111TH CONGRESS
1ST SESSION

# S. 1050

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.

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IN THE SENATE OF THE UNITED STATES

MAY 14, 2009

Mr. REID (for Mr. ROCKEFELLER (for himself, Mr. KOHL, and Mr. LEVIN)) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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# 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.

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Informed Consumer Choices in Health Care Act of 2009''.

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



**SEC. 2. FINDINGS.**

Congress finds the following:

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

(2) Based on the information currently provided by health insurers, patients are unable to predict what their health insurance coverage limits or out-of-pocket costs would be if they had a serious illness. 72 million adults under age 65 had problems paying medical bills or were paying off medical debt in 2007, and 61 percent of those were insured at the time care was provided.

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

(4) Consumers often find it difficult to navigate and evaluate their choices in today's health insurance markets and many select a suboptimal plan as a result.

(5) The Institute of Medicine of the National Academy of Sciences has estimated that nearly half of all American adults—90 million people—have difficulty understanding and using health information.

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

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

(8) Insurance forms provided to patients and providers are often confusing, difficult to reconcile

with medical bills, and vary widely from insurer to insurer, thereby adding complexity and administrative waste to the health care system.

(9) Research indicates that physicians divert substantial resources, as much as 14 percent of their total revenue, to ensure accurate insurance payments for their services. Hospitals spend as much as 11 percent of their total revenue on billing and insurance-related costs. These include time spent determining patient insurance eligibility and benefit structure. One study found that paperwork adds at least 30 minutes to every hour of patient care.

(10) According to the American Medical Association, there is wide variation in how often health insurers pay nothing in response to a physician claim and in how they explain the reason for the denial. There is no consistency in the application of codes used to explain the denials, making it extremely expensive for physician practices to determine how to respond.

(11) According to the American Medical Association, more than half of health insurers in a recent study did not provide physicians with the transparency necessary for an efficient claims processing system.

(12) According to the American Medical Association, payers vary widely on how often they use proprietary rather than public claims edits to reduce payments (ranging from zero to as high as nearly 72 percent). The use of undisclosed proprietary edits inhibits the flow of transparent information to physicians, adding additional administrative costs to reconcile claims.

(13) The Federal Government currently lacks capacity to carry out responsibility for oversight and enforcement of current law requirements on health insurance issuers and to provide States with technical assistance in effectively enforcing Federal minimum standards for health insurance.

(14) In order to improve the functioning of the private health insurance market, assure the application of existing requirements to health insurance coverage, and reduce administrative hassles for patients and providers, there is a need for periodic examinations and audits of such coverage, for greater disclosure of information regarding the terms and conditions of such coverage, and for the establishment of a Federal oversight office to ensure enforcement of standards.

**SEC. 3. NEW MINIMUM FEDERAL STANDARDS FOR HEALTH INSURANCE FORMS, QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-NETWORK COVERAGE.**

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

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

''(a) DEFINING INSURANCE TERMS; STANDARDIZING INSURANCE FORMS.—

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

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

''(A) IN GENERAL.—The Secretary shall provide for the development of standards for the definitions of terms used in group health insurance coverage, 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 Secretary 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 services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by insurance health insurance and

understand the extent of those medical benefits (or exceptions to those benefits).

''(3) STANDARDIZATION OF INSURANCE FORMS.—The Secretary shall provide for the development of standards for the forms used in connection with group health insurance coverage, including for—

''(A) applications for health insurance coverage;

''(B) explanations of benefits for such coverage;

''(C) filing of complaints, grievances, and appeals respecting such coverage; and

''(D) other common functions relating to such coverage as the Secretary deems appropriate.

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

''(5) PERSONALIZED STATEMENT.—The Secretary shall develop standards for an annual person-

alized statement that summarizes use of health care services and payment of claims with respect to an enrollee (and covered dependents) under group health insurance coverage in the preceding year.

''(6) APPLICATION OF STANDARDS.—No group health insurance coverage may be offered for sale after the date that is two years after date of the enactment of this section unless—

''(A) the benefits and other terms of coverage are consistent with the definitional standards developed under paragraph (2);

''(B) the application and form of coverage and related forms are consistent with the standardized forms developed under paragraph (3); and

''(C) there is provided coverage facts labels described in paragraph (4) with respect to the coverage.

