Statement
of
Michael Stapley
on behalf of
The ERISA Industry Committee

Submitted to
the Committee on
Education & Labor
of the U.S. House of Representatives

At a Hearing on
The Tri-Committee Draft Proposal
For Health Care Reform

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Chairman Miller, Ranking Member Kline, and other Members of the Committee: thank you for the opportunity to testify on the important subject of healthcare reform. I am speaking today on behalf of the ERISA Industry Committee, an association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC has a strong interest in proposals that affect its members' ability to continue to deliver high-quality, cost-effective benefits.

We must change the way we pay for and deliver health care in the United States. Reining in health care costs is absolutely essential to this country's future economic success. ERIC strongly supports reforms to the nation's healthcare system that will increase its efficiency, reduce costs, and extend health care coverage to those who are uninsured or underinsured.

ERIC has thought deeply about this subject. In 2007, we released *A New Benefits Platform for Life Security* that lays out our vision of a conceptual framework for overhauling our national approach to providing health and retirement security. Many of the positions we staked out in this *Platform* have been incorporated into proposals currently under consideration in Congress. Although we believe our Platform could make further significant contributions to the present debate, we will concentrate our remarks today on the legislative concepts that are currently under discussion.

Three basic principles are of fundamental importance to change and must be considered as we move forward.

1. **Do no harm.** The current voluntary employment-based system provides health coverage to 170 million people, about 61% of the non-Medicare population. This system has served both employers and employees well. Employers have the flexibility they need to tailor their plans to the needs of their workforce while also aggressively pursuing the innovative changes that have lead to substantial advancements in so many arenas, including the fields of wellness and prevention. Employees strongly support their employer provided benefits and benefit significantly from this system. They enjoy access to high-quality care with guaranteed issue, limited preexisting condition exclusions, a uniform premium structure, and the other advantages afforded participants in the large risk pools of group plans. Any health care reforms should build on the strengths of this system.

2. **Control costs.** The relentless increases in the cost of health care threaten the viability of U.S. corporations in a global economy, while the upward spiral in the costs of Medicare and Medicaid threatens our national solvency. In addition, a substantial portion of the health care we now consume, perhaps as much as 20% to 40%, has no value. The centerpiece of healthcare reform must focus on reducing these costs. Reform that fails to focus on cost control will not only ultimately prove ineffective but will undermine health care coverage.

3. **Expand access.** 47 million Americans do not have adequate access to health care. Of those, approximately half are unable to afford coverage. History will not judge kindly an affluent society that ignores this problem. We must remember, however, that inadequate access is aggravated, if not caused, by the high level of cost. Our effectiveness in solving the access problem depends on restraining the growth of health care costs.

With these foundation principles in mind, I would like to focus on what we can support in a responsible healthcare reform initiative.

1. ERIC strongly supports a **competitive, pluralistic health care system** in which employers and individuals have choices among several health plans that compete on the basis of quality, cost, and effectiveness. There is an urgent need to eliminate the significant waste in the current health care delivery system, establish a foundation for responsible cost management in the future, and systematically ensure quality health care for all Americans. Too many reforms pursued in the past have made changes at the edges of health care delivery when fundamental structural changes are needed. ERIC believes that a properly designed, responsibly regulated pluralistic system will be able to correct the deficiencies in the current system and produce significant improvements in costs, quality, and access.

2. ERIC's *Benefits Platform* supports the establishment of an **insurance exchange or gateway** that provides a fair and equitable method for the distribution of insurance products. If exchanges are established, they should follow uniform national standards.

3. **Employers should be given broad flexibility regarding how they choose to provide health benefits to their employees and their families** but should be protected from systematic adverse selection by the plans in the exchange. Employers should be given the option of choosing to continue in the current system and arrange for and sponsor their own health plan alternatives. At the same time, employers should have the flexibility to provide financial resources to their employees to purchase health plans through the insurance exchange from among competing health plans. The employer should not be required under any circumstance to provide financial resources to employees to purchase insurance through an insurance exchange when the employer has chosen to continue in the current system. To allow this would create systematic adverse selection problems that could ultimately result in the demise of the employer-based system. This is inconsistent with the stated objectives of the President to support the continuation of the current system.

