



GEORGETOWN UNIVERSITY

Health Policy Institute

**Testimony before the
U.S. House of Representatives
Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations**

ON

**“Examining the Impact of State Mandates on Employer-Provided Health
Insurance”**

The Interplay Between ERISA and State Health Policy Reform Efforts

**By:
Mila Kofman, J.D.
Associate Research Professor**

*3300 Whitehaven Street, NW Suite 5000 Box 571444
Washington, D.C. 20057-1485 Courier Delivery Zip Code: 20007
202-687-0880 202-687-3110 facsimile
<http://HPI.georgetown.edu>*

Good morning. My name is Mila Kofman and I am an associate research professor at Georgetown University's Health Policy Institute (Institute). Thank you for inviting me to testify today. It is both an honor and a privilege to be here.

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 reform initiatives, and market failures like insolvency and fraud. Currently I am the co-editor of the Journal of Insurance Regulation and serve 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. Prior to that, I was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, assisting small businesses in establishing health insurance purchasing coalitions and studying state small group reforms. My knowledge, therefore, is both practical and academic.

I want to thank you for your leadership in holding a hearing on state health reform initiatives and employer-sponsored medical benefits during "Cover the Uninsured Week." As the number of uninsured continues to rise, now at over 45 million people without any health coverage, you and other members of Congress, as well as state policymakers are trying to address this problem. As you know, 18,000 Americans die preventable deaths each year because they are uninsured. This problem is estimated to cost our economy \$60 to \$130 billion annually.¹

It is very timely to examine the interplay between ERISA and state health care reform initiatives. As states continue to find ways to address the health care crisis in the United States, ERISA continues to present a number of challenges to state-based reform. Today, I will discuss some of those challenges.

As you deliberate about state health reform efforts by looking at "fair share health care" and "pay or play" proposals, it is important to remember that there are practical considerations and legal parameters, e.g., ERISA. One such consideration is the cost of medical care. Health coverage is expensive because medical care is expensive. The double-digit premium increases of the past five years, can be explained in part by certain cost drivers including increased prescription drug costs and higher provider costs (in part due to mergers).² Utilization of services is also increasing -- we are using more health care services as our population ages and the number of people with chronic conditions continues to grow. It is important to address the cost drivers of medical care.

ERISA's limitations on what states can require of employers, lawsuits using ERISA to question state authority and challenge state reform initiatives, and other ERISA-related issues make it difficult for states to address the health care crisis. 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. Despite ERISA challenges to state initiatives, however, governors and state legislators are undeterred and continue to develop new strategies and successful programs to finance medical care for their residents.

Newest state initiatives background

In recent years, many states have sought to address the nation's health care crisis. State-based initiatives like "fair share health care" seek a more equitable way to finance medical care and I believe will help employers. Cost-shifting (for uncompensated care) costs over \$40 billion per year and hurts employers that provide comprehensive and generous benefits. The cost-savings from eliminating uncompensated care that state initiatives like "fair share" seek to accomplish will help those businesses.

ERISA has been used to challenge state reforms. For example, the Maryland Legislature passed a law, called “The Fair Share Health Care Fund Act” that requires 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 law requires a company that falls below 8% to pay an assessment to help fund Maryland’s health care programs for moderate and low-wage income earners and poor people and families.³ Maryland’s lawmakers passed this law 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, drawing down the programs’ resources; similar bills have been introduced in 18 other states. Scheduled to go into effect in January 2007, Maryland’s law was immediately challenged using ERISA.⁴

In April, Massachusetts lawmakers enacted broad health care reforms called the “Health Care Access and Affordability” (a.k.a. Massachusetts Health Care Reform Plan), which include a 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 care provided for free to patients but financed through public funding and other sources) in the state.⁵

Although both laws were carefully crafted to avoid ERISA preemption and many experts (including me) believe 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.⁶ It remains to be seen whether Maryland, Massachusetts, and other states seeking to implement meaningful reforms to address the nation’s health care problems will be precluded from achieving their goal of universal, affordable, and meaningful coverage for all residents.

