**<u>Talking Points</u>**

**Reduce Medical Loss Ratio Requirements -** While I agree with the goal of providing consumers with more value for health care dollars spent, the 80-85% medical loss ratios required for the individual and group markets in these bills exceed any similar state-level requirements. Unfortunately, many essential services that actually serve to lower the cost of medical care would not be included in these percentages. Especially during any transition period prior to 2014, 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, I strongly urge Congress to allow the states to lower the requirement to 75%, at least in the individual market to allow an adequate transition period, which is the rate used by many states.*

**Support NAIC Uniform Medical Loss Ratio Definitions**- The state role in crafting the definition of any MLR and in determining if the MLR level is adversely impacting the functionality of each state's specific insurance markets should be preserved. Many states already regulate loss ratios by insurers, and have developed workable definitions of what constitutes an effective ratio. Many states look beyond mere medical care costs and consider many other important 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 build upon this level of expertise. *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. This language should be preserved in any final legislation.*

**Support State-based Exchanges -** Each state should have the ability to design and maintain its own exchange to accommodate the varying needs of its own population, as is allowed in the Senate-passed legislation, H.R. 3590. And in creating these state-based exchanges, it is crucial that Congress preserve state-based flexibility and utilize existing state-based regulatory authority through the nation's governors and insurance commissioners. The HHS Secretary should not be required to duplicate the role of existing state insurance commissioners. This would simply create costly and confusing layers of dual regulation that will be unnecessarily complex for consumers and costly for states to administer. *States should be permitted to seek waivers for implementing their exchanges, beginning in 2014, as is allowed by H.R. 3590, as amended.*

**Maintain Existing Antitrust Laws –** Proposed changes to the McCarran-Ferguson Act are likely to affect the small to medium sized insurance companies, which now are permitted by state law to share loss data and trending information without coming under the scrutiny of very limited aspects of federal antitrust laws — although, like all insurers, they are subject to state antitrust laws and regulations. *Existing laws should be maintained to avoid undermining existing insurance regulatory authorities – the states – to the detriment of both policyholders and small carriers.*

**Support Role of the Agent -** Most Americans - whether poor, middle class, or high-paid - need and want expert advice when choosing their health insurance. Thus, I applaud Congressional

leadership's current support for explicitly authorizing a role for licensed agents. However, I have concerns with provisions in the House-passed legislation that grant authority to the national exchange’s commissioner, in consultation with the Small Business Administration, to provide a host of services to small employers. *Although the Small Business Administration is a valuable agency, it is already overworked, underfunded and struggling to fulfill key priorities in relation to its current duties and obligations. It is both costly and unnecessary to require a federal agency with no expertise in health insurance to duplicate services and regulatory authority that are already being provided at the state-level by both state-licensed health insurance agents and brokers and state insurance commissioners.*