

**S. 1955 the “Health Insurance Marketplace Modernization and Affordability Act of 2006,” Sponsored by Senator Michael Enzi (R-WY)**

While the AMA is supportive of efforts to enhance the flexibility of the health insurance market by facilitating options for increasing the number of insured individuals, we have serious concerns regarding S. 1955 as reported out of Committee. We strongly urge that certain changes be made to the bill that would expand affordable health insurance options for employees of small businesses without compromising important patient protections and the safe delivery of health care.

**AMA Concerns and Suggestions**

- **As reported out of Committee, this bill would significantly expand the types of businesses eligible to participate in Association Health Plans (AHP) – Titles I, II, and III**

Under the bill, all employers, regardless of the number of employees, are eligible to qualify as participating employers for all geographically available coverage options, thereby allowing any business to participate in an AHP and bypass state mandates and regulations.

The AMA recommends that the bill be changed to reflect a limitation on which employers can participate in an AHP. The AMA suggests that in order to qualify to participate in an AHP, businesses should be limited to those with a specific number of employees. The AMA believes the number could reflect the definition given “Small Employer” in Section 2791(e)(4) of the Public Health Services Act – an average of at least 2 but no more than 50 employees. In the alternative, the number could be greater than 50 but not higher than 100 in order to ensure that this legislation is truly pegged to help small businesses. The AMA believes, however, that any limitation on the number of employees should include a grandfather clause so businesses would not be penalized for growing. In addition, the AMA suggests that the bill include a mechanism whereby businesses that employ a certain number of employees that is close to the maximum could request review by the State for inclusion.

- **As reported out of Committee, AHPs could choose to offer plans that do not comply with any State mandatory benefit laws – Title II**

Title II provides Association Health Plans with two options: compliance with all state laws, or exemption from all state laws. If the insurer chooses the latter, it may provide a basic insurance option so long as it also provides what is referred to as an “Enhanced Option.” The “Enhanced Option” must, at a minimum, include such covered benefits, services, and categories of providers, as are covered by a State employee coverage plan in one of the five most populous States.

The AMA is concerned that as reported out of Committee, this bill could limit employees to two equally undesirable alternatives. The AMA strongly believes that changes need to be made to this legislation so that there is a guarantee of affordable premiums and reasonable cost sharing.

To accomplish this goal, the AMA suggests that the bill be revised in one of two ways. The first would be to eliminate the two options – “Basic Choice” or “Enhanced Choice.” Instead, the legislation could permit any plan that complies with section 8902(e) of Title 5 of the U.S. Code – The Federal Employee Health Benefit Plan. In the alternative, the legislation could replace the two options with a list of benefit, service, and provider mandates based upon an analysis of what is provided in the majority of states.

The second way to guarantee affordable premiums and reasonable cost sharing would be to amend the “Enhanced Choice” section so that it would exclude the highest deductible plans and those plans that do not include benefits for services mandated by the majority of states. The AMA is also in favor of creating more than two options if the Basic Choice/Enhanced Choice system remains.

- **As reported, S. 1955 would preempt State “administrative” regulations, including form and rate filing, market conduct review, prompt payment of claims, and internal review – Title III**

Under the bill, the following administrative regulations would be included in the categories noted above.

1. Form/rate filing: Creates procedures, timeframes, template forms, and processes for insurers to use to self-certify.
2. 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,” and makes sure examinations look at business practices rather than “infrequent errors.”
3. Prompt payment
4. Internal review

The bill directs use of a “harmonization” process for developing regulations to apply to the first two categories: form and rate filing and market conduct review. The criteria for harmonizing would be the following: NAIC standards and rules; standards in a plurality of states; federal laws; and what the Secretary of Labor deems necessary to “protect consumers or promote efficiency.” There are no firm requirements for the harmonization process.

