

Karen Ignagni
President &
Chief Executive Officer



November 5, 2009

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
The U.S. Capitol, Room H-232
Washington, D.C. 20515

The Honorable John Boehner
House Republican Leader
U.S. House of Representatives
The U.S. Capitol, Room H-204
Washington, D.C. 20515

Dear Speaker Pelosi and Republican Leader Boehner:

On behalf of America's Health Insurance Plans (AHIP), I am writing to express our opposition to H.R. 3962, the "Affordable Health Care for America Act," and to urge you to consider alternative approaches to health care reform that do not increase costs or disrupt the coverage on which millions of Americans currently rely.

Where Our Community Stands on Health Reform

Our community strongly is committed to insurance market reforms that combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating pre-existing condition exclusions and eliminating rating based on health status and gender. To ensure the success of these reforms, everyone needs to be part of the system and care needs to be made more affordable through system-wide cost containment. To that end, our members have committed to adopting administrative simplifications as their part of bending the cost curve. But the country also needs to put in place a strategy to reduce medical costs, which are 50 percent higher than in any other industrialized country, and refrain from adopting policies that will increase costs.



November 5, 2009

Page 2

Immediate Increases in the Cost of Coverage and Disruption of Coverage in 2010

Experience in the states has shown that insurance market reforms must be paired with an effective personal coverage requirement for these reforms to work. While the House bill would link these reforms beginning in 2013, it also would immediately in 2010 implement certain market reforms, such as new rules for pre-existing condition exclusions, a ban on lifetime limits, an extension of COBRA coverage, new benefit mandates, and allowing individuals through age 26 to remain on their parent's coverage as dependents – *before* taking the crucial step of bringing all Americans into the system.

However meritorious these goals may be, if not implemented with full individual participation, these reforms would force the reopening of existing contracts and increase the cost of coverage for American families by promising new benefits that cannot be supported by current premium levels. Moreover, in a voluntary system, these changes would encourage individuals to opt out if they are not anticipating serious medical problems, knowing that they will be able to purchase coverage if they experience health problems at any time later in the year.

Immediate Increases in Administrative Costs and Creating Instability in Rate Approval

The bill would establish a federal premium justification process, beginning in 2010, that would duplicate processes that already are in place at the state level, leading to regulatory confusion and higher administrative costs. From an operational standpoint, this proposal fails to recognize that many Americans already have chosen their coverage for 2010 and that others currently are in "open season." Although health plans already have submitted their 2010 rate proposals to state insurance regulators, they would need to refile these rates, creating confusion and uncertainty for consumers.

In addition, the new federal approval process fails to recognize that "actuarial" certification of rates is required at the state level and it requires the linkage between the underlying cost trend and any premium increases to be substantiated. A new and additional review process that would be added at the federal level based upon undefined and subjective criteria would at best be costly and confusing and at worst, because the federal process would not require actuarial soundness, could result in insufficient funds being available to pay benefits on behalf of enrollees.

Ignoring Cost Drivers

While the House bill requires health insurance plans to justify premiums, it does not require clinicians, hospitals, pharmaceutical companies or others to justify the medical costs that determine premium levels. If a justification process is needed anywhere, it should focus on underlying medical cost trends. Regrettably, the bill does not address in any meaningful way the fact that the United States spends significantly more per unit of service than every other industrialized country. Given the impact this has on our economy, the Congress' central policy objective should be to put in place a plan to shrink that huge differential through coordinated public-private efforts to reduce inappropriate care, improve system-wide performance and productivity, reduce administrative costs, and reward high performance and chronic care management.

To accomplish this objective, we have urged Congress to develop a plan for slowing the future growth rate of health care spending by 1.5 percentage points. Taking on this challenge – although difficult politically – will ensure that health reform will result in care and coverage that is affordable. Not taking on this challenge will ensure that subsidies are not sufficient to keep pace with rising health costs and that health cost trends will continue to outpace the ability of the economy to absorb them.

Placing Limits on Programs That Congress Should Want to Encourage

While we share your belief in the importance of transparency and the importance of giving consumers and policymakers the information they need to review performance, we are concerned about imposing arbitrary caps on administrative costs through proposed medical loss ratio (MLR) requirements, which also would take effect in 2010. These provisions would be counterproductive, particularly when Congress is expecting our community to deliver a massive change in administrative procedures that will simplify the processes for doctors and hospitals, along with increasing consumer support and advancing more disease management and care coordination.

All of these initiatives will require considerable expenditures that are accounted for as part of “administrative costs.” In addition, there will be significant new compliance costs as a result of the passage of health care reform legislation, which also would be captured under administrative costs.



