**FOR IMMEDIATE RELEASE** **CONTACT**: Laura Capps/ Melissa Wagoner
MAY 9, 2006 (202) 224-2633

****REMARKS AND SUMMARY INCLUDED****

**KENNEDY FIGHTS THE REPUBLICAN HEALTH PLAN THAT WILL RAISE PREMIUMS AND TAKE AWAY HEALTH BENEFITS THAT ALL AMERICANS DESERVE**

***JOINS RALLY WITH HEALTH ADVOCATES WORKING TO DEFEAT THE BILL***

***224 NATIONAL GROUPS, 41 ATTORNEY GENERALS and 8 INSURANCE COMMISSIONERS OPPOSE THE BILL***

Washington, DC: Today, as the Republican health bill reaches the Senate floor, Senator Kennedy led the fight to oppose it because it 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 his colleagues have offered an alternative bill to give small business real help and assistance to provide meaningful health coverage.

"The bill the Senate considers today undermines our progress on healthcare," Senator Kennedy said. "Its supporters say that the legislation is about helping small business. But the legislation the Senate considers today isn't an advance – it's a retreat. It's a retreat from our commitment to cancer. It's a retreat from our commitment to diabetes. It's a retreat from our commitment to mental health parity. We're here today to say that quality, affordable health care should be the right of each and every American."

Kennedy joined a rally of leading health advocacy groups who are working to defeat the bill because it is a major step backwards in the effort to provide better healthcare in this country. In addition to the advocates, forty-one attorney generals and eighteen Insurance Commissioners oppose the bill.

Democrats have offered a comprehensive alternative S.1955. The Small Employers Health Benefits Plan (S.2510) would allow small businesses with up to 100 employees to band together for lower health care prices by pooling their purchasing power and spreading their risk over a large number of participants.

Attached is Senator Kennedy's remarks from the press conference, a letter of opposition signed by 224 advocacy groups, and a summary of the bill.

**REMARKS OF SENATOR EDWARD M. KENNEDY**
**RALLY ON ENZI-NELSON BILL**
**(As Prepared for Delivery)**

We're here today to say that quality, affordable health care should be the birthright of each and every American.

And we're going to fight for that right this week in the United States Senate.

It's high time for the big insurance companies and drug companies and the special interests to get out of the way. It's time at long last for every American to have access to the best care, best treatment, and best cures that medicine has to offer.

Isn't that what we're for?

Isn't that what we're all about?

But the bill the Senate considers today undermines our progress.

Its supporters say that the legislation is about helping small business. But the legislation the Senate considers today isn't an advance – it's a retreat.

It's a retreat from our commitment to cancer.

It's a retreat from our commitment to diabetes.

It's a retreat from our commitment to mental health parity.

Let me ask you this. Are you going to let the Senate retreat from quality health care?
You can do better than that. Let them hear you loud and clear all the way down on K Street.

Tell them to take their hands off your health care.
Now, let me ask you again. Are you going to let the Senate take away your rights?

That's right. We are not going to retreat.

And let me ask our Republican friends this question.

If this is health week, then when's the vote on stem cell research?

If this is health week, then when's the vote on fixing the Medicare drug program?

If this is health week, then when's the vote on drug importation?

If this is health week, then when's the vote at long last to make health coverage the right of every man, woman, and child in America?

We know we can do it. We know that America can come together to get the job done.

So let's roll up our sleeves for progress this week -- for your health care, for your family's health care, for the nation's health care.

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May 8, 2006

Dear Senator:

The undersigned organizations are writing in opposition to the Health Insurance Marketplace Modernization and Affordability Act, S. 1955. This controversial legislation would preempt state insurance laws, not just in the small group market (as is done by Association Health Plan legislation), but also in the individual and large group markets. S. 1955 would eliminate all the progress states have made to ensure that consumers have adequate health coverage.

S. 1955 would take away the states' power to regulate health insurance. The bill preempts benefit, service and provider laws that states have enacted to ensure that consumers have adequate health coverage. Coverage for cancer screenings and treatment, diabetes supplies and education, mental health, preventive care, rehabilitation, well-child care and immunizations, maternity care, and other important health care needs would be lost. S. 1955 also exempts Small Business Health Plans (SBHPs, also known as AHPs) from state benefit, service and provider access laws.