''(7) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this subsection.

''(8) EVALUATION OF INFORMATION RESOURCES.—In developing, reviewing, and updating standards under this subsection, the Secretary shall

provide for testing and evaluation of information resources in general and to specific audiences including those with low literacy skills.

''(9) CONSULTATION.—In developing, reviewing, and updating standards under this subsection, the Secretary shall consult with, among others, the National Association of Insurance Commissioners, health care professionals, researchers, health insurance issuers, group health plans, patient advocates, and literacy experts.

''(b) QUALITY ASSURANCES FOR HEALTH INSURANCE.—

''(1) IN GENERAL.—The Secretary shall provide for the development of standards to assure the quality of benefits under group health insurance coverage. Such standards shall include standards relating to at least—

''(A) network adequacy and stability;

''(B) guaranteed coverage for one year of contracted benefits;

''(C) adequacy and stability of prescription drug networks;

''(D) utilization control systems; and

''(E) grievances and appeals.

''(2) APPLICATION OF PROVISIONS.—The provisions of paragraphs (5) through (9) of subsection (a) apply to standards developed under this subsection in the same manner as such provisions apply to standards developed under subsection (a).

''(c) MARKETING.—

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

''(A) marketing materials; and

''(B) sales commissions.

''(2) NONDISCRIMINATION.—No group health insurance coverage may be offered for sale after the date that is two years after date of the enactment of this section unless the issuer provides the Secretary with a written certification that all marketing materials, seminars, and other outreach efforts in connection with the offering of such coverage do not discriminate on the basis of income, race, gender, ethnicity, or other demographic factors as determined by the Secretary.

''(3) APPLICATION OF PROVISIONS.—The provisions of paragraphs (7) through (9) of subsection (a) apply to standards developed under this sub-

section in the same manner as such provisions apply to standards developed under subsection (a).

''(d) HONESTY IN COVERAGE OF OUT-OF-NETWORK PROVIDERS.—The Secretary shall provide for the development of standards for the accuracy and clarity of coverage for out-of-network providers, including cost sharing and payments to such providers, for health insurance issuers in group health insurance coverage that provide such coverage.''.

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

**''SEC. 2746. STANDARDS FOR HEALTH INSURANCE FORMS, QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-NETWORK COVERAGE.**

''The provisions of section 2708 shall apply under this part to individual health insurance coverage and enrollees in such coverage in the same manner as such provisions apply under part A in the case of group health insurance coverage and group health plans and participants and beneficiaries.''.

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

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

''(m) STANDARDS FOR HEALTH INSURANCE FORMS, QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-NETWORK COVERAGE.—The provisions of section 2708(a) of the Public Health Service Act shall apply to Medicare Advantage organizations, Medicare Advantage plans, and enrollees in such plans in the same manner as such provisions apply under such section to group health insurance coverage and group health plans and participants and beneficiaries.''.

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

''(m) STANDARDS FOR HEALTH INSURANCE FORMS, QUALITY, FAIR MARKETING, AND HONESTY IN OUT-OF-NETWORK COVERAGE.—The provisions of section 2708(a) of the Public Health Service Act shall apply to PDP sponsors, prescription drug plans, and enrollees in such plans in the same manner as such provisions apply under such section to group health insurance coverage and group health plans and participants and beneficiaries.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after the date that is 2 years after the date of the enactment of this Act.

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

**SEC. 4. HEALTH INSURANCE ACCOUNTABILITY INITIATIVES.**

(a) IMPROVED HEALTH INSURANCE ACCOUNTABILITY.—Title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

**"SEC. 2793. ACCOUNTABILITY INITIATIVES.**

''(a) IN GENERAL.—The Secretary, acting through the Office of Health Insurance Oversight established under section 2795, shall undertake activities in accordance with this section to promote accountability of health insurance issuers in meeting Federal health insurance requirements, regardless of whether this relates to health insurance in the individual or group market.

''(b) COMPLIANCE EXAMINATIONS AND AUDITS.—

''(1) IN GENERAL.—Without regard to whether or not there is a determination under section 2722(a)(2) or 2761(a)(2) with respect to a health insurance issuer, in carrying out this section, the Secretary shall conduct independent market conduct examinations and audits to monitor and verify the compliance of a health insurance issuer with Federal health insurance requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected noncompliance.

