

H.R. 241 - Small Business Health Fairness Act of 2005

Rep. Sam Johnson (R-TX)

H.R. 241 would allow trade, industry, and professional associations to sponsor Association Health Plans (AHPs). Plan sponsors would be allowed to offer fully insured or self-funded AHPs. Fully insured AHPs would be exempted from state mandated benefit laws and would be required to follow state rating laws, though the AHP would be considered a separate class for rating purposes. Self-funded AHPs would not be subject to state insurance regulations, and would be certified by the Department of Labor. The requirements of certification include federal solvency standards, payment of a \$5,000 annual fee, and maintenance of aggregate and specific excess stop-loss insurance and indemnification insurance coverage. Self-insured AHPs would be allowed to vary premiums on the basis of health status or industry to the extent allowed by each state's premium setting rules for coverage offered through associations.

Mandates

Preempts all mandates for AHPs. State laws with which filing and approval of a policy type offered by the AHP was initially obtained are exempted, to the extent that the law prohibits the exclusion of a specific disease.

Network Adequacy

Preempts state network adequacy requirements for AHPs

Licensure

Self-insured AHPs would be exempt from state licensure requirements.

Solvency

Allows associations to sponsor self-insured plans. These plans would be required to maintain aggregate and specific excess/stop loss coverage and maintain reserves and a surplus between \$500,000 and \$2 million. Associations will not have the assets to fulfill their fiduciary responsibilities in the event that reserves are insufficient to meet claims. Self insured plans must purchase indemnification insurance to pay claims that the plan is unable to pay due to termination. This insurance does not exist in the market today. Fully insured AHPs must follow state solvency standards and prompt pay requirements.

Premium Taxes

Allows states to impose a contribution tax on self-insured AHPs that does not exceed the tax imposed on insurers or HMOs for group coverage on if the plan commenced operations in the state after enactment.

Rating Rules

Preempts all rating rules for AHPs.

Federal Regulator

Allows AHPs to self-insure. AHPs must be certified by Secretary of Labor.

Market Segmentation

Federally regulated AHPs would be able to design plans to appeal primarily to healthy groups, segmenting the market and causing adverse selection.

Unlevel Playing Field

Self-insured AHPs would be exempt from all state regulation.

NAIC Responsibility

NAIC representative would serve on Solvency Standards Working Group

H.R. 506 - Health Partnership Through Creative Federalism Act

Rep. Tammy Baldwin (D-WI) & Rep. Tom Price (R-GA)

The bill would allow states, in consultation with local governments, to apply for funds with which to implement state health care expansion and improvement programs. The goals of these programs would be to:

- Increase health coverage and access;
- Ensure that patients receive high-quality, appropriate health care;
- Improve the efficiency of health care spending;
- Test alternative reforms, such as building on the public or private health systems, or creating new systems.

Local governments may also apply for funds if they can demonstrate unique demographic needs or a significant population size that warrants a substate program. Groups of states may also apply for funding for regional programs or projects. Applications for funding must:

- Describe the program's mechanism for reducing the numbers of the uninsured and provide a specific 5-year target;
- Describe the minimum benefits package provided to all classes of beneficiaries under the program;
- Describe how the program will coordinate with federal, state, and local programs;
- Provide for improvements in the availability of health care services in urban, rural, and frontier areas with underserved populations;
- Improve health care safety and quality and contain appropriate quality indicators;
- Provide that the state will implement systems to improve the efficiency of health care, including a 5-year target for reducing administrative costs;
- Describe the financing that will be required, the costs to businesses and individuals, and how the state will ensure the solvency of the program;
- Provide methodology for the appropriate use of information technology to improve the health infrastructure.

The programs may not impose any preexisting condition exclusions for covered benefits. If a project provides benefits through payment for, or a contract with, group coverage, preexisting condition exclusions may be allowed to the extent permitted by ERISA and HIPAA.

Programs may not have the effect of assuming costs that would otherwise be assumed by private insurers or other federal health insurance programs.

Coverage under a program will be treated as creditable coverage.

Provides Grants

The bill would provide grants to allow states to test innovative means of expanding health coverage and access.

S. 325 - Health Partnership Act

Sen. George Voinovich (R-OH) & Sen. Jeff Bingaman (D-NM)

The bill would allow states, in consultation with local governments and Indian tribes, to apply for funds with which to implement state health care expansion and improvement programs. The goals of these programs would be to:

- Increase health coverage and access;
- Ensure that patients receive high-quality, appropriate health care;
- Improve the efficiency of health care spending;
- Test alternative reforms, such as building on the public or private health systems, or creating new systems.