Insurance companies, instead of state-elected legislators, would now decide the benefits that consumers should have when they purchase health care. States would have no recourse to protect their own residents and they would lose any incentive to enact protective health insurance laws in the future and be laboratories for healthcare innovation.

An insurer would only need to meet one requirement in order to bypass a state's protections: offer a second plan that resembles a plan offered to state employees in one of the five most populous states. There are no limits on the cost-sharing an insurer can charge, nor is there a requirement that the plan be comprehensive. In fact, an insurer could choose a high deductible/HSA plan, an option now available to employees in at least one of the five most populous states. Again, a state has no recourse if this so-called enhanced option does not meet the needs of its residents.

S. 1955 also would preempt stronger state laws that limit the ability of insurers to vary premiums based on health status, age, gender and geography. For many older, sicker Americans and those with complex health needs and disabilities, this would price them out of the health insurance market, undermining the stated purpose of the legislation. The bill imposes on all the states an outdated model law created by the National Association of Insurance Commissioners (NAIC), rather than using the NAIC's current model standard that is more protective.

While the sponsors of S. 1955 have attempted to address the shortcomings of the AHP legislation, their solution makes things worse by endangering the quality of health care for the 68 million Americans in state-regulated group health plans and 16.5 million Americans with individual coverage. A bill that preempts over 1,000 state laws, raises premiums for those who need coverage the most, and leaves people uninsured for certain diseases, basic preventive care and events such as pregnancy, should be rejected.

We urge your opposition to this legislation.

Sincerely,

National Partnership for Women & Families
9 to 5 Association for Working Women
Action Alliance of Senior Citizens of Greater Philadelphia
Alabama Psychological Association
Alliance for Advancing Nonprofit Health Care
Alliance for Justice
Alliance for the Status of Missouri Women
American Academy of Child & Adolescent Psychiatry
American Academy of HIV Medicine
American Academy of Pediatrics

American Academy of Pediatrics – Nebraska Chapter
American Academy of Physician Assistants
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of People with Disabilities
American Association on Mental Retardation
American Chiropractic Association
American College of Nurse-Midwives
American Counseling Association
American Diabetes Association
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Foundation for the Blind
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Pediatric Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Speech-Language-Hearing Association
Arizona Action Network
Arizona Business and Professional Women
Arizona Psychological Association
Asociacion de Psicologia de Puerto Rico
Assistive Technology Law Center
Association of Medical School Pediatric Department Chairs
Association of University Centers on Disabilities
Association of Women's Health, Obstetric and Neonatal Nurses
B'nai B'rith International
Bazelon Center for Mental Health Law
C3: Colorectal Cancer Coalition
California Coalition for PKU and Allied Disorders
California Black Health Network
California Psychological Association
Campaign for Better Health Care - Illinois
Capital District Physician's Health Plan, Inc.
**Catholics for a Free Choice**
**Center for Civil Justice**
**Center for Justice and Democracy**
Center for Women Policy Studies
Children's Alliance
Citizen Action/Illinois
Citizen Action of New York
Clinical Social Work Guild 49, OPEIU
Coalition on Human Needs
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Progressive Action
Colorado Psychological Association
Committee of Ten Thousand
Communications Workers of America
Connecticut Citizen Action Group