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

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

''(c) DATA COLLECTION AND REVIEW.—

''(1) IN GENERAL.—The Secretary shall collect and review data from health insurance issuers on health insurance coverage to monitor compliance

with Federal health insurance requirements applicable to such issuers and coverage. Upon request by the Secretary, such issuers shall provide such data to the Secretary on a timely basis.

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

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

''(B) Rating practices to ensure compliance with such requirements.

''(C) 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 such requirements (including nondiscrimination in group coverage, guaranteed issue, and guaranteed renewability requirements applicable in all markets).

''(D) Post-claims underwriting and rescission practices to ensure compliance with such requirements relating to guaranteed renewability.

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

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

"(G) Information on issuance of certificates of creditable coverage.

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

"(I) Such other information as the Secretary may determine to be necessary to verify compliance with requirements of this title.

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

"(3) TREATMENT OF PROPRIETARY INFORMATION.—The Secretary may request under this subsection information that is proprietary or that reveals a trade secret, but such information shall not be subject to further disclosure to the general public in a manner that reveals proprietary information or a trade secret.

''(4) FORM AND MANNER OF INFORMATION.—Information under paragraph (1) shall be provided—

''(A) in a form and manner specified by the Secretary; and

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

''(5) ENFORCEMENT.—The Secretary shall have the same authority in relation to enforcement of requests for data under paragraph (1) as the Secretary has under section 2722(b).

''(6) COORDINATION WITH STATES.—

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

''(B) CLEARINGHOUSE.—The Secretary shall establish a clearinghouse for the sharing of data reported by health insurance issuers and for the findings from audits and investigations. Such clearinghouse may be established in

conjunction with the National Association of Insurance Commissioners.

''(7) COORDINATION WITH DEPARTMENTS OF LABOR AND TREASURY.—The Secretary shall coordinate with the Secretaries of Labor and Treasury with respect to requirements to report data that affect health insurance coverage sold in connection with group health plans.

''(d) HEALTH INSURANCE ACCOUNTABILITY GRANTS TO STATES.—

''(1) IN GENERAL.—The Secretary shall provide for grants to Departments of Insurance in States to strengthen their enforcement of Federal health insurance requirements with respect to health insurance issuers operating in such States. Such a grant shall only be made pursuant to an application made to the Secretary.

''(2) FUNDING.—

''(A) IN GENERAL.—Of the funds appropriated under subparagraph (B) for grants under this subsection, the Secretary shall provide a grant to each State with an application approved under paragraph (1).

''(B) ALLOCATION.—Funds so appropriated for any fiscal year shall be apportioned

among the States in accordance with a formula determined by the Secretary that takes into account the scope of health insurance subject to regulation under this title in each State and such other factors as the Secretary may specify.

''(C) APPROPRIATIONS AND AUTHORIZATIONS.—There is hereby appropriated, out of any funds in the Treasury not otherwise appropriated for the first fiscal year in which this section is in effect, $10,000,000 for grants under this subsection, to be available until expended. For each subsequent fiscal year there is authorized to be appropriated such sums as may be necessary for such grants.

''(e) FEDERAL HEALTH INSURANCE REQUIREMENTS DEFINED.—In this part, the term 'Federal health insurance requirements' means the requirements under this title insofar as they relate to health insurance issuers and health insurance coverage, whether in the individual or group market, and includes other requirements imposed under Federal law specifically in relation to the offering of health insurance coverage by health insurance issuers.''.

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

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

**"SEC. 2794. TRANSPARENCY INITIATIVES.**

"(a) IN GENERAL.—The Secretary, acting through the Office of Health Insurance Oversight established under section 2795, shall undertake activities in accordance with this section to promote transparency in costs, market practices, and other factors for health insurance coverage, regardless of whether the coverage is offered or in effect in the individual or group market.

"(b) DEVELOPMENT AND DISCLOSURE OF STANDARDIZED INFORMATION.—

"(1) IN GENERAL.—In carrying out this section, the Secretary shall provide for the development of—

"(A) standards for information about health insurance issuers, their health insurance policies, and their market practices with respect to such policies; and

"(B) standards for the disclosure of such information in a timely, consistent, and accurate manner by health insurance issuers about each health insurance policy marketed and in force.

