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116TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
116–50

EXPAND NAVIGATORS' RESOURCES FOR OUTREACH, LEARNING, AND LONGEVITY ACT OF 2019

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. 1386]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1386) to amend the Patient Protection and Affordable Care Act to provide for additional requirements with respect to the navigator program, 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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89–006

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 "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2019" or the "ENROLL Act of 2019".

SEC. 2. PROVIDING FOR ADDITIONAL REQUIREMENTS WITH RESPECT TO THE NAVIGATOR PROGRAM.

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

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

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

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

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

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

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

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

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) in subparagraph (C), by inserting after "qualified health plans" the following: ", State medicaid plans under title XIX of the Social Security Act, and State children's health insurance programs under title XXI of such Act"; and

(B) by adding at the end the following flush left sentence:

"The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.";

(3) in paragraph (4)(A)—

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

(B) in clause (i)—

(i) by inserting "not" before "be"; and

(ii) by striking "; or" and inserting ";";

(C) in clause (ii)—

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

(ii) by striking the period and inserting ";"; and

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

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

(4) in paragraph (6)—

(A) by striking "FUNDING.—Grants under" and inserting "FUNDING.—

"(A) STATE EXCHANGES.—Grants under"; and

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

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

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

PURPOSE AND SUMMARY

H.R. 1386, the "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2019" or the "ENROLL Act of 2019", was introduced on February 27, 2019, by Representatives Castor (D–FL), Blunt Rochester (D–DE), Crist (D–FL), and Wilson (D–FL), and referred to the Committee on Energy and Commerce.

The goal of H.R. 1386 is to fund the Navigator program for the Federally-Facilitated Marketplace (FFM) at $100 million per year. H.R. 1386 would require the Department of Health and Human Services (HHS) to ensure that Navigator grants are awarded to organizations with a demonstrated capacity to carry out the duties specified in the Affordable Care Act (ACA) and would require that there be at least two Navigator entities in each state. H.R. 1386 would further provide Navigators new duties pertaining to enrolling individuals in Medicaid and the Children's Health Insurance Program and would clarify that Navigators may carry out their duties at any time during a year. Lastly, the legislation would prohibit HHS from taking into account an entity's capacity to provide information relating to association health plans or short-term limited duration insurance (STLDI) in awarding grants.

BACKGROUND AND NEED FOR LEGISLATION

The ACA required exchanges to establish a Navigator program and award grants to Navigator entities. The law tasked Navigators with several marketplace enrollment responsibilities, including conducting public education activities to raise awareness of coverage availability on the marketplaces, facilitating enrollment in qualified health plans, and providing fair and impartial information on enrollment and financial assistance.

On August 31, 2017, HHS reduced funding for the Navigator program from $63 million to $36.8 million, a 40 percent cut from the previous year.[1] The Department further reduced funding for 2019 to $10 million.[2] The Department set the funding allocation based on a narrower goal of marketplace enrollment. A report by the Government Accountability Office (GAO) found that HHS described the enrollment goals in an "unclear manner" and failed to provide Navigator entities guidance on the performance measure.[3] The GAO report also concluded that HHS's decision to cut Navigator funding was based on "incomplete and problematic data."[4]

HHS stipulated that funding applications are to be evaluated based on a Navigator's ability to establish relationships with individuals who "may be unaware of the range of available options in addition to qualified health plans, such as association health plans [and] STLDI."[5] Lastly, HHS eliminated the requirement that each

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[1] Centers for Medicare & Medicaid Services, *Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period* (Aug. 31, 2017) (https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/downloads/policies-related-navigator-program-enrollment-education-8-31-2017pdf.pdf).

[2] Centers for Medicare & Medicaid Services, *Cooperative Agreement to Support Navigators in Federally-Facilitated Exchanges* (July 10, 2018) (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-Navigator-FOA-FAQs.pdf).

[3] Government Accountability Office, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* (Aug 23, 2018) (https://www.gao.gov/products/GAO-18-565).

[4] *Id.*

[5] *See* note 2.

marketplace have two Navigator entities and that Navigator entities maintain a physical presence in the area they are serving.[6]

H.R. 1386 would reverse HHS's actions to weaken the Navigator program and would reinstate navigator funding at $100 million per year. It would further strengthen the Navigator program by clarifying that Navigators can provide year-round assistance and enroll individuals in Medicaid and the Children's Health Insurance Program.

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. 1386:

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. 1386 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. 1386, the "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2019 " or the "ENROLL Act of 2019", was introduced on February 27, 2019, by Rep. Castor (D–FL), 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. 1386 for consideration of the bill. During markup, an amendment offered by Mr. Walden (R–OR) was defeated by a voice vote. Subsequently, the Subcommittee on Health agreed to a motion by Ms. Eshoo, Chairwoman of the Subcommittee, to favorably forward H.R. 1386 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. 1386. During the markup, Mr. Latta (R–OH)) offered an amendment to the bill that was defeated by a record vote of 22 years and 30 nays. An amendment was offered by Mr. Burgess that was adopted 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. 1386 favorably reported to the House, amended, by a record vote of 30 yeas to 22 nays.

