WRITTEN STATEMENT

OF

AMY N. MOORE

COVINGTON & BURLING LLP

BEFORE THE

**SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS**

OF THE

COMMITTEE ON EDUCATION AND LABOR

U. S. HOUSE OF REPRESENTATIVES

HEARING
**Health Care Reform:
Recommendations to Improve Coordination
of Federal and State Initiatives**

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Good morning, Mr. Chairman and Congressman Kline. I very much appreciate the opportunity to speak with you and the Subcommittee today about health care reform.

I am a partner in the law firm of Covington & Burling LLP. I have concentrated on employee benefit matters since 1984. I advise many of the nation's largest employers on issues affecting the group health plans they maintain for their employees. Most of the companies I represent have employees in more than one state, and some have employees in all 50 states. My firm also represents The ERISA Industry Committee, a nonprofit association committed to the advancement of the employee benefit plans of America's largest employers. I am testifying today on my own behalf.

The Subcommittee's focus on the coordination of federal and state initiatives is commendable. The health care system in this country has serious problems, and it will take the best efforts of federal and state policymakers, industry leaders, trade associations, and private individuals to address them. In the last six years alone, the cost of health care has increased at

3½ times the rate of inflation.[1] National expenditures on health care now consume 16 percent of the gross domestic product.[2] Although our health care system is among the most expensive in the world, it is far from being the most effective. Forty-seven million Americans, including more than 8 million children, have no health coverage.[3]

The rising cost of health care puts pressure on employers as well as on state governments and their citizens; and employers are actively seeking solutions to the problems in our health care system. In spite of these difficulties, employment-based health care remains the main source of health coverage for American workers and their families. The percentage of workers and their families who receive health coverage from employment-based plans has remained steady for decades.[4] Approximately 74 percent of workers are eligible for health benefits from their own employer, and more than 60 percent of workers are covered by their own employer's health plan.[5] Those who decline their own employer's health coverage often have coverage from a spouse's or other family member's employer.[6]

As this Subcommittee considers how to address the problems in our health care system, it should take care to preserve the aspects of the system that work well. Employers are able to offer health coverage to their workers in large part because their health plans are subject to uniform federal regulation, and are protected from inconsistent regulation at the state and local levels.

I would like to focus on the importance of ERISA preemption to the employment-based health care system. I have four key points.

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[1] Paul Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988–2005,* Employee Benefits Research Institute (EBRI) Issue Brief No. 303 (March 2007).

[2] The Henry J. Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace,* Publication No. 7031 (Feb. 2006).

[3] DeNavas-Walt, Proctor, and Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005,* U.S. Census Bureau (August 2006).

[4] Fronstin, EBRI Issue Brief No. 303, *supra.*

[5] *Id.*

[6] *Id.*

First, the employment-based health system delivers comprehensive health coverage to millions of Americans today, and it is the force behind some of the most promising innovations in health care. A strong ERISA preemption provision makes this system possible; any erosion of ERISA preemption will put it in jeopardy.

Second, Congress carefully considered the effect of ERISA preemption on state health reform efforts more than 30 years ago, when ERISA was enacted. Congress concluded that federal preemption was necessary to eliminate the threat of conflicting state and local regulation of employee benefit plans. As the House Committee on Education and Labor explained, "the Federal interest and the need for national uniformity are so great that the enforcement of state regulation should be precluded."[7] Experience has shown that this judgment was correct.

Third, permitting states to obtain waivers from ERISA not only will undermine the employment-based health system, it also will prove impractical. Granting waivers from ERISA is very much more complicated than granting waivers from Medicaid. No system exists, or can easily be created, to administer an ERISA waiver program.

Fourth, states do not need ERISA waivers in order to implement sound and effective health care reforms for their citizens. The problems most urgently in need of solutions—insuring the unemployed, providing reliable and accessible information on health care cost and quality, making affordable insurance available to individuals and small groups—are outside the scope of ERISA's preemption provision.

Employment-Based Health Coverage Is One of ERISA's Success Stories

Employment-based group health plans provide health coverage to more than 160 million Americans under age 65.[8] Although the employment-based health system is voluntary,

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[7] H.R. Rep. No. 1785, 94th Cong., 2d Sess. at 47 (1977).

[8] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Updated Analysis of the March 2006 Current Population Survey,* Employee Benefits Research Institute (EBRI) Issue Brief No. 305 (May 2007).

