

March 6, 2018

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

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

Submitted Electronically

Dear Mr. Acosta:

We appreciate the opportunity to comment on the proposed rules. We view the Association Health Plan approach expressed in the proposed rules as a potentially useful way to lower premiums and expand coverage without spending any additional federal funds. The self-employed stand to benefit the most.

Background and Context

In order to provide recommendations on the proposed rule, it is important to first understand the individual and small group markets today. The proposed rule is designed to offer individual and small group customers an affordable option. This will be accomplished by allowing them to band together and be regulated as large groups. That begs the question – what is it about the individual and small group markets that makes them so much more expensive than large group? What problems are we solving with the AHP structure?

Results of ACA Implementation

To start, one must step back and look at the ACA results for the commercial population in the individual and small group market segments. This excludes the Medicaid expansion of approximately 17 million people¹ (except for a few state-based waivers like NH's PAP program). We support the additional funding for this lower-income population, as it is unlikely that premiums could get low enough for them to pay for coverage on their own. Certain approaches have proven more effective and efficient than others in covering this lower-income population, but some federal financial support is warranted.

¹ 'Key Facts About the Uninsured Population', Kaiser Family Foundation, September 19, 2017.
<https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

Outside that population, however, the ACA results are mixed and have come with a large price tag². Overall, the ACA has shifted the uninsured in the commercial (i.e., not Medicare or Medicaid) market from the lower-middle income to the middle income. Lower-middle income individuals used to find it hard to afford insurance, but now they get a subsidy. Middle income individuals, however, are not eligible for subsidies and have seen huge and unaffordable premium increases (37% for 2018 and 24% for 2017³). The net effect:

- 29% of the unsubsidized individual market members dropped coverage from 2015 to 2016⁴; this is before the 24% premium increase for 2017 and 37% increase for 2018
- In line with CBO estimates made when the ACA was being implemented⁵, the small group market shrank by approximately 5 million⁶
- The individual market grew by about 6 million⁷, but the exchange market is less than half what was forecasted by the CBO (11 million versus a forecast of 24 million)⁸
- Exchange populations are heavily subsidized, with CMS reporting approximately 84% of all people on government exchanges receiving a subsidy⁹
- Premium increases in the individual market have been substantially higher than those in the small group market, and vastly higher than those seen in the large group market^{10,11}

² 'Here's How Many Billions Obamacare Will Cost in 2016', Money, March 24, 2016.

<http://time.com/money/4271224/obamacare-cost-taxpayers-2016/>

³ 'Premiums for Popular Obamacare Plans to Soar 37% for 2018', CNN Money, October 30, 2017.

<http://money.cnn.com/2017/10/30/news/economy/obamacare-premiums/index.html>

⁴ 'Is Part of the Health-Insurance Market Entering a Death Spiral?', National Review, August 3, 2017.

www.nationalreview.com/2017/08/obamacare-death-spiral-exchange-enrollment-down-29-percent/

⁵ 'Comparison of CBO's Estimates of the Effect of Insurance Coverage Provisions of the Affordable Care Act; CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Coverage Provisions Has Not Changed Much Over Time', Congressional Budget Office, May 14, 2013. <https://www.cbo.gov/publication/44176>

⁶ 'An Analysis of Individual and Small Group Health Insurance Trends', Mark Farrah Associate, June 5, 2017.

<http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-Individual-and-Small-Group-Health-Insurance-Trends.aspx>

⁷ When measured as of December 31 after mid-year disenrollment, the number is closer to 5 million. 'Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act', Kaiser Family Foundation, May 12, 2015. <https://www.kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/>

⁸ 'CBO's Record of Projecting Subsidies for Health Insurance under the Affordable Care Act: 2014-2016, Figure 5: Projections and Actual Numbers of People With Non-group Insurance Coverage Purchased Through the Marketplaces and the Basic Health Program', Congressional Budget Office, December 7, 2017.

<https://www.cbo.gov/publication/53094>

⁹ 'Total Marketplace Enrollment and Financial Assistance', Kaiser Family Foundation. www.kff.org/health-reform/state-indicator/total-marketplace-enrollment-a

¹⁰ 'Yes, It Was the "Affordable" Care Act That Increased Premiums', Forbes, March 22, 2017.

