109TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
109–378

HEALTH CARE CHOICE ACT OF 2005

FEBRUARY 16, 2006.—Ordered to be printed

Mr. BARTON of Texas, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 2355]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2355) to amend the Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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49–006

AMENDMENT

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as "Health Care Choice Act of 2005".

SEC. 2. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This Act is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 3. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 4. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

"In this part:

"(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

"(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

"(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

"(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

"(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

"(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

"(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

"(B) to pay other obligations in the normal course of business.

"(7) COVERED LAWS.—

"(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

"(i) individual health insurance coverage issued by a health insurance issuer;

"(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

"(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

"(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

"(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

"(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

"(8) STATE.—The term 'State' means only the 50 States and the District of Columbia.

"(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

"(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

"(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

"(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

"(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

"(E) Refusing to pay claims without conducting a reasonable investigation.

"(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

"(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

"(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

"(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

"(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

"(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

"(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

"(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

"(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

"(ii) The rating of an insurance policy or reinsurance contract.

"(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

"(iv) Premiums paid on an insurance policy or reinsurance contract.

"(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

"(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

"(vii) The financial condition of an insurer or reinsurer.

"(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

"(ix) The issuance of written evidence of insurance.

"(x) The reinstatement of an insurance policy.

"(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

"(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

"(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

"SEC. 2796. APPLICATION OF LAW.

"(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

"(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

"(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

"(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

"(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

"(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

"(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

"(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

"(D) to comply with a lawful order issued—

"(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

"(ii) in a voluntary dissolution proceeding;

"(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

"(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

"(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

"(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

"(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

"(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

"(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

"(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

'Notice

'This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

"(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

"(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

"(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

"(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

"(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

"(B) from raising premium rates for all policy holders within a class based on claims experience;

"(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

"(i) are disclosed to the consumer in the insurance contract;

"(ii) are based on specific wellness activities that are not applicable to all individuals; and

"(iii) are not obtainable by all individuals to whom coverage is offered;

"(D) from reinstating lapsed coverage; or

"(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

"(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

"(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

"(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

"(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

"(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

"(B) written notice of any change in its designation of its primary State; and

"(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

"(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

"(A) a member of the American Academy of Actuaries; or

"(B) a qualified loss reserve specialist.

"(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

"(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

"(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

"(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

"(j) STATE POWERS TO ENFORCE STATE LAWS.—

"(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

"(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

"(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

"(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

"(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

"SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

"A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

"SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

"(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless——

"(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

"(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External

Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

"(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a)(2)—

"(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

"(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

"(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

"(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

"(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

"(3) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

"(i) not be a related party (as defined in paragraph (7));

"(ii) not have a material familial, financial, or professional relationship with such a party; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

"(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

"(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

"(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

"(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

"(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other

health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

"(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

"(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

"(A) not exceed a reasonable level; and

"(B) not be contingent on the decision rendered by the reviewer.

"(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

"(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

"(B) The enrollee (or authorized representative).

"(C) The health care professional that provides the items or services involved in the denial.

"(D) The institution at which the items or services (or treatment) involved in the denial are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

"(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

"(8) DEFINITIONS.—For purposes of this subsection:

"(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

"(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

"SEC. 2799. ENFORCEMENT.

"(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

"(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

"(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

"(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

SEC. 5. SEVERABILITY.

If any provision of the Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the appli-

cation of the provisions of such to any other person or circumstance shall not be affected.

PURPOSE AND SUMMARY

The purpose of H.R. 2355, The Health Care Choice Act of 2005, is to allow for cooperative governing of individual health insurance coverage offered in interstate commerce.

BACKGROUND AND NEED FOR LEGISLATION

States currently impose a variety of different health insurance regulations and benefit mandates that result in premiums that vary widely among states. State policies, such as guaranteed issue, which requires insurers to accept anyone who applies regardless of health status; community rating, which forces insurers to charge every insured person the same premium regardless of age, gender, geographic location, or health status; and benefit mandates, largely dictate the cost of health insurance policy premiums. This can cause large discrepancies between states. Premiums for a health insurance policy for an individual in one state could in many cases be reduced annually by thousands of dollars if that individual were allowed to purchase health insurance in a different state.

A January 2005 study by the Council for Affordable Health Insurance (CAHI) concluded that there are currently 1,824 cumulative mandates on state health insurers. A 2004 study by eHealthInsurance found monthly premiums varied widely across different states. The eHealthInsurance study found that an insurance product for a family with a $2,000 family deductible and 20 percent coinsurance could be obtained in Kansas City, MO, for a monthly premium of $171.86, while that same coverage in Boston, MA, would cost $767.30 a month. Another study conducted by the Maine Heritage Policy Center found that even in neighboring states the costs of health insurance could vary widely. In their analysis of similar health insurance products offered by Anthem Blue Cross Blue Shield in both Maine and New Hampshire, it was found that individual health insurance plans for a 25-year-old male that included a $1,500 deductible with 20 percent co-insurance cost the Maine resident $495.89 a month, while a similar policy cost a 25-year-old New Hampshire resident just $127.65. That is a difference of $368.22 per month or $4,418.64 annually.

H.R. 2355 would allow an insurer to designate a primary state whose covered laws would apply to that individual health insurance coverage offered by the insurer. It would then allow the insurer to offer that coverage in any secondary state. H.R. 2355 would exempt a health insurer from the covered laws of the secondary state with respect to the regulation of its insurance products. It would also allow secondary states to require an insurer to (1) pay applicable premium and other taxes (including high risk pool assessments) that are levied on insurers under the laws of the state; (2) register with and designate the state insurance commissioner as its agent for the purposes of receiving service of legal documents or process; (3) submit to an examination of its financial condition by the state insurance commissioner if the insurance commissioner of the primary state has not done an examination within a period of time recommended by the National Association of Insurance Commissioners (NAIC) and in accordance with its ex-

aminer's handbook; (4) comply with a lawful order issued in a voluntary dissolution proceeding, or in a delinquency proceeding commenced by the State insurance commissioner where there has been a finding of financial impairment; (5) comply with an injunction issued by a court of competent jurisdiction, upon petition by the state insurance commissioner alleging that the issuer is in hazardous financial condition; (6) participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the state is required to belong; (7) comply with any state law regarding fraud and abuse (as defined in the bill), except that if the state seeks an injunction regarding fraudulent conduct, such an injunction must be obtained from a court of competent jurisdiction; and, (8) comply with any state law regarding unfair claims settlement practices (as defined in the bill).

In order to ensure that individuals buying coverage in a secondary state are aware that their policies are subject to the regulations of another state, H.R. 2355 requires a health insurer to inform purchasers in a secondary state that the policy is governed by the laws and regulations of the primary state. The bill would also prohibit insurers from offering health insurance in a secondary state unless that coverage is currently offered for sale in the primary state.

