

111TH CONGRESS
1ST SESSION

H. R. 2427

To amend title XXVII of the Public Health Service Act to establish Federal standards for health insurance forms, quality, fair marketing, and honesty in out-of-network coverage in the group and individual health insurance markets, to improve transparency and accountability in those markets, and to establish a Federal Office of Health Insurance Oversight to monitor performance in those markets, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 14, 2009

Ms. DELAURO (for herself, Ms. SCHWARTZ, Ms. SCHAKOWSKY, Mr. LIPINSKI, Mrs. CHRISTENSEN, Mrs. CAPPS, Mr. MCGOVERN, Mr. COURTNEY, Mr. BLUMENAUER, Mr. BERMAN, Mr. DELAHUNT, and Mrs. LOWEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XXVII of the Public Health Service Act to establish Federal standards for health insurance forms, quality, fair marketing, and honesty in out-of-network coverage in the group and individual health insurance markets, to improve transparency and accountability in those markets, and to establish a Federal Office of Health Insurance Oversight to monitor performance in those markets, and for other purposes.

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; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Informed Consumer Choices in Health Care Act of
6 2009”.

7 (b) **TABLE OF CONTENTS.**—The table of contents of
8 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. New minimum Federal standards for health insurance forms, quality,
fair marketing, and honesty in out-of-network coverage.

Sec. 4. Health Insurance accountability initiatives.

Sec. 5. Health insurance transparency initiatives.

Sec. 6. Office of Health Insurance Oversight.

Sec. 7. Standards and accountability and transparency initiatives for group
health plans through Departments of Labor and the Treasury.

9 **SEC. 2. FINDINGS.**

10 Congress finds the following:

11 (1) Effective competition in private health in-
12 surance markets requires that consumers must have
13 extensive and meaningful information about what
14 health insurance covers, what it costs, and how it
15 works.

16 (2) Based on the information currently provided
17 by health insurers, patients are unable to predict
18 what their health insurance coverage limits or out-
19 of-pocket costs would be if they had a serious illness.
20 72 million adults under age 65 had problems paying
21 medical bills or were paying off medical debt in

1 2007, and 61 percent of those were insured at the
2 time care was provided.

3 (3) It is difficult to impossible for consumers to
4 obtain a copy of a health insurance policy from an
5 insurance company before they purchase it.

6 (4) Consumers often find it difficult to navigate
7 and evaluate their choices in today's health insur-
8 ance markets and many select a sub-optimal plan as
9 a result.

10 (5) The Institute of Medicine of the National
11 Academy of Sciences has estimated that nearly half
12 of all American adults—90 million people—have dif-
13 ficulty understanding and using health information.

14 (6) The Office of Disease Prevention and
15 Health Promotion in the Department of Health and
16 Human Services reports that only 12 percent of the
17 population using a table can calculate an employee's
18 share of health insurance costs for a year.

19 (7) A RAND Corporation study found that
20 making it easier to get information about insurance
21 products and simplifying the applications process
22 would increase purchase rates as much as modest
23 subsidies would, and all these reports prove the need
24 for a fundamental improvement in the way insurance
25 choices are made available to consumers.

1 (8) Insurance forms provided to patients and
2 providers are often confusing, difficult to reconcile
3 with medical bills, and vary widely from insurer to
4 insurer, thereby adding complexity and administra-
5 tive waste to the health care system.

6 (9) Research indicates that physicians divert
7 substantial resources, as much as 14 percent of their
8 total revenue, to ensure accurate insurance pay-
9 ments for their services. Hospitals spend as much as
10 11 percent of their total revenue on billing and in-
11 surance-related costs. These include time spent de-
12 termining patient insurance eligibility and benefit
13 structure. One study found that paperwork adds at
14 least 30 minutes to every hour of patient care.

15 (10) According to the American Medical Asso-
16 ciation, there is wide variation in how often health
17 insurers pay nothing in response to a physician
18 claim and in how they explain the reason for the de-
19 nial. There is no consistency in the application of
20 codes used to explain the denials, making it ex-
21 tremely expensive for physician practices to deter-
22 mine how to respond.

23 (11) According to the American Medical Asso-
24 ciation, more than half of health insurers in a recent
25 study did not provide physicians with the trans-

1 parency necessary for an efficient claims processing
2 system.

3 (12) According to the American Medical Asso-
4 ciation, payers vary widely on how often they use
5 proprietary rather than public claims edits to reduce
6 payments (ranging from zero to as high as nearly 72
7 percent). The use of undisclosed proprietary edits in-
8 hibits the flow of transparent information to physi-
9 cians, adding additional administrative costs to rec-
10 oncile claims.