<https://www.forbes.com/sites/theapothecary/2017/03/22/yes-it-was-the-affordable-care-act-that-increased-premiums/#4453bfce11d2>

¹¹ 'While Premiums Soar Under Obamacare, Costs of Employer- Based Plans are Stable', New York Times, September 19, 2017. <https://www.nytimes.com/2017/09/19/health/health-insurance-premiums-employer.html>

- Competition on the exchanges has plummeted^{12,13} down to 700 insurers from 2400, and this despite the very high premium levels now being charged. In a functioning market, high premiums would attract new competition, not reinforce regional dominance.
- An estimated 28 million people remain uninsured¹⁴. Many individuals earn too much to get a meaningful subsidy but not enough to pay the very high premiums in the market today. Only those for whom the premiums are clearly a good deal – the very sick – or the very wealthy are now buying coverage with their own money
- Small employers have accelerated their exit from the market or are converting to various self-insured products (e.g., ‘level-funded’) that exempt them from regulations^{15,16}
- Likewise but to a lesser extent, individuals have been joining various religious aid societies and other largely unregulated attempts to fill the coverage and affordability gap^{17,18,19}

A functioning market is one in which buyers and sellers can find a price they can all accept. This is the case for the large group market today, but the federal ACA rules have inadvertently broken the fully-insured commercial market. Millions of individuals, hundreds of thousands of small businesses, and hundreds of insurers have simply left. Under today’s rules, they really have no choice.

What Isn’t the Problem: Required Benefits and Amount of Government Funding

There are two recurring – and overstated – storylines about why the individual and to a lesser extent small group insurance markets have been under such pressure since the ACA: (1) the first is that covered benefits are too rich and are a principal driver behind increasing premiums, and (2) the second is that significantly more government funding is required in order to cover sicker people.

Much of the public discussion about the ACA in general, and even with respect to the AHP proposal in particular, focuses upon benefit mandates and coverage requirements. Both are certainly important,

¹² ‘Insurer Participation on ACA Marketplaces, 2014-2018’, Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>

¹³ ‘Estimated Number of Health Plans on Federal Exchange Plummeted by Two-Thirds’, Modern Healthcare, January 28, 2018. <http://www.modernhealthcare.com/article/20180110/NEWS/180119985>

¹⁴ ‘Health Insurance Coverage’, National Center for Health Statistics, Center for Disease Control, August 2017. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf>

¹⁵ ‘Level Funding: An Alternative to the ACA for Small Groups’, Axene Health Partners. <http://axenehp.com/level-funding-alternative-aca-small-groups/>

¹⁶ ‘Why brokers should explore level-funded plans for small group clients’, BenefitsPro Magazine, April 18, 2017. <https://www.benefitspro.com/2017/04/18/why-brokers-should-explore-level-funded-plans-for/?slreturn=20180205131907>

¹⁷ ‘How Over a Million Christians Have Opted Out of Health Insurance’, BuzzFeedNews, June 1, 2017. https://www.buzzfeed.com/lauraturner/christian-health-care?utm_term=.ghYMLpP2E#.li6rMpGAg

¹⁸ ‘Why We Switched to Health Care Sharing (bye-bye Insurance)’, The Healthy Home Economist, January 28, 2018. <https://www.thehealthyhomeeconomist.com/health-care-sharing-instead-of-healthcare-insurance/>

¹⁹ ‘Onward, Christian Healthcare?’, New York Times, January 31, 2015. <https://www.nytimes.com/2015/02/01/opinion/sunday/onward-christian-health-care.html>

and both impact cost. The current differential between individual market premiums and premiums in the large group market, however, are not fundamentally driven by richer plan designs mandated in the individual market. These costs are predictable at this point and are not large enough alone to account for expensive premiums prevalent in the ACA individual market. To go to the extreme, removing all coverage provisions of the ACA would still leave a large premium differential between the individual and small group markets and the large group market.

The second narrative is that the government needs to spend more money in order to pay for an influx of sick people into the ACA markets. While additional funding would indeed drive down premiums, even the federal government cannot spend enough to fix the market. A functioning market needs two sources of capital in order to lower costs and cover more people: companies willing to risk their balance sheets, and consumers willing to pay their own money in exchange for a product that they value. This can be accomplished without any additional federal government money.

