II

117TH CONGRESS
1ST SESSION

S. 1002

To prohibit false or misleading advertising for health insurance coverage, require warnings and reporting with respect to noncomprehensive health plans, encourage enrollment in health plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 25, 2021

Mr. CASEY (for himself, Ms. BALDWIN, and Ms. STABENOW) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To prohibit false or misleading advertising for health insurance coverage, require warnings and reporting with respect to noncomprehensive health plans, encourage enrollment in health plans, 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 ''Junk Plan Accountability and Disclosure Act of 2021''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PROHIBITION OF FALSE OR MISLEADING ONLINE ADVERTISING FOR HEALTH INSURANCE COVERAGE

Sec. 101. Definitions.
Sec. 102. FTC oversight of online health insurance advertisements.

TITLE II—WARNINGS AND REPORTING REQUIREMENTS FOR NONCOMPREHENSIVE HEALTH PLANS

Sec. 201. Definitions.
Sec. 202. Requirements for notice regarding benefits.
Sec. 203. Reporting requirements.
Sec. 204. Enforcement.
Sec. 205. Regulations.

TITLE III—ENCOURAGING ENROLLMENT IN HEALTH PLANS

Sec. 301. Sense of Congress.
Sec. 302. Requiring Marketplace outreach, educational activities, and annual enrollment targets.
Sec. 303. Report on effects of website maintenance during open enrollment.
Sec. 304. Promoting consumer outreach and education.
Sec. 305. Improving transparency and accountability in the Marketplace.
Sec. 306. Improving awareness of health coverage options.
Sec. 307. Promoting State innovations to expand coverage.

TITLE I—PROHIBITION OF FALSE OR MISLEADING ONLINE ADVERTISING FOR HEALTH INSURANCE COVERAGE

SEC. 101. DEFINITIONS.

In this title:

(1) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(2) HEALTH INSURANCE COVERAGE.—The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care,

but excluding any group health plan) that are offered to individuals, including—

(A) a plan offered through an association;

(B) short-term limited duration insurance;

(C) a policy for such benefits that is not offered by a health insurance issuer (as such term is defined in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(2)); and

(D) other health care arrangements that are not health plans.

(3) NON-ACA COMPLIANT HEALTH INSURANCE COVERAGE.—The term ''non-ACA compliant health insurance coverage'' has the meaning given such term in paragraph (3) of section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) (as added by section 302).

(4) ONLINE PLATFORM.—The term ''online platform'' means any public-facing website, web application, or digital application, including a search engine or social network.

(5) QUALIFIED HEALTH PLAN.—The term ''qualified health plan'' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)).

SEC. 102. FTC OVERSIGHT OF ONLINE HEALTH INSURANCE ADVERTISEMENTS.

(a) PROHIBITIONS FOR ONLINE PRIVATE HEALTH INSURANCE ADVERTISEMENT.—

(1) IN GENERAL.—Subject to paragraph (3), a person may not post, publish, or otherwise display on the internet a deceptive advertisement for health insurance coverage.

(2) DECEPTIVE.—An online advertisement for health insurance coverage shall be considered deceptive if it—

(A) is likely to mislead, or has the effect of misleading, a reasonable individual to believe that such advertisement is made by, through, or on behalf of—

(i) Healthcare.gov;

(ii) a State or Federal American Health Benefit Exchange described in sections 1311 and 1321 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031, 18041); or

(iii) any other Federal, State, or local government entity;

(B) is likely to mislead, or has the effect of misleading, a reasonable individual about—

(i) the relative cost of enrolling in non-ACA compliant health insurance coverage as compared to the cost of enrolling in a qualified health plan;

(ii) the relative actuarial value of non-ACA compliant health insurance coverage as compared to a qualified health plan; or

(iii) the relative scope of benefits of non-ACA compliant health insurance coverage as compared to a qualified health plan;

(C) is likely to mislead, or has the effect of misleading, a reasonable individual to believe that the health insurance coverage advertised—

(i) complies with the requirements for qualified health plans under the Patient Protection and Affordable Care Act (Public Law 111–148), although the health insurance coverage does not meet such requirements; or

(ii) provides coverage for benefits that are not covered by such health insurance coverage; or

(D) is likely to mislead, or has the effect of misleading, a reasonable individual regarding

the scope, cost, or duration of coverage of the health insurance coverage being advertised.

