

Health Insurance Marketplace Modernization and Affordability Act of 2005
S. 1955 – Senators Enzi (R-WY) and Nelson (D-NE)
(Chairman’s Market)

TITLE I: Small Business Health Plans (SBHPs)

Section 101. Creates a new “Part 8” in ERISA to establish the rules for a Small Business Health Plan (SBHP)

Part 8 – Rules Governing Small Business Health Plans

Section 801. Establishes that an SBHP means a fully insured group health plan whose sponsor:

- 1) is organized and maintained in good faith, with a constitution and bylaws stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide *trade association, industry association, professional association, or chamber of commerce*, for substantial purposes other than obtaining medical coverage;
- 2) is established as a permanent entity which receives the active support of its members and requires dues to maintain members;
- 3) does not condition membership, dues or coverage under the plan on the basis of health-status related factors; and,
- 4) does not condition membership on the basis of a minimum group size.

Section 802. Requires that the Department of Labor establish, within 6 months after enactment, by interim final rule, procedures of an SBHP to be certified. This must include requirements for initial certification and continued certification.

If the Department of Labor does not act on a request for certification by a potential SBHP within 90 days of receipt, the SBHP will be deemed certified. If the Department of Labor then finds that the SBHP is no qualified, the certification may be revoked. If the applicant willfully or with gross negligence submitted an incomplete or inaccurate application, then the trustees may be fined up to \$500,000.

Section 803. Establishes the requirements on the sponsors Board of Trustees, including that: 1) the Board must maintain fiscal control of the plan in accordance with a plan document; 2) the Board must have in effect rules of operation and financial controls based on a 3-year plan of operation; 3) the Board members are individuals selected from the membership of the sponsor and may not be, except in a few instances, be a service provider.

The Board must have sole authority to approve applications for participation in the plan and contract with insurers.

Section 804. Establishes participation and coverage requirements for the SBHP.

Each participating employer must be a member of the sponsor, the sponsor, or an affiliated member (a person who would otherwise be eligible to be a member of the sponsor, but chooses to be a member of an affiliate, or the staff and employees of an organization where a member of a professional association is employed.)

Each participating must be an active or retired owner, officer, director, or employee of a participating employer, or the dependent of such individuals.

An SBHP may not discriminate against an eligible member or dependent and must make information about the plan readily available to all of its members.

Section 805. Establishes what plan documents the Board must have in writing.

Establishes the principle that an SBHP may not vary contribution rates (premiums+dues) based on industry or health-status related factors, except as allowed under the federal rating rules.

Requires that an SBHP that enrolls self-employed individuals or large groups must not violate the rating rules or access rules (guarantee issue, preexisting condition, etc) that would have otherwise been applied to them under state law.

Establishes that the SBHP has authority to design the benefit package, but must comply with the benefit rules created under Title II.

Requires that an SBHP must contract with a licensed insurer in the state of domicile. If the SBHP choose to sell into other states, the insurer must be licensed in those states, as well. Unless, when the insurer has submitted to a state an application for licensure (along with the materials from the domicile state's application) the state does not act on the application within 90 days. In such case, the license will be deemed granted and the insurer must agree to operate under the laws of that state. If the state finds that the insurer is violating their laws, a ground for disapproval is created. If the state eventually denies the application, the insurer must cease operations in the state.

An insurer may contract with insurers licensed in other states to service the members of the SBHP.

Section 806. Establishes filing fee of \$5,000 to apply for Department of Labor certification of SBHP and outlines the information that must be included in the application. Once an SBHP is certified, they must notify every state in which they plan to operate.

Section 807. SBHPs that voluntarily terminate must notify the participants and Department of Labor at least 60 days prior to termination. The notification to the Department of Labor must include a plan for winding up affairs and paying all obligations in a timely manner.

Section 808. Definitions and conforming amendments to other federal laws.

Section 102. Establishes that if the Department of Labor investigates the operations of an SBHP, they must consult with the state of domicile.