The Real Drivers of Premium Increases

Getting this private capital to voluntarily flow into the market requires the federal government to offer relief from two ACA programs. The first, Risk Adjustment, is specifically removed under the AHP proposed rules. As explained below, this is the single most important measure the federal government can take to reduce volatility, increase competition, and lower premiums significantly. If nothing else, allowing individuals and small employers to escape Risk Adjustment by joining into large-group AHPs would be worth the effort.

The second ACA program that drives up premiums is Medical Loss Ratio. To the extent that AHPs choose the fully-insured and not the self-funded option, MLR would still apply. As explained below, this program chases away insurers because it offers them a bad deal for the use of their capital. Essentially, MLR caps upside gains while issuers can experience unlimited losses. Eliminating the volatility caused by Risk Adjustment decreases the MLR problem, but it still does remain. It also rewards carriers for having the highest possible premiums, which is counter-productive when the public policy goal is to have lower premiums.

Broadly speaking, insurers look at three issues when trying to price their products:

1. Predictable costs (e.g., their members' claim costs, pharmacy trend, etc.)
2. Potential volatility around projected costs
3. Whether they can justify risking their capital base by selling insurance at the market price

Each of these is greatly magnified by the one before it. That is, insurers can easily price a product if the costs are predictable. The phrase in insurance circles is 'There is no such thing as a bad risk, just a bad price'. This is almost always the case in a functioning market.

Volatility around those projected costs becomes the next question. If there is significant volatility then insurers, as licensed and regulated financial institutions, must presume the worst and increase premiums. They have to do this with the full knowledge that significant premium increases often result in healthier consumers forgoing insurance entirely, thus weakening the overall risk pool.

In extreme and rare situations, volatility is so high that insurers become unwilling to remain in the market at any price. This is what has been happening in the ACA marketplace. For those in the insurance industry, this is a bizarre outcome because if left to itself health insurance is a very low-volatility corner of the insurance world. There are no catastrophic hurricanes or meteors crushing office buildings; health insurance is usually about predicting things like how many babies will be born within a given population and at what cost. This is why the cost of health coverage for large companies has been seeing mid-single digit increases and low volatility.

But the individual and small group health insurance markets – newly regulated by the federal government – is highly volatile today²⁰ (recall, the large group and self-funded parts of the market untouched by the federal government have *not* been volatile). This volatility and the resulting premium increases have all been driven by the government. The volatility can be broken into two: *transitional* government-driven volatility and *systemic* governmental-driven volatility.

Transitional volatility requires insurers to temporarily raise premiums above normal claims cost projections until data materializes and the market settles down. At various times, insurers have had some uncertainty regarding the impact some coverage provisions would have and how many people would sign up for ACA coverage. Examples include:

- The introduction of Essential Health Benefits (EHBs) and other benefits coverage issues
- Special Enrollment Periods (SEPs) that in effect allow consumers to add and drop from coverage more easily than in a normal commercial market
- Weak and generally unenforced mandate for the first few years of the ACA, which has now been reduced to no penalty²¹
- Cost Sharing Reduction (CSR) uncertainty, which in the end largely impacted the premiums for on-exchange Silver plans. That is, eliminating federal CSR funding simply drove up subsidy funding

²⁰ Monopoly or near-monopoly markets of course do not appear volatile. The reason that they are so concentrated, however, is that other insurers exited since they view the market rules as having created too much volatility. That leaves the market ‘stabilized’ at a very high premium level. In a functioning market, by contrast, robust competition pushes the market to reach a different stable pricing level. Simply put, monopoly-driven ‘stability’ is at a lot higher premiums than stability reached by having multiple competitors battle for consumers.

²¹ 6.5 million paid the mandate penalty and 12.7 million used one of 14 exemptions to avoid the penalty and still be uninsured

Several years later, however, many of these previously uncertain or volatile elements are now more predictable costs. Insurers in the state markets now have enough data and experience to predict the higher cost impact of the coverage provisions, so there is lower volatility around those. This decrease in volatility should have exerted downward pressure on premiums. The fact that premiums continue to increase underscores that these elements, while important, have not been the key drivers behind the decrease in competition and increase in premiums.

