U.S. Senate
Republican Policy
Committee

Legislative Notice

Jon Kyl, Chairman

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S. 1955 – Health Insurance Marketplace Modernization and Affordability Act of 2005

Calendar No. 417

Reported favorably by the Health, Education, Labor, and Pensions (HELP) Committee on April 27, 2006, with an amendment in the nature of a substitute, by a vote of 11 to 9 along party lines; no written report.

NOTEWORTHY

- A cloture petition was filed on Friday, May 5, on the motion to proceed to S. 1955. If cloture is not invoked on either of the medical liability bills (S. 22 and S. 23) during votes this evening, the Senate tomorrow will vote on the motion to invoke cloture on S. 1955.
- The bill would give small business owners the power to band together through their trade or industry associations and insure their employees using small business health plans. This pooling of small business groups affords the groups the power to negotiate for more affordable health care benefits.
- S. 1955 was introduced on November 2, 2005, and was reported favorably by the Senate Committee on Health, Education, Labor, and Pensions (HELP) on April 27, 2006. The bill is sponsored by Senator Enzi (R-WY), Chairman of the HELP Committee, and cosponsors include Senator Nelson (D-NE), who is a former state insurance director and former executive vice president of the National Association of Insurance Commissioners.
- The Congressional Budget Office (CBO) estimates that S. 1955 would increase federal revenues by $1 billion over 5 years and by $3.3 billion over 10 years. It would also reduce direct spending for the federal share of Medicaid by $235 million over 5 years and by $790 million over 10 years. CBO also estimates that S. 1955 would result in Medicaid savings to states of $180 million over 5 years and $600 million over 10 years.

Background

According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health insurance rose by 9.2 percent between spring 2004 and spring 2005.[1] At 9.2 percent, the increase in premiums far outpaces the rate of inflation (reported at 3.5 percent) and the increase in employee wages (reported at 2.7 percent).[2] Looking at the last five years, the numbers are even more shocking. Since 2000, premiums for family coverage have increased by 73 percent, while inflation increased by 14 percent and wages by 15 percent.[3]

As a result of the explosive growth in health insurance premiums, the percentage of employers offering health insurance to their employees during the last five years has dropped from 69 percent to just 60 percent.[4] The National Federation of Independent Business (NFIB), a small business advocacy group, reports that 27 million working people are uninsured, and that 63 percent of them are either self-employed or work for a small business.[5]

The actuarial firm Mercer Oliver Wyman indicates that the bill would reduce the cost of health insurance for small businesses by 12 percent, or about $1,000 per employee.[6]

Bill Provisions

Title I – Small Business Health Plans

Section 101 – Rules Governing Small Business Health Plans

This section creates a new "Part 8" of the Employee Retirement Income Security Act of 1974 (ERISA) to delineate the rules governing small business health plans (SBHPs).[7] The section defines an SBHP as a fully-insured group health plan sponsored by a bona fide trade or industry association that does not condition membership on health status or minimum group size. In addition, the new rules direct the Secretary of Labor to establish a process for certification of SBHPs (including payment of a $5,000 filing fee)

[1]Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005 Annual Survey," September 14, 2005, available at http://www.kff.org/insurance/7315/upload/7315.pdf.
[2]*Id.*
[3]*Id.*
[4]*Id.*
[5]Press Release, "Rising Cost of Health Insurance is Top Priority for Small Business," National Federation of Independent Business, April 13, 2006.
[6]Mercer Oliver Wyman letter to Todd McCracken, President of the National Small Business Association, March 7, 2006, available at http://nsba.biz/docs/2006_mercer_report.pdf.
[7]ERISA is P.L. 93-406, 88 Stat. 829, September 2, 1974.

and assessment of civil penalties for plans that offer coverage under certification predicated upon an incomplete or inaccurate application.

The section establishes requirements for SBHP sponsors, including that the sponsor has met or exceeded the sponsorship standards for at least three years before applying for certification, and that the employers participating in an SBHP be members of the plan's sponsoring organization. The rules further require that individuals covered by an SBHP be owners or employees of the plan sponsor (or dependents of an owner or employee).