Consumers for Affordable Health Care
Delaware Alliance for Health Care
Delaware Psychological Association
Department for Professional Employees, AFL-CIO
Disability Rights Wisconsin
District of Columbia Psychological Association
Easter Seals
Empire Justice Center
Epilepsy Foundation
Excellus Blue Cross Blue Shield
Families USA
Families with PKU
Family Planning Advocates of New York State
Florida Consumer Action Network
Georgia Rural Urban Summit
Guttmacher Institute
HIP Health Plan of New York
Hawaii Psychological Association
Health and Disability Advocates
Hemophilia Federation of America
Idaho Psychological Association
Illinois Alliance for Retired Americans
Illinois Psychological Association
Indiana Psychological Association
Institute for Reproductive Health Access
International Association of Machinists & Aerospace Workers
International Brotherhood of Electrical Workers
International Longshore & Warehouse Union
Iowa Citizen Action Network
Iowa Psychological Association
Kansas Psychological Association
Kentucky Task Force on Hunger
League of Women Voters
Maine Children's Alliance
Maine Dirigo Alliance
Maine People's Alliance
Maine Psychological Association
Maine Women's Lobby
Massachusetts Psychological Association
Maternal and Child Health Access
Mental Health Association in Michigan
Mental Health Legal Advisors Committee (Commonwealth of Massachusetts)
Michigan Association for Children with Emotional Disorders
Michigan Campaign for Quality Care
Michigan Citizen Action
Minnesota COACT
Minnesota Psychological Association
Missouri Association of Social Welfare
Missouri Progressive Vote Coalition
Montana Psychological Association
Montana Senior Citizens Association, Inc.

NAADAC – The Association for Addiction Professionals
NETWORK, a National Catholic Social Justice Lobby
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of Social Workers
National Association of Social Workers, Arizona Chapter
National Association of County Behavioral Health and Developmental Disability Directors
National Coalition for Cancer Survivorship
National Consumers League
National Council for Community Behavioral Health Care
National Council of Jewish Women
National Council on Independent Living
National Disability Rights Network
National Family Planning and Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Hemophilia Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Organization for Women
National Rehabilitation Association
National Research Center for Women & Families
National Urea Cycle Disorders Foundation
National Women's Health Network
*National Women's Law Center*
Nebraska Psychological Association
Nevada State Psychological Association
*New Hampshire Citizens Alliance*
*New Jersey Citizen Action*
New Jersey Psychological Association
*New Mexico PACE*
New Mexico Psychological Association
New York Civil Liberties Union Reproductive Rights Project
New York State Health Care Campaign
New York State Psychological Association
North Carolina Justice Center's Health Access Coalition
North Carolina Psychological Association
North Dakota PKU Organization
North Dakota Progressive Coalition
North Dakota Psychological Association
Northwest Health Law Advocates
Northwest Women's Law Center
Ohio Psychological Association
Oklahoma Psychological Association
Oregon Action
Oregon Advocacy Center
Oregon Psychological Association
Organic Acidemia Association
Patient Services, Inc.
Pediatrix Medical Group
Pennsylvania Council of Churches
Pennsylvania Psychological Association

Philadelphia Citizens for Children and Youth
Philadelphia Coalition of Labor Union Women
*Planned Parenthood Federation of America*
Planned Parenthood of New York City
Population Connection
*Progressive Maryland*
*Public Citizen*
*RESULTS*
Religious Coalition for Reproductive Choice
Reproductive Health Technologies Project
Rhode Island Ocean State Action
Rhode Island Psychological Association
Sargent Shriver National Center on Poverty Law
Save Babies Through Screening Foundation
Senior Citizens' Law Office
*Small Business Majority*
Society for Pediatric Research
South Dakota Psychological Association
Suicide Prevention Action Network USA
Summit Health Institute for Research and Education, Inc.
Tennessee Citizen Action
Tennessee Psychological Association
Texas Psychological Association
*The Arc of the United States*
*The Black Children's Institute of Tennessee*
*The Disability Coalition of New Mexico*
The Institute for Reproductive Health Access
*The Senior Citizens' Law Office*
The Virginia Academy of Clinical Psychologists
Triumph Treatment Services
USAction
USAction Education Fund
U.S. PIRG (Public Interest Research Group)
Union for Reform Judaism
United Association of Journeymen and Apprentices in the Plumbing and Pipe Fitting Industry
*United Cerebral Palsy*
*United Food and Commercial Workers*
*United Senior Action of Indiana*
*United Steelworkers International Union*
*United Vision for Idaho*
Univera Healthcare
Universal Health Care Action Network
Utah Health Policy Project
Vermont Coalition for Disability Rights
Vermont Office of Health Care Ombudsman
Voices for America's Children
Voices for Virginia's Children
Washington Citizen Action
Washington State Coalition on Women's Substance Abuse Issues
Washington State Psychological Association
West Virginia Citizen Action Group
West Virginia Psychological Association
Wisconsin Citizen Action

