National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

September 1, 2023

The Honorable Xavier Bacerra
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Julie Su
Acting Secretary of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

RE: CMS 9904-P

Sent electronically via www.regulations.gov

Dear Secretaries Bacerra, Su, and Yellen:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, an association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We are pleased to have the opportunity to comment on the proposed rule titled "Short-Term, Limited Duration Insurance; Independent Non-Coordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements, etc." and published in the *Federal Register* on July 12, 2023.

The members of NABIP work daily to help millions of people and businesses purchase, administer and utilize health insurance coverage. The coverage options our members work with include short-term limited duration insurance coverage (STLDI), excepted benefit plans and level-funded health plan arrangements, all of which are extensively addressed by the proposed rule. As such we are grateful for the opportunity the Departments of Health and Human Services, Labor, and Treasury ("the Departments") offer to provide comments on this measure. We have broken up our response by topic, and NABIP members who specialize in each type of coverage option provided their direct expertise to inform comments in each section.

Proposed Changes to the Structure of Short-Term Limited Duration Coverage

As you know, the Departments promulgated extensive new requirements for STLDI in 2016 before the end of the Obama administration. These rules changed the federal definition of STLDI that had been in place since the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by specifying the maximum duration of a STLDI policy would be three months, rather than the previous federal maximum of 12 months.

Under the original HIPAA STLDI rules, states determined the length and availability of short-term policies in their jurisdictions while abiding by the federal coverage duration ceiling of 12 months. While there were state-level variances in the availability and typical durations of such coverage, agents who sold these policies both directly and through online enrollment mechanisms reported that, before the implementation of the current federal rules, the average duration of the short-term policies they sold was five to six months.

In 2017, the Departments under the Trump administration reversed course on the definition of STLDI, allowing renewable 12-month duration STLDI policies to be sold as long they were approved by the applicable state and a consumer disclosure notice accompanied the product's sale. As a result, the short-term coverage marketplace expanded beyond those who are just simply seeking to fill a temporary coverage gap. In addition to the original typical STLDI consumers, many consumers now purchase STLDI instead of traditional individual coverage in the states where expanded short-term coverage is authorized.

According to our members who currently sell STLDI, these consumers typically do not have access to group coverage but are not eligible for exchange-based individual market premium tax credit subsidies and are seeking a lower-cost purchasing option. As the Departments note in the preamble to this proposed rule, short-term coverage is not comprehensive, so the consumer and overall market protections associated with these policies have proved insufficient for many consumers who buy STLDI instead of traditional individual coverage. Further, despite the existing disclosure notices and the best efforts of qualified and upstanding health insurance producers offering this coverage, the STLDI marketplace is prone to bad actors, and some consumers do not fully understand the limitations of the coverage they purchase.

The proposed regulation would largely return the STLDI marketplace to its status in 2016. STLDI policies would be limited to an initial coverage period of three months or less, with a maximum coverage period of four months if the coverage is renewed. NABIP understands the intentions of the Departments in seeking to end the availability of STLDI coverage that mimics traditional

individual insurance coverage. However, rather than drastically shifting the type of STLDI available again, we urge a middle-ground approach.

During the almost 20 years of the HIPAA-based STLDI rules, short-term medical policies only represented a small fraction of health insurance policies sold. However, when these policies were sold, they had a clear purpose: to serve as a bridge to more comprehensive coverage options. Their buyers included not only people seeking individual coverage, but also those in coverage waiting periods prior to the start of group plan enrollment, those with gaps between different employment opportunities, and people who were waiting for their next open enrollment opportunity after declining a group offer of coverage. Agents who sold these policies before 2017 report that at least half of their sales were to people transitioning between jobs and those who had purposely reduced hours or who had taken unpaid leave and could not afford or did not qualify for COBRA or other group continuation coverage options. Newly retired people seeking a temporary bridge to Medicare enrollment, Americans students studying abroad, and individuals temporarily in the United States on VISA programs were also typical STLDI consumers. All of these populations still exist and have need of STLDI as a coverage option today.