(3) LIABILITY OF ONLINE PLATFORMS.—If a person who is unrelated to the operator of an online platform pays or arranges to post, publish, or otherwise display an advertisement that violates paragraph (1) on the online platform—

(A) such person shall be deemed to have committed the violation of such paragraph; and

(B) the operator of the online platform shall not be liable for a violation of such paragraph.

(b) ENFORCEMENT BY THE COMMISSION.—

(1) UNFAIR OR DECEPTIVE ACTS OR PRACTICE.—A violation of this section or a regulation promulgated under this section shall be treated as a violation of a rule defining an unfair or deceptive act or practice under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

(2) POWERS OF THE FEDERAL TRADE COMMISSION.—

(A) IN GENERAL.—Except as provided in subparagraph (C), the Commission shall enforce this section in the same manner, by the same means, and with the same jurisdiction, powers,

and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section.

(B) PRIVILEGES AND IMMUNITIES.—Any person who violates this section or a regulation promulgated under this section shall be subject to the penalties and entitled to the privileges and immunities provided in the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

(C) NONPROFIT ORGANIZATIONS AND INSURANCE.—Notwithstanding section 4 or 6 of the Federal Trade Commission Act (15 U.S.C. 44, 46), section 2 of McCarran-Ferguson Act (15 U.S.C. 1012), or any other jurisdictional limitation of the Commission, the Commission shall also enforce this section and the regulations promulgated under this section, in the same manner provided in subparagraphs (A) and (B) of this paragraph, with respect to—

(i) organizations not organized to carry on business for their own profit or that of their members; and

(ii) the business of insurance, and persons engaged in such business.

(D) CONTINUED APPLICABILITY OF STATE LAW.—

(i) IN GENERAL.—This section shall only supersede a State law to the extent that this section is inconsistent with otherwise applicable State law.

(ii) CLARIFICATION.—A State law that provides additional protections to consumers than those protections provided in this Act shall not be considered inconsistent with this Act for purposes of clause (i).

(3) RULEMAKING.—The Commission shall promulgate in accordance with section 553 of title 5, United States Code, such rules as may be necessary to carry out this Act.

(4) AUTHORITY PRESERVED.—Nothing in this Act shall be construed to limit the authority of the Commission under any other provision of law.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the Commission's oversight of online advertisements for health insurance coverage pursuant to this section during the period which begins on the

date of enactment of this Act and ends 3 years thereafter. Such study shall include the following:

(A) The number of enforcement actions during such period taken by the Commission related to the oversight of online advertisements for health insurance coverage under this section.

(B) A description of the outcome of any such enforcement action.

(C) A description of any barrier to the Commission's enforcement authority under this section in relation to such advertisements.

(D) A description of how the Commission's oversight of online advertisements for health insurance coverage has protected consumers, including through means other than enforcement actions.

(2) REPORT.—Not later than 4 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

TITLE II—WARNINGS AND REPORTING REQUIREMENTS FOR NONCOMPREHENSIVE HEALTH PLANS

SEC. 201. DEFINITIONS.

In this title:

(1) APPLICABLE HEALTH PLAN.—The term ''applicable health plan''—

(A) means (except as provided in subparagraph (B))—

(i) health insurance coverage in the individual market providing excepted benefits, excluding—

(I) automobile liability insurance described in paragraph (1)(C) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c));

(II) automobile medical payment insurance described in paragraph (1)(E) of such section;

(III) limited scope dental or vision benefits described in paragraph (2)(A) of such section;

(IV) workers' compensation, or similar insurance, described in paragraph (1)(D) of such section;

(V) coverage for on-site medical clinics described in paragraph (1)(G) of such section; or

(VI) medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act) or coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code;

(ii) student health insurance coverage, as defined in section 147.145(a) of title 45, Code of Federal Regulations (or a successor regulation);

(iii) short-term limited duration insurance, as defined in section 144.103 of title 45, Code of Federal Regulations (or a successor regulation);

(iv) any health care arrangement for benefits or payments for medical care offered to individuals through an association; and

(v) any other health care arrangement for benefits or payments for medical care (other than under a Federal health care program) that is not health insurance coverage, or a group health plan, for purposes of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.), or chapter 100 of the Internal Revenue Code of 1986, including such an arrangement offered by a State farm bureau or a health care sharing ministry; and

(B) does not include—

(i) any group health plan;

(ii) any grandfathered health plan; and

(iii) any health insurance coverage to which the transitional policy, described in the letter issued on November 14, 2013, by the Centers for Medicare & Medicaid Services to insurance commissioners, or an extension of such policy, applies.

