FOR IMMEDIATE RELEASE **CONTACT:** Laura Capps/Melissa Wagoner
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KENNEDY FIGHTS REPUBLICAN PLAN TO RAISE HEALTH PREMIUMS AND TAKE AWAY THE HEALTH BENEFITS THAT ALL AMERICANS DESERVE

PUSHES FOR REAL HELP TO SMALL BUSINESS, MENTAL HEALTH PARITY, LOWER DRUG PRICES, AND MEDICARE FOR ALL

Washington, DC: Today the Senate Health Education Labor and Pensions Committee is considering a Republican plan that would raise the premiums and lower the benefits for millions of Americans who already have health coverage today. Although the bill has been presented as legislation for small businesses, the effects of this bill go far beyond the "small business plans" and would sweep away important protections for patients in every state-regulated insurance market. Senator Kennedy opposes the plan and will offer amendments to improve it, starting with mental health parity. Kennedy and his colleagues have offered an alternative bill to give small business real help and assistance to provide meaningful health coverage.

"Health care should be a right, not a privilege," Senator Kennedy said. "Unfortunately, for millions of Americans, the bill before us will do more harm than good. For far too many of our citizens, it will result in higher health costs and fewer benefits. The Democratic plan gives small businesses real help and assistance to provide meaningful health coverage. It cuts the cost of coverage by helping businesses with expensive health costs and by providing tax credits for health care. And it does it without making everyone else in America pay the price."

Because the Republican bill will sweep away the mental health protections that the citizens of 39 states worked years to secure, Senator Kennedy first offered an amendment to make mental health parity a priority in health insurance nationwide. Senator Kennedy said, "If you have bipolar disorder or attention deficit or any of a host of other treatable conditions, and live in one of the 39 states, you may have to return to the days when you tried to cope without treatment. We cannot allow this to happen. There is no reason in 21st century America that we should treat physical illnesses differently than mental illnesses."

Kennedy also offered other amendments to solve the health care crisis in this country such as fixing Medicare Part D, offering Medicare for all Americans, and allowing small businesses to buy drugs at the same price that the Veterans Administration does. Below is a summary of the Republican plan, Senator Kennedy's opening statement from the hearing, and summaries of his mental health parity amendment, his Medicare for All amendment, his Part D Fix amendment and his VA drug prices amendment.

THE HEALTH INSURANCE MARKETPLACE MODERNIZATION ACT
Insurance Companies Win but Patients Lose

Small businesses face increasing challenges affording the soaring costs of health care for their employees. Congress has a responsibility to provide small business with effective help in meeting those costs B but the Health Insurance Marketplace Modernization Act takes the wrong approach. Sweeping away essential protections for patients, and allowing insurance companies to cherry pick the healthiest workers, while redlining those with health care needs is no answer to the crisis that small businesses face.

The Health Insurance Marketplace Modernization Act is a wolf in sheep's clothing. Its effects go far beyond the small business market, and reach into every State and every area of health care coverage. In the guise of providing help to small businesses with the skyrocketing costs of health care, the bill:

$ Sweeps away essential State patient protections guaranteeing access to services such as well baby

care, immunization, cancer screening, access to specialists, and many other important services.

$ Nullifies State laws that guarantee affordable health insurance premiums for millions of Americans.

$ Allows insurance companies to cherry pick businesses with the healthiest workers while red-lining those whose workers have health care needs.

$ Gives insurance companies unprecedented powers to sue to protect their profits B but fails to give consumers the right to defend their rights in court.

$ Undermines the basic legal tools that state insurance commissioners use to ensure that consumers are not harmed by fraudulent or discriminatory actions by insurance companies.

The bill is so skewed to benefit industry over consumers that it does not even limit its impact to the new "small business health plans" B nor does it improve the affordability of coverage for the self-employed. It effects will be devastating B millions will pay more for the health insurance, while major corporations will line up for the lucrative business of providing skimpy coverage to those who need little health care.

STATEMENT OF SENATOR EDWARD M. KENNEDY

MARKUP OF SMALL BUSINESS HEALTH BILL

MARCH 8, 2006

Every Member of this Committee knows that small businesses face serious challenges in affording health care for their employees.

Health care should be a right, not a privilege. An individual who works for a realtor, or a restaurant, or a car dealer should have the same access to affordable, comprehensive and fair health care coverage as an employee of a large corporation.