HEARINGS

The Subcommittee on Health held a hearing on H.R. 2355 on June 28, 2005. The Subcommittee received testimony from: Merrill Matthews, Ph.D., Director, Council for Affordable Health Insurance (CAHI); Robert Garcia de Posada, Chairman/President, The Latino Coalition; Dr. David Gratzer, Senior Fellow, the Manhattan Institute; Mike Kreidler, Washington State Insurance Commissioner, and, Hunter Limbaugh, Chair, Advocacy Committee, American Diabetes Association.

COMMITTEE CONSIDERATION

On Wednesday, July 20, 2005, the Full Committee met in open markup session and favorably ordered H.R. 2355, reported to the House, as amended, by a recorded vote of 24 yeas and 23 nays, a quorum being present.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on amendments offered to the measure, including the names of those Members voting for and against. A motion by Mr. Barton to order H.R. 2355 reported to the House, as amended, was agreed to by a record vote of 24 yeas and 23 nays.

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 39

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment to the Shadegg amendment by Mr. Waxman, No. 1a, to prohibit an insurer from offering health insurance coverage in a secondary state, unless that secondary state's applicable state authority has approved and certified that the coverage would not adversely affect the state's market for individual health insurance coverage or undermine the benefit and consumer protections in that state.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 21 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns		X		Mr. Towns			
Mr. Gillmor				Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield				Mr. Gordon	X		
Mr. Norwood		X		Mr. Rush			
Ms. Cubin		X		Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering				Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis			
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson				Mr. Inslee	X		
Mr. Rogers				Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan							
Mr. Murphy							
Mr. Burgess		X					
Ms. Blackburn		X					

7/20/2005

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 40

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Shadegg, No. 1, to (1) clarify that the rating and renewal laws of the secondary state do not apply; (2) to clarify that secondary states can enforce their own laws with regards to issues such as maintaining, establishing or contracting to establish an adequate network of health care providers such as doctors and hospitals; (3) to permit secondary states to requiring an insurer to submit data collection or quality assurance information in accordance with secondary state law; (4) to add several items to the definition of "unfair claims practices"; (5) to permit any secondary state to require insurance agents commissions or other compensation to be subject to the provisions of the laws of that state; (6) to clarify that secondary states may also seek to stop, in a court of law, an insurer that violates any of the laws that the secondary state is allowed to enforce; (7) and, to clarify that insurance companies continue to have a HIPAA group-to-individual portability obligation under H.R. 2355.

DISPOSITION: **AGREED TO**, by a roll call vote of 24 yeas to 17 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton	X			Mr. Dingell		X	
Mr. Hall	X			Mr. Waxman		X	
Mr. Bilirakis	X			Mr. Markey		X	
Mr. Upton	X			Mr. Boucher			
Mr. Stearns	X			Mr. Towns			
Mr. Gillmor	X			Mr. Pallone		X	
Mr. Deal	X			Mr. Brown		X	
Mr. Whitfield	X			Mr. Gordon		X	
Mr. Norwood	X			Mr. Rush			
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus	X			Mr. Stupak		X	
Ms. Wilson	X			Mr. Engel			
Mr. Shadegg	X			Mr. Wynn			
Mr. Pickering	X			Mr. Green		X	
Mr. Fossella				Mr. Strickland		X	
Mr. Blunt				Ms. DeGette		X	
Mr. Buyer				Ms. Capps		X	
Mr. Radanovich				Mr. Doyle			
Mr. Bass	X			Mr. Allen		X	
Mr. Pitts	X			Mr. Davis			
Ms. Bono	X			Ms. Schakowsky		X	
Mr. Walden	X			Ms. Solis		X	
Mr. Terry	X			Mr. Gonzalez			
Mr. Ferguson	X			Mr. Inslee		X	
Mr. Rogers	X			Ms. Baldwin		X	
Mr. Otter				Mr. Ross		X	
Ms. Myrick							
Mr. Sullivan	X						
Mr. Murphy	X						
Mr. Burgess	X						
Ms. Blackburn	X						

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 41

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Green, No. 2, to prohibit an insurer from offering health insurance coverage in a secondary state unless the legislature of that secondary state has enacted into law a waiver of applicable health insurance regulations.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 18 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey			
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns			
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield		X		Mr. Gordon	X		
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts		X		Mr. Davis			
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson				Mr. Inslee			
Mr. Rogers				Ms. Baldwin	X		
Mr. Otter		X		Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn							

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 42

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Brown, No. 3, to prohibit an insurer from offering health insurance coverage in a secondary state unless the issuer also offers health insurance coverage that meets the laws of, and is regulated by, that secondary state, and to require the issuer to attest to the applicable state authority of the secondary state that any premium differential between the offering in the primary state and the offering in the secondary state for the same coverage is attributable only to the actuarial differential between the two offerings.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns			
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood		X		Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts		X		Mr. Davis			
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee			
Mr. Rogers				Ms. Baldwin	X		
Mr. Otter		X		Mr. Ross	X		
Ms. Myrick							
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 43

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Ms. DeGette, No. 5, to prohibit an insurer from offering coverage in a secondary state unless it complies with all the laws of the secondary state regarding access to coverage and benefits for individuals with diabetes.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 23 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns			
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield		X		Mr. Gordon	X		
Mr. Norwood		X		Mr. Rush			
Ms. Cubin				Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson		X		Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick							
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 44

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Markey, No. 8, to require an insurer to (1) provide an explanation of any variance of the coverage from the mandated benefits, consumer protections, fraud protections, or premium protections that would be provided under the secondary state's laws and regulations that would not apply; (2) to require a health insurer to notify its policyholders each time it changes its primary state; and, (3) to require a health insurance issuer offering insurance in a secondary state to maintain a website containing copies of each insurance policy form sold in each secondary state, copies of (or links to) the insurance law and regulation used in the primary state, a discussion of the rating approach used by the insurer including whether the rating varies by duration and how it approaches closed blocks of business, and information on how the applicant or policy holder can file a complaint with the applicable state authority of the primary state.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns		X		Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson				Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts		X		Mr. Davis			
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez			
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin			
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 45

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Stupak, No. 9, to prohibit an insurer from offering coverage in a secondary state unless the coverage meets the requirements specified in H.R. 2259 (as introduced in the 109th Congress) relating to access to specialists, obstetrical and gynecological care, and pediatric care.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 16 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns		X		Mr. Towns			
Mr. Gillmor				Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush			
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak	X		
Ms. Wilson				Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts		X		Mr. Davis			
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis			
Mr. Terry		X		Mr. Gonzalez			
Mr. Ferguson		X		Mr. Inslee	X		
Mr. Rogers				Ms. Baldwin			
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn							

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 46

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Ms. Capps, No. 10, to prohibit an insurer from offering coverage in a secondary state unless the insurer carries out a policy of not refusing to provide coverage for women who have had breast cancer that has been in remission for 5 years.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 15 yeas to 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton				Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield				Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin		X		Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella				Mr. Strickland			
Mr. Blunt				Ms. DeGette			
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen			
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis			
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan							
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 47

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An en bloc amendment by Mr. Green, No. 11, to (1) prohibit an insurer from offering coverage in a secondary state unless the coverage meets the requirements specified in section 113 (relating to access to emergency care) of H.R. 2259 (as introduced in the 109th Congress); and, (2) to prohibit an insurer from offering coverage in a secondary state unless the issuer offers comprehensive coverage for routine immunizations for children.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield				Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin		X		Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 48

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Ms. Capps, No. 12, to prohibit an insurer from offering health insurance coverage in a secondary state, if an applicable state authority of a secondary state forwards a complaint regarding a claim for benefit or market conduct to the applicable state authority of the primary state, and the authority of the primary state does not commence an investigation within 10 days or reach a decision within a reasonable time (or not more than 90 days).

