AHIP Center for Policy and Research

Side-by-Side Comparison of Association Health Plan Legislation (H.R. 525) and Recent Drafts of the Enzi Small Business Health Plan Bill (S. 1955)

		H.R. 525, the "Small Business Health Fairness Act" (as approved by the House of Representatives on July 26, 2005)	S. 1955, "the Health Insurance Marketplace Modernization and Affordability Act" (as introduced in the Senate on November 2,2005)	S. 1955 Changes Proposed in November 18, 2005 Discussion Draft	S. 1955, Changes Proposed in March 3, 2006 "Draft" Chairman's Mark
	Title I: Small Business Health Plans				
1	**Criteria for an Association Health Plan or a Small Business Group Health Plan**	A sponsor of an association health plan must: (1) be organized and maintained in good faith, with a constitution and by laws specifically stating its purpose and providing for periodic meetings on at least an annual basis as a bona fide trade association, industry association,	S. 1955 would establish "small business health plans" (SBHPs) – similar to AHPs but limited to fully-insured plans. Self-funded plans are *not* covered under S. 1955. (Section 801). The definition of "small business health plan" incorporates the criteria for "sponsoring" an association health plan in H.R. 525, but lacks clear and consistent criteria limiting	Proposes precluding SBHPs from conditioning membership in the association on minimum group size.	

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		professional association, or chamber of commerce for purposes other than that of obtaining or providing medical care; (2) be established as a permanent entity which receives the active support from its members and requires dues or payments on a periodic basis to maintain membership eligibility; and (3) not condition membership or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or their dependents, and not condition such dues or payments on the basis of group health plan participation. (Section 801)	SBHPs to HIPAA small groups (2-50). *Note:* Only Title II includes a limitation on group size by defining small-group market in Section 2911 and incorporating by reference in Section 2912.		

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2	**Certification of Plans**	Provides for a negotiated rulemaking to develop certification and class certification processes to be used by the Secretary of Labor. Self-funded coverage options would have to meet one of the following requirements to become certified: (1) offered self-funded coverage prior to the date of enactment; or (2) not restrict membership to one or more trades and businesses or industries and is eligible to employers representing a broad cross-section of businesses; or (3) restricts membership to one or more trades or businesses, or any other trade, business, or industry which has been identified as having average or above-average risk or health claims experience. (Section 802)	Requires the Secretary of Labor to establish an interim final rule for certification within 6 months of enactment. Also, requires the Secretary of Labor to establish a process for class certification and provides discretionary authority to develop a process for continued certification that may also include conditions for revocation. (Section 802)	Proposes replacing the class certification with a process for "deeming" certification of an SBHP if the DoL fails to act on an application within 90 days. DoL may later revoke certification for cause and may impose civil penalties up to $50,000 for materially incomplete or inaccurate applications, and $500,000 for willfully incomplete applications.	Would limit fines to those cases where applications were willfully or negligently submitted ($500,000). Fines for materially incomplete or inaccurate applications are eliminated from this draft. (Section 802)

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3	**Requirements Relating to Board of Trustees**	AHPs are operated under trust agreements, in which full fiscal control is granted to the board of trustees. Members of the board of trustees are selected from individuals who are owners, officers, directors, or employees of the participating employers or partners of the participating employer who actively participate in the business. Franchise networks and collectively bargained plans could be AHP sponsors if certain conditions are met. (Section 803)	Similar. The board of trustees has sole authority to approve applications for participation. The limitations on conflicted individuals who may be selected for the board do not apply to small group plans existing at enactment. (Section 803).		
4	**Effective Date (Title I)**	The sections addressing rules governing AHPs, enforcement provisions relating to AHPs, and cooperation between federal and state authorities would take effect one year after enactment. Sections clarifying the treatment of single- employer arrangements and collectively	Would be effective 1 year after the date of enactment. The Secretary of Labor would be required to issue all regulations prior to that date. (Section 103)	The effective date of this Title was revised to correct a technical mistake, but it appears that the drafters are still considering whether to give DOL a specific deadline for issuing regulations.	Effective date of this title would be 12 months after enactment. The Secretary of Labor will issue all necessary regulations within 6 months of enactment.