Congress should help the business community meet this crisis. I commend Senator Enzi and Senator Nelson for their leadership in wanting to address this major challenge.

But for millions of Americans, the bill before us will do more harm than good. For far too many of our citizens, it will result in higher health costs and fewer benefits.

The higher premiums that will result from this bill will affect primarily those who need health insurance the most – older workers, the disabled, and those with chronic conditions. That is because the legislation before us will allow health plans to cherry pick businesses with young and healthy employees, while redlining those who employ older workers or individuals with health care needs. Their insurance premiums already are high enough. We shouldn't be doing anything to make them even higher.

Make no mistake. The effects of this bill go far beyond the "small business plans" the bill establishes.

The bill sweeps away important protections for patients in every state-regulated insurance market.

Gone will be benefits such as cancer screening, childhood immunization, access to specialists, and countless other essential safeguards – not just for those in small business plans, but for millions of Americans across the country. The citizens of our states have fought long and hard for many of these rights under state laws. It is wrong for this Congress to erase those hard-won gains in this bill.

This proposal establishes unprecedented legal rights for insurance companies to bring action against states to protect their profits, but does nothing to help consumers to seek justice when they have been denied care or charged outrageous rates by insurance companies.

The proposal before us enacts major changes in the regulation of health care and undermines hundreds of state laws – yet we have had no hearings, and have no analysis by the Congressional Budget Office of the legislation's likely impact on costs and on the uninsured.

We should have the opportunity to examine this proposal closely and weigh its impact before proceeding.

We have a plan that will help small businesses with affordable health coverage for their workers while lowering costs and retaining today's benefits. Our plan would set up small business insurance pools in states that will make health insurance more affordable. And for small businesses that operate in more than one state, we establish a national pool with benefits equal to what those of us in Congress receive.

Our plan cuts the costs of health care for small businesses through tax credits, grants, and allowing small businesses to pool their insurance risk.

And it keeps in place today's good state regulations against massive premium hikes and for benefits that the state has determined its citizens should receive.

But in addition, every American knows that the health care crisis extends far beyond the needs of small businesses and their workers.

Our seniors and the disabled are outraged by the new Medicare prescription drug program. We have a duty to address this crisis.

Forty-six million Americans have no health insurance. The number has climbed from 40 million in 2000 to 46 million today. That's 4,000 people becoming uninsured every day.

But we've had no debate on any proposal to guarantee every American access to quality, affordable health care.

Costs are soaring out of control. Health care premiums have gone up over 70 percent in the last five years – over 5 times the overall rate of inflation in the economy. Almost one in five working families have seen their premiums go up over 15 percent – and one in ten have faced increases over 20 percent.

But action on a bill to cut health costs for our families through the greater use of modern information technology is stalled in this Congress.

Life-saving stem cell research has been held back by restrictions based on ideology not on science. But the stem cell research bill that the House passed with an overwhelming bipartisan majority has languished without debate for almost a year.

I welcome today's debate on health care. If this legislation is reported from our committee, it will

provide a long overdue opportunity to give the basic questions of health care the discussion they deserve. Surely, in a nation that spends far more on health care than any other, we can do better.

The Democratic Plan: The Small Employers Health Benefits Program (SEHBP) Act

Summary

The Small Employers Health Benefits Program (SEHBP) is based on the successful Federal Employees Health Benefits Program (FEHBP), which has provided extensive benefit choices at affordable prices to members of Congress and federal employees for decades. Last year, more than eight million people were banded together in the FEHBP purchasing pool and given choices among 10 national health insurance plans and a variety of local insurance plans. A total of 249 private insurance plans offered benefits to, and competed for the business of FEHBP enrollees in 2005.

By pooling small businesses across America into one risk and purchasing pool like FEHBP, the new SEHBP program will allow employers to reap the benefits of group purchasing power and streamlined administrative costs, as well as access to more plan choices. Health plans will bid to offer benefit packages to SEHBP enrollees. The Office of Personnel Management (OPM), which has been efficiently managing FEHBP for decades with less than one percent administrative cost. OPM will ensure that the health insurers bidding for access to the pool are offering appropriate benefits at reasonable prices as they have done with the federal program. This will free small business owners from the burden of negotiating with health plans.

Eligibility Requirements

- The SEHBP program will be open to all employers with up to 100 employees. OPM will have the authority to grant participation waivers to businesses with more than 100 employees.
- All employees of participating SEHBP employers will be eligible to receive coverage through SEHBP.