96 percent of employers with more than 100 workers offer health coverage to their employees.[9] Large employers bear the great majority of the cost of this coverage. For example, employers with more than 100 workers shoulder, on average, 82 percent of the cost of single coverage and 74 percent of the cost of family coverage.[10] Large employers spend approximately $3,300 per year for each employee with single coverage and approximately $8,000 per year for each employee with family coverage.[11]

Large employers are not only major providers of health care, they also are a major force behind the improvement of the health care system. Here are just a few examples of the ways in which employers are making health care safer, better, and more affordable for all Americans:

- **Quality and Safety.** Large employers and employer groups such as the Leapfrog Group are using their purchasing power to improve the safety and quality of health care by rewarding hospitals that provide high-quality care.

- **Information Technology.** Employers and employer groups are working to improve health information technology, such as electronic medical records and health information exchanges, to reduce medical errors and make health care more efficient.

- **Transparency.** Employers and employer groups are demanding better information about health care costs and outcomes, in an effort to make the health care system more efficient and more affordable.

- **Patient-Centered Care.** Individual employers, employer groups such as The ERISA Industry Committee, and physician groups have joined together in a Patient-Centered Primary Care Collaborative to develop and advance the concept that the Patient-Centered Medical Home, with a primary care

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[9] U.S. Department of Labor, Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2006* (August 2006).

[10] *Id.*

[11] *Id.*

physician coordinating a patient's care, is a better way to provide health care than the balkanized system that is too often the norm today.

- **Wellness Programs**. Employers recognize the importance of promoting good health among their employees: they are developing innovative programs and incentives to encourage exercise, weight loss, smoking cessation, regular physical examinations, and other healthy practices.

- **Consumer-Driven Care**. Large employers have been a significant force behind consumer-driven health care, which gives employees more flexibility and more responsibility to decide how best to spend their families' health care dollars.

Employment-based health plans provide affordable, comprehensive care to millions of workers and their families, and they drive innovation and improvement in the health care system as a whole. A major factor contributing to the success of employment-based health plans is the broad preemption provision in ERISA.

The Continued Vitality of Employment-Based Health Coverage Depends on ERISA Preemption

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA.[12] Because self-insured group health plans are not subject to state benefit mandates, companies that do business in more than one state can provide uniform health benefits to their employees across state lines. An employer with a nationwide work force can maintain a nationwide health program, with all of the cost savings and administrative efficiencies a uniform benefit program entails. The employer can provide all employees with the same health coverage regardless of where they live, where they work, or where their care is provided, and regardless of how often they are transferred during their careers.

It is no accident that ERISA includes a broad preemption provision. Before ERISA was enacted, employee benefit plans were regulated by a patchwork of state statutes,

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[12] ERISA § 514(a), 29 U.S.C. § 1144(a).

local ordinances, and court-made rules. An employer that provided benefits to a multistate work force encountered severe administrative difficulties and unnecessary expense as it attempted to comply with rules that differed from state to state, and sometimes from city to city. It was difficult or impossible for a large employer to tailor its benefit programs to the needs of its work force. Inconsistent and conflicting state mandates prevented employers from providing their employees with the best possible benefits at the most reasonable cost.

The bills passed by the House and Senate originally included a much narrower preemption provision, which would have superseded state law only in areas specifically regulated by the federal statute.[13] In conference, however, the members recognized that such a system was unworkable. Senator Javits, one of the chief architects of ERISA, explained that the narrow preemption provision "open[ed] the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." He concluded that "on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefit programs."[14]

The principal House sponsor of ERISA, Representative John Dent of Pennsylvania, was equally emphatic in describing the central importance of a broad preemption provision. Representative Dent stated:

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.[15]

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[13] H.R. 2, 93d Cong., 2d Sess., § 514(a) (1974) (House bill); H.R. 2, 93d Cong., 2d Sess., § 699(a) (Senate bill). For a discussion of the legislative history of ERISA's preemption provision, *see Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-100 (1983).

[14] 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits).

[15] 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent).

Senator Williams also emphasized the need to relieve employers of inconsistent state regulation:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.[16]

The ERISA conferees understood that the broad preemption provision included in ERISA would prevent state and local governments from experimenting with health reform. In fact, one of the main reasons that the conferees expanded the preemption provision was to preclude state-by-state health reform efforts.[17] Hawaii had already enacted a health reform measure while ERISA was being debated, and California was considering similar legislation. The conferees feared that inconsistent state laws regulating health care would undermine employment-based health plans, and they recognized that the narrow preemption provision included in the House and Senate bills was not sufficient to protect plans from this threat.

