



June 4, 2009

House Members Pelosi, Waxman, Miller, Stark and Rangel
Senators Baucus, Kennedy and Dodd
U.S. Congress
Washington, D.C. 20515

Dear Madam Speaker and Chairmen,

Ten years ago, many in Congress, including most of you, supported a comprehensive “Patient Bill of Rights” that was ultimately killed by health insurance lobbying. The measures would have protected patients against the worst insurance industry abuses and included strong legal accountability for insurers. The proposals now offered by the House and Senate make the need for such rights more critical than ever, yet outlines of the pending proposals fail to mention the HMO Patient Bill of Rights measures at all.

Both the House and the Senate recently debuted plans requiring all Americans to show proof that they own a health insurance plan or be treated as criminals—tax cheats facing thousands of dollars in fines. Yet the proposals fail to make insurers accountable for their actions. Nor do the Congressional plans cap what insurers can charge in monthly premiums or how much Americans would have to pay out-of-pocket, and do little to curb the most common abuses, particularly delay and denial of care.

Have we forgotten what the HMO and health insurance industry is capable of? Congress’ plan to require Americans to buy health insurance policies or face tax fines would further cede control of our health care system to an industry that has demonstrated that it will stop at nothing—including killing its customers—to make a profit. Not surprisingly, Americans are overwhelmingly opposed to such an approach: a national poll found that only 16% of Americans support mandatory purchase of policies from for-profit insurers. Insurers are less trusted than any other major industry in a 2009 Edelman survey of informed consumers (http://www.edelman.com/trust/2009/docs/Trust_Book_Final_2.pdf).

Legal accountability and robust regulatory controls must be put into place to curb the worst of the industry’s abusive practices, doubly so if Congress envisions passing a mandatory purchase requirement. Requiring Americans to buy insurance coverage from insurers who face no legal accountability will only lock them into the same problems plaguing consumers today. We urge you to put the HMO Patients’ Bill of Rights back on the table in developing health care reform legislation. The top problems plaguing health care consumers that are not adequately addressed by the House and Senate plans are:

- 1. Killing patients with fine print.** Health insurers have bankrupted and killed patients with the fine print of health insurance contracts. A consistent theme of the industry’s anti-consumer arsenal has been the use of incomprehensibly technical language buried in

insurance contracts to refuse needed care when care is needed most. Case in point: insurance companies now commonly refuse to cover certain proven treatments for autistic children by redefining them as “education.” Delays of such care during crucial periods of early development mean autistic children may never improve to their full potential. They also seize on “pre-authorization” and proper “coding” requirements to block care. The lack of legal accountability and financial consequence for insurers that refuse to honor promises to pay for health care encourages this practice. (See point 7 below).

2. **No definition of “medical necessity” and “experimental treatment.”** HMOs make false claims that doctor-recommended care is not “medically necessary” or is “experimental” in order to deny care that is too expensive. Though state laws provide factors for determining whether care is truly medically necessary or experimental, there are no effective financial consequences for such denials by false classification. As a result, insurance companies commonly use this tactic to dodge necessary and legally required treatments. (See point 7 below).
3. **Delays of medical care.** HMOs consistently delay care, tangling a request in bureaucracy, as another way of denying care—making patients wait so long that the requested treatment is no longer viable. Despite state independent medical review laws that can theoretically remedy denials, the lack of financial consequences for delay in most circumstances encourages this practice to continue. (See point 7 below).
4. **Junk insurance.** Far too often, patients find that their health insurance policies are not worth the paper they are printed on. Junk insurance policies that are often sold to individuals do not adequately cap out-of-pocket costs (copays and deductibles) and some even put dollar caps on certain treatments. Also increasingly common are very high-deductible policies, which require patients to pay thousands of dollars out-of-pocket before coverage kicks in. All of these are really insurance for health insurers because companies know that cash-strapped Americans will not be able to afford to go to the doctor even if they can pay the monthly premium. For example, Dana Christensen of California and her husband Doug bought a policy that promised unlimited chemotherapy coverage. Only after Doug got cancer did the Christensens discover that their insurance policy limited chemotherapy coverage to \$1,000 per day. Chemotherapy commonly costs \$17,000 or more a day. Dana was left with \$450,000 in unpaid medical bills when Doug died.
5. **Manipulating “risk.”** Not only do health insurance companies and HMOs use their internal rules for assessing risk—called “medical underwriting” guidelines—to refuse coverage to those with pre-existing conditions, even minor health issues like allergies, acne, and asthma, but also to charge higher rates to applicants with those conditions. Though the plan envisioned by the House and Senate would bar insurers from refusing to sell coverage based on an applicant’s health history, it is unclear to what extent companies will be allowed to continue to underwrite. Under the Senate plan, Americans with minor health conditions may be forced into the lowest tier insurance policies, which will carry the highest out-of-pocket costs and more limits on benefits. This scenario was a feature of the failed California effort in 2007-08 to mandate health insurance.

