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.

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Consumers Health Care Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

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

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

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

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

SEC. 3. OFFICE OF HEALTH PLAN MANAGEMENT.

(a) ESTABLISHMENT.—Not later than July 1, 2010, there shall be established within the Department of Health and Human Services an Office of Health Plan Management (referred to in this Act as the ''Office''). The Office shall be headed by a Director (referred to in this Act as the ''Director'') who shall be appointed by the President, by and with the advice and consent of the Senate.

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

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

the promulgation or administration of any regulation regarding the health insurance industry.

(d) PERSONNEL AND OPERATIONS AUTHORITY.—The Director shall have the same general authorities with respect to personnel and operations of the Office as the heads of other agencies and departments of the Federal Government have with respect to such agencies and departments.

SEC. 4. CONSUMER CHOICE HEALTH PLAN.

(a) IN GENERAL.—The Office shall establish and administer the Consumer Choice Health Plan (referred to in this Act as the ''Plan'') to provide for health insurance coverage that is made available to all eligible individuals (as described in subsection (d)(1)) in the United States and its territories.

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

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

(2) any additional regulations and requirements, as determined by the Director.

(c) BENEFITS.—

(1) IN GENERAL.—The Plan shall offer health insurance coverage at different benefit levels, provided that such benefits are commensurate with the required benefit levels to be provided by a health insurance plan under the National Health Insurance Exchange.

(2) MINIMUM BENEFITS FOR CHILDREN.—

(A) IN GENERAL.—The minimum benefit level available under the Plan for children shall include at least the services described in the most recently published version of the ''Maternal and Child Health Plan Benefit Model'' developed by the National Business Group on Health.

(B) AMENDMENT OF BENEFIT LEVEL.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, may amend the benefits described in subparagraph (A) based on the most recent peer-reviewed and evidence-based data.

(d) ELIGIBILITY AND ENROLLMENT.—

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

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

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

(3) EMPLOYER ENROLLMENT.—An employer shall be eligible to purchase health insurance coverage for their employees and the employees' dependents to the extent provided for all health benefits plans under the National Health Insurance Exchange.

(4) SATISFACTION OF INDIVIDUAL MANDATE REQUIREMENT.—An individual's enrollment with the Plan shall be treated as satisfying any requirement under Federal law for such individual to demonstrate enrollment in health insurance or benefits coverage.

(e) PROVIDERS.—

(1) NETWORK REQUIREMENT.—

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

U.S.C. 1395 et seq.) shall be required to provide services to any individual enrolled in the Plan.

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

(2) EXCEPTION.—Paragraph (1) shall not be construed as requiring a provider to accept new patients due to bona fide capacity limitations of the provider.

(3) OPT-OUT PROVISION.—

(A) MEDICARE.—A participating provider as described under paragraph (1)(A) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a participating provider in the Plan may elect to become a non-participating provider without affecting their

status as a participating provider under the Medicare program.

(B) MEDICAID AND CHIP.—A provider as described under paragraph (1)(B) shall be required to provide services to any individual enrolled in the Plan for the 3-year period following the establishment of the Plan. Upon the expiration of the 3-year period, a provider in the Plan may elect to cease provision of services under the Plan without affecting their status as a provider under the Medicaid program or the CHIP program.

(4) PAYMENT RATES.—

(A) INITIAL PAYMENT RATES.—

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

(ii) ADJUSTMENT.—The Director may reimburse providers at rates lower or higher than applicable under the Medicare program if the Director determines that the adjusted rates are appropriate and ensure that enrollees in the Plan are provided

with adequate access to health care services.

(B) SUBSEQUENT PAYMENT RATES.—Subject to subparagraph (C), upon the expiration of the 2-year period following the establishment of the Plan, the Director shall develop payment rates for reimbursement of providers in order to maintain an adequate provider network necessary to assure that enrollees in the Plan have adequate access to health care. In determining such payment rates, the Director shall consider—

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

(ii) best practices among providers;

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

(iv) geographic variation in health care costs;

(v) evidence-based practices;

(vi) quality improvement;

(vii) use of health information technology; and

(viii) any additional measures, as determined by the Director.

(C) PAYMENT RATE CONSULTATION.—The Director shall determine payment rates under subparagraph (B) in consultation with providers participating under the Plan, the Director of the Office of Personnel Management, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment and Access Commission.

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

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

(g) FINANCING.—

(1) TRANSITIONAL FUNDING.—

(A) IN GENERAL.—In order to provide for adequate funding of the Plan in advance of receipt of payments as described in paragraph

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

(B) RETURN OF FUNDS.—Upon the expiration of the 3-year period following the establishment of the Plan, the Director shall enter into a repayment schedule with the Secretary of the Treasury to provide for repayment of funds provided under subparagraph (A). Any expenditures made by the Plan pursuant to a repayment schedule established under this subparagraph shall not constitute administrative expenses as described in paragraph (2)(B).