Congress decided to bar state reform initiatives only after thoughtful deliberation. After carefully weighing the competing interests, the ERISA conferees concluded that national uniformity in the regulation of employee benefit plans was essential to the growth and soundness of these plans and outweighed the interest of state and local governments in regulating employee benefit plans within their borders.

This conclusion was tested again several years later and found to be sound. ERISA established a Joint Pension Task Force, consisting of the staffs of the House and Senate committees with primary jurisdiction over ERISA, and directed the Task Force to conduct a "full study and review" of the "effects and desirability" of the ERISA preemption provision.[18]

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[16] 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams).

[17] Michael S. Gordon, minority counsel to Senator Javits during the consideration and passage of ERISA, describing the history of ERISA's preemption provision in *Health Care Reform: Managed Competition and Beyond,* Employee Benefits Research Institute (EBRI) Issue Brief No. 135 (March 1993).

[18] *See* ERISA §§ 3021, 3022(a)(4), 88 Stat. 999 (1974).

Senator Javits observed that the Task Force had "the responsibility of studying and evaluating preemption in connection with State authorities and reporting its findings to the Congress. If it is determined that the preemption policy devised has the effect of precluding essential legislation at either the State or Federal level, appropriate modifications can be made."[19]

The Task Force monitored the implementation of ERISA for two years following the statute's enactment. In addition, the Subcommittee on Labor Standards of the House Committee on Education and Labor held eight days of oversight hearings in which it carefully and thoroughly examined the implementation of ERISA. The Subcommittee issued a report[20] concluding that ERISA's broad preemption provision was necessary and that the limited exceptions to ERISA preemption included in the original statute should be narrowed still further. The report reaffirmed the policy choice reflected in ERISA's preemption provision, that "the Federal interest and the need for national uniformity are so great that the enforcement of state regulation should be precluded."[21] The report explained:

> We remain convinced of the propriety and necessity for the very broad preemption policy contained in section 514. To the extent that the scheme of regulation is found to be deficient with respect to some or all of the plans covered by the Act, we are prepared to consider amendments expanding or modifying the federal standards. *We will be most reluctant to consider any remedy involving a limitation of the preemptive scheme as it applies to the plans [governed by ERISA].*[22]

The fact that employment-based health plans are free of state regulation does not mean that they are exempt from governmental standards. In the 30 years since ERISA was enacted, Congress has repeatedly imposed federal health mandates when it believed that they would improve the delivery of health care to employees and their families. For example, under federal law, employment-based group health plans must:

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[19] 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits).

[20] H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977).

[21] *Id.* at 47.

[22] *Id.* at 48 (emphasis added).

- provide health care continuation coverage to employees and dependents who lose their eligibility for employer group health coverage;[23]
- provide coverage mandated by state medical child support orders;[24]
- provide primary coverage to state Medicaid beneficiaries;[25]
- cover adopted children;[26]
- maintain coverage of pediatric vaccines at least at 1993 levels;[27]
- avoid imposing preexisting condition limitations, except within very narrow constraints;[28]
- offer special enrollment rights to individuals who lose other coverage, or who acquire a new spouse or dependent;[29]
- avoid discriminating against participants based on their health status;[30]
- cover a minimum hospital stay following childbirth;[31]
- provide the same annual and lifetime limits for mental health benefits that they provide for medical and surgical benefits;[32]
- cover reconstructive surgery following mastectomies;[33] and
- preserve the privacy of employees' medical records.[34]

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[23] ERISA §§ 601-08, added by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, § 10002(a) (1986).

[24] ERISA § 609, added by the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 4301(a) (1993).

[25] *Id.*

[26] *Id.*

[27] *Id.*

[28] ERISA § 701, added by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 101(a) (1996).

[29] *Id.*

[30] ERISA § 702, added by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 101(a) (1996).

[31] ERISA § 711, added by the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603(a)(5) (1996).

[32] ERISA § 712, added by the Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 702(a) (1996).

[33] ERISA § 713, added by the Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902(a) (1998).

[34] 45 C.F.R. § 164.504, implementing the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 261-64 (1996).

Although these federal mandates are sometimes costly and burdensome to administer, they at least have the virtue of applying uniformly to all employment-based health plans, regardless of where the employee lives or works.

The same considerations that prompted Congress to adopt a broad preemption provision 30 years ago still apply today. The voluntary employment-based health system is one of the success stories in the history of health care in America; but this system will continue to thrive only if employer plans continue to be protected from inconsistent regulation at the state and local levels.

