



National Association of Health Underwriters

America's Benefits Specialists

December 20, 2009

The Honorable Harry Reid
Majority Leader, U.S. Senate
522 Hart Senate Office Building
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader, U.S. Senate
361 A Russell Senate Office Building
Washington, DC 20510

Dear Leaders Reid and McConnell:

On behalf of the membership of the National Association of Health Underwriters (NAHU), a professional trade association representing more than 100,000 health insurance agents, brokers and employee benefit specialists from all across America, I would like to expressly state our formal opposition to H.R. 3590, *The Patient Protection and Affordable Care Act of 2009*. Instead of pushing a vote this week on this flawed measure that creates a balkanized insurance market, NAHU urges you in the strongest of terms to reconsider this legislation. We encourage you to work together on a bipartisan basis to develop an affordable and responsible means of achieving the needed reforms to our nation's health care delivery system. No legislation of this magnitude should rely on only the support of one party.

NAHU members help individuals and employers of all sizes purchase health insurance coverage, use their coverage effectively and make sure they get the most out of the benefits they have purchased. We want all Americans to have access to the highest quality and most efficient health care delivery system possible, and we do believe that changes to our existing system are necessary.

But responsible reform must begin by addressing the true underlying problem with our existing system: the cost of medical care. By far, the greatest access barrier to health insurance coverage in America today is cost. Great care must be taken when implementing market reforms on a national level to avoid inadvertently inducing cost increases in the existing private market system. Regardless of how "fair" a market reform idea might seem on its surface, it is not at all "fair" if it prices people out of the marketplace. Unfortunately, H.R. 3590 contains many elements that will only serve to drive up private health insurance costs significantly for millions of Americans families and businesses. Specifically, we have the following concerns about this legislation:

Minimum Loss Ratio Requirements

The minimum loss ratio requirements added to this legislation this past week will significantly and negatively impact coverage choice and affordability. While we agree

with the goal of providing consumers with more value for health care dollars spent, the 80-85% minimum loss ratios required for the individual and group markets in this bill far exceed any similar state-level requirements. This is especially true during the transition time prior to 2014 when insurers will have all of the same expenses they have today, plus those associated with preparation for transition to the new systems outlined in the legislation. If it is absolutely necessary to have a loss ratio requirement, we strongly implore you to lower the requirement to 75% in the individual market to allow an adequate transition period.

Many administrative functions performed by insurers, such as providing customer service lines and processing claims, are largely fixed costs. These fixed costs are a smaller percentage of a \$500 per month premium than a \$300 per month premium. That is why administrative costs in the individual market are larger as a percentage of premium than those in the group market. The limitations outlined in the current managers amendment will limit many key insurer cost containment practices including claims adjudication, fraud prevention, and other services that impact future premium increases because they reduce overall operational costs. We should be encouraging insurers to invest in these kinds of value-added services instead of punishing them.

Most importantly, this requirement does not take into account the need to address underlying cost drivers in health care. Unless those issues are addressed directly, no market reform measure will result in more affordable policies for the uninsured or those who already have coverage. Subsidies required to cover these individuals will correspondingly increase.

In addition, NAHU questions why Congress would not seek to include similar administrative strictures on other health care industries, including hospitals, doctors, pharmaceutical companies, medical device manufacturers, nursing homes, and the like. If the goal is to have government reduce administrative costs for health care dollars spent, it would only be sensible and equitable to apply similar requirements to all health care providers who will be involved in a reformed health care system.

Individual Responsibility Requirements

Regarding coverage affordability, another area in this bill gives us great pause are its provisions regarding the enforceability of the individual responsibility requirements. NAHU believes there must be adequate financial incentives for all Americans to obtain coverage—both through subsidies and also through significant financial consequences for those who have the means to maintain affordable coverage and elect not to do so. Not only are the financial penalties in H.R. 3590 insufficient, but we are also concerned about effective enforcement since the federal tax code is the only mechanism being used. In a country of this size, states must take on a larger enforcement role.

