61

AMENDMENT

OFFERED BY MR. MATHESON OF UTAH

[AHCAA_001]

Strike section 236.

Strike section 242 and insert the following:

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) IN GENERAL.—The Commissioner shall assist the American Health Benefit Exchanges in carrying out subtitle A of title II of this division and the duties described in subsection (b) and shall provide mechanisms by which such Exchanges may coordinate efforts.

(b) OTHER DUTIES CARRIED OUT BY AMERICAN HEALTH BENEFIT EXCHANGES.—Any reference in this Act or in the amendments made by this Act (other than this section and sections 201 and 241) to the Health Choices Commissioner (or to the Commissioner) shall be treated as a reference to the American Health Benefit Exchanges with respect to the State covered by such Exchange. Any reference in this Act or in the amendments made by this Act to the Health Insurance Exchange shall be treated as a reference to the American Health Benefit

Exchanges with respect to the State covered by such Exchange.

Strike subtitle A of title III of division A and insert the following:

Subtitle A—State-Based Health Insurance Exchanges

SEC. 301. ESTABLISHMENT OF STATE-BASED HEALTH INSURANCE EXCHANGES.

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

(1) PLANNING AND ESTABLISHMENT GRANTS.—Not later than 60 days after the date of enactment of this section, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—

(A) TOTAL DETERMINED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available for grants under this subsection.

(B) STATE AMOUNT.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary under which

each State shall receive an award in an amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population.

(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.—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 subtitles A and B of title II; and

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

(B) LIMITATION.—If a State is an establishing State or a participating State (as de-

fined in section 303), such State shall not be eligible for a grant renewal under subparagraph (A) as of the second fiscal year following the date on which such State was deemed to be an establishing State or a participating State.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection in each of fiscal years 2009 through 2013.

(b) AMERICAN HEALTH BENEFIT EXCHANGES.—An American Health Benefit Exchange (referred to in this section as an "Exchange") means a mechanism that—

(1) facilitates the purchase of health insurance coverage and related insurance products through the Exchange at an affordable price by qualified individuals and qualified employer groups; and

(2) meets the requirements of subsection (c).

(c) REQUIREMENTS.—

(1) ESTABLISHMENT.—An exchange shall be a governmental agency or nonprofit entity that is established by—

(A) a State, in the case of an establishing State (as described in section 303); or

(B) the Secretary, in the case of a participating State (as described in section 303).

(2) OFFERING OF COVERAGE.—

(A) IN GENERAL.—An exchange shall make available essential health benefits as specified under subtitle C of title II to qualified individuals and qualified employers.

(B) INCLUSION.—In making available coverage pursuant to subparagraph (A), an exchange may include a public health insurance option (as described in subtitle B).

(C) LIMITATION.—An exchange may not make available any health plan or other health insurance coverage that is not a qualified health plan.

(D) ALLOWANCE TO OFFER.—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 subtitle C of title II.

(E) STATES MAY REQUIRE ADDITIONAL BENEFITS.—Subject to the requirements of subparagraph (F), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits described in subtitle C of title II.

(F) ADDITIONAL BENEFITS.—

(i) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (E) that a qualified health plan cover benefits in addition to the essential health benefits required shall not affect the amount of a credit provided under subtitle C.

(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (E).

(3) FUNCTIONS.—An exchange shall, at a minimum—

(A) establish procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (l), of health plans as qualified health plans;

(B) develop and make available tools to allow consumers to receive accurate information on—

(i) expected premiums and out of pocket expenses (taking into account any

credits for which such individual is eligible under subtitle C);

(ii) the availability of in-network and out-of-network providers;

(iii) the costs of any surcharge assessed under paragraph (5);

(iv) data, by plan, that reflects the frequency with which preventive services rated "A" or "B" by the U.S. Preventive Services Task Force are utilized by enrollees, a comparison of such data to the average frequency of preventive services utilized by enrollees across all qualified health plans, and whether "A" and "B" rated preventive services are utilized by enrollees as frequently as recommended by the U.S. Preventive Services Task Force; and

(v) such other matters relating to consumer costs and expected experience under the plan as an exchange may determine necessary;

(C) utilize the administrative simplification measures and standards developed under this Act;

(D) enter into agreements, to the extent determined appropriate by the exchange, with navigators, as described in section 304;

(E) facilitate the purchase of coverage for long-term services and supports; and

(F) collect, analyze, and respond to complaints and concerns from enrollees regarding coverage provided through the exchange.

