

111TH CONGRESS  
1ST SESSION

# S. 1278

To establish the Consumers Choice Health Plan, a public health insurance plan that provides an affordable and accountable health insurance option for consumers.

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IN THE SENATE OF THE UNITED STATES

JUNE 17, 2009

Mr. ROCKEFELLER (for himself and Mr. BROWN) introduced the following bill;  
which was read twice and referred to the Committee on Finance

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## A BILL

To establish the Consumers Choice Health Plan, a public health insurance plan that provides an affordable and accountable health insurance option for consumers.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Consumers Health  
5 Care Act of 2009”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

8 (1) Americans need health care coverage that is  
9 always affordable.

1           (2) Americans need health care coverage that is  
2 always adequate.

3           (3) Americans need health care coverage that is  
4 always accountable.

5           (4) A public health insurance plan option that  
6 can compete with private insurance plans is the only  
7 way to guarantee that all consumers have affordable,  
8 adequate, and accountable options available in the  
9 insurance marketplace.

10 **SEC. 3. OFFICE OF HEALTH PLAN MANAGEMENT.**

11       (a) ESTABLISHMENT.—Not later than July 1, 2010,  
12 there shall be established within the Department of Health  
13 and Human Services an Office of Health Plan Manage-  
14 ment (referred to in this Act as the “Office”). The Office  
15 shall be headed by a Director (referred to in this Act as  
16 the “Director”) who shall be appointed by the President,  
17 by and with the advice and consent of the Senate.

18       (b) COMPENSATION.—The Director shall be paid at  
19 the annual rate of pay for a position at level II of the  
20 Executive Schedule under section 5313 of title 5, United  
21 States Code.

22       (c) LIMITATION.—Neither the Director nor the Office  
23 shall participate in the administration of the National  
24 Health Insurance Exchange (as defined in section 7) or

1 the promulgation or administration of any regulation re-  
2 garding the health insurance industry.

3 (d) PERSONNEL AND OPERATIONS AUTHORITY.—

4 The Director shall have the same general authorities with  
5 respect to personnel and operations of the Office as the  
6 heads of other agencies and departments of the Federal  
7 Government have with respect to such agencies and de-  
8 partments.

9 **SEC. 4. CONSUMER CHOICE HEALTH PLAN.**

10 (a) IN GENERAL.—The Office shall establish and ad-  
11 minister the Consumer Choice Health Plan (referred to  
12 in this Act as the “Plan”) to provide for health insurance  
13 coverage that is made available to all eligible individuals  
14 (as described in subsection (d)(1)) in the United States  
15 and its territories.

16 (b) REGULATORY COMPLIANCE.—The Plan shall  
17 comply with—

18 (1) all regulations and requirements that are  
19 applicable with respect to other health insurance  
20 plans that are offered through the National Health  
21 Insurance Exchange; and

22 (2) any additional regulations and require-  
23 ments, as determined by the Director.

24 (c) BENEFITS.—

1           (1) IN GENERAL.—The Plan shall offer health  
2 insurance coverage at different benefit levels, pro-  
3 vided that such benefits are commensurate with the  
4 required benefit levels to be provided by a health in-  
5 surance plan under the National Health Insurance  
6 Exchange.

7           (2) MINIMUM BENEFITS FOR CHILDREN.—

8           (A) IN GENERAL.—The minimum benefit  
9 level available under the Plan for children shall  
10 include at least the services described in the  
11 most recently published version of the “Mater-  
12 nal and Child Health Plan Benefit Model” de-  
13 veloped by the National Business Group on  
14 Health.

15           (B) AMENDMENT OF BENEFIT LEVEL.—

16           The Secretary of Health and Human Services,  
17 acting through the Director of the Agency for  
18 Healthcare Research and Quality, may amend  
19 the benefits described in subparagraph (A)  
20 based on the most recent peer-reviewed and evi-  
21 dence-based data.

22           (d) ELIGIBILITY AND ENROLLMENT.—

23           (1) ELIGIBILITY.—An individual who is eligible  
24 to purchase coverage from a health insurance plan

1 through the National Health Insurance Exchange  
2 shall be eligible to enroll in the Plan.

3 (2) ENROLLMENT PROCESS.—An individual  
4 may enroll in the Plan only in such manner and  
5 form as may be prescribed by applicable regulations,  
6 and only during an enrollment period as prescribed  
7 by the Director.

8 (3) EMPLOYER ENROLLMENT.—An employer  
9 shall be eligible to purchase health insurance cov-  
10 erage for their employees and the employees' de-  
11 pendents to the extent provided for all health bene-  
12 fits plans under the National Health Insurance Ex-  
13 change.

14 (4) SATISFACTION OF INDIVIDUAL MANDATE  
15 REQUIREMENT.—An individual's enrollment with the  
16 Plan shall be treated as satisfying any requirement  
17 under Federal law for such individual to dem-  
18 onstrate enrollment in health insurance or benefits  
19 coverage.

20 (e) PROVIDERS.—

21 (1) NETWORK REQUIREMENT.—

22 (A) MEDICARE.—A participating provider  
23 who is voluntarily providing health care services  
24 under the Medicare program established under  
25 title XVIII of the Social Security Act (42

1 U.S.C. 1395 et seq.) shall be required to pro-  
2 vide services to any individual enrolled in the  
3 Plan.

4 (B) MEDICAID AND CHIP.—A provider of  
5 health care services under the Medicaid pro-  
6 gram established under title XIX of the Social  
7 Security Act (42 U.S.C. 1396 et seq.), or the  
8 CHIP program established under title XXI of  
9 such Act (42 U.S.C. 1397aa et seq.), shall be  
10 required to provide services to any individual  
11 enrolled in the Plan.

