HEALTH CARE REFORM: RECOMMENDATIONS TO IMPROVE COORDINATION OF FEDERAL AND STATE INITIATIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

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C O N T E N T S

HEALTH CARE REFORM: RECOMMENDATIONS TO IMPROVE COORDINATION OF FEDERAL AND STATE INITIATIVES

Tuesday, May 22, 2007
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 3:00 p.m., in Room 2175, Rayburn House Office Building, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews, McCarthy, Tierney, Wu, Sestak, Loebsack, Hare, Courtney, Sarbanes, Kline, McKeon, Boustany, and Price.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Carlos Fenwick, Policy Advisor for Subcommittee on Health, Employment, Labor and Pensions; Michael Gaffin, Staff Assistant, Labor; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Policy Advisor; Michele Varnhagen, Labor Policy Director; Steve Forde, Minority Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Legislative Assistant; Victor Klatt, Minority Staff Director; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Professional Staff Member; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairman ANDREWS [presiding]. The subcommittee will come to order if everyone would please take their seats.

I first want to thank our witnesses and guests for their indulgence in the late starting of the hearing. We had a series of 10 votes on the House floor, which took us for a substantial period of time, and, unfortunately, there is going to be, I think, one more interruption in about an hour. But we very much appreciate the indulgence of those who traveled to be here today, and we thank you very, very much for your patience.

The purpose of today's hearing is to explore the issues that are raised by creative state solutions to the perplexing problem of the growing number of uninsured in our country.

The number seems to rise as time goes on. When I first had the privilege of being elected to this body in 1990, I believe we had 35 million uninsured, and then by the beginning of the 1990s, 1992-

1993, we had 40 million uninsured. Now it is somewhere between 45 million and 47 million uninsured.

There have been modest steps at the federal level, most especially the achievement in 1997 with the adoption of the State Children's Health Insurance Program, which is up for reauthorization this year. And I should indicate that we are involved in efforts with the Committee on Energy and Commerce to try to provide some additional employer options under that provision.

But the truth of the matter is the federal government has not made a dent in fixing this program. Creative state leaders around our country, both Republican and Democratic, have made significant progress, not always without controversy, but have made significant progress.

The purpose of our hearing today is twofold. It is to consider mechanisms by which state efforts to decrease the number of uninsured can be properly incorporated into the federal legal structure. That is to say: How can we give creative policymakers at the state level in both the Republican and Democratic parties the opportunity to effectuate good solutions to problems that will decrease the number of uninsured?

We are going to hear from two panels today about that question. One is a panel of three of our colleagues that have an innovative idea to encourage more state innovation. And then the second is from a panel that will consist of experts in this health care legal field as well as representatives of state governments from throughout the country.

The second question that we are going to address is how to strike the proper balance between innovative state solutions and the federal statute, the ERISA statute, which has governed this area of the law for 33 years. ERISA has set up a finely balanced structure, where the ability of employers to enjoy one set of rules through federal preemption has, in fact, encouraged a number of employers to voluntarily provide generous and sustained benefits for employees for a very long period of time.

I would like to believe that we do not have to choose between disrupting that balance and encouraging creativity at the state level. I do not think this is an ideological problem. I think it is a practical problem.

And I would invite comment from all of our colleagues on the subcommittee and the full committee in finding ways that we can retain the very laudable aspects of ERISA, which have given us a stable environment for employers to offer health benefits and pension benefits, but while at the same time encouraging creative state policymakers to do something we failed to do under both Democratic and Republican congresses and administrations in Washington, which is to reduce the number of uninsured people in the country.

I believe there is an inextricable link between the growing number of uninsured and the rising costs of health care for the insured, and I believe that until we make significant progress in reducing the number of uninsured, we will not make significant progress in reducing the burden of health insurance premiums, copays, deductibles and other costs for those who are insured.

So we want to kick off this discussion today. We, again, thank the witnesses for their discretion.

And, at this time, I would turn to the distinguished ranking member of the subcommittee from Minnesota, Mr. Kline.

Prepared Statement of Hon. Robert E. Andrews, a Representative in Congress From the State of New Jersey

Good afternoon and welcome the Health, Employment, Labor, and Pensions Subcommittee hearing today entitled "Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives." This is part II of the HELP Subcommittee's hearing series on solutions to covering the uninsured. During our last hearing, we heard testimony from several health care policy experts regarding various states' innovative ideas to address the problem of the uninsured. In this hearing, we will hear directly from several state officials regarding their state's health care initiatives and the challenges federal law presents to them. In addition, we will hear from several Members of Congress regarding a proposal that would establish a commission to provide certain waivers and grants to states who want to increase health care.

The purpose of today's hearing is to address the question of whether the federal government should provide states with waivers from the federal law known as the Employee Income Retirement Security Act (ERISA) in order to meaningfully implement their state health care initiatives. Although ERISA's original intent was to establish minimum funding and vesting standard for pension plans, its effect has created an unintended consequence that prohibits states from regulating employer-sponsored health plans.

While the United States spends over $1.6 trillion on health care annually, which represents over 15% of our Gross Domestic Product, we nevertheless remain the only industrialized nation that does not guarantee health care for all of our citizens. Today, with over 46 million Americans still without health insurance, Congress and states need to work together, now more than ever, to provide a solution to this dilemma. Whether we establish a national healthcare model or provide states with the necessary flexibility to implement smart, effective health care initiatives or devise a plan that improves coordination of federal and state health care initiatives, the time to do so is now. I look forward to hearing our witnesses' testimony today and the healthy debate we will have regarding a problem that has been ignored for far too long.

Mr. KLINE. Thank you, Mr. Chairman.

I, too, would like to thank the witnesses. It is always interesting and fascinating and enjoyable to see our colleagues down there at the witness table, so I am looking forward to hearing from them and then, of course, from the panel of experts which will follow them.

In the interest of time—and I know some of the panelists actually have plans to try to get on an airplane sometime this evening, so we will try to move through quickly—I have a statement which I would ask unanimous consent to be entered in the record.

Chairman ANDREWS. Without objection.

Mr. KLINE. And then I would just say that as we look at this problem of the uninsured and innovative ways to solve it, we would be very careful to recognize, as the chairman said, that we have a balance here. And we do not want to destroy the voluntary efforts of employers who provide the vast majority of health insurance for Americans, and we want to be very careful not to damage ERISA in such a way that it would preclude that service in providing that insurance.

So, with that, Mr. Chairman, I will just say thanks to the witnesses and yield back to you.

[The opening statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Ranking Republican Member, Subcommittee on Health, Employment, Labor, and Pensions

Good afternoon. I'd like to thank Chairman Andrews for convening this hearing this afternoon, on an issue that impacts every American. At a prior hearing in March, this Subcommittee examined the delivery of health care in this country, and began to explore many of the issues confronting our nation's health care system, including efforts to improve health care quality, access and affordability.

I think one the of the important points coming out of that hearing is that regardless of the problems that we may face, be it rising health care costs or the uninsured, it is very important that we keep in mind some of the success of the current employer-based health care system, a voluntary system that provides the most common form of health care coverage for individuals and workers.

For example, the current system delivers high quality coverage for about 160 million Americans. Testimony from the last hearing reflected the fact that American businesses are true innovators in efforts to redesign the health care system to improve price and quality transparency, and reduce costs. The private sector is leading efforts to help people learn the true costs of medical services, developing health care provider report cards, adopting value-based purchasing systems, and implementing wellness and disease management programs.

The driver behind the successes of the employment-based system is the federal ERISA law. Specifically, the existence of ERISA, and its preemption of state law, means that American businesses can provide high quality, uniform benefits to all their employees across state lines. And that means companies with workers across the nation can provide uniform national coverage, without having to worry about abiding by 50 different sets of rules in order to offer insurance, which prevents headaches and saves money.

