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ON

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

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Good afternoon. My name is Mila Kofman. I am an associate research professor at Georgetown University's Health Policy Institute (Institute). Mr. Chairman, I thank you and the Committee for your leadership and willingness to examine the Employee Retirement Income Security Act of 1974 (ERISA) and how it has been used to impede comprehensive state-based health care reform initiatives. It is both an honor and a privilege to testify before you on this matter.

As a way of background, researchers at the Institute conduct a range of studies on the uninsured problem. My specific focus is private health insurance. For the past decade I have studied regulation of health insurance products and companies, state and federal health care and coverage reform initiatives, new products, and market failures. Currently I am the co-editor of the Journal of Insurance Regulation and serve (as one of six non-regulator members) on the Consumer Board of Trustees of the National Association of Insurance Commissioners. Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on issues affecting ERISA health plans.

I believe it would be optimal for us to address the health care crisis in this nation in its entirety and for the federal government to ensure that all Americans have the same basic rights and protections related to health care no matter where one lives or works. However, absent meaningful and comprehensive federal reforms, the Congress should look for ways to make it easier for states to act. Currently, ERISA, a law Congress enacted more than 3 decades ago, is having a negative impact that most could not imagine when the law was passed. A law that was designed to protect workers against fraud and abuse in the private pension system has in fact become a major obstacle for state-based health care and coverage reforms.[1]

Some state policymakers are trying to respond to the health care crisis through new initiatives to help finance medical care, restructuring the private and public insurance programs to cover more people and to pay for it. ERISA has been used to challenge those state efforts, and has been a major impediment to comprehensive reform efforts.[2]

When ERISA was passed in 1974, the public policy was to promote a voluntary employer health coverage system where uniformity and administration of benefit programs was of most importance.[3] Now, more than three decades later, a different public policy discussion is taking place.

Now, our public policy discussions focus on the fact that we live in the wealthiest and most advanced country in the world, yet we allow 18,000 Americans to die preventable deaths each year because they are uninsured. The uninsured problem is estimated to cost our economy $60 to $130 billion annually.[4] The leading cause of personal bankruptcies in the United States is having an illness (the majority of those filers were insured).[5] The uninsured problem and the way we finance medial care handicaps American businesses in a global economy. The Big Three automakers spend more on health care than on steel. Our spending on health per capita is higher than Germany, Canada, France, Australia, and the United Kingdom (UK). Although we outspend those nations as a percentage of GDP, we have worse health outcomes – with Americans reporting more access to care problems than in the UK and Canada; we rank last out of 9 countries in terms of life expectancy behind Japan, France, Australia, Canada, Germany, New Zealand, the Netherlands, and the UK.[6]

Our medical care and health insurance coverage crisis continues to grow — now approximately 45 million people are without any health coverage and millions more have inadequate coverage. The majority of uninsured people either work or have a worker in their family (80% with either full time or part time worker). Premiums for people with insurance continue to increase in the

double digits with 25% of insured Americans (insured all year with group coverage) spending 10% or more of their income on premiums and out of pocket expenses for medical care. (The percentage of people with individual coverage who spend more than 10% of their income on premiums and medical care is 43%.) Health coverage is inaccessible for many, unaffordable for many more, and insecure for those who have it.[7]

So our 30-year old federal policy of encouraging employers to provide health coverage voluntarily has not worked as well as hoped for many Americans. It is time to reexamine ERISA and whether it serves our new priorities and public policy goals of tackling the cost of medical care and developing sustainable financing so we can provide medical care for all of America's working families and communities.

Unlike with civil rights laws, labor laws, environmental laws, and other areas where the federal government has stepped in to address an injustice and has received high marks for those federal efforts — in the area of financing medical care (with few exceptions), the federal government would not achieve a passing grade. Although through programs like Medicare, we have nearly universal coverage for our seniors, other federal interventions — mainly ERISA — have had questionable and in some cases a devastating effect on America's consumers. ERISA significantly restricts options and state-based solutions to the health coverage crisis in the United States.

