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Tuesday, December 2, 2008

President-elect Barack Obama
Chicago Transition Office
Kluczynski Federal Building, 38th floor
230 S. Dearborn St.
Chicago, IL, 60604

Sen. Tom Daschle
Washington Transition Office
451 6th St. NW
Washington, DC 20001

Dear President-elect Barack Obama,

The public wants, and the economy needs, an overhaul of America's health care system that guarantees affordable and high quality health care to all Americans. Patients, employers and the American economy simply cannot continue to pay so much more for health care and receive so much less than anywhere else in the world. Your campaign commitments to make health care affordable and available must not be undermined by those in the medical-insurance complex who seek to preserve their cash cows at the expense of the public.

As Election Day polls showed, health care remains most Americans' leading economic worry. We offer the advice in this letter based on more than a decade of experience pioneering HMO reform and insurance regulation in California and across America. Consumer Watchdog's founder authored the landmark insurance reform initiative Proposition 103 in 1988, which has saved California drivers $62 billion over 20 years. Our nonprofit consumer group was also one of the earliest critics of HMO abuse and our advocacy led to strong HMO patients' rights laws in more than 44 states. Our website—www.consumerwatchdog.org—offers more about our work and an extensive living library of the policy and politics of health care reform.

This letter provides three critical recommendations for health care reform:

- The most efficient and cost-effective way to provide the "public option" to the private market that you promised during your campaign is to open Medicare to all Americans.
- Any new federal health care reforms should not preempt stronger state laws and regulations; they should follow the model of existing federal law, which promotes a state-federal partnership.
- You should reject proposals to require consumers to purchase insurance from private companies, as you did during the campaign. The individual mandate is highly unfair and unaffordable in practice.

The advent of your administration has already inspired change. Washington is noisy with health care proposals. The health insurance industry's hasty announcement that it would support health insurance for all Americans—but only if all Americans are required to buy insurance policies with no regulation of rates or practices—is a testament to the power of your own health care message. The critical missing component in your commendable health care proposal is significant controls on health care costs and tough regulatory restrictions on the health insurance industry. We believe the recommendations below, within the framework of your plan, provide that necessary reform.

1. "Public Option" to the Private Insurance Market

Private health insurance is grossly inefficient and increasingly unaffordable. As you said on the campaign trail, developing one public insurance pool that provides coverage for all Americans has clear benefits over the current fragmented market. A single risk pool offers: 1) Simplicity—which is critical to garnering public support; 2) The broadest and cheapest sharing of risk; and, 3) Elimination of private insurance company waste, fraud and profiteering.

Any reasonable voice in the American health care debate will now admit that every American should be assured health care. Studies show that uninsured and underinsured Americans delay care until conditions become chronic, when treatment is more expensive and good health outcomes less likely.[1] The Urban Institute reports that 22,000 uninsured adults die prematurely each year as a direct result of lacking access to care.[2]

The best way to limit the cost of health care is to spread the cost over all 300 million Americans. "Risk sharing" is the historical role of insurance: spreading risk across broad demographic groups in society—sick and well, old and young, rich and poor—so that no individual bears the high cost of an unforeseen illness or catastrophe. The private health insurance system has abandoned this desirable model. The interest groups that represent the medical-insurance complex, particularly the insurance companies, don't want every American in the same pool. They know that larger groups mean more purchasing power and leverage for patients, and they fear the greater scrutiny and regulation of their charges and practices that must accompany such a federal reform.

In your campaign, you often spoke of offering consumers a "public option" to the private insurance market. Though a single risk pool that eliminates private health insurers is the best

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[1] *See* John Z. Ayanian et al*., Unmet Health Needs of Uninsured Adults in the United States,* Journal of the American Medical Association*,* 284, no.16 (2000): 2061-9; Richard G. Roetzheim et al, *Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes*, American Journal of Public Health 90, no.11 (2000): 1746-54; Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition*, Journal of the American Medical Association*,* 297, no.10 (2007): 1073-84; John Canto et al., *Payer Status and the Utilization of Hospital Resources in Acute Myocardial Infarction*, Archives of Internal Medicine, 160, no.6 (2000): 817-23.