The changes the Affordable Care Act (ACA) made to the individual health insurance marketplace also create a need for a year-long, short-term coverage option. Since the ACA utilizes a very short open-enrollment period (OEP) system for the individual health insurance marketplace (as opposed to a late-enrollment penalty system, as is used for Medicare participants), every year there are people who do not enroll during the OEP and therefore are shut out of the individual marketplace for a good portion of the year. Additionally, those who fall into a Medicaid coverage gap may buy short-term coverage because it is all they can afford. While of course it would be preferable for all these individuals to have comprehensive coverage year-round, health insurance coverage is, at its core, a financial protection product, not just a means of providing access to medical care. Individuals should be able to purchase at least some type of medical and financial protection for most of the year. In many cases, STLDI is the only means available to a consumer for interim coverage.

A way to strike a balance of providing an affordable and sufficient coverage option for those who are truly experiencing a gap and avoiding individuals electing STLDI over comprehensive individual policies could be adjusting the definition of STLDI to either six months, with one full renewal cycle, or to six months, with renewal coverage terminating on January 1, whichever is shorter. Further renewal options could be limited to people ineligible to purchase individual-market coverage using a premium tax credit. That way, consumers will still have a legitimate financial protection and health coverage option that lasts for an appropriate length, and those

who qualify can purchase traditional individual market coverage for the next calendar year during the OEP.

To aid individuals in understanding what these plans cover and what they don't, beyond the proposed revised consumer notification requirement, consideration should be given to expanding the Summary of Benefits and Coverage (SBC) to better describe the attributes of these policies. Comparison examples between short-term coverage and traditional ACA-compliant coverage will aid consumers in understanding at the time of purchase and use.

Proposed Changes to Excepted Benefit Coordination of Coverage Requirements

The proposed rule would significantly broaden the standard of permissible coordination between "excepted benefit" indemnity plans and group health plans considered to be ACA minimum essential coverage. Furthermore, the proposed rule would prevent employers from offering both types of coverage to the same group of employees. NABIP members have significant concerns with both proposed changes.

Currently, fixed indemnity medical coverage offered to group health plan participants is an "excepted benefit," meaning that HIPAA and ACA requirements for traditional group health coverage do not apply. To maintain excepted-benefit status, fixed indemnity policies must:

- be offered separately from other group coverage.
- not coordinate with other group coverage.
- not be specifically designed to counterbalance coverage exclusions contained in other available group health plan options.
- pay benefits even if the employee has other health coverage that pays benefits related to the same event.
- pay out a fixed dollar amount per day based on a specific event (such as hospitalization) or condition (such as a specific diagnosis).

The proposed rule would broaden the standard of prohibited coordination between fixed indemnity excepted benefits coverage and any group health plan maintained by the same plan sponsor. The terms "noncoordination" and "coordination" of hospital indemnity or other fixed indemnity insurance coverage for the purpose of being considered an excepted benefit was purposely left undefined in the underlying federal statute. The proposed rule offers the following new example of what the Departments would consider prohibited coordination :

> *Example: An employer sponsors a group health plan that offers a benefit package covering only preventive services (and excluding all other health benefits) and a hospital*

> *insurance policy paying a fixed dollar amount per day of hospitalization for a wide variety of illnesses that are not preventive services. Both the preventive-services plan and the hospital insurance policy are offered at the same time and can be elected together. The hospital insurance policy does not qualify as fixed-indemnity excepted-benefit coverage because the policy coordinates with exclusions in the preventive services plan. The result would be the same even if the preventive services plan were offered at a different time than the insurance policy and even if the insurance policy did not pay benefits for a wide variety of illnesses.*

This entirely new interpretation of coordination of coverage is in direct conflict with current marketplace practices and products. It is a common group health plan practice to offer employees multiple coverage options. Particularly in certain areas of the country and in certain industries, such as those that employ a large number of variable-hour and lower-wage workers, some large employers opt to offer employees coverage options that include not only coverage options that meet the ACA's definition of minimum essential coverage (MEC) and minimum value (MV) coverage, but also fixed medical indemnity coverage that currently qualifies as an excepted benefit. Doing so provides the workforce with a wider range of coverage options, at a wider range of price points. Employees are free to layer the excepted benefit policies offered with any of the ACA-compliant coverage options offered, and they are also free to elect coverage options separately or decline any or all coverage options that are made available to them.

