

111TH CONGRESS
1ST SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Mr. ROCKEFELLER introduced the following bill; which was read twice and referred to the Committee on _____

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(c)(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