[2] Stan Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, The Urban Institute, (2008).

approach to ending the waste, delay and difficulties of the current profit-driven, private system, establishing a public alternative is a sensible first step.

Of course, making the public pool a matter of choice carries risks. Would Americans overwhelmingly vote for the Medicare pool? Would the public pool force private insurers to compete? Or would private insurers be able to suck up the good risks–the young and healthy–and leave the bad risks for the public pool?

A carefully constructed "public option" to private insurance would provide an antidote to the market consolidation that has propelled premium increases and administrative inefficiencies, shrunk coverage and degraded quality. However, it can only succeed if it:

- Provides all Americans access to the largest risk pool possible. Universal access to Medicare provides the best option.
- Includes new regulation of private insurers to level the playing field with the new public option–namely guaranteed issue, community rating, and a guaranteed base benefit.
- Allows states to go beyond federal regulatory minimums, as has been the traditional model under existing federal health care laws.

Opening Medicare. Medicare offers an established, low-overhead health care delivery system. Medicare also comes with established relationships with health care providers which, though undercut by low reimbursement rates and a prescription drug program hamstrung by drug manufacturers, provide a solid base for expansion. The purchasing power of the Medicare's vast enrollment can be tapped to decrease costs for all Americans. Indeed, immediately allowing any American to join a Medicare-operated prescription drug bulk purchasing pool would reduce medication costs by up to 60%.[3]

Competition with a low-overhead health insurance alternative provided by Medicare will force private insurers to prove that they can be cost-effective while offering similarly comprehensive coverage. Leveling the playing field between private insurers and the public option by requiring all players to guarantee access at a fair price would significantly reduce costs and increase access to health care.

Medicare, despite the fiscal problems in its program for the elderly, vastly outperforms the private market on the basis of access and cost. In 2006, Medicare spent about $10,200 per beneficiary for Part A (hospital, home health care and hospice), Part B (doctor and outpatient) and Part D prescription drug coverage combined.[4] In comparison, a private insurance policy premium for a 64-year-old can easily cost $12,000-$16,000 a year *not including copays and deductibles and after excluding coverage for those with even minor health problems*. Millions of pre-Medicare retirees are currently considered uninsurable by private insurers due to past or current health problems and are refused coverage at any cost. Medicare, on the other hand, provides more affordable coverage while providing care to all comers, including the sickest who are currently shunned by private insurers.

[3] Patented Medicine Prices Review Board, Annual Report (Ottawa, Ont. PMPRB, 2002), p. 23.
[4] *Medicare Costs per Beneficiary*, *1970-2017*, Centers for Medicare & Medicaid Services, 2008.

If Medicare also covered the young, the estimated cost per person would plummet. Children in federally subsidized plans cost about $2,300 a year (including dental), and younger adults fall in the middle.

34.7% of Americans (89 million people) under the age of 65 did not have insurance for some part of the year during 2006.[5] 14 million people currently purchase individual insurance policies. These 100 million Americans would benefit from a low-cost, high quality public option to the private market, no matter what the level of subsidy. Allowing employer groups to join the public purchasing pool over time would further maximize cost savings.

Opening the Federal Employee Health Benefits (FEHB) program. Without modification, FEHB is a poor choice for the public option. FEHB, which provides health insurance for all federal employees, is a captive of private insurers. Enrollees are provided a choice of high-quality insurance plans, but program costs are higher than need be due to insurer overhead and profit demands. Without significant program changes designed to reduce high costs attributable to private market waste, the promise that all Americans could have access to the same health care as elected officials would be out of reach for most.