Employers normally offer all coverage options available to employees during a single open enrollment period for the convenience of all involved; however, each coverage option in a group health plan arrangement is distinct with individual benefit designs. Products are not offered to employees in any type of pairing or package, and all elections must be on an individual basis. While different policy elections may yield overlap in benefits, or lead to one product an employee selects providing benefits for something another product elected does not, those situations directly reflects market-based product design and individual employee selections. The ability to have overlapping benefits and/or purposeful coordination between coverage options based on personal choice is appealing to the employees who elect to stack coverage options. The pull of additional financial protection and perhaps multiple sources of benefits is similar to the attractiveness of access to flexible spending arrangements, or other account-based benefit options. In fact, employees often layer available account-based options with fixed indemnity coverage and more comprehensive traditional medical plans.

It is also important to note that different issuers and third-party administrators create fixed indemnity products than those who oversee the design of comprehensive major medical group

policy offerings. Any perceived coordination of benefits on the part of the employer plan sponsor is just that—a perception.

The changes proposed by this rule would eliminate the ability of employees to layer ACA-compliant coverage with fixed indemnity medical insurance, as a group health plan could offer one of these types of coverage but not both. Accordingly, the rule would eliminate a layer of financial protection and lower-cost coverage options that are important to many individuals and families covered by group plans. NABIP members routinely and directly participate in employer open enrollment processes. Based on our observations of employee purchasing behavior, our association is concerned that individuals who simply elect medical indemnity coverage when offered will no longer elect any coverage. While certainly it would be better if such individuals felt financially able to purchase more comprehensive coverage, every individual must ultimately make their own purchasing decisions. Removing fixed indemnity medical policies as part of greater group health plan offerings will just expose this type of employee to greater financial and medical risk. As for those individuals who elect to layer fixed indemnity medical coverage with a MEC or MV health plan offered by their employer, the consequence of this proposed rule would also be a reduction of choice and limitation of financial protection options.

While NABIP members can understand the intention behind the proposed rule's provisions, we believe there is a way to preserve market choice and protect vulnerable employees from purchasing coverage that offers them less protection than they may realize. The inappropriate coordination of coverage example included in the proposed rule is limited to MEC policies that only cover preventive services (and exclude all other health benefits) and a hospital insurance policy paying a fixed dollar amount per day of hospitalization for a wide variety of illnesses that are not preventive services. In any final rule, NABIP members would appreciate the clarification that preventive-care-only MEC policies are the only type of MEC policy that would fail to meet the non-coordination standard.

Further, NABIP believes any final rule should clarify that if a group plan sponsor offers a range of health plan options that include MEC coverage that includes a wider range of benefits than simply preventive care service coverage and/or coverage that meets the ACA's MV standard, then allowing employees the option of layering multiple types of coverage offerings including fixed indemnity medical benefit coverage that is designed and administered by an excepted benefit health plan service provider that is distinct from any ACA major medical coverage service provider or third-party administrator third provider is a permissible practice.

Changes to the Structure of Fixed Indemnity Plan Payments

In addition to broadening the coordination standard and limiting when fixed indemnity medical or hospitalization policies may be sold in a group environment, the proposed rule includes clarifications to the requirements concerning how benefits under fixed indemnity excepted benefits coverage must be paid. The measure would tie plan payments to a directly specified event, even if benefits related to the same event are covered under another group health plan maintained by the same plan sponsor. Further, the proposed rule would establish that any fixed amount must be payable per day (or per another period of time), regardless of the actual or estimated amount of expenses incurred, services or items received, the severity of illness or injury experienced by a covered person, or other characteristics particular to a course of treatment received, and not on any other basis (such as on a per-item or per-service basis).

NABIP members appreciate the specificity of permissible payments should this regulation be finalized as drafted. However, it should be noted that many fixed indemnity insurance products with payment structures that would be prohibited if this measure is finalized as drafted are currently in force in the marketplace and have been filed and approved by state insurance regulators. So finalizing the rule as drafted would mean every supplemental insurance carrier will need to refile in every state to make the needed changes.

Payment structures that vary based on the severity of illness or injury experienced by a covered person, or other treatment and care characteristics, can be very valuable to a consumer, as a person's out-of-pocket medical expenses are often directly related to the extent of their health issues and care needs. Changing the structure of products available today in this manner will limit consumer choice with seemingly little consumer-protection benefits.