Under this legislation, millions of healthy individuals will likely find it more financially advantageous to forgo coverage until they are sick and then utilize the guarantee-issue protections to temporarily obtain coverage and then drop it again. This adverse selection will make coverage tremendously more expensive for all Americans, because the market

reforms required by this measure will only work to reduce costs if all Americans participate continuously in the health coverage system, both when they are healthy and when they are sick. To improve the effectiveness of the individual responsibility requirements, we suggest:

- Financial penalties that are in line with the actual cost of coverage so that it would be more attractive to be insured than to pay the tax penalty for not being covered.
- A string of disincentives for healthy people who are not exempt from the individual mandate for financial reasons to forego coverage and simply pay the fine, and who subsequently obtain coverage if needed when sick or injured. Such individuals should be subject to late-enrollment penalty in addition to other penalties for those who have more than a 63-day break in coverage. Both Medicare Part B and Medicare Part D have such penalties for a very good reason. Why would we ignore sound actuarial practices and create incentives for people NOT to be insured?
- Establish an annual open enrollment period for individuals to purchase coverage under the guarantee-issue provisions and to allow plan changes. Exceptions should be made for individuals who undergo a life-changing event, such as the addition of a new child or a change in employment. The HIPAA qualifying event standards in current law could serve as a model for these exceptions.
- An increase in the role of employers in enrollment and enforcement. The auto-enrollment requirements for newly eligible individuals in available employer-sponsored health insurance plans could easily be extended to groups of 50 and more with an employee opt-out. In addition, if federal assistance were provided to even smaller employers to assist with the associated administrative costs, it is possible that they could auto-enroll newly eligible people too.
- Using employers as a point of coverage verification. Documentation could be required upon hiring and also on an annual basis, particularly for those who opt out of the employer-sponsored plan.
- Requiring coverage verification as a condition of receiving services at facilities like the state department of motor vehicles, schools and hospitals, which have already been established as points of purchasing coverage through the exchanges. Schools already do something similar with great success regarding vaccinations.

Rating Provisions

Another area that raises affordability concerns are the premium rating requirements. In order to prevent price increases in individual and small group markets, we believe it is critical that the age bands be set at to 5:1. These bands are much closer to the natural breakdown in age, and will have a substantial impact on pricing as state experience with age bands indicates. Age bands of 3:1 (as are proposed in this bill) have been shown on the state level to be devastating to health plan affordability.

Regarding group size relative to the rating provisions, we find it very disturbing that the most recent Manager's amendment changed this bill to provide no distinction between small and large employer groups that do not self-fund their health plans. Under current law, fully insured employer groups over 50 employees are treated very differently than

the small-group market, and these groups are typically rated based on their past claims experience. This market is the health insurance market working best today, and the rating reforms proposed by this measure, which would apply to all fully insured groups regardless of their size, would significantly increase costs in this market. It also would create adverse selection to the fully insured market, as the larger groups that choose to fully insure would only do so if they had concerns about their group's claims experience.

We specifically request that groups of more than 50 employees be permitted to use claims experience to determine their premium rates. This process is much different than prospective health status rating and is how all large groups develop premiums today. When we hear that large groups "community rate" their employees, what this really means is that the group develops rates that are the same for all participants in their employer group based on the employer's claims experience. Eliminating the ability to develop premiums in this manner will result in significant rate shock for many employers and their employees. It also means that employers and employees will not really be able to "keep the insurance coverage they have" because the structure and pricing of current coverage will be irrevocably changed by these proposed rating reforms.

Agent and Broker Provisions

NAHU does appreciate the provisions in this legislation that specifically ensures the role of licensed health insurance agents in state exchanges. However, we would like to see these provisions expanded and clarified to ensure that all policies available through the exchanges, including the new multistate plans and the co-op plans created by this legislation be available for purchase through an agent or broker. We believe that our nation's agent and broker community could do a great deal to enroll currently uninsured Americans who would be eligible for purchasing assistance under this legislation.

Structure of the Exchanges

NAHU has significant concerns about the regulatory structure proposed for the state-based exchanges in this legislation. We believe what is proposed simply creates costly and confusing layers of dual regulation that will be unnecessarily complex for consumers and costly for states to administer. Many functions proposed for the exchanges and also the Secretary of Health and Human Services are already being ably performed by state insurance commissioners. We are concerned that not only is this costly duplication of effort, but it also will leave consumers unsure of where to turn when problems or concerns arise. We strongly urge you to revise the exchange regulatory language, so that it more closely mirrors the legislation passed by the Senate Finance Committee earlier this year.

We also have great concerns about the adverse impact the new employee voucher provisions to allow choice included in the manager's amendment to H.R. 3590 will have on the integrity of employer-based health insurance plans. These provisions will require employers to give vouchers to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. In order for employers to be able to provide affordable coverage to all of their employees, adequate participation in employer-sponsored plan offerings is crucial. This new language will result in many workers leaving employer-sponsored coverage for the exchange,

thereby threatening the ability of many employers to continue to offer coverage to the remainder of their employees.