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield				Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 49

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Inslee, No. 13, to prohibit an insurer from offering coverage in a secondary state unless it complies with all the laws of the secondary state regarding access to coverage and benefits for individuals with pediatric cancer.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 24 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 50

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Ms. Baldwin, No. 14, to permit a secondary state to ban an insurer from selling coverage in a secondary state for a period up to 5 years, if the applicable state authority of the secondary state finds repeated violations of consumer protection laws by a health insurer licensed in another state.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 24 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman			
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel			
Mr. Shadegg		X		Mr. Wynn			
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 51

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Strickland, No. 15, to prohibit an insurer from offering coverage in a secondary state unless it complies with all the laws of the secondary state regarding access to coverage and benefits for pregnant women and children.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 20 yeas to 24 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns				Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown			
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

7/20/2005

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 52

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Allen, No. 16, to define the term 'covered laws' to not include any laws, rules, regulations, agreements, and orders governing coverage of, and access to, prescription drugs.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey	X		
Mr. Upton		X		Mr. Boucher			
Mr. Stearns		X		Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield		X		Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

7/20/2005

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 53

Bill: H.R. 2355, Health Care Choice Act of 2005.

AMENDMENT: An amendment by Mr. Strickland, No. 17, to prohibit an insurer from offering coverage in a secondary state unless it complies with all the laws of the secondary state regarding access to coverage and benefits for individuals with mental illness.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton		X		Mr. Dingell	X		
Mr. Hall		X		Mr. Waxman	X		
Mr. Bilirakis		X		Mr. Markey			
Mr. Upton		X		Mr. Boucher			
Mr. Stearns		X		Mr. Towns	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Deal		X		Mr. Brown	X		
Mr. Whitfield				Mr. Gordon			
Mr. Norwood				Mr. Rush	X		
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus		X		Mr. Stupak			
Ms. Wilson		X		Mr. Engel	X		
Mr. Shadegg		X		Mr. Wynn	X		
Mr. Pickering		X		Mr. Green	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. Allen	X		
Mr. Pitts				Mr. Davis	X		
Ms. Bono		X		Ms. Schakowsky	X		
Mr. Walden		X		Ms. Solis	X		
Mr. Terry		X		Mr. Gonzalez	X		
Mr. Ferguson	X			Mr. Inslee	X		
Mr. Rogers		X		Ms. Baldwin	X		
Mr. Otter				Mr. Ross	X		
Ms. Myrick		X					
Mr. Sullivan		X					
Mr. Murphy		X					
Mr. Burgess		X					
Ms. Blackburn		X					

7/20/2005

COMMITTEE ON ENERGY AND COMMERCE -- 109TH CONGRESS
ROLL CALL VOTE # 54

Bill: H.R. 2355, Health Care Choice Act of 2005.

MOTION: A motion by Mr. Barton to order H.R. 2355 reported to the House, amended.

DISPOSITION: **AGREED TO**, by a roll call vote of 24 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Barton	X			Mr. Dingell		X	
Mr. Hall	X			Mr. Waxman		X	
Mr. Bilirakis	X			Mr. Markey		X	
Mr. Upton	X			Mr. Boucher			
Mr. Stearns	X			Mr. Towns		X	
Mr. Gillmor	X			Mr. Pallone		X	
Mr. Deal	X			Mr. Brown		X	
Mr. Whitfield				Mr. Gordon			
Mr. Norwood				Mr. Rush		X	
Ms. Cubin				Ms. Eshoo			
Mr. Shimkus	X			Mr. Stupak			
Ms. Wilson	X			Mr. Engel		X	
Mr. Shadegg	X			Mr. Wynn		X	
Mr. Pickering	X			Mr. Green		X	
Mr. Fossella		X		Mr. Strickland		X	
Mr. Blunt	X			Ms. DeGette		X	
Mr. Buyer	X			Ms. Capps		X	
Mr. Radanovich	X			Mr. Doyle			
Mr. Bass	X			Mr. Allen		X	
Mr. Pitts				Mr. Davis		X	
Ms. Bono	X			Ms. Schakowsky		X	
Mr. Walden	X			Ms. Solis		X	
Mr. Terry	X			Mr. Gonzalez		X	
Mr. Ferguson		X		Mr. Inslee		X	
Mr. Rogers	X			Ms. Baldwin		X	
Mr. Otter				Mr. Ross		X	
Ms. Myrick	X						
Mr. Sullivan	X						
Mr. Murphy	X						
Mr. Burgess	X						
Ms. Blackburn	X						

7/20/2005

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a legislative hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 2355 is to lower health insurance premium costs and allow more people in the individual market to afford health insurance.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 2355, The Health Care Choice Act of 2005, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 12, 2005.

Hon. JOE BARTON,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2355, the Health Care Choice Act of 2005.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

DOUGLAS HOLTZ-EAKIN, *Director.*

Enclosure.

H.R. 2355—Health Care Choice Act of 2005

Summary: H.R. 2355 would amend the Public Health Service Act to permit an entity licensed by one state (the "primary" state) to offer health insurance coverage to individuals residing in that state, to also offer that health insurance coverage to individuals residing in a "secondary" state. Enacting H.R. 2355 would affect the federal budget in two ways: it would increase federal revenues from payroll and income taxes, and it would increase direct spending for

Medicaid. Those changes would begin in 2007, because the bill's provisions would take effect one year after enactment.

The increase in revenues would result largely from a reduction in the number of people who receive health insurance through employer-sponsored plans. That would reduce the share of compensation that is tax-advantaged (health insurance premiums) and increase the share that is taxable (wages and salaries). CBO estimates that enacting H.R. 2355 would increase federal revenues by $1.9 billion over the 2007–2010 period and $12.6 billion over the 2007–2015 period. Social Security payroll taxes, which are off-budget, account for about 30 percent of that amount.