ERISA directly and indirectly impacts states' ability to reform their health care marketplace. Today, I will discuss three adverse and arguably unforeseen negative impacts that ERISA has had on states' ability to successfully reform their markets:

1. ERISA limits states' ability to reform state-regulated health insurance markets and makes it difficult to have a successful coverage expansion initiative;

2. ERISA limits options and imposes hard to assess risks when considering state-based broad and comprehensive health care financing reforms (beyond insurance); and

3. ERISA has a deterrent effect, preventing some states from going forward with health care financing and coverage reforms.

1. ERISA limits states' ability to reform state-regulated health insurance markets and makes it difficult to have a successful coverage expansion initiative

In the 1990's state policymakers sought to improve access to health insurance for businesses and individuals using several approaches, which rely on risk spreading among a broad population and greater risk assumption by insurers. Guaranteed issue laws required insurers to sell coverage to sick groups and premium rate reforms prohibited or restricted the ability of insurers to charge higher premiums based on the health status and claims of a group.[8]

Such laws allowed employers with sicker workers to access private coverage. Through such risk pooling requirements, firms with sicker workers pay less than they otherwise would, which helps them to offer and maintain coverage. This, however, is frustrated by the ability of ERISA-covered employers to self-insure. When employers with healthy workers self-insure, their claims are not pooled with other businesses in the state regulated market; coverage is more expensive in state regulated products as fewer healthy people help pay for coverage for sicker ones.[9] The problem is magnified as small businesses rejoin the regulated market when their employees are no longer healthy, making coverage more expensive for all employers in the state-regulated market. ERISA has undermined these state-based insurance market reforms.

ERISA also impacts other types of state reforms. States may require insurers to keep people with medical needs, minimizing the burden on state and federally funded public insurance programs. For example, most states prohibit insurers from canceling insurance for dependent adult handicapped children who were covered by their parents' policies as minors. This requirement does not apply to self-insured ERISA plans. New state requirements aimed at keeping children insured by redefining "dependent" status, e.g., raising the age of dependent children (in New Jersey to age of 30) and including grandchildren as dependents, do not apply to self-insured ERISA health plans. While some large self-insured plans cover grandchildren for example, others do not. This means that state standards only reach part of the state's market. Dependents who do not qualify for group coverage or age-off parent's policies may join the ranks of the uninsured or may rely on state public insurance programs and publicly funded health centers, further taxing such programs.[10]

ERISA has also been an obstacle to achieving a public policy goal of broadly spreading the cost of certain medical conditions and achieving public health goals (such as immunizing the population against certain diseases, stabilizing mental health conditions, encouraging treatment for substance abuse, covering mammograms, or financing supplies to control diabetes).[11] The problem here is two fold when self-insured plans do not cover these services: (1) when medical care is provided through state funded programs, the result is a drain on public programs, and (2) because the cost of a benefit requirement is spread across a smaller population (among those in state-regulated products), the price is higher than it otherwise would be had the cost been spread over the entire population (self-funded and fully-insured plans). Again, it is important to remember that many large self-insured plans provide comprehensive, generous coverage for workers and their families (often much better than the insured products in state regulated markets).[12] The problem of equitably financing these benefits is when self-insured plans do not provide such benefits, but the benefits are required in the state-regulated market.

ERISA has also become an obstacle in how states finance new coverage initiatives. For example, in addition to market reforms, states have tried to expand access to health insurance coverage through public/private partnerships called "HIPCs" (health insurance purchasing cooperatives) – these are also known as purchasing alliances and purchasing pools (mostly for small businesses and self-employed people). The most recent examples include the "Connector" in Massachusetts, Dirigo Choice in Maine, and Insure Montana. These programs may use the state's purchasing power to negotiate rates and coverage with private insurance companies. Participating employers and individuals have a choice of products. State funding may be available to help pay for the premiums for moderate and low-income workers and families in some of these programs.[13]

While state coverage expansion efforts vary, none are free. They all rely on funding, and ERISA self-insured plans generally do not contribute to financing such programs. However, self-funded plans benefit when people with medical needs have insurance — there is less uncompensated care and therefore less cost-shifting. In other words, the cost of uncompensated care is borne by all people with insurance as the costs are shifted to all privately insured people — those in self-insured and fully insured plans. In 2005, privately insured people paid nearly $1000 more in premiums just to cover the cost-shift from uninsured patients.[14]