The key driver of increasing premiums is the systemic government-driven volatility. The ACA inadvertently increased this to unheard of levels. The greatest driver has been the failed Risk Adjustment program. Risk Adjustment (RA) was intended to equalize risk among populations, but instead has amplified the volatility associated with lower-cost products. A successful RA program such as those to which insurers voluntarily agree may transfer 1-2% of annual premiums from one insurer to another. *By contrast, CMS data show, the federal RA program has transferred an average of 10% of individual market premiums – with lower-cost options like Molina paying over 25% of total revenue.* Imagine running a business when 10% to 25% to 45% of your revenue might be taken, unpredictably and retroactively, by the government and given to your competitors.

Risk Adjustment as concept can work if designed and implemented well. The federal version has been neither. Attached are several documents to help explain the RA program and the negative practical effect it has had on the market:

1. CHOICES coalition of small, affordable insurers letter to HHS Secretary Burwell. NOTE: most of the carriers have scaled back or completely withdrawn from the market since this letter
2. Written testimony of Maryland Insurance Commissioner Al Redmer before the US House Oversight Committee
3. Letter from New York Department of Financial Services Superintendent Maria T. Vullo to HHS Secretary Burwell and CMS Acting Administrator Andy Slavitt
4. Letter from Illinois Acting Director of Insurance Anne Melissa Dowling to Kevin Counihan, CMS
5. Connecticut Division of Insurance press release
6. US House of Representatives – Committee on Energy and Commerce – Report on COOP program
7. Study by Milliman Actuarial – Sizing up Risk Adjustment volatility
8. NH Market stabilization – MHI letter to NHID
9. New Mexico Health Connections – Amended RA Complaint to suit filed in federal court
10. MHI – Amended RA Complaint to suit filed in federal court

While Risk Adjustment has seemed complicated as a topic, the results are straightforward: high volatility created by RA has driven competition from the markets.²²

²² The main defense of the RA program by some is that it is 'directionally correct'. That is, that if a company should pay something then it does indeed pay something. The standard 'directionally correct' is a hilarious joke in insurance circles because it does not distinguish between paying \$10 or \$10 million; both are amounts to be paid

The final nail in the economic coffin for insurers has been the Medical Loss Ratio, or MLR, rules. The idea behind this was to require insurers to spend at least a minimum percentage of premium on medical claims, 80% in the individual market and 85% for the group markets.

The MLR rule punishes affordability by rewarding higher premiums. If insurers keep only 15-20% of the premiums and their costs are very similar across their products, then higher premium benefits insurers. 15% of an \$800 monthly premium is better than 15% of a \$300 monthly premium for the insurers.

The MLR rule also makes it harder for innovators to come in and disrupt the market. Provider-based plans, for example, that try to better align care and gain medical efficiencies are twice penalized. First, they lose because they are cheaper and therefore can recover fewer admin dollars due to the MLR requirement. Secondly, they have less operating scale and therefore have a harder time competing in the early days.

Those two elements of the MLR rule pale in comparison to the last: The MLR rule chases capital away from the insured market. In a good year before the ACA, an insurer in a competitive market would typically earn about 1-2% of revenue on average. In a bad year, an insurer could lose a few percentage points. After a bad year, the insurer would raise premiums in order to generate additional earnings to restore the capital base depleted during the previous year.

Under MLR today, that dynamic is broken. An insurer could still potentially earn a small amount – say 1-2% of premium – in a good year. But if an insurer were to lose 4-5% in a year, it cannot under MLR raise premiums to restore its capital base.

The combination of RA and MLR is a government-created perfect storm that has forced premiums much higher, insurers to exit, and more than half the intended customers to flee²³. The massive systemic volatility created by the Risk Adjustment program and this MLR capital constraint has been devastating. Risk Adjustment can reduce an insurer's prior year revenue retroactively and massively; 25% of premium has been routine. This means that a 'bad year' is no longer losing 4-5% of premium; now a bad year could mean losing 30-40% of premium.

The insurers of course do have medical claims to pay and administrative costs to cover, so the bulk of the RA funds that are paid have to come from that insurer's capital reserves. Since the MLR rule effectively prohibits the insurer from ever generating earnings to replenish the capital base, the insurer finds itself stuck in a terrible quandary. It can only earn a small amount in the best of years (because gains are capped by MLR rules), but will lose an unlimited amount in a bad year, and the swings

and thus both are 'directionally correct' (n.b., use of the word 'correct' is the funny part because overall the results could be almost useless). Obviously in the real world of financial statements there is a huge difference, and insurers cannot file 'directionally correct' income statements and balance sheets with state regulators.