State Waivers From ERISA Preemption Will Undermine a Highly Successful System

The suggestion occasionally is made that states should be able to obtain waivers from ERISA's preemption provision so that they can experiment with health reform, including employer mandates. This proposal is problematic for several reasons.

First, it undermines the uniform federal system of regulation that Congress carefully constructed in ERISA and expanded in subsequent legislation, a system that has served employers and employees well for more than 30 years. If state and local governments are able to obtain waivers in order to regulate health care, employment-based health plans will be exposed to "the threat of conflicting and inconsistent State and local regulation" that Representative Dent foresaw when ERISA was enacted, and that Congress wisely took steps to prevent. Financial and administrative resources will be consumed by efforts to comply with a patchwork of local laws; employers will no longer be able to tailor their benefit programs to their employees' needs; and workers and their families will inevitably suffer.

Second, no system exists, or can easily be created, to administer an ERISA waiver program. The model that proponents of state waivers cite is the Medicaid statute, which allows the Secretary of Health and Human Services to grant exceptions to specific substantive requirements of the Medicaid program.[35] The Medicaid waiver program is administered by the

[35] Social Security Act § 1115, 42 U.S.C. § 1315 (authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program); Social Security Act § 1915(b), 42 U.S.C. § 1396n(b) (authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid); Social Security Act § 1915(c), 42 U.S.C. § 1396n(c) (authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings).

Centers for Medicare and Medicaid Services ("CMS"), the federal agency that is responsible for the Medicare and Medicaid programs. The CMS staff are expert in matters relating to the delivery of health care. The agency's mission requires it to develop and implement health policy; to interact with hospitals, doctors, and other health service providers; to maintain large databases of medical and payment information; and to administer complex health programs and health financing systems in cooperation with state governments and other partners. CMS's expertise in health matters ensures that the agency is well-positioned to evaluate the potential benefits and costs of state waiver proposals, and to determine whether federal grant dollars will be effectively spent on the alternative programs the states wish to implement.

In contrast, the Department of Labor, which is the federal agency responsible for ERISA's preemption provision, plays no role in the financing or delivery of health care. The Department of Labor administers a voluntary system in which employers make their own choices about the design and cost of their group health programs. Department of Labor staff have no basis for evaluating state health reform proposals; for determining whether a particular state waiver will impose burdens on employers that will outweigh any benefit the proposal might confer on the citizens of a particular state; or for monitoring the effects of the state program and assessing whether the waiver should be continued.

Unlike the Medicaid waiver program, an ERISA waiver program would not merely evaluate how federal grant dollars should be allocated. Instead, the ERISA waiver program would attempt to determine what administrative costs and substantive mandates state and local governments should be permitted to impose on employment-based health plans, and what effect local initiatives will have on nationwide benefit programs. Health care is not confined within state borders: it is provided in major medical markets that transcend state and local boundaries. The parties best able to determine how multistate employers should spend their health-care dollars are the employers themselves. A strong ERISA preemption provision is essential to preserve employers' ability to make the decisions that are in the best interest of their workers and the workers' families.

The States Do Not Need ERISA Waivers
In Order to Implement Health Reform

The states appropriately seek affordable, comprehensive health insurance for all their citizens. Large employers support these efforts, and most large companies already devote substantial resources to provide health coverage to their workers and the workers' families. The problems most urgently in need of solutions are outside the scope of ERISA's preemption provision: they lie with the unemployed and marginally employed, who do not receive health insurance through the workplace; with the lack of reliable and accessible information concerning health costs and health quality; and with the lack of affordable insurance for individuals and small groups.

The states do not need ERISA waivers in order to address these problems. ERISA does not prevent states from regulating the individual and small group insurance markets. Insurance—including insurance sold to employers—is expressly carved out of ERISA's preemption provision, so that states are free to exercise their traditional authority to regulate health insurance products sold within their borders.[36] State initiatives to increase access to health care, to make health care more affordable, and to improve the quality of health care likewise are not affected by ERISA. Nor does ERISA preclude individual mandates, such as Massachusetts' requirement that all of its citizens maintain a minimum level of health insurance. Accordingly, states may engage in a broad range of health reforms without any constraint under ERISA.

That completes my prepared statement. I will be pleased to answer any questions the Chairman or any members of the Subcommittee might have. Thank you for your attention.

[36] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).