(2) APPLICABLE STATE AUTHORITY; EXCEPTED BENEFITS; EXCHANGE.—The terms ''applicable State authority'', ''excepted benefits'', and ''Exchange'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(3) FEDERAL HEALTH CARE PROGRAM.—The term ''Federal health care program'' has the meaning given such term under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that such term includes the health insurance program under chapter 89 of title 5, United States Code.

(4) GRANDFATHERED HEALTH PLAN.—The term ''grandfathered health plan'' has the meaning given such term in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e)).

(5) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(6) HEALTH CARE SHARING MINISTRY.—The term ''health care sharing ministry'' has the mean-

ing given such term in section 5000A(d)(2)(B)(ii) of the Internal Revenue Code of 1986.

(7) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER; INDIVIDUAL MARKET.—The terms ''health insurance coverage'', ''health insurance issuer'', and ''individual market'' have the meanings given such terms in section 2791 of the Public Health Service Act.

(8) NON-ACA COMPLIANT HEALTH INSURANCE COVERAGE.—The term ''non-ACA compliant health insurance coverage'' has the meaning given such term in paragraph (3) of section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) (as added by section 302), except that such term shall not include any Federal health care program.

(9) PLAIN LANGUAGE.—The term ''plain language'' has the meaning given the term plain writing in section 3 of the Plain Writing Act of 2010 (5 U.S.C. 301 note).

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 202. REQUIREMENTS FOR NOTICE REGARDING BENEFITS.

(a) IN GENERAL.—Each applicable health plan shall offer to consumers, prior to enrollment, enrollment material that includes—

(1) a plain language explanation of the benefits included in such plan, including through forms that are culturally and linguistically appropriate for such consumers; and

(2) a warning page regarding such benefits in accordance with subsection (b).

(b) WARNING PAGE.—

(1) IN GENERAL.—The warning page required under subsection (a)(2) shall include—

(A) a clear statement indicating that the applicable health plan is not a comprehensive health plan because it is not required to comply with certain requirements under the Patient Protection and Affordable Care Act (Public Law 111–148) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.);

(B) a statement encouraging the consumer to review the plan documents carefully to ensure the individual is aware of—

(i) any exclusions or limitations regarding coverage of preexisting conditions

or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services); and

(ii) any lifetime or annual dollar limits on health benefits;

(C) a statement notifying the consumer that, if the plan expires or the individual loses eligibility for the plan, the individual may have to wait until the beginning of an open enrollment period to enroll in another plan;

(D) a statement notifying the consumer of the option to enroll in a qualified health plan, which is generally a more comprehensive health plan, through the Exchange operating in the State, including—

(i) a statement that most consumers who enroll in a qualified health plan receive help paying for their monthly premiums;

(ii) a statement that special enrollment periods are available through the Exchange;

(iii) a link to Healthcare.gov (or a successor website) or another website for the Exchange operating in the State; and

(iv) the phone number for the Exchange operating in the State; and

(E) a line for the signature of the consumer to acknowledge that the consumer has read and understands the provisions in the warning page, and for the date on which such signature is provided.

(2) ACCESSIBILITY.—

(A) IN GENERAL.—The warning page required under subsection (a)(2) shall be—

(i) located at the beginning of the enrollment material,

(ii) accessible to people with disabilities, including a physical, cognitive, or sensory disability, including accessibility to such people through the use of computers and other technology for receiving consumer information; and

(iii) written in plain language that is easily understood by individuals with an intellectual or other cognitive or processing disability.