11 (13) The Federal government currently lacks
12 capacity to carry out responsibility for oversight and
13 enforcement of current law requirements on health
14 insurance issuers and to provide States with tech-
15 nical assistance in effectively enforcing Federal min-
16 imum standards for health insurance.

17 (14) In order to improve the functioning of the
18 private health insurance market, assure the applica-
19 tion of existing requirements to health insurance
20 coverage, and reduce administrative hassles for pa-
21 tients and providers, there is a need for periodic ex-
22 aminations and audits of such coverage, for greater
23 disclosure of information regarding the terms and
24 conditions of such coverage, and for the establish-

1 ment of a Federal oversight office to ensure enforce-
2 ment of standards.

3 **SEC. 3. NEW MINIMUM FEDERAL STANDARDS FOR HEALTH**
4 **INSURANCE FORMS, QUALITY, FAIR MAR-**
5 **KETING, AND HONESTY IN OUT-OF-NETWORK**
6 **COVERAGE.**

7 (a) GROUP HEALTH INSURANCE.—Title XXVII of
8 the Public Health Service Act is amended by inserting
9 after section 2707 the following new section:

10 **“SEC. 2708. STANDARDS FOR HEALTH INSURANCE FORMS,**
11 **QUALITY, FAIR MARKETING, AND HONESTY**
12 **IN OUT-OF-NETWORK COVERAGE.**

13 “(a) DEFINING INSURANCE TERMS; STANDARDIZING
14 INSURANCE FORMS.—

15 “(1) IN GENERAL.—The Secretary shall provide
16 for the development of standards for the information
17 that health insurance issuers are required to provide
18 to group health plans to promote informed choice of
19 health insurance coverage by such plans.

20 “(2) STANDARD DEFINITIONS OF INSURANCE
21 AND MEDICAL TERMS.—

22 “(A) IN GENERAL.—The Secretary shall
23 provide for the development of standards for
24 the definitions of terms used in group health in-
25 surance coverage, including insurance-related

1 terms (including the insurance-related terms de-
2 scribed in subparagraph (B)) and medical
3 terms (including the medical terms described in
4 subparagraph (C)).

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

16 “(C) MEDICAL TERMS.—The medical
17 terms described in this subparagraph are hos-
18 pitalization, hospital outpatient care, emergency
19 room care, physician services, prescription drug
20 coverage, durable medical equipment, home
21 health care, skilled nursing care, rehabilitation
22 services, hospice services, emergency medical
23 transportation, and such other terms as the
24 Secretary determines are important to define so
25 that consumers may compare the medical bene-

1 fits offered by insurance health insurance and
2 understand the extent of those medical benefits
3 (or exceptions to those benefits).

4 “(3) STANDARDIZATION OF INSURANCE
5 FORMS.—The Secretary shall provide for the devel-
6 opment of standards for the forms used in connec-
7 tion with group health insurance coverage, including
8 for—

9 “(A) applications for health insurance cov-
10 erage;

11 “(B) explanations of benefits for such cov-
12 erage;

13 “(C) filing of complaints, grievances, and
14 appeals respecting such coverage; and

15 “(D) other common functions relating to
16 such coverage as the Secretary deems appro-
17 priate.

18 “(4) COVERAGE FACTS LABELS FOR PATIENT
19 CLAIMS SCENARIOS.—The Secretary shall develop
20 standards for coverage facts labels based on the pa-
21 tient claims scenarios described in section
22 2794(b)(4), which include information on estimated
23 out-of-pocket cost-sharing and significant exclusions
24 or benefit limits for such scenarios.

1 “(5) PERSONALIZED STATEMENT.—The Sec-
2 retary shall develop standards for an annual person-
3 alized statement that summarizes use of health care
4 services and payment of claims with respect to an
5 enrollee (and covered dependents) under group
6 health insurance coverage in the preceding year.

7 “(6) APPLICATION OF STANDARDS.—No group
8 health insurance coverage may be offered for sale
9 after the date that is two years after date of the en-
10 actment of this section unless—

11 “(A) the benefits and other terms of cov-
12 erage are consistent with the definitional stand-
13 ards developed under paragraph (2);

14 “(B) the application and form of coverage
15 and related forms are consistent with the stand-
16 ardized forms developed under paragraph (3);
17 and

18 “(C) there is provided coverage facts labels
19 described in paragraph (4) with respect to the
20 coverage.

21 “(7) PERIODIC REVIEW AND UPDATING.—The
22 Secretary shall periodically review and update, as
23 appropriate, the standards developed under this sub-
24 section.

