Monday, February 1, 2010

President Barack Obama
The White House
Washington, DC, 20500

The Honorable Harry Reid
Senate Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

RE: If You Abandon Comprehensive Health Care Reform, Piecemeal Action Must Improve, Not Worsen, Americans' Lives

Dear President Obama, Speaker Pelosi and Senator Reid,

Passage of a broad health reform bill that aims toward universal health coverage is the only outcome that would make life more secure, and health care less expensive, for all Americans. But as political division tears apart Congress, there are growing calls for more piecemeal reforms. Even worse, we hear proposals in Washington to adopt, under the mantle of bipartisanship, ideas that are high on the wish list of the insurance and medical industries.

The industry's list is topped by so-called "national" insurance plans. The proposals, based on previously failed legislation by Sens. Michael Enzi and Olympia Snowe, would guarantee only minimal benefits and allow insurers to evade more protective state laws and state enforcement actions. Such plans cover patients only until they fall seriously ill, when they run into a wall of denial and delay, with no local or state enforcer to whom they can turn. Plans that make it harder for patients to obtain the care their doctors advise will not expand health coverage.

A second Trojan Horse is proposed changes in medical malpractice law that could prevent injured patients from holding even very bad doctors accountable. Patients would be barred from receiving reasonable compensation for damage to their health and finances by an incompetent doctor or negligent hospital, while medical providers would have less incentive to prevent medical errors before they happen.

We urge you to resist unbalanced "compromises." However, if no comprehensive bill can be passed, we ask instead that you craft individual reforms that would comprise a framework for fairness and improvement in health care, including robust state-level reforms.

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The Desirable Dozen

Here are a dozen key proposals, many of them part of current legislation, that would reform insurance markets and lead to coverage improvement in the states:

1. **No mandate**. Partial reforms must not require anyone to purchase private insurance. This may seem self-evident, but mandatory purchase in some form may rise again if necessary curbs on the private insurance industry, including underwriting reforms and bans on policy rescission, remain on the table, as they should.

2. **Expand Medicaid**. Cover families up to 150 percent of the poverty level, as called for in the House bill. Fund with expansion of the Medicare payroll tax to some or all investment earnings. Encourage states to further expand Medicaid coverage under waivers allowing them to use the federal funding to cover more people.

3. **Encourage broader state reform**. Allow states to seek even broader waivers to fund efforts toward universal coverage. Study reforms like those in Massachusetts to identify strengths (such as near universal care) and weaknesses (poor curbs on costs), and suggest changes to strengthen other states' efforts.

4. **Control premium increases.** Set guidelines for states to limit what insurers can charge in premiums and require prior justification of rate increases before they are imposed. Allow public intervention in rate approval to provide a check on political influence in the oversight process, as with California's Proposition 103 requirements for property and casualty insurance rates. For more information, go to:
http://www.consumerwatchdog.org/insurance/;jsessionid=INIYZHBEAZ2O2CQQPABCFEQ

5. **Equalize legal accountability**. Make all insurers, including those providing employer-based insurance, accountable in state courts. This reform would end a form of medical apartheid that allows government employees and individual purchasers to hold insurers legally accountable for wrongful denials of necessary care, but denies private employees that right. For more information, go to: http://www.consumerwatchdog.org/patients/EqualJusticeForPatients/

6. **No rescission, less underwriting.** Bar post-claims cancellation of insurance policies after people get sick in all cases except those of deliberate falsehood. This would end the combing of sick patients' long-ago medical records in search of unrelated reasons to cancel policies that are no longer profitable. A related reform would require full transparency by insurance companies of the medical conditions that lead to rejection of many applicants and steep premium increases for others. Also, bar insurers from basing rates or rejections on any non-recurred condition after 5 years (not the current 10 years).

7. **Out of pocket limits**. Cap what patients must pay out of pocket when they get sick; bar "junk insurance" policies that carry no out of pocket limits and lead to loss of care and bankruptcy for patients who fall seriously ill. The potential sale of such junk insurance across state lines is among the risks of approving so-called national policies.

8. **Preserve state requirements.** Ban federal preemption of stronger state benefit laws like those of New York and California. Clarify that insurers must answer to state regulators for all benefit

disputes, so that patients have one clear path for complaint resolution.

9. **Enhance community rating**. Reduce the premium cost disparities among broad classes of people—older and younger, male and female, urban and rural. This would reduce the steep premium increases imposed as even longtime and healthy customers age, often leading to loss of health insurance. Limit health insurance premium range to no more than 5:1 for all reasons combined, and forbid gender rating.

10. **Reduce cherry-picking.** Insurers try to market their policies to the youngest and healthiest customers, and shed expensive claimants. To keep the competitive ground level, require annual reporting of insurers' member populations by age, health status and claims. Require insurers with younger, healthier purchasers to contribute to a fund that would compensate plans accepting older or sicker purchasers with higher medical expenses.

11. **No policy caps**. Bar lifetime and annual payment limits. The intent of insurance is to use a broad pool of policyholders to pay for the care of the relatively few who fall seriously ill in any one year. Yes, reforms should reduce incentives for doctors to overtreat by clarifying best practices. But at the same time the few people in dire need of expensive but effective treatment should not hit a wall of policy caps, either annual or lifetime.

12. **Make Medicare Advantage compete**. Grant Medicare Advantage contracts through regional competitive bidding, as originally envisioned. Medicare Advantage programs were invented in the 1980s as a way to reduce Medicare spending through managed care, competitive bidding and the free market. Intense lobbying by the health insurance industry undermined and finally eliminated price competition, resulting in a guaranteed overpayment to Medicare Advantage plans. The cost burden of this unjustified overpayment falls on taxpayers and patients in traditional Medicare. Split savings between Medicare and state reform plans.

These are not the only effective or helpful possible reforms. But together they offer a framework on which the states can act, with a baseline of market reform, active encouragement and some financial assistance from the federal government.

Sincerely,

Jamie Court Judy Dugan Jerry Flanagan Carmen Balber

cc: Members of the U.S. Congress