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		bargained arrangements under ERISA would take effect on enactment.			
5	**Transition Rules for Existing Association Health Plans**	Any existing health benefits program with a minimum of 200 participating employers having been in operation for a minimum of 10 years and licensed by a state shall be deemed a group health plan that meets all conditions established under Sections 801(a) and 803(a) upon filing for certification with the Secretary of Labor.	The Board of Trustee criteria for existing association-sponsored plans would be met if operated by a Board that is elected by participating employers (each of whom has one vote) and the Board has complete fiscal control over the arrangement. These existing plans could provide coverage only in those states that they were operating in as of the date of enactment. (Section 103(b))		
6	**Participation and Coverage Requirements**	AHPs would have to accept for coverage all employers that are members, or affiliated members, of the sponsoring organization. Eligible employers and individuals cannot be excluded from coverage on the basis of health status. (Section 804)	Same. (Section 804)		Adds language to further prevent discrimination against a particular participating employer or employee such that all eligible participating employers must make information about all coverage options "readily available." This provision appears designed to maximize employee choice over plan type. (Section 804(c)(2))

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7	**Plan Documents, Contribution Rates, and Benefit Options**	***Governing Instruments:*** The board of trustees for the AHP serves as the named fiduciary and plan administrator. ***Contribution (Premium) Rates:*** The contribution rates for any participating small employer may not vary on the basis of health status (as defined in HIPAA) and rates cannot vary on the basis of the employer's type of business or industry. However, an AHP may vary contribution rates based on the claims experience of the entire AHP. ***Marketing Requirements:*** State-licensed insurance agents must be used to distribute to small employers any self-funded AHP product in a manner comparable to that used to distribute fully-insured products. ***Minimum Number of Participants for Self-funded AHPs:*** A self-funded AHP must	Similar. There are no provisions addressing marketing requirements or the minimum number of participants. ***State licensure and informational filing:*** The sponsor's principal place of business determines the (domicile) state in which coverage is issued. The SBHP must be licensed in every state in which it operates. Licensure may be deemed if a state fails to act on an application within 90 days. Deeming of licensure will result in temporary preemption of state law relating to the rating and benefit provisions in the bill. States may still enforce other insurance laws and may revoke the licensure for material violations of state law. The SBHP may market and promote coverage during the 90 day period, but may not enroll or collect premiums during this period. (Section 805) *Note*: Special Plan Option for Individual Market – This section	***Groups of One.*** SBHPs can enroll groups of one (the self-employed) by using either the new small group premium rating rules (variation of + or – 25% upon issuance) or the new individual market rating rules described below under Title II. ***Licensure of Insurers.*** Insurers that provide coverage to SBHPs must be licensed in the SBHP's domicile state and must obtain licensure in every State in which participating employers in the SBHP are located. If an insurer's license is not approved or denied within 90 days in a particular State, the State's health insurance laws will be temporarily preempted but other State laws will remain in effect (other than the bill's special new rating or benefits rules). A SBHP or insurer can promote coverage but not enroll members or collect premiums while the 90-day	***Groups of One:*** Participating employers that are self-employed are eligible for an SBHP. However, the self-employed must be enrolled in accordance with rating rules that do not violate the rating rules for the self-employed of the state in which the (self-employed) employer is located. The language does not specify what rating rules are to be used. Guaranteed issue would not be required for the self-employed (unless the state of issuance had such a law). (Section 805(a)(3)(A)) ***Large Groups***: Participating large employers exceeding the bill's definition for "small" employer (50 or less) are eligible for an SBHP. However, they must enroll large-groups in accordance with rating rules that do not violate the rating rules for large-groups in the state in

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		have a minimum of 1,000 participants and beneficiaries as of the beginning of the plan year. ***Preemption of State Mandated Benefits:*** Would preempt state laws precluding an AHP, or a health insurance issuer offering coverage in connection with an AHP, from selecting the specific benefits to be included under its plan or coverage. However, AHPs must comply with state laws that prohibit exclusion of a specific disease from coverage, and an AHP must comply with federal mandates, including those relating to mental health, minimum maternity hospital stay for mothers and newborns, and breast reconstructive surgery for women with breast cancer undergoing a mastectomy. (Section 805)	provides the SBHP with the option of enrolling groups of one using either: (1) the small group rating provision of +/- 25% included in Title II of the bill or (2) Title II rating rules developed for the individual market that are actuarially justified and certified by a member of the American Academy of Actuaries and prohibits reunderwriting.	licensure period is pending.	which the participating employer is located. The language does not specify what rating rules are to be used. (Section 805(a)(3)(B)) ***Licensure****:* Clarifies that nothing shall limit the requirement that insurers of SBHPs are licensed in every state except the limited preemption for a state's failure to act on an application within 90 days. Allows coverage to be issued to a participating employer in a non-domicile state by an insurer that is licensed in the non-domicile state, thus allowing for an SBHP to have multiple insurers "servicing" different parts of the country. (Section 805(c)(2)) ***Preemption of State Mandated Benefits:*** Would preempt state laws precluding an SBHP, or a health

