



S. 1955 – Uninsuring the Insured

Contact: Jerry Flanagan, Carmen Balber, Dana Christensen – FTCR: (415) 497-1710 - cell
Jillian Aldebrom, Public Citizen: (202) 454-5135

Health insurance is not insurance if it doesn't protect us from financial disaster or provide basic medical coverage when we get sick.

S. 1955, the brainchild of Sen. Michael Enzi (R-Wyo.), is touted as a way to insure more people but would, in fact, erode existing coverage for those who already have health insurance and create more barriers to getting coverage for the 46 million Americans currently uninsured. S. 1955 will allow any HMO or insurer to ignore state patient protections, courts and regulators and sell junk health insurance. The bill is fundamentally flawed. Amendments to S. 1955 tinkering with benefit or rate rules will still result in a net loss for American consumers.

[View an exposé on the bill by the national PBS program NOW, "Payment Due," complete with a photo essay, "Barely Covered," and an analysis of the bill at:
http://www.pbs.org/now/politics/050506_primer.html]

This attack on states' rights puts millions of consumers, many of whom are business owners and self-employed, at risk in a move that amounts to national deregulation of health care. Under S. 1955, insurers could circumvent state health insurance regulation to price employers and families out of their current health plans and replace them with inferior policies. Insurance companies would be allowed to sell this junk insurance to individuals and employers at higher rates based on gender, age and where they live, even though this type of discrimination is currently illegal in many states.

Title III of the bill assigns a federal board pre-emption authority in a number of categories so broad and vaguely defined that they could ultimately be used to override HMO state Patients' Bill of Rights laws passed in 41 states. Title II of the legislation effectively deregulates the entire health insurance and HMO market.

Dana Christensen, who is featured in the NOW exposé, bought one of these policies, often referred to as "association health plans" or "small business health plans," and purchased a special chemotherapy rider. Dana was left with \$450,000 in unpaid bills when her husband, Doug, died of bone cancer. 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; S. 1955 would put her plan beyond the reach of this consumer protection statute.

Although Dana and Doug were told otherwise when they purchased the policy, when it came time to pay medical bills, the Christensens' realized that their policy had very limited maximum benefit ceilings and no cap on how much Doug and Dana had to pay out of pocket. The Christensens' policy covered only \$200 a day for hospital costs and \$1,000 a day for chemotherapy – even though actual costs were 20 times higher. In the end, the Christensens' insurer paid less than 18 percent of their medical costs.

Under S. 1955, insurers would have the right to offer these plans in every state at whatever price they chose. The danger is that these new federal association plans could become the most prevalent form of individual insurance.

Pre-empts State Patients' Bill of Rights Laws and Deregulates Health Insurance

S. 1955 allows a health insurer to avoid all state regulation so 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. But because the bill allows an insurer to price that policy prohibitively high, the requirement fails to offer consumers any real protection. Moreover, 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 in order to circumvent state regulation.

To add insult to injury, a health insurer retains its sweeping exemption from state regulation remains even if it fails to sell a single plan that meets the minimal state requirements. What the provision amounts to, therefore, is a giant skeleton key for health insurers that opens the door to total deregulation of the market.

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

The types of protections at risk are state HMO and insurer Patients' Bill of Rights laws passed in 41 states including requirements that insurers pay claims for covered benefits on time and abide by audits to ensure they are in compliance with the law. S. 1955 could mean the loss of required benefits such as coverage for a woman's visit to an OB/GYN and screenings for cervical and prostate cancers, bans on “drive thru” deliveries, and guarantees of independent medical review if an insurer denies coverage for a medically necessary treatment.

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” (Title III, Section 2932 (c)(2)(B)).

Bad for Business - Ignores Affordability, Removes Choice

S. 1955 purports to create a buying pool that would give small businesses more choice and purchasing power in the health care market. Instead, however, it would give health insurers still greater 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 in many states) than in making health care affordable.

By removing a state's right to require broad spreading of risk, which prevents "cherry-picking" of young, healthy policyholders, S. 1955 eliminates rather than enforces price controls. S. 1955 fails to limit health insurer overhead and profits, the fastest growing component of health care costs. And it 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.

Supporters claim that to make health care affordable we have to cut back on state-mandated benefits. But because the health insurance plans allowed by S. 1955 will likely exclude preventive treatments and exams, they would prevent early diagnosis of disease. 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 personal bankruptcies filed last year in the U.S. Three-quarters of Americans who 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 their 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 them even if they are offered.

No Accountability - S. 1955 Strips Individuals' Rights To Sue Insurers

Buyers of association plans have found themselves with unpaid medical bills following a serious illness that reach hundreds of thousands of dollars. State laws have permitted duped consumers some recourse. S. 1955 would significantly increase the number of Americans who could fall prey to these junk health plans and have nowhere to turn.

Ironically, at the same time as S. 1955 forecloses consumer access to judicial recourse, it expands the right of health insurers to sue over the new rules, allowing them to go directly to the court of appeals to challenge a state attempt to enforce patient protections.

Dana Christensen successfully sued her health insurer under state fraud laws because her association plan misrepresented the extent to which benefits were covered. 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.

Currently, individuals who buy health insurance on their own from associations like the National Association for the Self Employed have the right to sue under state common law if they are injured by their insurer. On the other hand, consumers who receive health coverage through a private employer cannot hold their HMO or insurer legally accountable for improper denials of treatment or improper processing of a claim. This is due to the U.S. Supreme Court's decision in *Pilot Life Insurance v. Dedeaux* 481 U.S. 44 (1987), which found that: "State common law

causes of action arising from the improper processing of a claim are preempted” by ERISA, which is federal law.

Title I, Section 101 (a) of S.1955 would amend ERISA to include health insurance policies purchased by individuals from associations, thereby depriving individuals who buy these plans of access to a remedy under state common law. S. 1955 would also revoke the savings clause acknowledgement of a state’s right to regulate health insurers and require coverage of basic benefits.

Under ERISA and the Pilot Life decision, lawsuits are removed to federal court where victims can only recover the cost of the procedure or service denied in the first place – no damages or penalties are allowed. The patient must prove the denial was arbitrary and capricious. If the patient dies before receiving the treatment, the insurer pays nothing. The prevailing party does not necessarily recover attorney fees.

Without the threat of legal accountability, HMOs and insurers are free to deny access to care for those with private employer-based coverage. The impact has been devastating for patients’ health – see <http://www.makingakilling.org/chapter5.html>

Creates an Epidemic of Underinsured – More Barriers for the Uninsured

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

Supporters claim that S. 1955 would decrease the number of uninsured workers. But insuring more people in plans that don't provide real coverage is not insurance. Encouraging employers to drop good plans for junk plans is even worse. Insurance that doesn't meet basic health care needs means patients will not be able to afford care even though they're counted as insured.