(4) SURCHARGES.—

(A) IN GENERAL.—An exchange may assess a surcharge on all health insurance issuers offering qualified health plans through the exchange to pay for the administrative and operational expenses of the exchange.

(B) LIMITATION.—A surcharge described in subparagraph (A) may not exceed 4 percent of the premiums collected by a qualified health plan.

(5) RISK ADJUSTMENT PAYMENT.—

(A) ESTABLISHING AND PARTICIPATING STATES.—

(i) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in

section 304) shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subparagraph (C) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(ii) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in section 304) shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subparagraph (C) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health

plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(B) CRITERIA AND METHODS.—The Secretary, in consultation with States shall establish criteria and methods to be used in carrying out the risk adjustment activities under this paragraph. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under parts C and D of title XVIII of the Social Security Act.

(C) SCOPE.—A health plan or a health insurance issuer is described in this subparagraph if such health plan or health insurance issuer provides coverage for an individual or for an employer group the size of which does not exceed—

(i) in the case of an employer with its primary place of business located in an establishing State, the criteria relating to the size of employers established by such State as described in section 202; or

(ii) in the case of an employer with its primary place of business located in a participating State, the criteria relating to the

size of employers established by the Secretary as described in section 202.

(6) FACILITATING ENROLLMENT.—

(A) IN GENERAL.—An exchange shall (through, to the extent practicable, the use of information technology) implement policies and procedures to—

(i) facilitate the identification of individuals who lack qualifying coverage; and

(ii) assist such individuals in enrolling in—

(I) a qualified health plan that is affordable and available to such individual, if such individual is a qualified individual;

(II) the medicaid program under title XIX of the Social Security Act, if such individual is eligible for such program;

(III) the CHIP program under title XXI of the Social Security Act, if such individual is eligible for such program; or

(IV) other Federal programs in which such individual is eligible to participate.

(B) CHOICE FOR INDIVIDUALS ELIGIBLE FOR CHIP.—A qualified individual who is eligible for the Children's Health Insurance Program under title XXI of the Social Security Act may elect to enroll in such program or in a qualified health plan. Where such individual is a minor child, such election shall be made by the parent or guardian of such child.

(C) OVERSIGHT.—The Secretary shall oversee the implementation of subparagraph (A)(ii) to ensure that individuals are directed to enroll in the program most appropriate under such subparagraph for each such individual.

(D) ACCESSIBILITY OF MATERIALS.—Any materials used by an exchange to carry out this paragraph shall be provided in a form and manner calculated to be understood by as many qualified individuals as possible including individuals with disabilities.

(7) CONSULTATION.—An exchange shall consult with stakeholders relevant to carrying out the activities under this subsection, including—

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

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

(C) employers who are eligible to participate in the exchange;

(D) State Medicaid offices and other relevant State agencies and departments; and

(E) advocates for enrolling hard to reach populations.

(8) STANDARDS AND PROTOCOLS.—

(A) IN GENERAL.—The Secretary, in consultation with the Office of the National Coordinator for Health Information Technology, shall develop interoperable, secure, scalable, and reusable standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs.

(B) COORDINATION.—The Secretary shall facilitate enrollment of individuals in programs described in subparagraph (A) through methods which shall include—

(i) electronic matching against existing Federal and State data to serve as evi-

dence of eligibility and digital documentation in lieu of paper-based documentation;

(ii) capability for individuals to apply, recertify, and manage eligibility information online, including conducting real-time queries against databases for existing eligibility prior to submitting applications; and

(iii) other functionalities necessary to provide eligible individuals with a streamlined enrollment process.