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					insurance issuer offering coverage through an SBHP, from selecting the specific benefits and services covered. (Section 805(b)).
8	**Maintenance of Reserves and Solvency for Self-funded Plans**	Self-funded AHPs must establish and maintain reserves sufficient for unearned contributions and benefit liabilities, maintain aggregate excess/stop loss insurance and establish and maintain a minimum surplus of $500,000, but no greater than $2 million. ***Alternative Means of Compliance:*** A self-funded AHP may achieve compliance with the reserve and solvency standards enumerated above through alternative methods that are no less protective of the interests of participants and beneficiaries. ***Payments to an AHP Fund:*** A self-funded AHP is required to	No comparable provision. S. 1955 is limited to fully insured plans.		

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		make annual payments of $5,000 to a fund that is intended to ensure continued payment of benefits in the event of financial distress or insolvency. The Secretary of Labor also has the discretion to require supplemental payments from an AHP and to make payments to insurers to maintain excess stop loss insurance for an AHP in financial distress. ***Solvency Standards Working Group:*** Within 90 days of enactment, the Secretary of Labor or applicable authority shall establish a Solvency Standards Working Group, whose membership consists of 15 members appointed by the Secretary. (Section 806)			
9	**Solvency for Fully-Insured AHPs**	Fully-insured AHPs must meet the solvency standards of the states in which they offer coverage. (Section 806)	Same		
10	**Requirements for**	Sponsors of AHPs are required to pay a filing fee of $5,000 and	Similar. Does not require that the application include a funding report.		Requires that a SBHP file notice of certification in every

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	Application and Related Requirements	submit an application for certification to the DOL. The application must include the following: (1) the names and addresses of the sponsor and the board of trustees; (2) the states in which the AHP intends to conduct business; (3) bonding requirements; (4) plan documents and other materials describing the benefits that will be provided to participants; (5) agreements with service providers; and (6) a funding report, which includes/demonstrates reserve levels, adequacy of contribution rates, and current and projected value of assets and liabilities. The board of trustees must engage the services of a qualified actuary to file an annual report to the board. (Section 807)	(Section 806)		state in which the SBHP operates (previous drafts only required such a filing in states having 25 percent or more of an SBHP's participants). (Section 806(c))

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11	**Voluntary Termination**	AHPs that voluntarily terminate are required to: (1) notify participants and beneficiaries not less than 60 days prior to the proposed termination date; (2) develop a plan for "winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the [AHP] is obligated"; and (3) submit such a plan in writing to the Secretary of Labor or the applicable authority. The process for voluntary termination would be prescribed through a rulemaking process. (Section 808)	Same. (Section 807)		
12	**Corrective Actions and Mandatory Termination**	The board of trustees is required to meet, on a quarterly basis, to determine whether the AHP is meeting solvency and reserve	No comparable provision.		

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		requirements. In the event that an AHP is failing to meet these requirements, the board must immediately notify the qualified actuary engaged by the AHP, who, in turn, has 30 days to implement a "corrective action" plan. Within 30 days of receiving recommendations from the actuary, the board must notify the Secretary of the board's action to forestall an impending insolvency. If an AHP fails to meet the reserve and solvency requirements and there is "a reasonable expectation" that the AHP will continue to fail to meet these requirements, the board, at the direction of the Secretary is required to terminate the AHP. In terminating, the board is required to "ensure that the affairs of the AHP will be wound up in a manner which will result in a timely provision of all benefits for which the [AHP] is			

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		obligated." (Section 809)			
13	**Trusteeship of Insolvent Association Health Plans**	The Secretary of Labor is required to assume trusteeship (and petition the appropriate U.S. District Court) of an AHP that is "unable to provide benefits when due or is otherwise in a financially hazardous condition." The Secretary would possess broad power as trustee, including to: (1) conduct any act authorized by the AHP; (2) require the transfer of all (or any part) of the assets and records of the AHP to the Secretary as trustee; (3) require the sponsor, the administrator, any participating employer, and any employee organization representing participants to furnish any information that the Secretary may "reasonably" need in order	No comparable provision.		