1 “(8) EVALUATION OF INFORMATION RE-
2 SOURCES.—In developing, reviewing, and updating
3 standards under this subsection, the Secretary shall
4 provide for testing and evaluation of information re-
5 sources in general and to specific audiences includ-
6 ing those with low literacy skills.

7 “(9) CONSULTATION.—In developing reviewing,
8 and updating standards under this subsection, the
9 Secretary shall consult with, among others, the Na-
10 tional Association of Insurance Commissioners,
11 health care professionals, researchers, health insur-
12 ance issuers, group health plans, patient advocates,
13 and literacy experts.

14 “(b) QUALITY ASSURANCES FOR HEALTH INSUR-
15 ANCE.—

16 “(1) IN GENERAL.—The Secretary shall provide
17 for the development of standards to assure the qual-
18 ity of benefits under group health insurance cov-
19 erage. Such standards shall include standards relat-
20 ing to at least—

21 “(A) network adequacy and stability;

22 “(B) guaranteed coverage for one year of
23 contracted benefits;

24 “(C) adequacy and stability of prescription
25 drug networks;

1 “(D) utilization control systems; and

2 “(E) grievances and appeals.

3 “(2) APPLICATION OF PROVISIONS.—The provi-
4 sions of paragraphs (5) through (9) of subsection
5 (a) apply to standards developed under this sub-
6 section in the same manner as such provisions apply
7 to standards developed under subsection (a).

8 “(c) MARKETING.—

9 “(1) IN GENERAL.—The Secretary shall provide
10 for the development of standards for the marketing
11 of group health insurance coverage. Such standards
12 shall include standards for at least—

13 “(A) marketing materials; and

14 “(B) sales commissions.

15 “(2) NONDISCRIMINATION.—No group health
16 insurance coverage may be offered for sale after the
17 date that is two years after date of the enactment
18 of this section unless the issuer provides the Sec-
19 retary with a written certification that all marketing
20 materials, seminars, and other outreach efforts in
21 connection with the offering of such coverage do not
22 discriminate on the basis of income, race, gender,
23 ethnicity, or other demographic factors as deter-
24 mined by the Secretary.

1 “(3) APPLICATION OF PROVISIONS.—The provi-
2 sions of paragraphs (7) through (9) of subsection
3 (a) apply to standards developed under this sub-
4 section in the same manner as such provisions apply
5 to standards developed under subsection (a).

6 “(d) HONESTY IN COVERAGE OF OUT-OF-NETWORK
7 PROVIDERS.—The Secretary shall provide for the develop-
8 ment of standards for the accuracy and clarity of coverage
9 for out-of-network providers, including cost sharing and
10 payments to such providers, for health insurance issuers
11 in group health insurance coverage that provide such cov-
12 erage.”.

13 (b) APPLICATION IN THE INDIVIDUAL MARKET.—
14 Such title is further amended by inserting after section
15 2745 the following new section:

16 **“SEC. 2746. STANDARDS FOR HEALTH INSURANCE INSUR-**
17 **ANCE FORMS, QUALITY, FAIR MARKETING,**
18 **AND HONESTY IN OUT-OF-NETWORK COV-**
19 **ERAGE.**

20 “The provisions of section 2708 shall apply under
21 this part to individual health insurance coverage and en-
22 rollees in such coverage in the same manner as such provi-
23 sions apply under part A in the case of group health insur-
24 ance coverage and group health plans and participants
25 and beneficiaries.”.

1 (c) APPLICATION TO THE MEDICARE ADVANTAGE
2 PROGRAM AND THE MEDICARE PRESCRIPTION DRUG
3 PROGRAM.—

4 (1) MEDICARE ADVANTAGE PROGRAM.—Section
5 1852 of the Social Security Act (42 U.S.C. 1395w–
6 22) is amended by adding at the end the following
7 new subsection:

8 “(m) STANDARDS FOR HEALTH INSURANCE FORMS,
9 QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-
10 NETWORK COVERAGE.—The provisions of section 2708(a)
11 of the Public Health Service Act shall apply to Medicare
12 Advantage organizations, Medicare Advantage plans, and
13 enrollees in such plans in the same manner as such provi-
14 sions apply under such section to group health insurance
15 coverage and group health plans and participants and
16 beneficiaries.”.