Background: ERISA

In 1974 the Employee Retirement Income Security Act (ERISA) was passed to regulate job-based health and pension benefits. Under ERISA, state laws that “relate to” an “employee benefit plan” are generally preempted. Not all state laws have been found to “relate to” an ERISA plan, however. And ERISA explicitly exempts regulation of insurance from its broad preemption, thus allowing states to regulate health insurance products and companies that sell coverage to ERISA plans. Employers that self-insure (also called self-funding) are not subject to state insurance laws, however. Self-insurance means that an employer is responsible for paying medical claims of workers and their dependents. When an employer buys health insurance, it pays a premium to an insurance company; this is called “fully-insured” and the insurance company not the employer is obligated to pay medical bills.

Insurance Reforms

ERISA presents challenges to meaningful state health reforms. As a way of example, take state benefit mandates. These are requirements for health insurance policies to cover certain benefits, like specific medical conditions and treatments. States have a wide range of such standards. For example, in 46 states health insurers are required to either cover (or offer to cover) benefits for diabetes supplies and education. Twenty-seven states require insurers to cover cervical cancer screening. Fifty states require coverage for mammograms and 32 require coverage for well-baby care (childhood immunizations and visits to pediatricians). Mandated benefits also include requirements that insurers reimburse certain types of medical providers, such as nurse practitioners. And they include state laws requiring coverage for special populations, e.g., adult handicapped children who age-off their parent’s policy and newborns (required to be covered from birth by their parent’s insurer).⁷

Benefit mandates are used to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage. Policymakers also

use benefit mandates to encourage people to seek certain care (immunizations and preventive services) that otherwise may not be obtained if people have to pay for it out-of-pocket.⁸

In the absence of mandates, adding optional benefits to a policy can distort the price if only people who need that benefit select coverage. For example, in Washington State premiums for policies that covered maternity and mental health benefits were anywhere from 30 to 100 percent more expensive than policies that excluded those two benefits. The choice in benefit design led consumers to select those specific benefits based on their expectation of using them, with adverse selection fueling a steep increase in premiums for those products.⁹ Also, absent a requirement, some services and benefits may not be available even as an add-on (or “rider”). For example, in states that do not require maternity to be covered, an individual policy with a maternity rider is rarely available; and even when available, the price for a maternity rider is higher than paying for the average pregnancy out-of-pocket.

With respect to mandated benefits, state policymakers make tradeoffs: balancing the cost (added to the premium) with the need to help their constituents finance costly illnesses. Here, the impact of ERISA is felt. Self-funded ERISA health plans are not subject to benefit requirements and thus can avoid helping to finance the cost of such coverage. This, however, frustrates the 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, or financing supplies to control diabetes). It is important to note that many self-funded large employer plans are comprehensive, covering for example diabetes supplies. Absent federal mandates, not all self-funded plans provide such coverage. When employers choose to self-fund, because the cost of mandates 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).

How mandated benefits add to the cost of health insurance has been an issue of longstanding controversy and depends on the extent to which mandates spread the cost of a particular health care service over a large number of policyholders. Literature on the cost of mandates generally does not consider the true cost of the benefit because many benefits would have been covered absent the mandate.¹⁰ Even so, a recent industry study, for example, found that mandates add minimally to the cost of premium (an estimated 5 percent).¹¹ Given the recent double-digit premium increases for employers (for some in the range of 20%-30% annually), the anticipated cost savings from a mandate-free environment would be minimal. Importantly, both employers exempt from state mandates (self-insured) and fully insured have seen their premiums increase. There is a reason why GM, for example, adds \$1500 to the price of each car to pay for health coverage for workers and retirees. It is because the cost of medical care is expensive and thus reflected in the price of coverage; it is not because of mandates. So eliminating mandates will not address the rising costs of coverage.

