National Partnership for Women & Families

S. 1955: Claims Don't Meet Reality

PREEMPTION

Claim: S. 1955 does not preempt state insurance laws.

Reality: The bill explicitly preempts state laws. It prevents states from enforcing laws they have passed to guarantee access to basic benefits, as well as to prevent insurers from charging unaffordable premiums to businesses that employ older or sicker workers, or women of childbearing age. The preemption of state law is explicitly written into the bill (pp. 47-48, pp. 56-57).

In addition, Title I (establishing federally certified "Small Business Health Plans" or AHPs), preempts state regulation of associations that are certified by the Department of Labor. It also preempts state laws that regulate the coverage offered through associations certified by the Department of Labor.

Claim: Title III of S. 1955 only preempts simple administrative functions and will not affect the states' ability to regulate insurance.

Reality: Title III of S. 1955 preempts the most basic tools of state insurance regulation including: requirements that insurers file policy forms specifying covered benefits; requirements that insurers file rates and an explanation of how rates are calculated; requirements that insurers actually pay claims for covered benefits accurately and on time; requirements that insurers conduct fair appeals when claims are denied; and requirements that insurers submit to periodic or targeted audits, called market conduct examinations, to ensure they are in compliance with laws and regulations.

New federal standards in all these areas would be established by an appointed board (that includes the insurance industry, but no consumer representation). The federal government would have no capacity to enforce these new standards. Instead, states would be allowed to enforce federal rules, but S. 1955 authorizes insurance companies to sue states in federal court if they do not like state enforcement.

Claim: There is no need to specifically protect existing state laws that cover classes of people, such as newborn children. S. 1955 does not touch those laws.

Reality: S. 1955 contains broad, general language that preempts state insurance laws and includes no provision explicitly retaining laws that require insurers to cover newborns, adopted children, disabled dependents, or other vulnerable populations. Whether or not the bill's broad preemption also invalidates these protections remains an open question and will be litigated in federal court. If supporters of S. 1955 believe that these state laws are not preempted by the bill, they should agree to clarifying amendments.

AFFORDABILITY AND CHOICE

Claim: S. 1955 gives business owners more affordable coverage options.

Reality: While small businesses want more affordable coverage, their employees deserve coverage that's worth something. No one would buy a car that's inexpensive because it's missing its engine, transmission, breaks, wheels, seats, and doors. A health insurance policy that leaves people uninsured for certain diseases, basic preventive care, or events like pregnancy, is not real coverage.

Claim: S. 1955 will make health care more affordable.

Reality: S. 1955 does nothing to address the problem of health care costs and their growth, which are the real challenges facing employers today. Instead, the bill allows insurers to charge higher premiums and impose higher cost-sharing on workers while leaving them uninsured for basic health needs and increasing the costs for those who need health care most to a prohibitive level. Instead of spending time on bills that shift costs to the most vulnerable Americans, we should be working toward solutions that actually contain health care costs and make health care more affordable.

Claim: S. 1955 provides more choices to businesses and does not take away any options that they currently have (including policies or benefits currently required under state law). S. 1955 provides businesses with three options: (1) a new low-cost option, (2) coverage that meets existing state laws, and (3) an "enhanced" option that matches the benefits and services of a plan offered to state employees in one of the five most populous states.

Reality: The bill guarantees only two bad choices, because no rational insurer will offer a plan that meets the states' benefits and service requirements (option 2) when offered the "choice" to offer policies completely free of these requirements. Thus, the remaining choices are: option 1, a low-cost, stripped-down policy designed by the insurer; and option 3, the so-called "enhanced" option that has no limits on cost-sharing, allowing for extremely high deductibles and coinsurance. While both options (1) and (3) may cost less up front, they leave people uninsured for major medical needs.

Claim: Business owners won't buy bad coverage for their employees. After all, they're buying the same coverage for their own families.

Reality: Small business owners and their workers can only buy what they can afford, and we know that they need help with the cost of meaningful health coverage. Unfortunately, S. 1955 does not give real help to small businesses. Instead, it promotes coverage that leaves business owners, their workers, and their families uninsured for certain diseases, basic preventive care, and events like pregnancy. This is hardly a solution for small businesses seeking affordable health care.

COMPARISON TO ORIGINAL AHP BILL

Claim: Unlike the original association health plan (AHP) proposal, this bill does not lead to adverse selection (a problem also known as "cherry picking," when young and healthy people are in one insurance pool, while older, sicker, and vulnerable people are in a separate pool that becomes unaffordable and over time disappears).

Reality: S. 1955 leads to adverse selection, but in different ways. Cherry picking can occur through discriminatory pricing of premiums, benefit design, and marketing practices. S. 1955 would allow insurers to engage in all three practices in ways that states currently prohibit or limit.

- Title I of the bill would segment insurance markets by allowing associations to create separate risk pools and cherry pick using all three methods and, in doing so, cover only healthy people. As a result, premiums in the rest of the state-based small group market will be substantially higher as healthy people are pulled out of that market by AHPs.

- Title II of the bill allows all insurers in the small group market to charge very different premiums to all small groups based on the health care needs of their workers and dependents and a host of other factors. In addition to the broad variation they can charge based on health status, the bill allows unlimited premium surcharges based on age, gender, geography, group size, and other factors.

- Title II also subjects group and individual health insurance to cherry picking through benefit design. The bill allows insurers to discourage coverage among sick individuals by offering policies that will only be attractive to those without immediate health care needs. While S. 1955 requires insurers to offer a choice of two policies, there is no requirement that one must be comprehensive. Even if comprehensive policies are offered, sicker individuals will gravitate toward the higher level of coverage, raising the average cost of that coverage beyond what is affordable. Over time, insurers cannot sustain policies offering greater coverage if only sick people buy them. The end result of S. 1955 is to shift costs to older and sicker people, resulting in many eventually losing coverage altogether.