Section 103. Requires the Department of Labor to publish regulations within 6 months of enactment of this legislation and makes this Title effective 12 months after the date of enactment.

Title II: Market Relief

Section 201. Amends the Public Health Service Act to create new federal rating requirements and mandated benefit, provider and services rules.

Title XXIX –Health Insurance Market Place Reform

Section 2901. Establishes that the terms “health insurance coverage”, “health insurance issuer”, “group health plan”, and “individual health insurance have the same meaning given in HIPAA.

Part I – Rating Requirements

Section 2911. a) Establishes definitions; b) defines of the federal small group rating rules.

b) The “Model Small Group Rating Rules” means adapted rating rules drawn from the Adopted Small Employer Health Insurance Availability Model Act of 1993 of the NAIC, consisting of the following:

1) Premium Rates – Premium rates are subject to the following provisions:

A) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.

B) Within a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage shall not vary from the index rate by more than 25%.

C) The percentage increase in the premium rate charged for a new rating period may not exceed the sum of: the percentage change in the new business premium rate; any adjustment, not to exceed 15%, due to claims experience; and any adjustment due to change in coverage or case characteristics.

D) Any adjustment in premium rates for claim experience, health status, or duration of coverage may not be charged to individual employees or dependents.

E) An insurer may use industry as a case characteristic but the differential between industries may not exceed 15%.

F) An insurer must apply rating factors, including case characteristics, consistently across the class of business.

G) Plans issued or renewed within the same calendar month shall be treated as having the same rating period.

H) A plan that contains a restricted network provision shall be considered similar coverage to a plan that does not contain a similar provision if the restriction results in substantial differences in claim costs.

I) An insurer may use age, gender, industry, geographic area, family composition, group size, and participation in wellness programs as case characteristics without approval of the Commissioner.

J) Premium rates must comply with these rules notwithstanding any assessments required by a State's small employer carrier reinsurance program.

2) Separate Classes of Business – An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to:

A) The insurer's use of more than one type of system for the marketing and sale of plans;

B) The insurer's acquisition of a class of business from another carriers;

C) The insurer's provision of coverage to an association group (not SBHPs).

3) An insurer may establish up to 9 separate class of business – SBHPs are not counted in this calculation, but other associations would be counted.

4) The Commissioner may allow for other groupings if petitioned and the Commissioner finds that such action would enhance the efficiency and fairness of the small group marketplace.

5) An insurer may not transfer a small employer involuntarily from on class of business to another.

6) The Commissioner may suspend the rating rules for an insurer if petitioned and the Commissioner finds that finds that the suspension if reasonable when considering the financial condition of the insurer or that such action would enhance the efficiency and fairness of the small group marketplace.

Section 2912. Requires publication of regulations and establishes transitional rating rules for those states that currently have significantly tighter rating bands for health-status related factors

- a) The Secretary of HHS must publish regulations to implement the Model Small Group Rating Rules within 6 months after enactment of the Act.
- b) The Secretary of HHS must, within 6 months of enactment, publish transition rules for insurers in states with health-status related factor rating bands (or limitations) that are less than 12.5% from the index rate within the class of business. The Secretary must develop these in consultation with the NAIC and the transition period may not exceed 5 years.
- c) An insurer that has departed the small group market in a state may reenter the market (any state prohibition being preempted for 24 months) if they have been out of the market for at least 180 days.
- d) The Secretary, in consultation with the NAIC, shall develop transition rules for those insurers in states with tight rating bands to ease transition of “old business”.

Section 2913. Establishes preemption of state rating rules.

If a state has adopted, or chooses to adopt, the federal Model Small Group Rating Rules as the state law then it is an “Adopting State.” If the state does not adopt the federal rules then it is a “Non-Adopting State.”