(C) ASSISTANCE.—The Secretary shall award grants to enhance community-based enrollment to—

(i) States to assist such States in—

(I) contracting with qualified technology vendors to develop or acquire electronic enrollment software systems;

(II) contracting with community and consumer focused nonprofit organizations with experience working with consumers, including the uninsured and the underinsured, to establish Statewide helplines for enrollment assistance and referrals; and

(III) establishing public education campaigns through grants to qualifying organizations for the design and implementation of public education campaigns targeting uninsured and traditionally underserved communities; and

(ii) community-based organizations for infrastructure and training to establish electronic assistance programs.

(9) NOTIFICATION.—With respect to the standards and protocols developed under subsection (9), the Secretary—

(A) shall notify States of such standards and protocols; and

(B) may require, as a condition of receiving Federal funds, that States or other entities incorporate such standards and protocols into such investments.

(d) CERTIFICATION.—An exchange may certify a health plan if—

(1) such health plan meets the requirements of subsection (l); and

(2) the exchange determines that making available such health plan through such exchange is in

the interests of qualified individuals and qualified employers in the States or States in which such exchange operates.

(e) GUIDANCE.—The Secretary shall develop guidance that may be used by an exchange to carry out the activities described in subsection (c).

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An exchange may operate in more than one State, provided that each State in which such exchange operates permits such operation.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary exchange, provided that—

(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 community rating area.

(g) PORTALS TO STATE EXCHANGE.—The Secretary shall establish a mechanism, including an Internet website, through which a resident of any State may identify any exchange operating in such State.

(h) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY TIER.—A qualified employer may select to provide support for coverage of employees under a qualified health plan at any tier of cost sharing described in subtitle C.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A TIER.—Each employee of a qualified employer may choose to enroll in a qualified health plan that offers coverage at the tier of cost sharing selected by an employer described in subparagraph (A).

(3) SELF-EMPLOYED INDIVIDUALS.—

(A) DEEMING.—An individual who is self-employed (as defined in section 401(c)(1) of the Internal Revenue Code of 1986) shall be deemed to be a qualified employer unless such individual notifies the applicable exchange that such individual elects to be considered a qualified individual.

(B) ELIGIBILITY.—In the case of a self-employed individual making the election described in subparagraph (A)—

(i) the income of such individual for purposes of subtitle C shall be deemed to be the total business income of such individual;

(ii) premium payments made by such individual to a qualified health plan shall not be treated as employer-provided coverage under section 106(a) of the Internal Revenue Code of 1986; and

(iii) the individual shall not be eligible for a credit under subtitle C.

(i) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(j) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in an individual plan, including individuals who do not purchase such a plan through the exchange, to be a member of a single risk pool.

(2) GROUP HEALTH INSURANCE POLICIES.—A health insurance issuer shall consider all enrollees in a group health plan, other than a self-insured group health plan, including individuals who do not purchase such a plan through the exchange, to be a member of a single risk pool.

(k) EMPOWERING CONSUMER CHOICE.—

(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this subtitle shall be construed to prohibit a health insurance issuer from offering a health insurance policy or providing coverage under such policy to a qualified individual where such policy is not a qualified health plan. Nothing in this subtitle shall be construed to prohibit a qualified individual from enrolling in a health insurance plan where such plan is not a qualified health plan.

(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this subtitle shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is not a qualified health plan to offer benefits required under State law.

(3) VOLUNTARY NATURE OF EXCHANGES.—

(A) CHOICE, TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an exchange.

(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified plan or to participate in an exchange.