2. Beyond Insurance Reforms: ERISA limits options and imposes hard to assess risks when considering state-based broad and comprehensive health care financing reforms; ***New Generation of Reforms — Equitable, Fair, and Sustainable Financing of Medical Care***

Absent system wide reforms at the federal level, some states have taken on the task of reforming the delivery and financing of medical care. Some have concluded that the voluntary system of employers providing coverage and people buying coverage voluntarily has not

worked. The new generation of state-based reforms is moving toward bold, comprehensive system-wide reforms, which may include a personal responsibility to purchase insurance and an expectation that employers will help pay for coverage. Mandatory participation requirements and fair and equitable contribution from employers may be the "next generation" of incremental reforms in the United States. Some states, however, also have "single" payer legislation and other *non-incremental* approaches seeking to provide access to medical care to their residents. Again, it remains to be seen whether individuals using ERISA preemption are effective in challenging meaningful state reforms.

In the last few years, many states have looked at "fair share" bills as a way to more equitably finance medical care. These initiatives also demonstrate the fiscal responsibility of states to develop programs that are sustainable financially over time.

ERISA has been used successfully to preclude such state reforms. For example, Maryland's lawmakers passed "Fair Share Health Care Fund Act" in response to financial pressure on public programs, after learning that Maryland's public programs covered many employees of at least one large national company.[15] The law would have required companies with more than 10,000 employees in Maryland to pay for medical care and coverage for their employees in the amount equal to or more than 8% of salaries (6% for non-profits). The state would have collected an assessment from companies that fell below 8%; the assessment would have helped fund Maryland's health care programs for moderate and low-wage income earners and poor people and families. Scheduled to go into effect in January 2007, Maryland's law was immediately challenged using ERISA and in January 2007 the Fourth Circuit Court of Appeals found Maryland's fair share law to be preempted by ERISA.[16]

In April 2006, Massachusetts lawmakers enacted broad health care reforms called the "Health Care Access and Affordability" act (a.k.a. Massachusetts Health Care Reform Plan). Among several standards and funding mechanisms, there is a new requirement that employers with more than 10 employees provide health coverage or pay an annual fee per employee to help finance medical care that their employees use (currently that care is provided for free to patients but financed through public funding and other sources) in the state.[17]

Although both laws were carefully crafted to avoid ERISA preemption and many experts concluded that these laws would not be preempted, it is difficult to predict (even for ERISA experts) how a federal court may interpret the scope of ERISA.[18] The Fourth Circuit decision shows that ERISA limits options that states otherwise would have and poses hard to assess risks to comprehensive reform that may vary according to the precise design of the reform and the shifting views of the courts on the scope of ERISA preemption.

3. ERISA has a deterrent effect, preventing some states from going forward with health care financing and coverage reforms

In addition to its direct, adverse effect on states, ERISA has had an indirect negative impact on states' ability to reform their health care marketplace – the deterrent effect. The very real threat of ERISA litigation has stopped many states from considering new ways to achieve financing reforms and universal access to care. For example, in 2006 there were 28 states with "fair share" bills. Maryland's policymakers passed the legislation but were not able to win the ERISA-based challenge to the law. Consequently, in 2007, there were only 3 states that had fair share bills introduced, down from 28 states in 2006.[19] The chilling effect of the Maryland ERISA court decision was felt around the nation. With one decision, the Fourth Circuit Court of Appeals stopped state policymakers around the nation from even debating and discussing the public policy behind fair share bills similar to Maryland's.