Local governments, Indian tribes, and Indian health organizations may also apply for funds if they can demonstrate unique demographic needs or a significant population size that warrants a substate program. Groups of states may also apply for funding for regional programs or projects.

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S. 334 – Healthy Americans Act

Sen. Ron Wyden (D-OR)

The bill would establish:

1. a guarantee of *private* insurance coverage for all Americans;
2. federal standards for private insurance plans;
3. premium subsidies and eligibility requirements for such subsidies;
4. wellness program requirements;
5. a Health Start program for children;
6. supplemental Medicaid coverage for elderly and disabled persons;
7. Medicaid options for long-term care insurance; and
8. medical records standards.

Individuals would purchase private health insurance ("Healthy Americans Private Insurance"--called "HAPI" plans) from a state-operated purchasing cooperative called the "Health Help Agency." The bill would establish "standardized" plans similar in concept to current Medicaid standardization, and state mandates would be preempted.

Individuals are required to have HAPI plan coverage. Insurers participating in the Health Help Agency are required to cover all individuals and cannot discriminate in benefits or premiums based on health status. Employers are required to convert employer health benefit contributions into wages, and employers not providing health benefits would make "fair share" payments to the federal government for health plan support.

The proposal retains the Medicare program but also includes several changes that include: (1) Part B premiums that reward healthy behavior; (2) primary care services management; (3) drug price negotiation under Part D and plan switching rules; (4) end-of-life care improvements. There does not appear to be any changes to the current federal Medicaid standards.

Rate Regulation

Community rating or adjusted community rating principles established within the state will be used. States may permit variation based only upon geography, smoking status, and family size. States must permit carriers to provide premium discounts and other incentives to enrollees based on participation in wellness, chronic care management, and other programs designed to improve the health of participants.

Mandates

Plans must provide benefits that are at least actuarially equivalent to a standard plan that is equivalent to the Blue Cross Blue Shield Standard Plan provided under the Federal Employees Health Benefits Program. Benefits in addition to the standard plan must be priced and displayed separately. Plans must make available separate coverage for abortion services. Plans must provide full parity in the application of mental health benefits and must provide coverage for reconstructive surgery following a mastectomy.

Guaranteed Issue

Plans must provide for the guaranteed availability and renewability of all coverage in a manner similar to HIPAA small group requirements.

NAIC Responsibility

The bill directs the NAIC to develop a long-term care model regulation to incorporate limitations on the groups or packages of benefits that may be offered under a long-term care policy, uniform language and definitions to be used with such benefits, a uniform policy format, and other standards required by the Secretary of HHS.

Provides Subsidies

Individuals and families below 100% of the federal poverty level (FPL) would be entitled to a subsidy for the full basic premium amount. Incomes and families between 100% and 400% of FPL would be entitled to a partial subsidy on a sliding scale.

S. 1019 – Universal Health Care Choice and Access Act ***Sen. Tom Coburn (R-OK)***

S. 1019 is a far-reaching piece of legislation that addresses a number of elements of health care reform. It combines provisions that would:

- allow employers to reimburse employees for the purchase of nongroup health insurance policies and to contribute different amounts to different plans;
- promote healthy lifestyles and disease prevention;
- create a tax rebate program to help individuals purchase health insurance in the nongroup market;
- expand health savings accounts;
- expand private coverage and means testing in the Medicare program;
- allow individuals to redirect Medicare payroll taxes into Medical Retirement Accounts to fund health care in retirement;
- rewrite the formula used to distribute Medicaid funds among the states;
- allow individuals to use Medicaid funds to purchase private coverage;
- encourage better coordination of care for dual eligibles;
- establish state health courts;
- encourage the adoption of interoperable health records;
- expand the use of private facilities in Veterans Administration and Indian Health Service health care; and
- encourage states to create high risk pools.

