

STATE ALLOWANCE FOR A VARIETY OF EXCHANGES ACT

MAY 3, 2019.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PALLONE, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1385]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1385) to amend the Patient Protection and Affordable Care Act to preserve the option of States to implement health care marketplaces, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “State Allowance for a Variety of Exchanges Act” or the “SAVE Act”.

**SEC. 2. PRESERVING STATE OPTION TO IMPLEMENT HEALTH CARE MARKETPLACES.**

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

(1) in subsection (a)—

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

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

“(6) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—

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

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

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

“(D) ELIGIBLE STATE DEFINED.—For purposes of this paragraph, the term ‘eligible State’ means a State that, as of the date of the enactment of this paragraph, is not operating an Exchange (other than an Exchange described in section 155.200(f) of title 45, Code of Federal Regulations).”;

(2) in subsection (d)(5)(A)—

(A) by striking “OPERATIONS.—In establishing an Exchange under this section” and inserting “OPERATIONS.—

“(i) IN GENERAL.—In establishing an Exchange under this section (other than in establishing an Exchange pursuant to a grant awarded under subsection (a)(6))”; and

(B) by adding at the end the following:

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

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

(1) in paragraph (1), by striking “If” and inserting “Subject to paragraph (3), if”;

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

“(3) CLARIFICATION.—This subsection shall not apply in the case of a State that elects to apply the requirements described in subsection (a) and satisfies the requirement described in subsection (b) on or after January 1, 2014.”.

**PURPOSE AND SUMMARY**

H.R. 1385, the “State Allowance for a Variety of Exchanges Act” or the “SAVE Act”, was introduced on February 27, 2019, by Reps. Andy Kim (D–NJ) and Brian K. Fitzpatrick (R–PA) and referred to the Committee on Energy and Commerce.

The goal of H.R. 1385 is to provide states with \$200 million in federal funds to establish state-based marketplaces.

**BACKGROUND AND NEED FOR LEGISLATION**

The Affordable Care Act (ACA) provided states the option to establish their own marketplaces or rely on the Federally-Facilitated Marketplace (FFM). The law also provided grants to states to support the planning and establishment of state-based marketplaces. These grants, however, could be awarded only up until January 1,

2015. Accordingly, states no longer have access to federal funds to establish a state-based marketplace.

States that operate their own marketplaces have greater control over their insurance markets and can tailor consumer outreach and financial assistance to meet the needs of their population. Enrollment in state-based marketplaces has remained stable and premiums are lower overall, compared to the FFM.<sup>1</sup> Moreover, state-based marketplaces that opted for longer open enrollment periods beyond the FFM's shortened six-week period experienced higher enrollment gains in 2018.<sup>2</sup>

#### COMMITTEE HEARINGS

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearing was used to develop or consider H.R. 1385:

On March 6, 2019, the Subcommittee on Health held a legislative hearing entitled, "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access." The hearing focused on H.R. 1385 and two other bills. The Subcommittee received testimony from the following witnesses:

- Peter Lee, Executive Director, Covered California;
- Audrey Morse Gasteier, Chief of Policy, Massachusetts Health Connector; and
- J.P. Wieske, Vice President, State Affairs, Council for Affordable Health Coverage.

#### COMMITTEE CONSIDERATION

H.R. 1385, the "State Allowance for a Variety of Exchanges Act" or the "SAVE Act", was introduced on February 27, 2019, by Rep. Kim (D–NJ), and referred to the Committee on Energy and Commerce. The bill was subsequently referred to the Subcommittee on Health on February 28, 2019. Following legislative hearings, on March 26, 2019, the Subcommittee met in open markup session, pursuant to notice, on H.R. 1385 for consideration of the bill. During markup, an amendment offered by Mr. Bucshon (R–IN) was defeated by a record vote of 10 yeas to 18 nays. Subsequently, the Subcommittee on Health agreed to a motion by Ms. Eshoo, Chairwoman of the Subcommittee, to favorably forward H.R. 1385 to the full Committee on Energy and Commerce, without amendment, by a voice vote.