Furthermore, states need upfront funding and a resource investment to implement new state programs (like the Massachusetts Connector). The possibility that such initiatives are found later to be preempted by ERISA may deter states from taking the big financial risk of moving forward with their new programs. Their decision may also be impacted by the high litigation costs involved in ERISA preemption cases.[20]

Another deterrent effect is that ERISA restricts states to a limited set of ideas. In recent months I have been working with various groups in Colorado. Last year Colorado's policymakers established a Blue Ribbon Commission charged with developing a comprehensive reform package to achieve universal access to care and reform health care financing in the state. Every discussion I have had with stakeholders has included issues around ERISA and the uncertainty that it brings to state-based reforms. And in those discussions, I advised that a new state initiative could be challenged using ERISA (even frivolous challenges are a concern due to state budget constraints) and that some ideas should not be considered because courts have said "no" to those, e.g., coverage benefit mandates on self-insured ERISA plans.[21]

Some states, prior to proposing reforms, seek to understand their markets better – to determine who is uninsured and underinsured. But even simple data collection from self-insured plans by insurance regulators may be deterred, as regulators must consider how to structure data collection requests to avoid ERISA preemption challenges.[22]

ERISA's deterrent effect is not new. You may remember the significant reforms Washington State passed in the early 1990s. These would have required universal coverage by 1999 for all citizens as well as making other significant changes in the insurance market. All were based on the assumption that the U.S. Congress would amend the law to allow Washington State an exemption from ERISA. When this did not occur, most of the reforms were repealed.[23]

Conclusion and Recommendations

ERISA's limitations on what states can require of employers, and lawsuits using ERISA to question state authority and challenge state reform initiatives, make it difficult for states to address the health care crisis. As some states try to be creative in addressing the uninsured problem, ERISA continues to grow as an obstacle and in many ways, restricts states to the consideration of a more limited set of ideas. This makes it difficult to adopt successful reforms, to cover millions of Americans who do not have health insurance, to address the ever growing cost of health coverage for people who are insured, and to assure that in fact health insurance is adequate, accessible, and secure for people who are sick today, and those of us who will become sick in the future.

Mr. Chairman, this committee and the United States Congress have the power and opportunity to address these issues. As I've noted, my preference would be for the federal government to develop a meaningful and comprehensive national solution to the health care crisis. However, absent that, I urge you to take a close look at ERISA *vis a vis* states' ability to achieve universal access to medical care and equitable and sustainable financing. As you examine the 1974 law, you have options, three of which include:

- allow federal regulators to give exemptions from ERISA to states – with standards established for such exemptions;

- amend ERISA clarifying that the types of reforms in Massachusetts and Maryland's Fair Share Act are not preempted by ERISA. (This would eliminate the expense of potential future litigation on these issues); and

- clarify that certain types of state reforms (beyond Massachusetts and Maryland's Fair Share laws) are not preempted by ERISA.

There are pros and cons to these and other options. What ever you decide to do, however, the time to act is now. As the number of people in the United States without health insurance continues to rise, governors and state legislators continue to look for ways to address the problem despite ERISA challenges. Some states are looking for equitable and effective ways to finance medical care for their residents. They are looking for ways to improve the health of their residents and communities, as well as to remove some of the barriers that make American businesses less competitive world-wide (by improving the health of workers for example). Many states will continue to explore what is and is not allowed under ERISA but this means more litigation, which is not an optimal way to reform the health care coverage and financing system in the United States.

I encourage you to look for measures that will encourage and support meaningful state initiatives. It is also important to remember that many self-funded large employer plans provide generous benefits to workers and dependents, covering expensive medical conditions and covering people with significant medical needs. Federal interventions must be carefully crafted as to not undermine comprehensive benefits that many have. It is clear that America's businesses need real help to address factors driving cost increases for medical care so they can keep their workers healthy and stay competitive in a global economy.

Thank you for your consideration of this important issue, and I look forward to assisting you as you look for ways to address the ever growing problem of millions of Americans without health insurance and rising costs of coverage for all Americans.

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[1] In some cases ERISA has been used by crooks as a shield to hide illegal civil and criminal activities. Mila Kofman, Kevin Lucia, and Eliza Bangit, Proliferation of Phony Health Insurance: States and the Federal Government Respond, BNA Plus (2003) (hereinafter Fraud Report); GAO, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, GAO-04-312 (Feb. 2004).

[2] Federal preemption of state law may be appropriate when federal law is more protective than state law and there is sufficient oversight and enforcement capacity to make federal protections meaningful.

