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

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, KEY GROUPS, FIGHT BILL THAT WOULD ELIMINATE STATE BENEFITS LIKE CANCER SCREENINGS

Washington, DC: Today, the Senate Health Education Labor and Pensions Committee continued its negotiations of 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, including one that would strike the language relating to state benefits. Kennedy and his colleagues have offered an alternative bill to give small business real help and assistance to provide meaningful health coverage.

"Unfortunately, the bill before us includes damaging provisions to repeal existing laws that make healthcare coverage more affordable for millions of Americans. It sets up the barest of bare bones standards for benefits – sweeping aside requirements to cover cancer screening, well baby care, immunization, access to specialists and many other needed services." Senator Kennedy said. "In the name of helping small businesses afford health insurance for their workers, the Republican plan is a blank check for the insurance industry and a bad deal for patients, resulting in higher premiums and lower benefits for millions of Americans with reliable health coverage today."

Kennedy offered amendments to help 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. He also offered an amendment that would strike the preemption language in the bill and allow states to choose whether or not to adopt the rating rules, benefit package, and harmonization standards promulgated under the Act. Below is a summary of the Republican plan, Senator Kennedy's statement on state choice, and summaries of his mental health parity amendment, his Medicare for All amendment, his Part D Fix amendment and his VA drug prices amendment.

Also attached is the lengthy list of groups that oppose the Republican bill.

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.

GROUPS THAT OPPOSE S,1955

National Association of Insurance Commissioners

American Academy of Pediatrics
American Association of People with Disabilities
American Diabetes Association
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Nurses Association
American Psychological Association
Families USA
National Disability Rights Network
National Mental Health Association
National Spinal Cord Injury Association
National Partnership for Women & Families

California Insurance Commissioner, John Garamendi
Nevada Insurance Commissioner, Alice Molasky-Arman
Mental Health Liaison Group
American Cancer Society
AARP
Lance Armstrong Foundation
National Conference of Insurance Legislators
American Academy of Child & Adolescent Psychiatry
American Academy of Physician Assistants
American Federation of State, County and Municipal Employees
American Chiropractic Association
American Pediatric Society
American Podiatric Medical Association
Arc of the United States
Association of Medical School Pediatric Department Chairs
Bazelon Center for Mental Health Law
Brain Injury Association of America
Communications Workers of America
Guttmacher Institute
International Association of Machinists & Aerospace Workers
International Brotherhood of Electrical Workers
International Longshore & Warehouse Union
International Union of Painters and Allied Trades
National Association of Social Workers
National Family Planning and Reproductive Health Association
National Women's Law Center
Planned Parenthood Federation of America
Small Business Majority
Society for Pediatric Research
United Cerebral Palsy
United Steelworkers International Union (USW)

STATEMENT OF SENATOR EDWARD M. KENNEDY

STATE CHOICE AMENDMENT

SMALL BUSINESS HEALTH INSURANCE MARKUP

MARCH 15, 2006

This bill includes damaging provisions to repeal existing laws that make health care coverage more affordable for millions of Americans. The bill says that it is fine to charge one group of people more than another because of their gender, or because they have a history of illness or work in a particular industry.

It sets up the barest of bare bones standards for benefits – sweeping aside requirements to cover cancer screening, well baby care, immunization, access to specialists and many other needed services.

But through all this, the supporters of the bill claim it's all optional, since they're not really preempting State laws. They claim States have the right to choose whether to adopt the bare bones

benefit package or not. They say States have the ability to choose to accept the rating rules that abolish standards that have helped millions of Americans afford coverage.

That argument ignores the fact that the bill before us uses the word "preempt" or "supersede" 21 separate times, nullifying good laws on essential medical services.

Let's look at just a few examples. On page 57, the bill says, "This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market."

That sentence alone strikes down laws requiring coverage of well-baby care, cancer screening, access to specialists, and many other vital services.

On page 59, the bill denies states the ability to require insurance companies to offer needed benefits. It gives the insurance industry unprecedented rights to sue States that try to enforce their own laws requiring good coverage.

I remember many objections on the other side of the aisle when we tried to let patients defend their rights in court if they're denied needed services by HMOs. But this bill gives insurance companies extraordinary rights to take action against states for trying to enforce laws that require insurance companies to cover basic needed services.

Supporters of the bill claim that all these new programs are voluntary. If that's truly the case, they should accept my amendment, which strikes the preemption of State protections.

It gives States a real choice to determine whether to go beyond the weak standards established at the federal level to provide real protections for their people.

If the bare bones plans under this bill are as good an idea as its supporters believe, States should rush to adopt them – but let's at least give them the choice to say no.

If doing away with protective rating laws is as good an idea as the supporters of this bill claim, States will embrace it voluntarily – but let's make sure they can say no if they wish to, as New Hampshire already has done.

Congress should not enact laws to deprive people of rights and protections. Time after time, we have enacted laws that provide a basic floor of protection – but allow States to reach beyond that floor if that's what's best for their people of the State.

In Kassebaum-Kennedy, we set a Federal floor for protections in terms of portability of health care coverage – but we allowed states to go beyond the Federal standard if they chose.

In CHIP, the Children's Health Insurance Program, we established a basic level of services that all states have to provide – but States have the discretion to go beyond that if they decide it's important for the people of their state.

In the genetic discrimination bill the Senate voted to adopt last year, we set a federal minimum standard. But we left in place State laws that exceeded that standard.

Time after time, we've set minimum standards at the federal level, but allowed States to go beyond them

This bill turns that principal on its head. If a state decides to require all insurance plans to

cover cancer screening or immunization or access to specialists – this bill denies them the right to do so.

It tells the people of Massachusetts, and Wyoming, and Tennessee – and every other state – that they don't have the right to provide greater protections for their people than this bill provides.

That's the wrong course for Congress to take.

The right course is to allow good state laws that protect patients to stand– not force States to abandon them.

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.