''(2) INFORMATION TO BE DISCLOSED.—

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

''(i) Full policy contract language.

''(ii) A summary of the information described in paragraph (3).

''(iii) For each of the scenarios developed under paragraph (4), the coverage facts label information developed under section 2709(a)(4).

''(B) PERSONALIZED STATEMENT.—In carrying out this section, the Secretary shall require health insurance issuers to disclose to enrollees, in such standardized manner as the Secretary specifies, an annual personalized statement described in section 2708(a)(5).

''(3) INFORMATION TO BE DISCLOSED.—The information described in this paragraph is at least the following:

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

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

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

''(D) Information on provider participation and provider directories.

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

''(F) Information on 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) Information on civil or criminal actions successfully concluded against the issuer by any governmental entity.

"(H) Benefit exclusions and limits.

"(4) DEVELOPMENT OF PATIENT CLAIMS SCENARIOS.—

"(A) IN GENERAL.—In order to improve the ability of individuals and group health plans to compare the coverage and value provided under different health insurance coverage, the Secretary shall develop a series of patient claims scenarios under which benefits (including out-of-pocket costs) under such coverage can be simulated for certain common or expensive conditions or courses of treatment, such as maternity care, breast cancer, heart disease, diabetes management, and well-child visits.

"(B) CONSULTATION AND BASIS.—The Secretary shall develop the scenarios under this paragraph—

"(i) in consultation with the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, health professional societies, patient advo-

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

''(ii) based upon recognized clinical practice guidelines.

''(5) MANNER OF DISCLOSURE.—

''(A) IN GENERAL.—The standards under paragraph (1)(B) shall provide for health insurance issuers to disclose the information under this subsection—

''(i) with all marketing materials;

''(ii) on the web-site of the issuer; and

''(iii) at other times upon request.

''(B) CONTRACT LANGUAGE.—Such standards also shall require the disclosure of full policy contract language in printed form upon request.

''(c) APPLICATION OF ENFORCEMENT PROVISIONS.—The provisions of sections 2722 and 2671 shall apply to enforcement of the requirements of this section in the same manner as such provisions apply to the provisions of part A or part B, respectively. Under such provisions the States shall have initial (and primary) enforcement authority with respect to such requirements, except that the Secretary under section 2793 may directly monitor compliance with such provisions as well.''.

(b) CONFORMING AMENDMENTS REGARDING DISCLOSURE OF INFORMATION.—

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

''(e) REFERENCE TO DISCLOSURE OF INFORMATION.—For provision requiring disclosure of information by health insurance issuers, see section 2794(d).''.

(2) REFERENCE IN THE INDIVIDUAL MARKET.—Section 2761 of the Public Health Service Act is amended by adding at the end the following new subsection:

''(e) REFERENCE TO DISCLOSURE OF INFORMATION.—For provision requiring disclosure of information by health insurance issuers, see section 2794(d).''.

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

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

**''SEC. 2795. OFFICE OF HEALTH INSURANCE OVERSIGHT.**

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

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

"(b) DUTIES.—

"(1) PROMOTION OF ACCOUNTABILITY IN HEALTH INSURANCE.—

"(A) IN GENERAL.—The Director shall implement accountability initiatives under section 2793.

"(B) CLEARINGHOUSE.—The Director shall provide, in consultation with the National Association of Insurance Commissioners, for a clearinghouse for State health insurance regulators to share information concerning, and help them to enact and enforce, Federal health insurance requirements.

"(2) PROMOTE TRANSPARENCY IN HEALTH INSURANCE.—The Director shall implement transparency initiatives under section 2794.

"(3) CONSUMER INFORMATION, ASSISTANCE.—

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

including through carrying out activities under this paragraph.

''(B) INFORMATION RESOURCES.—The Director shall develop health insurance information resources for consumers, including coverage facts labels for patient claims scenarios developed under section 2794(b)(4) and web-based information on average price ranges for out-of-network services based on geography.

''(C) SERVICE.—The Director shall establish a consumer assistance service that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

''(4) HEALTH INSURANCE CONSUMER ASSISTANCE GRANTS.—

''(A) IN GENERAL.—The Director shall provide for grants to public, private or not-for-profit consumer assistance organizations to develop, support, and evaluate consumer assistance programs related to selecting and navigating health care coverage. Such a grant shall

only be made pursuant to an application made to the Director. In making such grants, the Director shall attempt to ensure regional and geographic equity.