In a “Non-Adopting State,” insurers may send a letter to the Secretary of HHS and the Commissioner stating they wish to be an “eligible insurer” and use the federal rating rules rather than the state rating rules. A state may not then enforce the state rating rules, but may enforce the federal rules (in theory.) If an insurer wishes to abide by the state rating rules in a “Non-Adopting State”, it may by choosing not to be an “eligible insurer.”

This section shall not supersede any State law to the extent necessary to permit individuals or the insurance department of the State to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules.

Section 2914. Creates federal court jurisdiction over civil actions involving the interpretation of this part.

An “eligible insurer” may bring an action in federal district court if a “Non-Adopting State” attempts to enforce state law or in any way retaliate against the insurer. The insurer may only sue for injunctive or equitable relief. The district court must issue a judgment within 120 days after filing, unless both parties agree to an extension. The court of appeals must issue a judgment within 60 days from filing.

Section 2915. Requires the Secretary, in consultation with the NAIC, to review the impact of this part on access, cost and market functioning in the small group market every 5 years and make recommendations for change, if necessary.

Part II – Lower Cost Plans

Section 2921. Establishes definitions for “Adopting State”, “Non-Adopting State”, and “Eligible Insurer”. They are the same as under Part I.

Section 2922. Establishes rules for selling plans that do not meet state mandates.

- a) Not later than 6 months after enactment of this Act, the Secretary of HHS shall publish regulations implementing this part. The regulations must establish that if an insurer offers, in a state, a plan that does not comply with one more benefit, service or provider mandates of the state, then it must also offer a plan that includes all the benefits covered by the state employee plans of the 5 most populated states.
- b) Small Business Health Plans may begin selling the above plans 12 months after enactment of this Act. Insurers may begin selling the above plans to those outside of the Small Business Health Plans 15 months after enactment of this act.

Section 2923. Preempts any state law that would prevent the offering, marketing or implementing of these plans in a “Non-Adopting State.” This section shall not supersede any State law to the extent necessary to permit individuals or the insurance department of the State to obtain relief under State law to require an eligible insurer to comply with the federal benefit requirements.

Section 2924. Creates federal court jurisdiction over civil actions involving the interpretation of this part.

An “eligible insurer” may bring an action in federal district court if a “Non-Adopting State” attempts to enforce state law or in any way retaliate against the insurer. The insurer may only sue for injunctive or equitable relief. The district court must issue a judgment within 120 days after filing, unless both parties agree to an extension. The court of appeals must issue a judgment within 60 days from filing.

Title III: Harmonization of Health Insurance Laws

Section 301. Amends the Public Health Service Act to add the following Subtitle in Title XXIX.

Subtitle B – Regulatory Harmonization

Section 2931. Establishes definitions for “Adopting State”, “Non-Adopting State”, and “Eligible Insurer”. They are the same as under Title II.

Section 2932. Creates a Board to establish harmonized standards for Form Filing and Rate Filing, Market Conduct Review, Prompt Payment of Claims, Internal Review, and External Review.

a) Not later than 3 months after enactment of this title, the Secretary of HHS, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board, which shall be composed of:

- Four State insurance commissioners as recommended by the NAIC (2 Democrats, 2 Republicans). One commissioner shall be designated chair of the Board, and other the vice-chair.
- Four representatives of State government, two governors (1 Democrat, 1 Republican) and two State legislators (1 Democrat, 1 Republican).
- Four representatives of health insurers, one that offer coverage in all markets, one that offers coverage in the small group market, one that offers coverage in the large group market, and one that offers coverage in the individual market.
- Two representatives of insurance agents and brokers.
- Two independent representatives of the American Academy of Actuaries.
- A representative of the Secretary shall serve as ex officio member.

The Secretary shall also establish an advisory panel to provide advice to the Board:

- Two representatives of Small Business Health Plans.
- Two representatives of employer, of which one must represent small employers and one large employers.
- Two representatives of consumer organizations.
- Two representatives of health care providers.