On April 3, 2019, the full Committee met in open markup session, pursuant to notice, to consider H.R. 1385. During the markup, Mr. Pallone (D–NJ) offered an amendment to the bill that was agreed to by a voice vote. At the conclusion of consideration of the bill, the Committee on Energy and Commerce agreed to a motion by Mr. Pallone, Chairman of the Committee, to order H.R. 1385 favorably reported to the House, amended, by a record vote of 29 yeas to 22 nays.

<sup>1</sup>The Commonwealth Fund, *Health Insurance Markets Perform Better in States That Run Their Own Marketplaces* (Mar 7, 2018) ([www.commonwealthfund.org/blog/2018/health-insurance-markets-perform-better-states-run-their-own-marketplaces](http://www.commonwealthfund.org/blog/2018/health-insurance-markets-perform-better-states-run-their-own-marketplaces)).

<sup>2</sup>Urban Institute, *What Explains 2018's Marketplace Enrollment Rates?* (June 2018) ([www.urban.org/sites/default/files/publication/98650/marketplace2018\\_2001877.pdf](http://www.urban.org/sites/default/files/publication/98650/marketplace2018_2001877.pdf)).

## COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee advises that a record vote was taken on final passage of H.R. 1385. A motion by Mr. Pallone to order H.R. 1385 favorably reported to the House, amended, was agreed to by a record vote of 29 yeas to 22 nays. The following is that record vote taken during Committee consideration, including the names of those members voting for and against:

**COMMITTEE ON ENERGY AND COMMERCE – 116<sup>th</sup> CONGRESS  
ROLL CALL VOTE # 15**

**BILL:** H.R. 1385, the “State Allowance for a Variety of Exchanges (SAVE) Act”

**MOTION:** A motion by Mr. Pallone to order H.R. 1385 favorably reported to the House, amended. (Final Passage)

**DISPOSITION:** **AGREED TO** by a roll call vote of 29 yeas to 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Pallone	X			Rep. Walden	X		
Rep. Rush	X			Rep. Upton	X		
Rep. Eshoo	X			Rep. Shimkus	X		
Rep. Engel				Rep. Burgess	X		
Rep. DeGette	X			Rep. Scalise	X		
Rep. Doyle	X			Rep. Latta	X		
Rep. Schakowsky	X			Rep. Rodgers	X		
Rep. Butterfield	X			Rep. Guthrie	X		
Rep. Matsui	X			Rep. Olson	X		
Rep. Castor	X			Rep. McKinley	X		
Rep. Sarbanes	X			Rep. Kinzinger			
Rep. McNerney	X			Rep. Griffith	X		
Rep. Welch	X			Rep. Bilirakis	X		
Rep. Lujan	X			Rep. Johnson	X		
Rep. Tonko	X			Rep. Long	X		
Rep. Clarke	X			Rep. Buschon	X		
Rep. Loeb sack	X			Rep. Flores	X		
Rep. Schrader	X			Rep. Brooks	X		
Rep. Kennedy	X			Rep. Mullin			
Rep. Cardenas	X			Rep. Hudson	X		
Rep. Ruiz	X			Rep. Walberg	X		
Rep. Peters	X			Rep. Carter	X		
Rep. Dingell	X			Rep. Duncan	X		
Rep. Veasey	X			Rep. Gianforte	X		
Rep. Kuster	X						
Rep. Kelly	X						
Rep. Barragan	X						
Rep. McEachin							
Rep. Blunt Rochester	X						
Rep. Soto	X						
Rep. O’Halleran	X						

04/03/2019

## OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX  
EXPENDITURES

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

With respect to the requirements of clause (3)(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for H.R. 1385 from the Director of the Congressional Budget Office:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, April 25, 2019.*

Hon. FRANK PALLONE, Jr.,  
*Chairman, Committee on Energy and Commerce,  
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1385, the State Allowance for a Variety of Exchanges Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lisa Ramirez-Branum.