[3] According to Michael S. Gordon, minority Counsel to former Senator Jacob Javits (NY - R), who was involved in drafting and passing ERISA legislation, expanding ERISA preemption language to include health benefits was necessary to gain political support from the American Bar Association and AFL/CIO. Also according to Gordon, some members of Congress realized that ERISA would make it impossible for states to address health care and coverage issues. Michael S. Gordon, "ERISA Pre-emption and Health Care Reform: A History Lesson" originally published in 1993 and reprinted in EBRI Notes May 2007, Vol 28, #5, page 7 – 9, available at www.ebri.org. According to Gordon, it was not a "simple oversight" to include broad preemption related to health plans but a political necessity. Whether some, many, all, or none of the members of Congress in 1974 intended to promote uniformity or other public policy goals with ERISA is something historians may never be able to conclude with certainty. However, in interpreting ERISA's preemption language, courts have relied on apparent public policy goals behind the statute. The Fourth Circuit Federal Court of Appeals in striking down state law noted, "Because Maryland's Fair Share Health Care Fund Act effectively requires employers in Maryland covered by the Act to restructure their employee health insurance plans, it conflicts with ERISA's goal of permitting uniform nationwide administration of these plans." Retail Industry Leaders Association v. Fielder, 475 F.3d 180, 183 (Court of Appeals 4th Circuit January 17, 2007). The court went on to say, citing Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004) and other Supreme Court cases, "[t]he primary objective of ERISA was to 'provide a uniform regulatory regime over employee benefit plans.'" So whether promoting uniformity in the 1970s was the principle reason, one of many reasons, or not a reason behind ERISA's broad preemption matters little. Judges have concluded that uniformity in plan administration was the primary objective.

[4] For highlights see, Press Release, January 14, 2004, "IOM Report Calls for Universal Health Coverage by 2010; Offers Principles to Judge, Compare Proposed Solutions" available at www4.nationalacademies.org/news.nsf/isbn.

[5] See David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy" Health Affairs Web Exclusive February 2005.

[6] See Commonwealth Fund charts, Spending on Health, 1980–2004 (Data source: OECD Health Data 2005 and 2006) and Access Problems Because of Costs in Five Countries, 2004, available at www.cmwf.org;

[7] Sara Collins, et al, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families; September 14, 2006, The Commonwealth Fund; Distribution of the Nonelderly Uninsured by Family Work Status, States (2004-2005), U.S. (2005), KFF at http://www.statehealthfacts.org.

[8] Not all states had such reforms. By the mid-1990's, 36 states had "guaranteed-issue" laws that required insurers to sell at least two policies to small businesses. BCBSA, *State Legislative Health Care and Insurance Issues: 2005*

Survey of Plans, December 2005, page 57. In 1996, the Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) requiring insurers to sell all their small group policies on a guaranteed-issue basis.

[9] See Mila Kofman and Karen Pollitz, "Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change," Journal of Insurance Regulation Vol. 24 No. 4 page 77 – 108 (Summer 2006). Additionally, self-insurance allows employers to save money by avoiding the cost of paying for reserves and minimum capital. Such requirements apply to insurers and are designed to ensure solvency. There are no solvency requirements for health plans in ERISA. While saving some cost, the trade-off here is that people in ERISA self-insured plans have fewer protections than those in fully-insured plans, and as such may be stuck with medical bills if their employer goes bankrupt. When an insurer becomes insolvent, outstanding medical claims are paid for by guaranty funds. There is no similar safety-net for people in self-insured arrangements. A problem for state policy makers is that ERISA self-funded plans do not contribute to state programs like guaranty funds, which are financed through assessments on health insurance companies. A broader financing base would make these safety-nets less costly; and of course, protect all workers against their health plan's insolvency.

[10] Not all states have these requirements. To expand access to private coverage, five states have guaranteed issue and community/adjusted community rating protections for individuals purchasing coverage on their own (not through an employer). Other states provide no or only limited access to private coverage. This is an example of ERISA coupled with a lack of reforms in the states leaves people without options. It is also an example of where a national approach, perhaps establishing a federal floor of protections for all Americans and allowing states to enhance those would achieve better protections for all Americans.

[11] Which benefits are required to be covered is in part a function of how successful a particular group advocating for the mandate is in a state. Enacting benefit mandates is not done in a vacuum but is a part of a legislative process.