The AMA is concerned with the breadth of State regulations that would be preempted under Title III and the lack of patient safeguards provided in the harmonization process. The AMA strongly suggests that this bill remove from the preempted categories any regulations that could, in any way, affect patient care or treatment, such as national database regulations. In addition, the AMA believes that certain limitations and requirements for the harmonization process should be put in place, including safeguards against regulations that would consistently mirror the least restrictive state regulations and/or requirements that the federal rules incorporate or improve upon the state laws they replace.

For prompt payment, uniformity would be established by using the standards set forth in section 1842(c)(2) of the Social Security Act (SSA). The AMA is concerned with these standards as they are significantly weaker than the majority of state prompt payment laws. For example, the SSA does not provide any mechanism for physicians to challenge plans for failure to remit payment in a timely fashion, so long as the plan asserts that it pays 95 percent of all claims in a timely fashion, regardless of whether the plan is late paying 100 percent of a single physician's claims. For this reason, the AMA suggests that the bill exempt state prompt payment laws from preemption or, in the alternative, utilize a uniform federal standard for prompt payment based upon the AMA Model Prompt Payment Legislation or S. 2551, The Prompt Payment of Health Benefits Claims Act of 2006, proposed by Robert Menendez (D-NJ).

For internal review regulations, uniformity would be established by creating standards that are consistent with the requirements found under the Employee Retirement Income Security Act (ERISA), section 503. These provisions are significantly stronger than many of the corresponding State regulations, which would result in stronger patient protections for those seeking internal review of benefit denials and challenges. For this reason, the AMA supports adoption of the ERISA standards for internal review.

- **It is unclear whether S. 1955, as reported out of Committee, would preempt external review laws**

S. 1955 is silent on external appeals, and because ERISA, the law that is to provide the basis for regulations regarding internal review under this bill, does not provide for an external review process, it is unclear whether state external appeals laws would be altered.

The AMA believes that S. 1955 should clarify treatment of external review. We recommend that the bill include language in Title III that would specifically exempt external review laws from preemption. In the alternative, the AMA feels strongly that if a uniform standard is desirable, such a standard should be based on the AMA's External Review Model Legislation.

The AMA feels strongly that any federal external review standard must do the following: require inclusion of a description of the external review process in plan literature and written notification of the external review process with the initial denial letter, or with the initial denial letter and every subsequent denial letter; ensure that adequate time is allowed for patients to request external review and prohibit plans from overlapping the internal review process with the external review finding deadline; require regulators to screen cases for eligibility for external review based upon a set of objective measures; ensure that external reviewers are not bound by a plan's definition of medical necessity; give patients the right to appeal a denial based on any reason, including but not limited to medical necessity, experimental or investigational therapies, or benefit/coverage issues; allow patients to appeal a denial

for care that has already been provided; and ensure that external review decisions are binding on health plans.

- **This bill could create wider disparities in coverage and affordability by preempting State rating rules - Title I, Title II**

As reported, S. 1955 allows contribution rates to be set based on claims experience so long as the rates vary using the same methodology used for regulating premium rates in the State subject to the rating regulations outlined in the bill. The rating regulations in the bill outline a banded rating system. Under the banded rating system, insurers can 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. In addition, they can vary premium rates based on age, sex, geography, and participation in a wellness program, as long as those rating factors are applied consistently. In subsequent years, insurers can increase premiums by up to 15 percent based on the claims experience of a business. These adjusted rates will be charged to the employer as a whole, not to the individual employees.

In order to ensure that older and/or sicker employees are not being priced out of the market as a result of expanded rate bands, the AMA suggests that the bill be amended so that the Model Small Group Rating Rules would be based upon the Small Employer Health Insurance Availability Model Act of 2000, which limits risk adjustments to the index rate to 10 percent, and limits adjustment to the index rate for renewal to 10 percent annually. The AMA also suggests that risk factors that can be considered for premium rate setting be limited to age, family composition, and geographic region, as suggested in the NAIC Model Act of 2000.