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(a)(1)) is amended by inserting “(or, in the case of health insurance coverage offered in the individual or small group market in a State for which there is an applicable waiver in effect

under section 2701(b) of the Public Health Service Act for a plan year, the essential health benefits applicable under such waiver)” after “subsection (b)”.

**SEC. 137. CONSTRUCTIONS.**

(a) **NO GENDER RATING.**—Nothing in this Act shall be construed as permitting health insurance issuers to discriminate in rates for health insurance coverage by gender.

(b) **NO LIMITING ACCESS TO COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS.**—Nothing in this Act shall be construed as permitting health insurance issuers to limit access to health coverage for individuals with preexisting conditions.

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**SEC. 214. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COVERAGE.**

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(b) **ADVANCE PAYMENT OF CREDIT.**—Section 1412 of the Patient Protection and Affordable Care Act ~~is amended by adding at the end the following new subsection, as added by section 202, is amended to read as follows:~~

“(f) **APPLICATION TO CERTAIN PLANS.**—The Secretary and the Secretary of the Treasury shall prescribe such regulations as each respective Secretary may deem necessary in order to establish and operate the advance payment program established under this section for individuals covered under qualified health plans (whether enrolled in through an Exchange or otherwise) in such a manner that protects taxpayer information (including names, taxpayer identification numbers, and other confidential information), provides robust verification of all information necessary to establish eligibility of taxpayer for advance payments under this section, ensures proper and timely payments to appropriate health providers, and protects program integrity to the maximum extent feasible.”.