Sincerely,

KEITH HALL,  
*Director.*

Enclosure.

<b>H.R. 1385, State Allowance for a Variety of Exchanges Act</b>			
As ordered reported by the House Committee on Energy and Commerce on April 3, 2019			
Millions of Dollars	2019	2019-2024	2019-2029
Direct Spending (Outlays)	0	196	196
Revenues	0	0	0
Deficit Effect	0	196	196
Spending Subject to Appropriation (Outlays)	0	0	0
Pay-as-you-go procedures apply?	Yes	<b>Mandate Effects</b>	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	No	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

No Under the Affordable Care Act (ACA), HHS was authorized to provide grant funds to states to plan and establish on-line platforms—also known as health care marketplaces—where people without health care insurance could find information about health insurance options and also purchase health care insurance. The authority for HHS to award such grants expired at the end of 2014.

H.R. 1385 would appropriate \$200 million to HHS to provide grants to states that, as of the date of enactment of the bill, were not operating a health care marketplace. The bill also would limit a grant to a period of two years and would prohibit HHS from awarding a grant after December 31, 2022. CBO estimates that enacting the bill would increase direct spending by \$196 million over the 2019–2029 period.

Details of the estimated budgetary effect of H.R. 1385 are shown in Table 1. The costs of the legislation fall within budget function 550.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 1385

	By fiscal year, millions of dollars—														2019– 2024	2019– 2029
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029					
	Increases in Direct Spending															
Budget Authority .....	200	0	0	0	0	0	0	0	0	0	0	0	0	0	200	200
Estimated Outlays .....	0	86	80	16	14	0	0	0	0	0	0	0	0	0	196	196

The CBO staff contact for this estimate is Lisa Ramirez-Branum. The estimate was reviewed by Leo Lex, Deputy Assistant Director for Budget Analysis.

#### FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

#### STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to provide states with \$200 million in federal funds to establish state-based marketplaces.

#### DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 1385 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

#### COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 1385 contains no earmarks, limited tax benefits, or limited tariff benefits.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

*Section 1. Short title*

Section 1 designates that the short title of the Act may be cited as the “State Allowance for a Variety of Exchanges Act” or the “SAVE Act”.

*Section 2. Preserving state option to implement health care marketplaces*

Section 2 amends Section 1331 of the ACA. Section 2 appropriates \$200 million and provides the Secretary of the Department of Health and Human Services the authority to award grants to eligible states for the purposes of establishing a state-based exchange. This section defines eligible states as states currently on the FFM and state-based exchanges on the FFM platform. The section requires that the grants be available for a period of two years and includes a limitation that the grants may not be awarded after December 21, 2022. The section also requires states receiving grant funding to ensure that the state exchange is self-sustaining beginning on January 1, 2024.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

**PATIENT PROTECTION AND AFFORDABLE CARE ACT**

\* \* \* \* \*

**TITLE I—QUALITY, AFFORDABLE  
HEALTH CARE FOR ALL AMERICANS**

\* \* \* \* \*

## Subtitle D—Available Coverage Choices for All Americans

\* \* \* \* \*

### PART 2—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

#### SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT.—

(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION.—No grant shall be awarded [under this subsection] *under this paragraph or paragraph (1)* after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(6) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—

(A) IN GENERAL.—*There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$200,000,000 to award grants to eligible States for the uses described in paragraph (3).*

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

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

(D) *ELIGIBLE STATE DEFINED.*—For purposes of this paragraph, the term “eligible State” means a State that, as of the date of the enactment of this paragraph, is not operating an Exchange (other than an Exchange described in section 155.200(f) of title 45, Code of Federal Regulations).

(b) **AMERICAN HEALTH BENEFIT EXCHANGES.**—

(1) **IN GENERAL.**—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an “Exchange”) for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a “SHOP Exchange”) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) **MERGER OF INDIVIDUAL AND SHOP EXCHANGES.**—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) **RESPONSIBILITIES OF THE SECRETARY.**—

(1) **IN GENERAL.**—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare

Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.