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		to administer the AHP; and (4) conduct other duties as may be necessary to protect the interests of AHP participants and beneficiaries and providers of medical care. (Section 810)			
14	**State Assessment Authority**	Allows a state to assess a "contribution tax" or premium tax on self-funded AHPs not to exceed any tax imposed on health insurers or health maintenance organizations and must otherwise be non-discriminatory. (Section 811)	No comparable provision.		
15	**Definitions and Rules of Construction**	***Conforming Amendments to Preemption Rules*** AHPs would have broad exemption from state mandates and regulation. Preempts all state laws that would preclude or have the effect of precluding a health insurance issuer from offering coverage in connection with an AHP except those for (1) solvency standards; and (2)	Similar conforming amendment to preemption rules. (Section 808) Very small groups are defined as those including fewer than 2 participants, although that term does not have separate meaning in states that regulate groups of one under the same rules as the small group market. This definition does not appear to be incorporated into the operative terms of the bill.		Clarifies the definition of "affiliated member" so as to include employees of affiliated member associations. (Section 808(a)(1)) Clarifies the definition of "health insurance coverage" under the bill as not including HIPAA "excepted benefits,"

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		prompt pay requirements. ***Disclosure of Solvency Protections Related to Self-funded and Fully-Insured Options Under AHPs*** AHPs must include a description of the solvency or guaranty fund protection secured pursuant to this Act or applicable State law in the AHP's summary plan description. ***Report to Congress Regarding Certification of Self-funded Association Health Plans*** The Secretary of Labor must send a report to Congress by January 1, 2008, that documents the effect AHPs have had, if any, on reducing the number of uninsured Americans.	Small employers are defined as in HIPAA (groups with up to 50) although that term is not incorporated in any bill section.		thus precluding application to supplemental products. (Section 808(a)(6)) Clarifies that "participating employers" are not to be deemed "plan sponsors" for purposes relating to coverage renewal. (Section 808(c)) Language was added to ensure that nothing shall "inhibit the development of health savings accounts." (Section 808(d))
16	**Enforcement Provisions Relating to AHPs**	Provides for criminal penalties, including imprisonment for up to 5 years, for any "person who willfully falsely represents" an AHP or other similarly certified arrangement.	No comparable provision.		

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		The appropriate U.S. district court may also issue cease-and-desist orders, upon a finding by the Secretary of HHS that an AHP is not operating in accordance with the rules of this act, or is not certified as an AHP or appropriately licensed or approved by a particular state. (Section 5)			
17	**Cooperation Between Federal and State Authorities**	***Recognition of Primary Domicile State*** DOL will consult with the primary domicile State with respect to enforcement and certification of AHPs. This "primary domicile state" would be the state in which the health insurance policy was initially filed and approved.	Similar. (Section 102).		
	Title II: Near-Term Market Relief				
18	**Near-Term Market Relief (TITLE II)**	No comparable provision.	Provides for the development of a process to institutionalize rating reform. Provides for the development of "interim" national rules within 6	Proposes a rule of construction to ensure that "eligible insurers" are able to amend existing policies consistent with Title II. (Section 2925)	Redefines "adopting state" (for all provisions related to small-group rating rules) to include those states that have adopted in their entirety either the "Model Small Group

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			months for regulating the small-group and individual markets that will remain in effect until the harmonized standards take effect and supersede the interim national rules.		Rating Rules" or the "Transitional Model Small Group Rating Rules." (Section 2911(a)) Clarifies the definition of "health insurance coverage" under the bill as not including HIPAA "excepted benefits," thus precluding application to supplemental products. (Section 2911(a)(3)) ***Rating Structure:*** Clarifies that the small-group rating rules are those from the 1993 NAIC "Adopted Small Employer Health Insurance Availability Model Act" and writes them directly into the statute. These rules limit the variance of any class of business to no more than 20 percent over the index rate for a carrier's entire block of small group business. In addition, limits variance among a similar

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					class of the small group market to 25 percent of the index rate, and limits annual adjustments to no more than 15 percent (based on health status). (Section 2911(b)) In addition, allows small employer carriers to utilize industry as a case characteristic as long as the highest rate factor associated with any industry is no greater than 15 percent higher than the lowest rate factor for an industry. (Section 2911(b)(1)(E)). A definition of index rate is included in this draft and defined as, for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate. (Section 2911

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					(a)(6)). The base premium rate is defined as, for each class of business with respect to a rating period, the lowest premium rate charged that could have been charged under a rating system for that class of business by the small-employer carrier to small employers with similar case characteristics for similar coverage. (Section 2911(a)(3)). Provides the Commissioner with the authority to suspend, for a specific period, the premium rating rules for one or more small employers included within a class of business if the Commissioner determines that the suspension is reasonable considering the financial conditions of the carrier and/or efficiency and fairness in the marketplace. (Section 2911(b)(6)).