The increase in direct spending would result from the enrollment in Medicaid of people who, under current law, would either be covered through an employer-sponsored plan or purchase an individual insurance policy. CBO estimates that enacting H.R. 2355 would increase federal direct spending for Medicaid by $160 million over the 2007–2010 period and $1.0 billion over the 2007–2015 period.

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 2355 would cause an increase in direct spending of greater than $5 billion in at least one of the 10-year periods between 2016 and 2055.

H.R. 2355 would preempt a broad range of state insurance laws that otherwise would apply to health insurance issuers that are licensed in one state and sell policies in another. The preemptions would limit the application of state laws, and thus would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). These preemptions of state regulatory authority would not result in additional spending by states. States may, however, lose some revenues as a result of lower collections for licensing fees, but those losses would be minimal. Consequently, CBO estimates that the cost of the mandates would be far below the threshold established in UMRA ($62 million in 2005, adjusted annually for inflation).

The bill would have other effects on state budgets—increasing spending for Medicaid, but also increasing revenues from some tax sources. CBO estimates that increased enrollment in Medicaid would result in additional spending by states of $760 million over the 2007–2015 period.

H.R. 2355 contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 2355 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN REVENUES										
Income and HI Payroll Taxes (on-budget)	0	70	170	370	640	980	1,340	1,520	1,620	1,710
Social Security Payroll Taxes (off-budget)	0	40	90	200	330	490	660	740	780	820
Total Changes in Revenues	0	110	260	570	970	1,470	2,000	2,260	2,400	2,530

	By fiscal year, in millions of dollars—									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	0	10	20	50	80	120	160	170	190	200
Estimated Outlays	0	10	20	50	80	120	160	170	190	200

Note.—HI = Hospital Insurance (Part A of Medicare).

Basis of estimate: The provisions of H.R. 2355 would take effect one year after enactment. For this estimate, CBO assumes that H.R. 2355 will be enacted in the fall of 2005. Therefore, the bill would affect spending and revenues beginning in fiscal year 2007. For simplicity, the following discussion of distributional effects (such as changes in premiums and in the number of people with health insurance coverage) assumes that the ultimate effects would be realized in the first year. The estimated budgetary effects, however, reflect CBO's expectation that it would take 5 to 10 years before the ultimate effects on health insurance markets of enacting the bill would be realized.

H.R. 2355 would amend the Public Health Service Act to permit an entity licensed by one state to offer health insurance coverage to individuals residing in that state, to also offer that health insurance coverage to individuals residing in a secondary state. The bill would permit such individual health insurance coverage [1] to be offered in a secondary state only if the primary state uses a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

The individual health insurance policies offered in a secondary state would be exempt from the laws and regulations of that state with respect to consumer protections, mandated coverage of services or benefits, and other rules affecting the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage. Those policies would be required to comply with the laws and regulations of the primary state, and the insurance issuer would be required to provide for a process for covered individuals to appeal coverage decisions to an independent medical reviewer.

Under current law, issuers of individual health insurance must be licensed in the state in which they offer such coverage, and the coverage must comply with the laws and regulations of that state. There is considerable variation across states in two areas that have a substantial effect on the price of individual health insurance:

- Mandates that require coverage of certain services or benefits, and
- Rules affecting the extent to which insurers may charge different prices for coverage offered to individuals expected to incur costs above or below the average.

In general, health insurance that includes coverage of mandated benefits will cost more than it would if those benefits were not required. In aggregate, this estimate assumes that if only those benefit mandates imposed by the states with the lowest-cost mandates were in effect in all states, the price of individual health insurance would be reduced by about 5 percent, on average.

[1] Individual health insurance coverage is offered to individuals, rather than through a group (such as an employer.) Such individual coverage may provide health insurance benefits to a single individual, or to several people (such as the members of a family).

Limiting the extent of variation in the prices charged to individuals expected to incur costs above or below the average tends to increase the price charged to individuals expected to have lower-than-average costs, while lowering the price for people expected to have higher-than-average costs. Such price compression also tends to increase the average price compared to an alternative in which variation in the prices charged more closely reflects the costs that individuals are expected to incur. That is because price compression makes coverage more affordable to people who expect to incur relatively high costs (so more of them purchase the coverage), whereas price compression increases the cost of coverage for people who would be expected to incur relatively low costs (so fewer of them purchase the coverage than if those individuals were charged prices that more closely reflect their expected cost).

Under H.R. 2355, CBO expects that individual health insurance would be offered across state lines to individuals in states with relatively expensive coverage mandates and rate-setting rules that permit relatively little variation in the prices an insurer may charge. The insurers offering those policies would be licensed in, and regulated by, states that do not have those characteristics.

For most people in a secondary state, the price of individual health insurance coverage offered by an insurer licensed in a primary state would be lower than the price under current law of individual coverage offered by an insurer licensed by their state. Conversely, individual health insurance coverage from out-of-state insurers either would not be offered to people expected to have relatively high health care costs, or it would be offered at a price that is higher than the price under current law of individual coverage offered by an insurer licensed by their state. The shift of individuals expected to have relatively low health care costs to out-of-state insurance coverage would increase the price of coverage offered by insurers licensed in-state, and could lend to erosion of the availability of such coverage by insurers located in secondary states.

Federal revenues

CBO estimates that enacting H.R. 2355 would increase federal tax revenues by $1.9 billion over the 2007–2010 period and $12.6 billion over the 2007–2015 period. (The bill would have no effect on revenues in 2006.) Social Security payroll taxes, which are off-budget, account for about 30 percent of those amounts. Those amounts are the net effect of increases in revenue resulting from a reduction in the number of people covered by employer-sponsored health insurance, increases in revenue from self-employed individuals who will purchase individual coverage under current law, and decreases in revenue from a rise in the number of self-employed individuals who purchase individual health insurance. The reduction in the number of people covered by employer-sponsored health insurance accounts for over 90 percent of the estimated change in federal tax revenues.

Some employers (especially smaller ones) would find it desirable to stop offering coverage to their employees because the insurance available in the individual market had become cheaper. In addition, some people with relatively low health care costs who, under current law, will obtain health insurance coverage through an employer, would choose instead to purchase individual health insur-

ance coverage from an out-of-state insurer. That would increase the per-person cost of the employer's group health insurance, and would result in additional employers deciding to drop the group coverage. Based on CBO's analysis of research on the responses of individuals and firms to changes in the price of health insurance, CBO estimates that, if the full effect of H.R. 2355 were realized immediately, about 1 million people—including both employees and covered dependents—would lose employer-sponsored health insurance coverage.