Fixed Indemnity Notice Requirement

The Departments propose to require a consumer notice be provided when offering fixed indemnity excepted benefits coverage in the group market, just as a notice must now be provided when fixed indemnity excepted benefits coverage is marketed and sold in the individual market. This measure also specifies new content for the consumer notice that must be provided when offering fixed indemnity excepted benefits coverage. NABIP members appreciate the inclusion of model text for the proposed new notice. It will be very helpful to those involved with the sale and marketing of fixed indemnity policies, and its inclusion will surely lead to greater distribution compliance.

Clarification of the Tax Treatment of Group Plan Options Paying Benefits Regardless of Incurred Medical Expenses

NABIP members appreciate the proposed regulatory clarification of existing requirements about the tax treatment of group health plan options that pay benefits regardless of actual

incurred medical expenses if premiums for such a policy are paid by an employee on a pre-tax basis. The proposed rule specifies that if policy premiums are paid pre-tax through a Section 125 plan, then any benefit payments are considered taxable income. However, if premiums are paid on a post-tax basis (not included in any Section 125 cafeteria plan), resulting benefits are not taxable. Any claim payment made under such a policy would have to be substantiated by the related group health plan to verify that the related expense was for tax-free medical care.

NABIP members note that this would represent a significant change from current practices. While employer plans routinely substantiate medical expenses, such as for reimbursement under account-based plans, group plan sponsors will need to adopt new substantiation procedures for indemnity coverage. However, this clarification reflects prior IRS guidance and the indications of a recently published IRS letter ruling concerning a fixed indemnity "wellness program." NABIP members believe that official verification such as is outlined in the proposal will be helpful in the marketplace.

Request for Information on Level-Funded Health Plans

Many NABIP members help employers that choose to offer health insurance coverage to their employees with the design and implementation of their group benefit plan arrangements. This includes assisting employers that offer level-funded coverage to their employees. In our members' experience, employers of all sizes opt for level-funded coverage generally as a means of transitioning from fully insured group coverage to a self-funded plan. Many employers remain with level-funded arrangements for years, finding the middle ground between the two types of coverage desirable. Additionally, our members report that the potential issue indicated by the Departments in the proposed rule of the unintentional creation of multiple employer welfare arrangements due to improper segregation of funds by plans' service providers is in no way reflective of current market practices.

Based on our members' vast and direct experience with level-funded plan arrangements, we offer the following answers to the questions posed in the RFI.

How prevalent are level-funded group health plans among private and public employers? How many individuals are covered under level-funded plans? The Departments are also interested in information or data on whether the percentage of plan sponsors offering level-funded plans varies by state, geographic area or other factors.

In our members' experience, approximately 15-20 percent of employers providing group health insurance coverage offer level-funded health plans. While certainly some groups that opt for level-funded coverage would also be eligible for small-group fully insured coverage, that is not the typical level-funded group consumer. Instead, our members report that by far the most

common level-funded group plan has anywhere between 50 and several hundred eligible employees.

Are there data other than KFF's Employer Health Benefits Survey that the Departments should consider?

The Self Insurance Institute of America, the Employee Benefits Research Institute, and the Society of Professional Benefit Administrators, as well as annual benefit surveys by Mercer, Segal, and PWC would be good entities to turn to for practical-level data. NABIP would also be happy to survey its membership for additional specific information if needed by the Departments.

What factors are leading an increasing number of plan sponsors, particularly small employers, to utilize level-funded plans?

Rising cost of fully insured plans, lack of transparency of employer groups' claims reporting, lack of cost containment regarding pharmacy costs, ability to receive a portion or all of any claims reserve from expected claims are all reasons why small employers consider level funding options. The benefits of offering level-funded coverage include increased affordability of coverage costs on a monthly basis, the potential of even greater savings through recoupment of surplus payments, monthly predictability of costs, mitigation of risk, increased health plan data insights, more administrative service support than may be available with a traditional self-funded arrangement, and the seamless integration of stop-loss coverage.

What are the administrative costs associated with offering level-funded plans, and how do these costs compare to the administrative costs associated with offering fully insured plans?