17 (2) MEDICARE PRESCRIPTION DRUG PRO-
18 GRAM.—Section 1860D–4 of the Social Security Act
19 (42 U.S.C. 1395w–104) is amended by adding at
20 the end the following new subsection:

21 “(m) STANDARDS FOR HEALTH INSURANCE FORMS,
22 QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-
23 NETWORK COVERAGE.—The provisions of section 2708(a)
24 of the Public Health Service Act shall apply to PDP spon-
25 sors, prescription drug plans, and enrollees in such plans

1 in the same manner as such provisions apply under such
2 section to group health insurance coverage and group
3 health plans and participants and beneficiaries.”.

4 (3) EFFECTIVE DATE.—The amendments made
5 by this subsection shall apply to plan years begin-
6 ning after the date that is 2 years after the date of
7 the enactment of this Act.

8 (d) APPLICATION TO FEHBP.—The provisions of
9 section 2708(a) of the Public Health Service Act shall
10 apply to the Federal Employees Health Benefits Program
11 under chapter 89 of title 5, United States Code, and to
12 contractors, health plans, and enrollees in such plans in
13 the same manner as such provisions apply under such sec-
14 tion to group health insurance coverage and group health
15 plans and participants and beneficiaries.

16 **SEC. 4. HEALTH INSURANCE ACCOUNTABILITY INITIA-**
17 **TIVES.**

18 (a) IMPROVED HEALTH INSURANCE ACCOUNT-
19 ABILITY.—Title XXVII of the Public Health Service Act
20 is amended by adding at the end the following new section:
21 **“SEC. 2793. ACCOUNTABILITY INITIATIVES.**

22 **“(a) IN GENERAL.—**The Secretary, acting through
23 the Office of Health Insurance Oversight established
24 under section 2795, shall undertake activities in accord-
25 ance with this section to promote accountability of health

1 insurance issuers in meeting Federal health insurance re-
2 quirements, regardless of whether this relates to health in-
3 surance in the individual or group market.

4 “(b) COMPLIANCE EXAMINATIONS AND AUDITS.—

5 “(1) IN GENERAL.—Without regard to whether
6 or not there is a determination under section
7 2722(a)(2) or 2761(a)(2) with respect to a health
8 insurance issuer, in carrying out this section, the
9 Secretary shall conduct independent market conduct
10 examinations and audits to monitor and verify the
11 compliance of an health insurance issuer with Fed-
12 eral health insurance requirements. Such audits may
13 include random compliance audits and targeted au-
14 dits in response to complaints or other suspected
15 non-compliance.

16 “(2) RECOUPMENT OF COSTS.—In connection
17 with such examinations and audits, the Secretary is
18 authorized to recoup from health insurance issuers
19 reimbursement for the costs of such examinations
20 and audits of such issuers.

21 “(3) RELATION TO OTHER AUTHORITY.—The
22 authorities under this section are in addition to any
23 authorities of the Secretary, including authorities
24 under sections 2722(b) and 2761(b).

25 “(c) DATA COLLECTION AND REVIEW.—

1 “(1) IN GENERAL.—The Secretary shall collect
2 and review data from health insurance issuers on
3 health insurance coverage to monitor compliance
4 with Federal health insurance requirements applica-
5 ble to such issuers and coverage. Upon request by
6 the Secretary, such issuers shall provide such data
7 to the Secretary on a timely basis.

8 “(2) ELEMENTS TO REVIEW.—In carrying out
9 this subsection, the Secretary shall review at least
10 the following:

11 “(A) Underwriting guidelines to ensure
12 compliance with applicable Federal health in-
13 surance requirements.

14 “(B) Rating practices to ensure compliance
15 with such requirements.

16 “(C) Enrollment and disenrollment data,
17 including information the Secretary may need
18 to detect patterns of discrimination against in-
19 dividuals based on health status or other char-
20 acteristics, to ensure compliance with such re-
21 quirements (including nondiscrimination in
22 group coverage, guaranteed issue, guaranteed
23 renewability requirements applicable in all mar-
24 kets).

1 “(D) Post-claims underwriting and rescis-
2 sion practices to ensure compliance with such
3 requirements relating to guaranteed renew-
4 ability.

5 “(E) Marketing materials and agent guide-
6 lines to ensure compliance with applicable Fed-
7 eral health insurance requirements.

8 “(F) Data on the imposition of pre-exist-
9 ing condition exclusion periods and claims sub-
10 jected to such exclusion periods.

11 “(G) Information on issuance of certifi-
12 cates of creditable coverage.

13 “(H) Information on cost-sharing and pay-
14 ments with respect to any out-of-network cov-
15 erage.

16 “(I) Such other information as the Sec-
17 retary may determine to be necessary to verify
18 compliance with requirements of this title.