Also, the studies on the cost of mandates generally do not consider the cost to the patient. In other words, if a health plan is excused from covering a treatment, then it does not mean that your illness disappears. It just means that you pay for it out-of-pocket, if you can afford it. And if not, then assuming you still receive the care, the cost of your treatment is added to the cost of uncompensated care (generally paid with public funds and cost-shifting to privately insured patients).¹² The question here is who pays for your illness: your health plan because it is required by a mandate, you pay out-of-pocket if you can afford it, or other people with comprehensive coverage pay for it (through cost-shifting). Additionally, studies on the cost of mandates generally do not consider system-wide costs, that is affordability issues and the increased costs of delayed or foregone medical care when patients cannot afford needed medical services.¹³

State Regulated Health Insurance Products: ERISA's impact

ERISA influences prices for regulated health insurance products. Self-insuring allows employers to avoid having their medical claims pooled with other employers; especially for mid-size (500 employees or less) and small businesses that employ a relatively healthy workforce, this may be an advantage.¹⁴ Smaller firms that employ workers with higher medical needs are less likely to self-insure and are more likely to buy state-regulated products. Since guaranteed-issue laws were enacted, requiring insurers to sell products to any small business, it has in fact become easier to buy insurance. In the past insurers were free to sell insurance only to businesses with healthy workers. In addition, state small group rate reforms require insurers to pool risk and in some states insurers are prohibited (or restricted) from charging higher rates to businesses with sicker workers. Through risk pooling requirements, firms with sicker workers pay less than they otherwise would, which helps them to offer and maintain coverage. If employers with self-funded plans (small and mid-size) in fact have more favorable risk than other employers, the cost for state regulated products may be lowered if all businesses participated and everyone's claims experience was pooled.¹⁵

State Market Reforms and Programs: background and ERISA challenges

State insurance regulation has sought to promote several policy objectives, such as assuring the financial solvency of insurance companies, promoting risk spreading, protecting consumers against fraud, and ensuring that consumers are paid the benefits that they are promised. Also as products and markets evolve, e.g., managed care in the 1990's, states have responded to some abusive industry practices through "patient protections" like guaranteed access to emergency services and specialists, and external review of denied claims for medical care.

State policy makers have also instituted certain rules for insurance companies, establishing who they must sell coverage to, how products must be priced, and the types of benefits that must be covered. Absent legislative interventions, in a private health insurance market, insurers adopt practices to avoid incurring high medical claims, including denying coverage to applicants who have health conditions or a history of health problems. An estimated 20% of people account for about 80% of health care spending.¹⁶ Avoiding even a small number of high-cost individuals can substantially reduce an insurer's losses.

In addition to market reforms, state policymakers have tried a variety of ways to help their residents and businesses to access and afford health coverage. ERISA presents a number of challenges to states in how to finance certain health coverage programs. For instance, states require insurers to pay premium taxes and assessments, which helps to pay for certain state health programs for residents including high-risk pools. Risk pools are state programs for people with high medical needs who insurance companies won't cover. Thirty-three states have such pools. In 2004, they covered approximately 180,000 people. States fund high-risk pools in a variety of ways, but many rely on revenue from premium taxes and assessments on health insurance companies. For self-insured plans, an exemption from premium taxes is a small cost savings, but it cuts the amount of available revenue from health insurance companies by approximately 50% -- the estimated portion of the insured population that is in self-funded plans.¹⁷

Another approach to expand access to health insurance has been through public/private partnerships called "HIPCs" (health insurance purchasing cooperatives) – these are also known as purchasing alliances and purchasing pools for small businesses. These programs use the state's purchasing power to negotiate rates and coverage with private insurance companies.¹⁸ Participating employers have a choice of products and typically a choice of insurers. Arizona, California, New Mexico, and New York City have such purchasing pools for small businesses.¹⁹ One of the newest operational programs was established in 2005 in Montana. The state has used its purchasing power to negotiate rates that are better than available in the private market and is using tobacco taxes to help pay for the cost of coverage in the pool for moderate income wage earners.