The administrative fees associated with offering a level-funded plan vary based on the services provided by the entity administering the coverage, the size of the group, the geographic area, and market-based competition and negotiation. Make no mistake, significant administrative costs are involved with offering fully insured coverage, but the difference is that these costs are included as part of the overall premiums and are far less transparent to the consumer. In our members' experience, the administrative costs associated with offering fully insured coverage are often more than with level-funded plans because of transparency and market-based competition among administrative service providers.

What types of benefits are commonly offered or not offered by level-funded plans?

The level-funded plan benefit plans most typically offered in the marketplace are created and administered by large health insurance issuers. These issuers offer level-funded coverage with

benefit designs that either mirror or very closely mirror their fully insured coverage offerings, as this level of coverage is what level-funded consumers expect and demand.

What kinds of level-funded benefit options are generally made available to plan sponsors? How do the benefit packages differ from fully insured plans? Do level-funded plan arrangements offer robust benefits similar to the comprehensive coverage offerings of fully insured plans?

Yes, level-funded group coverage is robust and very closely mirrors fully insured coverage offered to and purchased by midsize employer plan sponsors.

Are benefits provided by level-funded plans generally as comprehensive as fully insured plans available to small employers? What benefits and consumer protections are generally no longer included when a small employer converts its plan from fully insured coverage to a level-funded arrangement? Are changes in benefits and consumer protections communicated to plan participants and beneficiaries, and if so, how?

Yes, level-funded plans include robust benefit designs that are either identical to or very closely based on existing fully insured plan offerings. The same benefits and consumer protections apply to level-funded plans as those that apply to other self-funded plan arrangements. Therefore, a level-funded plan is not subject to most state-level benefit mandates. Still, they are subject to all federal level requirements, as well as consumer protections that apply to self-funded plans specifically and all group health plans generally.

Further, a level-funded plan and its employer plan sponsor is subject to all federal requirements directed at plans based on the size of the group. When an employer elects any form of self-funded coverage, whether it a traditional arrangement or a level-funded one, the change in status and increased compliance responsibilities and liabilities are disclosed to the plan sponsor. This differentiation is an essential component of level-funded coverage, and it would not be possible for a plan sponsor to misunderstand the changes to their benefit plan financing structure. As for plan participants, the plan's underlying financing structure is communicated in the exact way as with fully insured coverage. The status of the plan is disclosed in all ERISA plan documents, including the summary plan description, and it is noted on each coverage option's summary of benefits and coverage.

Are additional safeguards needed with respect to level-funded arrangements to ensure that individuals and/or small employers are not subjected to unexpected costs resulting from the stop-loss coverage failing to comply with federal group health plan requirements? How do level-funded plans determine anticipated administrative costs and expected claims costs?

No. The benefit of a level-funded plan is that the sponsor pays a set amount each month that is based on an estimation of the group's maximum claims costs, as well as the premium for any

underlying stop-loss policy maintained by the entity administering the plan and the plan's administrative services fees. There are no unexpected costs to the employer plan sponsor. All fees are fully disclosed to the employer up front, and there are no mid-year cost or coverage changes. The entity that offers the level-funded plan to the employer performs the claims cost estimation based on underwriting and actuarial estimates. The associated administrative fees for level-funded coverage are negotiated by the employer group with the issuer offering and administering the plan. These fees are transparent and are competitive between the various available level-funded plan administrations.

With respect to stop-loss coverage, how and by whom is the attachment point determined and what factors are considered in setting the attachment point?

Stop-loss coverage is integrated fully with the level-funded plan and the structure of the stop-loss coverage involved is determined, purchased and maintained by the entity offering and administering the coverage option. A level funded plan, similar to a self-funded plan, typically has both individual stop-loss protection and aggregate stop-loss protection. The individual stop-loss attachment point for each group is based on the groups size, actuarial risk, and overall expected claim cost. Employers all contribute to the individual stop-loss attachment point pool and the pool is evaluated each year for appropriate pricing to maintain a sustainable risk pool. The aggregate stop-loss attachment point is based on a blend of a groups historical claims experience (when available) and manual rates.