12 (2) EXCEPTION.—Paragraph (1) shall not be  
13 construed as requiring a provider to accept new pa-  
14 tients due to bona fide capacity limitations of the  
15 provider.

16 (3) OPT-OUT PROVISION.—

17 (A) MEDICARE.—A participating provider  
18 as described under paragraph (1)(A) shall be  
19 required to provide services to any individual  
20 enrolled in the Plan for the 3-year period fol-  
21 lowing the establishment of the Plan. Upon the  
22 expiration of the 3-year period, a participating  
23 provider in the Plan may elect to become a non-  
24 participating provider without affecting their

1 status as a participating provider under the  
2 Medicare program.

3 (B) MEDICAID AND CHIP.—A provider as  
4 described under paragraph (1)(B) shall be re-  
5 quired to provide services to any individual en-  
6 rolled in the Plan for the 3-year period fol-  
7 lowing the establishment of the Plan. Upon the  
8 expiration of the 3-year period, a provider in  
9 the Plan may elect to cease provision of services  
10 under the Plan without affecting their status as  
11 a provider under the Medicaid program or the  
12 CHIP program.

13 (4) PAYMENT RATES.—

14 (A) INITIAL PAYMENT RATES.—

15 (i) IN GENERAL.—During the 2-year  
16 period following the establishment of the  
17 Plan, providers shall be reimbursed at such  
18 payment rates as are applicable under the  
19 Medicare program.

20 (ii) ADJUSTMENT.—The Director may  
21 reimburse providers at rates lower or high-  
22 er than applicable under the Medicare pro-  
23 gram if the Director determines that the  
24 adjusted rates are appropriate and ensure  
25 that enrollees in the Plan are provided

1 with adequate access to health care serv-  
2 ices.

3 (B) SUBSEQUENT PAYMENT RATES.—Sub-  
4 ject to subparagraph (C), upon the expiration  
5 of the 2-year period following the establishment  
6 of the Plan, the Director shall develop payment  
7 rates for reimbursement of providers in order to  
8 maintain an adequate provider network nec-  
9 essary to assure that enrollees in the Plan have  
10 adequate access to health care. In determining  
11 such payment rates, the Director shall con-  
12 sider—

13 (i) competitive provider payment rates  
14 in both the public and private sectors;

15 (ii) best practices among providers;

16 (iii) integrated models of care delivery  
17 (including medical home and chronic care  
18 coordination models);

19 (iv) geographic variation in health  
20 care costs;

21 (v) evidence-based practices;

22 (vi) quality improvement;

23 (vii) use of health information tech-  
24 nology; and

1 (viii) any additional measures, as de-  
2 termined by the Director.

3 (C) PAYMENT RATE CONSULTATION.—The  
4 Director shall determine payment rates under  
5 subparagraph (B) in consultation with pro-  
6 viders participating under the Plan, the Direc-  
7 tor of the Office of Personnel Management, the  
8 Medicare Payment Advisory Commission, and  
9 the Medicaid and CHIP Payment and Access  
10 Commission.

11 (5) ADOPTION OF MEDICARE REFORMS.—The  
12 Plan may adopt Medicare system delivery reforms  
13 that provide patients with a coordinated system of  
14 care and make changes to the provider payment  
15 structure.

16 (f) SUBSIDIES.—The Plan shall be eligible to accept  
17 subsidies, including subsidies for the enrollment of individ-  
18 uals under the Plan, in the same manner and to the same  
19 extent as other health insurance plans offered through the  
20 National Health Insurance Exchange.

21 (g) FINANCING.—

22 (1) TRANSITIONAL FUNDING.—

23 (A) IN GENERAL.—In order to provide for  
24 adequate funding of the Plan in advance of re-  
25 ceipt of payments as described in paragraph

1 (2), beginning July 1, 2010, there are trans-  
2 ferred to the Plan from the general fund of the  
3 Treasury such amounts as may be necessary for  
4 operation of the Plan until the end of the 3-  
5 year period following the establishment of the  
6 Plan.

7 (B) RETURN OF FUNDS.—Upon the expi-  
8 ration of the 3-year period following the estab-  
9 lishment of the Plan, the Director shall enter  
10 into a repayment schedule with the Secretary of  
11 the Treasury to provide for repayment of funds  
12 provided under subparagraph (A). Any expendi-  
13 tures made by the Plan pursuant to a repay-  
14 ment schedule established under this subpara-  
15 graph shall not constitute administrative ex-  
16 penses as described in paragraph (2)(B).

17 (2) SELF-FINANCING.—

18 (A) IN GENERAL.—The Plan shall be fi-  
19 nancially self-sustaining insofar as funds used  
20 for operation of the Plan (including benefits,  
21 administration, and marketing) shall be derived  
22 from—

23 (i) insurance premium payments and  
24 subsidies for individuals enrolled in the  
25 Plan; and

1 (ii) payments made to the Plan by  
2 employers that do not offer health insur-  
3 ance coverage to their employees.

4 (B) LIMITATION ON ADMINISTRATIVE EX-  
5 PENSES.—Not more than 5 percent of the  
6 amounts provided under subparagraph (A) may  
7 be used for the annual administrative costs of  
8 the Plan.

9 (3) CONTINGENCY RESERVE.—

10 (A) IN GENERAL.—The Director shall es-  
11 tablish and fund a contingency reserve for the  
12 Plan in a form similar to the contingency re-  
13 serve provided for health benefits plans under  
14 the Federal Employees Health Benefits Pro-  
15 gram under chapter 89 of title 5, United States  
16 Code.