The rules require plan sponsors to furnish information about coverage options to all eligible employers and prohibit discrimination against eligible employers and employees based on health status. Furthermore, the rules require SBHP sponsors to adhere to the portability, guaranteed issue, and guaranteed renewability requirements set forth in the *Health Insurance Portability and Accountability Act of 1996* (HIPAA).[8]

Section 101 also sets forth rules governing SBHP documentation, contribution rates, and benefit options. The rules prohibit variation in contribution rates from participating employers based on the health status of their employees or the type of business in which they are engaged; however, the rules permit the use of claims experience as a factor in varying contribution rates (to the extent that such variation is allowed by law in the state where the participating employer is located, and subject to the new rating harmonization standards created in Title III of this bill). Furthermore, SBHP sponsors may offer coverage to self-employed members of an association, provided that the premiums for coverage of self-employed individuals are rated using the rating rules that govern the individual insurance market in the state in which the self-employed individual is located. SBHP sponsors are given discretion to design their own benefit options, subject to the requirements set forth in Title II of the bill.

Finally, the section sets forth rules regarding the licensing and operation of SBHPs. For legal purposes, an SBHP is domiciled in the state in which the plan sponsor is headquartered. SBHPs must be licensed in every state in which participating employers are located; an SBHP may operate temporarily in a non-domicile state if the state has not acted on a licensure application within 90 days of its submission (the SBHP will be subject to the state's laws until the plan becomes licensed in that state or is denied licensure).

The bill provides that, subject to Title II of the bill, state laws regarding rating and benefits are preempted with respect to SBHPs and to the extent that such state laws would prohibit an SBHP from operating in that state.

Section 102 – Cooperation Between Federal and State Authorities

Section 102 requires the Secretary of Labor to consult with state officials in enforcing the requirements for certification of SBHPs.

[8]P.L. 104-191, 110 Stat. 1998, August 21, 1996.

Section 103 – Effective Date and Transitional and Other Rules

Section 103 provides that Title I will become effective one year from the date of enactment of the bill. It also directs the Secretary of Labor, within six months of enactment, to issue the regulations necessary to carry out Title I.

Finally, this section requires that existing association health benefit programs be deemed to be SBHPs, provided that they apply to the Secretary for certification.

Title II – Market Relief

Section 201 – Market Relief

Title II of the bill creates in the *Public Health Service Act* (enacted as part of HIPAA) a new Title 29 titled "Health Care Insurance Marketplace Modernization." The provisions in this title apply primarily to the small group market.

Part I – Rating Requirements

This part of Title II directs the Secretary of Health and Human Services (HHS), within six months of enactment and in consultation with the National Association of Insurance Commissioners (NAIC), to promulgate regulations implementing the Model Small Group Rating Rules (defined as the banded rating rules adopted by the NAIC in 1993 and outlined in new Subsection 2911(b) create by this bill). The title also gives the Secretary of HHS discretion to provide for a graduated transition to the Model Rules so as to minimize market disruption. It also creates a two-year window during which health insurers who, prior to the date of enactment, had withdrawn from the small group market may re-enter such market.

If a state chooses not to adopt the Model Small Group Rating Rules, that state will be designated a "non-adopting state." Insurance carriers in non-adopting states that meet certain criteria (provided below) will be permitted (though not required) to sell insurance in that state using the federal Model Rules instead of the applicable state rules. In order to qualify for preemption, the insurer must provide proper notification to HHS and the state insurance commissioner and must incorporate the terms of the Model Rules into its insurance contracts. A qualifying insurer in a non-adopting state may, under the provisions in this section, bring a civil action in federal court against any state agency or official that retaliates or otherwise punishes the insurer for offering or seeking to offer coverage in that state under the federal Model Rules.

Finally, this part of Title II requires the Secretary of HHS, in consultation with NAIC, to review the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market and to make appropriate legislative recommendations to Congress. Such reviews will be required every five years.

Part II – Affordable Plans

This part of Title II establishes flexibility for health insurance issuers wishing to sponsor SBHPs by implementing benefit choice standards. It provides that the health insurance issuer may offer a plan that does not comply with one or more mandates regarding covered benefits, services, or categories of providers in a given state, provided that the insurer also offers in that state an alternate "high-option" plan that includes the same covered benefits, services, and categories of providers as are covered by a state employee coverage plan in one of the five most populous states (currently, these states are California, Florida, Illinois, New York, and Texas).