Under current law, the employer's share of premiums for employer-sponsored health insurance and most of the employee's share of those premiums are exempt from taxation. By reducing the number of people covered by employer-sponsored health insurance, H.R. 2355 would reduce the share of employees' compensation that is tax-advantaged (health insurance premiums) and would increase the share that is taxable (wages and salaries). CBO estimates that H.R. 2355 ultimately would reduce annual spending on employer-sponsored health insurance by $5 billion in 2006 dollars. (That change is less than 1 percent of total tax-advantaged spending on employer-sponsored health insurance in the United States.) Some of the resulting increase in taxable income from wages and salaries would be offset by higher itemized deductions for taxpayers who lose employer-sponsored health insurance, itemize their deductions, and spend more than 7.5 percent of their adjusted gross income on health care and health insurance.

The tax treatment of spending on individual health insurance coverage generally is less generous than for employer-sponsored coverage. However, spending on individual coverage by self-employed individuals is deductible. For the self-employed who will buy individual health insurance under current law, CBO estimates that H.R. 2355 ultimately would reduce spending on premiums by $600 million in 2006 dollars. Almost all of that reduction would result from a net reduction in premiums for self-employed people who continue to purchase individual insurance. (Some of those self-employed people who retain individual coverage would pay higher premiums.) Self-employed individuals who would drop coverage in response to higher premiums account for less than $50 million of that estimated change in spending on premiums.

H.R. 2355 would reduce the price of individual insurance for some self-employed people who are expected to incur relatively low health care costs, live in secondary states, and will be uninsured under current law. Ultimately, CBO estimates that some of those self-employed people would spend about $300 million (in 2006 dollars) to buy individual coverage under H.R. 2355.

Direct spending

H.R. 2355 would affect the number of people who enroll in Medicaid. Some people who would lose employer-sponsored health insurance would enroll in Medicaid, whereas others who, under current law, would be covered by Medicaid would instead enroll in health insurance. On net, CBO estimates that enacting H.R. 2355 would increase federal spending for Medicaid by $160 million over the 2007–2010 period and $1.0 billion over the 2007–2015 period.

Medicaid Spending for People Who Lose Private Coverage. About 25 percent of employees are in families with incomes under 200

percent of the Federal Poverty Line (FPL). Some of those people would potentially be eligible for Medicaid. CBO estimates that about 40 percent of people losing employer-sponsored coverage would have incomes under 200 percent of the FPL, about 25 percent of them would be eligible for Medicaid, and about 50 percent of them would enroll. CBO assumes that those people would be somewhat more costly than that average Medicaid-eligible individual, and that federal spending for Medicaid would increase by about $1.1 billion over the 2007–2015 period.

Medicaid Savings for People Who Gain Private Coverage. Of the people gaining employer-sponsored insurance under H.R. 2355, CBO estimates that approximately 10 percent would have incomes under 200 percent of the FPL. Of these, about one-half are children and one-half are adults. About one-third of those children would otherwise be enrolled in Medicaid, and about 8 percent of adults would otherwise be enrolled in Medicaid, CBO estimates. Assuming that those children and adults would be less costly than average, implementing H.R. 2355 would decrease federal Medicaid spending by about $100 million over the 2007–2015 period as a result of this shift to private health insurance coverage.

Effect of H.R. 2355 on the number of people with and without health insurance

CBO estimates that enacting H.R. 2355 would not have a substantial effect on the number of people who have health insurance coverage: compared to current law, there could be a small increase or decrease in the number of uninsured individuals. We estimate that about 1 million people would lose or drop employer-sponsored coverage. Many of those people would obtain individual health insurance coverage, as would many people who are uninsured under current law—resulting in a small net impact on the number of people with health insurance.

H.R. 2355 would reduce the price of individual health insurance coverage for people expected to have relatively low health care costs, while increasing the price of coverage for those expected to have relatively high health care costs. Therefore, CBO expects that there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage. Relatively healthy individuals are likely to be more price-sensitive than unhealthy individuals (and there are more relatively healthy people). As a result, CBO assumes that there would be a net increase in the total number of people with individual coverage. We expect that the magnitude of that increase would be roughly similar to the number of people who lost employer-sponsored coverage.

Estimated long-term effects on direct spending: Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 2355 would cause an increase in direct spending of greater than $5 billion in at least one of the 10-year periods between 2016 and 2055. Those costs would come from increased spending on Medicaid. We estimate that the increase in Medicaid spending would reach $200 million in 2015, and would continue to grow.

Estimated impact on state, local, and tribal governments: H.R. 2355 would preempt a broad range of insurance laws that other-

wise would apply to health insurance issuers that are licensed in one state (the primary state) and provide insurance coverage in another state (a secondary state). The preemption would limit the application of state laws, and thus would be intergovernmental mandates as defined in UMRA. Health insurance issuers would be exempt from laws in secondary states that establish coverage requirements or regulate insurance with the exception of requirements to register with the secondary state, submit to financial reviews under limited circumstances, participate in solvency associations, or comply with state laws governing fraud, abuse, or unfair claims settlements. The bill specifically would allow secondary states to collect premium taxes on policies sold within the state.

The preemption of state regulatory authority would impose no duty on states that would result in additional spending. States may, however, lose some revenues as a result of lower collections for licensing fees, but those loses would be minimal.

The bill would have other effects on state budgets—increasing spending for Medicaid, but also increasing revenues from state income taxes. CBO estimates that increased enrollment in Medicaid would result in additional spending by states of $760 million over the 2007–2015 period.

CBO estimates that the bill would have a positive impact on income tax collections by state governments, but the magnitude of that change is unclear. A decrease in the proportion of employer-sponsored insurance, which many states exempt from income for tax purposes, as part of total compensation packages would result in more compensation that is subject to state income tax collections. Because of uncertainty about the expected changes in coverage among individual states and different tax rates in each state, CBO cannot estimate the magnitude of the increase. State collections of premium taxes would also change, but because of uncertainty about shifts between types of insurance that are taxable and those that are exempt from taxes and because of different tax rates among the states, CBO cannot estimate either the direction or the magnitude of any net change in those collections.

Estimated impact on the private sector: H.R. 2355 contains no private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Tom Bradley, Shinobu Suzuki, and Jeanne De Sa. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen and David Auerbach.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 designates the title of the bill as the "Health Care Choice Act of 2005."

Section 2. Specification of constitutional authority for enactment of law

Section 2 specifies that this Act is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

Section 3. Findings

Section 3 establishes the findings for the legislation.

Section 4. Cooperative governing of individual health insurance coverage

Section 4(a) amends Title XXVII of the Public Health Service Act by adding at the end a new Part D entitled "Cooperative Governing of Individual Health Insurance Coverage" as set out below.

Section 2795. Definitions

The bill would add a new section 2795 to define the terms relating to the Cooperative Governing of Individual Health Insurance Coverage.

Section 2796. Application of law

New section 2796(a) states that the applicable laws of a primary state shall apply to individual health insurance coverage offered by a health insurer in the primary state, and in any secondary state. This provision would only apply if the coverage and the issuer comply with the conditions of this section with respect to the offering of coverage in any secondary state.