17 (B) REVENUE.—Any revenue generated  
18 through the contingency reserve established in  
19 subparagraph (A) shall be transferred to the  
20 Plan for the purpose of reducing enrollee pre-  
21 miums, reducing enrollee cost-sharing, increas-  
22 ing enrollee benefits, or any combination there-  
23 of.

24 (4) GAO FINANCIAL AUDIT AND REPORT.—Be-  
25 ginning not later than October 1, 2011, the Comp-

1 troller General shall conduct an annual audit of the  
2 financial statements and records of the Plan, in ac-  
3 cordance with generally accepted government audit-  
4 ing standards, and submit an annual report on such  
5 audit to the Congress.

6 (5) SUPERMAJORITY REQUIREMENT FOR SUP-  
7 PLEMENTAL FUNDING.—Upon certification by the  
8 Comptroller General that the financial audit de-  
9 scribed in paragraph (4) indicates that the Plan is  
10 insolvent, supplemental funding may be appropriated  
11 for the Plan if such measure receives not less than  
12 a three-fifths vote of approval of the total number  
13 of Members of the House of Representatives and the  
14 Senate.

15 (h) TRANSPARENCY.—

16 (1) IN GENERAL.—Beginning with the first  
17 year of operation of the Plan through the National  
18 Health Insurance Exchange, the Director shall pro-  
19 vide standards and undertake activities for pro-  
20 moting transparency in costs, benefits, and other  
21 factors for health insurance coverage provided under  
22 the Plan.

23 (2) STANDARD DEFINITIONS OF INSURANCE  
24 AND MEDICAL TERMS.—

1 (A) IN GENERAL.—The Director shall pro-  
2 vide for the development of standards for the  
3 definitions of terms used in health insurance  
4 coverage under the Plan, including insurance-  
5 related terms (including the insurance-related  
6 terms described in subparagraph (B)) and med-  
7 ical terms (including the medical terms de-  
8 scribed in subparagraph (C)).

9 (B) INSURANCE-RELATED TERMS.—The  
10 insurance-related terms described in this sub-  
11 paragraph are premium, deductible, co-insur-  
12 ance, co-payment, out-of-pocket limit, preferred  
13 provider, non-preferred provider, out-of-network  
14 co-payments, UCR (usual, customary and rea-  
15 sonable) fees, excluded services, grievance and  
16 appeals, and such other terms as the Director  
17 determines are important to define so that con-  
18 sumers may compare health insurance coverage  
19 and understand the terms of their coverage.

20 (C) MEDICAL TERMS.—The medical terms  
21 described in this subparagraph are hospitaliza-  
22 tion, hospital outpatient care, emergency room  
23 care, physician services, prescription drug cov-  
24 erage, durable medical equipment, home health  
25 care, skilled nursing care, rehabilitation serv-

1           ices, hospice services, emergency medical trans-  
2           portation, and such other terms as the Director  
3           determines are important to define so that con-  
4           sumers may compare the medical benefits of-  
5           fered by health insurance plans and understand  
6           the extent of those medical benefits (or excep-  
7           tions to those benefits).

8           (3) DISCLOSURE.—

9           (A) IN GENERAL.—In carrying out this  
10          subsection, the Director shall disclose to Plan  
11          enrollees, potential enrollees, in-network health  
12          care providers, and others (through a publically  
13          available Internet website and other appropriate  
14          means) relevant information regarding each pol-  
15          icy of health insurance coverage marketed or in  
16          force (in such standardized manner as deter-  
17          mined by the Director), including—

18                   (i) full policy contract language; and

19                   (ii) a summary of the information de-  
20                   scribed in paragraph (4).

21          (B) PERSONALIZED STATEMENT.—The Di-  
22          rector shall disclose to enrollees (in such stand-  
23          ardized manner as determined by the Director)  
24          an annual personalized statement that summa-  
25          rizes use of health care services and payment of

1 claims with respect to an enrollee (and covered  
2 dependents) under health insurance coverage  
3 provided through the Plan in the preceding  
4 year.

5 (4) REQUIRED INFORMATION.—The informa-  
6 tion described in this paragraph includes, but is not  
7 limited to, the following:

8 (A) Data on the price of each new policy  
9 of health insurance coverage and renewal rating  
10 practices.

11 (B) Claims payment policies and practices,  
12 including how many and how quickly claims  
13 were paid.

14 (C) Provider fee schedules and usual, cus-  
15 tomary, and reasonable fees (for both in-net-  
16 work and out-of-network providers).

17 (D) Provider participation and provider di-  
18 rectories.

19 (E) Loss ratios, including detailed infor-  
20 mation about amount and type of non-claims  
21 expenses.

22 (F) Covered benefits, cost-sharing, and  
23 amount of payment provided toward each type  
24 of service identified as a covered benefit, includ-  
25 ing preventive care services recommended by

1 the United States Preventive Services Task  
2 Force.

3 (G) Civil or criminal actions successfully  
4 concluded against the Plan by any govern-  
5 mental entity.

6 (H) Benefit exclusions and limits.

7 (5) DEVELOPMENT OF PATIENT CLAIMS SCE-  
8 NARIOS.—

9 (A) IN GENERAL.—In order to improve the  
10 ability of individuals and employers to compare  
11 the coverage and relative value provided under  
12 the Plan, the Director shall develop and make  
13 publically available a series of patient claims  
14 scenarios under which benefits (including out-  
15 of-pocket costs) under the Plan are simulated  
16 for certain common or expensive conditions or  
17 courses of treatment (including maternity care,  
18 breast cancer, heart disease, diabetes manage-  
19 ment, and well-child visits).

