May 8, 2009

President Barack Obama
Senator Edward Kennedy
Senator Max Baucus

Dear Mr. President and Sens. Kennedy and Baucus,

When the chief executive of the HMO lobby calls for a "complete overhaul of the rules" governing the health insurance industry, as top lobbyist Karen Ignagni did on Tuesday in the U.S. Senate Finance Committee, the reaction of most Americans is to run for cover.

The insurers are hoping to kill or gut the "public option" to private insurance coverage—the reform that the industry hates most because of its value to consumers—in exchange for new federal regulation of the industry. This is a false compromise. Federal regulation would be a boon to the industry, and has long been on the insurers' wish list because over the last decade almost every state has developed comprehensive patient protection laws that the insurers loathe.

Insurers would like to take advantage of the moment of reform to eviscerate HMO Patients' Bill of Rights laws enacted in nearly every state and replace them with window-dressing federal rules that clear the way for the worst of the industry's practices. This is not a new campaign. It was nearly enacted in 2006. Consumer Watchdog and other consumer organizations fought to a narrow defeat of Senator Mike Enzi's (R-WY) bill, S. 1955, which would have enacted President Bush's promised "Association Health Plans" expansion.

The Enzi bill was described in terms similar to those used by Ignagni, CEO of America's Health Insurance Plans, to describe the federal "standards" the insurers are willing to accept if the public option is taken off the table. Such "harmonization" at the federal level of "inconsistent" state laws will result in lowest common denominator regulations enforced from an impossible distance. Done the industry's desired way, an individual's state common law right to sue an insurer for even the most egregious misbehavior would also be erased.

Covered Benefits

Federal standards could mean the loss of state benefits such as a California woman's right to visit an OB-GYN, a New Jersey child's access to a Hepatitis B inoculation, and a Tennessee patient's coverage for diabetes treatment. A panoply of other benefits and patient services could also be eviscerated, including screenings for cervical and prostate cancers, newborn care, mental health care, a right to a second opinion, and guarantees of independent medical review if an insurer denies coverage for a medically necessary treatment.

States like California, Massachusetts, and New York have some of the nation's strongest patient protections—well beyond those represented by the plurality of other states—and therefore would

certainly see patient rights rolled back. For a summary of some of the state laws that could be lost, view a series of charts compiled by the National Conference of State Legislators at: http://ncsl.org/programs/health/hmolaws.htm and http://ncsl.org/programs/health/healthmc.htm (see "State Insurance Mandated Coverage").

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 small 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 telling you is that state coverage mandates that ensure access to basic health care needs actually save the system money by preventing and managing disease, or treating it before it becomes severe and more expensive to care for.

Any federal regulation should be regarded as a minimum on patient protection and should not limit states from establishing additional regulation or from enforcing current laws. Federal limitations on state regulation would 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. Additionally, states have regulatory and enforcement expertise based on decades of responsibility. Do you really want to require a Montanan or Californian or New Yorker to call the Federal Trade Commission to lodge a complaint against her HMO? Or require the state itself to beg federal overseers for discipline against bad insurers?

HMO & Insurer Accountability

Legal accountability in state courts when HMOs and insurance companies put profits before patients has been a central tenet in the patients' rights movement. Not only does legal accountability in the courts help those harmed by insurer malfeasance, the threat of legal accountability provides an inoculating effect to the broader society by forcing insurers to look beyond their bottom-line. When HMOs and insurers know they will face legal and public scrutiny for their actions, the companies are more likely to provide the care patients need without delay.

The last time insurers tried to federalize health insurance law in the way suggested by Ignagni they also tried to gut legal accountability for their actions by barring an individual—who buys a private insurance policy on her own—from holding her insurer accountable under state common law.

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[1] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* 21 (Washington, D.C. January 2000).
[2] Massachusetts Division of Health Care Finance and Policy, *Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature* 4 (Boston, MA 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, May 2008, p. 2, *available at* http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/May/The-Building-Blocks-of-Health-Reform--Achieving-Universal-Coverage-and-Health-System-Savings.aspx

Already, patients 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 concluded that: "State common law causes of action arising from the improper processing of a claim are preempted."

Under the Employee Retirement Income Security Act (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. The so-called "insurance savings clause" of ERISA allows states only the right to regulate the business of insurance and to require insurers to cover basic services. 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

Title I, Section 101 (a) of Senator Enzi's S.1955 would have amended ERISA to include insurance policies purchased by individuals through loose professional associations. Under S. 1955, individuals who bought these plans would forfeit their remedies under state common law. S. 1955 also would have revoked the acknowledgement of a state's right to regulate health insurers and require coverage of basic benefits. This is not a plan to be repeated. The Pilot Life decision should be reversed by Congress, and the ERISA pre-emption ended, not extended.

A Federal Floor, Not a Ceiling

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. Federal pre-emption of common law suits would only further insulate HMOs when they cause harm.

Insurers are not conceding a thing. They are trying to turn the squelching of a beneficial public option into a double victory. They need all of you to play along with the charade in order to succeed in killing state patient protections as well as any government competitor. If you allow the insurance industry to prevail in this deception, the worst public fears about insurers' lobbying power in Washington will be proven correct.

Sincerely,

Jerry Flanagan
Health Care Policy Director

Carmen Balber
D.C. Director