Wisconsin Psychological Association
Women of Reform Judaism
World Institute on Disability
Wyoming Psychological Association

# SUMMARY OF THE BILL
# The Health Insurance Marketplace Modernization Act Will Increase Costs and Reduce Benefits for Many

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Senate Democrats have a longstanding commitment to making health care affordable for all and are committed to addressing the unique and serious challenges small businesses face trying to find affordable health insurance. But while there is bipartisan support for addressing this problem, the Health Insurance Marketplace Modernization and Affordability Act (HIMMA), S. 1955, takes the wrong approach and could make a bad situation worse for many small businesses and for millions of other Americans who could lose health benefits on which they rely. Instead of making health coverage more affordable for all small business employees, S. 1955 would reduce access to important health benefits and substantially increase premiums for people who need health coverage the most. S. 1955 goes far beyond small business coverage, gutting state regulation of health insurance in all markets, thereby undermining critical benefits and protections for consumers.

Under HIMMA, carefully constructed insurance rules that states have adopted, and continue to support, would be preempted by new federal rules. The authority to set standards for adequate health benefits and fair premium rates would be taken out of the hands of state governors and legislatures and replaced with greater latitude for insurers. Specifically, S. 1955:

- Preempts existing state benefit requirements that assure consumers that their health insurance will provide sufficient protection against the cost of illness and cover preventive services that help identify medical problems at earlier, more treatable stages.

- Preempts requirements in many states that ensure fair and stable insurance premiums by limiting the factors such as age, health status, and gender that insurers can use in setting premiums and limiting the variation that insurers can charge different groups.

- Creates a process, in which the interests of insurers would be represented but the concerns of consumers would be given little voice, that would establish federal standards for other consumer protections typically regulated by states such as: form and rate filing requirements (which help states prevent insurers from selling products that do not comply with state rules); market conduct reviews; prompt payment of claims; and internal reviews.

- Envisions that states would enact the federal standards in the bill or, if they do not, allows

insurers to operate according to the federal standards, regardless of state requirements.

While the proposed changes may reduce premiums for some groups, they would increase premiums and out-of-pocket costs for others, especially those who need health coverage the most. Preempting these state laws would reduce much of the risk-sharing that many states now require, which would force older and sicker groups to cover a greater share of health care costs.

Reduces access to critical benefits. HIMMA replaces state benefit requirements with a new standard that would allow insurers and small business health plans to offer "basic" benefit plans (that would not have to include state-required benefits) as long as they also make available an "enhanced" benefit plan (which would be equivalent to one of the benefit plans available to state employees in one of the five most populous states). While preempting state benefit requirements may provide some benefit to healthy groups who do not need those benefits at this time, premium savings would likely be modest since required benefits typically do not add much to the overall cost of health insurance. In addition, it undermines the reason most people want health insurance in the first place – to help cover their costs if they become sick. Moreover, preempting state benefit requirements would substantially increase health costs for people who require those benefits. The bill would create adverse selection problems, trigger a "race to the bottom," and would likely hinder access to critical health care services.

- States have taken steps to ensure that health insurance sold in their states provides adequate protection for those who need it. States have required insurers to cover certain benefits, services, and health care providers, such as cancer screenings, maternity care, mental health services, well-child care, costs related to clinical trials, and diabetes supplies and education. By requiring all health plans to cover these benefits, the cost is spread across all insured groups and, therefore, these benefits are more affordable for people who need them.

- The new standard in S. 1955 would create a serious adverse selection problem: healthy groups would join bare-bones plans, and older and sicker groups would join "enhanced" benefit plans (although there is no guarantee that these enhanced plans will actually offer comprehensive coverage). Insurers already will have an incentive and the freedom to price enhanced benefit plans at unaffordable rates and, as healthy groups shift to bare-bones plans, premiums would spiral upward for enhanced benefit plans because healthy groups would no longer be helping to cover their cost. Older and sicker groups would have to pay substantially more than they do today for comprehensive coverage and may find themselves unable to afford premiums for the health plans that cover their health care needs.

