



Thursday, April 8, 2010

President Barack Obama
The White House

Speaker Pelosi, Senate Leader Reid and House and Senate supporters of health reform
The United States Congress

Secretary Kathleen Sebelius
Department of Health and Human Services

Dear President Obama, Members of Congress and Secretary Sebelius,

The enactment of broad health reform into law is, as you know, only the start of providing health coverage to all Americans at a fair price. Not only must the White House and Congress close loopholes in the newly enacted law, but the White House must also strongly repel efforts already under way by insurers and other corporate interests to undermine Department of Health and Human Services (“HHS”) regulations while they are being written.

Key questions left unanswered in the legislation—including the scope of health benefits that insurers must provide under the new law—will be addressed over the next months and years by federal regulators. Congress must stand ready to continuously clarify and strengthen the law against efforts to nullify its broad and progressive intent.

Attached to this letter is a list of ten problem areas in the new federal law that, if not addressed, will be exploited by health insurers and drug companies looking to charge more for less health care. Consumers will brook no excuses for failure by the White House or Congress to strongly defend newly won consumer protections, fill dangerous loopholes in the law, and ward off an onslaught of well-funded lobbyists.

Chief among the loopholes is the legislation’s failure to adequately limit what insurers can charge American families and business owners for coverage, even though tens of millions of Americans are being required to purchase private health insurance policies. Without the strongest possible review and prior approval of health insurance rates, insurers will be able to raise rates nearly without limit and use rate-setting as a vehicle for continuing to cherry-pick the healthiest customers. While HHS regulations can give stronger encouragement to state regulation under the new federal law, only Congress can require state regulation, set timelines, provide more robust funding to aid the states and define conditions under which the federal government would step in when states fail.

Other key loopholes and problem areas include (see the attached for the complete list):

- **Weakening of benefits.** Pre-emption of stronger state benefit requirements by so-called Nationwide and Multi-state plans will threaten the survivability of the state Exchanges and eliminate health and consumer protections in many states. This is a “race to the

bottom” provision that may allow insurers to sell highly profitable bare-bones policies under the guise of cutting costs. Consumers who fall seriously ill would suffer the consequences.

- **States Rights to Innovate.** Under the current law, states must wait until 2017 for waivers from the federal government to use federal Medicaid, Medicare, tax subsidies and other funds to support state alternatives to the private insurance market, whether that be by adopting a state single-payer model or a state "public option." If the federal government will require all Americans to purchase private insurance by 2014 or face tax fines, then by 2014 the federal government must also give states the right to use their share of federal funds to support alternate, state-based health reform.
- **Medicare Advantage pushback.** Private, for-profit Medicare Advantage systems will spend hundreds of millions of dollars on glossy marketing to attract a higher percentage of healthier seniors into such plans. The result could be a lobbying coup that prevents cuts in Medicare Advantage overpayments, cripples efforts to stabilize Medicare costs and may even push traditional Medicare into an economic death spiral.
- **Pharmaceutical price spiral.** Pharmaceutical companies’ large and unwarranted recent price increases on heavily used drugs have already eliminated any cost savings from an industry promise to “reduce” Medicare drug prices by \$8 billion a year. Further Congressional action is needed to allow direct bargaining for drugs by Medicare, which is the only way to steadily curb drug prices.
- **Continued rescission.** The federal law allows insurers to define the terms of future coverage rescissions when customers fall seriously ill in the fine print of their policies. The law limits rescission of health policies to instances of fraud or “intentional misrepresentation,” however no new regulatory oversight of rescission is provided to ensure that omissions or errors are indeed fraudulent or intentional, rather than innocent mistakes.

Consumer Watchdog appreciates the size of the job ahead, having spent 20 years defending strong insurance rate review and regulation in California’s property and casualty insurance markets. Insurance companies never give up their quest for new loopholes and better profits. A system of health care built only on private insurance thus requires absolute vigilance by all levels of government.

The attached detailed list of weak points in the new law, especially regarding the conduct of insurers and others, also suggests some remedies. Surely the least that Americans can expect from this law, and its effort to provide insurance at an affordable price, is that government will not allow the corporations that opposed the law to cripple it after the fact.

Sincerely,



Jerry Flanagan



Judy Dugan



Carmen Balber

10 Danger Points and Loopholes in the New Federal Health Reform Law

1. Lack of Insurer Rate Regulation. The health care reform law will ultimately require every American to show proof of having health insurance or face a tax penalty. Yet nothing in the federal legislation adequately restrains how much a health insurer can charge for coverage. If states fail to block excessive rate increases, the federal government must ensure that coverage is affordable by requiring insurers to seek “prior approval” of health insurance rate increases, as auto insurers are required to do under California’s Proposition 103. For more information on Proposition 103, go to: <http://www.consumerwatchdog.org/insurance/>

- Section 2794 of the Senate legislation only provides that insurers must publish a “justification” on their websites for increases found to be “excessive.” Nothing in the bill, however, provides a federal mechanism to bar such excessive increases.
- Instead, the federal law provides \$250 million in grants to states for “reviewing” insurance rates, and if state law provides, “approving” proposed increases.
- Furthermore, the federal law’s requirement that insurers spend 80% or 85% of the premiums they collect on health care services will—absent strict rate regulation—perversely encourage insurers to raise their premium rates. In the same way that a Hollywood agent who gets a 20% cut of an actor’s salary has an incentive to seek the highest salary, insurers will have incentive to increase health care costs and raise premiums so that their 20% cut is a larger dollar amount.