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

[6] Department of Health and Human Services, *HHS Notice of Benefit and Payment Parameters for 2019,* 83 Fed. Reg. 16930 (April 17, 2018).

to report legislation and amendments thereto. The Committee advises that two record votes were taken during consideration of H.R. 1386. An amendment offered by Mr. Latta was defeated by a record vote of 22 years to 30 nays. A motion by Mr. Pallone to order H.R. 1385 favorably reported to the House, amended, was agreed to by a record vote of 30 yeas to 22 nays. The following are the record votes taken during Committee consideration, including the names of those members voting for and against:

COMMITTEE ON ENERGY AND COMMERCE – 116th CONGRESS
ROLL CALL VOTE # 16

BILL: **H.R. 1386**, the "Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act of 2019"

AMENDMENT: An amendment offered by Mr. Latta, No. 1, to require navigators to inform an individual who is considering enrollment in a qualified health plan that covers abortion, that such plan provides coverage for abortion services, and that the issuer of the plan is required to collect from the individual the proportion of the premium allocable to the coverage of such services.

DISPOSITION: NOT AGREED TO by a roll call vote of 22 yeas to 30 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		X		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. Loebsack		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

COMMITTEE ON ENERGY AND COMMERCE – 116th CONGRESS
ROLL CALL VOTE # 17

BILL: **H.R. 1386**, the "Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act of 2019"

MOTION: A motion by Mr. Pallone to order H.R. 1386 favorably reported to the House, amended. (Final Passage)

DISPOSITION: AGREED TO by a roll call vote of 30 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	X			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. Loebsack	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

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 1386 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. 1386 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 Act may be cited as the "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2019" or the "ENROLL Act of 2019".

Section 2. Providing for additional requirements with respect to the Navigator Program

Section 2 amends Section 1311 of the ACA and requires HHS to award grants to Navigator entities based on an entity's demonstrated capacity to carry out the duties specific under Section 1311 of the ACA. The section prohibits HHS from taking into account a Navigator entity's capacity to provide information relating to association health plans or STLDI in awarding grants. The section requires that grants are awarded to at least two entities, one of which must be a community and consumer-focused nonprofit group. The section establishes new Navigator duties pertaining to enrolling individuals in Medicaid and the Children's Health Insurance Program and clarifies that all Navigator duties may be carried out at any time during a year. The section funds Navigator grants at $100 million per year out of the user fees collected from participating health issuers on the FFM and establishes that the funds may remain available until expended.

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

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Subtitle D—Available Coverage Choices for All Americans

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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 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.

(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 requirement 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, 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.

(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).

(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 by the Secretary for purposes of section 2791(b)(5) of the Public Health Service Act); and

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

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

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

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.

(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*, State medicaid plans under title XIX of the Social Security Act, and State children's health insurance programs under title XXI of such Act*;

(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.

The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.

(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) *not* be a health insurance issuer[; or]*;*

(ii) *not* 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[.]*;*

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

(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] *FUNDING.—*

(A) STATE EXCHANGES.—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.

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

(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.

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DISSENTING VIEWS

This legislation redirects $100 million annually from the exchange user fee program to the Navigator program. The Centers for Medicare and Medicaid Services (CMS) recently proposed reducing the Federally-facilitated marketplace (FFM) exchange user fee from 3.5 to 3.0 percent, prior to the introduction of H.R. 1386.[1] This user fee reduction was maintained in the final rule published in the Federal Register April 25, 2019.[2]

The Patient Protection and Affordable Care Act (PPACA) established the Navigator program and enrollment education to provide guidance to enrollees, inform consumers of Open Enrollment Periods, and notify potential enrollees about ways to sign up for coverage.[3] For plan year 2017, Navigators received a total of $62.5 million in grants and enrolled 81,426 individuals,[4] which accounted for less than one percent of total enrollees. Meanwhile, according to CMS, "[b]y contrast, agents and brokers assisted with 42 percent of [Federally Facilitated Exchange (FFE)] enrollment for plan year 2018, which cost the FFE only $2.40 per enrollee to provide training and technical assistance."[5] For this reason, Navigator grantees received funding for plan year 2018 based on their ability to reach enrollment goals for the previous year. Therefore, the Navigator program should not be provided additional funding, particularly because the program has failed to reach enrollment goals and have

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[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227 (2019), Centers for Medicare and Medicaid Services, *Proposed rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020,* (Jan. 17, 2019), *available at* https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-00077.pdf.

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454 (2019); Centers for Medicare and Medicaid Services, *Final rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020,* (April 25, 2019), *available at* https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.

[3] 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)).

[4] Centers for Medicare and Medicaid Services, *CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment,* (Aug. 31, 2017), *available at* https://www.cms.gov/newsroom/press-releases/cms-announcement-aca-navigator-program-and-promotion-upcoming-open-enrollment.

[5] *Id.*

been proven highly inefficient and susceptible to waste. The program should not be granted further taxpayer dollars that are likely to be inefficiently used.

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