- By no longer requiring that all insurance policies provide adequate health benefits, S. 1955 would trigger a race to the bottom. Competitive pressures and a need to avoid adverse selection will provide a strong incentive for insurers to offer health plans with minimal coverage. No insurer will want to offer a health plan that older and sicker groups would be attracted to. With the proliferation of bare-bones plans, more people will have health coverage that will not protect them when they need it. Inadequate coverage could prevent patients from obtaining needed medical care or expose them to unmanageable out-of-pocket costs.

- While supporters of HIMMA note that insurers will also have to offer an enhanced benefit plan, this requirement provides no protection for patients who are likely to need state-required benefits. The bill provides no assurance that enhanced plans will be affordable and, as noted above, the adverse selection problem almost ensures that they will be unaffordable. There is nothing in the bill, for example, that would prevent an insurer from offering an enhanced plan with a deductible of thousands of dollars. Also, the standard for an enhanced benefit plan is a tenuous one. If one of the five most populous states decides to offer its state workers an option of a slimmed-down benefit plan that excludes important benefits, then the "enhanced" benefit standard in all states would be similarly

reduced. Decisions taken in one state would effectively set health care coverage standards for all other states.

Increases premiums to older and less healthy groups. The bill preempts state premium-setting rules and replaces them with an outdated guideline that would undercut efforts by many states to make premiums more affordable and stable for those who need health coverage the most. S. 1955 would give insurers in many states greater latitude to charge higher rates to less healthy people, older groups, women, small businesses with fewer workers, and higher-risk industries.

- States have taken different approaches to setting rules for establishing premium rates. Some states permit insurers to charge older and sicker groups much higher premiums than healthy groups, while other states place stricter limits on the premiums that insurers can charge different groups. Each state's decision reflects its determination about what constitutes a fair premium and to what extent healthy groups should help cover the cost of more expensive groups.

- S. 1955 preempts state rating rules for small groups and replaces them with an outdated model act developed by the National Association of Insurance Commissioners (NAIC) in 1993. S. 1955 would permit insurers and small business health plans to charge premiums that are much higher for older and sicker groups than healthy groups. The bill permits premiums to vary +/- 25 percent within a class of business (for groups with similar characteristics) and +/- 20 percent between classes. Insurers could increase rates further on the basis of age, gender, geographic area, and group size. According to some estimates, the rating rules in HIMMA would allow insurers and small business health plans to charge some groups as much as 25 times more than others. (Memo from the Deputy Commissioner of the New Hampshire Department of Insurance to the NAIC, March 13, 2006)

- NAIC itself has rejected the rating model that HIMMA would impose nationwide. Instead of recommending rating bands, as it did in 1993, it now recommends adjusted community rating, which does not allow rating to be based on health status. The new NAIC model sets stricter limits on how much insurers can vary premiums than the original 1993 model, yet S. 1955 allows insurers to follow the outdated NAIC standard. Furthermore, only four states currently follow the health and industry ratings requirements in the 1993 NAIC model. Many other states modified the 1993 NAIC model before enacting these rating rules in their state, setting additional limits on how much insurers can charge certain groups. (Kofman and Pollitz, April 2006)

- The lenient rating rules in S. 1955 means older and less healthy groups in states that have enacted more protective rating rules (e.g., adjusted and pure community rating or tighter rating bands) would be charged dramatically higher premiums than they would be under current rules. Ten states currently have adjusted or pure community rating for all insurers in the small group market while two additional states require adjusted community rating for certain insurers. Many other states have rating bands that place more limits on insurers' ability to charge higher premiums based on medical needs, industry, employer size, age, gender and other factors than the 1993 NAIC model used by S. 1955. (Kofman and Pollitz, Georgetown University, April 2006)

- New Hampshire's experience provides a cautionary tale about possible consequences of shifting from adjusted community rating to rating bands similar to those proposed under S. 1955. When New Hampshire shifted from adjusted community rating to rating bands in 2003, premiums increased dramatically for many small businesses with older and less healthy workers. New Hampshire lawmakers responded by repealing the rate bands in 2005 and restoring adjusted community rating rules. Now S. 1955 would force New Hampshire to adopt again the rating bands that the state just rejected. (Center on Budget and Policy Priorities, April 26, 2006)

- S. 1955 would also leave in place some of the obstacles that self-employed people face when

trying to find affordable and accessible health coverage. While the self-employed could join SBHPs, these plans would have to abide by state rating and underwriting rules. Self-employed individuals in states that do not guarantee issue could find that an insurer excludes them from coverage or that the premium charged by an insurer is unaffordable because of the lenient rating rules in the state's individual market.