2. Pre-emption of Stronger State Laws. Several provisions of the federal law allow insurers to sell bare-bones coverage that bypasses more robust state health care coverage requirements including, for example, AIDs testing, reconstructive surgery and autism treatments. These provisions must be repealed outright or amended to follow the model of other federal health care laws, like HIPPA and COBRA, which provide for a federal-state partnership rather than federal pre-emption of more protective state standards and enforcement duties. Under the law as written, preemption of state requirements is built into three types of coverage.

- “Nationwide Plans” (§ 1333 (b)). Under this provision, an insurer need only comply with benefit requirements of the state from which the coverage is sold. Since insurers will seek to sell coverage from states with the least protective patient standards, this provision will result in insurers selling coverage at the new minimum level to be defined by federal regulators in the future. Insurers will lobby the insurer-funded National Association of Insurance Commissioner (NAIC), which has an advisory role in developing the new minimum federal “essential coverage” requirements, the White House and Congress to adopt the weakest interpretation of the federal minimum benefits. Unstated but implicit is that insurers would market such coverage to lure consumers out of more robust policies. State legislatures could “opt out” of allowing the nationwide plans to be sold in their respective states, but given the lobbying might of insurers, this provision is the virtual equivalent of requiring states to allow the sale of such bare-bones plans, which will not have to comply with state benefit requirements.
- “Multi-State Plans” (§ 1334). Similarly, under this provision insurers could sell coverage in any state under federal benefit guidelines and ignore stronger state laws. States could

require insurers to abide by additional requirements but only if states fully paid any additional costs associated with additional benefits. State governments cannot bar a Multi-State Plan from selling in their respective states.

- “Compacts” (§ 1333 (a)). Under the health care Compacts provision, policies that would be sold in two or more states would only be subject to the laws and regulations of the state in which the coverage was “written or issued,” regardless of where the policies are sold. As with the Nationwide Plans and Multi-State Plans, this provision would allow a race to the bottom of health care coverage, as ultimately defined under federal “essential coverage” regulations. Since states must legislatively “opt-in” to Compact agreements, market observers tend to agree that Nationwide Plans and Multi-State plans will be more prevalent than Compacts.

3. States Rights to Innovate. The new federal law bars states from adopting state-based solutions to health care until 2017 even though by 2014 most Americans must show proof of owning private insurance policies or face tax fines. Under the current law, states must wait until 2017 for waivers from the federal government to use federal Medicaid, Medicare, tax subsidies and other funds to support state alternatives to the private insurance market, whether that be by adopting a state single-payer model or a state "public option." Rightly a state can only receive such waivers if the state can demonstrate that the alternative health care approach will provide health coverage that is at least as comprehensive as the coverage required under the federal law. However, if the federal government will require all Americans to purchase private insurance by 2014 or face tax fines, then by 2014 the federal government must also give states the right to use their share of federal funds to support alternate, state-based health reform. Specifically, new legislation must provide an explicit right by 2014 for states to establish universal coverage similar to Medicare for all residents, and make automatic any federal waivers necessary for states to take control of their health care systems, including Medicare and ERISA waivers.

4. Medicare Advantage. The law’s reduction of large overpayments made to the private, for-profit Medicare Advantage (MA) plans does not begin in earnest until at least 2014. Insurers, particularly those associated with the United Health Group, have stated their intention to aggressively seek enrollment of more traditional Medicare patients into the MA plans in the next few years. Then, with its larger percentage of healthier clients, the industry will be positioned to demand delay of cuts and put traditional Medicare into an economic death spiral. Much of this scenario depends on the ability of private insurers to market the MA plans heavily, while Congress has forbidden traditional Medicare to send seniors so much as a brochure prior to their initial signup. MA and traditional Medicare must be put on more nearly level ground in their ability to describe their services to seniors prior to enrollment.

5. Big Pharma. Pharmaceutical companies have increased prices on average 9% over the last year, with larger increases in branded drugs heavily used by seniors. Unless these increases are rolled back, and future prices curbed, Big Pharma will more than cancel out its promised \$8 billion a year in price “cuts,” turning a concession by the industry into a sham. Only allowing traditional Medicare to bargain directly with drug manufacturers for price concessions, as the Veterans Administration already does, can prevent such gaming of prices by drug makers.