Notwithstanding the successes of ERISA, states continue to have a role to play in this process, and many have developed health care proposals worthy of consideration. However, certain state proposals may undermine the efficiencies developed under ERISA, and have adverse impacts on the ability to provide efficient, affordable health care coverage. We must be wary of any attempts, however well-intentioned, to impose state mandates that detract from the goal of improving access and efficiency.

When we explore whether or not the federal government should provide "temporary" waivers of ERISA preemption to permit states to more freely experiment, we must be mindful of the impact on the current structure, and take care not penalize "good actors" that are providing the type of health care benefits so highly valued by Americans. Also, we must be mindful of the potential difficulties associated with creating a waiver program, the fact that waivers once granted are unlikely to be revoked, and the potential that we will incur significant costs in permitting waivers of ERISA preemption.

In addition, we must not forget that the Committee has taken the lead in efforts to improve the current system, such as the creation of Association Health Plans which would make it easier for individuals and small businesses obtain affordable health care coverage comparable to that provided by multi-state employers. I am hopeful we can continue to work together to reach consensus on measures to provide more affordable and efficient ways of providing health care benefits.

Despite what we may agree to be the flaws of the current system, the private sector, as opposed to government, is in the best position to lead reform efforts and effectuate change. While there is a role for government, we must recognize the potential impact of any change, and take care to improve the system while not unnecessarily disrupting the high quality coverage enjoyed by most Americans.

I'd like to welcome our distinguished witnesses today, including three of my colleagues who are here to discuss their bill, H.R. 506, the Health Partnership Through Creative Federalism Act, which is a helpful proposal that seeks to address some of the very problems we will discuss today. I look forward to everyone's testimony.

Chairman ANDREWS. Thank you, Mr. Kline.

Without objection, all members will have 14 days to submit additional materials for the hearing record.

I am pleased to welcome three of our colleagues—the third is on his way—who have introduced some innovative legislation to encourage creative solutions at the state level with respect to this problem.

Congressman Tom Price is a member of our committee. He is a second-term member representing the 6th District of Georgia. He is a physician. He is known as Dr. Price. Tom has been an outspoken advocate for patient-centered health reform and for finding solutions for covering the uninsured.

And, Tom, we look forward to your comments.

Congresswoman Tammy Baldwin is a fifth-term congresswoman representing the 2nd Congressional District of Wisconsin. She is a leading advocate for universal health care, protecting Social Security and Medicare, and increasing support for public education, including financial aid for higher education.

Welcome, Tammy.

And to join us in just a moment—he will go third—is another member of our committee, Congressman John Tierney, who is a 6th District member representing Massachusetts' 6th District. He has developed a national reputation as an effective legislator fighting for America's working families. John is also a member of our subcommittee.

So I would ask, Congressman Price, if you would like to lead off. We welcome you home to your home committee.

Dr. PRICE. I thank you, Mr. Chairman. If I may, I will yield to Congresswoman Baldwin, who was——

Chairman ANDREWS. That will be just fine.

Tammy, welcome.

Dr. PRICE [continuing]. The genius behind of all of this at the beginning.

Chairman ANDREWS. Glad to have you with us. You should know that any written statement will be entered into the record, without objection. And you are welcome to make an oral statement at this time.

STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman, and thank you, Ranking Member Kline. I very much appreciate the opportunity to testify before the committee today.

I think members of the subcommittee are undoubtedly aware that over 46 million Americans are uninsured. Millions more are underinsured. In fact, the Commonwealth Fund recently released a study estimating that there are 16 million Americans who are underinsured, meaning that their insurance did not adequately protect them against catastrophic health-care expenses.

So, in aggregate, we have 62 million Americans with no health insurance, sporadic coverage or insurance coverage that leaves them exposed to high health-care costs. Sixty-two million is about 20 percent of our nation's population, one in five.

Meanwhile, as was noted in the chairman's opening statement, Congress has taken no significant steps to provide health care to these uninsured and underinsured Americans, and this lack of progress is not for want of ideas. We all know that various proposals have been floating around in Congress for years, even decades.

Believe it or not, we have been talking about this issue at the federal level for more than 60 years. The first bill calling for na-

tional health care was introduced in the House by Representative John Dingell, Sr., in 1943, and as a tribute to his father, his son, John Dingell, Jr., has been introducing that same bill as H.R. 15 every session since.

In every session, we have a number of bills purporting to increase access or to create a national health-care system. About 24 bills to expand health-care coverage have already been introduced in this 110th congressional session. Sixty-two bills were introduced in the 109th Congress, and most were intensely partisan.

So, clearly, on the issue of health care for all, we are not at a loss for words or ideas, but we still have not figured out how to get the job done.

But where we are seeing the job get done is at the state level. Innovative proposals in states such as Massachusetts, Vermont, Maine, Oregon and California and my home state of Wisconsin demonstrate a clear desire on the part of states to reach an agreement and move forward.

Yet when one studies these proposals, it is clear that the states are constrained by federal laws and regulations. There is a reason why we see state proposals that are often very similar, and that is because states are all operating under the same set of constraints that we have imposed upon them under ERISA, under our tax laws and under a plethora of health-care laws and regulations.

Recognizing this and feeling that we could not afford additional years or decades of inaction at the federal level, I convened my colleagues, Dr. Price, Mr. Tierney, and last session our former colleague Bob Beauprez of Colorado, in crafting H.R. 506, the Health Partnership Through Creative Federalism Act.

And our bill is noteworthy, I think, for a number of reasons. First of all, as a commentator in a medical journal just mentioned, it is both an end and a means. In other words, it addresses both the substantive problem that we confront in this nation, but also the political obstacles that we face in moving forward on health-care reform.

It is also bold. You could not describe this as an incremental approach, and a recent analysis of rival health-care reform plans pending in Congress right now indicates that about 20 million additional Americans would be covered if only 15 states put forward applications to participate in this creative federalism concept.

It is also bipartisan. Right now, it enjoys 66 cosponsors just a few months after introduction: 36 Democrats and 30 Republicans. These are people who disagree intensely on how to get the job done, but have come together around this bill so that we can test our rival ideas in the states.

It is also a budget-friendly bill because of its budget neutrality provisions. It allows the federal government to be a helpful partner to states which are already taking the lead in making reforms. The federal government should be helping the states as they try new approaches, not hindering them.

But this bill, as I mentioned, does not simply throw money at the problem. We are looking for systemic change and encouraging bold innovation. Our bill authorizes grants to individual states or portions of states to enact the strategy best suited for them, and under

our plan, states will have a lot of freedom to think creatively and independently.

I note my time is over. So I will hope that you read the rest of my preprinted comments.

[The statement of Ms. Baldwin follows:]

Prepared Statement of Hon. Tammy Baldwin, a Representative in Congress From the State of Wisconsin

Thank you Chairman Andrews, Ranking Member Klein and Subcommittee members, and thank you for inviting me to testify before you today.

As members of this subcommittee are undoubtedly aware, 46 million Americans are uninsured. Millions more are underinsured. The Commonwealth Fund recently released a study estimating that there are 16 million Americans who are underinsured—meaning their insurance did not adequately protect them against catastrophic health care expenses. That means that 62 million Americans either have no health insurance, have only sporadic coverage, or have insurance coverage that leaves them exposed to high health care costs. 62 million is nearly 21% of all Americans. One in five.

Meanwhile, Congress has taken no significant steps to provide health care to these uninsured and underinsured Americans. And this lack of progress is not for want of ideas.

We all know the various proposals that have been floating around Congress for years, and even decades.

Believe it or not, we've been talking about this issue at the federal level for more than sixty years. The first bill calling for national health care, was introduced in the House by Rep. John Dingell Sr. in 1943 (and his son has been introducing that same bill every year since).

