HEALTH POLICY MEMO from Families USA

March 23, 2006

Summary of S. 1955:
The Health Insurance Marketplace Modernization Act

Quick Overview: The Health Insurance Marketplace Modernization Act (HIMMA), introduced by Senator Michael Enzi of Wyoming, has two major components. The first, Title I of the Act, allows small businesses to band together to buy health insurance. These "Small Business Health Plans" (SBHPs), previously known as Association Health Plans or AHPs, would be exempt from most state laws and regulations governing health insurance. The second major component (Titles II and III) of this Act extends this exemption to much of the private market. Title II grants an exemption from most state laws and regulations to most insurers operating in the private market. Whether such an insurer sells policies to individuals, to small groups, or to large groups, it will not have to follow state requirements regarding benefits, services, or providers, and small group insurers will also be exempt from state rating rules. Title III establishes a commission to write new federal regulations that set aside, or preempt, state laws governing health insurance marketing, prompt payment, internal review, and form filing. This commission has no meaningful consumer participation.

Title I: Small Business Health Plans (SBHPs)

Which Entities Qualify as SBHPs?

- These entities can be trade associations, industry associations, professional associations, "cooperative" corporations, or chambers of commerce;
- These entities must be permanent entities that requires dues, that exist for purposes other than health benefits, and that have been in operation for at least three years;
- The entities cannot make membership contingent on health status, group size, or health plan participation.

How Are SBHPs Certified?

- In order to be certified, SBHPs must pay a filing fee and provide plan documents and identifying information to the Department of Labor. They must also provide notice to the states in which they plan to operate. The Secretary of Labor consults with the state where the SBHP is based ("domiciled") when certifying a plan.
- If the Secretary of Labor doesn't act on an application within 90 days, the SBHP automatically becomes temporarily certified.
- If an association has existed for at least 10 years and has at least 200 employers, it is automatically certified in any state in which it operates.

Who Can Participate in an SBHP?

- An employer, along with its employees and their dependents, can participate if the employer is a member or affiliate of the sponsoring association, corporation, or chamber of commerce. Participating employers cannot offer some employees individual market coverage instead of SBHP coverage, and they cannot exclude employees from participation based on their health.
- Active and retired owners and self-employed individuals in associations may also participate.

What Kinds of Plans Can SBHPs Offer?

- SBHPs can offer insurance without regard to state laws that govern benefits, services, and providers, but only if they also offer an alternative "comprehensive" option.
- The "comprehensive" option must be modeled after the covered services, benefits, and providers of a state employee health plan in one of the five most populous states (California, Florida, Illinois, New York, and Texas). The comprehensive option can be any plan offered to state employees in any of those five states, and the SBHP must offer only one such plan. It does not need to provide the benefits formally mandated in the state in which the SBHP operates.
- Since the "comprehensive" option does not have to adopt the cost-sharing of the state plan on which it is modeled, an SBHP could offer these "comprehensive" benefits in the form of a high-deductible plan and/or HSA. In fact, an SBHP could offer a high-deductible plan coupled with an HSA as its only "comprehensive" option. High-deductible plans require enrollees to pay the full cost of care out-of-pocket until they reach the deductible amount, which may be particularly difficult for low- and middle-income workers. As a result, HSAs may induce consumers to skip necessary health care services.

How Much Can Premium Rates Vary in an SBHP?

- SBHPs can choose whether to set premium rates according to the state's laws that limit premium rate variation or according to the 1993 standards established by the National Association of Insurance Commissioners (NAIC).
- The 1993 NAIC standards allow premium rates to vary by +/- 25 percent based on health status and have no limits on premium rate variation for sex, age, or geography.

Can SBHPs Treat Individuals in the Same Company Differently?

- SBHPs cannot vary payment rates for participating employers based on the health status of the employees or the type of business, nor can they exclude particular employees within a company from coverage based on health status. However, SBHPs can vary rates charged to employers based on claims experience or based on other factors allowed in the state's small group market.

There are exceptions to this nondiscrimination language: Self-employed individuals in SBHPs do not have guaranteed issue1 protection (that is, a law requiring insurers to cover them) unless the state provides this protection to other self-employed individuals. In addition, premium rates for

the self-employed in SBHPs cannot vary more than is allowed under the state's rating rules for other self-employed individuals. Similarly, if large employers participate in an SBHP, they are still subject to state premium rating rules for large employers.

Title II: Deregulation of the Private Health Insurance Market

What Are the Licensing Requirements for Insurers?

- Insurers must be licensed in each state in which they offer insurance and must inform the state of their intention to offer coverage under the new benefit and rating rules 30 days before doing so.