The legislation also incorporates Rep. John Shadegg's Health Care Choice Act from the 109th Congress (H.R. 2355). That legislation would allow health insurance issuers to sell individual health insurance policies in secondary states under the laws of a state designated by the issuer (primary state) if the coverage and issuer comply with other conditions of the bill. The bill exempts issuers from any secondary state's laws that would prohibit or regulate the operation of the issuer in that state, except that any state may require such an issuer to: (1) pay applicable premium and other taxes which are levied on insurers, brokers, or policyholders in that state; (2) register with and designate the state insurance commissioner as its agent for the purpose of receiving services of legal documents or process; (3) submit to a qualified examination of its financial condition if the primary state has not done an examination within the period recommended by the NAIC; (4) comply with a lawful order issued in a delinquency proceeding related to a financial impairment or in a voluntary dissolution proceeding; (5) comply with an injunction issued by a court of competent jurisdiction upon a petition by the state insurance commissioner alleging that the issuer is in hazardous financial condition; (6) participate in any insurance insolvency guaranty association or similar association to which an issuer in the state is required to belong; (7) comply with any state law regarding fraud and abuse or unfair claims settlement practices; or (8) comply with the applicable requirements for independent review with respect to coverage offered in the state.

The bill requires each issuer issuing individual health insurance coverage in both primary and secondary states to submit to: (1) the insurance commissioners of such states a copy of the plan of operation or feasibility study and written notice of any change in its designation of its primary state and of its compliance with all the laws of the primary state; and (2) the insurance commissioner of each secondary state a copy of the issuer's quarterly financial statement that was submitted to the primary state.

The bill also prohibits an issuer from offering, selling, or issuing individual health insurance coverage in a secondary state if the state insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all issuers, though the bill does not specify any requirements for an acceptable risk-based capital formula.

S. 1019 gives sole jurisdiction to the primary state to enforce the primary state's covered laws in the primary state and any secondary state. The secondary state may notify the primary state if the coverage offered in a secondary state fails to comply with the covered laws of the primary state.

Mandates	Would allow broad preemption of mandates in the individual market by allowing policies in low-mandate states to be sold in high-mandate states.
Market Conduct	Does not allow secondary states to conduct market conduct exams. Sets federal definitions of "fraud and abuse" and "unfair claims settlement practices." Only allows for secondary state financial exams if the primary state has not conducted one in the period recommended by NAIC.
External Review	Sets federal standards for external review if either primary or secondary state has not statute. Secondary state law continues to apply to external review.
Guaranteed Issue	Would allow the sale of non-GI policies in GI states. Would require GI to HIPAA-eligible individuals in states with no high risk pool.
Licensure	Would only require that insurers be licensed or hold a certificate of authority in the primary state.
Premium Taxes	Permits secondary states to collect premium taxes and guaranty fund contributions.
Other Revenues	Would result in some loss of licensing fees.
Rating Rules	Would preempt individual rating rules by allowing the sale of out of state plans under the laws and regulations of a second, more lightly regulated state.
Federal Standards	Sets federal definitions of "fraud and abuse" and "unfair claims settlement practices." Sets federal fallback standards for independent external reviews.
Cost Shifting	Would push high-cost individuals out of individual and employer-sponsored coverage and into Medicaid and the ranks of the uninsured, leading to \$1 billion in increased Medicaid spending, \$760 million in increased state Medicaid spending, and higher uncompensated care costs.
Unlevel Playing Field	Would create unlevel playing field favoring plans sold from states with light regulation of individual policies.
Encourages Fraud	The concentration of regulation in lightly regulated states with few resources would be an invitation to fraud, as secondary states would lose the ability to review marketing materials
Provides Subsidies	The legislation would create new Medi-Choice rebates to purchase a high deductible health plan. The rebates would be up to \$2,000 annually for individuals or up to \$5,000 annually for families.

President's Health Care Budget Proposals

In his State of the Union address and in his budget submission to Congress, President Bush outlined a two-pronged health care proposal that would change the tax treatment of health benefits and would reprogram Medicaid funds currently directed toward hospitals that treat a disproportionate share of low-income patients to create a new federal grant program.

The tax element of the President's proposal would shift the tax treatment of health insurance premiums to count them as taxable income for employees, while providing a new standard deduction for all those who purchase health insurance. The new deduction, \$7,500 for individuals and \$15,000 for families, would be indexed to the consumer price index. The proposal would not effect the tax treatment of health insurance premiums for employers.

The tax provisions would be paired with a new "Affordable Choices Initiative" that would redirect a portion of Medicaid Disproportionate Share Hospital Payments to fund grants to states to help low income individuals or those with medical conditions that make them difficult to insure purchase basic private health insurance at affordable premiums. The administration has suggested a number of strategies that states could adopt to provide this coverage, including high risk pools, direct premium assistance, and small business and individual pooling initiatives.

Other Proposals

The NAIC followed the following pieces of legislation during the 109th Congress, which remain under discussion, but have not been reintroduced in the 110th Congress.

