

This section relates to health benefit exchanges that are voluntarily established by a State.

There's a widespread belief that a state-exchange gives a state more control over its destiny. That's incorrect. Despite being voluntarily created by States, federal control of a section 1311 exchange is complete, total, and absolute. Such exchanges are administrative implements of the federal government. The HHS Secretary has autocratic and arbitrary power. Examples of such are highlighted below.

H. R. 3590—55

## PART II—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

Exchanges to be established by Jan. 1, 2014, however, such exchanges are voluntary. See [sect. 1321](#).

"Exchange" is particularly defined in [1311\(d\)\(1\)](#). (This definition is important in [sect. 1321\(a\)\(1\)](#).)

You can shop for a "qualified" plan, i.e., government-dictated plans. More [here](#).

Micro-managing, examples #1-4:

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The Secretary sets criteria for certification and accreditation

HHS approval is needed for marketing,

for the selection of providers participating,

and of the populations served.

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; and

(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.

Micro-managing, examples #5-7:

The secretary must approve the forms a state wants to use.

(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).

Micro-managing, example #8:  
The HHS Secretary, not you, dictates health-plan ratings.

Micro-managing example #9:  
The HHS Secretary sets the standards for a state's (mandatory) internet portal.

Micro-managing example #10:  
Requirements dictated by the HHS Secretary with respect to a state exchange's enrollment periods.

A 1311 exchange is defined as an entity that is established by a State.

Such a definition excludes federally-imposed exchanges.

(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 to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).

(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

Only government plans may be sold.

States may require additional benefits, but, for people who receive federal subsidies, states must subsidize those people's added benefits (from state funds).

Micro-managing examples #11-15.

State exchanges MUST

- use the HHS Sec's certification,
- provide a toll-free number,
- provide standardized internet website,
- use ratings approved by HHS,
- and use HHS formats.

of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

Exchanges must automatically enroll you in Medicaid, CHIP, or other programs, if they decide you are eligible.

(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;

A state exchange must provide the IRS with names and SSNs of people who receive tax credits (subsidies), if either...

(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—

...the employer didn't provide "minimum essential coverage",

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

or if the IRS determines that the coverage provided was "unaffordable to the employee."

(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.—

States exchanges must monitor and report the EMPLOYMENT status of individuals to the IRS.

Once established, a State must bear all the costs of operating an exchange, forever.

Micro-managing example #16:

Feds approve salaries of state exchange employees.

State exchanges may not lobby for changes.

(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) 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 may take this information, and the information and the recommendations provided to the Exchange by the State under

Voluntarily-established state exchanges are fully controlled by federal standards, viz., by HHS Secretary fiat.

Micro-managing example #17:

Certified health plans in state exchanges must get permission to raise premiums.

If a premium increase is deemed excessive, the plan loses its certification to sell in the Exchange.

Interstate cooperations require HHS approval.

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.

(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; and

(D) the implementation of wellness and health promotion activities.

(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

Qualified health plans in a state exchange may only contract with hospitals under certain HHS guidelines and conditions.

HHS Secretary may arbitrarily require "mechanisms to improve health care quality," a subjective judgement made by the Secretary.

#### NAVIGATOR GRANT PROGRAM

A grant program that exchanges are required to create, that funds PR organizations to advertise and promote Obamacare, enrollment, and specifically promote awareness of and application for subsidies.

Communications are required to be "culturally and linguistically appropriate," which logically implies "multilingual, and multi-cultural."

The HHS Secretary may arbitrarily grant waivers, favors, and exemptions.

nonprofit groups, chambers of commerce, unions, small business development centers, 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.

A "Navigator," a mandatory granted program in a state exchange, is tasked with promoting and advertising, recruiting, and assisting the public in enrolling for Obamacare,

and providing referrals to assist with a) grievances and questions about plans and benefits, and b) determinations made under such plans.

Micro-managing example #18: HHS dictates advertising style. By implication, this language requires that communications be multi-lingual and multi-cultural.

FEDERAL SUPREMACY  
State exchanges may not do anything contrary to the policy of the HHS Secretary.

"Navigators" promote & advertise the availability of Obamacare subsidies to the public.