March 5, 2018

The Honorable R. Alexander Acosta
Secretary of Labor
U.S. Department of Labor
Employee Benefits Security Administration
Office of Regulations and Interpretations
200 Constitution Avenue, NW Room N-5655
Washington, DC 20210

EMAIL: e-ORI@dol.gov

Re: Definition of Employer — Small Business Health Plans RIN 1210-AB85

Dear Mr. Secretary,

This letter serves to comment on the Department of Labor's (Department's) Notice of Proposed Rulemaking related to Association Health Plans (AHPs). I am writing on behalf of CAI Insurance Agency, Inc. (CAI) and our wholly owned healthcare Third Party Administrator (TPA), Benovation. CAI is a privately held insurance agency, brokerage and consulting firm located in Cincinnati, OH. CAI operates a healthcare TPA named Benovation – which designs, builds, and operates self-funded healthcare Plans on behalf of our client employers. Our clients include small businesses, sole proprietors, public entities, not-for-profit organizations, and larger employers. Our customers are located in multiple states and have employees residing across the country. We routinely advise and consult with both large and small businesses regarding their healthcare Plans, including fully insured programs, self-funded options, Multiple Employer Welfare Arrangements (MEWAs), AHPs (as currently constructed), and programs designed to complement each of these options.

CAI/Benovation applauds the Administration's efforts to expand access to affordable healthcare options to employers via Executive Order 13813. Small businesses, independent contractors, and working owners often find that few health insurance options are available to them – and those that are available frequently prove to be unaffordable. Expanding the applicability of AHPs is one method to expand the options available to small businesses that if implemented effectively, could positively affect the cost of plans to which these entities could apply. These comments are intended to identify those proposed regulations that could interfere with the objectives of improving access to alternatives and reducing cost.

Perhaps the most significant challenge the Department faces to effectively expand the utility of AHPs involves the current dual Federal and State regulatory oversight of AHPs and MEWAs. As written, the proposed regulations maintain the current dual regulatory structure. The result is that most MEWAs and AHPs currently operated are restricted to business in a single State. Complying with the capital, coverage mandates, and operational requirements of more than one State while operating a health Plan is a significant challenging. This complication effectively eliminates the opportunity to create and operate a MEWA or AHP with employers domiciled in multiple States. For States with substantial population centers located on or near a State border – Cincinnati is an example, with a Metropolitan Statistical Area encompassing parts of three states

– the requirement to comply with each State's MEWA and insurance regulations has, in real practice, prohibited MEWAs and AHPs from offering their Plans across State lines. It is recommended, therefore, that the Department's final regulations related to self-funded AHPs default to Federal oversight and regulation rather than the dual Federal and State regulations as proposed. Single employer, self-funded health Plans are subject to ERISA and regulated on a Federal level. ERISA was written as the ultimate consumer protection law. Self-funded Plans are effective at reducing healthcare cost increases, excel at innovation, and routinely provide more cost effective solutions than fully insured Plans.

The Department has expressed concerns regarding financial solvency and the failure of some MEWAs and AHPs in the past. While it is true that some of these programs were not operated responsibly, most MEWAs and AHPs have provided quality benefits at reasonable costs and lived up to their responsibilities. Adoption of a Federal solvency standard applicable all self-funded AHPs will protect consumers and businesses, while simplifying compliance requirements and facilitating the operation of AHPs across State lines. This flexibility will greatly improve the ability of homogenous associations with members across the country (or multiple States) to create a program for their constituents. This will also permit the AHP plans to expand their participation, improve purchasing power, and create larger more stable risk profiles.

If standalone Federal regulation and oversight is not feasible, it is recommended that the Department consider rulemaking that will apply a single State's solvency and MEWA regulations to an AHP. For example, the State where the AHP is domiciled dictates the regulations the AHP must comply with. This will not only permit the reasonable operation and compliance of homogeneous AHPs, but also AHPs formed to serve geographic regions, as proposed. Using Cincinnati as an example, if CAI were to form an AHP "The Greater Cincinnati AHP" headquartered in Cincinnati, OH the State of Ohio MEWA regulations would apply to the operation of the AHP, regardless of where the employer was located – which could be in Southwestern Ohio, Northern Kentucky, or Southeastern Indiana. As currently proposed, "The Greater Cincinnati AHP" would be required to comply with Federal regulations as well as the MEWA regulations for three States – making the program essentially unworkable due to its regulatory burden. This fact is why most MEWAs currently operate within the border of a single State.

The Department requests input on how to define an Association. Clearly, homogenous employers that share industry concerns could benefit by expanding the definition of permissible AHPs. Like businesses often have similar needs regardless of location. They share financial similarities, look to attract and retain employees with similar skills, and frequently share information and best practices with peers. Permitting these employers to band together to create a health Plan that specifically addresses these concerns makes practical sense.