(l) CRITERIA FOR CERTIFICATION.—

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

(A) not employ marketing practices that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) employ methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice;

(C) ensure a wide choice of providers (in a manner consistent with applicable network adequacy provisions under section 215);

(D) make available to individuals enrolled in, or seeking to enroll in, such plan a detailed description of—

(i) benefits offered, including maximums, limitations (including differential cost-sharing for out of network services), exclusions and other benefit limitations;

(ii) the service area;

(iii) required premiums;

(iv) cost-sharing requirements;

(v) the manner in which enrollees access providers; and

(vi) the grievance and appeals procedures;

(E) provide coverage for at least the essential health care benefits established under subtitle C of title II;

(F)(i) is accredited by the National Committee for Quality Assurance or by any other entity recognized by the Secretary for the accreditation of health insurance issuers or plans; or

(ii) receives such accreditation within a period established by an exchange for such ac-

creditation that is applicable to all qualified health plans;

(G) implement a quality improvement strategy described in subsection (m)(1);

(H) have adequate procedures in place for appeals of coverage determinations; and

(I) may not establish a benefit design that is likely to substantially discourage enrollment by certain qualified individuals in such plan.

(2) REQUEST TO NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary model criteria for the certification of qualified health plans, that addresses the elements described in subparagraphs (A) through (I) of paragraph (1). In developing such criteria, the National Association of Insurance Commissioners shall consult with appropriate Federal agencies, consumer representatives, insurance carriers, and other stakeholders.

(3) REQUIRED CONSIDERATION.—If the model criteria described in paragraph (2) are submitted to the Secretary by the date that is 9 months after the date on which a request is made under such paragraph, the Secretary shall consider such model cri-

teria in promulgating the regulations under paragraph (1).

(m) 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 as defined in section 1302, 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).

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

(o) QUALITY IMPROVEMENT.—

(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2012 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 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).

(p) CONTINUED APPLICABILITY OF MENTAL HEALTH PARITY.—Section 2716 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.

SEC. 302. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—

(1) IN GENERAL.—An exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) INVESTIGATIONS.—The Secretary may investigate the affairs of an exchange, may examine the properties and records of an exchange, and may require periodical reports in relation to activities undertaken by an exchange. An exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS.—An exchange shall be subject to annual audits by the Secretary.

(4) PATTERN OF ABUSE.—If the Secretary determines that an exchange or a State has engaged in serious misconduct with respect to compliance with, or carrying out activities required, under this subtitle, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments

per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this subtitle, the Secretary shall provide for the efficient and non-discriminatory administration of exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this subtitle; and

(B) the Secretary has authority for under this subtitle or any other Act.

(b) GAO OVERSIGHT.—Not later than 5 years after the date of enactment of this section, the Comptroller General shall conduct an ongoing study of exchange activities and the enrollees in qualified health plans offered through exchanges. Such study shall review—

(1) the operations and administration of exchanges, including surveys and reports of qualified health plans offered through exchanges and on the experience of such plans (including data on enrollees in exchanges and individuals purchasing health insurance coverage outside of exchanges), the expenses

of exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which exchanges meets their goals;

(2) any significant observations regarding the utilization and adoption of exchanges; and

(3) where appropriate, recommendations for improvements in the operations or policies of exchanges.

SEC. 303. ALLOWING STATE FLEXIBILITY.

(a) OPTIONAL STATE ESTABLISHMENT OF EXCHANGE.—During the 3-year period following the date of enactment of this section, a State may—

(1)(A) establish an exchange (as defined for purposes of section 301);

(B) adopt the insurance reform provisions as provided for in title II (and the amendments made by such title); and

(C) agree to make employers who are State or local governments subject to subtitles B and C of title II;

(2)(A) request that the Secretary operate (for a minimum period of 5 years) an exchange in such State;

(B) adopt the insurance reform provisions as provided for in subtitles A, B, and C of title II (and the amendments made by such subtitles); and

(C) agree to make employers who are State or local governments subject to sections 162 and 163 of the Affordable Health Choices Act; or

(3) elect not to take the actions described in paragraph (1) or (2).

(b) ESTABLISHING STATES.—

(1) IN GENERAL.—If the Secretary determines that a State has taken the actions described in subsection (a)(1), any resident of that State who is an eligible individual shall be eligible for credits under section 3111 of the Public Health Service Act (42 U.S.C. 201 et seq.), as added by section 2301, beginning on the date that is 60 days after the date of such determination.