Dramatic Expansion of Medicaid

Another provision that gives us pause is the expansion of the federal Medicaid program to individuals up to 133% of the federal poverty level (FPL). While we agree that Medicaid provides an important financial and health security safety-net, we believe it should be limited to the truly medically needy with incomes at or below 100% FPL. Such a dramatic expansion of Medicaid would not only be financially crippling in the long-run to our already struggling state governments, but it will also displace millions of Americans from private coverage. This Medicaid program increase will further exacerbate the public-program cost shift to privately insured Americans, which, at current Medicaid payment levels, contributes to increasing the costs the average privately insured family of four by almost \$1800 a year.

New National Long-Term Care Program

The CLASS Act provisions in this legislation create a huge new federal long-term care program that threatens the private long-term care insurance market, a market that provides a better benefit for lower cost from the day of enforcement of the contract, not in 5 years as the legislation envisions. While the idea of offering long-term care coverage to working Americans is well-intentioned, the CLASS Act provisions will be unable to accomplish this goal. The new nationalized long-term care product that is the centerpiece of these provisions has unfortunately been repeatedly under-priced, from \$35 to \$65/month to \$125/month. The American Academy of Actuaries concluded that this new product would have to cost \$160/month and the Centers for Medicare and Medicaid Services now concludes that it would have to cost \$180/month in order to be financially viable. There is widespread and bipartisan agreement that the CLASS Act will be a financial albatross for our nation once it is fully implemented, and we urge that these provisions be stricken from the final bill.

Financing of the Measure

The financing mechanisms proposed for the current bill would significantly, and negatively, impact the health care industry, consumers, employers and our overall economy. The health insurance fee alone would extract over \$6 billion in additional taxes each year from certain health insurance companies. As administrative expenses increase with the tax, it is inevitable that insurers will be forced to raise premium costs to compensate. This means that businesses, employees and consumers will see an increase in their premiums. The BlueCross BlueShield Association estimates that premiums will increase by \$360 per year on small-employer family coverage as a result of this tax alone. When the goal of health insurance reform is to make health insurance affordable and accessible for all Americans, why implement a plan that would raise costs?

The proposed taxes on insurers will also result in significant job loss for many insurers, which only works to further harm our already fragile economy. The current tax provisions in the bill will be enforced on 2010 contracts that have already been priced and sold prior to the enactment of the bill. This means that the taxes were not included when pricing plans. In 2011, there will be a new tax liability. So, when pricing health insurance for 2011, consumers

will be hit with taxes for two years at one time. This decreases affordability – the exact opposite of what consumers expect with health reform.

Of course this assumes that the insurers will be able to absorb the losses during 2010, which is unlikely to be the case. Many insurers who have already been forced to lay off workers during the past year will be forced to do so again with projections of up to 20% of the workforce for some insurers. Since insurers generally represent a significant portion of the workforce for the cities where they are located, this new tax will create a negative impact on the financial stability of many communities.

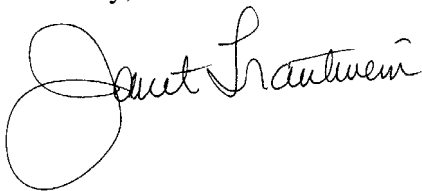
In addition to our concerns about the annual tax on insurer premiums, we have significant concerns about the proposed excise tax on high-cost health plans. Since this tax is not properly indexed for inflation and this bill does so little to control the medical care costs that truly drive health insurance premiums, eventually all plans will fall under this excise tax umbrella. It is not responsible to finance health care reform on the backs of Americans who already are doing the responsible thing and purchasing private health insurance coverage.

NAHU also objects to the massive proposed cuts in funding to Medicare, particularly the Medicare Advantage program. The cuts in H.R. 3590 will effectively eliminate this popular coverage option for more than 6 million seniors who are happily insured under Medicare Advantage plans today. Allowing seniors in one state an exemption from the cuts where payment issues are already at issue is exacerbating the acknowledged payment inequities.

NAHU acknowledges the effort you have invested in health reform, but we have grave concerns that H.R. 3590 will do much more to harm American health care consumers than help them as it is currently structured. Consumers are the clients of our members, and their well-being is our primary interest in health reform. Our health insurance agents, brokers and consultants want to achieve a workable solution to improving our health care system. We urge you to halt this process now and work together on legislation that will actually achieve our common goal: a world-class and affordable health care system for all Americans.

If you have any questions, or if we can be of any additional assistance, please do not hesitate to contact me at jtrautwein@nahu.org or 703-276-3806.

Sincerely,

A handwritten signature in black ink that reads "Janet Trautwein". The signature is written in a cursive style with a large, looping initial "J".

Janet Trautwein
Executive Vice President and CEO
National Association of Health Underwriters

cc: The Membership of the United States Senate