FEHB could provide a low-overhead public option by adding a "self-insured" plan to the variety of private insurance companies that currently sell coverage to federal employees. California Public Employees Retirement System (CALPERS) provides a model for such an approach. Approximately one-fourth of the state workers and retirees in CALPERS are enrolled in a "self-insured" pool that bypasses high insurer overhead. Doctors and hospitals are paid directly and only a small percentage of program costs are spent to access physician and hospital networks organized by private insurers. Its disadvantage is that it is too small a pool to achieve maximum savings. Its current costs are also skewed higher by an older risk pool.

2. If Private Insurance Is Retained, States Must Continue to Regulate Health Insurance.

Any public option that falls short of eliminating the private insurance system will require private market reforms. Your plan rightly establishes a national insurance pool and bars private insurers from cherry picking the best risks by refusing to issue, or charging more for, coverage based on a person's health condition or age. This regulatory baseline is necessary to ensure that the private market is not allowed to leave only the sickest Americans to the public pool. Minimum guaranteed benefits are also necessary to ensure that private insurers do not undercut the public option by flooding the market with cheap policies that provide junk coverage.

However, any such federal regulation should be a minimum on patient protection and should not limit states from establishing additional regulation or from enforcing current laws. Establishing a national ceiling on regulation could mean the loss of HMO Patients' Bill of Rights laws passed in 44 states. Hardest hit under such an approach would be states like California, New York, Massachusetts, Texas and Virginia, which have adopted more protective standards than other states. These hard-fought state protections include a woman's right to visit an OB/GYN, screenings for cervical and prostate cancers, newborn care, mental health care, a right to a second

[5] *Wrong Direction: One Out of Three Americans Are Uninsured*, Families USA, Sept. 2007.

opinion, and guarantees of independent medical review if an insurer denies coverage for a medically necessary treatment.

Federal limitations on state regulation would also suffocate a state's ability to quickly respond to local threats to the health of residents. States have traditionally been the laboratories of innovation in health care policy, and should continue to be while new minimum federal standards provide a baseline for those states that have lagged behind in patient protection.

Existing federal health care laws provide a model for a federal-state partnership rather than federal pre-emption of more protective state standards and enforcement duties. Medicaid, HIPPA, COBRA, and the CHIPP program for children's health insurance all provide minimum federal standards and funding but allow states to fit the federal program to local needs, provide enforcement, and adopt regulations not envisioned by federal law. Additionally, states have regulatory and enforcement expertise based on decades of responsibility.

3. An "Individual Mandate" That Fails to Cap What Insurers Can Charge, Or Guarantee Comprehensive Benefits, is No Model For National Reform.

Opponents of sharing risk prefer to discuss health care reform in terms of sharing "responsibility." The "shared responsibility" approach touted by many insurers, employers, and some health care professionals focuses on *who* pays for health insurance, not how much it costs or what is covered. Individuals, employers and taxpayers all pay into the system. Their emphasis is not on the quality of coverage or the size of the risk pool, but on forcing the participants to pay—some with government subsidies, others without.

The central tenet of the "responsibility" approach requires individuals to purchase insurance coverage from private firms. Massachusetts has adopted this approach with mixed results. Governor Arnold Schwarzenegger tried the mandatory insurance approach in California but was foiled. Senator Hillary Clinton pinned her hopes on a version of the approach—and you properly criticized it during the primary elections. What killed the California legislation was that Schwarzenegger's plan would have required middle-class Californians to buy insurance *regardless of its cost, without regulating what insurers can charge for coverage, and with no guarantee that essential services would be covered.*

A mandatory purchase regime, particularly one without a true public option such as universal access to Medicare and without vigorous cost controls and guaranteed benefits, amounts only to a government-funded customer delivery system for the fragmented, wasteful private insurance market. It will not solve our nation's health care problems and will only encourage the industry to demand higher premiums and more taxpayer subsidies, while providing less health care.