(B) MULTIPLE LANGUAGES.—An applicable health plan shall make the warning page required under subsection (a)(2) available in the top 15 languages spoken by individuals with limited English proficiency in the State in which the plan is offered.

(C) RESTRICTION ON PROMOTING ENROLLMENT IN NON-ACA COMPLIANT HEALTH INSURANCE COVERAGE.—The warning page required under subsection (a)(2) shall not include any provision—

(i) promoting enrollment in any non-ACA compliant health insurance coverage; or

(ii) directing consumers to a source that could enroll the consumer in any non-ACA compliant health insurance coverage.

(3) ADDITIONAL STATE REQUIREMENTS.—A State may require applicable health plans to include information, in addition to the information required under this section, in the warning page required under subsection (a)(2), except that any such additional information shall not—

(A) replace the information required under this section;

(B) promote enrollment in any non-ACA compliant health insurance coverage;

(C) direct consumers to a source that could enroll the consumer in any non-ACA compliant health insurance coverage; or

(D) otherwise conflict with a requirement under this section.

(c) RECORDS OF SIGNATURES.—

(1) IN GENERAL.—An administrator of an applicable health plan shall maintain a record of the signature of a consumer obtained under subsection (b)(1)(E) while the consumer is enrolled in the plan and for, at a minimum, 2 years after the consumer is no longer enrolled in such plan. The Secretary may, through regulations under section 205, require an applicable health plan to maintain such record for a period longer than 2 years after the consumer is no longer enrolled in the plan.

(2) REIMBURSEMENT.—

(A) IN GENERAL.—In the case that a consumer claims, within the period and in accordance with the procedures described in subparagraph (C), that an applicable health plan did not cover a health benefit while the consumer was enrolled in such plan and the administrator

of such plan is not able to provide proof of the record required under paragraph (1) with respect to that consumer, the plan shall reimburse the consumer, in an amount determined under subparagraph (B), for such benefit.

(B) AMOUNT.—

(i) IN GENERAL.—Except as provided under clause (ii), such reimbursement shall be equal to (the greater of)—

(I) the amount the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986), available in the Exchange operating in the State in which the consumer resided at the time of enrollment, would have paid for the health benefit if the consumer were enrolled in such plan and the health benefit was provided in-network; or

(II) if applicable, an amount determined by the State in which the consumer resides at the time of enrollment.

(ii) COVERAGE REQUIRED BY PLAN DOCUMENTS.—In the case described in subparagraph (A), if the Secretary or applicable State authority determines that the applicable health plan was required to provide coverage of the health benefit claimed by the consumer based on statements included in the plan documents, the applicable health plan shall reimburse the consumer in an amount determined in accordance with such plan documents.

(C) CLAIMS.—The Secretary shall, through regulations under section 205, establish procedures for the filing of claims under subparagraph (A), including by setting the period during which a claim under such subparagraph shall be filed. Such period shall be not less than 2 years after the consumer is no longer enrolled in the plan.

(3) LIABILITY UNDER OTHER APPLICABLE LAWS.—The ability of an applicable health plan to produce proof of a record required under paragraph (1) shall not shield the plan, including any administrator, insurance broker, or operator of the plan, from liability under other applicable State or Fed-

eral law for any deceptive practice that the plan, including any such administrator, insurance broker, or operator, engaged in while enrolling a consumer in the plan.

SEC. 203. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Not later than November 1 of the first calendar year following the date of enactment of this Act, and November 1 of each year thereafter, an applicable health plan shall submit to the Secretary a report containing each of the following (with respect to the plan year covered by the reporting period):

(1) The total enrollment in the applicable health plan.

(2)(A) A statement of whether the applicable health plan used an insurance broker.

(B) If such plan used an insurance broker, an indication of the number of consumers who were enrolled in the plan through an insurance broker.

(3) The total amount of claims submitted for payment to the applicable health plan.

(4) The total amount of claims denied by the applicable health plan.

(5) Information on any marketing materials the applicable health plan used to enroll consumers in the plan, including—

(A) an indication of whether the plan used any online advertisements; and

(B) a copy of any marketing material used, including any online advertisement.

(6) Any other information regarding enrollment, coverage, or advertising the Secretary determines appropriate through regulations issued under section 205.