[12] For more information about large employer health plans, see Kaiser Family Foundation annual employer survey (available at www.kff.org).

[13] For more information about older programs, see Kofman, Mila, *Issue Brief: Group Purchasing Arrangements: Issues for States,* State Coverage Initiatives, April 2003 available at www.statecoverage.net/pdf/issuebrief403.pdf.

[14] In 2005, it is estimated that $29 billion was paid by privately insured people charged higher rates to cover the cost of medical care for uninsured people; $43 billion is the total estimate but some of that amount was paid by state and federal programs. Paying a Premium, The Added Cost of Care for the Uninsured, Families USA, Washington DC, June 2005, pages 15-16. Arguably, employers with the most comprehensive plans (many of which are large self-insured plans) take on more of this burden than the employers that do not offer coverage or offer more limited coverage – precisely the inequity that Maryland's Fair Share law sought to address.

[15] Interestingly, there was a difference of opinion among large employers about the need for the law, with some lobbying for its passage and others opposing.

[16] See Plaintiff's Complaint, Retail Industry Leaders Association v. James D. Fielder, U.S. District Court for the District of Maryland (February 7, 2006); Retail Industry Leaders Association v. James D. Fielder, 435 F.Supp.2d 481 (U.S. District Court for the District of Maryland July 19, 2006); Retail Industry Leaders Association v. Fielder, 475 F.3d 180, 183 (Court of Appeals 4th Circuit January 17, 2007) (upholding district court's decision finding Maryland's Fair Share Health Care Act preempted by ERISA). In its ruling, the appellate court found that Maryland law "effectively requires employers in Maryland covered by the Act to restructure their employee health insurance plans, it conflicts with ERISA's goal of permitting uniform nationwide administration of these plans." Id. at 183.

[17] Massachusetts Reforms (House No. 4850) amends several state statutes including the insurance code.

[18] Maryland's Attorney General analyzed the bill and concluded that ERISA would not preempt it. See Letter from Joseph Curran, Attorney General, Maryland, to Michael Busch, Speaker of the House, Maryland General Assembly, January 9, 2006 (copy available from author). For a comprehensive analysis of ERISA and state authority to reform health care coverage and financing see, Patricia Butler. "ERISA Preemption Manual for State Health Policymakers," State Coverage Initiatives, Alpha Center, and National Academy for State Health Policy, January 2000. In Fielder, AARP, among others, filed an amicus brief arguing that the Maryland law is not preempted. AARP was represented by Mary Ellen Signorille, who for a number of years was the co-author of "ERISA Basics: Preemption" for the American Bar Association, and then served as Chair of the Employee Benefits Committee of the Labor and Employment Law Section of the ABA. This demonstrates that even nationally recognized ERISA experts cannot predict how courts would rule on ERISA challenges.

[19] See National Conference of State Legislatures, 2006-2007 Fair Share Health Care Fund Or "Pay or Play" Bills: Can states mandate employer health insurance benefits? at http://www.ncsl.org/programs/health/payorplay2007.htm For a discussion of fair share legislation, see Cassandra Cole and Kathleen McCullough, "A Review of the Issues Surrounding Fair Share Health Care Bills," Journal of Insurance Regulation, Vol. 25 No.1, page 25-40 (Fall 2006).

[20] Litigating an ERISA preemption case involving a health insurance scam related to a multiple employer welfare arrangement cost one state over $500,000. See Fraud Report.

[21] More information about the Commission and all proposals recommended to the Commission are available at http://www.colorado.gov/208commission. For an analysis of Fielder's implications for other state proposals, see Patricia Butler, "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision, State Coverage Initiatives and National Academy for State Health Policy, November 2006.

[22] E-mail communications with Kent Michie, Insurance Commissioner, Utah Insurance Department, May 10, 2007.

[23] E-mail communications with Beth Berendt, Deputy Insurance Commissioner, Rates and Forms, Office of Insurance Commissioner, Washington State, May 10, 2007. See also Lawrence Brown and Michael Sparer, "Window Shopping: State Health Reforms in the 1990s" Health Affairs, Vol. 20 No.1, page 50, at 53 (January/February 2001).