Other states have tried to make coverage more affordable through “reinsurance,” subsidizing the cost of big losses (claims). This would limit insurers’ losses and thus seeks to keep premiums lower. Reinsurance programs have been tried in 21 states. Healthy New York, a state-wide program, for example, covers over 100,000 people and uses the state’s tobacco settlement funds to subsidize a portion of high-cost claims under the program.²⁰

While these state coverage expansion efforts vary, none are free. They all rely on some 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 -- self-insured and fully insured plans.

In addition to funding, these state programs rely on insurers assuming significant risk. As policymakers provide new incentives for employers to withdraw from state-regulated policies (as some bills pending before Congress would do), insurers would have greater incentive to dump their poor risks.²¹ States may allow insurers to do so but pressure on state coverage expansion programs will be great. Expansion of ERISA is likely to escalate this pressure and impact adversely state coverage programs that rely on insurers taking on significant risk and on insurer assessments to spread cost broadly across the insured population.

ERISA abuses

Operators of unauthorized entities (a.k.a. phony insurance companies) have used ERISA as a way to avoid or to delay state regulator actions. By way of background, phony insurance entities collect premiums but don’t pay medical bills, instead using the money for personal gain. During the most recent cycle of health insurance scams, more than 200,000 policyholders were left with over \$252 million in unpaid medical bills. The federal government and the states identified 144 scams between 2001 and 2003; the federal government shut down 3 and the states shut down 41.²² Operators of health insurance scams claim that they are regulated by the federal government under ERISA and therefore exempt from state regulation. Some create complex legal documents that, at least on paper, raise questions about their legal status under ERISA.

Although Congress clarified ERISA in 1983, some ambiguities remain and operators of phony health plans continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court. Operators of phony plans use this tactic to delay final court action, which gives them an opportunity to spend or hide assets. This use of ERISA makes it difficult for states to protect their residents against criminal behavior.²³ Expanding ERISA, for example through AHPs or similar legislation, is likely to increase ERISA-related scams.²⁴

Conclusion

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, financing medical care through private and public insurance despite ERISA challenges. States are looking for equitable and effective ways to finance medical care for their residents. For this reason, Congress should be cautious when looking at proposals that seek to expand ERISA or to deregulate the market. Not only will some proposals not accomplish their desired goal, but they may actually add to the uninsured problem, make it even more difficult for state-based reforms to succeed and drive-up costs for people who have insurance. I encourage you to look for measures that will encourage and support 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. 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.

¹ 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.

² For example, in 2004, health care spending included: 30.4% for hospital care, 21.3% for physician services, 10.0% for prescription drugs. Distribution of National Health Expenditures, by Type of Service, 1994 and 2004. page 5, Trends and Indicators in the Changing Health Care Marketplace, KFF 2006 available at www.kff.org. Spending on prescription drugs increased two to five times more than spending on hospital care and physician services between 1995 and 2000. Id. at 6.

³ See 2005 Regular Session, SB 790, Veto Override version, Jan. 12, 2006.

⁴ See Plaintiff's Complaint, Retail Industry Leaders Association v. James D. Fielder, U.S. District Court for the District of Maryland (February 7, 2006).

⁵ Massachusetts Reforms (House No. 4850) amends several state statutes including the insurance code.

⁶ 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).

⁷ See Kofman, Mila and Karen Pollitz, "Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), available at www.allhealth.org.

⁸ 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.

⁹ See Kirk, Adele, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Policy, Politics and Law* Vol. 25, No. 1, 2000.

¹⁰ Chollet, Deborah "Finance Committee Hearing: Health Care Coverage for Small Businesses: Challenges and Opportunities. Questions Submitted for the Record" April 13, 2006 (copy available from author).

¹¹ See Bender, Karen and Beth Fritchen, "*Health Insurance Marketplace Modernization and Affordability Act of 2006*," Mercer Report, March 2006, page 4 (copy available from author).