6. Health coverage rescissions. A key rallying cry for federal reform was the insurer practice known as rescission—retroactive cancellation of coverage after a patient makes a claim for health care services. Insurers often argue that a rescission is warranted because the patient intentionally failed to report minor health problems when applying for coverage. Such

rescissions are carried out unilaterally by the insurer and regardless of whether the patient even knew about, or understood the significance of, the health problem the insurer claims was intentionally omitted from the application. Since an applicant's health condition is no longer relevant to determining insurability, coverage rescissions should be barred outright.

- However, section 2712 of the Senate legislation allows for rescission of health policies on the basis of fraud or the “intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.”
- The insurers are left to define the terms of future coverage rescissions in the fine print of their policies. No new regulatory oversight of rescission is provided to ensure that omissions or errors are indeed fraudulent or intentional, rather than innocent mistakes.

7. Legal accountability for insurers that deny care. Patients who have health coverage paid for in part or full by employers cannot hold insurers legally accountable for denying medically necessary treatments. 132 million Americans with private employer-paid health coverage cannot recover damages against an insurer even if the company's failure to approve treatment kills a loved one. The new federal health reform law fails to fix this justice-denying loophole created by a 1987 Supreme Court decision in the case of *Pilot Life v. Dedeaux*, even as the law requires individuals and employers to share in the cost of health coverage or face tax penalties. When government requires the purchase of health insurance policies it must guarantee access to justice when insurers wrongfully deny treatment to patients. The *Pilot Life v. Dedeaux* loophole must be closed.

- If an insurer wrongly denies a doctor's recommendation on the grounds that the care is not a covered benefit, as is very common now, the various consumer protections in the reform law, including out-of-pocket caps and prohibitions on annual and lifetime policy limits caps, will be ineffective to protect patients. Read more here: <http://www.consumerwatchdog.org/patients/EqualJusticeForPatients/>

8. Definition of medical expenses. Consumer Watchdog has called on the Obama Administration and the Department of Health and Human Services (“HHS”) to probe insurance giant WellPoint Inc. in light of a message to its investors describing how WellPoint would simply re-label administrative costs as “medical care” in response to the new health reform law. The message follows revelations that WellPoint, parent company of Anthem Blue Cross, also intentionally padded already huge premium increases in California, just in case regulators demanded reductions. The new federal health reform law requires that insurers spend at least 80% of customers' premiums on medical care in the individual insurance market, and 85% in the employer/group market. HHS must narrowly define what constitutes medical care to block gaming of the new medical loss ratio requirement by health insurers.

- In a message to investors reported by Dow Jones wires, WellPoint said: “WellPoint's (WLP) medical cost ratio should rise and its overhead-expense ratio decline this year as the insurer reclassifies various types of costs. Disease management, medical management and a nurse hotline, for example, ‘are being reclassified because they represent additional benefits provided to our members,’ They'll now be part of the medical cost ratio, the percentage of premium revenue used to pay members' health-care costs.”
- In particular, the addition of “medical management” is a grab bag that may include purely administrative units whose job is to deny as much expensive care as possible, and may

include billing. HHS must narrowly define what constitutes medical care to block gaming of the new medical loss ratio requirement by health insurers. See more on WellPoint rate padding at: <http://www.consumerwatchdog.org/patients/articles/?storyId=33357>

9. Inadequate Federal Fallback. Consumer Watchdog advocates for frontline state enforcement with strong federal fallback if states fail to act. States are the local cops on the beat and can respond faster to local threats and with greater knowledge of the local market. But there should be pathways for federal regulators to become fully aware of the failure of state fraud enforcement through public intervenor groups and reporting requirements that tip federal regulators to local inaction. The threat of strong federal fallback is the kind of carrot and stick approach that would encourage state regulators to act where they otherwise may not. However, federal enforcement fallback provisions are virtually absent from the bill. For example, under section 1321(c) federal regulators shall step in to operate a state Exchange if (and only if) a state fails to implement one at all. Section 10606 addresses Medicare provider fraud and fraud generally on government health care programs, not fraud by private health insurance companies. 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 levels but allow states to fit the federal program to local needs, provide enforcement, and adopt more robust regulations not envisioned by federal law.

10. Sick kids. The ink was hardly dry on the health reform law when the insurance industry started saying that no matter what Congress thought it passed and no matter what President Obama said, they did not have provide coverage to sick children right away. Any ambiguities in the language of the reform law must be cleared up in regulation, something White House spokesman Robert Gibbs emphasized in a briefing last week: "To ensure that there is no ambiguity on this, the Secretary of Health and Human Services, Kathleen Sebelius, is preparing to issue regulations next month making sure that the term 'preexisting' applies to both a child's access to a plan and his or her benefits once he or she is in a plan," said Gibbs. The Obama Administration must follow through on that promise. The main private insurer lobbying group, Americans Health Insurance Plans, has since said it will not fight the new coverage of previously excluded children and conditions, but the provision must also be clearly stated in regulations implementing the law.