20 (B) CONSULTATION.—The Director shall  
21 develop the patient claims scenarios described  
22 in subparagraph (A)—

23 (i) in consultation with the Secretary  
24 of Health and Human Services, the Na-  
25 tional Institutes of Health, the Centers for

1 Disease Control and Prevention, the Agen-  
2 cy for Healthcare Research and Quality,  
3 health professional societies, patient advo-  
4 cates, and other entities as deemed nec-  
5 essary by the Director; and

6 (ii) based upon recognized clinical  
7 practice guidelines.

8 (6) MANNER OF DISCLOSURE.—The Director  
9 shall disclose the information under this sub-  
10 section—

11 (A) with all marketing materials;

12 (B) on the website for the Plan; and

13 (C) at other times upon request.

14 **SEC. 5. ESTABLISHMENT OF AMERICA'S HEALTH INSUR-**  
15 **ANCE TRUST.**

16 (a) ESTABLISHMENT.—As of the date of enactment  
17 of this Act, there is authorized to be established a non-  
18 profit corporation that shall be known as the “America’s  
19 Health Insurance Trust” (referred to in this Act as the  
20 “Trust”), which is neither an agency nor establishment  
21 of the United States Government.

22 (b) LOCATION; SERVICE OF PROCESS.—The Trust  
23 shall maintain its principal office within the District of  
24 Columbia and have a designated agent in the District of  
25 Columbia to receive service of process for the Trust. No-

1 tice to or service on the agent shall be deemed as notice  
2 to or service on the corporation.

3 (c) APPLICATION OF PROVISIONS.—The Trust shall  
4 be subject to the provisions of this section and, to the ex-  
5 tent consistent with this section, to the District of Colum-  
6 bia Nonprofit Corporation Act.

7 (d) TAX EXEMPT STATUS.—The Trust shall be treat-  
8 ed as a nonprofit organization described under section  
9 170(e)(2)(B) and section 501(c)(3) of the Internal Rev-  
10 enue Code of 1986 that is exempt from taxation under  
11 section 501(a) of the Internal Revenue Code of 1986.

12 (e) BOARD OF DIRECTORS.—

13 (1) IN GENERAL.—The Board of Directors of  
14 the Trust (referred to in this Act as the “Board”)  
15 shall consist of 19 voting members appointed by the  
16 Comptroller General.

17 (2) TERMS.—

18 (A) IN GENERAL.—Subject to subpara-  
19 graph (C), each member of the Board shall  
20 serve for a term of 6 years.

21 (B) LIMITATION.—No individual shall be  
22 appointed to the Board for more than 2 con-  
23 secutive terms.

24 (C) INITIAL MEMBERS.—The initial mem-  
25 bers of the Board shall be appointed by the

1 Comptroller General not later than October 1,  
2 2010, and shall serve terms as follows:

3 (i) 8 members shall be appointed for  
4 a term of 5 years.

5 (ii) 8 members shall be appointed for  
6 a term of 3 years.

7 (iii) 3 members shall be appointed for  
8 a term of 1 year.

9 (D) EXPIRATION OF TERM.—Any member  
10 of the Board whose term has expired may serve  
11 until such member's successor has taken office,  
12 or until the end of the calendar year in which  
13 such member's term has expired, whichever is  
14 earlier.

15 (E) VACANCIES.—

16 (i) IN GENERAL.—Any member ap-  
17 pointed to fill a vacancy prior to the expi-  
18 ration of the term for which such mem-  
19 ber's predecessor was appointed shall be  
20 appointed for the remainder of such term.

21 (ii) VACANCIES NOT TO AFFECT  
22 POWER OF BOARD.—A vacancy on the  
23 Board shall not affect its powers, but shall  
24 be filled in the same manner as the origi-  
25 nal appointment was made.

1 (3) CHAIRPERSON AND VICE-CHAIRPERSON.—

2 (A) IN GENERAL.—The Comptroller Gen-  
3 eral shall designate a Chairperson and Vice-  
4 Chairperson of the Board from among the  
5 members of the Board.

6 (B) TERM.—The members designated as  
7 Chairperson and Vice-Chairperson shall serve  
8 for a period of 3 years.

9 (4) CONFLICTS OF INTEREST.—An individual  
10 may not serve on the Board if such individual (or an  
11 immediate family member of such individual) is em-  
12 ployed by or has a financial interest in—

13 (A) an organization that provides a health  
14 insurance plan;

15 (B) a pharmaceutical manufacturer; or

16 (C) any subsidiary entities of an organiza-  
17 tion described in subparagraphs (A) or (B).

18 (5) COMPOSITION OF THE BOARD.—

19 (A) POLITICAL PARTIES.—Not more than  
20 10 members of the Board may be affiliated with  
21 the same political party.

22 (B) DIVERSITY.—In appointing members  
23 under this paragraph, the Comptroller General  
24 shall ensure that such members provide appro-

1           priately diverse representation with respect to  
2           race, ethnicity, age, gender, and geography.

3           (C) CONSUMER REPRESENTATION.—10  
4           members of the Board shall be independent and  
5           non-conflicted individuals representing the in-  
6           terests of health care consumers. Each member  
7           selected under this subparagraph shall rep-  
8           resent 1 of the 10 Department of Health and  
9           Human Services regions in the United States.

