



# National Association of Health Underwriters

*America's Benefits Specialists*

## **KEY CONFERENCE HEALTH CARE REFORM ISSUES**

As Congress begins the process of combining the House- and Senate-passed comprehensive health reform bills into one piece of legislation, 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, believes that the following issues and concerns are paramount to successful implementation of any national health reform legislation:

### **ROLE OF HEALTH INSURANCE AGENTS, BROKERS AND CONSULTANTS**

We appreciate that both the Senate- and House-passed measures specifically ensure the continued role of licensed health insurance agents, brokers and consultants. However, we would like to see these provisions expanded and clarified to ensure that all policies available through the exchanges, including any new plans that may be created by this legislation, such as co-op and/or multistate plans, be available for purchase through an agent or broker and that these policies could be subsidized, should the purchasing individual/family be eligible. In addition, the House-passed bill includes provisions that grant authority to the national exchange's commissioner and Small Business Administration to provide a host of services to small employers that are duplicative to services and regulatory authority already being provided by state-licensed health insurance agents and brokers and state insurance commissioners. *We recommend the SBA provisions be eliminated from any final bill.*

### **IMMEDIATE REFORMS—ENSURING AN EFFECTIVE TRANSITION**

Both the House- and the Senate-passed bills include many immediate changes to the private health insurance market, such as the elimination of benefit limits, medical loss ratio requirements and cost-sharing. We have concerns that any effective dates in 2010 will not allow for enough time to implement the required changes, particularly on existing health plan contracts. *We urge that all reforms become effective no earlier than 12 months after enactment.*

### **MINIMUM MEDICAL LOSS RATIOS**

Both the House- and Senate-passed legislation contain strict medical loss ratio (MLR) requirements for insurers. While we agree with the goal of providing consumers with more value for health care dollars spent, the 80-85% MLRs required for the individual and group markets in these bills far exceed any similar state-level requirements and could have a significant impact on the viability of the private health insurance marketplace. 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. *We strongly urge Congress to allow the states to lower the requirement to 75% (which is the level used in many states), at least in the individual market, to allow an adequate transition period.*

Also, the Senate-passed legislation, H.R. 3590, requires the National Association of Insurance Commissioners to develop uniform definitions regarding the MLR and how the consumer rebate is calculated by December 31, 2010. We strongly encourage Congress to preserve this language in any final legislation, since most states already effectively regulate loss ratios by insurers, and we should build upon this level of expertise. *NAHU would also like to see regulatory authority over the MLR process, including appeals, granted to each state's insurance commissioner, who, as the primary regulator, will have a*

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*much more immediate grasp of the intricacies of each state's insurance market. State-level uniformity in this area could be ensured by requiring the development of model laws and regulations by the NAIC.*

### **TAXATION OF PRIVATE HEALTH INSURANCE PREMIUMS**

The Senate-passed legislation 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. And since the tax would be enforced on 2010 contracts that have already been priced and sold, when pricing health insurance for 2011, consumers will be hit with taxes for two years at one time. The tax would also result in significant job loss for many insurers, further harming our already fragile economy. *We recommend that this proposed tax be eliminated from any final bill or, at minimum, the amount be reduced and the imposition of the tax be delayed until 2014 when the majority of the reforms the tax would be financing actually take effect, to preserve consumer premium affordability in the transition.*

### **STRUCTURE OF THE EXCHANGES**

Each state should have the ability to design and maintain its own exchange to accommodate for the varying needs of our diverse population, as is allowed in the Senate-passed legislation, rather than the national exchange created in the House bill. In creating these state-based exchanges, it's crucial that Congress preserve existing state-based flexibility and regulatory authority, not require the secretary of Health and Human Services or a national insurance exchange commissioner to duplicate the role of existing state insurance commissioners and governors. In addition, we support the Senate-passed language that preserves both the individual and group private insurance markets independent of the exchanges. *We strongly encourage the revision of the exchange regulatory language so that it more closely mirrors the legislation passed by the Senate Finance Committee earlier this year, which utilized the existing state regulatory structure very effectively and provided for a degree of state-by-state uniformity by requiring model laws and regulations to be developed by the NAIC. In addition, states should be permitted to seek waivers for implementing their exchanges, beginning in 2014, as is allowed by the Senate-passed legislation.*

### **INSURANCE MARKET REFORMS**

The premium rating requirements in both versions of the legislation will have a serious impact on health plan affordability. *In order to prevent price increases in individual and fully insured employer group markets, we believe it is critical that the age bands be set at to 5:1. We also encourage Congress to add variations for participation in employer wellness programs and rating for tobacco use to help with medical care cost-containment, as is allowed in the Senate-passed legislation.*

Regarding group size, neither bill provides a 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 now included in both bills would apply to all fully insured groups regardless of their size, and 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 fully insured groups of more than 50 employees be permitted to use claims experience to determine their premium rates.*

Another issue that could impact health plan affordability is the provisions in the House-passed legislation that would require health insurance carriers to pool of all individual and fully insured group products together. These markets are actuarially very distinct, and requiring them to be pooled together would make coverage much more expensive for many small and mid-sized employers. *We recommend that the Senate provision to allow separate pools for the individual, small and large-group markets be used.*