(2) SELF-FINANCING.—

(A) IN GENERAL.—The Plan shall be financially self-sustaining insofar as funds used for operation of the Plan (including benefits, administration, and marketing) shall be derived from—

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

(ii) payments made to the Plan by employers that do not offer health insurance coverage to their employees.

(B) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided under subparagraph (A) may be used for the annual administrative costs of the Plan.

(3) CONTINGENCY RESERVE.—

(A) IN GENERAL.—The Director shall establish and fund a contingency reserve for the Plan in a form similar to the contingency reserve provided for health benefits plans under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(B) REVENUE.—Any revenue generated through the contingency reserve established in subparagraph (A) shall be transferred to the Plan for the purpose of reducing enrollee premiums, reducing enrollee cost-sharing, increasing enrollee benefits, or any combination thereof.

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

troller General shall conduct an annual audit of the financial statements and records of the Plan, in accordance with generally accepted government auditing standards, and submit an annual report on such audit to the Congress.

(5) SUPERMAJORITY REQUIREMENT FOR SUPPLEMENTAL FUNDING.—Upon certification by the Comptroller General that the financial audit described in paragraph (4) indicates that the Plan is insolvent, supplemental funding may be appropriated for the Plan if such measure receives not less than a three-fifths vote of approval of the total number of Members of the House of Representatives and the Senate.

(h) TRANSPARENCY.—

(1) IN GENERAL.—Beginning with the first year of operation of the Plan through the National Health Insurance Exchange, the Director shall provide standards and undertake activities for promoting transparency in costs, benefits, and other factors for health insurance coverage provided under the Plan.

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

(A) IN GENERAL.—The Director shall provide for the development of standards for the definitions of terms used in health insurance coverage under the Plan, including insurance-related terms (including the insurance-related terms described in subparagraph (B)) and medical terms (including the medical terms described in subparagraph (C)).

(B) INSURANCE-RELATED TERMS.—The insurance-related terms described in this subparagraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Director determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(C) MEDICAL TERMS.—The medical terms described in this subparagraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation serv-

ices, hospice services, emergency medical transportation, and such other terms as the Director determines are important to define so that consumers may compare the medical benefits offered by health insurance plans and understand the extent of those medical benefits (or exceptions to those benefits).

(3) DISCLOSURE.—

(A) IN GENERAL.—In carrying out this subsection, the Director shall disclose to Plan enrollees, potential enrollees, in-network health care providers, and others (through a publically available Internet website and other appropriate means) relevant information regarding each policy of health insurance coverage marketed or in force (in such standardized manner as determined by the Director), including—

(i) full policy contract language; and

(ii) a summary of the information described in paragraph (4).

(B) PERSONALIZED STATEMENT.—The Director shall disclose to enrollees (in such standardized manner as determined by the Director) an annual personalized statement that summarizes use of health care services and payment of

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

(4) REQUIRED INFORMATION.—The information described in this paragraph includes, but is not limited to, the following:

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

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

(C) Provider fee schedules and usual, customary, and reasonable fees (for both in-network and out-of-network providers).

(D) Provider participation and provider directories.

(E) Loss ratios, including detailed information about amount and type of non-claims expenses.

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

the United States Preventive Services Task Force.

(G) Civil or criminal actions successfully concluded against the Plan by any governmental entity.

(H) Benefit exclusions and limits.

(5) DEVELOPMENT OF PATIENT CLAIMS SCENARIOS.—

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

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

(i) in consultation with the Secretary of Health and Human Services, the National Institutes of Health, the Centers for

Disease Control and Prevention, the Agency for Healthcare Research and Quality, health professional societies, patient advocates, and other entities as deemed necessary by the Director; and

(ii) based upon recognized clinical practice guidelines.

(6) MANNER OF DISCLOSURE.—The Director shall disclose the information under this subsection—

(A) with all marketing materials;

(B) on the website for the Plan; and

(C) at other times upon request.

SEC. 5. ESTABLISHMENT OF AMERICA'S HEALTH INSURANCE TRUST.

(a) ESTABLISHMENT.—As of the date of enactment of this Act, there is authorized to be established a nonprofit corporation that shall be known as the ''America's Health Insurance Trust'' (referred to in this Act as the ''Trust''), which is neither an agency nor establishment of the United States Government.

