

119TH CONGRESS  
1ST SESSION

# H. R. 1776

To amend the Patient Protection and Affordable Care Act to establish a reinsurance program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 3, 2025

Mr. PALMER introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Patient Protection and Affordable Care Act to establish a reinsurance program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “New Health Options  
5 Act of 2025”.

6 **SEC. 2. CREATION OF A REINSURANCE PROGRAM FOR A**

7 **NEW HEALTH INSURANCE RISK POOL.**

8 (a) IN GENERAL.—Part V of subtitle B of title I of  
9 the Patient Protection and Affordable Care Act (42

1 U.S.C. 18061 et seq.) is amended by adding at the end  
2 the following new section:

3 **“SEC. 1344. REINSURANCE PROGRAM FOR CERTAIN OFF-EX-**  
4 **CHANGE PLANS.**

5 “(a) IN GENERAL.—There is established a Reinsur-  
6 ance Program, to be administered by the Secretary of  
7 Health and Human Services, to provide payments to  
8 health insurance issuers with respect to claims for eligible  
9 individuals for the purpose of lowering premiums for such  
10 individuals.

11 “(b) FUNDING.—

12 “(1) APPROPRIATION.—For the purpose of pro-  
13 viding funding for the Reinsurance Program, for  
14 each year during the period beginning on January 1,  
15 2026, and ending on December 31, 2030, there is  
16 appropriated out of any monies in the Treasury not  
17 otherwise obligated an amount equal to the product  
18 of \$50 and the aggregate number of member months  
19 for all eligible individuals enrolled in a covered plan  
20 during such year.

21 “(2) LIMITATION ON APPROPRIATION.—In no  
22 year shall the appropriation for the Reinsurance  
23 Program authorized in paragraph (1) exceed  
24 \$6,000,000,000.

1           “(3) USE OF UNEXPENDED FUNDS.—Appro-  
2           priated amounts remaining unexpended at the end of  
3           any year may be used to make payments under the  
4           Reinsurance Program in any future year.

5           “(4) LIMITATION ON USE OF FUNDS.—No  
6           funds received under the Reinsurance Program may  
7           be used to pay for services described in section  
8           1303(b)(1)(B)(i) (as in effect on the date of the en-  
9           actment of this section).

10          “(c) OPERATION OF PROGRAM.—

11           “(1) IN GENERAL.—The Secretary shall estab-  
12           lish parameters for the operation of the Reinsurance  
13           Program consistent with this section.

14           “(2) DEADLINE FOR INITIAL OPERATION.—Not  
15           later than 120 days after the date of the enactment,  
16           the Secretary shall establish sufficient parameters to  
17           specify how the Program will operate for 2026.

18           “(3) DEFINITIONS.—In this section:

19           “(A) COVERED PLAN.—The term ‘covered  
20           plan’ means individual health insurance cov-  
21           erage (as such term is defined in section 2791  
22           of the Public Health Service Act)—

23           “(i) with respect to which the issuer  
24           of such coverage has made the election de-  
25           scribed in section 1312(c)(1)(A); and

1 “(ii) that does not provide coverage  
2 for services described in section  
3 1303(b)(1)(B)(i) (as in effect on the date  
4 of the enactment of this section).

5 “(B) ELIGIBLE INDIVIDUAL.—The term  
6 ‘eligible individual’ means an individual enrolled  
7 in a covered plan.

8 “(d) ATTACHMENT DOLLAR AMOUNT AND PAYMENT  
9 PROPORTION.—

10 “(1) IN GENERAL.—The Secretary shall annu-  
11 ally establish an attachment point, payment propor-  
12 tion, and reinsurance cap with respect to claims for  
13 eligible individuals for payments under the Reinsur-  
14 ance Program, consistent with the following:

15 “(A) The attachment point for the period  
16 beginning January 1, 2026, and ending Decem-  
17 ber 31, 2026, shall be \$110,000.

18 “(B) The payment proportion for the pe-  
19 riod beginning January 1, 2026, and ending  
20 December 31, 2026, shall be 90 percent.

21 “(C) The reinsurance cap for the period  
22 beginning January 1, 2026 and ending Decem-  
23 ber 31, 2026, shall be \$300,000.

24 “(2) ADJUSTMENT AUTHORITY.—The Secretary  
25 may adjust any amounts described in paragraph (1)

1 as necessary to ensure the Reinsurance Program  
2 does not make payment for a year in excess of the  
3 amount available for such year under subsection  
4 (b).”.