19 “(J) The application to issuers of penalties
20 for violation of such requirements, including the
21 failure to produce requested information.

22 “(3) TREATMENT OF PROPRIETARY INFORMA-
23 TION.—The Secretary may request under this sub-
24 section information that is proprietary or that re-
25 veals a trade secret, but such information shall not

1 be subject to further disclosure to the general public
2 in a manner that reveals proprietary information or
3 a trade secret.

4 “(4) FORM AND MANNER OF INFORMATION.—
5 Information under paragraph (1) shall be pro-
6 vided—

7 “(A) in a form and manner specified by
8 the Secretary; and

9 “(B) within 30 days of the date of receipt
10 of the request for the information, or within
11 such longer time period as the Secretary deems
12 appropriate.

13 “(5) ENFORCEMENT.—The Secretary shall have
14 the same authority in relation to enforcement of re-
15 quests for data under paragraph (1) as the Sec-
16 retary has under section 2722(b).

17 “(6) COORDINATION WITH STATES.—

18 “(A) IN GENERAL.—The Secretary shall
19 coordinate with State insurance regulators so
20 that data with respect to health insurance
21 issuers and coverage are collected and reported
22 in a common format.

23 “(B) CLEARINGHOUSE.—The Secretary
24 shall establish a clearinghouse for the sharing
25 of data reported by health insurance issuers

1 and for the findings from audits and investiga-
2 tions. Such clearinghouse may be established in
3 conjunction with the National Association of In-
4 surance Commissioners.

5 “(7) COORDINATION WITH DEPARTMENTS OF
6 LABOR AND TREASURY.—The Secretary shall coordi-
7 nate with the Secretaries of Labor and Treasury
8 with respect to requirements to report data that af-
9 fect health insurance coverage sold in connection
10 with group health plans.

11 “(d) HEALTH INSURANCE ACCOUNTABILITY GRANTS
12 TO STATES.—

13 “(1) IN GENERAL.—The Secretary shall provide
14 for grants to Departments of Insurance in States to
15 strengthen their enforcement of Federal health in-
16 surance requirements with respect to health insur-
17 ance issuers operating in such States. Such a grant
18 shall only be made pursuant to an application made
19 to the Secretary.

20 “(2) FUNDING.—

21 “(A) IN GENERAL.—Of the funds appro-
22 priated under subparagraph (B) for grants
23 under this subsection, the Secretary shall pro-
24 vide a grant to each State with an application
25 approved under paragraph (1).

1 “(B) ALLOCATION.—Funds so appro-
2 priated for any fiscal year shall be apportioned
3 among the States in accordance with a formula
4 determined by the Secretary that takes into ac-
5 count the scope of health insurance subject to
6 regulation under this title in each State and
7 such other factors as the Secretary may specify.

8 “(C) APPROPRIATIONS AND AUTHORIZA-
9 TIONS.—There is hereby appropriated, out of
10 any funds in the Treasury not otherwise appro-
11 priated for the first fiscal year in which this
12 section is in effect, \$10,000,000 for grants
13 under this subsection, to be available until ex-
14 pended. For each subsequent fiscal year there is
15 authorized to be appropriated such sums as
16 may be necessary for such grants.

17 “(e) FEDERAL HEALTH INSURANCE REQUIREMENTS
18 DEFINED.—In this part, the term ‘Federal health insur-
19 ance requirements’ means the requirements under this
20 title insofar as they relate to health insurance issuers and
21 health insurance coverage, whether in the individual or
22 group market, and includes other requirements imposed
23 under Federal law specifically in relation to the offering
24 of health insurance coverage by health insurance issuers.”.

1 **SEC. 5. HEALTH INSURANCE TRANSPARENCY INITIATIVES.**

2 (a) IN GENERAL.—Title XXVII of the Public Health
3 Service Act, as amended by section 3, is further amended
4 by adding at the end the following new section:

5 **“SEC. 2794. TRANSPARENCY INITIATIVES.**

6 “(a) IN GENERAL.—The Secretary, acting through
7 the Office of Health Insurance Oversight established
8 under section 2795, shall undertake activities in accord-
9 ance with this section to promote transparency in costs,
10 market practices, and other factors for health insurance
11 coverage, regardless of whether the coverage is offered or
12 in effect in the individual or group market.

13 “(b) DEVELOPMENT AND DISCLOSURE OF STAND-
14 ARDIZED INFORMATION.—

15 “(1) IN GENERAL.—In carrying out this sec-
16 tion, the Secretary shall provide for the development
17 of—

18 “(A) standards for information about
19 health insurance issuers, their health insurance
20 policies, and their market practices with respect
21 to such policies; and

22 “(B) standards for the disclosure of such
23 information in a timely, consistent, and accu-
24 rate manner by health insurance issuers about
25 each health insurance policy marketed and in
26 force.