Participation and Coverage

- Employees may join SEHBP when first hired or during an annual open enrollment period.
- Prior to each annual enrollment period, employers will receive a booklet detailing the insurance plans available. OPM will work to ensure a range of choices are available, like in the federal employees plan. There will be at least one plan that is equivalent in benefits to the nationwide plans in FEHBP.
- Coverage choices are made by the employee. Each individual may choose a health plan according to his or her own needs.
- SEHBP enrollees who have at least six months of health insurance coverage immediately prior to enrollment in an SEHBP plan will face no pre-existing condition waiting period. To prevent people from waiting until they get sick to enroll, health plans will be allowed to exclude coverage for pre-existing conditions for up to six months for people without coverage immediately prior to enrollment (reduced by one day for each day of immediately previous coverage). The pre-existing condition provisions are consistent with HIPAA.

- In an effort to balance premium prices with consumer protections, participating plans will be allowed to apply "adjusted community rating" to their premiums. The SEHBP plan is similar to a model developed by the National Association of Insurance Commissioners in 2000, which allows plans to vary premiums based on age, geography and family composition within strict limits to prevent extreme variations in price. If a state has rating rules that are stricter than the rules laid out in this bill, the state is held harmless, meaning they can maintain their current rating structure.

Encouraging Participation among Health Plans

- Health plans interested in bidding in the SEHBP pool must be licensed in the state in which they will operate. Nationwide plans much be registered in all 50 states.
- Health insurers who offer products in SEHBP during its first two years of existence will be insured against losses through a three-percent risk corridor and a reinsurance pool for high-cost individuals. Risk corridors are contractual safeguards that limit the downside risk and upside gain for an insurer. The federal government has experience with risk corridors in TriCare, the health system for military families. The risk corridor will be in place for five years and begin phasing down after three years. The reinsurance pool will pay 80 percent of an individual's cost when claims exceed $50,000 in one year. The reinsurance pool will also be in place for five years.
- Once the risk pool stabilizes and insurers have claims experience on which to accurately base their premiums, the program will switch to the "service charge" system currently employed by FEHBP.

Benefit and Solvency Mandates

- SEHBP enrollees in local plans will be covered by state consumer protection laws, such as benefit mandates and solvency standards. State insurance commissioners will continue to regulate solvency, grievance processes, internal review and network adequacy laws, among other things. National plans will be required to provide similar protections under the oversight of OPM.
- Like FEHBP, OPM will have the authority to require plans to limit enrollees' annual out-of-pocket expenses, include patient consumer protections and provide parity for coverage of mental and physical health care.

Cost

- The federal costs associated with this program will include the tax credits that will encourage employers to participate and provide coverage to their employees, providing the two-year risk corridor and reinsurance to health plans to encourage their participation, set-up costs for OPM and public outreach costs. Administrative costs will eventually be included in the premiums, meaning the program will pay for itself.

The Paul Wellstone Mental Health Equitable Treatment Act Amendment of 2006
Summary

Approximately 50 million Americans experience some form of mental illness each year. Unfortunately too many forgo medical treatment due to the high out-of-pocket cost of treatment as private health insurance plans typically provide lower levels of coverage for treating mental illness than for treating other illnesses. This bill

will eliminate the discriminatory treatment of mental illness by requiring insurers provide parity between mental health benefits and medical and surgical benefits.

Full Parity for All Mental Illnesses

While the Mental Health Parity Act of 1996 (MHPA) was a major step forward in ending insurance discrimination, it fell short of full parity. The 1996 law focused only on catastrophic benefits B requiring annual or lifetime dollar limits for mental health coverage be no more restrictive than medical or surgical coverage.

The Paul Wellstone Mental Health Equitable Treatment Act Amendment of 2006 will take parity a significant step further.

< It will provide **full parity** - equalizing all treatment limitations and financial requirements for all physical and mental illnesses. Financial limitations include not only lifetime and annual limits, but all financial terms and conditions, including deductibles, coinsurance, and limitations on the total amount that may be paid for benefits under the plan.

< It will provide full parity for **all mental illnesses**. This includes all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most comprehensive diagnostic tool available to mental health providers.

< It is not an insurance mandate . The bill requires only that insurance policies which cover mental illnesses, provide mental health benefits at parity with other medical and surgical benefits.

< It protects small businesses. Only companies with 50 or more employees will be covered under the law.

