Providence St. Joseph Health

March 5, 2018

The Honorable Preston Rutledge
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
Room N-5655
200 Constitution Avenue NW
Washington, D.C. 20210

Submitted electronically via regulations.gov

RE: Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans

Dear Assistant Secretary Rutledge:

On behalf of Providence St. Joseph Health System and Providence Health Plans, thank you for the opportunity to provide feedback in response to the Department of Labor Notice of Proposed Rulemaking titled Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans (83 FR 614).

Providence St. Joseph Health System is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence St. Joseph Health combines Providence Health & Services and St. Joseph Health and includes a diverse family of organizations. Together, we employ more than 111,000 people who serve in 50 hospitals, 829 clinics, two health plans and hundreds of programs and services in Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. Our unique not-for-profit organization is transforming health care for the future through digital innovation, population health, mental health, specialty institutes and clinical quality. Each year we work to provide care and services where they are needed most, including investments in community benefit that in 2017 totaled more than $1.6 billion.

Providence Health Plan and Providence Health Assurance are not-for-profit health care service contractors that issue or administer health coverage for more than 600,000 members through commercial group, Medicare Advantage, Medicaid and Individual/family plans in Oregon and Washington. Providence Health Plan has more members in the Oregon Individual market than any other insurer and is the only state-wide insurer on the Oregon Exchange. Our plans are offered in response to each community's unique needs, and have received national recognition for quality, customer satisfaction and loyalty, health care integration, disease management and wellness campaigns.

We appreciate the opportunity to provide our comments to the Department. Respectfully, we have serious concerns about the impact of many aspects of the proposed rule on the stability of health insurance markets and on the health and ability of our enrollees to access needed services. We urge the Department to retain existing requirements regarding AHP formation and eligibility in order to ensure healthy marketplaces in which consumers are protected from fraud and financial uncertainty. Furthermore, we urge the Department to respect the role of state governments in regulating health insurance and issue a final rule that allows states to ensure health insurance products meet the unique needs of their citizens.

Stable Insurance Markets

Recommendation: Retain existing "bona fide" association standard and AHP eligibility requirements; Retain existing statutory definition of employer.

As drafted, the proposed rule will have a significant impact on the stability of the individual and small group markets. It relaxes the requirements for an association to be considered a single multi-employer plan under ERISA and will increase the availability of coverage that is exempt and separate from ACA coverage standards and risk pools. This broadened availability of AHPs and relaxed commonality of interest standards proposed by the draft rules opens the door to fraudulent AHP behavior along with insolvency and unpaid claims that accompany such fraudulent behavior much like the market saw with MEWAs in the 1990s prior to market reforms.

Commonality of interest

The draft rules relax the "commonality of interest" requirement such that employers tied only by being in the same industry or geographic area may band together to form an association for the sole purpose of offering health coverage. This is far too broad and will result in the formation of fraudulent associations or in employers seeking to form or join such associations in order to sidestep many of the ACA's consumer protections such as rating factor and essential health benefit coverage requirements.

We strongly urge the Department to retain the existing standards ("bona fide") in order to promote healthy marketplaces and protect consumers. The commonality of interest test should be limited to closely related industries and businesses with employment relationships. Further, the use of a common metropolitan area to establish commonality of interest should be eliminated. Lastly, associations should not be eligible to establish health plans if they are formed solely for the purpose of offering health coverage.

Definition of employer

As drafted, the proposed rules alter the statutory definition of employer to include working owners who lack common law employees. We are concerned that this change not only exceeds the Department's statutory authority but also creates confusion and contributes to the erosion of the individual market. The proposed definition would allow healthier, self-employed individuals to enroll in AHPs that offer cheaper, less comprehensive coverage while leaving less healthy individuals and those with chronic conditions and disabilities with increasingly costly and less available coverage in the ACA market. We urge the Department to retain the existing statutory definition of employer in the final AHP rules in order to reduce further individual market destabilization and erosion.

Protect Consumers
Recommendation: Retain existing "bona fide" association standard and AHP eligibility requirements; Retain existing statutory definition of employer.

In addition to market stability concerns, the proposed rules also create significant consumer concerns related to the affordability, availability and comprehensiveness of health coverage. In order to protect consumers, we strongly urge the Department to retain the existing requirements that apply to AHPs including the "bona fide" AHP eligibility requirements in addition to the existing statutory definition of employer.

The newly created AHPs under the proposed rule would be exempt from many of the ACA consumer protections and free to rate on factors like age, group size and type of industry in which an employer works. Associations could also design their products in a way that makes them unattractive to those with health needs or certain conditions and thus discourages them from enrolling. For example, AHPs may exclude prescription drug, maternity or mental health coverage. This type of flexibility is likely to siphon healthy risk away from the ACA individual and small group markets and raise premiums in those markets because AHPs are able to offer cheaper, less comprehensive coverage that appeals to younger and healthier consumers. The net result is that many consumers, particularly those with health needs, chronic conditions or disabilities, will be left unable to afford or purchase coverage that meets their needs.

The proposed rule could also impact the ability of individuals to qualify for and receive marketplace subsidies while working for a small employer who does not offer health coverage. Under the ACA, individuals with an offer of "affordable" employer-sponsored coverage that meets minimum standards are unable to receive subsidies to purchase coverage through the marketplace. Thus, if a small employer opts to purchase AHP coverage an individual who previously qualified for subsidized marketplace coverage may lose access to that option. This particularly troubling if the individual in question (or the individual's family members) has a health condition or disability that necessitates the comprehensive coverage and protections afforded by ACA plans.

Respect role of state government
Recommendation: Maintain state authority to oversee and regulate AHPs

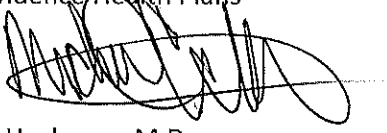
States currently provide oversight and regulation of AHPs. This is necessary in order to protect consumers from AHP plan failure and fraud. The proposed rules, as drafted, do not include any additional mechanisms or resources for federal oversight of these plans. Instead, federal regulators would primarily rely on AHP self-reporting to identify any potential financial issues. We are concerned that this type of oversight will not be sufficient to protect consumers, and as such, we urge the Department to retain existing state authority to oversee and regulate AHPs to ensure that consumers are protected from fraud and offered plans that best meet their needs.

While Providence St. Joseph Health and Providence Health Plan support the Department's goal to expand access, increase choice and decrease costs associated with health insurance, we are concerned that the proposed rules will actually contravene these goals for many, especially the poor and vulnerable that we are committed to serve. We urge the Department to retain existing regulations that protect consumers and respect the role of state governments in regulating insurance.

Thank you for the opportunity to provide our comments. For more information please contact Carrie Smith, Chief Compliance Officer, Providence Health Plans at Carrie.Smith@providence.org.

Sincerely,

Michael Cotton
Chief Executive Officer
Providence Health Plans



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