(b) EXEMPTIONS.—An applicable health plan shall be exempt from the requirement under subsection (a) if—

(1) the plan is required under the law of each State in which the plan is offered to submit all information required under subsection (a) to the applicable State authority in each such State; and

(2) the applicable State authority in each such State reviews such information and has a process for addressing any such information that is misleading or incorrect.

(c) TRANSMITTAL TO STATES.—Not later than 2 months after receiving a report under subsection (a) from an applicable health plan, the Secretary shall transmit the report to the applicable State authority of each State in which the plan is offered.

(d) PUBLIC AVAILABILITY.—

(1) IN GENERAL.—The Secretary shall make all information submitted under subsection (a) available to the public through a publicly accessible website.

(2) PUBLICIZING WEBSITE.—The Secretary shall publicize the website under paragraph (1), including through agreements with applicable State authorities and national and State organizations representing consumers.

SEC. 204. ENFORCEMENT.

The Secretary shall have the authority to enforce the requirements under section 202 (except the additional State requirements under subsection (b)(3) of such section) and section 203 against an applicable health plan in the same manner as the Secretary may under section 2723(b) (without regard to the limitation under paragraph (1)(A) of such section) enforce a requirement under parts A and D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) against a health insurance issuer that violates a provision of such part, including through civil money penalties and procedures for administrative and judicial review under section 2723(b)(2) of such Act (42 U.S.C. 300gg–22(b)(2)).

SEC. 205. REGULATIONS.

(a) IN GENERAL.—The Secretary may issue regulations to carry out this title, including—

(1) regulations to establish enforcement procedures authorized under section 204; and

(2) subject to subsection (b), regulations for establishing requirements for the warning page required under section 202(a)(2) that are in addition to the requirements provided under section 202.

(b) LIMITATION ON REQUIREMENTS FOR WARNING PAGE.—A requirement in a regulation described in subsection (a)(2) shall not—

(1) use any language to promote enrollment in any non-ACA compliant health insurance coverage;

(2) direct consumers to a source that could enroll the consumer in any non-ACA compliant health insurance coverage; or

(3) otherwise conflict with a requirement under this title.

TITLE III—ENCOURAGING ENROLLMENT IN HEALTH PLANS

SEC. 301. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) when individuals search for phrases related to health insurance, internet search engines, including Google, Bing, and Yahoo, should display an answer box that directs individuals to—

(A) Healthcare.gov and the associated toll free number, 1–800–318–2596, with respect to searches originating in States in which a Federal Exchange is operating; and

(B) a link and phone number for the appropriate State-based Exchange, with respect to searches originating in States in which a State Exchange is operating; and

(2) the answer box related to Healthcare.Gov in response to a search described in paragraph (1) should be placed in ''position zero'', above all other content, including advertisements.

SEC. 302. REQUIRING MARKETPLACE OUTREACH, EDUCATIONAL ACTIVITIES, AND ANNUAL ENROLLMENT TARGETS.

(a) IN GENERAL.—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:

''(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 in-

dividuals about qualified health plans offered through the Exchange, including by informing such individuals 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, individuals in rural areas, veterans, and young adults) and shall be provided to populations residing in high health disparity areas (as defined in subparagraph (E)) served by the Exchange, in addition to other populations served by the Exchange.

''(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 subparagraph (B):

"(i) The term 'non-ACA compliant health insurance coverage' means—

"(I) health insurance coverage, or a group health plan, that is not a qualified health plan; and

"(II) other health care arrangements that are not health plans.

"(ii) Such term includes the following:

"(I) An association health plan.

"(II) Short-term limited duration insurance (as defined in section 144.103 of title 45, Code of Federal Regulations (or a successor regulation)).

"(D) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are hereby appropriated for fiscal year 2023 and each subsequent fiscal year, $100,000,000 to carry out this paragraph. Funds appropriated under this subparagraph shall remain available until expended.