Opens the door for fraud and abuse. Small employers can be prime targets for health coverage scams. States play a leading role in identifying and shutting down unlicensed health insurers – which can promise affordable coverage but leave policyholders with large unpaid medical bills – as well as ensuring that licensed health plans adhere to state insurance requirements. The inadequate oversight and enforcement mechanisms in S. 1955 could create opportunities for bad actors to take advantage of small businesses seeking affordable health coverage.

- Attorneys General in 41 states have expressed their "strong opposition" to S. 1955, which they said "will erode state oversight of health insurance plans and eliminate consumer protections in the areas of mandated benefits and internal grievance procedures." They noted that after Congress exempted Multiple Employer Welfare Arrangements (MEWAs) from state law in the 1970s, at least 398,000 consumers were left with more than $123 million in unpaid claims. (National Association of Attorneys General letter, April 27, 2006)

- HIMMA would establish federal standards but not provide federal authority or resources to enforce those standards. Instead, the bill's supporters envision that state officials will monitor and enforce federal standards that they did not create and may not agree with. With no provisions for a back-up enforcement role for the federal government, the bill creates the possibility of a regulatory vacuum with little or no oversight of insurers.

- The bill contains a strong disincentive for states to conduct rigorous oversight and enforcement. Insurers would be given the right to sue states in federal court when they disagree with the interpretations or actions of state regulators. However, consumers would be denied this same access to federal court. The bill includes no federal cause of action for consumers to go to federal court to ensure that insurers adhere to the federal standards.

- The bill would deem a small business health plan (SBHP) to be federally certified if the Department of Labor does not act on its application within 90 days. Given the short timeframe and limited resources, it is unclear how thoroughly the Department of Labor could review a SBHP's application.

Would be less effective at lowering costs and expanding coverage than alternative proposals. By focusing solely on providing health coverage through multiple association plans and lacking any financial assistance for small businesses, S. 1955 will be less successful than alternatives like legislation sponsored by Senators Durbin and Lincoln (S. 2510) at giving small businesses some of the same advantages that large businesses have.

- Small businesses have an especially difficult time affording health insurance and are typically charged higher premiums than large groups. Because of their smaller size, they are less able to achieve administrative economies of scale, spread risk, and negotiate better rates.

- S. 1955 is likely to be less effective in addressing key obstacles small businesses face – higher administrative costs and lack of bargaining power – than the Durbin-Lincoln bill. S. 1955 envisions administrative savings and bargaining power coming from the formation of multiple association-based small business plans. But the Durbin-Lincoln bill would create a much larger insurance pool (available to all small businesses with fewer than 100 workers) that would be better able to lower administrative costs through economies of scale and to negotiate lower rates through enhanced

bargaining power. (Nichols, April 6, 2006)

- S. 1955 would, as noted earlier, not address some of the obstacles that self-employed people face when trying to find affordable and accessible health coverage. While the self-employed could join SBHPs, these plans would have to abide by state rating and underwriting rules, which could make coverage unaffordable or inaccessible, especially for the self-employed who are older or in less-than-perfect health. In contrast, the Durbin-Lincoln bill would allow the self-employed to participate in its large small employer pool and benefit from guarantee issue and adjusted community rating.

- S. 1955 also does not provide a health insurance tax credit to small businesses whereas the Durbin-Lincoln bill would provide a tax credit to employers on behalf of low-wage workers that would be equal to 25 percent of the cost of self-only policies, 30 percent of premiums for employees who are either married or are single with a child, and 35 percent for family policies. To be eligible, employers would have to agree to pay at least 60 percent of each employee's health insurance premium. The Durbin-Lincoln bill also includes a temporary reinsurance pool that would cover much of the cost of high-cost claims.

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