The Cost is Low

< The Congressional Budget Office has estimated that providing full parity for all mental illnesses will cause insurance premiums to rise by less than 1%.

< The bill is modeled on the mental health coverage in the Federal Employees Health Benefit Program (FEHBP), the program that covers Congress.

< The Office of Personnel Management testified that the cost of implementing full parity is only 1.3% of premiums, roughly $1/month for self-enrollees, and $2/month for families.

Background on Mental Health Parity

Mental Illness Insurance Issues

Over 50 million American adults experience some form of mental illness each year and over 5.5 million have a

severe mental illness, such as major depression or schizophrenia.

Private health insurance plans have typically provided lower levels of coverage for treating mental illness than for treating other illnesses due to concerns about cost and adverse selection. Common ways health plans have restricted coverage of mental illness include: (1) lower annual or lifetime dollar limits; (2) lower service limits such as the number of covered hospital days or outpatient visits; and (3) higher cost-sharing requirements such as deductibles, co-payments, or coinsurances. As a result of limited coverage, individuals with mental illness often do not seek treatment, and those receiving treatment can quickly exhaust their benefits.

Current Law - Mental Health Parity Act of 1996

• □□□□The Parity Act of 1996 focused on Acatastrophic@ benefits only C requiring only that annual and lifetime dollar limits for mental health coverage be no more restrictive than for all medical and surgical coverage.

• □□□□The law exempted employer-sponsored plans with 50 or fewer employees, group plans that experienced a 1% or more increase in plan costs because of compliance.

Proposed Amendment – Senator Paul Wellstone Mental Health Equitable Treatment Act of 2006

• □□□□The AMental Health Equitable Treatment Act of 2006 prohibits health plans from placing discriminatory treatment limits or financial requirements that are different from other medical and surgical benefits.

MEDICARE PART D FIX AMENDMENT

As a result, the great unfinished business of Medicare in recent years has been to provide coverage for the drugs that millions of seniors need to protect their health and save their lives. Sadly, the Republican Medicare bill failed to live up to the promise of Medicare.

Instead of the Medicare that seniors know and trust, the drug benefit was turned over to HMOs and other insurance companies. Instead of allowing Medicare to bargain for discounts on prescription drugs, as the Veterans Administration does for drug for veterans, such bargaining for lower costs for seniors was made illegal.

The result has been a disaster. The bill that passed was a nightmare of complexity and confusion. Seniors across the country were denied the drugs they need, or were forced to pay exorbitant fees to fill their prescriptions. The time has come to address these serious flaws and give seniors the Medicare drugs benefit they deserve.

To address these serious problems, the legislation:

- Gives every Medicare beneficiary the choice of receiving their drug benefit through traditional Medicare, with a formulary that is not allowed to change from day to day or state to state.

- Allows Medicare to negotiate the same good discounts on drug prices that the VA gets for veterans.

- Eliminates excessive subsidies to private insurance plans (the slush fund, the overpayments, and the bonuses for having healthier enrollees).

- Eliminates the demeaning assets test.

- Establishes a consistent nationwide premium for Medicare drug coverage.

- Reduces the annual deductible for drug coverage.

- Increases the share of seniors' drug costs that Medicare will pay.

- Eliminates the so-called "doughnut hole" that will force seniors to bear the full costs of their drugs one a minimum is reached.

- Provides true security against runaway costs by assuming the full costs of drug purchases once a maximum out of pocket spending limit is reached.

• □□□□It provides full parity for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV).

• □□□□The legislation does not include expansions for substance abuse.

• □□□□The legislation exempts group health plans offered by employers with less than 50 employees.

Parity for Federal Employees
Federal employees currently have mental health parity in their health benefits. Benefits coverage for mental health and substance abuse conditions is equalized in the Federal Employees Health Benefits (FEHB) Program. Parity in the FEHB Program means that benefits coverage for mental health, substance abuse, medical, surgical, and hospital providers will have the same limitations and cost-sharing such as deductibles,

coinsurance, and copays. This amendment is modeled after the mental health benefits provided through the Federal Program.

MEDICARE FOR ALL:
QUALITY, AFFORDABLE, HEALTH CARE
FOR ALL AMERICANS

America faces a health care crisis. Too many Americans are uninsured, and the number of the uninsured is increasing at an accelerating rate. No American family is more than one pink slip or one employer decision to drop coverage away from being uninsured. Health care costs are too high and are rising at double-digit rates. Our dysfunctional health care financing system makes it harder for American businesses to compete in the global economy, creates incentives to outsource jobs abroad, has slowed job growth even as the economy recovers, and has been an especially heavy burden on manufacturing.