And every session, a number of bills are introduced purporting to increase access or create a national system. About twenty-four bills to expand health care coverage have already been introduced this session. Roughly 62 were introduced in the 109th Congress.

Clearly, on the subject of health care for all, we're not at a loss for words or ideas, but we still haven't figured out how to get the job done. And that is simply unacceptable.

But where we are seeing the job get done is at the state level. Innovative proposals in states such as Massachusetts, Vermont, Maine, Oregon, California, and my home state of Wisconsin demonstrate a clear desire on the part of the states to reach an agreement and move forward.

Yet when one studies these proposals, it's clear that states are constrained by federal laws and regulations. There's a reason why the state proposals are often very similar, and that's because the states are all operating under the same set of constraints that we have imposed upon them.

Recognizing this and feeling that we could not afford additional years of inaction at the federal level, I joined my colleagues Dr. Price and Mr. Tierney in crafting H.R. 506, the "Health Partnership through Creative Federalism Act."

Our bill is noteworthy because it allows the federal government to be a helpful partner to states which are already taking the lead and making reforms.

The federal government should be helping the states as they try new approaches, not hindering them. But, this bill does not throw a bunch of money at the problem of the uninsured. We're looking for systemic change and encouraging innovation.

Our bill authorizes grants to individual states, or groups or portions of states, to enact the strategy best suited for them. Under our plan, states have a lot of freedom to think creatively and independently.

The bill is quite simple. Congress would authorize grants to individual states, groups of states, or portions of states to carry out any of a broad range of strategies to increase health care coverage. States desiring to participate in a health care expansion and improvement program would submit an application to a bipartisan "State Health Innovation Commission."

The Commission would consider applications that include a variety of approaches, such as tax credits, expansion of Medicaid or SCHIP, creation of pooling arrangements like the FEHBP, single payer systems, health savings accounts, or a combination of these or other options.

Some of these state applications might involve waivers of various federal law or regulation. Some states might ask that certain provisions of ERISA be waived. Some might ask for more flexibility in their state's Medicaid program. We don't know exactly what the states might propose, but we want to allow them the opportunity to

think creatively and to seek temporary waivers of the federal laws which currently constrain them.

After reviewing the state proposals, the Commission would submit to Congress a slate of recommended state applications that represent a variety of approaches.

States receiving grants would be required to report on their progress. At the end of a five-year period, the Commission would be required to report to Congress whether the states are meeting the goals of the Act and recommend future action Congress should take regarding overall reform.

And I'm happy to report to you that this is an approach that continues to gather bipartisan support. As of today, the bill has 66 cosponsors and the cosponsors are almost evenly split between Democrats and Republicans: 36 Democrats and 30 Republicans.

Our Health Partnership Through Creative Federalism is a major step in the right direction. This is an idea whose time has come; it is bold; it is bipartisan; and it is budget-friendly. It provides states with an opportunity to innovate without the current constraints of federal laws and regulations.

Again, Mr. Chairman, thank you for the opportunity to testify today and thank you for taking up this important topic.

Chairman ANDREWS. Thank you, Representative. As I said, without objection, your full statement will be entered into the record.

Congressman Price?

STATEMENT OF HON. TOM PRICE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Dr. PRICE. Thank you, Mr. Chairman and Ranking Member Kline and other distinguished members of the committee and staff. I want to thank you for holding this hearing on a critical issue and allowing me to participate.

We certainly all know that there are many challenges facing the health-care system today, and the uninsured are at the top of the list, with 46 million lacking health insurance at some point during the year 2005. The rate of episodically uninsured has increased by more than 5 million over the last 4 years.

And as a physician for over 25 years, I have seen firsthand the problems with the health-care delivery system, and each result in a decreasing ability for those responsible for providing the care from being able to fulfill their mission.

Now the partisan battles, as have mentioned, both from the left and the right have blocked any real solutions for moving forward at the federal level. It is clear that one size cannot fit all, and that approach is not likely possible at the federal level in the near future.

Consequently, many states have determined that they must act in the absence of federal results. Massachusetts, Minnesota, Pennsylvania, Vermont, California are just a few of the states who are attempting to correct the flaws within the current system.

There have been efforts to expand universal coverage, to allow for tax incentives, to implement an individual mandate and even create preventative and wellness programs. Now this activity we ought to praise and we should continue to encourage this kind of innovation and creativity.

States have some significant advantages when it comes to health reform. They already have the responsibility of regulating health insurance and of licensing health-care providers, and often they have local demographic advantages with a more uniform population than the nation as a whole.

It has sincerely been my privilege to work with Representative Baldwin and Representative Tierney, along with Representative Beauprez in the last Congress, on this federalist approach that would help foster innovation and state reforms.

Our proposal would encourage states or regions or localities to come up with a diverse set of ideas, each unique to their own particular challenges, to increase coverage for the uninsured.

An endless variety of approaches might be implemented, tax credits, expansion of Medicaid or SCHIP, creation of pooling arrangements like the Federal Employee Health Benefits program, single-payer systems, health savings accounts or a defined benefit insurance model.

A custom-made health-care financing system can be designed to fit the states' preferences, rather than having to implement a system designed for the entire nation.

H.R. 506 would work by encouraging states to submit a health-care expansion and improvement proposal to a bipartisan commission composed of local, state and federal representatives. A slate of proposals would then be sent to Congress for an up or down vote.

Grants to assist in implementation of their health reforms would be awarded, and the recipients would be required to report on the progress throughout the 5-year period. This would give states more flexibility around restrictive federal regulations that inhibit covering the uninsured.

By expanding state waiver authority and allowing flexibility in other federal requirements, states may be more expansive with their reform ideas.

What a great benefit it would be to allow the laboratory of the states an opportunity to shed greater light on various health coverage options.

Now, when it comes to reforming our health-care system, the three of us have very different ideas as to what it should look like, and I suspect that is true across the panel before me, and that is why this bill makes so much sense.

Reform that may work in one state or region might not work in another or might not work well in another, and members of Congress in this program do not have to pick one solution over another. It allows each of us to highlight our preferred model.

Due to the political paralysis at the federal level, allowing states to foster innovation and competition, we will finally get to see positive and encouraging health-care solutions.

Let me also take this opportunity to thank subcommittee members Ms. McCarthy, Mr. Wu, Mr. Holt, Mr. Hare, Mr. Marchant and Mr. Walberg who are among the 66 cosponsors—30 Republicans and 30 Democrats—of this bipartisan bill. I am sincerely and truly enthusiastic about the possibilities for success across our nation with this type of approach to our vexing challenge.

I thank you for the opportunity to be with you, and I look forward to any questions that you might have as we move forward.

[The statement of Dr. Price follows:]

Prepared Statement of Hon. Tom Price, M.D., a Representative in Congress From the State of Georgia

Good afternoon. I would like to thank Chairman Andrews, Ranking Member Kline, other distinguished members and staff for holding this critical hearing and for allowing me to participate.

Our nation's health care system is facing a serious crisis. As a physician for 25 years, I have seen firsthand the problems with the health care delivery system. With more than 46 million lacking health insurance at some point during 2005, the rate of episodically uninsured has increased by more than 5 million over the last four years. This is due to a variety of factors including rising health care costs and decreasing employer-based coverage.

Due to its broad scope and complexity, the challenge and consequences of the lack of health insurance in America does not have a quick fix. And the partisan battles over what type of major reform should be implemented seemingly have blocked any real solutions from moving forward. For the past decade the focus on reform from the left has been support for moving us toward a single-payer system. On the right, the push has been toward market-based or consumer-directed health plans. If any conclusion may be reached about our current dilemma, it is clear that a one-size-fits-all approach may not be possible on the federal level in the near future.