While H.R. 2355 would exempt a health insurer from the covered laws of the secondary state with respect to the regulation of its insurance products, new section 2796(b) would allow secondary states to require that primary state insurers do several things: This would include requiring the insurer to (1) pay applicable premium and other taxes (including high risk pool assessments) that are levied on insurers under the laws of the state; (2) register with and designate the state insurance commissioner as its agent for the

purposes of receiving service of legal documents or process; (3) submit to an examination of its financial condition by the state insurance commissioner if the insurance commissioner of the primary state has not done an examination within a period of time recommended by the National Association of Insurance Commissioners (NAIC) and in accordance with its examiners' handbook; (4) comply with a lawful order issued in a voluntary dissolution proceeding, or in a delinquency proceeding commenced by the state insurance commissioner where there has been a finding of financial impairment; (5) comply with an injunction issued by a court of competent jurisdiction, upon petition by the state insurance commissioner alleging that the issuer is in hazardous financial condition; (6) participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurer in the state is required to belong; (7) comply with any state law regarding fraud and abuse (as defined in the bill), except that if the state seeks an injunction regarding fraudulent conduct, such an injunction must be obtained from a court of competent jurisdiction; and, (8) comply with any state law regarding unfair claims settlement practices.

New section 2796(c) requires that a health insurer offering coverage from a primary state into any secondary state must provide a notice to beneficiaries that the coverage they are offering is governed by the laws and regulations of another state. The notice must also contain information that the policy may be less expensive than others offered because it is not subject to all of the insurance laws and regulations of the secondary state, including coverage of some services or benefits mandated by the laws of the secondary state.

New section 2796(d) prohibits the practice of re-underwriting an individual based on a health status-related factor. However, this section does not prohibit a health insurer from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742 of the Public Health Service Act. Further, it does not prohibit an insurer from (1) raising premium rates for all policy holders within a class based on claims experience; (2) changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer; (3) reinstating lapsed coverage; or, (4) retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

New section 2796(e) prohibits a health insurance issuer from offering individual health insurance coverage in a secondary state unless that coverage is currently offered for sale in the primary state.

New section 2796(f) provides that any state may require a person acting, or offering to act, as an agent or broker for a health insurer with respect to the offering of individual health insurance coverage obtain a license from that state, with commissions or other compensation subject to the provisions of the laws of that state, except that a state may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

New section 2796(g) requires health insurance issuers that issue coverage in both primary and secondary states to submit to the in-

surance commissioner of each state (1) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business); (2) written notice of any change in its designation of its primary state; and, (3) written notice from the issuer of the issuer's compliance with all the laws of the primary state. The issuer must also submit to any secondary state insurance commissioner a copy of the issuer's quarterly financial statement submitted to the primary state. This statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries, or a qualified loss reserve specialist.

New section 2796(h) states that nothing in this section shall be construed to affect the authority of Federal or state court from enjoining the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance, or the solicitation or sale of individual health insurance coverage that violates the requirements of section 2796(b)(1).

New section 2796(i) clarifies that states have the ability to enjoin conduct that violate that state's laws to which the health insurer is subject.

New section 2796(j) further clarifies that nothing in this legislation shall affect the authority of any state to make use of its powers to enforce the laws of the state to which the insurer is subject. However, any injunction regarding the conduct described in section 2796 (h) must be obtained from a Federal or state court of competent jurisdiction.

New section 2796(k) clarifies the states' authority to sue, and states that nothing shall affect the authority of any state to bring action in any Federal or State court.

New section 2796(l) clarifies that nothing in this section affects the applicability of state laws generally applicable to persons or corporations.

New section 2796(m) clarifies the guaranteed availability of coverage to Health Insurance Portability and Accountability Act of 1996 HIPAA eligible individuals. If a health insurer is offering coverage in a primary state that does not accommodate residents of secondary states or does not provide a working mechanism for residents of a secondary state, and the secondary state has not adopted a qualified high risk pool, the issuer shall comply with the guaranteed availability requirements for eligible individuals in section 2741 of the Public Health Service Act.

Section 2797. Primary state must meet Federal floor before issuer may sell into secondary states

New section 2797 clarifies that a health insurer may not offer, sell, or issue individual insurance coverage in a secondary state if the state insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurers.

Section 2798. Independent external appeals process.

New section 2798 prohibits a health insurance issuer from offering, selling, or issuing individual health insurance coverage in a secondary state unless both the secondary and primary state do not have legislation or regulations in place establishing an independent review process for individuals covered by individual health insurance, or in the lack of legislation or regulations, the issuer provides an independent review mechanism substantially identical to that prescribed in the "Health Carrier External Review Model Act" of the National Association of Insurance Commissioners. Under this mechanism, the review must be conducted by an independent medical reviewer, or panel of such reviewers, which meet several qualification requirements. In referring a denial of a claim for an independent medical review, the panel must include a physician (allopathic or osteopathic) or other health care professional, defined as someone that provides health care services to individual patients on average at least two days per week. They must also be appropriately credentialed or licensed in one or more states to deliver health care services; and typically treat the condition, make the diagnosis, or provide the type of treatment under review. In the case of an external review relating to a child, a reviewer must have expertise in pediatrics. Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section must be reasonable and not contingent on the decision. The reviewer must also not be directly involved in the case nor related to the parties involved.

Section 2799. Enforcement

New section 2799 establishes the enforcement mechanism of the legislation. With respect to specific individual health insurance coverage, the primary state for such coverage has sole jurisdiction to enforce the primary state's covered laws in the primary state and any secondary state. However, any secondary state has the authority to enforce its laws as set forth in the exceptions specified in the bill. In reviewing action initiated by the applicable secondary state authority, the court of competent jurisdiction shall apply the covered laws of the primary state. In the case of individual health insurance coverage offered in a secondary state that fails to comply with the covered laws of the primary state, the applicable state authority of the secondary state may notify the applicable state authority of the primary state.

Section 4(b) establishes the effective date of this Act to be one year after the date of enactment.

Section 4(c) requires the Comptroller General of the United States to study and report to the Congress annually at the end of each of the five years following the effective date of this Act. This report shall include the number of uninsured and under-insured individuals, the availability and cost of health insurance policies for individuals with pre-existing medical conditions, the availability and cost of health insurance policies, the elimination or reduction of different types of benefits under health insurance policies offered in different states, and cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

Section 5. Severability

Section 5 provides that if any provision of the Act or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this Act and the application of the provisions of such to any other person or circumstance shall not be affected.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

* * * * * * *

PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

SEC. 2795. DEFINITIONS.

In this part:

(1) PRIMARY STATE.—The term "primary State" means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

(2) SECONDARY STATE.—The term "secondary State" means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

(3) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term "individual health insurance coverage" means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

(5) APPLICABLE STATE AUTHORITY.—The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

(6) HAZARDOUS FINANCIAL CONDITION.—The term "hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(B) to pay other obligations in the normal course of business.

