

Summary: The Health Care CHOICE Act of 2005

As reported by the Committee on Energy and Commerce on July 20, 2005

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## **Background**

H.R. 2355, the Health Care CHOICE Act - legislation seeking to expand access and affordability in the individual health insurance market - was introduced by Representative John Shadegg (R-AZ) on May 12, 2005. The Energy and Commerce Subcommittee on Health held a hearing on June 28<sup>th</sup>, and on July 20<sup>th</sup> the full committee reported the legislation (as amended) by a vote of 24-23.

The CHOICE Act would change rules in the individual insurance market to allow health insurers to file a policy in the state of their choosing – which the bill calls the “primary state” – and sell coverage in any state under the laws of the primary state. All other states in which they sell this coverage would be designated “secondary states.”

Health insurers would be exempt from mandates, advertising, underwriting and rating rules in the secondary state, but they would be required to: pay premium and other applicable taxes (e.g., high-risk pool assessments); participate in state guaranty funds; comply with state laws governing fraud and abuse and unfair claims settlement practices; undergo financial examinations under certain circumstances,<sup>1</sup> and comply with certain court orders.<sup>2</sup> Secondary state regulations relating to “care or cost management techniques,” including network access or adequacy, quality assurance and provider contracting would continue to apply. Additionally, in order to sell coverage in a secondary state, the health insurer must offer that coverage in the primary state. Other key provisions include:

### **Federal Floor for Solvency and External Review**

In order to sell individual coverage in a secondary state, a health insurer must be licensed in a primary state that: (1) uses a risk-based capital formula for solvency; and (2) has an independent external review law or rules for policyholders with individual coverage. The bill provides detailed direction on individuals qualified to perform independent review and the scope of that review. The independent review requirement does not apply if the insurer has an independent

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<sup>1</sup> Insurers would be required to undergo financial exams in the secondary state if the primary state had not conducted an exam within the time frame recommended by the NAIC. In these instances, the exam must be conducted according to the NAIC’s examiners’ handbook, and it must be “coordinated to avoid unjustified duplication and unjustified repetition.”

<sup>2</sup> Insurers would be required to comply with court orders issued in a secondary state as part of delinquency proceedings or voluntary dissolution proceedings, and with injunctions issued upon a finding by the State Insurance Commissioner that the insurer was in hazardous financial condition.

review mechanism deemed by the primary state's insurance commissioner to be functionally equivalent to the NAIC's Health Carrier External Review Model Act.

## **Notice**

Health insurers would be required to provide a notice to all policyholders purchasing their coverage in secondary states, indicating that the policy is governed by the laws of the applicable primary state; that it may be less expensive than others because it is not subject to all the mandated benefit or consumer protection laws of the applicable secondary state; and that policyholders should carefully review the benefits and exclusions of the policy.

## **Rating**

When renewing individual policies in either primary or secondary states, health insurers would be prohibited from moving or reclassifying individuals from the rating class they were in at the time the contract was issued based on their health status. Moreover, when renewing individual policies in primary or secondary states, insurers may not increase an individual's premiums based on health status-related factors, change of health status-related factors, or claims experience. In addition, the amended legislation includes language that affirms the rights of individuals with guaranteed availability under the Health Insurance Portability and Accountability Act (HIPAA).

However, insurers may terminate a class of coverage according to the bill's provisions; they may raise premium rates for all policyholders within a class based on claims experience; they may change premiums or offer discounted premiums to individuals who engage in wellness activities under certain conditions; they may reinstate lapsed coverage; and they may retroactively adjust rates if the initial rates were set based on misrepresentation by the individual.

## **Enforcement**

The primary state would have sole jurisdiction to enforce its laws affecting the health insurer in both the primary state and the secondary state. The secondary state would retain authority to enforce its laws that continue to apply to health insurers licensed in a primary state (e.g., laws related to premium taxes, guaranty funds, agent licensing), and the secondary state may notify authorities in a primary state if insurers fail to comply with a primary state's laws. Finally, the secondary state would retain the authority to enforce its laws relating to fraud and abuse and unfair claims settlement practices – as those terms are defined broadly in the legislation.

## **Effective Date and Study**

The legislation would become effective one year from the date of enactment, and would mandate that the Government Accountability Office (GAO) conduct an ongoing study of its impacts on; (1) the number of uninsured and under-insured, (2) the availability and cost of health insurance for those with pre-existing conditions, (3) changes in the types of benefits available in different states, and (4) cases of fraud and abuse relating to policies offered under the legislation.