¹² In 2004, uncompensated care totaled \$40.7 billion. Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Issue Update 2004, Kaiser Family Foundation available at www.kff.org. One study estimates that cost-shifting adds over \$900 annually to the cost of family coverage. "Paying a Premium: The Added Cost of Paying for Care for the Uninsured" Families USA (June 2005) available at www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

¹³ According to a RAND study, doubling co-payments for long-term prescription drug use caused patients to decrease the recommended use, which resulted in more and longer incidents in the hospital, including increased emergency room visits. Goldman, D. et al, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *JAMA*, May 19, 2004, Vol. 291, No. 19, page 2344. One recent study found that patients delay going to the doctor, for example, because of affordability issues. Michelle Doty et al "Seeing Red: Americans Driven Into Debt by Medical Bills," Commonwealth Fund (August 2005) available at www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf.

¹⁴ Small businesses that self-insure may not be able to properly reserve for claims. The financial risk they take on is high.

¹⁵ See Attachment A in Kofman, Mila and Karen Pollitz, "Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), available at www.allhealth.org. 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.

¹⁶ See Berk, Marc and Alan Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, (March/April 2001): 145-149.

¹⁷ Financing risk pools is also a question of fairness. Arguably because former workers of ERISA self-funded plans may enroll in high-risk pools, it is fair to ask self-funded employers to help finance that coverage. For a discussion of funding mechanisms and more information about state high-risk pool programs, see "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis" 18th Edition, 2004-2005, Communicating for Agriculture and the Self-Employed, Inc.

¹⁸ Maine also has a program similar to a purchasing pool, called Dirigo. Among its many features, it helps pay for the cost of private health insurance for moderate income wage earners insured through the program. The coverage is through a private insurer. Funding for the program partly comes through Medicaid.

¹⁹ Kofman, Mila, *Issue Brief: Group Purchasing Arrangements: Issues for States*, State Coverage Initiatives, April 2003 available at <http://www.statecoverage.net/pdf/issuebrief403.pdf>.

²⁰ Chollet, Deborah, *The Role of Reinsurance in State Efforts to Expand Coverage*, State Coverage Initiatives, October 2004; see also, Chollet, Deborah and Carolyn Watts, *Pooling and Reinsurance in Washington State Insurance Markets*, 24 *Journal of Insurance Regulation* 81 (Winter 2005); Swartz, Katherine, "Reinsurance: How States Can Make Health Coverage More Affordable For Employers and Workers," Commonwealth Fund, July 2005.

²¹ For example, prior to guaranteed-issue requirements in the small group market, states allowed commercial insurers to choose to whom to sell coverage. In many states, Blue Cross/Blue Shield plans were looked to as insurers of "last resort" and generally offered coverage on a guaranteed issue basis. With a changing marketplace in the 1980s, as more large employers began to take themselves out of the insurance market (and self-funding their medical benefits), the market became more fragmented. Commercial carriers became more selective in who they would cover. Financial pressure on many Blues plans as insurers of last resort became significant. Taxpayer subsidies and whole scale market reforms became necessary requiring commercial insurers to bear more risk for sick groups. See Kofman, Mila and Karl Polzer, "What Would Association Health Plan Mean for California: Full Report?" Prepared for the California HealthCare Foundation, January 2004 available at <http://www.chcf.org/documents/insurance/AHPFullReport.pdf> (hereinafter California AHP Report).

²² U.S. General Accounting Office, *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, GAO-04-312 (Feb. 2004).

²³ Also some entities have developed complex "ERISA" schemes that they claim allows an exemption from state insurance laws protecting small businesses or to avoid state initiatives to increase the availability of affordable health insurance coverage. Unlike the outright scams these schemes straddle the line between regulatory violations and criminal conduct.

²⁴ In the case of American Benefit Plans, although the Texas Insurance Department had a letter from the U.S. Department of Labor stating that the arrangement was subject to state regulation, one of its promoters, nonetheless, removed the state case to a federal court. See Kofman, Mila "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Georgetown University Health Policy Institute, July 2005, available at <http://hpi.georgetown.edu/ahp.html>.