Employers that opt for level-funded coverage are certainly informed about how these policies work on the back end but, from the employer's perspective, they pay a predetermined and set amount monthly for the group coverage, which includes their stop-loss coverage, and the administrating issuer manages the stop-loss coverage on their behalf.

A level funded plan, similar to a traditional self-funded plan, typically has both individual stop-loss protection and aggregate stop-loss protection. The individual stop-loss attachment point for each group is based on the groups size, actuarial risk, and overall expected claim cost. Employers all contribute to the individual stop-loss attachment point pool and the pool is evaluated each year for appropriate pricing to maintain a sustainable risk pool. The aggregate stop-loss attachment point is based on a blend of a groups historical claims experience (when available) and manual rates.

What impact, if any, does the use of level-funding for plans offered by small employers have on the fully insured small-group market?

There is no discernable impact on the fully insured group market.

How do plans' service providers manage plan sponsors' contributions for level-funded plans, including amounts that exceed actual plan costs (that is, costs for claims, administrative fees and stop-loss premiums)? Are such arrangements consistent with section 403 of ERISA?

During the plan year, the plan sponsor pays a set and level amount monthly to the entity administering their level-funded arrangement. This amount represents an estimate of the plan's maximum claims costs based on underwriting and actuarial predictions and includes the cost of the integrated stop-loss coverage and the administration fee charged by the third-party administrator. At the end of the plan year, the administering entity provides the plan sponsor with an accounting of the plan's costs incurred during the plan year. The employer plan sponsor either receives a refund if costs are less than anticipated or, if the costs are higher than anticipated, the employer will pay a higher set amount for the subsequent year's coverage. These arrangements are managed to be consistent with Section 403 of ERISA.

How are the amounts of any refunds paid to plan sponsors by stop-loss providers determined? Are refunds remitted to participants and beneficiaries who have made contributions under the plan? If so, how are they determined and remitted?

The amount of any rebate depends on the claims costs incurred by the plan participants during the plan year. How the funds are distributed depends on the structure of the plan; however, typically, any rebate would be considered a plan asset under ERISA and need to be utilized for the benefit of plan participants. Many level-funded arrangements are structured so that the rebate is applied to the plan's premiums for the following year, thereby lowering contribution costs for both plan participants and the employer plan sponsor. Alternatively, suppose the plan sponsor receives a direct payout. In that case, the funds must be used to benefit all plan participants and may be distributed to participants and beneficiaries who may have made contributions under the plan in means similar to those utilized by sponsors of fully insured group coverage that receive medical loss ratio rebates.

How do plan sponsors of level-funded arrangements account for compliance with the consumer protections and mandated benefits that would apply to health benefits provided by a plan sponsor through a level-funded arrangement that is reimbursed through stop-loss insurance?

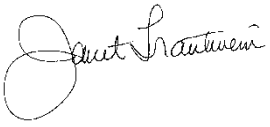
Level-funded coverage is fully integrated with the underlying stop-loss coverage. There are no differences in the coverage and benefits provided to plan participants based on who ultimately bears the cost of the claim.

Do employers offering level-funded plans generally understand and comply with any applicable reporting requirements under sections 6055 and 6056 of the Code?

Yes. If the affected employer offering level-funded coverage is an applicable large employer (ALE) for the purposes of the ACA, they comply with Section 6055 and Section 6056 in the same way as other ALEs. Suppose these employers engage with a service provider to assist with their ACA reporting obligations (as most ALEs do). In that case, the applicable vendor will determine the type of coverage offered by the employer and then appropriately assist with completing and submitting Form 1094 and all three parts of Forms 1095 C issued by the employer, as they would with traditional self-funded coverage. If an employer that offers level-funded coverage is not also an ALE, then the group's third-party administrator will inform the group of the need to issue and file Forms 1094 and 1095 B. These entities then typically engage with a vendor to prepare, file and distribute their forms, typically at a much lower cost than what is born by all ALEs. In some cases, the third-party administrator of a level-funded plan may prepare, file and distribute Forms 1094 and 1095 B on behalf of small-group level-funded plan clients.

Thank you for the opportunity to provide input on all the changes addressed by this far-reaching proposal. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nabip.org.

Sincerely,



Janet Stokes Trautwein

Chief Executive Officer

National Association of Benefits and Insurance Professionals