''(B) GRANT REQUIREMENT.—As a condition of receiving such a grant, an organization shall be required to collect and report data to the Director on the types of problems and inquiries encountered by consumers they serve. Data shall be used by the Director to inform enforcement activities and be shared with State insurance regulators, the Department of Labor, and the Secretary of the Treasury.

''(C) APPROPRIATIONS AND AUTHORIZATIONS.—There is hereby appropriated, out of any funds in the Treasury not otherwise appropriated for the first fiscal year in which this section is in effect, $30,000,000 for grants under this paragraph, to be available until expended. For each subsequent fiscal year there are authorized to be appropriated such sums as may be necessary for such grants.

''(5) ADMINISTRATION OF HIGH RISK POOL.—The Director shall administer the high risk pool program under section 2745.

''(6) ADMINISTRATION OF GRANTS TO STATE INSURANCE DEPARTMENTS.—The Director shall administer the program of grants to State insurance departments under section 2793(d).

''(e) PERIODIC REPORTS.—The Director shall submit periodic reports to Congress on the Office's activities.

''(d) COORDINATION.—

''(1) FEDERAL OFFICIALS.—The Director shall coordinate, with the Secretaries of Labor and Treasury, activities under this section with respect to requirements that affect health insurance coverage offered in connection with group health plans, including coordination in —

''(A) development and dissemination of information; and

''(B) consumer inquiries and complaints relating to Federal health insurance requirements.

''(2) STATE HEALTH INSURANCE REGULATORS.—In carrying out the Office's activities, the Director shall—

''(A) coordinate with State health insurance regulators regarding data collection and disclosure and audit and enforcement activities

in order to avoid duplication and to use regulatory resources most efficiently;

"(B) monitor State efforts to implement and enforce consumer protections consistent with Federal health insurance requirements;

"(C) provide technical assistance to States seeking to implement and enforce consumer protections consistent with such requirements; and

"(D) provide for regular communication with such regulators to coordinate enforcement efforts and sharing of information.

"(e) TRANSFER OF PERSONNEL AND RESOURCES.—The Secretary shall provide for the transfer to the Office of those personnel and resources within the Department of Health and Human Services that, as of the date of the enactment of this section, relate directly to the responsibilities of the Director under this section.

"(f) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts made available under subsection (b)(4)(C), there are authorized to be appropriated to carry out this section $20,000,000 for the first fiscal year beginning after the date of the enactment of this section and such sums as may be necessary for subsequent fiscal years.".

(b) CONFORMING AMENDMENTS REGARDING ADDITIONAL AUTHORITY.—

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

''(c) REFERENCE TO ADDITIONAL AUTHORITY.—For additional Secretarial authorities with respect to requirements under this part, see sections 2793 and 2794.''.

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

''(c) REFERENCE TO ADDITIONAL AUTHORITY.—For additional Secretarial authorities with respect to requirements under this part, see sections 2793 and 2794.''.

**SEC. 7. STANDARDS AND ACCOUNTABILITY AND TRANSPARENCY INITIATIVES FOR GROUP HEALTH PLANS THROUGH DEPARTMENTS OF LABOR AND THE TREASURY.**

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

promote quality, fair marketing, and honesty in out-of-network coverage under such plans and to permit participants to make an informed decision in cases where they are offered a choice of coverage under such a plan.

(b) ACCOUNTABILITY AND TRANSPARENCY INITIATIVES.—In coordination with the Secretary of Health and Human Services, the Secretaries of Labor and the Treasury shall jointly undertake accountability and transparency initiatives with respect to group health plans similar to those undertaken by the Secretary of Health and Human Services with respect to group and individual health insurance coverage under sections 2793 and 2794 of the Public Health Service Act, as added by sections 4 and 5 of this Act.

(c) GROUP HEALTH PLAN DEFINED.—In this section, with respect to the Secretary of Labor and the Secretary of the Treasury, the term ''group health plan'' has the meaning given such term for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and chapter 100 of the Internal Revenue Code of 1986, respectively.

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