10           (D) REMAINING REPRESENTATION.—

11           (i) IN GENERAL.—9 members of the  
12           Board shall be selected based on relevant  
13           experience, including expertise in—

14                   (I) community affairs;

15                   (II) Federal, State, and local  
16                   government;

17                   (III) health professions and ad-  
18                   ministration;

19                   (IV) business, finance, and ac-  
20                   counting;

21                   (V) legal affairs;

22                   (VI) insurance;

23                   (VII) trade unions;

24                   (VIII) social services; and

1 (IX) any additional areas as de-  
2 termined by the Comptroller General.

3 (ii) INCOME FROM HEALTH CARE IN-  
4 DUSTRY.—Not more than 4 of the mem-  
5 bers selected under this subparagraph shall  
6 earn more than 10 percent of their income  
7 from the health care industry.

8 (6) MEETINGS AND HEARINGS.—The Board  
9 shall meet and hold hearings at the call of the  
10 Chairperson or a majority of its members. Meetings  
11 of the Board on matters not related to personnel  
12 shall be open to the public and advertised through  
13 public notice at least 7 days prior to the meeting.

14 (7) QUORUM.—A majority of the members of  
15 the Board shall constitute a quorum for purposes of  
16 conducting the duties of the Trust, but a lesser  
17 number of members may meet and hold hearings.

18 (8) EXECUTIVE DIRECTOR AND STAFF; PER-  
19 FORMANCE OF DUTIES.—The Board may—

20 (A) employ and fix the compensation of an  
21 Executive Director and such other personnel as  
22 may be necessary to carry out the duties of the  
23 Trust;

24 (B) seek such assistance and support as  
25 may be required in the performance of the du-

1           ties of the Trust from appropriate departments  
2           and agencies of the Federal Government;

3           (C) enter into contracts or other arrange-  
4           ments and make such payments as may be nec-  
5           essary for performance of the duties of the  
6           Trust;

7           (D) provide travel, subsistence, and per  
8           diem compensation for individuals performing  
9           the duties of the Trust, including members of  
10          the Advisory Council (as described in subsection  
11          (f)); and

12          (E) prescribe such rules, regulations, and  
13          bylaws as the Board determines necessary with  
14          respect to the internal organization and oper-  
15          ation of the Trust.

16          (9) LOBBYING COOLING-OFF PERIOD FOR MEM-  
17          BERS OF THE BOARD.—Section 207(c) of title 18,  
18          United States Code, is amended by inserting at the  
19          end the following:

20                 “(3) MEMBERS OF THE BOARD OF DIRECTORS  
21                 OF THE AMERICA’S HEALTH INSURANCE TRUST.—  
22                 Paragraph (1) shall apply to a member of the Board  
23                 of Directors of the America’s Health Insurance  
24                 Trust who was appointed to the Board as of the day

1 before the date of enactment of the Consumers  
2 Health Care Act of 2009.”.

3 (f) ADVISORY COUNCIL.—

4 (1) ESTABLISHMENT.—The Board shall estab-  
5 lish an advisory council that shall be comprised of  
6 the insurance commissioners of each State (includ-  
7 ing the District of Columbia) to advise the Board on  
8 the development and impact of measures to improve  
9 the transparency and accountability of health insur-  
10 ance plans provided through the National Health In-  
11 surance Exchange.

12 (2) MEETINGS.—The advisory council shall  
13 meet not less than twice a year and at the request  
14 of the Board.

15 (g) FINANCIAL OVERSIGHT.—

16 (1) CONTRACT FOR AUDITS.—The Trust shall  
17 provide for financial audits of the Trust on an an-  
18 nual basis by a private entity with expertise in con-  
19 ducting financial audits.

20 (2) REVIEW AND REPORT ON AUDITS.—The  
21 Comptroller General shall—

22 (A) review and evaluate the results of the  
23 audits conducted pursuant to paragraph (1);  
24 and

1 (B) submit a report to Congress containing  
2 the results and review of such audits, including  
3 an analysis of the adequacy and use of the  
4 funding for the Trust and its activities.

5 (h) RULES ON GIFTS AND OUTSIDE CONTRIBU-  
6 TIONS.—

7 (1) GIFTS.—The Trust (including the Board  
8 and any staff acting on behalf of the Trust) shall  
9 not accept gifts, bequeaths, or donations of services  
10 or property.

11 (2) PROHIBITION ON OUTSIDE FUNDING OR  
12 CONTRIBUTIONS.—The Trust shall not—

13 (A) establish a corporation other than as  
14 provided under this section; or

15 (B) accept any funds or contributions  
16 other than as provided under this section.

17 (i) AMERICA'S HEALTH INSURANCE TRUST FUND.—

18 (1) IN GENERAL.—There is established in the  
19 Treasury a trust fund to be known as the “Amer-  
20 ica’s Health Insurance Trust Fund” (referred to in  
21 this section as the “Trust Fund”), consisting of  
22 such amounts as may be credited to the Trust Fund  
23 as provided under this subsection.

24 (2) TRANSFER.—The Secretary of the Treasury  
25 shall transfer to the Trust Fund out of the general

1 fund of the Treasury amounts determined by the  
 2 Secretary to be equivalent to the amounts received  
 3 into such general fund that are attributable to the  
 4 fees collected under sections 4375 and 4376 of the  
 5 Internal Revenue Code of 1986 (relating to fees on  
 6 health insurance policies and self-insured health  
 7 plans).