(2) **RULE OF CONSTRUCTION.**—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) **RATING SYSTEM.**—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) **ENROLLEE SATISFACTION SYSTEM.**—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) **INTERNET PORTALS.**—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist

States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(6) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(d) REQUIREMENTS.—

(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) OFFERING OF COVERAGE.—

(A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) LIMITATION.—

(i) IN GENERAL.—An Exchange may not make available any health plan that is not a qualified health plan.

(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

- (A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).
- (B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—
- (i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).
- (ii) STATE MUST ASSUME COST.—A State shall make payments—
- (I) to an individual enrolled in a qualified health plan offered in such State; or
- (II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;
- to defray the cost of any additional benefits described in clause (i).
- (4) FUNCTIONS.—An Exchange shall, at a minimum—
- (A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;
- (B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- (C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- (D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);
- (E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;
- (F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;
- (G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;
- (H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual require-

ment or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS.—

(A) NO FEDERAL FUNDS FOR CONTINUED [OPERATIONS.—  
] [In establishing an Exchange under this section] OPERATIONS.—

(i) *IN GENERAL.*—*In establishing an Exchange under this section (other than in establishing an Exchange pursuant to a grant awarded under subsection (a)(6)), the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.*

(ii) *ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.*—*In establishing an Exchange pursuant to a grant awarded under subsection (a)(6), the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2024, including allowing the Exchange to charge assessments or user fees to participating*

*health insurance issuers, or to otherwise generate funding, to support its operations.*

(B) PROHIBITING WASTEFUL USE OF FUNDS.—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS.—An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) CERTIFICATION.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make

such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(3) TRANSPARENCY IN COVERAGE.—

(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

- (i) Claims payment policies and practices.
- (ii) Periodic financial disclosures.
- (iii) Data on enrollment.
- (iv) Data on disenrollment.
- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.
- (ix) Other information as determined appropriate by the Secretary.

(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. The term “plain language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) GROUP HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary’s rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

- (A) each State in which such Exchange operates permits such operation; and
  - (B) the Secretary approves such regional or interstate Exchange.
- (2) **SUBSIDIARY EXCHANGES.**—A State may establish one or more subsidiary Exchanges if—
- (A) each such Exchange serves a geographically distinct area; and
  - (B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.
- (3) **AUTHORITY TO CONTRACT.**—
- (A) **IN GENERAL.**—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.
  - (B) **ELIGIBLE ENTITY.**—In this paragraph, the term “eligible entity” means—
    - (i) a person—
      - (I) incorporated under, and subject to the laws of, 1 or more States;
      - (II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and
      - (III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or
    - (ii) the State medicaid agency under title XIX of the Social Security Act.
- (g) **REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.**—
- (1) **STRATEGY DESCRIBED.**—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—
    - (A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
    - (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
    - (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
    - (D) the implementation of wellness and health promotion activities; and

- (E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
- (2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).
- (3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).
- (h) QUALITY IMPROVEMENT.—
- (1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—
- (A) a hospital with greater than 50 beds only if such hospital—
- (i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and
  - (ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or
- (B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.
- (2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).
- (3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).
- (i) NAVIGATORS.—
- (1) IN GENERAL.—An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).
- (2) ELIGIBILITY.—
- (A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.
- (B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that—
- (i) are capable of carrying out the duties described in paragraph (3);

- (ii) meet the standards described in paragraph (4); and
- (iii) provide information consistent with the standards developed under paragraph (5).

(3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—

- (A) conduct public education activities to raise awareness of the availability of qualified health plans;
- (B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;
- (C) facilitate enrollment in qualified health plans;
- (D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- (E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) STANDARDS.—

- (A) IN GENERAL.—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—
  - (i) be a health insurance issuer; or
  - (ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) FUNDING.—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) CONFLICT.—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

### PART 3—STATE FLEXIBILITY RELATING TO EXCHANGES

#### SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a);

or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—

(1) IN GENERAL.—**[If]** *Subject to paragraph (3), if—*

(A) a State is not an electing State under subsection (b);

or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within

the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(3) CLARIFICATION.—*This subsection shall not apply in the case of a State that elects to apply the requirements described in subsection (a) and satisfies the requirement described in subsection (b) on or after January 1, 2014.*

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

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## DISSENTING VIEWS

This bill provides \$200 million for States to establish State-based Marketplaces (SBMs). The bill is not paid for.