For this reason, many states have determined that they have no option left to coming up with their own health care reforms as more of their population becomes uninsured and their health care dollars spiral out of control. Massachusetts, Minnesota, Pennsylvania, Vermont, and California are several states that have attempted to correct some of the flaws found within the current health care system. We have seen efforts to expand to universal coverage, allow for tax incentives, implement an individual mandate, and even create preventative and wellness programs. These types of bold reforms should be praised. We should continue to encourage this type of innovation and creativity.

States have some advantages when it comes to health reform. States already have the responsibility for regulating health insurance and licensing health care providers. They have local demographic advantages in reforming the health care system, as states usually have a more uniform population than the country as a whole. A custom-made health care financing system can be designed to fit the state's preferences rather than having to implement a system designed for the entire nation.

Rep. Baldwin, Rep. Tierney (along with former Rep. Beauprez last Congress) and I have spent over two years working on a federalist approach that would help foster innovation and state health reforms. By encouraging states, regions, and localities to come up with a diverse set of ideas, we may benefit from the use of multiple approaches—conservative and liberal—to solving the problem of the uninsured. H.R. 506, the Health Partnership through Creative Federalism Act, gives states and regions the flexibility to try new ways of covering their uninsured population. An endless variety of approaches might be implemented—tax credits, expansion of Medicaid or SCHIP, creation of pooling arrangements like FEHBP, single-payer systems, health savings accounts, or a defined benefit insurance model.

H.R. 506 would work by encouraging states to submit a health care expansion and improvement proposal to a bipartisan commission composed of local, state and federal representatives. The commission would consider the state applications, weigh the pros and cons, and choose a variety of approaches. The slate of proposals would then be sent to Congress for an "up or down" vote. If approved, states would receive grants to assist in implementation of their health reforms and would be required to report on the progress throughout the five-year period. The commission would be responsible for reporting to Congress on whether states are meeting their goals and whether the reforms should continue.

This bill would also give states more flexibility around restrictive federal regulations that inhibit covering their uninsured. By expanding state wavier authority and allowing flexibility in other federal requirements, states may be more expansive with their reform ideas. What a great benefit it would be to allow the laboratory of the states an opportunity to shed greater light on various health coverage options.

When it comes to reforming our nation's health care system, the three of us have very different ideas as to what this should look like. That is why this bill makes so much sense. We allow for all of our ideas, and others, to be tested. Reform that may work in one state or region might not work as well in another. Let the states foster innovation and competition. I truly believe this is where we will finally get to see positive and encouraging health care solutions. Please allow me to also thank Subcommittee Members Ms. McCarthy, Mr. Wu, Mr. Holt, Mr. Hare, Mr. Marchant, and Mr. Walberg, who are among the 66 cosponsors—30 Republicans and 36 Democrats—of this bipartisan bill. I hope today's testimony will encourage other members

of this Subcommittee and our colleagues on the full Education and Labor Committee to support this vital legislation. I am enthusiastic about the possibilities for success across our nation with this approach to a vexing challenge.

Thank you and I look forward to your questions.

Chairman ANDREWS. Tom, thank you very much.

John Tierney, welcome.

STATEMENT OF HON. JOHN TIERNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. TIERNEY. Thank you, Mr. Chairman and——

Chairman ANDREWS. John, your microphone is not on. See, you are inexperienced. [Laughter.]

Mr. TIERNEY. You would think I would know. Next week, it will be too close or too far away, right?

Thank you, Mr. Chairman. I thank all of my colleagues for giving us the opportunity to talk with you here today.

When I first got elected in 1966—1996—my 30-odd years here in Congress—but in 1996, I advocated for universal health care, but in the single-payer form. And there was a big raging debate at that time and it continued for a while, but it was clear after a while that that was a big ship to turn around, to try to get everybody moving in the same direction.

There were others that advocated as passionately for different ways, but little disagreement about the fact that everybody wanted universal coverage, every American covered with quality, comprehensive, affordable health care.

The concept came to the idea that maybe we could do it in a way that has been outlined by my colleagues here. Obviously, I was not the first to have that idea, and it was good to not only start working with them and Mr. Beauprez who has now moved on from Congress, but with people from the National Governors Association, Stu Butler, Henry Aaron, a whole group of people who are interested in trying to put this together and getting some momentum behind it.

I will not go into the details of the plan. My written testimony has that, but you have already heard that from my colleagues. But I do want to address the issue of ERISA and waivers on that. I think that is critical.

If we are going to have any movement of a system that allows states to really get creative and to make some new ideas work, then they have to have the ability to waive a number of federal regulations and laws and most notably ERISA. So I would encourage everybody to look at that issue and be inclined to look at it with favor.

It is time, given the fact that Maryland's Fair Share Health Care Fund Act was based on the ERISA preemption, and that is the same with a lot of different states who have to move in that direction.

Let me just mention a little bit about what Massachusetts did. I know the chairman had asked that we touch on that in the testimony. Massachusetts enacted legislation that I would say is near universal in its reach out.

We did that by expanding SCHIP to a certain degree, by merging the state's nongroup and small group health insurance markets, by creating a public entity known as the Commonwealth Health Insurance Connector to, in essence, if you will, connect individuals and small business with affordable, quality health insurance plans.

It is all very innovative in that sense, but we had some efforts to go to to reach consensus on that. The fact of the matter is that employers—we are hoping to encourage them to continue covering people, but if they do not, they are going to have to pay an annual sum per employee of $295.

Now that is the provision that Governor Romney vetoed before he went out and took credit for the bill, but the fact of the matter is that there has to be some mechanism there to encourage employers to cover people or to participate in putting money into a fund that can then be used to subsidize, you know, individuals who cannot afford a policy.

So the Connector group creates policies that are affordable. We subsidize people into certain income categories, and then others have to pay on an as-can-afford basis on that.

There are still going to be about 60,000 people, it is estimated, that will fall in the cracks, and they may well be people that are self-employed, working at home from Web sites.

My office has been working lately actively with state officials, with a group called the Freelancers Group, another group Creative Economy Association of the North Shore, where I live, to try and find a way to have either the Connector group allow itself to create a policy for them or to allow these groups to create a policy which they can afford so that people that are self-employed and create so much a part of our economy now probably in all of our districts also have access to that.

It is a crucial step, I think, and probably the only way that we are going to move forward is to allow a number of different models to be put forth. As Tom Price said, probably it is going to be the situation where urban communities are different than rural communities, different parts of the country differ on that, but we need a series of models or pilots that we can then see what works and take up the scale. I think this bill allows us to move in that direction.

I was pleased and honored to work with my colleagues on this. If the three of us can work together, then probably anybody with varying and disparate views can work together because we had a lot of room between where we were on this.

So I thank you, Mr. Chairman. I thank my colleagues again for allowing us to put this measure before you for consideration and look forward to working with all of you on it.

Thank you.

[The statement of Mr. Tierney follows:]

Prepared Statement of Hon. John F. Tierney, a Representative in Congress From the State of Massachusetts

Good afternoon. I would like to thank Chairman Andrews for inviting me to speak before the Subcommittee today.

When first elected, in 1996, I advocated for Universal Health Care, preferring the "single payer" concept. I still support that concept. However, a number of people sharing the belief in covering all citizens with quality comprehensive care have pro-

posed other means which they believe would best reach that end. With this impasse, a number of people have been committed to exploring all possible avenues to address the ever-increasing number of Americans without health insurance and to expand access to quality, affordable health insurance for all of those in need.

Realizing this impending impasse, I have authored and supported legislation designed to allow states federal resources to develop and implement creative proposals to improve their constituencies' access to health insurance as well as utilize the lessons learned from such state-based initiatives to inform the growing national debate on how to proceed with any potential reform of our country's health care system as a whole.