4. **Incentives in the current financing system must be changed from risk avoidance to responsible cost management**. The foundation principle of a fair and equitable financing system for health care must be that the cost of disease and injury must be distributed across all plans offered through the exchange. In the end it is the expectation that health plans offered through the exchange should be strongly incentivized to differentiate their products and premiums based on efficiencies generated by better administrative practices derived from improved payment systems, disease management, utilization management, case management, lifestyle management and other innovative initiatives designed to lower cost, increase quality and improve accountability. Large employer plans have pursued these goals with notable success.

5. **Transparency and accountability of both providers and health plans must be improved**.

    - There has been much discussion on the need for better provider transparency in terms of both cost and quality. We are fully supportive of these initiatives.

    - There has been less discussion about the need for better **health plan** transparency and accountability. It is widely recognized that the practices of some private health plans create an enormous frustration to both consumers and providers of health care. Medicare does provide a good example of more consistent administration of health plans. In a restructured system, it will be important to establish mechanisms where there can be standardization and full transparency of administrative practices of health plans that are offered through the exchange. This might include disclosure of health expense loadings, the number and cost of denied claims, the efficiency of claims administration and other administrative practices, and consumer assessments of each health plan.

6. ERIC strongly supports **payment reform**. There is strong evidence that financial incentives must drive the changes that are desired. President Obama's budget director, Peter Orszag, recently stated that, for example, "nearly 30% of Medicare's cost could be saved without negatively affecting health outcomes if spending in high and medium cost areas could be reduced to the level in low cost areas". In both the private and public sectors, we must stop rewarding providers for doing more and instead incentivize them to provide high quality health care that delivers true value to the American consumer. It is irresponsible to perpetuate a system in which between 20% and 40% of the health care delivered has no value. Payment reform is essential to this objective.

7. Every citizen should be required to obtain health care coverage, **with standards established at the federal level.** Because a significant portion of the population is unable to afford adequate coverage, ERIC would support subsidies to assist financially disadvantaged individuals.

I would like to devote my remaining remarks to the areas in current legislative proposals where the "Do no harm" principle is most at risk.

Taxation of benefits: Several proposals have been made to curtail the favorable tax treatment for employees of employer-provided health benefits. One proposal would eliminate the exclusion entirely. Others would impose a cap based on the value of health insurance, an individual's income, or a combination of the two.

ERIC has serious concerns with limiting the ability of an employee to exclude from income the value of employer-provided health insurance. If this exclusion were curtailed, many large employers would follow one of two approaches. Some would redesign their plans to meet the new cost standard in the legislation, below which taxation would not be imposed. This would necessarily mean that their employees would be provided with less generous health coverage.

Other employers would choose to keep their existing plans; if the value of the plan exceeded the standard in the legislation, employees would face taxation on the "excess" value. If this were to occur, employment-based insurance would suffer. Young, healthy employees would either seek to exit their employers' plans in search of cheaper coverage rather than pay taxes on a more expensive plan or pressure their employers to reduce coverage. If younger workers sought cheaper coverage elsewhere, an employer plan that once had a favorable and balanced risk pool would now be left with an older, sicker, more costly population whose premiums would eventually become unsustainable. Loss of a large, viable risk pool would greatly diminish an employer's ability to offer efficient and innovative health care coverage to its employees. As the cost of providing benefits increased, more employers would exit the system.

There are also equity and administrative issues associated with a tax cap that need to be carefully assessed. We are concerned that if a cap is to be imposed, it not discriminate against individuals by virtue of higher premium costs due to geography, the demographic composition of the group, or because they happen to work for a small firm.

A public plan: ERIC has several serious concerns with the creation of a public plan that would compete with the current private marketplace. Although at present we do not know how this new plan would be structured, we have profound reservations with the prospect of a public plan modeled after Medicare. Medicare does provide an example of an efficient, consistent, and fair claims administrator; there are also examples of consistent, fair claims administrators among private health plans. Medicare is not, however, a sterling example of what a restructured financing system should look like. In fact, Medicare has perpetuated some of the cost problems that we have in our current health care system by rewarding those who provide more care, regardless of value.