(7) COVERED LAWS.—

(A) IN GENERAL.—The term "covered laws" means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

(i) individual health insurance coverage issued by a health insurance issuer;

(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

(8) STATE.—The term "State" means only the 50 States and the District of Columbia.

(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term "unfair claims settlement practices" means only the following practices:

(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

(E) Refusing to pay claims without conducting a reasonable investigation.

(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

(10) FRAUD AND ABUSE.—The term "fraud and abuse" means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

(ii) The rating of an insurance policy or reinsurance contract.

(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

(iv) Premiums paid on an insurance policy or reinsurance contract.

(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

(vii) The financial condition of an insurer or reinsurer.

(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

(ix) The issuance of written evidence of insurance.

(x) The reinstatement of an insurance policy.

(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

SEC. 2796. APPLICATION OF LAW.

(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

(D) to comply with a lawful order issued—

(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

(ii) in a voluntary dissolution proceeding;

(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

"Notice

"This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any

exclusions, limitations, or conditions for such services or benefits.”.

(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

(B) from raising premium rates for all policy holders within a class based on claims experience;

(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

(i) are disclosed to the consumer in the insurance contract;

(ii) are based on specific wellness activities that are not applicable to all individuals; and

(iii) are not obtainable by all individuals to whom coverage is offered;

(D) from reinstating lapsed coverage; or

(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

(B) written notice of any change in its designation of its primary State; and

(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

(A) a member of the American Academy of Actuaries; or

(B) a qualified loss reserve specialist.

(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

(j) STATE POWERS TO ENFORCE STATE LAWS.—

(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering

coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless——

(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the "Health Carrier External Review Model Act" of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a)(2)—

(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(3) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

(i) not be a related party (as defined in paragraph (7));

(ii) not have a material familial, financial, or professional relationship with such a party; and

(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

(I) a non-affiliated individual is not reasonably available;

(II) the affiliated individual is not involved in the provision of items or services in the case under review;

(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(B) PRACTICING DEFINED.—For purposes of this paragraph, the term "practicing" means, with respect to an indi-

vidual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term "related party" means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

(B) The enrollee (or authorized representative).

(C) The health care professional that provides the items or services involved in the denial.

(D) The institution at which the items or services (or treatment) involved in the denial are provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

(8) DEFINITIONS.—For purposes of this subsection:

(A) ENROLLEE.—The term "enrollee" means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(B) HEALTH CARE PROFESSIONAL.—The term "health care professional" means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

SEC. 2799. ENFORCEMENT.

(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable

State authority of the secondary State may notify the applicable State authority of the primary State.

* * * * * * *

DISSENTING VIEWS OF REPRESENTATIVES DINGELL, WAXMAN, MARKEY, TOWNS, PALLONE, BROWN OF OHIO, GORDON, RUSH, ESHOO, STUPAK, ENGEL, WYNN, GENE GREEN OF TEXAS, STRICKLAND, DEGETTE, CAPPS, DOYLE, ALLEN, DAVIS, SCHAKOWSKY, SOLIS, GONZALEZ, INSLEE, BALDWIN, AND ROSS

H.R. 2355, the "Health Care Choice Act of 2005", is a serious threat to the individual health insurance market. This legislation would allow health insurance companies to be licensed in one State but then sell policies in any of the other 49 States without meeting the other State's consumer protection and insurance laws. Democrats strenuously objected to the legislation on a number of grounds and offered a series of amendments to correct its fundamental flaws.

Erosion of consumer protections

One of the most serious concerns with this legislation is that it would erode State consumer protections. States would be powerless to stop out-of-State insurance companies from selling coverage in their State which did not meet important State consumer and benefit protections. The legislation would undermine access to coverage and benefits for all consumers in the individual insurance market, and it would particularly hurt those with either existing medical needs, such as diabetics, cancer patients, pregnant women, and asthmatics, or those who develop a need for care. It would allow insurers to craft policies that serve only the healthy and avoid the sick either by excluding them outright from coverage or by pricing policies out of reach.

Numerous advocacy groups expressed concerns with H.R. 2355. The American Diabetes Association indicated: "The Association is concerned that by permitting insurers to be licensed in only one State, H.R. 2355 could cause the end of guaranteed-issue individual health insurance policies. Many people with diabetes rely on this type of policy when employers do not offer coverage, or when they are self-employed. Under these policies, consumers can never be turned down for health insurance coverage because of their health status. However, insurers in other States without these types of provisions can and usually do deny coverage to individuals with diabetes because of their pre-existing condition." [1]

In a letter to Representative Ted Strickland on H.R. 2355, the National Mental Health Association noted: "As you know, mental illnesses are the leading cause of disability and premature death in this country. Absent strong laws, discriminatory health-insurance practices that limit people's access to needed mental health

[1] June 24, 2005, letter from the American Diabetes Association to Representative John B. Shadegg.

care are widespread across the country. Enactment of this legislation would, in our view, be a setback for many people with mental illnesses who have won protections against such discrimination under State laws."[2]

The March of Dimes stated in testimony submitted to the Committee: "We have strong reservations about any proposal that would have the effect of putting at risk existing State coverage protections for pregnant women, infants and children. In our judgment, health insurers should not be allowed to sell coverage that excludes maternity and pediatric benefit protections approved by individual States. As illustrated by experience with maternity coverage in the individual insurance market, permitting exclusion of basic benefits can have the perverse result of making such benefits unaffordable or even unavailable."[3]

FamiliesUSA said: "Under the Health Care Choice Act, the rights and protections granted by many States will be undercut by a small number of States that have fewer—or no—protections."[4]

The National Partnership for Women and Families stated: "Insurers could select the State with the most lenient rules, and thereby circumvent State laws that protect consumers from unfair rates and rate hikes. These insurers would be exempt from critical consumer protections such as guaranteed coverage for individual with preexisting conditions, and required coverage of critical health benefits like mammography screenings and preventive care."[5]

In an effort to protect such individuals from harm under this legislation, Democrats offered a number of amendments that would have prohibited insurers from discriminating against these groups by excluding needed benefits or excluding them from coverage. Amendments were offered that would require insurers operating in a State to comply with that State's laws regarding access to coverage and benefits for individuals with diabetes, mental illness, pediatric cancer, and breast cancer, as well as to protect access and benefits for pregnant women and children. Amendments were also offered to protect State laws regarding access to prescription drug coverage and ensuring access to immunizations for children. Unfortunately, all of these amendments were defeated by the Majority.