Obviously, I wasn't alone in having this idea, or similar notions, and now I've had the pleasure to join with other members—Congresswoman Baldwin and Congressman Price—and use the considerable intellect of others knowledgeable in health care policy: Stuart Butler, Henry Aaron, representatives of the National Governors Association to name several, in drafting the Health Partnership Through Creative Federalism Act.

This critical piece of legislation would create a commission comprised of federal, state, and local stakeholders to solicit and review state—and also potentially multi-state or sub-state—plans to expand health insurance coverage for their residents. The commission would recommend a range of plans to Congress for approval and, if approved, these states would then receive grants through the Department of Health and Human Services to implement the plans for five years and periodically report on results.

I think that the diversity incorporated into both the commission composition and the plan selection process, combined with the bill's reporting requirements that will help ensure consistent accountability and assessment of the approved plans, make this measure well-suited to lower the number of uninsured Americans and expand access to quality, cost-efficient coverage.

Mr. Chairman, I understand that one of your specific aims in holding today's hearing is to examine the Employee Retirement Income Security Act (ERISA), its potential impact on the ability of states to implement initiatives to expand health insurance coverage, and whether some form of ERISA waivers may be appropriate in this regard.

This is indeed a timely point of interest given the recent legal challenge to Maryland's "Fair Share Health Care Fund Act" based on ERISA preemption and the growing momentum in many states to engage in similar efforts. In that vein, I want to note that our bill specifically allows for state plans approved by Congress under the Act to seek "exceptions to otherwise applicable federal statutes, regulations, and policies," such as and including ERISA.

Going back to the broader principles of the bill, quite frankly, this legislation is, in my view, long overdue. Absent federal action on the issue, many states have taken, or are beginning to take, action of their own accord to address their uninsured populations and expand access to care. Indeed, my own state of Massachusetts has been a pioneer in this regard, having enacted legislation last year to achieve near-universal coverage of the Bay State's residents through a combination of approaches.

Among other things, the Massachusetts plan includes expansion of Medicaid and State Children's Health Insurance Program—or SCHIP—eligibility, individual premium subsidization, merging of the state's non-group and small-group health insurance markets, and creation of a public entity—the Commonwealth Health Insurance Connector—to help "connect," if you will, individuals and small businesses with affordable, quality health insurance plans. These innovative approaches may have benefited greatly from this legislation. As more and more states look to follow Massachusetts's lead, now is the time to show them that they've got the federal government's support.

Employers continue to offer coverage, hopefully, but those who do not are assessed a per-employee sum which is paid into the system funding subsidies for individuals qualifying on an income basis. The goal is to have nearly all residents with insurance by July 2007.

I say that the Massachusetts plan achieves "near-universal" coverage because there are an estimated 60,000 Massachusetts residents, many of whom are self-employed, who are projected to continue to be unable to afford health insurance under the Commonwealth's plan. I am now actively working with local stakeholders—including entities like the Freelancers Union and the Creative Economy Association of the North Shore—in conjunction with state officials, to generate additional approaches that will expand access to coverage to these 60,000 individuals.

My point here is that efforts to expand access to health insurance seem to be occurring everywhere, and Congress must step up to the plate.

We have a responsibility to the American people to work with state and local governments to facilitate access to quality, affordable health care, and the Health Partnership Through Creative Federalism Act is a crucial step toward this end.

Again, thank you, Mr. Chairman, for having me here today.

Chairman ANDREWS. Well, thank each of the three of you very, very much. I am impressed by the scope of the ideological reach of the cosponsors of this bill, and it really does show that there is a practical orientation to getting the job done.

We are fortunate to be able to ask our colleagues questions about this at any time in our daily interaction, so I am not going to ask any questions at this time, so we can get on with the second panel, but I would ask Mr. Kline at this point if he has questions.

Does anyone on our side have a question they would like to ask the members of the panel? Please feel free. There will only be a limited penalty. [Laughter.]

Mr. TIERNEY. We are still signing other cosponsors, Mr. Chairman.

Chairman ANDREWS. Okay.

And anyone else on the minority side?

Dr. Boustany?

Dr. BOUSTANY. We will have plenty of time to discuss this, but I am concerned that this does create a new bureaucracy, and it may have so many cosponsors because it may not in effect accomplish much, too. So I have some concerns, and I would like to point that out, but at least we will have plenty of time to discuss the bill as time goes forward.

Chairman ANDREWS. If the gentleman would yield, my intention is to have as free flowing a discussion as we can, not just in this hearing, but as the process goes forward, so those kind of views can be entertained.

We, by no means, offer this bill as a perfect template for what to do. But I offer it as an encouraging sign that members with very different views on this issue can come together and try to get something done, and I assure you there will be a free-flowing discussion.

Dr. BOUSTANY. Yes. Reclaiming my time, I think that is laudable, and I think it is great that we have the full partisan divide engaged in this, and that is important. But I read through the summary of the bill, and I have some major concerns.

Chairman ANDREWS. I think Representative Baldwin wanted to comment.

Ms. BALDWIN. I think we had a lot of discussion and would share a concern about creating some sort of significantly large new bureaucracy. What instead we have done is create a State Health Innovation Commission. It is of limited duration. It is to solicit and receive the applications from the states, try to assure some diversity and to recommend back to the Congress of the United States a slate of proposals to be given grant funding and to be analyzed over the course of a 5-year pilot program.

It is limited in terms of funding for this entity, and we would foresee that it would not be something that would be a permanent part of the bureaucracy. It would be housed within the Department of Health and Human Services, but most of the appointees to the commission are political. They sort of know how Congress works,

how state legislatures work. They would largely not be compensated and would be very much, I think, not what you would describe as a bureaucracy by any means.

Dr. BOUSTANY. Well, I guess the concern I have is: What does it add to what currently is in place with the secretary of health and human services and his staff?

Secondly, my understanding of the bill also creates a whole number of rules changes to the House of Representatives with this expedited section which I have some concerns about, including motions to recommit and certain waivers and points of orders that could be raised, and I think we can work with it as we go forward.

We will have plenty of time to discuss this.

Chairman ANDREWS. We will certainly consult Mr. Price on any changes in the House rules about motions to recommit, I assure you.

Were there any other comments from the members?

Again, we thank our colleagues very much for this very important contribution. We thank you.

We are going to move on to the second panel. I would ask them to take their seats. Again, I apologize for the delay in getting to this portion of the hearing.

All right. Well, ladies and gentlemen, welcome to the subcommittee. The procedure we are going to follow is I am going to read a brief introduction of the witnesses. We will get through each of the introductions and then start on the statements.

As you may have heard with the first panel, your written statements will be made a part of the record in their entirety, and we would ask you to do a 5-minute oral synopsis of your statement.

You will see the light box that is in front of you. When the light indicates yellow, it means you have 1 minute remaining. When it reaches red, we would ask you to wrap up so we can get to questions.

Again, we very much appreciate everyone's presence.

Mila Kofman is an associate research professor at Georgetown University Health Policy Institute. She conducts a range of studies on the uninsured and underinsured problems focused on private market reforms, regulation, access and affordability. Ms. Kofman has testified on several occasions before the U.S. Senate, our House of Representatives and state legislatures. She is recognized and cited as a national expert on insurance regulation, unauthorized insurance and ERISA. She was a federal regulator at the U.S. Department of Labor from 1997 to 2001. Ms. Kofman holds a law degree from the Georgetown University Law Center and a B.A. degree in government and politics from the University of Maryland at College Park, summa cum laude.

Welcome, Ms. Kofman.

I want to ask if my colleague from Maryland, Mr. Sarbanes, will introduce our next witness, as he has worked with him and knows him.

Mr. SARBANES. Thank you.

Chairman ANDREWS. Congressman Sarbanes?