- 6. Dumping the sick.** Postclaims underwriting includes the current practice of insurers waiting until someone gets sick with an expensive-to-treat illness to then go back and seek a reason to cancel the policy. Presumably, companies could not leave patients uninsured after a major illness under the plan envisioned by the Congress, but nothing in House or Senate documents bars an insurer from transferring a sick patient into the lowest-benefit policies. As more sick people dominate such policy categories—called “risk bands”—the policies available to them become more and more expensive. Ultimately fewer people can afford them and lose their policies or are forced into ineffective coverage (see “junk insurance” above). In the industry this process is called the “death spiral.” Other more mundane postclaims underwriting—for example, raising premiums or out-of-pocket costs after a patient gets sick—also effectively block access to care and are not barred under the House and Senate plans. The lack of legal accountability and financial consequence for insurers that dump patients, or price them out of policies, when they get sick encourages this practice. (See point 7 below).
- 7. No accountability.** For patients who receive health coverage through a private employer, HMOs and health insurers face no financial consequences for mishandling claims. The Supreme Court decision in *Pilot Life Insurance v. Dedeaux* stated that “state common law causes of action arising from the improper processing of a claim are preempted.” Under the Employee Retirement Income Security Act (ERISA) and the *Pilot Life* decision, lawsuits are removed to federal court where victims can only recover the cost of the procedure or service denied in the first place—no damages or penalties are allowed. As a result, HMOs and insurers are largely free to deny access to care without fear of reprisal or financial consequences. Any health care overhaul should overturn *Pilot Life* and restore the reach of state common law.
- 8. Refusing access to expensive doctor recommended medications and devices.** HMOs and insurers often refuse to authorize and pay for “off-label” use of expensive medications used to save cancer patients even though there is substantial evidence of their efficacy. For example insurers have routinely denied the use of Avastin for ovarian cancer even though it has been proven highly effective. State-of-the-art prosthetic devices are routinely denied as not “medically necessary.” The lack of financial consequences for HMOs that refuse to defer to doctors encourages these practices.
- 9. Balance billing and Network Restrictions.** Many Americans have been surprised to receive a bill from an emergency room doctor after receiving emergency treatment. The problem is that physicians who are not part of the injured person’s HMO or insurance network are unsatisfied by the insurance company’s low payment for treatment. The practice of physicians sending an additional bill to the patient to make up the difference between what the insurer paid and what the doctor believed was the fair cost of the service—known as “balance billing”—is rooted in the problem that insurance companies refuse to pay fair rates. A recent lawsuit settled by New York Attorney General Andrew Cuomo found that health insurers grossly underestimate so-called “customary and reasonable” payments for PPO care, which leads physicians to send the large balance of the bill to patients.
- 10. Staggering rate increases.** Though a handful of health insurers control the market, no federal government entity is charged with overseeing insurance pricing. As a result,

Americans experience cartel-like cost increases—largely driven by health insurance overhead and profit. Double-digit annual premium increases—ranging from 30-80% this year for individuals and small business owners—force many into high deductible insurance policies. As a May 27 *New York Times* article describes, federal regulation is necessary since the industries' recent promises to coordinate to voluntarily reduce rates would violate anti-trust laws.

The current Congressional plans fail to address these problems and do not include the kind of robust legal accountability and regulatory controls necessary to protect our health from insurance companies. At a minimum, health care reform should include these HMO accountability measures:

- Require that for all policies, whether treatments, medications, or devices are “medically necessary” or “experimental” shall be determined by independent medical experts who give deference to the treating physician’s recommendation.
- Restore legal accountability and financial consequences for the wrongful denial of a treatment request by establishing the right of all patients to recover damages under state common law in the event that an insurer mishandles their claim.
- Provide out-of-pocket maximums that guarantee that no insured patient will go bankrupt paying medical bills.
- Adopt a federal ban on balanced billing that guarantees no insured patient is held financially responsible in collections for an insurer’s refusal to fully pay a legitimate claim.
- Adopt a national ban on medical underwriting and post-claims underwriting.
- Require mandatory premium and benefit regulation by state insurance commissioners to guarantee that policies are reasonably priced and include adequate benefits.

As we have previously written, any health care reform should include a public option to the for-profit insurance market. However, that does not replace the need for legal and regulatory protections for those Americans who choose to buy from the private market. These are essential elements of reform that are in danger of being left off the table. We ask not only that you address these problems in legislation, but to also hold separate hearings to hear evidence from patients, doctors and experts on these abuses and the need to remedy them.

Sincerely,



Jamie Court



Jerry Flanagan

cc: President Obama