H.R. 2355 - Health Care Choice Act

Rep. John Shadegg (R-AZ)

While Rep. Shadegg continues to advocate this legislation, he was unable to attract sufficient support to pass it in the 109th Congress, and the new Democratic majority will make passage extremely unlikely. H.R. 2355 would have allowed health insurance issuers to sell individual health insurance policies in secondary states under the laws of a state designated by the issuer (primary state) if the coverage and issuer comply with other conditions of the bill.

H.R. 3891 - States' Right to Innovate in Health Care Act

Rep. John Tierney (D-MA)

H.R. 3891 would have allowed states to apply for grants for the purposes of developing and implementing universal comprehensive health care, with simplified administration and to improve the cost-effectiveness of the health care delivery system. Up to 10 states could have received planning grants for the purposes of developing state plans. These planning grants would have been effective for up to 30 months, and could not have exceeded \$3.75 million each. States that developed state plans could have applied for demonstration grants to implement their plans. These grants would have

been effective for up to 7 years, and could not have exceeded \$10 million plus \$3 per eligible state resident. One or more contiguous states could have filed a joint application for planning and demonstration grants.

H.R. 5288 - Small Business Health Plans Act ***Rep. Tom Allen (D-ME)***

Rep. Allen has been working on revisions to this legislation and plans to reintroduce his bill for the 110th Congress.

H.R. 5288 would have established a small employer health benefits program for employers with 50 or fewer employees, overseen by the Secretary of HHS. Each state would have established a pooling arrangement for employees employed in that state. A national pooling arrangement would have been established for employees in states that did not adopt pooling arrangements. Health pooling arrangements would have offered at least two different health insurance policies. Employers would have been required to cover at least 50% of the premium for employees, but not for dependents. Coverage offered through the pooling arrangements would have been required to be substantially similar to any of the four largest plans under the FEHBP and could not include health underwriting, preexisting condition exclusions, differential benefits or differential premiums on the basis of health.

The bill would also have established programs to provide premium assistance to small employers on a sliding scale, taking into account the average level of compensation for employees and the number of employees, and would have provided for reinsurance coverage for 75% of all claims that exceeded \$100,000, or an amount determined by the Secretary.

S. 1955 - Health Insurance Marketplace Modernization Act ***Sen. Michael Enzi (R-WY), Sen. Ben Nelson (D-NE)***

While this legislation has not yet been reintroduced in the 110th Congress, Sens. Nelson and Enzi continue discussions with other senators to secure support for the legislation.

As reported by the Senate Committee on Health, Education, Labor, and Pensions, S. 1955 would have allowed trade and professional associations to sponsor fully-insured Small Business Health Plans (SBHPs) through insurers licensed in every state in which coverage is offered. The Department of Labor would have been responsible for certifying SBHPs. With some notable exceptions, SBHPs would HAVE remained subject to state regulation. State small group rating rules would have been preempted unless they are identical to the 1993 NAIC model. SBHPs would have been rated separately from the rest of a state's small business pool. A regulatory harmonization board, chaired and co-chaired by NAIC members, would have harmonized rate and form filing, internal review, market conduct review, and prompt pay rules. In all markets, carriers would have been allowed to offer a benefit package that does not include all state mandates. If they chose to do so, the carrier would also have been required to offer a "high" option that included the benefits in the state employee plan in one of the five most populous states.

S. 2510 - Small Employers Health Benefits Program Act of 2006 ***Sen. Richard Durbin (D-IL), Sen. Blanche Lincoln (D-AR)***

Sens. Durbin and Lincoln continue to seek support for their legislation and are expected to reintroduce their legislation.

S. 2510 would have created a new Small Employers Health Benefits Program (SEHBP), administered by the Office of Personnel Management, to provide health coverage for non-federal employees of employers with 1-100 employees. Participating employers would have been required to offer SEHBP coverage to all employees and could not offer any other health insurance plan. The SEHBP would have been patterned after the Federal Employees Health Benefits Program (FEHBP). Carriers offering coverage through the program would have been required to be licensed in each state in which coverage is offered and meet minimum standards set for the FEHBP. State laws regulating the nature, provision, or extent of coverage or benefits would have been preempted, as would state rating rules. Premiums could have varied based upon age and geography only. OPM would have established a reinsurance fund to reimburse up to 80% of catastrophic claims over \$50,000 in a given year. The bill would also have provided a refundable tax credit to employers contributing at least 60% of the premium for their employees' coverage.