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19	**Interim Rating Reform**	No comparable provision.	Within 6 months of enactment, the Secretary of HHS shall through expedited rulemaking consult with the NAIC to promulgate "National Interim Model Rating Rules" based on the 1992 model NAIC rules on premium rating and premium variation. The base premium rate of covered individuals may vary based upon health conditions by a factor of +/- 25 percent on issuance and +/- 15 percent on renewal. (Section 2912) The Secretary of HHS has discretionary authority to provide for a "graduated" transition of up to 3 years and develop different standards based upon whether a state has rating band requirements that allow variance by more than 50 percent. The Secretary of HHS would also have discretionary authority to establish transitional independent rating classes for old and new business and any additional transitional standards deemed necessary. (Section 2912(c))	Proposes requiring the Secretary of HHS to develop, within 6 months, interim individual market rating rules that would remain in place until the "harmonized" rules under Title III were issued. These interim rules would be effective in the first plan year after being promulgated and would have to: (1) be actuarially justified and certified by a member of the American Academy of Actuaries; and (2) preclude re-underwriting on renewal (although initial offers could be based upon health status). Proposes establishing a window for "Market Re-entry" into the small group market without regard to the HIPAA 5 year waiting period. The window period would exist from 180 days after enactment to 24 months after enactment, although it would not preempt state law prescribing a waiting	Directs the Secretary, in consultation with the NAIC, to promulgate, within 6 months of enactment, "Model Small Group Rating Rules." ***Transition Rules*:** In states that currently have highly restrictive rating rules or "community rating" laws, the "Model" rules shall be preceded by "Transitional Model Small Group Rating Rules" for a period of up to five years (from the date of promulgation of the model rules) "to the extent necessary to provide for a graduated transition" to the Model Small Group Rating Rules. Transitional rules are to be promulgated by the Secretary and NAIC no later than 12 months after enactment. (Section 2912(b)). **Note:** This latest draft clarifies that out-of-state SBHPs are required to use the same transition rules as in-state

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				period of more than 180 days. (Section 2912(e))	carriers. (Section 2912 (b)(1)(a)). ***Transition Criteria:*** Coverage offered in a state having in place premium rating bands or premium limits that varied by less than 12.5 percent from the index rate within a class of business on the date of enactment of the bill shall be eligible for the transition rating rules to be promulgated by the Secretary. Coverage offered in a state with premium bands or premium limits that varied by more than 12.5 percent from the index rate shall not be eligible for the transition rules. (Section 2912(b)(2)). ***Other Transitional Authority:*** The Secretary is given broad authority to provide for the application of the transitional rules as "necessary for an effective transition."(Section

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					2912(b)(3)) ***Transitioning of Old Business:*** An eligible insurer may apply the rules governing premium variation during transition separately to coverage offered prior to the end of the 5 year transition period. (Section 2912(d)(11)).
20	**Adopting/Non-Adopting States**	No comparable provision.	A State can be an "adopting" state and enact state laws mirroring the standards set forth in three different portions of S. 1955 relating to (1) near-term market relief rating requirements; (2) the Compendium for lower cost plans; and (3) harmonized standards. Insurers would have to satisfy state law in these states. A state can be a non-adopting state and keep its state laws in place and an insurer can notify HHS and the state that it wishes to offer insurance in accordance with the standards in S. 1955. In this case, the standards		