What Kinds of Plans Can Insurers Offer in the Individual, Small Group, and Large Group Markets?

- Insurers in the individual, small group, and large group markets can offer insurance without regard to state laws pertaining to benefits, services, or providers, but only if they also offer an alternative "comprehensive" option.
- The "comprehensive" option must be modeled after the covered services, benefits, and providers of a state employee health plan in one of the five most populous states (California, Florida, Illinois, New York, and Texas). The comprehensive option can be any plan offered to state employees in any of those five states, and the insurer must offer only one such plan. It does not need to provide the benefits formally mandated in the state.
- Since the "comprehensive" option does not have to adopt the cost-sharing of the state plan on which it is modeled, an insurer could offer these "comprehensive" benefits in the form of a high-deductible plan. In fact, an insurer could decide to offer the "comprehensive" option only in the form of a high-deductible plan.
- The provisions exempting plans from state benefit protections go into effect for small business plans within 12 months of enactment and, for other plans, within 15 months. These provisions supercede state laws with respect to benefits, services, and provider mandates.

What Are the Rating Requirements for Non-SBHP Small Group Market Plans?

- Insurers in the small group market would be able to vary premium rates by +/- 25 percent based on health status, by +/- 20 percent based on the type of business, and by +/-15 percent based on the industry. There are no restrictions on their ability to vary premium rates based on age, sex, or geography as long as those rating factors are applied consistently. In subsequent years, insurers could increase premiums by up to 15 percent based on the claims experience of a business.
- These rules are based on the 1993 NAIC standards.
- These adjusted rates will be charged to the employer as a whole, not to the individual employees.

- Insurers will be able to choose whether to follow the NAIC rules or the individual states' rules. Since insurers are likely to choose the rules that offer them the greatest leeway, this provision, in essence, sets a ceiling on the stringency of premium rating rules—but no floor.

Can States Enforce Their Own Laws and Regulations?

- No. Insurers will be able to sue states and individual officials for attempting to enforce their own state regulations. They can sue for injunction and "equitable relief."
- Insurers can file suit either in U.S. District Court or directly in the U.S. Court of Appeals.

Title III: "Harmonization"

A commission will be appointed to review and "harmonize" state insurance laws. This commission will consist of the following members:

- Voting members: four state insurance commissioners (two Republicans, two Democrats), as recommended by NAIC; four state officials (two governors and two legislators; two Republicans, two Democrats); four insurers (one small market, one large market, one individual market, and one all markets); two insurance agents/brokers; and two actuaries (from the American Academy of Actuaries).
- Non-voting members: two SBHPs, two employers (one large, one small), two consumer organizations, and two providers.
- The first harmonization commission dissolves after it issues its recommendations. In three years, the Secretary of Health and Human Services (HHS) may consult with a group representing interests similar to those of the first commission in order to propose revised "harmonized" standards.

Areas Designated for "Harmonization":

- Form/rate filing: Creates procedures, timeframes, template forms, and processes for insurers to use to self-certify.
- Market conduct review: Sets standards for reporting, complaint data, examination, participation in national databases, avoids "state duplication of examinations of same eligible insurer," sets "reasonable fines and penalties," makes sure examinations look at business practices rather than "infrequent errors."
- Prompt payment: Uses Medicare standards.
- Internal review: Uses ERISA standards. The bill is silent on external appeals, and since ERISA does not provide for an external review process, it is not clear whether or not state external appeals laws would be altered.

Criteria for Harmonizing:

- NAIC standards and rules, standards followed in a plurality of states, federal laws, and what the Secretary of Labor deems necessary to “protect consumers or promote efficiency.”

Enactment of Harmonizing Regulations:

- The Secretary of HHS shall issue recommendations as “interim final regulations.”
- Harmonized regulations may be revised every three years. These revised standards would be issued through a rulemaking process with notice and comment.

State Laws That Do Not Conform Can Be Evaded:

- If a state does not adopt the harmonized rules or the model rate regulations, insurers can still notify the states that they are doing business following the harmonized rules and model rates regulations rather than the states’ rules.

Insurers Can Sue States:

- Insurers will be able to sue states and individual officials for attempting to enforce their own state regulations. They can sue for injunction and “equitable relief.”
- Insurers can file suit either in District Court or directly in the U.S. Court of Appeals.

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1 Health insurance sold on a guaranteed issue basis cannot turn applicants down based on health or risk status. States have various laws about guaranteed issue: States may require that all insurers (or that certain insurers) provide guaranteed issue policies, and they may require guaranteed issue policies to be offered to all individual consumers or only to consumers who had previous coverage from a group insurer.