8 (3) FINANCING FOR FUND FROM FEES ON IN-  
 9 SURED AND SELF-INSURED HEALTH PLANS.—

10 (A) GENERAL RULE.—Chapter 34 of the  
 11 Internal Revenue Code of 1986 is amended by  
 12 adding at the end the following new subchapter:

13 **“Subchapter B—Insured and Self-Insured**  
 14 **Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

15 **“SEC. 4375. HEALTH INSURANCE.**

16 “(a) IMPOSITION OF FEE.—In the case of any speci-  
 17 fied health insurance policy issued after October 1, 2009,  
 18 there is hereby imposed a fee equal to—

19 “(1) for policies issued during fiscal years 2010  
 20 through 2013, 50 cents multiplied by the average  
 21 number of lives covered under the policy; and

22 “(2) for policies issued after September 30,  
 23 2013, \$1 multiplied by the average number of lives  
 24 covered under the policy.

1       “(b) LIABILITY FOR FEE.—The fee imposed by sub-  
2 section (a) shall be paid by the issuer of the policy.

3       “(c) SPECIFIED HEALTH INSURANCE POLICY.—For  
4 purposes of this section:

5           “(1) IN GENERAL.—Except as otherwise pro-  
6 vided in this section, the term ‘specified health in-  
7 surance policy’ means any accident or health insur-  
8 ance policy (including a policy under a group health  
9 plan) issued with respect to individuals residing in  
10 the United States.

11           “(2) EXEMPTION FOR CERTAIN POLICIES.—The  
12 term ‘specified health insurance policy’ does not in-  
13 clude any insurance if substantially all of its cov-  
14 erage is of excepted benefits described in section  
15 9832(c).

16           “(3) TREATMENT OF PREPAID HEALTH COV-  
17 ERAGE ARRANGEMENTS.—

18           “(A) IN GENERAL.—In the case of any ar-  
19 rangement described in subparagraph (B)—

20                   “(i) such arrangement shall be treated  
21 as a specified health insurance policy, and

22                   “(ii) the person referred to in such  
23 subparagraph shall be treated as the  
24 issuer.

1           “(B) DESCRIPTION OF ARRANGEMENTS.—

2           An arrangement is described in this subpara-  
3           graph if under such arrangement fixed pay-  
4           ments or premiums are received as consider-  
5           ation for any person’s agreement to provide or  
6           arrange for the provision of accident or health  
7           coverage to residents of the United States, re-  
8           gardless of how such coverage is provided or ar-  
9           ranged to be provided.

10          “(d) ADJUSTMENTS FOR INCREASES IN HEALTH  
11          CARE SPENDING.—In the case of any policy issued in any  
12          fiscal year beginning after September 30, 2014, the dollar  
13          amount in effect under subsection (a) for such policy shall  
14          be equal to the sum of such dollar amount for policies  
15          issued in the previous fiscal year (determined after the ap-  
16          plication of this subsection), plus an amount equal to the  
17          product of—

18                 “(1) such dollar amount for policies issued in  
19                 the previous fiscal year, multiplied by

20                 “(2) the percentage increase in the projected  
21                 per capita amount of National Health Expenditures  
22                 from the calendar year in which the previous fiscal  
23                 year ends to the calendar year in which the fiscal  
24                 year involved ends, as most recently published by the

1 Secretary of Health and Human Services before the  
2 beginning of the fiscal year.

3 “(e) TERMINATION.—This section shall not apply to  
4 policy years ending after September 30, 2019.

5 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

6 “(a) IMPOSITION OF FEE.—In the case of any appli-  
7 cable self-insured health plan issued after October 1,  
8 2009, there is hereby imposed a fee equal to—

9 “(1) for plans issued during fiscal years 2010  
10 through 2013, 50 cents multiplied by the average  
11 number of lives covered under the plan; and

12 “(2) for plans issued after September 30, 2013,  
13 \$1 multiplied by the average number of lives covered  
14 under the plans.

15 “(b) LIABILITY FOR FEE.—

16 “(1) IN GENERAL.—The fee imposed by sub-  
17 section (a) shall be paid by the plan sponsor.

18 “(2) PLAN SPONSOR.—For purposes of para-  
19 graph (1) the term ‘plan sponsor’ means—

20 “(A) the employer in the case of a plan es-  
21 tablished or maintained by a single employer,

22 “(B) the employee organization in the case  
23 of a plan established or maintained by an em-  
24 ployee organization,

25 “(C) in the case of—

1                   “(i) a plan established or maintained  
2                   by 2 or more employers or jointly by 1 or  
3                   more employers and 1 or more employee  
4                   organizations,

5                   “(ii) a multiple employer welfare ar-  
6                   rangement, or

7                   “(iii) a voluntary employees’ bene-  
8                   ficiary association described in section  
9                   501(c)(9),

10                  the association, committee, joint board of trust-  
11                  ees, or other similar group of representatives of  
12                  the parties who establish or maintain the plan,  
13                  or

14                  “(D) the cooperative or association de-  
15                  scribed in subsection (c)(2)(F) in the case of a  
16                  plan established or maintained by such a coop-  
17                  erative or association.

18                  “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—  
19                  For purposes of this section, the term ‘applicable self-in-  
20                  sured health plan’ means any plan for providing accident  
21                  or health coverage if—

22                         “(1) any portion of such coverage is provided  
23                         other than through an insurance policy, and

24                         “(2) such plan is established or maintained—

1           “(A) by one or more employers for the  
2 benefit of their employees or former employees,

3           “(B) by one or more employee organiza-  
4 tions for the benefit of their members or former  
5 members,

6           “(C) jointly by 1 or more employers and 1  
7 or more employee organizations for the benefit  
8 of employees or former employees,

9           “(D) by a voluntary employees’ beneficiary  
10 association described in section 501(c)(9),

11           “(E) by any organization described in sec-  
12 tion 501(c)(6), or

13           “(F) in the case of a plan not described in  
14 the preceding subparagraphs, by a multiple em-  
15 ployer welfare arrangement (as defined in sec-  
16 tion 3(40) of Employee Retirement Income Se-  
17 curity Act of 1974), a rural electric cooperative  
18 (as defined in section 3(40)(B)(iv) of such Act),  
19 or a rural telephone cooperative association (as  
20 defined in section 3(40)(B)(v) of such Act).