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			in S. 1955 would preempt state law with respect to the insurance offered by these "eligible insurers." It appears that an insurer in a non-adopting state can continue to adhere to/comply with state law in areas covered by the Compendium and Harmonized Standards should it choose to do so.		
21	**Eligible/Non-eligible Insurers**	No comparable provision.	A state can be a non-adopting state and keep its state laws in place and an insurer can notify HHS and the state that it wishes to offer insurance in accordance with the standards in S. 1955. In this case, the standards in S. 1955 would preempt state law with respect to the insurance offered by these "eligible insurers."		Eligible insurers would retain the right to issue policies under the bill in non-adopting states 30 days after notifying the non-adopting state's insurance department. (Section 2911(a)(2))
22	**Preemption of Rating Law in Non-Adopting States (those not adopting interim rating reform)**	No comparable provision.	Broadly preempts most state law relating to rating in the small group insurance market in "non-adopting" states with respect to eligible insurers, i.e., those states that have not adopted either the NAIC model rules or the interim model rules developed by the Secretary.		***Preemption***: At the conclusion of the 5 year transition period, the Model Small Group Rating Rules will be in effect in all non-adopting states. (Section 2912(b)(1)) The preemption would not

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					alter existing preemption under ERISA and would only apply to insurers that qualify as eligible insurers offering small-group coverage. (Section 2913(b)(3))
23	**Civil Actions and Jurisdiction (Titles II and III)**	No comparable provision.	In titles II and III of the bill, Federal district courts are granted exclusive jurisdiction over civil actions involving interpretation of the new law. Health insurance issuers may bring action in Federal district courts for injunctive or other equitable relief against a non-adopting state in connection with the application of a state law that violates the new law. For certain violations, health insurance issuers may sue for damages against the non-adopting state and if successful in such an action, reasonable attorneys fees and costs. (Sections 2914, 2924 and 2934)	Proposes requiring insurers to establish that discrimination by a non-adopting state was willful and intentional in order to recover damages.	Clarifies that an eligible insurer may bring action in district court for injunctive or other equitable relief against any officials or agents of non-adopting States in connection with any conduct or action, or proposed conduct or action that would violate preemption of state law. For certain violations, an eligible insurer may bring action directly to the United States Court of Appeals for the circuit in which the non-adopting state is located. However, eliminates the requirement for the Court to award the health insurance issuer reasonable attorneys fees if the health insurer prevails. . (Section 2914(b)).

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					Whether an action is filed in a district or appeals court, judgment shall be based on a review of the merits of all questions presented and not any conduct or action, or proposed conduct or action, of a non-adopting state. (Section 2914(e)). Includes language to ensure expedited review of civil actions. In the case of an action brought in a district court, the court must issue a judgment within 120 days unless all parties agree to an extension. In the case of an action brought directly to a United States Court of Appeals, the Court must issue a judgment within 60 days unless all parties agree to an extension. (Section 2914(d)).
24	**Lower Cost**	No comparable provision.	States would be divided into		Eliminates the State Benefit

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	Plans and Relief from Mandates		adopting or non-adopting based upon whether they approved a "State Benefit Compendium" in its entirety as the exclusive law of the state as it relates to benefit, service and provider mandates in the group and individual market. (Section 2921) For adopting states, all those benefits, services and mandates included in the Compendium would be binding on health insurance issuers.		Compendium and implements "Benefit Choice Standards." No later than 6 months after enactment, the Secretary is to issue by interim final rule Benefit Choice Standards for lower cost and comprehensive plan options. The Benefit Choice Standards provide for a lower cost plan option that is not required to comply with all state benefit, service or provider mandates as long as an "enhanced" plan option is also offered to purchasers. The lower cost option may be offered in the small-group, individual, and large-group market, or through a SBHP. The enhanced plan option would include at a minimum, such benefit, service, and categories of providers as is covered by the State employee coverage plans in one of the 5 most populous

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					states. Beginning three months after enactment, on the first day of the calendar year, the Secretary will publish in the Federal Register the covered benefits, services and categories of providers covered by the State employee coverage plans in the 5 most populous states. Currently, these states include California, Texas, New York, Florida, and Illinois (Section 2922).
25	**Transition Rules for Offering Lower Cost Plans**	No comparable provision.	Provides for a 2 step process beginning with the compiling of an interim "List of Required Benefits" to be developed by the Secretary of HHS within 3 months of enactment to include all benefits, services and provider mandates required in at least 45 states. (Section 2922)		No transition rules are required for implementing the Benefit Choice Standards.
26	**The "State Benefit Compendium" and Harmonized**	No comparable provision.	Within 12 months of enactment, the Secretary of HHS would issue a "State Benefit Compendium" or harmonized description of benefit, service and provider mandates. The		See Benefit Choice Standards as described above. Replaces State Benefit Compendium.