²³ Please see footnotes 3-14

between good and bad years are much wider and less predictable due to Risk Adjustment. There are only two survivable market positions: 1) be a very large, very expensive insurer in what (for them) is hopefully something close to a monopoly market with very high premiums and high federal subsidies, or 2) exit the market. Look around the ACA individual markets today, and that is increasingly what one sees.

The Association Health Plan rules offer a way out of the Risk Adjustment debacle. By joining into a fully-insured AHP, those individuals and their plan would not be subject to RA. MLR would unfortunately still be a feature, but without the RA systemic volatility the impact of the MLR rules would be lessened.

The above is not an academic or theoretical view. New Hampshire today offers a clear example how the RA and MLR programs inadvertently harmed unsubsidized consumers and how an AHP could help many of them. In NH in 2017, only 63% of the individuals on the exchange received subsidies. This indicates that those without subsidies saw premiums that were affordable and could choose to buy them.

In January 2018, the lowest-cost product in the market was 74% more expensive than had been the case just one month earlier. Given this, reportedly thousands of the unsubsidized individuals dropped coverage²⁴²⁵²⁶. Hospitals did not raise their costs by 74%, nurses and doctors did not hike their charges, and even the high cost of some pharmaceuticals was not the issue. Instead, these premium increases are due to bad federal government policy.

The good news is that the AHP – by exempting AHP enrollees from Risk Adjustment – could allow a massive premium reduction. Much of that 74% increase from 2017 could be wiped out for consumers in an AHP. Furthermore, by unshackling competition the market should quickly find more insurers willing to compete and further drive down prices. At the end of the day market competition – not increasing federal subsidies for high-cost monopoly insurers – is what will drive down premiums and increase the number of insured Americans.

The focus of the above has been on the individual market segment because it is currently the one in most acute crisis. The small group market shares the governmental afflictions of Risk Adjustment and Medical Loss Ratio, but the relative importance of those and other factors is weighted differently. The following is a high-level summary of the relative impacts of the governmental policies referenced above:

²⁴ '2017 Marketplace Monthly Report – NH.gov'.

https://www.nh.gov/insurance/lah/documents/mktplc_month_enrl_rpt_2017.pdf

²⁵ January data is actual; preliminary February data is un-reconciled. '2018 Marketplace Monthly Report – NH.gov'. https://www.nh.gov/insurance/lah/documents/mktplc_month_enrl_rpt_2018.pdf

²⁶ CMS typically releases final enrollment data in Q2.

Government policy	Individual Market relative impact	Small Group relative impact
Benefits mandates and coverage requirements (e.g., Essential Health Benefits)	1	2
Uncertainty regarding governmental policies (e.g., CSR funding, Special Enrollment Periods, etc.; issue varies by year)	2	1
Risk Adjustment	5	4
Medical Loss Ratio	2	3
TOTAL	10	10

The ten points in each of the above columns do not drive similar dollar impact, however. From our personal experience in the individual market, premiums have been driven well over 50% higher as a result of the above governmental actions. For the small group market, the impact has been about half that of the individual market. Both are far too large, and both can be solved without spending federal tax dollars.

Proposed AHP Rules

We support many of the proposed rules. However, neither these nor other rules comprehensively address the driver of increased premiums: the Risk Adjustment and Medical Loss Ratio programs. Therefore, in addition to the recommendations below, we encourage you to expand the Risk Adjustment exemption as widely as possible; Risk Adjustment is the single most competition-killing and price-increasing factor in the market today. We also encourage you to work to limit or remove the Medical Loss Ratio factor. Leaving it in place simply encourages smaller and smaller employers to self-insure, which in the end is less efficient for the market and less good for consumers.