"(E) HIGH HEALTH DISPARITY AREA DEFINED.—For purposes of subparagraph (A), the term 'high health disparity area' means a contiguous geographic area that—

"(i) is located in one census tract or ZIP code;

"(ii) has measurable and documented racial, ethnic, or geographic health disparities;

"(iii) has a low-income population, as demonstrated by—

"(I) average income below 138 percent of the Federal poverty line; or

"(II) a rate of participation in the special supplemental nutrition program under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) that is higher than the national average rate of participation in such program;

"(iv) has poor health outcomes, as demonstrated by—

"(I) lower life expectancy than the national average; or

"(II) a higher percentage of instances of low birth weight than the national average; and

''(v) is part of a Metropolitan Statistical Area identified by the Office of Management and Budget.

''(4) ANNUAL ENROLLMENT TARGETS.—For plan year 2022 and each subsequent plan year, in the case of an Exchange established or operated by the Secretary within a State pursuant to this subsection, the Secretary shall establish annual enrollment targets for such Exchange for such year.''.

(b) GRANTS FOR STATE EXCHANGES.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended by adding at the end the following:

''(l) OPEN ENROLLMENT OUTREACH GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants to States that have established an Exchange pursuant to this section, for purposes of assisting such States in conducting open enrollment outreach with respect to qualified health plans.

''(2) APPLICATIONS.—A State desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan demonstrating how the State will use the grant funds to carry out outreach

and educational activities consistent with the requirements under section 1321(c)(3).

"(3) AWARDS.—

"(A) IN GENERAL.—The Secretary shall award grants under this subsection as follows:

"(i) The Secretary shall award an initial round of grants to each qualifying State in the amount of $1,000,000.

"(ii) If amounts remain available under this subsection after awards are made under clause (i), the Secretary shall award eligible States that received an award under clause (i) an amount determined appropriate by the Secretary based on—

"(I) the State's total population;

"(II) the percentage of the State's population that is uninsured;

"(III) the percentage of the State's population that is difficult to insure; and

"(IV) such other factors as the Secretary determines appropriate.

"(B) AVAILABLE UNTIL EXPENDED.—With respect to a State receiving a grant under

this subsection, the grant funds shall remain available until expended.

''(C) MATCHING REQUIREMENT.—

''(i) IN GENERAL.—Subject to clause (iii), as a condition for receiving a grant under this section, a State shall be required to expend non-Federal funds, at minimum, in an amount equal to the lesser of—

''(I) 25 percent of the amount received under the grant for the purpose described in paragraph (1); or

''(II) $1,000,000.

''(ii) PREVIOUS ALLOCATIONS.—A State may apply funding allocated to the purpose described in paragraph (1) prior to receipt of the grant to satisfy the requirement of clause (i).

''(iii) WAIVER.—The Secretary may waive the requirement under clause (i) in response to—

''(I) a public health emergency or a disaster; or

''(II) an economic recession or other economic hardship that results

in an increase in uninsured individuals.

''(4) LIMITATION ON USE OF FUNDS.—No funds appropriated under this subsection shall be used for expenditures for promoting non-ACA compliant health insurance coverage (as such term is defined in section 1321(c)(3)(C)).

''(5) APPLICATION TO MEDICAID AND CHIP OUTREACH AND ENROLLMENT GRANTS.—Funds received by a State under a grant awarded under this subsection—

''(A) shall not be taken into consideration by the Secretary when determining whether to award the State a grant under section 2113 of the Social Security Act (42 U.S.C. 1397mm); and

''(B) may not be used by the State to satisfy the maintenance of effort requirement under subsection (e) of such section.

''(6) FUNDING.—To carry out this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $50,000,000 for fiscal year 2023 and each subsequent fiscal year.''.

(c) STUDY AND REPORT.—Not later than 30 days after the date of the enactment of this Act, the Secretary

of Health and Human Services shall release to Congress all aggregated documents relating to studies and data sets that were created on or after January 1, 2014, and related to marketing and outreach with respect to qualified health plans offered through Exchanges under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.).

SEC. 303. REPORT ON EFFECTS OF WEBSITE MAINTENANCE DURING OPEN ENROLLMENT.

Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report examining whether the Department of Health and Human Services has been conducting maintenance on the website commonly referred to as ''HealthCare.gov'' during annual open enrollment periods (as described in section 1311(c)(6)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)(B)) in such a manner so as to minimize any disruption to the use of such website resulting from such maintenance.