The Patient Protection and Affordable Care Act (PPACA) provided States with the option of building their own SBM or utilizing the Federally-facilitated marketplace (FFM).<sup>1</sup> An unlimited authorization and appropriation was made available to States in the form of grants for the planning and establishment of SBMs. No funding was awarded after December 31, 2014, in accordance with the law. In 2018, 11 States and the District of Columbia operated SBMs,<sup>2</sup> five States operated on a State-based Marketplace-Federal Platform (SBM-FP), and six States operated on a State-Partnership Marketplace (SPM).<sup>3</sup> According to the Congressional Research Service (CRS), 17 States were awarded roughly \$4.5 billion in grants to plan and establish grants.<sup>4</sup>

While Federal funding for the establishment of SBMs has expired, current law continues to allow States to establish their own exchange. New Jersey recently announced its intention to create a SBM, where the insurance commissioner said, “We believe we can operate a State-based exchange and provide additional benefits to New Jersey residents with the funding we currently send to Washington, estimated to be over \$50 million for 2019.”<sup>5</sup>

The Committee on Energy and Commerce issued a Majority Staff report entitled, “Implementing Obamacare: A Review of CMS’ Management of the State-Based Exchanges,” on September 13, 2016.<sup>6</sup> Among the report’s key findings in 2016:

- The Centers for Medicare and Medicaid Services (CMS) is not confident that the remaining SBEs will be sustainable in the long term;
- As of September 2016, every SBE still relies upon Federal establishment grant funds—20 months after SBEs were to be self-sustaining by law; and,

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<sup>1</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119, (2010) (as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No 111–152, 124 Stat. 1029 (2010)).

<sup>2</sup> Henry J. Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2018*, available at <https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?activeTab=map&currentTimeframe=0&selectedDistributions=marketplace-type&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited April 17, 2019).

<sup>3</sup> *Id.*

<sup>4</sup> Congressional Research Service, *Overview of Health Insurance Exchanges* (June 20, 2018), available at [https://www.crs.gov/Reports/R44065#\\_Toc524344378](https://www.crs.gov/Reports/R44065#_Toc524344378).

<sup>5</sup> Ryan Hutchins, *New Jersey Proposes State-Based Obamacare Exchange*, Politico (Mar. 22, 2019), available at <https://www.politico.com/states/new-jersey/story/2019/03/22/new-jersey-proposes-state-based-obamacare-exchange-929807>.

<sup>6</sup> Committee on Energy and Commerce, *Implementing Obamacare A Review of CMS’ Management of the State-Based Exchanges*, (Sept. 13, 2016), available at [https://archives.energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160916Review\\_of\\_CMS\\_Management\\_of\\_the\\_State\\_Based\\_Exchanges\\_0.pdf](https://archives.energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160916Review_of_CMS_Management_of_the_State_Based_Exchanges_0.pdf).

- CMS eased the transition for failed SBEs to join HealthCare.gov by allowing them to keep user fees collected by insurance carriers intended to pay for the use of HealthCare.gov.

Any SBMs that would be funded by this bill is likely to face the same challenges numerous other states have faced and as many have proven, are not sustainable in the long term. In fact, when the 2016 Majority Staff report was issued, every SBM still relied on Federal establishment grant funds almost two years after the SBMs were supposed to be self-sustaining under the law. This bill is not paid for and states can pursue this option using state dollars if they wish. This bill is not a responsible use of taxpayer dollars.

GREG WALDEN,  
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mittee on Energy and  
Commerce.*

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committee on Health,  
Committee on Energy and  
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