With respect to the proposed AHP program generally, we encourage the Department to ensure that certain ACA consumer protections stay in place; they do not add significant costs, and they are critical to ensuring access to healthcare. History has shown us that similar association-type insurance structures have risked a benefits “race to the bottom.” The Department can avoid that outcome by explicitly stating that states have the power to regulate benefits offered through the AHPs, maintaining guaranteed issue, and helping consumers and employers to compare their options by requiring an Actuarial Value (AV) scoring for all AHP plans. Like an ‘MPG’ sticker on a new car, an AV score helps consumers know what they are buying. Transparency is needed in all markets, and AV scoring is an imperfect but nonetheless useful tool for consumers

1. Overview of Proposed Regulation

We agree that the determination of whether an AHP would be buying insurance as a large group or small group plan would be determined by reference to the number of employees in the entire AHP. A suggested clarification is to allow an AHP to be set up in a manner consistent with its *intended* number of employees. For example, an AHP set up to serve the self-employed in a market will have zero members on the first day. Those members will sign up once the AHP is established and marketed to them.

We also note that some states have rules that require association-type groups to be regulated by small group rules, regardless of the size of the association. Similarly, some states have rules that require associations to have been in existence for some period of time (“seasoning requirements”) before they can issue business. We recommend that such rules should not be allowed to apply to AHPs, or they will subvert the intention of the AHP rules and block access to low cost premiums to consumers in some states.

2. Section 4.a. Employers Could Band Together for Single Purpose of Obtaining Health Coverage

We agree that it is appropriate to allow employers to band together if they are 1) in the same trade, industry, line of business, or profession, or 2) have a principal place of business within a region that does not exceed the boundaries of the same state or the same metropolitan area (even if the metropolitan area includes more than one State).

We suggest clarifications to both, however. For the former, the ‘same trade, industry, line of business, or profession’ should be viewed very broadly. As mentioned above, the individual insured ACA market is in even worse shape than the small group insured market. An association such as ‘Self-employed in New Hampshire’ should be allowed to help those consumers secure more affordable insurance.

The ‘principal place of business’ standard may be confusing without clarification. It is standard in the insurance industry to declare a ‘situs’ state for large employer clients. This is typically where the company is headquartered and/or where most of the employees reside. It would be inappropriate, as an extreme example, for all AHPs to pick as a situs one small state with perceived regulatory advantages. If most of the members of the AHP are or are anticipated to be in given state, then that should be the situs state whose regulations are relevant, even if it is not the site of the association’s headquarters.

Another way to address this issue could be to set simple caps on the percentage of members of a given AHP that can reside in another state. There will always be dependents away at college, for example, so there must be some allowance made. But a threshold cap of 15% could take that into account.

Note that broader administrative efficiencies would be possible, albeit to a lesser degree. A restaurateur or company like Uber, for example, could still have centralized administration for multiple AHPs serving their contractors in various states. Each AHP would need to comply with local states’ large group regulations in this example. In this example, there could be a group that is ‘United Associations of

the Self-Employed in New England’ as an administrative umbrella organization. Underneath it – and subject to state large group insurance regulations – is ‘The Association of Self-employed in New Hampshire’, ‘The Association of Self-employed in Massachusetts’, etc. The same could be the case for Uber drivers, FedEx drivers, etc.

3. Section 4.b. The Group or Association Must Have an Organizational Structure and Be Functionally Controlled by Its Employer Members

The structure as outlined in the proposed rules appears practical and reasonable as well as justified under ERISA. We suggest adding transition language that would allow a newly-formed association of self-employed individuals, for example, to be established under an initial Board comprised of the AHP organizers. Once established and membership has been recruited, then the AHP could transition to the ongoing governance structure (e.g., the membership votes on officers).

The concerns that AHPs be sufficiently separate from an underlying insurance carrier are important. If the construct is to be efficient, however, the AHP and the insurer should coordinate some functions. In this respect, the AHP is functioning more like a private-sector exchange. Just as exchanges now work with insurers to market, enroll members, process payments, etc., so should an AHP. The governance needs to be separate, but operations should be allowed to be as integrated and efficient as possible.

4. Section 4.c. Group or Association Plan Coverage Must Be Limited to Employees of Employer Members and Treatment of Working Owners

We agree that expressly proving that it is appropriate for working owners, such as sole proprietors and other self-employed individuals, to be able to elect to act as employers for purposes of participating in an employer group or association and also be treated as employees of their businesses for purposes of being covered by the group or association’s health plan. The self-employed individuals are those who have been most hurt by the skyrocketing individual market premiums over the last few years. Many get little to no subsidy, and the full cost of the increase has fallen on them. As referenced above, HHS has found that over 11 million Americans fall into this category now. We just witnessed this scenario in NH, where thousands in the individual market just dropped coverage this past January when premiums shot up over 70%. An AHP would allow many of these individuals to again be able to afford paying for their own insurance.

