

Regulating insurance: who wins and who loses?

By Joel B. Finkelstein

The latest tussle over insurance legislation pits the American Cancer Society and its supporters against business associations that want to establish national pools under one Federal rule, and not the many mandates of individual states. This time around, the legislation appears to have a better chance of passing in both the House and Senate. And that has the ACS worried that patients will be harmed.

It isn't exactly "sex-sells" marketing, but the American Cancer Society (ACS) recently launched an advertising campaign featuring a bra and the tag line: "Don't let the Senate leave women exposed." What the ad means to convey is the consensus of several patient advocacy groups that legislation in the Senate would allow private insurers to circumvent hard-won state mandates guaranteeing access to cancer screening, prevention, and treatment for millions of patients.

"The bottom line for us at the American Cancer Society is that we know this bill, while well intentioned, would actually be worse than no bill," says John Seffrin, PhD, the association's chief executive officer. "It would jeopardize access to critical cancer screenings and treatment, including, of all things, mammograms." Dr. Seffrin made his remarks at a recent press briefing announcing the launch of the ACS Cancer Action Network (CAN), which will work to counter Senate Bill 1955 (S. 1955), The Health Insurance Marketplace Modernization and Affordability Act, recently passed through the US Senate Health, Education, Labor, and Pensions Committee.

ACS is working jointly with the American Diabetes Association and AARP.

Economies of scale

The bill is the latest measure al-

lowing national associations to establish benefit packages that operate under one set of Federal rules, rather than the various state rules with which they now must comply. The associations and business groups that have lobbied for these types of bills contend that by allowing them to work more easily on a national level, they could negotiate better deals with insurers and take advantage of economies of scale, just as large, self-insured corporations currently do.

Consolidation in the marketplace has led to a decline in competition among health care plans and that in turn has led to a decline in the percent of each premium dollar that goes to pay medical cost, along with a strong trend toward higher premiums, higher profits, and higher stock prices, James Robinson, PhD, MPH, told the *Washington Post* recently. Dr. Robinson is a professor of health economics at the University of California, Berkeley.

"This appears to have been accomplished on the backs of small employers who have borne the brunt of these double-digit rate increases for the past 5 years," says Joseph Rossmann, vice president of fringe benefits at Associated Builders and Contractors (ABC).

This legislation would allow associations such as ABC to level the playing field and offer its members more affordable alternatives, said Mr. Rossmann. One of the main

provisions of S. 1955 is to allow certified associations to establish national insurance pools regulated under Federal rules with coverage provided by licensed private insurers. Although the association plans could offer coverage options that varied from state-required benefits, they would also have to offer a benefit option that complied with some state mandates. In addition, the bill does away with a state-mandated community rating, reverting to national rules based on a model developed by the National Association of Insurance Commissioners.

Who wins, who loses?

The need to comply with a growing and varied list of state requirements has made it increasingly difficult for association health plans to remain viable, said Mr. Rossmann. Over the past several years, the company that provided coverage for ABC members has pulled out of one state after another. "ABC had a strong and viable program, which was gradually dismantled by well-intentioned insurance reform," he said.

State mandates have also played a key role in ensuring access to necessary medical care, say opponents of S. 1955. The bill threatens to wipe away important patient protections that advocacy groups like the ACS have worked to pass in the states. For example, 49 states currently require

that private insurers provide access to mammography services. Those mandates would be negated under the proposed law, in part allowing insurance companies to lower premiums by 2% to 3%, according to a recent report from the Congressional Budget Office (CBO).

That analysis of S. 1955 estimated that lower prices would result in cov-

Discriminating against the little guy

LIKE MANY THINGS IN LIFE, health coverage favors scale. Larger businesses evade benefit mandates that smaller ones must cover. No national numbers on small business health benefits exist, but recent data from Florida, which is probably representative on this issue, showed that the number of small businesses offering health benefits fell 52% between 1996 and 2004. Benefit mandates aren't the main drivers of unrelenting cost growth, but they contribute to it.

Private health coverage—bought by individuals and businesses—accounts for about half the money that drives American healthcare and comes in two forms. Smaller businesses buy insurance from companies that assume the financial risk and management associated with potential health events.

Currently, insurance programs are regulated by agencies in the states where they are active. In every state, healthcare special interests—from chiropractors to cancer associations—lobby legislators to mandate health benefits that every state-regulated health plan must cover.

But benefit mandates don't apply to larger businesses that can self-fund health coverage under ERISA, the 1974 Employee Retirement Income Security Act. Larger businesses assume the financial risk associated with health events and typically manage their health plans through "Administrative Services Only" arrangements. The Federal law that guides ERISA plans allows employer-sponsors to define their own benefits packages and trumps state regulations.

In other words, mandated benefits may be hard won and worthwhile, but they're applied unevenly and are borne by those least capable of affording them.

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erage for 700,000 currently uninsured people by 2011, when impact of the legislation peaks. However, 100,000 people who had coverage would lose it under the proposed law. The newly covered people would generally be patients with lower health costs than those who lost their insurance, according to the CBO.

"We're all for increasing access, but not at the cost of failing to cover the things that patients need when they are diagnosed with cancer or any other disease," said Daniel E. Smith, CAN's national vice president of government relations. Under S. 1955, there will be no guarantee that insurers will have to cover services crucial to cancer prevention, clinical trials, or off-label drug use, according to Mr. Smith. "This bill would overturn 20 years of work we have put in at the state level."

Going without

People who are uninsured are already going without this type of coverage, said the S. 1955's sponsor, Sen. Mike Enzi (R-Wyo.). "If you can't afford insurance, you aren't getting coverage for any procedures, mandated or not. My bill would allow a small business benefit health association to offer a more affordable healthcare package that may not include some of the state's benefit mandates, but it would be required to offer a comprehensive alternative package," he added.

However, the bill would also undo state community rating strategies designed to ensure that health coverage is available to everyone at an average cost. While community rating has also been blamed for pushing up the cost of premiums, states that have tried going without them have seen health insurance become unaffordable for their older and sicker residents, according to experts.

"This bill really takes insurance in the wrong direction," says Dr. Seffrin. "The idea of insurance is to spread the risk as far as you possibly can. What this bill does is break that up

into much smaller pieces."

An old idea, not so new again

Creating national rules for association health plans (AHPs) is not a new idea. Some variety of AHP legislation has been introduced and passed in the House for the past 8 years. However, until now similar legislation has made little headway in the Senate.

What makes S. 1955 different from those previous bills is that under this legislation, all private insurers would become eligible to play by the new Federal rules, not just association-based plans. "The Enzi bill is even worse, because it expands the universe of plans that are going to be able to ignore these mandated coverages," Mr. Smith said.

This difference has had an immediate impact. Although private insurers have opposed previous AHP legislation—including the bill currently pending in the House—industry opposition has dropped off for S. 1955, leading some experts to predict that this version of AHP reform has the best chance of passing of any previous proposal.

That has ACS, as well as its partners, worried enough to launch its national campaign in the hope of turning public opinion against the measure. The ACS is also speaking to members of the House and Senate to educate them about the implications of the bill before it comes up for a floor vote. The more members learn about the legislation, the less they like it, the groups said.

"This bill really turns the whole regulation of insurance upside down," said Dr. Seffrin. "Today it is a state-regulated enterprise. This bill in essence seeks to establish very minimal Federal standards to replace a whole range of different things that consumers and employees receiving health insurance from their employers have come to expect today."