(2) CONTINUED REVIEW.—The Secretary shall establish procedures to ensure continued review by the Secretary of the compliance of a State with the requirements of subsection (a). If the Secretary determines that a State has failed to maintain compliance with such requirements, the Secretary may revoke the determination under subparagraph (A).

(3) DEEMING.—A State that is the subject of a positive determination by the Secretary under paragraph (1) (unless such determination is revoked under paragraph (2)) shall be deemed to be an "establishing State" beginning on the date that is 60 days after the date of such determination.

(c) REQUEST FOR THE SECRETARY TO ESTABLISH AN EXCHANGE.—

(1) IN GENERAL.—In the case of a State that makes the request described in subsection (a)(2), the Secretary shall determine whether the State has enacted and has in effect the insurance reforms provided for in title III.

(2) OPERATION OF EXCHANGE.—

(A) POSITIVE DETERMINATION.—If the Secretary determines that the State has enacted and has in effect the insurance reforms described in paragraph (1), the Secretary shall establish an exchange in such State as soon as practicable after making such determination.

(B) NEGATIVE DETERMINATION.—If the Secretary determines that the State has not enacted or does not have in effect the insurance reforms described in paragraph (1), the Secretary shall establish an exchange in such State

as soon as practicable after the Secretary determines that such State has enacted such reforms.

(3) PARTICIPATING STATE.—The State shall be deemed to be a "participating State" on the date on which the exchange established by the Secretary is in effect in such State.

(4) ELIGIBILITY.—Any resident of a State described in paragraph (3) who is an eligible individual shall be eligible for credits under subtitle C beginning on the date that is 60 days after the date on which such exchange is established in such State.

(d) FEDERAL FALLBACK IN THE CASE OF STATES THAT REFUSE TO IMPROVE HEALTH CARE COVERAGE.—

(1) IN GENERAL.—Upon the expiration of the 3-year period following the date of enactment of this section, in the case of a State that is not otherwise a participating State or an establishing State—

(A) the Secretary shall establish and operate an exchange in such State;

(B) the insurance reform provisions provided for title II shall become effective in such State, notwithstanding any contrary provision of State law;

(C) the State shall be deemed to be a "participating State"; and

(D) the residents of that State who are eligible individuals shall be eligible for credits under subtitle C beginning on the date that is 60 days after the date on which such exchange is established, if the State agrees to make employers who are State or local governments subject to applicable requirements of this Act.

(2) ELIGIBILITY OF INDIVIDUALS FOR CREDITS.—With respect to a State that makes the election described in subsection (a)(3), the residents of such State shall not be eligible for credits under subtitle C until such State becomes a participating State under paragraph (1).

SEC. 304. NAVIGATORS.

(a) IN GENERAL.—The Secretary shall award grants to establishing or participating States to enable such States (or the exchanges operating in such States) to enter into agreements with private and public entities under which such entities will serve as navigators in accordance with this section.

(b) ELIGIBILITY.—

(1) IN GENERAL.—To be eligible to enter into an agreement under subsection (a), an entity shall

demonstrate that the entity has existing relationships with, or could readily establish relationships with, employers and employees, consumers (including the uninsured and the underinsured), and self-employed individuals, likely to be eligible to participate in the program under this subtitle.

(2) TYPES.—Entities described in paragraph (1) 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, small business development centers, other licensed insurance agents and brokers, and other entities that the Secretary determines to be capable of carrying out the duties described in subsection (c).

(c) DUTIES.—An entity that serves as a navigator under an agreement under subsection (a) shall—

(1) conduct public education activities to raise awareness of the program under this subtitle;

(2) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of credits under subtitle C;

(3) facilitate enrollment in a qualified health plan; and

(4) provide information in a manner determined by the Secretary to meet the needs of the population served by the exchange.

(d) STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish standards for navigators under this section, 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 section and to avoid conflicts of interest.

(2) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop guidelines regarding the duties described in subsection (c).