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	Benefit Descriptions		Compendium is based on the mandates in at least 45 states, as identified on the "List". To account for differences among states, the Secretary of HHS shall use a common approach to define the scope and application of state law that reflects the approach used by a plurality of states. (Section 2922(b)) The State Benefit Compendium shall be updated every 2 years. (Section 2922(d))		
27	**Effective Date**	No comparable provision.	The "State Benefit Compendium" becomes effective the later of 12 months from the date of enactment of the bill or on issuance of the interim final rule. (Section 2922(b))		The requirements concerning lower cost plans are to apply to SBHPs beginning 12 months after enactment. With respect to non-association based coverage, the requirements concerning lower cost plans are effective beginning 15 months after enactment.
28	**Special Expedited SBHP Coverage Under the**	No comparable provision.	After the Secretary of HHS issues the List of Required Benefits (at 3 months after enactment), the required scope and application of benefits is determined by the List		

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	List		and either (1) the scope and application of benefits in the state of the sponsor's principal place of business; or (2) if the state of the sponsor's principal place of business does not require the mandate, the scope and application of the state in which the largest number of the SBHP's employers are located. (Section 805(b)) [This provision is actually in Title I, but is more appropriately placed in Title II of this chart for discussion purposes.] *Note:* This provision suggests that SBHPs could operate under the "List of Required Benefits" interim period for an indeterminate period.		
29	**Non-Association Coverage Under the List Should the Transition Exceed 12 Months**	No comparable provision.	In the event the Secretary of HHS fails to issue a final interim rule establishing the "State Benefit Compendium" within 12 months of enactment, non-SBHP coverage provided by traditional insurers to small groups would have to adhere to either (1) the benefit mandates in		Bill does not require interim rule with Benefit Choice Standards.

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			the state the policy is offered or (2) if the state does not mandate the benefit, the scope of it as defined in the state in which the greatest number of the insurer's small employer policyholders are located. (Section 2922(c))		
30	**Preemption of Law for Non-Adopting States**	No comparable provision.	Provides for broad preemption of state law in those non-adopting states with respect to eligible insurers, including any provision of law or regulation that would discriminate against insurers offering or seeking to offer coverage consistent with the "State Benefit Compendium" in a non-adopting state. Coverage by an eligible insurer offered in conjunction with the Compendium would be limited to group insurance, and not include individual insurance. An insurer in an adopting state could offer coverage under the Compendium in both the individual and group markets. The preemptive authority would not apply to the extent necessary to enforce existing state law relating to		Similar to previous version except preemption applies to Benefit Choice Standards instead of Compendium.

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			benefits provided for in the Compendium or to the extent necessary to permit individuals or an insurance department to obtain relief under state law. (Section 2923)		
Title III: Harmonization of Health Insurance Laws					
31	**Harmonization of Standards (TITLE III)**	No comparable provision.	In consultation with the NAIC, the Secretary of HHS will establish a Commission on Health Insurance Standards Harmonization to develop recommendations that harmonize inconsistent state laws impacting health insurance in accordance with laws adopted in the plurality of States. If Federal law imposes any requirements, the Federal law shall be deemed the plurality. The Commission's members will be appointed by the Secretary of HHS and represent a broad cross-section of stakeholders. The Commission will identify and recommend standards for the small-group, large-group and individual insurance markets in the following areas: rating, access to coverage, and	Proposes limiting the scope of the Commission's work to the small group and individual markets (removing large group). Proposes removing state laws relating to high-risk pools from the scope of the Commission's review. The Commission would also include two members representing SBHP interests. Proposes extending the deadline for reporting recommendations to the Secretary of HHS to 3 years.	Clarifies the definition of "health insurance coverage" under the bill as not including HIPAA "excepted benefits," thus precluding application to supplemental products. (Section 2931(4)) Directs the Secretary to establish a 16-person "Health Insurance Consensus Standards Board," (instead of Commission on Health Insurance Standards Harmonization) in consultation with the NAIC, within 3 months of enactment. The "Board" shall consist of 16 voting members to be appointed by the Secretary based upon recommendations from

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			patient protection. The Commission will provide the Secretary of HHS with its recommendations no later than 1 year after enactment. The Secretary of HHS will issue final regulations for harmonized standards within 120 days of receiving the recommendations. The Secretary's final regulations will be effective 2 years after issue. The Secretary of HHS will update the harmonized standards every two years and will ask the NAIC to issue a report every 2 years identifying the updated standards. (Section 2932).		professional associations representing the following: 1. four insurance commissioners; 2. four representatives of state government (two Governors and two state legislators); 3. four representatives of health insurers (one representing the small-group, large-group, and individual market, and one representing insurers that offer coverage in all markets); 4. two representatives of insurance brokers; and 5. two representatives of the American Academy of Actuaries. The Secretary shall also establish an "advisory panel" to provide advice to the Board and shall appoint its members after considering recommendations from professional associations