Our most fundamental concern with a public plan based on Medicare, however, is the potential for even greater cost-shifting than exists today. Right now ERIC members subsidize the cost of Medicare. This includes both administrative and claim costs. One example of the administrative subsidy relates to the fact that Medicare does not pay anything for transaction fees associated with the electronic movement of claims from providers to Medicare intermediaries. These transaction costs are not free. They must be absorbed by other paying customers, including employer plans.

Moreover, according to most providers, Medicare's reimbursement rates do not cover their costs. Contrary to what many people say, these rates are not negotiated, they are mandated. Providers argue that in most cases they accept these rates because they want to continue treating patients that have been treated all of their lives. Hospitals argue that they have no choice. They believe that they survive only because they are able to charge higher rates to private plans and other customers. In short, the provider shortfall from Medicare is shifted to the private sector, a practice that is unacceptable in a reformed system.

At the end of the day, ERIC's position is that if a public plan could be fairly fashioned, it must not be structured in such a way that employer plans end up bearing the burden of additional cost shifts. Health care costs are already rising at an unsustainable rate. Increased cost-shifting would trigger the warning light that causes employers to rethink whether they can afford to provide high quality health care to their employees. An exodus of employment-based plans from the nation's healthcare system would diminish the development of practices to improve the quality of health care and the pursuit of innovative strategies to bring healthcare costs under control that are core strengths of the employment-based system.

Employee opt-outs: We are also concerned about the adverse selection that would be experienced if individual participants in employer-sponsored plans were permitted to opt out of the employer plan and into a public plan, especially if the employer were compelled to pay for the individual's participation in the public plan and/or finance any subsidy given low-income individuals who opted out. If permitted, an opt-out would undermine the demographic fairness of a large risk pool that is a feature of employer plans. Over time, young, healthy employees would seek cheaper coverage outside of the employer's plan, and older, sicker employees would remain in the plan. Eventually, employer plans would become havens for employees with the worst risk profiles, and this would be reflected in ever-higher premium costs. At some point, employers would no longer be able to provide affordable coverage to their workers.

Employer mandates: Employer mandates, especially their manifestation in the "pay-or-play" penalties currently under discussion, have the potential to seriously harm employer-sponsored plans. ERIC members generally provide high quality benefits with generous employer contributions; thus, it would appear that a "pay or play" requirement would have little or no relevance for us. As we have learned from the experience in Massachusetts, however, this is not always the case, and – as is so often true in life – the devil is in the details. For instance, if the employer mandate only required that employers offer a set minimum package of benefits to employees that met a specified, modest actuarial value, then many - but not all - major employers would meet that bar. But if the mandate were to require that all full-time employees were to be covered, and full-time were defined as working 25 hours per week, many other employers would drop below the bar. If the mandate were to further include no cost-sharing for prevention or wellness and full coverage of mental health benefits, others would drop out.

Employer mandates by definition restrict our ability to devise and operate health care plans that best meet the needs of our employees. Mandates increase costs and limit flexibility. Coupled with punitive regulatory regimes, employer mandates will discourage employers from continuing to provide quality, affordable health care to their employees. This is not an idle threat; one need look

no farther than the nation's moribund defined benefit plan system to see the effects of overly complex rules and regulations.

Preemption: I would be remiss if I did not take this opportunity to underscore the absolute inviolability of ERISA preemption. Without the national uniformity made possible by ERISA's preemption doctrine, large multistate employers simply could not offer quality healthcare coverage to their employees. Its importance was recognized by the original sponsors of ERISA as critical to ensuring that employers provided sound and secure benefits. Any future legislation must continue to accord preemption and national uniformity of regulation a similar priority.

Conclusion: ERIC is committed to the goal of reforming the nation's healthcare system in a responsible manner that will extend health care to those without it and that will reverse the current fatal escalation in the costs of health care. Equally important, I believe, is that this reform be accomplished without undermining the system that currently offers quality health care to 170 million satisfied Americans.

ERIC intends to continue to play a constructive role in this debate.

Thank you, and I would be happy to respond to any questions.