Creation of a regulatory void; increase in fraud

The bill would strip regulatory authority from State insurance commissioners and prevent them from protecting residents of their State from unlicensed insurance companies. Section 2976 exempts a health insurer from complying with the covered laws of a State, such as consumer protections (i.e., access to emergency care, access to specialty care); benefit protections (i.e., diabetes coverage, maternity coverage, mental illness coverage, etc.); protections on premiums that can be charged; fraud and abuse laws (other than those that meet the narrow definition of fraud and abuse in the

[2] July 19, 2005, letter from Michael Faenza, National Mental Health Association, to Representative Ted Strickland.

[3] March of Dimes testimony submitted to the Committee on Energy and Commerce on H.R. 2355, June 28, 2005.

[4] Statement of Ron Pollack on H.R. 2355, the "Health Care Choice Act" for the record before the Committee on Energy and Commerce, June 28, 2005.

[5] Statement of the National Partnership of Women and Families on H.R. 2355, "National Health Care Advocate Opposes the Health Care Choice Act", June 28, 2005.

legislation); protections on access to coverage (i.e., guarantee issue and renewability, pre-existing condition protections); and other laws relating to insurance. For these laws, if a consumer had a problem with an unlicensed insurance policy, he or she would have to request that an out-of-State insurance commissioner take action, if that other State even had such protections. The insurance commissioner in the consumer's home State could not assist them.

Democrats offered a number of amendments to address this matter including: requiring the State insurance commissioners to certify that a policy licensed in another State would not cause harm to in-State consumers before such a policy could be sold in the State; allowing a State to enforce laws against an unlicensed insurance plan if the licensing State did not take action; and allowing a State to ban unlicensed bad actors from the State if the company was found to violate required laws. All of these amendments were defeated on near party-line votes.

The removal of regulatory oversight by this legislation will provide an environment ripe for unscrupulous actors to enter States and defraud consumers. Rather than simplify insurance regulation, this legislation would make it more complex because of the varying State and Federal standards that would apply to companies operating without being licensed in that State. The insurance laws of the State where the company is licensed would apply in most instances, but in some instances, such as in the case of certain fraud laws or external appeals, the State laws where the consumer lives would apply. In other cases, a Federal standard would apply. For example, there is a Federal standard for premium reclassifications, enforced by the licensing State, and a Federal standard for external appeals in instances where a State has no policy, enforced by that State.

Consumers would be required to sort through the different layers of regulation to determine to whom and where certain provisions applied and where they would go to enforce them. Today, consumers know to turn to their State office for assistance. Under this legislation, insurers could frequently change the State in which they are licensed. Consumers would have to canvass different States to find out where their policy was regulated at the time their problem occurred. Moreover, having to navigate a State insurance department hundreds of miles away in another State would create significant obstacles for consumers seeking to file complaints. Thus, the legislation establishes operational and practical barriers to filing and investigating complaints. The end result would likely be little oversight of insurers.

Moreover, State insurance departments are not equipped to serve residents of other States. In addition, State insurance departments do not have the resources to enforce or even monitor the conduct of insurance companies beyond its borders in a State where the insurer is not licensed. Under this legislation many consumer complaints or problems would go unaddressed and insurance companies would get away with bad practices with no consequences.

Insufficient consumer information

Adding to Democrats' concerns about fraud is the lack of information required to be provided to consumers about the policies li-

censed in another State they would be purchasing. The legislation, at section 2976(c), requires a brief notice to be provided to consumers indicating which State laws and regulations govern that policy. Democrats offered an amendment to improve the information provided to consumers by insurance companies in order to ensure that individuals were making an informed choice in purchasing a policy not licensed and regulated primarily by their State.

The amendment would have required insurers offering coverage in a State where they were not licensed to provide an explanation in easy to understand language of any variance of that policy from the mandated benefits, consumer protections, fraud protections, or premium protections that would be provided under the State's laws where the insurer is not licensed that would not apply. In addition, the amendment would have required that each time an insurer changed the State in which it was licensed, it must notify policy holders in writing of the change, and must include a summary of any material changes in law and regulation between the old and new primary jurisdiction as well as where to contact in the State where the plan is licensed to file a complaint.

Finally, the amendment would have required insurers to maintain a website (and provide information in each policy on how to access that site) containing: (1) copies of each insurance policy form sold in other States where it was not licensed; (2) copies of or links to the insurance law and regulation used in the State where it was licensed; (3) a discussion of the rating approach used by the licensing State including whether it varies by duration and how it approaches closed blocks of business; and (4) information on how the applicant or policy holder can file a complaint with the insurance regulator of the licensing State. This amendment, like all other Democratic amendments, was defeated.

Erosion of choice

H.R. 2355 is likely to lead to an erosion of choice for consumers as a result of a number of different factors. Insurance companies that currently offer more diverse policies including broader benefits and using less restrictive underwriting rules would find it difficult to continue offering that coverage as unlicensed out-of-State insurers moved into the market. These out-of-State policies would siphon off the healthy "good risks" into bare-bones policies, raising costs in more comprehensive health insurance policies. Ultimately, this would create a competitive disadvantage for any insurer that wished to (or was required by law to) meet more comprehensive State consumer protection standards. Consumers would find that policies that offered more comprehensive coverage and protections were no longer available or were unaffordable.

To address this matter, Democrats offered an amendment which would require any insurer wishing to offer a policy in a State where it was not licensed (and thus did not meet the States consumer protections, benefit protections, access, rate or other requirements) to also offer a second policy that did meet all of the State standards. This would ensure that consumers were, in fact, able to decide which type of policy best met their needs by guaranteeing

that both State-regulated and out-of-State unlicensed policies were offered to consumers. The amendment was defeated.

Evisceration of State legislative authority

Because this legislation would allow insurance companies to circumvent State laws by operating without a license in that State, it usurps the legislative authority of State legislatures. By allowing insurance companies to choose which State to be licensed in, this legislation would block the ability of State legislatures to enact laws that had stronger protections than those of another State. There would be no incentive for States to pass laws to protect residents if the insurer could just register elsewhere to avoid it. Rather than foster a climate of continual improvement in industry practices, it would encourage companies to choose as its primary State the one with the lowest standards. Democrats objected to the Federal Government supplanting State powers in this manner, particularly as the end result would be fewer protections for consumers. An amendment to return authority to State legislatures was also defeated.

Summary

In short, we have grave reservations about H.R. 2355 and its effect on millions of Americans who obtain their health coverage in their State's individual health insurance market. This bill, which was brought directly to the full Committee for consideration after only one hearing in the Subcommittee on Health, clearly would allow health insurance companies to avoid important State consumer protections and as such avoid serving individuals with medical needs. The legislation also sets up a confusing and inadequate regulatory structure that is certain to lead to an increase in fraudulent health insurance companies operating across the Nation. States, under the legislation, will have little ability to enforce their laws for their residents against plans operating without a license in that State. And, licensing States will not have the resources or potentially even the desire to assist out-of-State consumers experiencing problems with an out-of-State insurance company.

For all of these reasons, we strongly oppose this legislation.

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