Claim: S. 1955 gives associations the power to negotiate on behalf of and provide lower prices to small businesses.

Reality: Under the bill, associations evaluate each small business owner individually and charge different rates based on the make up of each business' employees. This is the same as the original AHP legislation. Associations could charge businesses with high medical needs significantly more than businesses with healthy employees. On top of this, associations can apply additional, unlimited premium surcharges to businesses based on age, gender, group size (with very small firms penalized the most), and other factors. Insurers can even "redline" premiums based on geographic neighborhoods. Proponents suggest that all small businesses will be charged the same low rate, but this obscures the fact that purchasing through an association does not make these businesses part of a big group. They are all judged and charged on their own.

ENFORCEMENT AND LAWSUITS AGAINST STATES

Claim: State regulatory oversight is preserved.

Reality: Enforcement is ultimately left to insurers and federal courts. S. 1955 creates three scenarios under which states regulation might take place, all of which compromise existing state authority. First, states might adopt new federal health insurance standards created by the bill. However, interpretation of the bill's standards is given exclusively to federal courts. State enforcement could be severely hampered if insurers challenge the state in federal court. Second, states can choose not to adopt new federal standards. S. 1955 allows insurance companies to sue so-called non-adopting states in federal court if these states try to enforce their existing laws. Third, states can choose not to adopt or enforce federal health insurance standards. However, S. 1955 gives **no** authority to the federal government to enforce new federal standards under Titles II and III. Nor does S. 1955 specify any federal sanctions (criminal or civil money penalties) for insurers that violate federal standards. Finally, while S. 1955 gives insurers the right to sue state regulators, it does not authorize injured consumers to go to federal court to seek enforcement of federal standards.

Claim: The ability of insurance companies to sue states in federal court is necessary to ensure enforcement of the bill.

Reality: Lawsuits against states are not necessary for enforcement. There are other enforcement models that could be adopted. For example, the Health Insurance Portability and Accountability Act (HIPAA) set a common federal floor of protection, but did not expose states to lawsuits as a method of enforcement. Instead, HIPAA required HHS to enforce the law (including imposition of civil money fines on violators), should states fail to act.

STUDIES CITED BY S. 1955 PROPONENTS

Claim: S. 1955 will decrease the number of uninsured Americans by 8 percent, according to a new study.

Reality: The recent Mercer study of S. 1955 does not mention the number of older, sicker and more vulnerable individuals who will be priced out of coverage due to the preemption of state laws that limit price discrimination. Nor does the study mention the millions of American who may become underinsured as a result of S. 1955's sweeping elimination of current state requirements that health insurance cover basic services (such as diabetes care, mental health care, home healthcare, hospital care following a mastectomy, rehabilitation care following accidents, prescription drugs, chemotherapy and others).

The study notes the bill's intent to allow insurance companies an unlimited ability to charge higher premiums to small businesses based on their employees' "age, gender, geographic area, family composition, group size and participation in wellness programs." Any gains in coverage among those who are young, healthy and male will be at the expense of those who need health coverage the most. Furthermore, newly covered individuals will remain at risk if they purchase inadequate coverage. Research shows medical bills are the leading cause of personal bankruptcy in the U.S. and many of these filers have health insurance.

Even if we accepted the Mercer study's estimate of the number of people who would gain coverage, it represents only 2.2 percent of the 45 million uninsured, while all Americans with state-regulated coverage would find their insurance less secure and more expensive when they need it most. The 8 percent figure cited by the bill's proponents is based on only a subset of the uninsured.

Claim: Premiums will drop by 12 percent under S. 1955, a savings of about $1000 per employee, according to a new study.

Reality: The actual study never claims that the bill saves $1000 per employee. The study presents its findings in the aggregate, which is highly deceptive and masks the real and negative impact the bill will have on those who need health care the most. The report itself admits that the "magnitude of decreases will vary significantly by state. The premium decreases will be modest in states that already have adopted rating regulations equal to or broader [less protective] than those contained in the proposed legislation." For states that have put in place stronger protections for those who are older, or facing chronic and complex health conditions, women of childbearing age, or very small businesses, premiums will go up. The primary savings from the bill accrue to small businesses that employ young and healthy workers and are located in states that historically have chosen to protect the most vulnerable but who won't be able to enforce those protections under this bill. While some in those states will see lower premiums, those who need health coverage the most will see their rates rise.

Claim: State mandated benefits add between 5 and 22 percent to the cost of health care, according to the GAO.

Reality: The 1996 GAO report, cited by S. 1955 supporters, looked at the impact of state benefit requirements on total claims, not on the impact the requirements have on premiums. In fact, the elimination of state benefit protections would lead to one-time savings of only 5 percent, according to the new Mercer study touted by the bill's sponsors. The bulk of those limited savings come from eliminating the more costly benefits, such as maternity and mental health benefits, which are fundamental to adequate insurance coverage. The relatively small potential savings gained from wiping out important consumer protections hardly make a dent in the double digit premium increases that have occurred year after year over the past half decade.

A 2003 GAO report includes comments from the NAIC that reflect more accurately the impact of wiping away state insurance laws:

> "NAIC agreed with our finding that the costs associated with benefit and provider mandates over what businesses would normally incur are estimated to be relatively small. NAIC also commented that mandates provide important protections for consumers and help prevent insurers from limiting their risk by denying coverage for certain benefits or limiting access to certain providers. NAIC further noted that such mandates have been carefully considered and adopted by state legislators. . . . Finally, NAIC highlighted the states' long-standing role in providing consumer protections for health insurance, such as small group market reforms for premium rates and eligibility practices. . . ."