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					representing the following: 1. two representatives of SBHPs; 2. two representatives of employers, one representing small employers and one representing large employers; 3. two representatives of consumer groups; and 4. two representatives of health care providers. (Section 2932(a)) The Board is required to make recommendations for each element of the categories described below within 18 months, and the Secretary has an additional 120 days to certify "harmonization" standards. Detailed provisions for qualifications of board members, disclosure, and staffing are provided in the legislation.

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					The scope of harmonization applies to the large-group, the small-group and individual markets. The Board is directed to develop harmonized standards for the elements in the following process categories: **Form Filing and Rate Filing:** Form and rate filing standards are to be developed that promote speed to market and include the following defined areas for states that require such filings: 1. procedures for form and rate filing for administrative filing processes; 2. timeframes for filings to be reviewed by a State if review is required before they are deemed appropriate; 3. timeframes for an eligible insurer to respond to state requests following its review;

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					4. a process for an eligible insurer to self-certify; 5. state development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers; 6. procedures for the resubmission of forms and rates; 7. disapproval rationale of a form or rate filing based on material omission or violations of non-preempted state law or federal law with violations cited and explained; and 8. a rationale for hearings based on violations of non-preempted state law or insurer requests. (Section 2932(b)(A)). **Market Conduct Review:** 1. mandatory participation in national databases;

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					2. confidentiality of examination materials; 3. identification of the state agency with primary responsibility for examinations; 4. consultation and verification of complaint data with eligible insurer prior to state actions; 5. consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer; 6. examinations that seek to correct material errors and harmful business practices; 7. transparency and publishing of state's examination standards; 8. coordination of market conduct analysis; 9. coordination and non-duplication between state examinations of the same eligible insurer; 10. rationale and protocols

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					to be met before a full examination is conducted; 11. requirements on examiners prior to beginning examinations, such as budget planning and work plans; 12. consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives; and 13. reasonable fines and penalties for material errors and harmful business practices. (Section 2932(b)(B)). **Prompt Pay of Claims*:*** The Board is to harmonize prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act, and be consistent with the timing and notice requirements of the claims procedure rules,

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					and include appropriate exceptions for fraud, non-payment of premiums, or late submission of claims. (Section 2932(b)(C)). **Internal Review*:*** Standards for claims procedures are to be consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under ERISA. (Section 2932(b)(D)). While criteria for external review are not included in this draft, it is the intention of Congressional staff to include such criteria in the final bill. The NAIC is currently working to finalize criteria for external review. In addition, the Board is required to consider: 1. any model acts or regulations of the NAIC in

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					each of the process categories; 2. substantially similar standards followed by a plurality of states; 3. any federal law requirements related to the specific process categories; and 4. in the case of a standard adopted that differs substantially from any NAIC model acts or regulations, standards followed by a plurality of states, or any federal requirements, the Board must provide the Secretary evidence that such a standard is necessary to protect consumers, promote speed to market, or administrative efficiency. (Section 2932(d)(2)).
32	**Application and Preemption of**	No comparable provision.	Provides for broad preemption of state law in non-adopting states with respect to eligible insurers, including		Directs the Secretary to establish a process for certifying the standards by

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	Harmonized Standards		any provision of law or regulation that would discriminate against insurers offering or seeking to offer coverage consistent with the "State Benefit Compendium" in a non-adopting state. The preemptive authority would not apply to the extent necessary to enforce existing state law relating to benefits provided for in the harmonized standards or to the extent necessary to permit individuals or an insurance department to obtain relief under state law. (Section 2933)		category in a manner that achieves regulatory uniformity, is minimally necessary to protect consumers and maintain competition, and does not limit innovative health products. (Section 2932(d)) Provides that the certified standards will directly preempt state law, shall be effective 18-months from the date the Commission adopted standards. Every 3 years thereafter, a report shall be issued to Congress by former members of the Board and Advisory Panel examining the impact of the legislation. Based on the report and in consultation with the NAIC and entities represented by the Board, the Secretary may update the harmonized standards through notice and comment rulemaking. (Section 2932(f))

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