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

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

(c) APPLICATION OF PROVISIONS.—The Trust shall be subject to the provisions of this section and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(d) TAX EXEMPT STATUS.—The Trust shall be treated as a nonprofit organization described under section 170(c)(2)(B) and section 501(c)(3) of the Internal Revenue Code of 1986 that is exempt from taxation under section 501(a) of the Internal Revenue Code of 1986.

(e) BOARD OF DIRECTORS.—

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

(2) TERMS.—

(A) IN GENERAL.—Subject to subparagraph (C), each member of the Board shall serve for a term of 6 years.

(B) LIMITATION.—No individual shall be appointed to the Board for more than 2 consecutive terms.

(C) INITIAL MEMBERS.—The initial members of the Board shall be appointed by the

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

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

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

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

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

(E) VACANCIES.—

(i) IN GENERAL.—Any member appointed to fill a vacancy prior to the expiration of the term for which such member's predecessor was appointed shall be appointed for the remainder of such term.

(ii) VACANCIES NOT TO AFFECT POWER OF BOARD.—A vacancy on the Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(3) CHAIRPERSON AND VICE-CHAIRPERSON.—

(A) IN GENERAL.—The Comptroller General shall designate a Chairperson and Vice-Chairperson of the Board from among the members of the Board.

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

(4) CONFLICTS OF INTEREST.—An individual may not serve on the Board if such individual (or an immediate family member of such individual) is employed by or has a financial interest in—

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

(B) a pharmaceutical manufacturer; or

(C) any subsidiary entities of an organization described in subparagraphs (A) or (B).

(5) COMPOSITION OF THE BOARD.—

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

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

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

(C) CONSUMER REPRESENTATION.—10 members of the Board shall be independent and non-conflicted individuals representing the interests of health care consumers. Each member selected under this subparagraph shall represent 1 of the 10 Department of Health and Human Services regions in the United States.

(D) REMAINING REPRESENTATION.—

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

(I) community affairs;

(II) Federal, State, and local government;

(III) health professions and administration;

(IV) business, finance, and accounting;

(V) legal affairs;

(VI) insurance;

(VII) trade unions;

(VIII) social services; and

(IX) any additional areas as determined by the Comptroller General.

(ii) INCOME FROM HEALTH CARE INDUSTRY.—Not more than 4 of the members selected under this subparagraph shall earn more than 10 percent of their income from the health care industry.

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

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

(8) EXECUTIVE DIRECTOR AND STAFF; PERFORMANCE OF DUTIES.—The Board may—

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

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

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

(C) enter into contracts or other arrangements and make such payments as may be necessary for performance of the duties of the Trust;

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

(E) prescribe such rules, regulations, and bylaws as the Board determines necessary with respect to the internal organization and operation of the Trust.

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

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

before the date of enactment of the Consumers Health Care Act of 2009.''.

(f) ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—The Board shall establish an advisory council that shall be comprised of the insurance commissioners of each State (including the District of Columbia) to advise the Board on the development and impact of measures to improve the transparency and accountability of health insurance plans provided through the National Health Insurance Exchange.

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

(g) FINANCIAL OVERSIGHT.—

(1) CONTRACT FOR AUDITS.—The Trust shall provide for financial audits of the Trust on an annual basis by a private entity with expertise in conducting financial audits.

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

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

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

(h) RULES ON GIFTS AND OUTSIDE CONTRIBUTIONS.—

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

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

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

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

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

(1) IN GENERAL.—There is established in the Treasury a trust fund to be known as the ''America's Health Insurance Trust Fund'' (referred to in this section as the ''Trust Fund''), consisting of such amounts as may be credited to the Trust Fund as provided under this subsection.

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

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

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

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

"Subchapter B—Insured and Self-Insured Health Plans

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—In the case of any specified health insurance policy issued after October 1, 2009, there is hereby imposed a fee equal to—

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

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

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

''(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

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

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy issued in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy shall be equal to the sum of such dollar amount for policies issued in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

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

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

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

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

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan issued after October 1, 2009, there is hereby imposed a fee equal to—

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

''(2) for plans issued after September 30, 2013, $1 multiplied by the average number of lives covered under the plans.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

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

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

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

"(2) such plan is established or maintained—

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

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

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

in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

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

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

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

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument where-

by a contract of insurance is issued, renewed, or extended.

"(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

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

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

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

"(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

"(C) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code,

"(D) the Consumer Choice Health Plan established under the Consumers Health Care Act of 2009,

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

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(F) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

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

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

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

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

SEC. 6. DUTIES OF AMERICA'S HEALTH INSURANCE TRUST.