Defining which individuals may participate in an AHP can be difficult, and if care is not taken then administering such a process could be prohibitively expensive. We agree that the AHP should be allowed to rely on written representations from the individual seeking to participate as a working owner.

The threshold by which such an individual should judge his or her eligibility should be whether the income they earn surpasses the premiums *or* they work 30 or more hours a week *or* 120 hours a month

are reasonable. The key is the use of 'or', since some businesses are seasonal. Additional clarity could be added by inserting the word 'average' before each of these triggers.

Prohibiting any individual who is eligible for coverage at an employer or under a spouse's plan from participating in AHPs should be struck. As has been seen under the ACA's enrollment results, 6.5 million people chose to pay penalties and 12.7 million individuals filed for and received exemptions from penalties in the past because the options available to them were prohibitively expensive. If those individuals could receive coverage under an AHP more affordably, then refusing them the option to do so would be deeply inappropriate. The government should not be in the business of refusing its citizens the ability to purchase a more affordable product that they prefer. That imperative is underscored when millions today cannot afford the current products due to federal government policies like RA and MLR and not market forces.

Recall that overall, the individual and small group total enrollment before the ACA and today has not changed very much. The ACA did cover about 17 million more Americans under Medicaid. About 6 million more people are covered under the individual market today, with approximately 10 million of them on the exchanges. Of those on the exchange, about 8.5 million receive federal subsidies. Altogether, the commercial (i.e., non-Medicaid) population covered has remained about even over the last five years at 30 million. Over 13 million Americans who were forecasted by the CBO to be covered on the exchanges are instead un-insured²⁷.

The big change has been who is uninsured. Prior to the ACA, the lower middle class was unable to afford coverage. People who earned less than they could get Medicaid, and those middle income and above could afford coverage of some kind. Today, the lower middle class get subsidies on the exchanges. But premiums have risen so high that the middle-middle class can no longer afford to pay. They make too much for a subsidy but cannot write a check to cover such high premiums.

These are the people who need help today, and the AHP can be one vehicle by which it can be provided.

The proposed rule rightly highlights that some activities such as a startup may result in some unique circumstances. Instead of coming up with a long list of 'I before E except after C' type of rules, keeping it simple and having the burden of compliance be borne by the individual signing and not the AHP is appropriate.

5. Section 4.d. Health Nondiscrimination Protections

The risk of discrimination is real, and the proposed rule addresses the issue well to start. Prohibiting restrictions in membership based on any health factor (paragraph (d)(1)) is completely appropriate.

²⁷ Please see footnotes 4-9.

Likewise, charging individuals or employers different premiums based upon health status would also be inappropriate and is dealt with in the proposed rules.

CMS has requested comments whether putting such restrictions on AHPs would create involuntary cross-subsidization across firms that would form and use of AHPs. In short, such cross-subsidization is exactly what insurance is designed to do. Allowing different rates within the association would replicate the failed approach that many associations took in pre-ACA days.

One issue raised by several, including the NAIC, is that benefit packages could be constructed in a discriminatory fashion. This may be a risk, but is one that the states should be explicitly empowered to protect against. Fully-insured large group coverage under an AHP should follow all state regulations that apply to the large groups and have no federal exemption or pre-emption. States have primary responsibility to regulate insurers and have a long and successful history of protecting consumers. State rules that apply to the broader large-group market should also apply to AHPs. This may include, for example, state network adequacy and benefits rules that already apply to the whole large group market.

Some limited pre-emption of state authority is required. For example, Massachusetts requires that Associations follow small group rules and New Hampshire has a 'seasoning' requirement that requires an Association to have been in existence for more than five years before it can offer health coverage to its members. In addition, states may attempt to constrain the federal AHP rules with a cloud of new rules and regulations that could hamper AHP development. None of these should be permitted.