21           “(d) ADJUSTMENTS FOR INCREASES IN HEALTH  
22 CARE SPENDING.—In the case of any plan issued in any  
23 fiscal year beginning after September 30, 2014, the dollar  
24 amount in effect under subsection (a) for such plan shall  
25 be equal to the sum of such dollar amount for plans issued

1 in the previous fiscal year (determined after the applica-  
2 tion of this subsection), plus an amount equal to the prod-  
3 uct of—

4 “(1) such dollar amount for plans issued in the  
5 previous fiscal year, multiplied by

6 “(2) the percentage increase in the projected  
7 per capita amount of National Health Expenditures  
8 from the calendar year in which the previous fiscal  
9 year ends to the calendar year in which the fiscal  
10 year involved ends, as most recently published by the  
11 Secretary of Health and Human Services before the  
12 beginning of the fiscal year.

13 “(e) TERMINATION.—This section shall not apply to  
14 plans issued after September 30, 2019.

15 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

16 “(a) DEFINITIONS.—For purposes of this sub-  
17 chapter—

18 “(1) ACCIDENT AND HEALTH COVERAGE.—The  
19 term ‘accident and health coverage’ means any cov-  
20 erage which, if provided by an insurance policy,  
21 would cause such policy to be a specified health in-  
22 surance policy (as defined in section 4375(c)).

23 “(2) INSURANCE POLICY.—The term ‘insurance  
24 policy’ means any policy or other instrument where-

1 by a contract of insurance is issued, renewed, or ex-  
2 tended.

3 “(3) UNITED STATES.—The term ‘United  
4 States’ includes any possession of the United States.

5 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

6 “(1) IN GENERAL.—For purposes of this sub-  
7 chapter—

8 “(A) the term ‘person’ includes any gov-  
9 ernmental entity, and

10 “(B) notwithstanding any other law or rule  
11 of law, governmental entities shall not be ex-  
12 empt from the fees imposed by this subchapter  
13 except as provided in paragraph (2).

14 “(2) TREATMENT OF EXEMPT GOVERNMENTAL  
15 PROGRAMS.—In the case of an exempt governmental  
16 program, no fee shall be imposed under section 4375  
17 or section 4376 on any covered policy or plan under  
18 such program.

19 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-  
20 FINED.—For purposes of this subchapter, the term  
21 ‘exempt governmental program’ means—

22 “(A) any insurance program established  
23 under title XVIII of the Social Security Act,

1           “(B) the medical assistance program es-  
2           tablished by title XIX or XXI of the Social Se-  
3           curity Act,

4           “(C) the Federal Employees Health Bene-  
5           fits Program under chapter 89 of title 5,  
6           United States Code,

7           “(D) the Consumer Choice Health Plan es-  
8           tablished under the Consumers Health Care Act  
9           of 2009,

10           “(E) any program established by Federal  
11           law for providing medical care (other than  
12           through insurance policies) to individuals (or  
13           the spouses and dependents thereof) by reason  
14           of such individuals being—

15                   “(i) members of the Armed Forces of  
16                   the United States, or

17                   “(ii) veterans, and

18           “(F) any program established by Federal  
19           law for providing medical care (other than  
20           through insurance policies) to members of In-  
21           dian tribes (as defined in section 4(d) of the In-  
22           dian Health Care Improvement Act).

23           “(c) TREATMENT AS TAX.—For purposes of subtitle  
24 F, the fees imposed by this subchapter shall be treated  
25 as if they were taxes.

1 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
 2 standing any other provision of law, no amount collected  
 3 under this subchapter shall be covered over to any posses-  
 4 sion of the United States.”.

5 (B) CLERICAL AMENDMENTS.—

6 (i) Chapter 34 of such Code is amend-  
 7 ed by striking the chapter heading and in-  
 8 serting the following:

9 **“CHAPTER 34—TAXES ON CERTAIN**  
 10 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

11 **“Subchapter A—Policies Issued By Foreign**  
 12 **Insurers”.**

13 (ii) The table of chapters for subtitle  
 14 D of such Code is amended by striking the  
 15 item relating to chapter 34 and inserting  
 16 the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

17 **SEC. 6. DUTIES OF AMERICA’S HEALTH INSURANCE TRUST.**

18 (a) INSURANCE PLAN RANKINGS AND WEBSITE.—

19 (1) WEB-BASED MATERIALS.—The Trust shall  
 20 establish and maintain a website that provides infor-  
 21 mational materials regarding the health insurance  
 22 plans provided through the National Health Insur-

1       ance Exchange, including appropriate links for all  
2       available State insurance commissioner websites.

3               (2) PLAN RANKINGS.—The Trust shall develop  
4       and publish annual rankings of the health insurance  
5       plans provided through the National Health Insur-  
6       ance Exchange, based on the assignment of a letter  
7       grade between “grade A” (highest) and “grade F”  
8       (lowest). The Trust shall provide for a comparative  
9       evaluation of each plan based upon—

- 10               (A) administrative expenditures;
- 11               (B) affordability of coverage;
- 12               (C) adequacy of coverage;
- 13               (D) timeliness and adequacy of consumer  
14       claims processing;
- 15               (E) available consumer complaint systems;
- 16               (F) grievance and appeals processes;
- 17               (G) transparency;
- 18               (H) consumer satisfaction; and
- 19               (I) any additional measures as determined  
20       by the Board.