SEC. 304. PROMOTING CONSUMER OUTREACH AND EDUCATION.

(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 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 in section 144.103 of title 45, Code of Federal Regulations (or a successor regulation)); 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).

In awarding such grants, an Exchange may consider an entity's record with respect to waste, fraud, and abuse for purposes of maintaining the integrity of such Exchange.'';

(2) in paragraph (3)—

(A) by amending subparagraph (C) to read as follows:

''(C) facilitate enrollment, including with respect to individuals with limited English proficiency and individuals with chronic illnesses, in qualified health plans, State Medicaid plans under title XIX of the Social Security Act, and State child health plans under title XXI of such Act;'';

(B) in subparagraph (D), by striking ''and'' at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and'';

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) provide referrals to community-based organizations that address social needs related to health outcomes.''; and

(E) 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 a semicolon;

(C) in clause (ii)—

(i) by inserting ''not'' before ''receive''; and

(ii) by striking the period and inserting a semicolon; and

(D) by adding at the end the following:

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

''(iv) receive opioid specific education and training that ensures the navigator can best educate individuals on qualified health plans offered through an Exchange, specifically coverage under such plans for opioid health care treatment.''; 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 2022 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2022.

SEC. 305. IMPROVING TRANSPARENCY AND ACCOUNTABILITY IN THE MARKETPLACE.

(a) OPEN ENROLLMENT REPORTS.—For plan year 2022 and each subsequent year, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in coordination with the Secretary of the Treasury and the Secretary of Labor, shall issue biweekly public reports during the annual open enrollment period on the performance of the federally facilitated Exchange operated pursuant to section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)). Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the number of unique website visits;

(2) the number of individuals who create an account;

(3) the number of calls to the call center;

(4) the average wait time for callers contacting the call center;

(5) with respect to applications for enrollment—

(A) the number of such applications submitted;

(B) the total number of individuals on submitted applications for enrollment;

(C) the number of individuals on such submitted applications who are determined eligible for enrollment in a qualified health plan;

(D) the number of individuals on such submitted applications who are determined or assessed eligible for the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(E) the number of individuals on such submitted applications who are determined or assessed eligible for the State Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(F) the number of individuals on such submitted applications who are determined eligible

for a premium assistance credit under section 36B of the Internal Revenue Code of 1986;

(G) The number of individuals on such submitted applications who are determined eligible for cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071); and

(H) a breakdown of the data described in subparagraphs (A) through (G) by age, sex, race and preferred language, where such information is available;

(6) the number of individuals who enroll in a qualified health plan; and

(7) the percentage of individuals who enroll in a qualified health plan through each of—

(A) the website;

(B) the call center;

(C) navigators;

(D) agents and brokers;

(E) the enrollment assistant program;

(F) directly from issuers or web brokers; and

(G) other means.

(b) OPEN ENROLLMENT AFTER ACTION REPORT.—For plan year 2022 and each subsequent year, the Sec-

retary, in coordination with the Secretary of the Treasury and the Secretary of Labor, shall publish an after action report not later than 3 months after the completion of the annual open enrollment period regarding the performance of the Exchange described in subsection (a) for the applicable plan year. Each such report shall include a summary, including information on a State-by-State basis where available, of—

(1) the open enrollment data reported under subsection (a) for the entirety of the enrollment period; and

(2) activities related to patient navigators described in section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)), including—

(A) the performance objectives established by the Secretary for such patient navigators;

(B) the number of consumers enrolled by such a patient navigator;

(C) an assessment of how such patient navigators have met established performance metrics, including a detailed list of all patient navigators, funding received by patient navigators, and whether established performance objectives of patient navigators were met; and

(D) with respect to the performance objectives described in subparagraph (A)—

(i) whether such objectives assess the full scope of patient navigator responsibilities, including general education, plan selection, and determination of eligibility for tax credits, cost-sharing reductions, or other coverage;

(ii) how the Secretary worked with patient navigators to establish such objectives; and

(iii) how the Secretary adjusted such objectives for case complexity and other contextual factors.