Expanding the definition of acceptable AHPs geographically or by region presents a bit more of a challenge. Existing political subdivisions (State, County, Township, City, etc.) are obvious possibilities, though the smaller subdivisions may serve to limit the opportunity to grow enrollment to levels suitable to sustain an AHP. The US Census Bureau has identified Metropolitan Statistical Areas (MSAs) throughout the United States that demonstrate high degrees of economic and social ties that could serve well as a geographic marker to create an

AHP. MSAs will often demonstrate unique healthcare characteristics that can be served by an AHP created specifically for that region. As an example, healthcare costs in the Dayton, OH MSA are approximately 1.8 times as much as they are in the Cincinnati MSA. AHPS tailored for each region can focus on cost drivers and risk management techniques that specifically address the needs of that particular population, improving long term results.

In the example cited above, "The Greater Cincinnati AHP" could enroll employers with locations in 15 Counties located in three separate States. Utilizing MSAs to create and organize AHPs will address the Department's concern about metro areas covering multiple states (Washington, DC, Philadelphia, New York/Newark, Kansas City, Cincinnati, etc.) – but only if the aforementioned Federal (or Federal + Single State) regulatory scheme is enacted. Otherwise, AHPs will be compelled to operate within a single State, but only portions of a metro area. This fact is demonstrated in today's MEWA regulatory environment: Two large insurers currently operate self-funded MEWAs in the State of Ohio, including Southwestern Ohio incorporating parts of the Cincinnati-Middletown-MSA. These offerings are not available to employers located in Northern Kentucky or Southeastern Indiana, even though they represent approximately 25% of the MSA's population, and more closely align with Cincinnati than Lexington or Louisville, KY.

The proposed Regulations appear to prohibit clinical underwriting or risk adjusted pricing by AHPs. Without the ability to underwrite the healthcare risk of applicants, AHPs will suffer the very same fate as the Co-Ops created by the Affordable Care Act (ACA). Adverse selection sunk the ACA Co-Ops, more so than inadequate financial support or poor leadership. Without the ability to charge more to assume greater risk or underwrite medically, the Co-Ops were doomed to fail before they could build the necessary market share to endure unexpected adverse claims experience. It should also be noted that in most States, major insurers are offering self-funded health plans to employers with as few as five enrolled employees. These self-funded plans are medically underwritten (typically requiring medical questionnaires) and there is no guarantee of acceptance. Renewals are underwritten according to the risk of the employer group and priced accordingly. In some states, self-funded MEWAs will underwrite groups with as few as two enrolled employees. Many of the loudest voices expressing concerns about the viability of the ACA community rated programs are themselves offering underwritten products that they claim undermine the community rated pool.

Finally, the Department gives special attention to Sole Proprietors, Partnerships and "working owners." These individuals often have to endure the most difficult struggle to find adequate health insurance Plans. There are few options for businesses with less than 3 enrolled employees, and many exist only on the individual Marketplaces. These Plans are expensive and many have limited provider networks, coupled with high out of pocket requirements. We sympathize with these working owners, and want to identify solutions that will make it easier to provide quality healthcare options for this cohort. However, we urge caution when considering permitting these individuals to enroll in AHP offerings. There is substantial opportunity for manipulation and fraud. Further research and rule making should be considered to prevent larger employers from "dumping" sick employees into AHPs or Marketplace plans. While we seek to provide solutions for legitimate Sole Proprietors and fledgling businesses, the qualifications for

eligibility specified in the proposed Regulations and the fact that there is no mechanism for verification exposes AHPs to the real possibility of fraud.

Conclusion

The expansion of AHPs is a worthwhile effort. AHPs can provide an effective alternative for businesses, particularly small businesses, if properly operated and regulated. AHPs can thrive if regulated effectively and efficiently. Exclusive Federal oversight will provide the greatest opportunity for AHPs to thrive nationwide. If exclusive Federal oversight is not possible, the AHPs State of domicile should be the only State regulatory requirements imposed upon the AHP, regardless of the location of the AHP's clients. This will permit AHPs to operate effectively across State lines. If self-funded AHPs are not permitted to underwrite or adjust price based upon the risk of the applying employer, they will not be sustainable and will fail in much the same fashion as the ACA Co-Ops. Finally, including Sole Proprietors and "working owners" is a worthwhile idea. However, further attention should be given to regulations preventing fraudulent enrollments and dumping.

CAI applauds the efforts of the Administration and the Department to expand access to quality, affordable healthcare Plans to employers of all sizes. We appreciate the work that has gone into the proposed Regulations and the opportunity to make these comments. WE welcome the opportunity to answer questions or engage in further discussion. Please direct inquiries to: Kevin Schlotman, Vice President Employee Benefits (kschlotman@my-benovation.com) or call 513-872-7505.