21               (3) INFORMATION AVAILABLE ON WEBSITE BY  
22       ZIP CODE.—The annual rankings of the health in-  
23       surance plans (as described in paragraph (2)) shall  
24       be available on the website for the Trust (as de-  
25       scribed in paragraph (1)), and the website for the

1 National Health Insurance Exchange, in a manner  
2 that is searchable and sortable by zip code.

3 (4) CONSUMER FEEDBACK.—

4 (A) CONSUMER COMPLAINTS.—The Trust  
5 shall develop written and web-based methods  
6 for individuals to provide recommendations and  
7 complaints regarding the health insurance plans  
8 provided through the National Health Insur-  
9 ance Exchange.

10 (B) CONSUMER SURVEYS.—The Trust  
11 shall obtain meaningful consumer input, includ-  
12 ing consumer surveys, that measure the extent  
13 to which an individual receives the services and  
14 supports described in the individual’s health in-  
15 surance plan and the individual’s satisfaction  
16 with such services and supports.

17 (b) DATA SHARING.—

18 (1) IN GENERAL.—An organization that pro-  
19 vides a health insurance plan through the National  
20 Health Insurance Exchange shall provide the Trust  
21 with all information and data that is necessary for  
22 improving transparency, monitoring, and oversight  
23 of such plans.

24 (2) ANNUAL DISCLOSURE.—Beginning with the  
25 first full year of operation of the National Health

1 Insurance Exchange, an organization that provides a  
2 health insurance plan through the National Health  
3 Insurance Exchange shall annually provide the Trust  
4 with appropriate information regarding the fol-  
5 lowing:

6 (A) Name of the plan.

7 (B) Levels of available plan benefits.

8 (C) Description of plan benefits.

9 (D) Number of enrollees under the plan.

10 (E) Demographic profile of enrollees under  
11 the plan.

12 (F) Number of claims paid to enrollees.

13 (G) Number of enrollees that terminated  
14 their coverage under the plan.

15 (H) Total operating cost for the plan (in-  
16 cluding administrative costs).

17 (I) Patterns of utilization of the plan's  
18 services.

19 (J) Availability, accessibility, and accept-  
20 ability of the plan's services.

21 (K) Such information as the Trust may re-  
22 quire demonstrating that the organization has a  
23 fiscally sound operation.

24 (L) Any additional information as deter-  
25 mined by the Trust.

1           (3) FORM AND MANNER OF INFORMATION.—In-  
2           formation to be provided to the Trust under para-  
3           graphs (1) and (2) shall be provided—

4                   (A) in such form and manner as specified  
5                   by the Trust; and

6                   (B) within 30 days of the date of receipt  
7                   of the request for such information, or within  
8                   such extended period as the Trust deems appro-  
9                   priate.

10           (4) INFORMATION FROM THE DEPARTMENT OF  
11           HEALTH AND HUMAN SERVICES.—

12                   (A) IN GENERAL.—Any information re-  
13                   garding the health insurance plans that are of-  
14                   fered through the National Health Insurance  
15                   Exchange that has been provided to the Sec-  
16                   retary of Health and Human Services shall also  
17                   be made available (as deemed appropriate by  
18                   the Secretary) to the Trust for the purpose of  
19                   improving transparency, monitoring, and over-  
20                   sight of such plans. Such information may in-  
21                   clude, but is not limited to, the following:

22                           (i) Underwriting guidelines to ensure  
23                           compliance with applicable Federal health  
24                           insurance requirements.

1 (ii) Rating practices to ensure compli-  
2 ance with applicable Federal health insur-  
3 ance requirements.

4 (iii) Enrollment and disenrollment  
5 data, including information the Secretary  
6 may need to detect patterns of discrimina-  
7 tion against individuals based on health  
8 status or other characteristics, to ensure  
9 compliance with applicable Federal health  
10 insurance requirements (including non-dis-  
11 crimination in group coverage, guaranteed  
12 issue, and guaranteed renewability require-  
13 ments applicable in all markets).

14 (iv) Post-claims underwriting and re-  
15 scission practices to ensure compliance  
16 with applicable Federal health insurance  
17 requirements relating to guaranteed renew-  
18 ability.

19 (v) Marketing materials and agent  
20 guidelines to ensure compliance with appli-  
21 cable Federal health insurance require-  
22 ments.

23 (vi) Data on the imposition of pre-ex-  
24 isting condition exclusion periods and  
25 claims subjected to such exclusion periods.

1 (vii) Information on issuance of cer-  
2 tificates of creditable coverage.

3 (viii) Information on cost-sharing and  
4 payments with respect to any out-of-net-  
5 work coverage.

6 (ix) The application to issuers of pen-  
7 alties for violation of applicable Federal  
8 health insurance requirements (including  
9 failure to produce requested information).

10 (x) Such other information as the  
11 Trust may determine to be necessary to  
12 verify compliance with the requirements of  
13 this Act.

14 (B) REQUIRED DISCLOSURE.—The Sec-  
15 retary of Health and Human Services shall pro-  
16 vide the Trust with all consumer claims data or  
17 information that has been provided to the Sec-  
18 retary by any health insurance plan that is of-  
19 fered through the National Health Insurance  
20 Exchange.

21 (C) PERIOD FOR PROVIDING INFORMA-  
22 TION.—Information to be provided to the Trust  
23 under this paragraph shall be provided by the  
24 Secretary within 30 days of the date of receipt  
25 of the request for such information, or within