Mr. SARBANES. Yes. Thank you, Mr. Chairman. Thanks for holding this hearing, and thank you for letting me join the committee mostly for purposes of introducing John Colmers, who is now the

secretary of the Department of Health and Mental Hygiene in Maryland under Maryland Governor Martin O'Malley.

From November 2000 through January 2007, Mr. Colmers was a senior program officer for the Milbank Memorial Fund. This fund is an endowed national foundation that provides nonpartisan analysis, study, research and communication on significant issues in health policy.

Before that, he spent 19 years—and this is how I came to know him—in Maryland state government, where he held various positions, including executive director of the Maryland Health Care Commission and the Health Services Cost Review Commission which is the agency that oversees Maryland's all-payer hospital rate-setting system.

He has a B.S. from Johns Hopkins University and an MPH from UNC-Chapel Hill and is past chair of the steering committee of the Reforming States Group, a bipartisan group of executive and legislative leaders.

I practiced health-care law for 18 years in Baltimore, and John Colmers was always somebody who had a stellar reputation. I cannot think of anyone better suited to speak to the issues you are addressing today than him.

Thank you very much.

Chairman ANDREWS. Thank you very much, John.

And welcome, Mr. Secretary. We are happy to have you here.

John Morrison was elected as the state auditor of Montana, the commissioner of insurance and securities in November of 2000, and re-elected in 2004. John has been working to reduce the number of uninsured Montanans since taking office. He is a member of the state bar association ethics committee and a coauthor of dozens of opinions on ethical issues. He is a past president of the Montana Trial Lawyers Association. He represented Montana in the states' tobacco litigation, represented the New York Times and other media organizations in the Unabomber case. John received his bachelor's degree in philosophy and politics from Whitman College in the state of Washington and a law degree from the University of Denver.

Mr. Morrison, welcome to the committee. We are delighted to have you here.

I am especially happy to welcome my friend, Kevin Covert, whom I have known for a very long time, both in a professional and personal capacity.

It is great to see you, Kevin.

He is the vice president and deputy general counsel for human resources at Honeywell International. In this role, Kevin leads a department of over 15 legal professionals with responsibility for all legal matters, including litigation, compliance and corporate transactions relating to labor, employment, employee benefits and compensation. Kevin is a graduate of Ryder University, Rutgers University School of Law and NYU, with his LLM in taxation.

Kevin, it is great to have you with us today.

Amy Moore is a law partner at Covington & Burling in Washington, D.C., a fine firm, and co-chairs Covington's employee benefits and executive compensation practice. She advises public and private clients on a wide range of tax, ERISA and employment law

issues concerning all types of benefit programs. She is a graduate of Mount Holyoke College, received an M.A. from the University of Virginia and a J.D. from the University of Virginia School of Law.

Welcome, Ms. Moore. We are happy to have you with us.

And finally, last but certainly not least, the commissioner of New Jersey's Department of Banking and Insurance Steven Goldman. He was sworn into that office on March 20, 2006. Prior to his nomination by Governor Jon Corzine, Commissioner Goldman was a senior member and 22-year veteran of the outstanding firm of Sills Cummis Epstein & Gross where he focused on corporate law, focusing specifically on mergers and acquisitions, banking and finance, joint ventures and leverage buyouts. Commissioner Goldman earned a master's of law in taxation from New York University School of Law, a J.D. from the George Washington University School of Law, and a bachelor's degree in political science from Boston University. He lives in Woodcliff Lake, New Jersey, with his wife and three children.

Welcome, Commissioner Goldman.

Welcome to each of you. Again, we will proceed. Your written statements have been entered into the record.

And, Ms. Kofman, we will begin with your 5-minute oral synopsis. Welcome.

STATEMENT OF MILA KOFMAN, J.D., ASSOCIATE RESEARCH PROFESSOR, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Ms. KOFMAN. Thank you very much, Mr. Chairman. I thank you and the committee for your leadership and willingness to examine how ERISA has been used to impede state-based health-care reform initiatives.

Although I believe we should address the health-care crisis as a nation and develop a national solution to ensure that all Americans have the same basic rights and protections no matter where one life or works, absent meaningful and comprehensive federal reforms, you should look for ways to make it easier for states to act.

A law Congress enacted more than three decades ago, ERISA, has become a major obstacle to states. Unlike public policy discussions three decades ago when ERISA was passed, in 2007, we have 18,000 Americans who die preventable deaths because they are uninsured.

The leading cause of personal bankruptcies in America is having an illness. We have millions without insurance and millions who are underinsured. Eighty percent of the uninsured are in families with either one full-time or part-time worker. One in four people with group coverage and nearly half with individual health insurance spend 10 percent or more of their income on medical expenses.

Health coverage is inaccessible for many, unaffordable for many more, and insecure for those who have it. While some states are trying to respond, ERISA, a 1974 law, is a major obstacle. Today, I will highlight for you three negative impacts that ERISA has had on state efforts.

First, ERISA limits states' ability to reform state-regulated health insurance markets and makes it difficult to pay for coverage expansion programs.

For example, state guarantee-access and rating laws designed to make insurance more affordable for small businesses with sicker workers have been undermined by ERISA, which allows employers to self-insure. When small businesses with healthy workers self-insure, their claims are not pooled with others and coverage is more expensive in state-regulated products as fewer healthy people help pay for the sicker ones.

Another example is when states raise the age of dependent children, like in New Jersey, to the age of 30 to keep people covered longer in group coverage. That requirement does not apply to self-insured ERISA health plans.

Financing coverage expansion has also been a problem. Some states have public-private partnerships, HIPCs, alliances, purchasing pools for individuals and small businesses. While programs vary, none are free and ERISA self-insured plans generally do not help pay for them.

Second, ERISA limits state options when considering broad and comprehensive health-care financing reforms beyond reforming the insurance market.

For example, some states have concluded that employers should help pay for medical coverage for their workers. One way is through fair share laws that establish minimum standards for how much employers contribute. These proposals would assess a penalty on employers that fall below the threshold, and those penalties would help pay for public health programs and clinics.

To this end, Maryland passed the fair share law. The law was immediately challenged and was found preempted by ERISA. In Maryland, the law was a response to many workers of one large company using public insurance programs and clinics and draining public resources. Interestingly, the company in question increased its spending on health care for workers, but challenged the law anyway through one of their associations.

Massachusetts last year passed broad reforms. One new requirement there is that employers with more than 10 employees provide health insurance or pay a fee. Already, there are rumors that some of the lawyers who challenged the Maryland law are looking for businesses to represent in Massachusetts so they can go to federal court and use ERISA to challenge Massachusetts' reforms.

What is important here is that Maryland and Massachusetts laws were carefully crafted to avoid ERISA challenges and ERISA preemption, but as demonstrated in the Maryland case, your odds in Vegas are better than your odds in predicting how ERISA will be interpreted by federal courts.

The third negative impact of ERISA is that it has a deterrent effect. The ERISA threat has stopped many states from considering or even debating certain reforms. Last year, there were 28 states with fair share bills; this year, three had those bills.

There are also practical resource problems. States need upfront money to implement new programs like the Massachusetts Connector. The ERISA preemption risk deters many from even trying.

In conclusion, Mr. Chairman, this committee and the Congress have the power and opportunity to make it easier for states to achieve universal access to health care and coverage.

As you examine the 1974 law, you have many options, three of which include allowing federal regulators to give ERISA exemptions, clarifying that Massachusetts and Maryland type reforms are not preempted or clarifying that certain types of state reforms, beyond Massachusetts and Maryland, are not preempted.

There are, of course, pros and cons to any approach. Whatever you decide to do, however, the time to act is now. Many states will continue to explore what is and is not allowed under ERISA, but this means more litigation, which is not a good way to respond to the health-care crisis or to reform our market.

Thank you for your consideration. I look forward to assisting you as you look for ways to address the health-care crisis in America. The health-care crisis is really a silent disease on the middle class. It is killing the middle class, and I hope that this is the year that Congress will act.