As discussed elsewhere, we do not believe that self-funded AHPs for small employers are likely to offer significant enough advantages over existing self-funded options (e.g., 'level-funded') to be as significant of a factor competitively. Fully-insured AHPs for the self-employed should be the most compelling offering and the focus of the AHP effort.

Another issue is whether consumers will understand the relative coverage offered by competing plans. We suggest that the AHP plans offered are each scored to reflect their Actuarial Value ('AV'). Actuarial Value reflects what percentage of all potential claims should be covered by the plan. Under the ACA, a plan with an AV of 60% is a Bronze, 70% is a Silver, etc.

Taking a similar approach and having plans report their AV would help consumers understand the relative merits of one plan versus another. This would allow better comparison shopping and a more efficient market.

The federal AV calculator has gone through some changes and works reasonably well. There are also robust AV models in the private sector. One or more of these AV models should be required to be run for each of the plans being offered and posted for consumers, just as all new cars have a sticker that displays the projected miles per gallon.

A second concern, and one raised briefly in the proposed rules, is that the AHPs devolve into a high-churn environment with healthier people and sicker people continually jockeying for a fleeting advantage. The key to stable pricing in a competitive market is to have risk pools that are defined and have integrity. That is, the risk-taking insurer has a reasonably good idea of who will be in the pool and that the pool will tomorrow look a lot like it did today.

To help foster such stable pools and to minimize the incentive for individuals, companies, or AHPs to constantly change things, we suggest explicitly allowing multi-year discounts and/or setup fees in the first year. For example, allowing a 10% discount after the first year and/or a \$500 initiation fee would both discourage churn and help keep volatility and therefore premiums lower overall.

In the midst of this discussion regarding adverse selection, we must pause and reiterate what is happening today in the individual market. Today, lower income people get a subsidy. As result, most do sign up. Lower incomes tend to correlate with lower health status, and so the pools in most states tend to be somewhat sicker than the population at large.

ACA rules have inadvertently driven out many of those middle income individuals who cannot afford the high individual market premiums. Only those who are very sick find it financially beneficial to buy those high-priced products with their own money. Furthermore, the ACA rules have inadvertently penalized lower-cost plans that tend to attract consumer who think they are healthier. As a result of all of the above, the market has already experienced adverse selection. Getting those consumers back into the market by offering them affordable products is exactly what a well-designed AHP program should accomplish.

CMS has requested comments regarding whether these proposed rules provide both sufficient protection and also leave enough room to allow for flexibility and innovation. This is a hard balancing act. What has been clear is that innovation through regulation – that is, smart professors or politicians in DC working spreadsheets or constituent meetings – has not been effective. Costs have ballooned higher in both the private sector and the federal budget. Instead, regulations need to set broad consumer protections and then leave the innovating to the market.

To again refer to the car market, we note that the Trump administration chose to continue the Obama administration policy with respect to the self-driving vehicle industry. The decision was effectively to hold back on regulations and trying to dictate standards and requirements and such out of Washington. The language used by both administrations was very similar: they expressed a desire to allow innovation to flourish and to not stifle innovation with too much DC rule-making too early.

Healthcare desperately needs innovation. Outside of Medicaid expansion, we have not addressed the coverage gap in this country. The cost problem is swamping every payor – federal government, state governments, employers, and individuals. Clear federal standards as outlined in the AHP proposed rules (with a few modifications as we suggest above), clear deference to state regulatory authority with

respect to their own consumer protections for the large group market, and lowered governmental risk by exemption from the Risk Adjustment program are all appropriate steps. They will combine to unleash innovation in each of the states and re-introduce competition in a market that has quickly ossified into one with very few, very big, and very expensive insurance options. And as a result, approximately 11 million people who get no subsidy and have been forced to drop their insurance because the increases have been too big, and 28 million overall remain un-insured.

The good news is that these changes are simple ones and would cost taxpayers nothing. Efficient healthplans could lower premiums 20 to 35 percent today. Competition will then force expensive insurers to configure more affordable products and costly fee-for-service providers to become efficient or lose patients.

Market-based innovation and competition have solved cost and access problems across the American economy for 250 years. Healthcare needs it now. No health care plan can work unless we attract both the missing half of consumers and more insurance competition. Fix federal rules and we can.

Sincerely,

Tom Policelli
CEO, Constitution Health, Inc.