The effective date of this part will be one year from the date of enactment for coverage issued to participating employers of an SBHP and 15 months from the date of enactment for coverage issued to groups or individuals other than participating employers of SBHPs.

Under this part, the Secretary of HHS is required, within six months of enactment, to issue regulations related to benefit choice standards in adherence with the terms of the bill.

The terms governing adopting states versus non-adopting states and permissible civil action are the same as those provided in Part I of this title. Insurers may modify contracts to comply with the terms of this part, notwithstanding other provisions of law.

Finally, the title contains a provision clarifying that nothing in the terms set forth in Title II shall be construed to inhibit the development of health savings accounts.

Title III – Harmonization of Health Insurance Standards

Section 301 – Health Insurance Standards Harmonization

Title III creates within Title 29 of the *Public Health Service Act* (as added by Title II of the bill) a new Subtitle B titled "Standards Harmonization."

This title directs the Secretary of HHS, in consultation with NAIC, to establish a Health Insurance Consensus Standards Board (hereinafter referred to as "the Board") to develop recommendations for harmonization of certain categories of state insurance law. The title provides guidelines for the composition of the Board and the qualifications of its members and sets forth guidelines for staffing and operation of the Board. In addition, the title provides guidelines for the composition of an advisory panel to advise the Board.

The rules provided in this title supersede state laws to the extent that such laws relate to the areas of insurance regulation addressed in the harmonized standards. The terms governing adopting states versus non-adopting states and permissible civil action

are the same as those provided in Parts I and II of Title II. Insurers may modify contracts to comply with the terms of this part, notwithstanding other provisions of law.

Title III authorizes the appropriation of such sums necessary to carry out the provisions of Subtitle B (principally for staffing and operation of the Board).

Finally, the title contains a provision clarifying that nothing in the terms set forth in Title III shall be construed to inhibit the development of health savings accounts.

Cost

The Congressional Budget Office (CBO) estimates that enacting S. 1955 would increase federal revenues from payroll and income taxes and would reduce federal spending for Medicaid.

The increase in federal revenues would result from a reduction in the total amount spent on employer-sponsored health insurance; this assumption is based on the idea that, as the implementation of S. 1955 brings down employers' costs of providing non-taxable health care coverage to their employees, employers will pass the savings on to their employees in the form of higher wages and salaries (taxable income). As a result, the bill's provisions would reduce the share of compensation that is tax-advantaged (health insurance premiums) and would increase the share that is taxable (wages and salaries). According to CBO, this shift would increase federal revenues by $1 billion over the 2007-2011 period and by $3.3 billion over the 2007-2016 period.

CBO also estimates that S. 1955 would reduce direct spending for the federal share of Medicaid by $235 million over the 2007-2011 period and by $790 million over the 2007-2016 period. This decrease in federal spending would result from enrollment of individuals currently covered under the Medicaid program in new, employer-sponsored plans. CBO also estimates that this shift in enrollment would result in Medicaid savings to states of $180 million over the 2007-2011 period and $600 million over the 2007-2016.

Administration Position

As of press time, no Statement of Administration Policy (SAP) had been issued for S. 1955.

Possible Amendments

It is expected that a series of amendments relating to the benefit mandate and rating provisions in Titles II and III will be offered by Senate Democrats. Mandate amendments may include attempts to require SBHPs to offer coverage of specific

disease-related drugs, devices, or procedures. Anticipated rating amendments include requiring SBHPs to use the 2000 NAIC Model Rules rather than the 1993 Model Rules as prescribed in the bill.

The fact that a particular mandate is not specifically included in the bill does not mean that the benefit, service, or provider will not be covered under SBHPs. Every state has a number of coverage mandates, and SBHPs will be subject to some level of mandates, depending on where they are licensed. The bill's sponsors argue that mandates relating to covered benefits, services, or categories of providers are not necessary and only serve to increase the cost of this legislation. Furthermore, they note that it is not in the interest of SBHP sponsors to be overly restrictive in their attempt to design affordable plans, since small business owners and their families will be covered by the same plans as small business employees.