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NAHU also wants to confirm that any new reform would retain the wide range of health plan product choices consumers have available to them now and allow for further marketplace innovation. *To control costs and ensure that current policies remain available—particularly all qualified high-deductible health plans—we would like to see the minimum actuarial value for qualified benefit plans set at the 60% level set by the Senate bill, rather than 70%, as currently proposed in the House-passed legislation.*

### **HIGH-RISK POOLS AND RISK ADJUSTMENT PROVISIONS**

Both the House and Senate bills would immediately create a new national high-risk pool that could be duplicative of programs already operating in 35 states. *Rather than creating a new national pool to serve states that already have well-functioning and long-standing high-risk pools, existing pools should be able to continue operations under federal standards and any new legislation should target its limited resources to the few states without such programs.*

Also, both bills include additional risk-adjustment provisions once the exchanges and market reforms become effective, and we feel the Senate-passed provisions are more comprehensive and will do more to keep coverage affordable, particularly during the transition years as the overall pool of covered Americans grows. However, we are concerned about the funding for the reinsurance and risk-corridor provisions. *While we agree it is appropriate to have the industry share in the financing, we are concerned the overall reinsurance funding, particularly in the early years, is not sufficient and would like to see an increased federal investment in the reinsurance mechanism.*

### **ENSURING AN EFFECTIVE AND ENFORCEABLE INDIVIDUAL MANDATE**

In order to ensure health insurance premium affordability for all individual and group purchasers under the insurance market reforms proposed in both the Senate- and House-passed bills, an enforceable and effective individual mandate to obtain health insurance coverage is necessary. NAHU believes there must be adequate incentives for all Americans to obtain coverage—both through subsidies and through significant financial and insurance-related consequences for those who have the means to maintain affordable coverage and elect not to do so. We are concerned about enforcement in both versions of this legislation, as the financial penalties are insufficient and the Federal Tax Code is the only enforcement mechanism being used. Under both versions of this legislation, healthy individuals may find it more financially advantageous to forgo coverage until they are sick and then utilize the guaranteed-issue protections, causing a tremendous cost and adverse selection problems.

*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 insurance-related 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. These should include an annual open-enrollment period and a strict late-enrollment penalty.*
- *An increase in the role of employers in enrollment, enforcement and coverage verification.*
- *Requiring coverage verification as a condition of receiving state and local 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.*

### **GOVERNMENT-RUN PUBLIC PLAN OPTION**

The inclusion of any government-run public plan option is unnecessary, would likely displace tens of millions of happily insured Americans from the conventional marketplace and exacerbate the worst

elements of the current system: gross inefficiency, high costs and bureaucracy. *We urge the elimination of government-run public plan provisions from any final legislation.*

### **EMPLOYER MANDATE**

The employer-based system must be at the core of any health reform effort, but the provision of benefits must be a voluntary action on the part of employers. We are opposed to an employer mandate—especially one with a structure as proposed in the House bill, which far exceeds what millions of struggling American businesses can afford to offer their employees and dependents. These provisions will negatively impact new job creation, cause the loss of millions of current jobs, suppress wages and perpetuate instability in what is an already fragile American economy. *We strongly urge that an employer requirement to provide coverage be stricken from any final legislation.*

### **MEDICAID EXPANSION**

Both the House- and Senate-passed bills include dramatic expansions of Medicaid that would not only be financially crippling in the long run to our already struggling state governments, but will also displace millions of Americans from private coverage. The proposed expansion will also 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 \$1,800 a year. *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.*

### **NEW NATIONAL LONG-TERM CARE PROGRAM**

The CLASS Act provisions in both bills 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 five 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. *There is widespread and bipartisan agreement that the CLASS Act will be a financial albatross for our nation when fully implemented, and we urge that it be stricken from the final bill.*

### **FUNDING**

In addition to our concerns about the annual tax on insurer premiums, we oppose the other proposed financing mechanisms in both the House- and Senate-passed bills. The Senate legislation relies on an excise tax on high-cost health plans as its primary means of funding. Since this tax is not properly indexed for inflation and the Senate 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.

The House bill's mechanism of financing this endeavor also raises serious concerns, as it hinges primarily upon an income tax surcharge that will disproportionately affect our nation's small-business owners. These citizens are responsible for job creation and will already be shouldering enormous new costs and responsibilities as a result of other provisions in this bill.

We also object to the massive proposed cuts in funding to the Medicare Advantage program contained in both the House and Senate bills. The proposed cuts to Medicare Advantage will effectively eliminate this popular coverage option for more than 6 million seniors who are happily insured under this program today.

NAHU believes the Congress should not attempt to finance health care reform on the backs of Americans who already are doing the responsible thing and purchasing private health insurance coverage and creating American jobs as small business owners. *Instead, it is wholly appropriate for Congress to consider health-related excise taxes in financing health reform that can help deliver revenue and simultaneously discourage unhealthy lifestyles that are a major component in fueling growing health care costs.*