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March 24, 2006

The Honorable Sam Brownback  
Hart Senate Building, Room 303  
Washington, D.C.

Dear Senator Brownback,

We are writing to urge you to oppose S. 1955 (Enzi, Wyo.) which would allow any HMO or insurer to ignore state benefit and service mandates and sell junk health insurance, often deceptively marketed as “association” or “small business” health plans. S. 1955 will allow insurance companies to override HMO Patients’ Bill of Rights laws passed in 41 states.

The current attack on states’ rights puts millions of patients, many of whom are business owners and self-employed, at risk in a move that amounts to national deregulation of health care.

Dana Christensen bought one of these “association health plan” policies and a special chemotherapy rider, yet was left with nearly half a million dollars in unpaid bills when her husband, Doug, died of bone cancer. These limited benefit health plans have very low maximum benefit payments and no out of pocket maximums for patients, despite fraudulent marketing that claims the plans are better than HMOs. On his death bed Doug urged Dana to divorce him to avoid liability for the bills, which she refused to do. Dana was ultimately able to hold her insurance company accountable and recover her costs under state anti-fraud laws that S. 1955 would put association health plans beyond the reach of.

Please see the attached Los Angeles Times exposé about the Christensens’ struggle. We provide the information below in hope that you will take an active role in organizing opposition to the measure among your colleagues in the Senate.

## **Pre-empts State Oversight & Allows Junk Health Insurance**

S. 1955 allows any insurer to avoid all state regulation as long as it “offers” at least one plan that provides benefits equal to those provided to state employees in one of the five most populous states. However, the bill allows an insurer to price that policy prohibitively high, thus rendering the apparent protection meaningless. Further, one of the five most populous states, Florida, recently approved a high-deductible, low-benefits health plan for state employees. Under S. 1955 any insurer could choose to offer the Florida low-benefits plan and thereby avoid all state regulation.

This massive exemption holds even if no plan that meets the minimal state requirements is actually sold and opens the door to total deregulation of the health insurance market.

In place of the careful review of patient needs that led to laws establishing basic requirements of health insurance coverage, Title II of S. 1955 allows the U.S. Secretary of Health and Human Services (HHS) to unilaterally override state law. This pre-emption applies to any insurer or HMO selling any type of policy, not just those sold as association plans.

S. 1955 could mean the loss of required benefits such as a woman's right to visit an OB/GYN, screenings for cervical and prostate cancers, newborn care, bans on "drive thru" deliveries, and guarantees of independent medical review if an insurer denies coverage for a medically necessary treatment.

Furthermore, Title III of the bill assigns a federal board pre-emption authority in a number of categories so broad and vaguely defined they could ultimately be used to override HMO Patients' Bill of Rights laws passed in 41 states. The types of protections at risk are requirements that insurers pay claims for covered benefits on time and abide by audits to ensure they are in compliance with the law.

The weak federal rules would likely not resemble the state laws they replaced. In fact, when replacing state law with federal rules, the federal "harmonizing" board appointed by the Secretary of HHS need only "consider...similar standards followed by a plurality of States."

## **Bad for Business - Ignores Affordability, Removes Choice**

The bill is marketed as a way to give small businesses more choice and buying power in the health care market. Instead it gives insurance companies even more control over price and treatment options. Business associations and insurance companies supporting the legislation are more interested in profitably selling insurance under the new rules and undercutting state regulation (which is currently strong and effective) than in making health care affordable.

S. 1955, despite the PR campaign on behalf of the bill, does nothing to control costs. In fact, the bill removes a state's right to require broad spreading of risk, which prevents "cherry-picking" of young, healthy policyholders. The bill allows insurers to sell inferior coverage at higher rates based on gender, age, geographic area and other factors disallowed by many states under community rating laws. S. 1955 does nothing to limit health insurer overhead and profits, the fastest growing component of health care costs.

Supporters claim that to make health care affordable we have to cut back on state-mandated benefits. However, instead of making health care affordable, these plans are likely to curb early diagnosis of disease by eliminating preventive treatments and exams. Delaying care makes treatment more costly to the policyholder and ultimately to taxpayers, who pick up the bill when individuals cannot pay outrageous out of pocket costs. The risk here is great given that unaffordable medical bills caused half of the bankruptcies filed last year in the U.S. Three-quarters of Americans that declared bankruptcy in 2005 had health insurance.

S. 1955 would tempt small business owners and other employers, even those already providing legitimate insurance, to cut health care costs by pushing employees into junk health plans. As Dana Christensen's experience shows, these plans would be marketed as comprehensive insurance at an affordable price. Policyholders won't find out the truth until it's too late.

Nothing in the bill requires insurers to sell more comprehensive plans. In any case, small employers won't be able to afford these false choices.

## **No Accountability**

Buyers of association plans have found themselves with unpaid medical bills from the tens of thousands to hundreds of thousands of dollars after falling seriously ill. State laws have given duped consumers some recourse. S. 1955 would significantly increase the number of Americans that could fall prey to these junk health plans and remove accountability under state law when they do.

Dana Christensen successfully sued under state fraud laws because her association plan misrepresented the extent to which benefits were covered. The policy provided no stop loss, which would have capped the amount that she was required to pay, and covered only \$200 a day for hospital costs and \$1,000 a day for chemotherapy even though

actual costs were ten times higher. The Christensens' insurance company, Mega Life and Health, is currently the subject of half a dozen civil lawsuits in state courts, as well as a multi-state market conduct examination. S. 1955 would remove the company's liability.

State and private actions are critical to ensure that this company is held accountable and that unpaid medical bills are provided for. However, under Title I, Section 103 (b) of S. 1955, existing association plans like Mega would be provided immunity from pending and future court cases. The bill also extends the ERISA exemption from state common law to any company that sells these bare bones plans. If the health plans inappropriately deny claims, policyholders will be unable to collect damages at all.

Ironically, S. 1955 expands insurers' right to sue over the new rules, allowing insurers to directly file challenges in the court of appeals when states attempt to enforce patient protections. The bill also provides expedited review provisions for insurers while taking those rights away from patients.

## **Creates an Epidemic of Underinsured**

S. 1955 would create a huge underinsurance problem in the treatment of diabetes, cancer and other severe chronic problems.

Supporters claim that S. 1955 will decrease the number of uninsured workers. But "insuring" more people in plans that don't provide real coverage is a sham. Health plans that don't meet the basic requirements of insurance – including preventive care or protection against financial catastrophe in the case of serious illness – mean that patients will not be able to afford care even though they're counted as insured.


As Dana Christensen's story shows, patients need more protections from junk health insurance, not less. We look forward to answering any questions you may have.

Sincerely,



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