5 (b) ELECTION TO OPT OUT OF SINGLE RISK  
6 POOL.—

7 (1) IN GENERAL.—Section 1312(c)(1) of the  
8 Patient Protection and Affordable Care Act (42  
9 U.S.C. 18032(c)(1)) is amended—

10 (A) by striking “A health insurance  
11 issuer” and inserting the following:

12 “(A) IN GENERAL.—A health insurance  
13 issuer”;

14 (B) in subparagraph (A), as inserted by  
15 paragraph (1), by inserting “and other than  
16 any health plan with respect to which such  
17 issuer has elected for this subparagraph not to  
18 apply” after “grandfathered health plans”; and

19 (C) by adding at the end the following new  
20 subparagraph:

21 “(B) TREATMENT OF PLANS OPTING OUT  
22 OF SINGLE RISK POOL.—A health insurance  
23 issuer shall consider all enrollees in all health  
24 plans offered by such issuer in the individual  
25 market with respect to which such issuer has

1           made the election described in subparagraph  
2           (A) to be members of a single risk pool.”.

3           (2) PROHIBITING SINGLE RISK POOL OPT OUT  
4           FOR QUALIFIED HEALTH PLANS.—Section  
5           1301(a)(1)(C) of the Patient Protection and Afford-  
6           able Care Act (42 U.S.C. 18021(a)(1)) is amend-  
7           ed—

8                   (A) in clause (iii), by striking “and” at the  
9                   end;

10                   (B) in clause (iv), by striking the period  
11                   and inserting “; and”; and

12                   (C) by adding at the end the following new  
13                   clause:

14                           “(v) has not made the election de-  
15                           scribed in section 1312(c)(1)(A) with re-  
16                           spect to such plan.”.

17           (3) EFFECTIVE DATE.—The amendments made  
18           by this subsection shall apply with respect to plan  
19           years beginning on or after January 1, 2026.

20           (c) REMOVING AGE PREMIUM VARIATION LIMITA-  
21           TION FOR CERTAIN PLANS.—

22                   (1) IN GENERAL.—

23                           (A) REMOVAL OF LIMITATION FOR CER-  
24                           TAIN PLANS.—Section 2701(a)(1)(A)(iii) of the  
25                           Public Health Service Act (42 U.S.C

1 300gg(a)(1)(A)(iii)) is amended by inserting  
2 “or, in the case of such coverage with respect  
3 to which the issuer of such coverage has made  
4 the election described in section 1312(c)(1)(A)  
5 of the Patient Protection and Affordable Care  
6 Act, by more than an actuarially justified  
7 amount for adults” before “; and”.

8 (B) EFFECTIVE DATE.—The amendment  
9 made by subparagraph (A) shall apply with re-  
10 spect to plan years beginning on or after Janu-  
11 ary 1, 2026.

12 (2) MAINTAINING AGE PREMIUM VARIATION  
13 LIMITATION FOR QUALIFIED HEALTH PLANS.—Sec-  
14 tion 1301(a)(1) of the Patient Protection and Af-  
15 fordable Care Act (42 U.S.C. 18021(a)(1)), as  
16 amended by subsection (b), is further amended—

17 (A) in subparagraph (B), by striking  
18 “and” at the end;

19 (B) in subparagraph (C)(v), by striking  
20 the period and inserting “; and”; and

21 (C) by adding at the end the following new  
22 subparagraph:

23 “(D) with respect to the premium rate  
24 charged by such plan, if such plan varies such  
25 rate by age, does not vary such rate by more

1           than 3 to 1 for adults (consistent with section  
2           2707(c) of the Public Health Service Act).”.

3           (d) TREATMENT OF OPT OUT PLANS IN RELATION  
4 TO INDIVIDUAL HEALTH COVERAGE REIMBURSEMENT  
5 ARRANGEMENTS.—The Secretaries of Health and Human  
6 Services, Labor, and the Treasury shall not fail to treat  
7 any individual health insurance coverage (as defined in  
8 section 2791 of the Public Health Service Act (42 U.S.C.  
9 300gg–91)) as eligible for integration with an individual  
10 health care reimbursement arrangement on the basis that  
11 the health insurance issuer (as so defined) of such cov-  
12 erage has made the election described in section  
13 1312(c)(1)(A) of the Patient Protection and Affordable  
14 Care Act (as inserted by subsection (b)).