Thank you.

[The statement of Ms. Kofman follows:]

Prepared Statement of Mila Kofman, J.D. Associate Research Professor, Health Policy Institute, Georgetown University

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, Mary-

land'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 cov-

erage 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.

ENDNOTES

[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 mat-

ters 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).

Chairman ANDREWS. Well, Ms. Kofman, thank you very much, and I apologize for mispronouncing your first name. It is Mila, I understand.

Ms. KOFMAN. I respond to everything. [Laughter.]

Chairman ANDREWS. Well, excuse me for that, and thank you for your testimony.

Secretary Colmers, welcome.

STATEMENT OF JOHN COLMERS, SECRETARY, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Mr. COLMERS. Chairman Andrews, Ranking Member Kline and members of the subcommittee, my name is John Colmers. I am the secretary of the Maryland Department of Health and Mental Hygiene, and I appreciate the opportunity to testify before you today on state health-care reforms and the challenges posed by ERISA and opportunities to improve coordination of federal and state initiatives.

As you have already heard, ERISA was adopted in 1974 with the reasonable goal of allowing multi-state employers to offer comparable benefits across state lines. Preemption, however, has had unintended consequences for states and for large numbers of people with private self-funded plans who fall outside of state regulatory oversight.

Maryland has had recent experience in attempting to expand access to a pay-or-play initiative, the Fair Share Health Care Fund Act. My testimony today will offer the benefits of that experience and describe limits on voluntary efforts in states to expand access. I will conclude with some suggested modifications to ERISA in the absence of broad reform or the granting of state waiver authority.

Most state initiatives to voluntarily expand employer-sponsored insurance coverage have attempted to provide low-cost or subsidized product to employers to offer their workers. To date, these voluntary initiatives have had modest success.

Several states have created voluntary programs that offer subsidies to encourage employers to offer insurance or offer those subsidized products to low-income workers. For example, in Maine, they attempted to reach near universal coverage by providing a new source of coverage for small businesses and low-income individuals. There were significant subsidies offered, and yet to date,

the initiative has enrolled less than 20,000 people, well less of the goal that they had established.

Many states have passed laws to allow insurance carriers to sell products that do not include all of the state required benefits. In Maryland, for example, we have a limited benefit policy, and after a year of being offered, only one group has enrolled 10 people. This leaves states to consider mandatory approaches. To the extent that these strategies place requirements on employers, however, they run headlong into federal preemption of ERISA.

Maryland's experience with the Fair Share Health Care Fund Act is an example. That bill gave employers with 10,000 or more employees a choice: either spend at least 8 percent—or in the case of a nonprofit plan, 6 percent—of their payroll on health insurance costs or pay the difference into a fund that supports the Medicaid program. The act was struck down by the federal district court and the Fourth Circuit upheld the lower court's decision.

The state has dropped any further appeal, and while many policymakers and legal scholars have debated whether such pay-or-play approach is allowable under ERISA, it is clear that states attempting these approaches face a long and potentially contentious process with the courts.

In addition to legal obstacles, many states face practical obstacles to mandated approaches. Most states have porous borders and need to remain economically competitive with their neighbors. The only state that has an employer mandate in place is Hawaii, and they have the luxury of thousands of miles of ocean surrounding it.

A sustainable strategy to cover the nation's 47 million uninsured is likely to build off the base of an employer-sponsored insurance. While state reforms should continue to be supported, in my view, comprehensive reform that affects employers needs to come from the federal government.

However, recognizing that, in the absence of national health-care reform, states will continue to move ahead with what they can. Congress may consider granting ERISA exemptions. It could in the meantime adopt more modest changes that could help states move forward.

These might include:

One, explicitly allowing states to apply premium taxes to employer plans. Currently, states have largely leveraged funds through assessments on delivery systems—that is provider taxes—rather than direct assessments on employers. A federally limited premium tax would allow an assessment to be specifically targeted.

Two, allow states to collect data from ERISA plans. Currently states do not have the explicit authority to collect information on who and what is covered by an ERISA plan, and this is information that is critical for state policymakers to plan reforms.

Three, set a federal floor on benefits. A federal floor for benefits or standardization of benefits would assure adequacy of coverage for individuals receiving health-care benefits through ERISA plans.

And finally, four, strengthen consumer protections for those covered by ERISA plans. Strong state consumer protections do not apply to individuals covered by ERISA plans. Currently, limited federal oversight is provided by the Department of Labor, and this

oversight could be strengthened and enforced and could be coordinated with the states.

In summary, states have tried voluntary strategies to encourage employers to offer insurance. These strategies have offered only modest effects. So far, the courts have interpreted ERISA as preventing states from considering mandatory strategies. In the absence of national reform, there are some more modest changes that could be done.

I would echo the chairman's suggestion that the first and foremost thing that you can do is reauthorize SCHIP. It is critically important. You should also consider changes to the Medicaid program to make that much more affordable and easier to operate.

Again, thank you for the opportunity, and I would be happy to answer questions.

[The statement of Mr. Colmers follows:]

Prepared Statement of John Colmers, Secretary, Maryland Department of Health and Mental Hygiene

Chairman Andrews, Ranking Member Kline, and members of the Subcommittee, my name is John Colmers. I am the Secretary of the Maryland Department of Health and Mental Hygiene. I appreciate the opportunity to testify before you today on state health care reform efforts, the challenges posed by the federal Employee Retirement Income Security Act (ERISA), and opportunities to improve coordination of federal and state initiatives.

Background

ERISA was adopted in 1974 with the reasonable goal of allowing multi-state employers to offer comparable benefits across state lines. ERISA preempted state regulation of employee benefit plans. It has had the effect of exempting the health benefits offered by self-funded employers from any regulatory oversight. This occurred because the federal government did not issue regulations for health coverage comparable to those it issued for defined benefit pensions. The combination of preemption and lack of federal action created a regulatory vacuum that exempts health coverage offered by self-funded employers from any oversight. This vacuum segments the insurance market for which the state versus the federal government is primarily responsible. In Maryland, about half of individuals with private sector employer-sponsored insurance are covered by self-funded plans.

The majority of individuals still get their health insurance through their employer. Recent declines in employer-sponsored insurance account for much of the growth in the uninsured; but employer-sponsored insurance remains the centerpiece of our nation's health financing system. The preference for employer-sponsored insurance is embedded in the federal tax system with about $200 billion in tax incentives to purchase insurance through employers.

Voluntary Efforts to Improve Employer-Sponsored Insurance

States have tried to implement a number of voluntary measures to increase the number of individuals who receive health insurance coverage through their employer, or more recently, to halt the erosion of employer-sponsored insurance. Most of these state initiatives have attempted to provide low-cost or subsidized products for employers to offer their workers. To date, these voluntary initiatives have had modest success.

Several states have created voluntary programs that offer subsidies to encourage employers to offer insurance or offer subsidized insurance to low-income workers. The enrollment experience of these programs has usually been well below program goals. Further, the majority of uninsured who are helped by these programs enroll as individuals rather than through their employers. So these efforts have done little to improve the rate of employer-sponsored insurance. Other state initiatives to improve employer-sponsored insurance have also had modest success. For example, many states have passed laws that allow insurance carriers to sell products that do not include all of the state-required benefits. These limited benefit plans have had very low enrollment. This was the case with Maryland's limited benefit policy—after a year of being offered, only one group enrolled with 10 individuals.

Voluntary policies have had limited success in strengthening or sustaining the employer-sponsored insurance system, leaving states to consider mandatory ap-

proaches. To the extent that the strategies place requirements on employers regarding health benefits, they run head into the federal preemption of ERISA.