November 5, 2009

Page 4

Impact of a Government-Run Plan

We share the concerns that providers, employers, and patients have raised about the significant disruption a new government-run plan would have on the current health care system. A new government-run plan would bankrupt hospitals, dismantle employer coverage, exacerbate cost-shifting from Medicare and Medicaid, and ultimately increase the federal deficit. By contrast, strong market rules and consumer protections will ensure that nobody falls through the cracks and will do so without disrupting the coverage of Americans who like and want to keep their current health plans.

Although the House bill would direct the Secretary to negotiate payment rates with providers, the Secretary does not have the infrastructure or capability to do this. All health care markets are local and payment rates need to be negotiated at the local level. Lacking the tools and resources to negotiate with providers in every local market across the nation, the Secretary ultimately would be forced to resort to imposing some variation of Medicare payment rates on providers participating in the government plan.

This outcome would exacerbate the cost-shifting that already occurs, from public programs to private payers, as a result of the inadequate reimbursement rates that Medicare and Medicaid pay to hospitals and physicians. According to a recent Milliman study, an average family of four already pays a hidden tax of more than \$1,500 annually on their premiums because Medicare and Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector.

Creating More Regulatory Complexity Without Additional Value

As we work toward the shared goal of ensuring that all Americans have access to high-quality, affordable health care coverage, real reform should seek to avoid duplicative regulation that makes coverage less affordable and should include workable rules to ensure that existing coverage remains stable and within reach of individuals, families and employers. Rather than building on existing state regulations, the House bill creates a new federal agency and Commissioner with broad authority to oversee and regulate many aspects of health insurance that are currently the subject of extensive state regulation (e.g., coordination of benefits, external review, prompt pay, and consumer appeals and grievances) as well as federal oversight (e.g., ERISA requirements for employer-sponsored coverage). The establishment of dual

November 5, 2009

Page 5

and overlapping regulation will not be transparent to consumers and only will increase the cost of coverage.

In addition, the House bill would delegate open-ended authority to the new Health Choices Commissioner – including authority to make changes to rules relating to the existing employer market, regardless of whether that coverage was offered in the exchange – and establish a regulatory structure for the new Health Insurance Exchange that replicates functions now being carried out by state insurance commissioners. These provisions would create an overly complex regulatory environment without providing concomitant value for consumers.

Breaking the Promise That People Can Keep their Existing Coverage

Since the beginning of this debate, the American people have been promised that health care reform will allow them to keep their current coverage if they like it. Despite this promise, the grandfathering provisions of the House bill would not preserve the existing coverage of many Americans who are currently satisfied. Even small changes in the terms of an existing plan could eliminate that option for current enrollees.

Similarly, the age bands in the House bill would undermine existing coverage for younger families by placing a large burden on them to subsidize the higher costs of older workers. For example, moving from a 5:1 age band to a 2:1 age band would result in a 59 percent increase in premiums for individuals age 18 to 30. We are concerned that these provisions would significantly disrupt the existing coverage of young families, encouraging them to leave the pool rather than face rate shock. In addition, the actuarial values that the bill would establish for benefit packages would be significantly higher than the coverage options that many people choose today, creating another potential source of coverage disruption.

CLASS Act

While we support the goals of the proposed CLASS Program and recognize the importance of easing the financial burdens associated with long-term care, we are concerned that this program, in its current form, proposes an inadequate premium structure and benefits that cannot be maintained. These concerns are reinforced by an analysis released by the American Academy of Actuaries in July. This study also concluded that, in a relatively short time period, the program will either need increased premiums and/or significant benefit reductions.



November 5, 2009

Page 6

Eliminating MA Choices for Millions of Seniors

We continue to strongly oppose the Medicare Advantage funding cuts proposed by the House bill, and we are deeply concerned about the harmful impact such reductions would have on health care choices and benefits for the 10 million Medicare beneficiaries who rely on Medicare Advantage plans to meet their health care needs. An October 21 memorandum by the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) discussed the likely impact of the Medicare Advantage funding cuts in the original House bill (which also are included in H.R. 3962). The chief actuary estimates that by 2014, when the Medicare Advantage funding cuts would be fully phased in, enrollment in Medicare Advantage plans would decrease by about 64 percent (from its projected level of 13.2 million under current law to 4.7 million under the bill).

We thank you for considering our serious concerns on these important issues. As the legislative process moves forward, we will continue to work to advance bipartisan legislation that covers all Americans, makes coverage more affordable, and improves quality.

Sincerely,

A handwritten signature in black ink, appearing to read "Karen Ignagni". The signature is fluid and cursive, with a long, sweeping underline.

Karen Ignagni