Not surprisingly, the mandatory purchase of health insurance is unpopular with middle-class Americans when they are told they could have to pay some of the premium costs, according to a 2008 Campaign for Consumer Rights poll. Less than one in five voters (16%) support such a plan. Nearly two-thirds (63%) are opposed when told there is no limit on what insurers could charge. (The poll is available at: http://www.campaignforconsumerrights.org). According to a

recent poll by the Harvard School of Public Health and Massachusetts Blue Cross Blue Shield Foundation, only 37% of those impacted by Massachusetts' individual mandate support it.

Proponents of mandatory purchase say you cannot force insurers to sell policies to everyone if Americans are not required to buy them. Insurers claim that in the absence of such a mandate many people will wait until they become sick before they buy insurance. The truth is that people want to buy health insurance. The 89 million Americans that did not have health insurance for some part of 2006 are largely well, working families who flit in and out of coverage.[6] They are trying, but they just cannot afford to stay insured. The insurers and the medical complex are the chief problem, not the uninsured. Sick and well would join the new market if the product was affordable and those with trivial medical conditions were not excluded. Small employer groups of two or more have to be sold a policy today, regardless of employees' health condition. There is no gaming by employers and groups, as insurers repeatedly suggest would happen if the individual market followed the same rules.

Mandatory auto insurance has been in force in California for two decades and has failed miserably, though insurance regulation has improved its performance. When insurance was mandatory *without* premium regulation, 38% of drivers were uninsured. After passage of Proposition 103 and the creation of the strongest auto insurance regulation in the nation,[7] rates fell and so did the uninsured motorist rate. Still, today, about one in six drivers still has no auto insurance.

There is a big difference between universal participation in a cost-effective government program that protects us all (like Medicare) and being forced to buy an unregulated private product. A mandate may get us closer to universal insurance coverage, but we'll still be far from achieving universal health care. Why? Because the requirement will likely be for "affordable," bare-bones policies—the kind that comes with $5,000 deductibles, big co-pays and holes in coverage and benefits.

As states, like Massachusetts, have pushed for coverage expansions—while refusing to regulate health insurance overhead and profit, provide an option to the private market or guarantee minimum benefits—the inevitable outcome is a proliferation of bare-bones junk insurance. Under such an approach, patients might be technically "insured" but will not receive the coverage needed when they get sick:[8]

- Despite the state's stronger patient protections and lower percentage of uninsured, premium costs under the individual mandate continue to escalate. As a result, the board implementing the new law was forced to cut back on coverage benefits and shift toward high-deductible plans that reduced access to care.

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[6] *Wrong Direction: One Out of Three Americans Are Uninsured*, Families USA, Sept. 2007.
[7] Robert J. Hunter, *Why Not The Best? The Most Effective Auto Insurance Regulation in the Nation*, Consumer Federation of America, June 2001. *Available at:* www.consumerwatchdog.org/documents/7634.pdf
[8] *See* Robert Pear, *AARP Orders Investigation Concerning Its Marketing*, New York Times, November 18, 2008.

- Despite dramatic reductions in coverage, premiums continue to increase and fewer Massachusetts resident can afford health coverage. New enrollment numbers for the state-subsidized Commonwealth Care health plans show that the number of people newly enrolled fell from July to September.

Elements of the Massachusetts law, including guaranteed access, community rating and subsidies to lower-income communities, provide models for national reform. However, the "individual mandate" is not a national model in part because Massachusetts had relatively few uninsured to begin with, and most insurers in the state are nonprofits. Almost every other state is dominated by inefficient, for-profit insurers and currently lack adequate laws to protect patients against price discrimination.

Even with its initial advantages, Massachusetts' failure to establish a minimum benefit and regulate insurance premiums has already undercut coverage and increased both state and individual costs in subsidized plans, while reducing the rate of new coverage in unsubsidized mandatory purchases. Its example shows the pitfalls of declining to grapple straightforwardly with the role of the insurance industry in creating the U.S. health care crisis.

We look forward to working with the your transition team and administration.

Sincerely,

Harvey Rosenfield Jamie Court Jerry Flanagan Judy Dugan