(a) INSURANCE PLAN RANKINGS AND WEBSITE.—

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

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

(2) PLAN RANKINGS.—The Trust shall develop and publish annual rankings of the health insurance plans provided through the National Health Insurance Exchange, based on the assignment of a letter grade between ''grade A'' (highest) and ''grade F'' (lowest). The Trust shall provide for a comparative evaluation of each plan based upon—

(A) administrative expenditures;

(B) affordability of coverage;

(C) adequacy of coverage;

(D) timeliness and adequacy of consumer claims processing;

(E) available consumer complaint systems;

(F) grievance and appeals processes;

(G) transparency;

(H) consumer satisfaction; and

(I) any additional measures as determined by the Board.

(3) INFORMATION AVAILABLE ON WEBSITE BY ZIP CODE.—The annual rankings of the health insurance plans (as described in paragraph (2)) shall be available on the website for the Trust (as described in paragraph (1)), and the website for the

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

(4) CONSUMER FEEDBACK.—

(A) CONSUMER COMPLAINTS.—The Trust shall develop written and web-based methods for individuals to provide recommendations and complaints regarding the health insurance plans provided through the National Health Insurance Exchange.

(B) CONSUMER SURVEYS.—The Trust shall obtain meaningful consumer input, including consumer surveys, that measure the extent to which an individual receives the services and supports described in the individual's health insurance plan and the individual's satisfaction with such services and supports.

(b) DATA SHARING.—

(1) IN GENERAL.—An organization that provides a health insurance plan through the National Health Insurance Exchange shall provide the Trust with all information and data that is necessary for improving transparency, monitoring, and oversight of such plans.

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

Insurance Exchange, an organization that provides a health insurance plan through the National Health Insurance Exchange shall annually provide the Trust with appropriate information regarding the following:

(A) Name of the plan.

(B) Levels of available plan benefits.

(C) Description of plan benefits.

(D) Number of enrollees under the plan.

(E) Demographic profile of enrollees under the plan.

(F) Number of claims paid to enrollees.

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

(H) Total operating cost for the plan (including administrative costs).

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

(J) Availability, accessibility, and acceptability of the plan's services.

(K) Such information as the Trust may require demonstrating that the organization has a fiscally sound operation.

(L) Any additional information as determined by the Trust.

(3) FORM AND MANNER OF INFORMATION.—Information to be provided to the Trust under paragraphs (1) and (2) shall be provided—

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

(B) within 30 days of the date of receipt of the request for such information, or within such extended period as the Trust deems appropriate.

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

(A) IN GENERAL.—Any information regarding the health insurance plans that are offered through the National Health Insurance Exchange that has been provided to the Secretary of Health and Human Services shall also be made available (as deemed appropriate by the Secretary) to the Trust for the purpose of improving transparency, monitoring, and oversight of such plans. Such information may include, but is not limited to, the following:

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

(ii) Rating practices to ensure compliance with applicable Federal health insurance requirements.

(iii) Enrollment and disenrollment data, including information the Secretary may need to detect patterns of discrimination against individuals based on health status or other characteristics, to ensure compliance with applicable Federal health insurance requirements (including non-discrimination in group coverage, guaranteed issue, and guaranteed renewability requirements applicable in all markets).

(iv) Post-claims underwriting and rescission practices to ensure compliance with applicable Federal health insurance requirements relating to guaranteed renewability.

(v) Marketing materials and agent guidelines to ensure compliance with applicable Federal health insurance requirements.

(vi) Data on the imposition of pre-existing condition exclusion periods and claims subjected to such exclusion periods.

(vii) Information on issuance of certificates of creditable coverage.

(viii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(ix) The application to issuers of penalties for violation of applicable Federal health insurance requirements (including failure to produce requested information).

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

(B) REQUIRED DISCLOSURE.—The Secretary of Health and Human Services shall provide the Trust with all consumer claims data or information that has been provided to the Secretary by any health insurance plan that is offered through the National Health Insurance Exchange.

(C) PERIOD FOR PROVIDING INFORMATION.—Information to be provided to the Trust under this paragraph shall be provided by the Secretary within 30 days of the date of receipt of the request for such information, or within

such extended period as the Secretary and the Trust mutually deem appropriate.

(5) NON-DISCLOSURE OF HEALTH INSURANCE DATA.—The Trust shall prevent disclosure of any data or information provided under this paragraph that the Trust determines is proprietary or qualifies as a trade secret subject to withholding from public dissemination. Any data or information provided under this paragraph shall not be subject to disclosure under section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act).

SEC. 7. DEFINITION OF NATIONAL HEALTH INSURANCE EXCHANGE.

In this Act, the term ''National Health Insurance Exchange'' means a mechanism established or recognized under Federal law for coordinating the offering of health insurance coverage to individuals in the United States through the establishment of standards for benefits, cost-sharing, and premiums for such health insurance coverage.

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