1 “(2) INFORMATION TO BE DISCLOSED.—

2 “(A) IN GENERAL.—In carrying out this
3 section, the Secretary shall require health insur-
4 ance issuers to disclose to enrollees, potential
5 enrollees, in-network health care providers, and
6 others through a publicly available Internet
7 website and other appropriate means at least
8 the following concerning each policy of health
9 insurance coverage marketed or in force, in
10 such standardized manner as the Secretary
11 specifies:

12 “(i) Full policy contract language.

13 “(ii) A summary of the information
14 described in paragraph (3).

15 “(iii) For each of the scenarios devel-
16 oped under paragraph (4), the coverage
17 facts label information developed under
18 section 2709(a)(4).

19 “(B) PERSONALIZED STATEMENT.—In
20 carrying out this section, the Secretary shall re-
21 quire health insurance issuers to disclose to en-
22 rollees, in such standardized manner as the
23 Secretary specifies, an annual personalized
24 statement described in section 2708(a)(5).

1 “(3) INFORMATION TO BE DISCLOSED.—The in-
2 formation described in this paragraph is at least the
3 following:

4 “(A) Data on the price of each new policy
5 of health insurance coverage and renewal rating
6 practices.

7 “(B) Information on claims payment poli-
8 cies and practices, including how many and how
9 quickly claims were paid.

10 “(C) Information on provider fee schedules
11 and usual, customary, and reasonable fees (for
12 both network and out-of-network providers).

13 “(D) Information on provider participation
14 and provider directories.

15 “(E) Information on loss ratios, including
16 detailed information about amount and type of
17 non-claims expenses.

18 “(F) Information on covered benefits, cost-
19 sharing, and amount of payment provided to-
20 ward each type of service identified as a covered
21 benefit, including preventive care services rec-
22 ommended by the United States Preventive
23 Services Task Force.

1 “(G) Information on civil or criminal ac-
2 tions successfully concluded against the issuer
3 by any governmental entity.

4 “(H) Benefit exclusions and limits.

5 “(4) DEVELOPMENT OF PATIENT CLAIMS SCE-
6 NARIOS.—

7 “(A) IN GENERAL.—In order to improve
8 the ability of individuals and group health plans
9 to compare the coverage and value provided
10 under different health insurance coverage, the
11 Secretary shall develop a series of patient
12 claims scenarios under which benefits (including
13 out-of-pocket costs) under such coverage can be
14 simulated for certain common or expensive con-
15 ditions or courses of treatment, such as mater-
16 nity care, breast cancer, heart disease, diabetes
17 management, and well-child visits.

18 “(B) CONSULTATION AND BASIS.—The
19 Secretary shall develop the scenarios under this
20 paragraph—

21 “(i) in consultation with the National
22 Institutes of Health, the Centers for Dis-
23 ease Control and Prevention, the Agency
24 for Healthcare Research and Quality,
25 health professional societies, patient advo-

1 cates, and others as deemed necessary by
2 the Secretary; and

3 “(ii) based upon recognized clinical
4 practice guidelines.

5 “(5) MANNER OF DISCLOSURE.—

6 “(A) IN GENERAL.—The standards under
7 paragraph (1)(B) shall provide for health insur-
8 ance issuers to disclose the information under
9 this subsection—

10 “(i) with all marketing materials;

11 “(ii) on the web site of the issuer; and

12 “(iii) at other times upon request.

13 “(B) CONTRACT LANGUAGE.—Such stand-
14 ards also shall require the disclosure of full pol-
15 icy contract language in printed form upon re-
16 quest.

17 “(c) APPLICATION OF ENFORCEMENT PROVISIONS.—

18 The provisions of sections 2722 and 2671 shall apply to
19 enforcement of the requirements of this section in the
20 same manner as such provisions apply to the provisions
21 of part A or part B, respectively. Under such provisions
22 the States shall have initial (and primary) enforcement au-
23 thority with respect to such requirements, except that the
24 Secretary under section 2793 may directly monitor compli-
25 ance with such provisions as well.”.

1 (b) CONFORMING AMENDMENTS REGARDING DIS-
2 CLOSURE OF INFORMATION.—

3 (1) REFERENCE IN THE GROUP MARKET.—Sec-
4 tion 2713 of the Public Health Service Act (42
5 U.S.C. 300gg–13)) is amended by adding at the end
6 the following new subsection:

7 “(c) REFERENCE TO DISCLOSURE OF INFORMA-
8 TION.—For provision requiring disclosure of information
9 by health insurance issuers, see section 2794(d).”.

