



November 16, 2009

Senate Majority Leader Harry Reid
United States Senate
Hart Senate Office Building, Room 522
Washington, DC 20510

RE: Don't Let Health Reform Gut State Health Laws

Dear Senator Reid:

We are writing to urge you to oppose provisions contained in the Senate Finance health care reform legislation that would pre-empt state health benefit mandate laws, replace them with less protective federal "minimum" standards and undermine state enforcement efforts. Under the terms of the Finance bill, millions of Americans could lose insurance coverage of important medical treatments and services such as AIDS/HIV testing, reconstructive surgery, home health care services, and child delivery and mastectomy minimum hospital stays.

Instead, the final Senate health reform bill should be modeled on existing federal health care laws which provide for a federal-state partnership rather than federal pre-emption of more protective state standards. Minimum federal standards should set a floor, not a ceiling, on state health care protections.

Seventeen states with more than fifty health benefit mandates in state law have the most to lose under pre-emption provisions of the Finance legislation. (See Chart 1 below.) Those states, including your home state of Nevada, represent 54% of the U.S. population: California, Colorado, Connecticut, Florida, Louisiana, Massachusetts, Maryland, Maine, Minnesota, New Mexico, Nevada, New York, Pennsylvania, Rhode Island, Texas, Virginia and Washington.

Under the provisions of the Finance bill, approximately 87 million Americans, who are currently enrolled in individual policies or receive health coverage from non-self insured employers, are at risk of being sold junk insurance that does not protect them when they get sick.

The Senate Finance committee bill would allow health insurers to sell "Nationwide" insurance policies that override state health benefit mandates approved by state legislatures with new, less protective provisions designed by a private organization, the National Association of Insurance Commissioners (NAIC). In developing the federal guidelines, the NAIC, heavily influenced by health insurance companies, would merely take "into account how each benefit is offered in a majority of states." Therefore, many treatment mandates appearing in fewer than 26 states would apparently not be covered under the Nationwide policies. (See Chart 2 below). Patients purchasing Nationwide policies would likely be unaware that their insurance was riddled with holes until they needed to use it.

Another provision of the Finance bill would allow insurers to form "interstate compacts" to sell policies across state lines while being subject only to the health benefit mandate laws of the state in which the insurance policy is "written or issued." Insurers would certainly choose to

be regulated by the weakest state. A similar provision was inserted in the U.S. House of Representative bill, H.R. 3962, shortly before it was voted on.

Provisions in the bill allowing states to “opt-out” of permitting Nationwide plans and “opt-in” to interstate compacts offer little protection. The 1,000 health insurance lobbyists estimated to be working the federal health reform bill, and the industry’s unlimited capacity to buy votes with campaign contributions, would be marshaled to advance the insurers’ interest at the state level.

Insurers claim that eliminating these patient protections is essential to reducing costs in the system. However, the data suggests otherwise. The Congressional Budget Office found that five of the state coverage mandates considered by insurers to be the most expensive have in fact only a marginal impact on premiums, ranging from 0.28 to 1.15 percent.¹ Massachusetts, which has among the strongest state mandates, calculated the total net cost on premiums to be only 3 percent to 4 percent.² Compare that to the 25 percent to 27 percent of premiums that goes to insurer overhead and profit.³ What insurers are not saying is that state coverage mandates that ensure access to basic health care needs are necessary to prevent and manage disease, or to treat it before it becomes severe and more expensive to care for.

Both the “Nationwide plans” and “state compact” pre-emption scenarios are similar to a failed 2006 bill, S.1955, by Sen. Enzi (R-Wyo.) who championed President Bush’s health reform agenda. Pre-emption of state health care laws was a bad idea in 2006, and it is a bad idea now.

States have traditionally been the laboratories of innovation in health care and insurance reform. Instead of taking away regulatory power from the states, Congress should recognize and promote successful state insurance regulation like California’s landmark insurance regulation initiative, Proposition 103. Proposition 103 has resulted in \$61.8 billion in savings to California automobile drivers. Read more about that successful state reform and its application to health insurance at: <http://www.consumerwatchdog.org/patients/articles/?storyId=30813>.

Sincerely,



Jerry Flanagan

cc: President Obama
U.S. Senate
U.S. House of Representatives

¹ Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* 21 (January 2000).

² Massachusetts Division of Health Care Finance and Policy, *Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature* 4 (July 2008).

³ Cathy Schoen, et al., “Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance,” *Health Affairs*, Volume 27, No. 3, May/June 2008, p. 647. A public option based on Medicare is expected to provide premiums more than 30 percent lower than private market premiums as a result, in part, of Medicare’s lower administrative costs. Karen Davis et. al., “The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings,” CommonWealth Fund Issue Brief, p. 2 (May 2008).

Chart 1 – States With the Most To Lose Under Pre-Emption

State	Total Mandates	State	Total Mandates
AK	32	MT	40
AL	21	NC	50
AR	43	ND	34
AZ	47	NE	32
CA	56	NH	44
CO	51	NJ	45
CT	54	NM	57
DC	27	NV	52
DE	28	NY	51
FL	52	OH	29
GA	45	OK	38
HI	24	OR	40
IA	26	PA	52
ID	13	RI	70
IL	47	SC	29
IN	34	SD	30
KS	39	TN	41
KY	41	TX	57
LA	50	UT	23
MA	52	VA	60
MD	66	VT	30
ME	55	WA	57
MI	25	WI	34
MN	68	WV	38
MO	41	WY	34
MS	29		

Source: Craig Bruce & J.P. Wieske, “Health Insurance Mandates in the States 2009,” Council for Affordable Health Insurance,” page 4 (2009).

Chart 2 - Mandates At Risk Under “Nationwide Plans” – Mandates Appearing in Less than 26 States

Benefit Mandate	Number of States
AIDS/HIV Testing/Vaccine	9
Alzheimers	2
Ambulatory Surgery	11
Ambulance/Transportation Services	11
Ambulatory Cancer Treatment	3
Anti-psychotic Drugs	7
Asthma Education	2
Autism	23
Bilateral Cochlear Implant	3
Blood Lead Poisoning Screening	9
Blood Products	3
Bone Marrow Transplant	11
Bones Mass Measurement	16
Cancer Pain Medication	5
Chemotherapy	7
Chlamydia	5
Cleft Palate	15
Clinical Trial	23
Congenital Bleeding Disorder	3
Early Intervention Service	6
Hearing Aids for Minor	14
Home Health Care	20
Hospice Care	12
HPV Vaccine	13
Kidney Disease	4
Long Term Care	5
Lyme Disease	5
Mastectomy	23
Mastectomy Minimum Stay	25
Maternity	23
Minimum Hysterectomy Stay	2
Morbid Obesity Treatment	6
Newborn Hearing Screening	18
Newborn Sickle Cell Testing	4
Orthotic and/or Prosthetics	16
Other Infertility Service	9
Ovarian Cancer Screening	7
Pediatric Asthma Education/Self-Mgmt.	2
Port Wine Stain Elimination	2
Prescription Drugs	3
Psychotropic Drugs	3
Reconstructive Surgery	2
Rehabilitative Service	7
Second Surgical Opinion	11
Smoking Cessation	5
Telemedicine	8
Testicular Cancer	3
TMJ Disorders	20
Wilms Tumor	2

Source: Craig Bruce & J.P. Wieske, “Health Insurance Mandates in the States 2009,” Council for Affordable Health Insurance,” page 5-6 (2009).

The Council for Affordable Health Insurance report is available here:
<http://www.ncsl.org/IssuesResearch/Health/ManagedCareStateLaws/tabid/14320/Default.aspx#mandates>