

Section-by-Section Analysis of the “Health Care Choice Act of 2005,” H.R. 2355
(as introduced in the House of Representatives on May 12, 2005)

H.R. 2355	
Findings	The lack of uniformity in state law is a barrier to interstate commerce that negatively impacts the ability of insurers to offer affordable coverage and individuals to secure affordable coverage in the individual health insurance market. [Sec. 3]
Determination of State Law – the “CHOICE”	<p>Allows a health insurance policy “issuer” to determine a “primary state” for laws governing the sale and regulation of individual health insurance policies. All other jurisdictions would be deemed “secondary” states. Generally, issuers are exempt from the laws of the secondary state. [Sec. 2796(b)]</p> <p>Secondary states could require in-state agents or brokers to be licensed, but could not enact any measure that would otherwise discriminate against the out-of-state issuer. An issuer’s primary state could only be changed upon policy renewal. [Sec. 2795]</p>
Conditions for Selling Policies in a “Secondary” State	<p>1. A health insurance “issuer” must be licensed in a primary state that:</p> <ul style="list-style-type: none"> i. uses a risk-based capital formula for solvency; <i>and</i> ii. provides for independent review for individuals covered individual policies. <p>2. Issuers may only offer for sale in a secondary state those policies previously offered in the primary state [Sec. 2796(e)]</p> <p>Note: The independent review requirement can be waived if the primary state’s insurance commissioner determines the issuer has such a mechanism that is functionally equivalent to the NAIC Model Act for External Review.</p> <p><u>Issuer</u> is defined under Section 2791(b)(2) of the Public Health Service Act to include insurance companies or other organizations licensed to sell insurance in a State and subject to State law regulating insurance. This is also the same definition used in HIPAA. [Sec. 2797]</p>
Limited Exceptions for the application of “Secondary” State law	<p>Issuers would have to pay all applicable premium taxes and assessments paid in the secondary state by in-state issuers. Issuers may have to designate the secondary state’s insurance commissioner as its agent for purposes of receiving service of process. [Sec. 2796)(b)(1)]</p>
Limited Right to Examination by Secondary State Insurance Commissioner	<p>The secondary state’s insurance commissioner may conduct an examination of the issuer’s financial condition:</p> <ol style="list-style-type: none"> 1. if the insurance commissioner of the primary state has not conducted an examination within the time frame prescribed by the NAIC. (Such examinations shall be coordinated to avoid unjustified duplication and repetition.) 2. to comply with a lawful order issued pursuant to a finding of financial impairment under a state examination or a voluntary dissolution proceeding. 3. to comply with an injunction secured by the state insurance commissioner alleging the issuer is in “Hazardous Financial Condition” meaning that based upon the present or reasonably anticipated financial condition an issuer is likely unable to meet obligations of policy holders and anticipated claims or pay other obligations in the normal course of business. 4. to participate in any insurance guaranty association that in-state health insurance issuers are required to belong to. 5. to comply with state law pertaining to unfair claims settlement practices (as defined in the act – see below). 6. to comply with state law pertaining to fraud and abuse (as defined in the act – see below). [Sec. 2796)(b)(1)(C)]

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Unfair Claims Settlement Practices	<p><u>Unfair Claims Settlement Practices</u> means <i>only</i> the following:</p> <ol style="list-style-type: none"> 1. knowing misrepresentations of fact 2. failure to acknowledge with “reasonable promptness” communications relating to claims. 3. failure to implement reasonable standards for the prompt investigation and settlement of claims. [Sec. 2795(9)] 4. failure to promptly and equitably settle claims for which liability is clear. 5. refusal to pay claims without conducting an investigation. 6. failure to inform a claimant within a reasonable period of a conducting an investigation of disputed claims.
Fraud and Abuse	<p><u>Fraud and Abuse</u> means an intentional act or omission knowingly committed to conceal material information relating to:</p> <ol style="list-style-type: none"> 1. presenting or causing to be presented false information of material fact regarding the following; policy renewal, policy rating, claims for payment or benefit, premiums, payment terms, documents filed with regulators, financial statements, changes in status of lines of insurance offered in a market or withdraw from that market. 2. solicitation of new or renewal insurance risks on behalf of an insurer or reinsurer by a person who knows or should know that the insurer or reinsurer is insolvent at the time. 3. transacting insurance in violation of laws requiring licensure or other certification to transact the business of insurance. 4. attempts to commit, aid or abet in a conspiracy to commit the acts proscribed in this section. [Sec. 2795(10)]
Clear and Conspicuous Disclosure	<p>Issuers would be required to provide notice in 12 point bold type as prescribed under the act to include the following:</p> <ol style="list-style-type: none"> 1. the name of the issuer and appropriate governing “primary” jurisdiction. 2. a statement that the policy may be less costly than others (in-state) because it may not include all mandates, including benefits and coverage requirements. 3. a statement that the policy may not include all consumer protection laws (in-state) or restrictions on rate changes. 4. a statement that the policy requires close review of terms and services before purchasing. [Sec. 2796(c)]
Limitations on Rating Changes	<p>On renewal, issuers would be prohibited from using health status to reclassify individuals from the rating class they were in at the time the contract was first issued. Similarly, issuers would be prohibited from increasing premiums based upon health status or claims experience.</p> <p>Under an exception to the general rule, issuers could:</p> <ol style="list-style-type: none"> 1. terminate or discontinue a class of coverage. 2. raise premiums for all policy holders within a given class based upon claims experience of the entire class. 3. change premiums if such changes were incentives for wellness programs. 4. reinstate lapsed coverage. 5. adjust retroactively rates that were initially low because of misrepresentation of material fact by the insured.[Sec. 2796(d)]
Jurisdiction and Choice of Law (procedural)	<p>The primary state’s law applies to all legal proceedings, including actions initiated by the secondary state insurance commissioner. [Sec. 2798(e)]</p>
Licensure and Filing of Documents	<p>Standard documents would have to be filed with the insurance commissioner of both the primary and secondary state, including the appropriate financial statements and certification of loss reserves, a copy of the plan of operation or feasibility study, and written notice of any change in designation of the “primary” state. [Sec. 2796 (g)]</p>
Enforcement	<p>The primary state has the sole authority to enforce covered laws of both the primary and secondary state, subject to the limited exceptions listed in Section 2796(b). [Sec. 2798(a)]</p> <p>The secondary state may “notify” the primary state regulator of any failure to adhere to applicable primary state law. [Sec. 2798(d)]</p>
Effective Date	<p>Issuers could select a “primary” state one day following enactment and begin selling policies. [Sec. 2798(b)]</p>