(c) REPORT ON ADVERTISING AND CONSUMER OUTREACH.—Not later than 3 months after the completion of the annual open enrollment period for plan year 2022, the Secretary shall issue a report on advertising and outreach to consumers for the open enrollment period for plan year 2022. Such report shall include a description of—

(1) the division of spending on individual advertising platforms, including television and radio advertisements and digital media, to raise consumer awareness of open enrollment;

(2) the division of spending on individual outreach platforms, including email and text messages, to raise consumer awareness of open enrollment; and

(3) whether the Secretary conducted targeted outreach to specific demographic groups and geographic areas.

(d) PROMOTING TRANSPARENCY AND ACCOUNTABILITY IN THE ADMINISTRATION'S EXPENDITURES OF EXCHANGE USER FEES.—For plan year 2022 and each subsequent plan year, 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 expenditures 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(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) on outreach and enrollment activities, navigators, maintenance of Healthcare.gov, and operation of call centers.

SEC. 306. IMPROVING AWARENESS OF HEALTH COVERAGE OPTIONS.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of Health and Human Services, shall update, and make publicly available in a prominent location on the website of the Department of Labor, the model Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to in this section as ''COBRA'') continuation coverage general notice and the model COBRA continuation coverage election notice developed by the Secretary of Labor for purposes of facilitating compliance of group health plans with the notification requirements under section 606 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166). In updating each such notice, the Secretary of Labor shall include information regarding any Exchange established under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) through which a qualified beneficiary may be eligible to enroll in a qualified health plan, including—

(1) the publicly accessible Internet website address for such Exchange;

(2) the publicly accessible Internet website address for the Find Local Help directory maintained by the Department of Health and Human Services

on the healthcare.gov Internet website (or a successor website);

(3) a clear explanation that—

(A) an individual who is eligible for continuation coverage may also be eligible to enroll, with financial assistance, in a qualified health plan offered through such Exchange, but, in the case that such individual elects to enroll in such continuation coverage and subsequently elects to terminate such continuation coverage before the period of such continuation coverage expires, such individual will not be eligible to enroll in a qualified health plan offered through such Exchange during a special enrollment period; and

(B) an individual who elects to enroll in continuation coverage will remain eligible to enroll in a qualified health plan offered through such Exchange during an open enrollment period and may be eligible for financial assistance with respect to enrolling in such a qualified health plan;

(4) information on consumer protections with respect to enrolling in a qualified health plan offered through such Exchange, including the requirement

for such a qualified health plan to provide coverage for essential health benefits (as defined in section 1302(b) of such Act (42 U.S.C. 18022(b)) and the requirements applicable to such a qualified health plan under parts A and D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.); and

(5) information on the availability of financial assistance with respect to enrolling in a qualified health plan, including the maximum income limit for eligibility for a premium tax credit under section 36B of the Internal Revenue Code of 1986.

(b) NAME OF NOTICES.—In addition to updating the model COBRA continuation coverage general notice and the model COBRA continuation coverage election notice under paragraph (1), the Secretary of Labor shall rename each such notice as the ''model COBRA continuation coverage and Affordable Care Act coverage general notice'' and the ''model COBRA continuation coverage and Affordable Care Act coverage election notice'', respectively.

(c) CONSUMER TESTING.—Prior to making publicly available the model COBRA continuation coverage general notice and the model COBRA continuation coverage election notice updated under paragraph (1), the Secretary of Labor shall provide an opportunity for consumer testing

of each such notice, as so updated, to ensure that each such notice is clear and understandable to the average participant or beneficiary of a group health plan.

(d) DEFINITIONS.—In this subsection:

(1) CONTINUATION COVERAGE.—The term ''continuation coverage'', with respect to a group health plan, has the meaning given such term in section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162).

(2) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 607 of such Act (29 U.S.C. 1167).

(3) QUALIFIED BENEFICIARY.—The term ''qualified beneficiary'' has the meaning given such term in such section 607.

(4) QUALIFIED HEALTH PLAN.—The term ''qualified health plan'' has the meaning given such term in section 1301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18021).

SEC. 307. PROMOTING STATE INNOVATIONS TO EXPAND COVERAGE.

(a) IN GENERAL.—Subject to subsection (d), the Secretary 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 (42 U.S.C. 18001 et seq.) 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) 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 2022 through 2024. Such amount shall remain available until expended.

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