The chair and vice chair of the Board may: A) employ and fix the compensation of an Executive Director and such other personnel deemed necessary to carryout the duties of the Board; B) seek assistance from Federal departments and agencies; C) enter into contracts as necessary to conduct

the work of the Board; D) make advance, progress, or other payments which relate to the work of the Board; E) provide transportation and subsistence for persons serving without compensation; F) prescribe the rules for the internal organization and operation of the Board.

b) The Board shall identify and recommend nationally harmonized standards for each of the following categories:

A) Form Filing and Rate Filing – Standards shall be established which promote speed to market and include the defined areas listed below:

- (i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.
- (ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.
- (iii) Timeframes for an eligible insurer to respond to State requests following its review.
- (iv) A process for an eligible insurer to self-certify.
- (v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.
- (vi) Procedures for the resubmission of forms and rates.
- (vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.
- (viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

B) Market Conduct Review – Market conduct review standards in those defined areas listed below:

- (i) Mandatory participation in national databases.
- (ii) The confidentiality of examination materials.
- (iii) The identification of the State agency with primary responsibility for examinations.
- (iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.
- (v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.
- (vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.
- (vii) Transparency and publishing of the State's examination standards.
- (viii) Coordination of market conduct analysis.
- (ix) Coordination and nonduplication between State examinations of the same eligible insurer.
- (x) Rationale and protocols to be met before a full examination is conducted.
- (xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.
- (xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.
- (xiii) Reasonable fines and penalties for material errors and harmful business practices.

C) Prompt Payment of Claims – Standards shall be established that are similar to those in the Social Security Act for Medicare, including the appropriate exceptions for fraud, nonpayment of premiums, or late submission of claims.

D) Internal Review – Standards for claims procedures shall be established that are consistent with the procedures established under ERISA and Department of Labor regulations.

The Board shall make recommendations to the Secretary of HHS for each element of the categories described above within each such market. These recommendations may not disrupt, expand, or duplicate the benefit, service or provider mandate standards established under Title II.

c) The Board shall develop the recommendations after considering: A) any model acts or regulations of the NAIC; B) substantially similar standards followed by a plurality of States; and, C) any Federal law requirement related to these specific process areas. If the Board's recommendations differ

substantially from these established standards, then the Board must provide evidence to the Secretary of the necessity of the variance to protect health insurance consumers or promote speed to market or administrative efficiency.

d) The Board shall complete its recommendations within 18 months of its appointment. The Secretary shall certify the recommendations within 120 of their receipt. The standards certified by the Secretary shall be effective 18 months after the Board adopts the recommendations.

e) The Board terminates after making its recommendations.

f) The Secretary, in consultation with the NAIC and members of the entities represented on the Board and Advisory Panel, shall, no sooner than every 3 years, review the impact of this Subtitle and make recommendations for change, if necessary.

g) The Secretary must publish the standards on the Internet website of the Department of HHS and must provide sample contract language that incorporates the harmonized standards.

h) States must adopt the harmonized standards within 18 months after adopted by the Board or become a "Non-Adopting State."

Section 2933. Establishes that all State laws of a "Non-Adopting State" insofar as they relate to the areas of harmonized standards as applied to an "Eligible Insurer" are superseded. All State laws of the "Non-Adopting State" that prohibit an "Eligible Insurer" from offering, marketing or implementing health insurance consistent with the harmonized standards or have the effect of retaliating against an "Eligible Insurer" are superseded.

This section shall not supersede any State law to the extent necessary to permit individuals or the insurance department of the State to obtain relief under State law to require an eligible insurer to comply with the harmonized standards.

Section 2934. Creates federal court jurisdiction over civil actions involving the interpretation of this subtitle.

An "eligible insurer" may bring an action in federal district court if a "Non-Adopting State" attempts to enforce state law or in any way retaliate against the insurer. The insurer may only sue for injunctive or equitable relief. The district court must issue a judgment within 120 days after filing, unless both parties agree to an extension. The court of appeals must issue a judgment within 60 days from filing.

Section 2925. Such funds as necessary to carry out this subtitle are authorized to be appropriated.

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