15 **SEC. 3. PROMOTION OF HIGH-VALUE CARE.**

16           (a) IN GENERAL.—Subpart II of part A of title  
17 XXVII of the Public Health Service Act (42 U.S.C.  
18 300gg–11 et seq.) is amended by adding at the end the  
19 following new section:

20 **“SEC. 2730. APPLICATION OF CERTAIN OUT-OF-NETWORK**  
21 **COSTS TO DEDUCTIBLES AND OUT-OF-POCK-**  
22 **ET MAXIMUMS.**

23           “(a) IN GENERAL.—A group health plan, and a  
24 health insurance issuer offering group or individual health  
25 insurance coverage, shall, in the case that an individual

1 enrolled under such plan or coverage is furnished items  
2 or services by a health care provider or health care facility  
3 that does not have in effect a contractual relationship with  
4 such plan or issuer for the furnishing of such items or  
5 services and such individual incurs any out-of-pockets  
6 costs with respect to such items and services, at the option  
7 of such individual, apply such costs to any deductible or  
8 out-of-pocket maximum applicable to items and services  
9 furnished by health care providers or health care facilities  
10 with contracts in effect with such plan or issuer for the  
11 furnishing of such items or services, but only if the fol-  
12 lowing requirements are met:

13           “(1) The item or service furnished by such pro-  
14           vider or facility without a contract in effect with  
15           such plan or issuer is an item or service for which  
16           benefits are available under such plan or coverage.

17           “(2) The amount charged by such provider or  
18           facility for such item or service is equal to or less  
19           than—

20                   “(A) the lowest amount recognized by the  
21                   plan or coverage as payment for such item or  
22                   service out of all health care providers and  
23                   health care facilities with a contract in effect  
24                   with such plan or issuer to furnish such item or  
25                   service in the same rating area (as defined for

1 purposes of section 2701) in which the item or  
2 service described in paragraph (1) was fur-  
3 nished; or

4 “(B) the 25th percentile of charges for  
5 such item or service furnished in the same  
6 State in which the item or service described in  
7 paragraph (1) was furnished.

8 “(b) DISCLOSURE OF INFORMATION.—A group  
9 health plan, and a health insurance issuer offering group  
10 or individual health insurance coverage, shall, with respect  
11 to each item or service for which benefits are available  
12 under such plan or coverage, make available the lowest  
13 amount described in subsection (a)(2)(A) and the 25th  
14 percentile described in subsection (a)(2)(B) to all individ-  
15 uals enrolled under such plan or coverage.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall apply to plan years beginning on or  
18 after January 1, 2026.

19 **SEC. 4. DISCLOSURE OF LOWER PRICES.**

20 Part E of title XXVII of the Public Health Service  
21 Act (42 U.S.C. 300gg–131) is amended by adding at the  
22 end the following new section:

23 **“SEC. 2799B-10. DISCLOSURE OF LOWER PRICES.**

24 “(a) IN GENERAL.—Beginning January 1, 2026,  
25 each health care provider and health care facility shall dis-

1 close to patients and prospective patients enrolled in a  
2 group health plan, group or individual health insurance  
3 coverage, or a Federal health care program (as defined  
4 in section 1128B but including the program established  
5 under chapter 89 of title 5, United States Code) being  
6 furnished or seeking to be furnished an item or service  
7 by such provider or facility for which benefits are available  
8 under such plan, coverage, or program, as applicable,  
9 whether the amount of cost sharing (including deductibles,  
10 copayments, and coinsurance) that would be incurred by  
11 such individual for such item or service under such plan,  
12 coverage, or program, as applicable, exceeds the charge  
13 that would apply for such item or service for an individual  
14 without benefits under any such plan, coverage, or pro-  
15 gram for such item or service.

16 “(b) ADDITIONAL ENFORCEMENT.—In addition to  
17 any other penalty applicable with respect to a violation of  
18 subsection (a), an individual who is harmed by a violation  
19 of this section by a health care provider or health care  
20 facility may bring an action against such provider or facil-  
21 ity in an appropriate district court of the United States  
22 for—

23 “(1) appropriate injunctive relief; and

24 “(2) damages in an amount that is equal to the  
25 amount provided for such harm in a civil action

1 under the law of the State in which the provider or  
2 facility is located.”.

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