America's failure to assure the basic human right to health care to all its citizens was one of the great public policy failures of the 20th century. Recent data emphasizes the urgency of redressing this failure. Forty-six million Americans are uninsured, and the most recent Census Bureau figures show that the number of uninsured increased by nearly one million Americans in 2005 alone.[i] <#_edn1> Even these figures understate the problem. Over a two year period, 82 million Americans—one out of every three non-elderly Americans--will be uninsured for a significant period of time.[ii] <#_edn2>

After a brief period of stability in the mid-90s, health care costs are rising at unacceptable rates far in excess of inflation. Health insurance premiums have risen at double-digit rates since 2000, and have increased a whopping 73% in the last five years.[iii] <#_edn3> Health care spending reached 16% of GDP, the highest level in our nation's history.[iv] <#_edn4>

The high level of American health care costs combined with a financing system that places the burden of paying for coverage on employers who voluntarily choose to offer health insurance puts American firms at a competitive disadvantage. As a proportion of GDP spent on health care, America is first in the world by a large margin. By that standard, we spend 49% more than the Swiss, the next highest spending country, 88% more than the Germans, 150% more than the British, and 160% more than the Japanese, according to the latest data from the OECD.[v] <#_edn5> Our extraordinary level of health spending, however, is not reflected in better health outcomes. Among the world's leading industrialized countries, the United States ranks 22nd in average life expectancy and 25th in infant mortality.[vi] <#_edn6>

Not only are our health care costs much higher than our trading competitors, but our system forces employers to finance a much higher proportion of costs than firms abroad, because foreign systems rely much more on broad-based public financing.[vii] <#_edn7> The heavy burden the health care financing system adds to labor costs in the United States also acts as a drain on hiring and provides an additional incentive for outsourcing jobs abroad.

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[i] <#_ednref1> . U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage: 2004," August, 2005.
[ii] <#_ednref2> . Families USA, "One in Three: Non-elderly Americans Without Health Insurance, 2002-2003," June, 2004.
[iii] <#_ednref3> Kaiser Family Fund and Health Research and Education Trust, Employer Health Benefits 2005 Annual Survey

[iv] <#_ednref4> . CMS, Office of Actuary, "National Health Expenditures." 2006 report.
[v] <#_ednref5> OECD, *OECD Health Data 2005*
[vi] <#_ednref6> Ibid.
[vii] <#_ednref7> National Association of Manufacturers and Manufacturers Alliance, "How Structural Costs Imposed on U.S. Manufacturers Harm Workers and Threaten Competitiveness," December, 2003.

VA Prices Amendment

Summary

This amendment requires the Secretary of Health and Human Services to set up a group purchasing pool from which employees of small businesses may buy prescription drugs. The purchasing pool is guaranteed the prices paid by the Veterans Administration, generally the lowest prices for prescription drugs in the United States.

Everyone has a problem with the high cost of health care. And the cost is getting higher and higher. This is what makes health insurance out of reach for so many small businesses.

Increasing costs for drugs are a major driver of higher health care costs. Drug usage is up, and for the past few years, brand drug prices have increased at double the rate of inflation. In 2004, total expenditures for prescription drugs increased 8 percent over 2003, from $174 billion to $188 billion.

This amendment allows small business employees to purchase prescription drugs at the price the Veterans Administration pays for them, which are generally the lowest prices available.

To get an idea of the savings, compare the prices that private plans negotiate for prescription drugs to those available through the VA. In December, Families USA did such a study. For 20 drugs, they compared the lowest price under Medicare drug plans to the price through the VA. For all but one drug, the VA price is lower.

For 10 of the drugs, the VA price saves you at least a third, at least $261 for the year. The average annual savings on a drug is $316. Some of the price differences are staggering. For 20 milligram tablets of Zocor (ZOH-core), the cholesterol drug, a year's supply through the VA costs $168, and the lowest plan price is $1,324, a savings of $1,156. The savings on Lipitor (LIP-a-tore) are less, but still significant: $293.

This amendment is a good way to save money for small businesses and their employees, and to make small business health plans more affordable. I urge you all to support it.

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