10 (2) REFERENCE IN THE INDIVIDUAL MAR-
11 KET.—Section 2761 of the Public Health Service
12 Act is amended by adding at the end the following
13 new subsection:

14 “(c) REFERENCE TO DISCLOSURE OF INFORMA-
15 TION.—For provision requiring disclosure of information
16 by health insurance issuers, see section 2794(d).”.

17 **SEC. 6. OFFICE OF HEALTH INSURANCE OVERSIGHT.**

18 (a) IN GENERAL.—Title XXVII of the Public Health
19 Service Act, as amended by sections 3 and 4, is amended
20 by adding at the end of part C the following new section:

21 **“SEC. 2795. OFFICE OF HEALTH INSURANCE OVERSIGHT.**

22 “(a) ESTABLISHMENT.—There is established within
23 the Department of Health and Human Services an Office
24 of Health Insurance Oversight (referred to in this section
25 as the ‘Office’). The Office shall be headed by a Director

1 of Health Insurance Oversight (referred to in this section
2 as the ‘Director’) who shall be appointed by and report
3 directly to the Secretary.

4 “(b) DUTIES.—

5 “(1) PROMOTION OF ACCOUNTABILITY IN
6 HEALTH INSURANCE.—

7 “(A) IN GENERAL.—The Director shall im-
8 plement accountability initiatives under section
9 2793.

10 “(B) CLEARINGHOUSE.—The Director
11 shall provide, in consultation with the National
12 Association of Insurance Commissioners, for a
13 clearinghouse for State health insurance regu-
14 lators to share information concerning, and help
15 them to enact and enforce, Federal health in-
16 surance requirements.

17 “(2) PROMOTE TRANSPARENCY IN HEALTH IN-
18 SURANCE.—The Director shall implement trans-
19 parency initiatives under section 2794.

20 “(3) CONSUMER INFORMATION, ASSISTANCE.—

21 “(A) IN GENERAL.—The Director shall
22 provide for consumer information assistance on
23 health insurance coverage, and Federal health
24 insurance consumer protections under this title,

1 including through carrying out activities under
2 this paragraph.

3 “(B) INFORMATION RESOURCES.—The Di-
4 rector shall develop health insurance informa-
5 tion resources for consumers, including cov-
6 erage facts labels for patient claims scenarios
7 developed under section 2794(b)(4) and web-
8 based information on average price ranges for
9 out-of-network services based on geography.

10 “(C) SERVICE.—The Director shall estab-
11 lish a consumer assistance service that, directly
12 or in coordination with State health insurance
13 regulators and consumer assistance organiza-
14 tions, receives and responds to inquiries and
15 complaints concerning health insurance cov-
16 erage with respect to Federal health insurance
17 requirements and under State law.

18 “(4) HEALTH INSURANCE CONSUMER ASSIST-
19 ANCE GRANTS.—

20 “(A) IN GENERAL.—The Director shall
21 provide for grants to public, private or not-for-
22 profit consumer assistance organizations to de-
23 velop, support, and evaluate consumer assist-
24 ance programs related to selecting and navi-
25 gating health care coverage. Such a grant shall

1 only be made pursuant to an application made
2 to the Director. In making such grants, the Di-
3 rector shall attempt to ensure regional and geo-
4 graphic equity.

5 “(B) GRANT REQUIREMENT.—As a condi-
6 tion of receiving such a grant, an organization
7 shall be required to collect and report data to
8 the Director on the types of problems and in-
9 quiries encountered by consumers they serve.
10 Data shall be used by the Director to inform
11 enforcement activities and be shared with State
12 insurance regulators, the Department of Labor,
13 and the Secretary of the Treasury.

14 “(C) APPROPRIATIONS AND AUTHORIZA-
15 TIONS.—There is hereby appropriated, out of
16 any funds in the Treasury not otherwise appro-
17 priated for the first fiscal year in which this
18 section is in effect, \$30,000,000 for grants
19 under this paragraph, to be available until ex-
20 pended. For each subsequent fiscal year there
21 are authorized to be appropriated such sums as
22 may be necessary for such grants.

23 “(5) ADMINISTRATION OF HIGH RISK POOL.—

24 The Director shall administer the high risk pool pro-
25 gram under section 2745.

1 “(6) ADMINISTRATION OF GRANTS TO STATE
2 INSURANCE DEPARTMENTS.—The Director shall ad-
3 minister the program of grants to State insurance
4 departments under section 2793(d).