During committee markup of the bill, 17 amendments were offered and rejected. Many of these mandate amendments may have been offered more for political purposes than for improvement of the bill. Such amendments put Senators in the position of having to vote against the amendment *not* because they oppose the particular benefit, but because the amendments would add unnecessary costs to the bill and reduce the flexibility of benefit design that SBHPs are meant to provide to small business owners. Any of these amendments, or similar ones, may be offered during consideration of the bill by the full Senate. The amendments offered in committee are as follows:

Women's Health Care

Senator Murray (D-WA) offered an amendment that would have required SBHPs to provide coverage for mammography services, as well as for minimum hospital stays and secondary consultations for women who undergo mastectomies and lymph node dissections as treatment for breast cancer.

Senator Clinton (D-NY) offered an amendment that would prohibit preemption of any state law that requires coverage for women's health care services, including bone density screening, cervical cancer screening, clinical trials, mammography, maternity care, and direct access to obstetrical and gynecological care.

Domestic Violence

Senator Murray offered an amendment that would prohibit preemption of any state law that provides for coverage of services for victims of domestic violence. The amendment would also prohibit insurers from "discriminating" against victims of domestic violence by denying, restricting, excluding, or limiting health care coverage for such individuals, or by adding a premium differential to any policy or health benefit plan.

Children and Newborns

Senator Dodd (D-CT) offered an amendment that would prohibit preemption of any state law that relates to newborns' and children's health, including mandates for well-baby care and immunizations.

Senator Dodd also offered an amendment that would prohibit the preemption of any state law that requires coverage for the care and treatment of autism.

Obesity

Senator Harkin (D-IA) offered an amendment that would require SBHP sponsors to cover obesity screenings and intensive behavioral interventions, as recommended by the U.S. Preventive Services Task Force. It would also require SBHP sponsors to cover any preventive service that receives an "A" or "B" rating from that task force, including obesity screening, counseling for tobacco use, and others.

Wellness Programs

Senator Harkin offered an amendment that would require the Director of the Centers for Disease Control and Prevention (CDC) to study workplace wellness programs and determine which ones have the greatest impact on sustaining behavioral change in employees. The CDC would be required to report the study results to Congress within one year of the bill's enactment.

Clinical Trials

Senator Dodd offered an amendment that would prohibit preemption of any state law that requires coverage of services for beneficiaries enrolled in clinical trials.

Medicare

Senator Kennedy (D-MA) offered an amendment that would require SBHP sponsors to offer eligible individuals the option of obtaining their prescription-drug coverage through Medicare, even if such coverage is offered by their employers.

Senator Clinton offered an amendment that would require insurance companies that offer Medicare Advantage plans to create programs to subsidize health insurance for small businesses and the uninsured. It would require plans to use any overpayments they receive from Medicare to fund their programs, and would require plans to submit annual program reports to HHS.

Rating

Senator Kennedy offered an amendment that would require SBHPs to use the most up-to-date NAIC rating rules as the interim standard for rating.

Senator Dodd offered an amendment that would limit rating variation by prohibiting premium differences of more than a 2 to 1 ratio in the entire small group market, and would grandfather states that currently have larger ratios.

Senator Clinton offered an amendment that would prohibit preemption of state rating laws that are more stringent than those provided in the bill.

Preemption

Senator Reed (D-RI) offered an amendment that would specify that any state or local health insurance law not specifically preempted by the bill would not be construed as being preempted.

Senator Kennedy offered an amendment that would permit states to opt out of the SBHP program; states would have the option to adopt or reject federal rating rules, federal benefit choice standards, or federal harmonization standards, without allowing for federal preemption in non-adopting states.

Miscellaneous Amendments

Senators Dodd and Reed offered an amendment that would have required a study by the Government Accountability Office (GAO) of the impact of S. 1955 before implementing its provisions. If GAO determined that the bill would increase, rather than decrease, costs for small businesses, the amendment would have prohibited the law from taking effect.

Senator Reed offered an amendment that would establish a benefit review panel to determine which core benefit mandates should apply to SBHPs. This panel would be established before the underlying bill would take effect.