5 “(c) PERIODIC REPORTS.—The Director shall submit
6 periodic reports to Congress on the Office’s activities.

7 “(d) COORDINATION.—

8 “(1) FEDERAL OFFICIALS.—The Director shall
9 coordinate, with the Secretaries of Labor and Treas-
10 ury, activities under this section with respect to re-
11 quirements that affect health insurance coverage of-
12 fered in connection with group health plans, includ-
13 ing coordination in —

14 “(A) development and dissemination of in-
15 formation; and

16 “(B) consumer inquiries and complaints
17 relating to Federal health insurance require-
18 ments.

19 “(2) STATE HEALTH INSURANCE REGU-
20 LATORS.—In carrying out the Office’s activities, the
21 Director shall—

22 “(A) coordinate with State health insur-
23 ance regulators regarding data collection and
24 disclosure and audit and enforcement activities

1 in order to avoid duplication and to use regu-
2 latory resources most efficiently;

3 “(B) monitor State efforts to implement
4 and enforce consumer protections consistent
5 with Federal health insurance requirements;

6 “(C) provide technical assistance to States
7 seeking to implement and enforce consumer
8 protections consistent with such requirements;
9 and

10 “(D) provide for regular communication
11 with such regulators to coordinate enforcement
12 efforts and sharing of information

13 “(e) TRANSFER OF PERSONNEL AND RESOURCES.—
14 The Secretary shall provide for the transfer to the Office
15 of those personnel and resources within the Department
16 of Health and Human Services that, as of the date of the
17 enactment of this section, relate directly to the responsibil-
18 ities of the Director under this section.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—In addi-
20 tion to amounts made available under subsection
21 (b)(4)(C), there are authorized to be appropriated to carry
22 out this section \$20,000,000 for the first fiscal year begin-
23 ning after the date of the enactment of this section and
24 such sums as may be necessary for subsequent fiscal
25 years.”.

1 (b) CONFORMING AMENDMENTS REGARDING ADDI-
2 TIONAL AUTHORITY.—

3 (1) GROUP MARKET.—Section 2722 of such Act
4 (42 U.S.C. 300gg–22) is amended by adding at the
5 end the following new subsection:

6 “(c) REFERENCE TO ADDITIONAL AUTHORITY.—For
7 additional Secretarial authorities with respect to require-
8 ments under this part, see sections 2793 and 2794.”.

9 (2) INDIVIDUAL MARKET.—Section 2761 of
10 such Act (42 U.S.C. 300gg–61) is amended by add-
11 ing at the end the following new subsection:

12 “(c) REFERENCE TO ADDITIONAL AUTHORITY.—For
13 additional Secretarial authorities with respect to require-
14 ments under this part, see sections 2793 and 2794.”.

15 **SEC. 7. STANDARDS AND ACCOUNTABILITY AND TRANS-**
16 **PARENCY INITIATIVES FOR GROUP HEALTH**
17 **PLANS THROUGH DEPARTMENTS OF LABOR**
18 **AND THE TREASURY.**

19 (a) STANDARDS.—In coordination with the Secretary
20 of Health and Human Services, the Secretaries of Labor
21 and the Treasury shall establish for group health plans
22 standards comparable to the standards developed by the
23 Secretary of Health and Human Services for group health
24 insurance coverage under section 2708 of the Public
25 Health Service Act, as added by section 3(a), in order to

1 promote quality, fair marketing, and honesty in out-of-net-
2 work coverage under such plans and to permit participants
3 to make an informed decision in cases where they are of-
4 fered a choice of coverage under such a plan.

5 (b) ACCOUNTABILITY AND TRANSPARENCY INITIA-
6 TIVES.—In coordination with the Secretary of Health and
7 Human Services, the Secretaries of Labor and the Treas-
8 ury shall jointly undertake accountability and trans-
9 parency initiatives with respect to group health plans simi-
10 lar to those undertaken by the Secretary of Health and
11 Human Services with respect to group and individual
12 health insurance coverage under sections 2793 and 2794
13 of the Public Health Service Act, as added by sections 4
14 and 5 of this Act.

15 (c) GROUP HEALTH PLAN DEFINED.—In this sec-
16 tion, with respect to the Secretary of Labor and the Sec-
17 retary of the Treasury, the term “group health plan” has
18 the meaning such term for purposes of part 7 of subtitle
19 B of title I of the Employee Retirement Income Security
20 Act of 1974 and chapter 100 of the Internal Revenue Code
21 of 1986, respectively.

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