Maryland's experience with the Fair Share Health Care Fund Act is an example of how state reforms that affect employers are challenging because of ERISA. The Fair Share Health Care Fund Act gave employers with 10,000 or more employees a choice: either spend at least 8% (6% for nonprofit employers) of their payroll on health insurance costs or pay the difference into a fund that supports the Medicaid program. This policy responded to the growing body of evidence that many low-income workers or their dependents are covered by state Medicaid, SCHIP programs, or are uninsured. The Fair Share Health Care Fund Act was struck down by the Federal District Court which held that the law would have required an employer to expand its ERISA health plan which could interfere with the uniform national administration of the firm's plan. In January 2007, the Fourth Circuit Court of Appeals upheld the lower court's decision. The State has dropped any further appeal of the decision. Many policy makers and legal scholars have debated whether or not a "pay or play" approach is allowable under ERISA, but it is clear that states attempting these approaches face a long and potentially contentious process with the courts.

In addition to the obstacle of federal preemption, states find it difficult to go too far in imposing requirements on employers. States have borders and need to remain economically competitive with their neighbors. The only state that has an employer mandate in place is Hawaii. Hawaii's law preceded ERISA and received specific exemption. Further, it is the only island state, sharing borders with thousands of miles of ocean.

A sustainable strategy to cover the nation's 47 million uninsured is likely to build off the base of employer-sponsored insurance. State reforms that affect employer-sponsored insurance are important because they test new ideas. However, comprehensive reforms that affect employers need to come from the national level because of the legal limitation of ERISA as well as the practical limitations on how aggressive states can be in imposing requirements on employers.

Modifications to ERISA

In the absence of national health care reform, states will continue to move ahead with what they can. Certainly, we are seeing evidence of that now with many Governors and Legislatures moving ahead on reforms. ERISA does not allow for state waivers. Therefore, unless there is a favorable court ruling state-specific exemptions would need to be authorized legislatively. While Congress may consider granting such exemptions, it could in the meantime adopt more modest changes that could help states move forward. ERISA could be modified to allow states to test reforms that may be more practical for them to implement. These include:

1. Explicitly allow states to apply premium taxes to employer plans. Currently, states have largely leveraged funds through assessments on the delivery system rather than direct assessments on employers. The Supreme Court held this was allowable in its 1995 Travelers[1] ruling: A premium tax would allow an assessment to be specifically targeted; whereas an assessment on the delivery system has the effect of raising costs for all users of the health system, including those without insurance.

2. Allow states to collect data from ERISA plans. Currently states do not have the authority to collect information on who and what is covered by ERISA plans. This is critical information for state regulators to understand what is going on in their insurance market.

3. Set a federal floor on benefits. Because of ERISA preemption states are not able to define the scope of benefits provided by ERISA plans. A federal floor for benefits or standardization of benefits would assure adequacy of coverage for individuals receiving health benefits through an ERISA plan.

4. Strengthen consumer protections for those covered by ERISA plans. Maryland approved strong consumer protections and oversight several years ago, but those protections do not apply to individuals covered by ERISA plans. Currently, limited federal oversight is provided by the Department of Labor. This oversight should be strengthened and enforcement should be coordinated with states.

Conclusion

States have tried voluntary strategies to encourage employers to offer insurance. These strategies have resulted in only modest enrollment. So far, the courts have interpreted ERISA as preventing states from considering mandatory strategies with

[1] N.Y. State Conf. of Blue Cross & Blue Shield Plans v Travelers Insurance, 514 U.S. 645 (1995).

employers. The need for states to remain economically competitive also limits their ability to consider mandatory strategies. Strategies to universally expand coverage that build on the employer sponsored insurance system ultimately need to come from the national level.

In the absence of national health care reform, states can be important testing grounds for reforms. There are specific changes to ERISA that could help pave the way for more states to act.

I appreciate the opportunity to testify and thank you for taking up this important issue.

Chairman ANDREWS. Thank you, Mr. Secretary. I will tell you that we are, as I say, engaged in discussions to try to help more employers find a way to be a part of SCHIP as well.

Mr. Morrison, is your proper title secretary, auditor? What is proper?

Mr. MORRISON. Auditor or commissioner. Just do not call me late for dinner. [Laughter.]

Chairman ANDREWS. Okay. Well, welcome, Mr. Auditor, to the subcommittee.

STATEMENT OF JOHN MORRISON, MONTANA STATE AUDITOR AND COMMISSIONER OF INSURANCE AND SECURITIES

Mr. MORRISON. Thank you, Chairman Andrews, Ranking Member Kline, members of the committee. Thank you for your attention to this issue.

Like other states, Montana has taken the bull by the horns and is working to find new, innovative solutions to solve the health-care crisis. In 2007's legislative session, which we just completed, the state senate and house passed a joint resolution to create an interim committee to study ways to study universal, portable, affordable health insurance coverage for all Montanans that involves private health insurance issuers and incorporates existing public programs. The bill directs the interim committee to examine the concept of a health insurance exchange as well as mandating private universal coverage.

In addition, in 2005, my office prepared legislation that created the Insure Montana Program. Governor Schweitzer joined me in requesting introduction of the bill and signed it into law that year. This program, administered by the insurance department, creates a voluntary purchasing pool for small employers with two to nine employees and provides premium assistance to both the employees based on income and the employers.

In addition, there are tax credits for other small employers who sponsor small group health plans. Insure Montana now makes health coverage affordable for nearly 10,000 Montana small business employees and their families, and with the help of the federal Medicaid waiver, we hope to raise that to 15,000 in the next biennium.

Montana is a rural state with many small employers and a 19 percent uninsured rate. The existing health-care crisis spreads across America, but the best solutions for addressing the problem vary from state to state.

Solutions that work in Massachusetts or in California may not work in Montana, and that is why state-based health reforms may be the most expeditious solution to a growing national problem.

States can experiment with reforms on a smaller scale, so the effectiveness of those reforms can be tested.

ERISA preemption of state regulation has been an obstacle to some state-based health-care reforms and will continue to be an obstacle to some reforms now being contemplated.

For example, the 2007 Montana legislature passed a new law that requires health insurance plans to allow parents to continue to insure their children under the parent's health insurance policy until age 25, even if the child is not a full-time student.

This is a simple, but important reform because the age group between 19 and 30 years old typically has the highest uninsured rates. Continuing to cover those young adults on their parents' policies is a cost-effective way to provide health coverage for those individuals. Dependents who lose coverage under their parents' health plan often end up on public insurance programs or subsidized clinics or incur unreimbursed medical care.

The new law cannot be applied to self-funded employer health plans because of ERISA and, therefore, can only be a partial solution.

As with any study, the HJ 48 interim committee that I described will need to collect data about health plans—benefits offered, number of individuals covered, amount of claims paid and cost of coverage. ERISA generally prevents states from collecting data from self-funded health plans and, therefore, states are left in a position of trying to find solutions for problems to which they only have limited information. State data collection should be safe from ERISA preemption.

Some years ago, Montana created the Montana Comprehensive Health Association, which is our high-risk pool. It is funded by a 1 percent assessment on premiums. Because of ERISA preemption, self-funded employer plans do not contribute to the funding for this program, even though their employees are able to take advantage of the portability and high-risk sections.

In order to keep premiums affordable, we instituted a premium assistance program for individuals who are 150 percent or below the federal poverty level. We sought federal funding for this in 2001, and Montana became a pilot program for the broader federal effort to assist state high-risk pools. However, continued funding for the federal grant program for the high-risk pools has not been reauthorized.

As we in Montana begin to study new reforms to address the health-care crisis, we must always test the ERISA waters. Critics may bring ERISA challenges against state laws, causing uncertainty, significant delay and significant litigation costs. If the states had the ability to apply to the secretary of labor for a waiver of preemption in advance of attempting certain reforms, most of that uncertainty would be removed.

Montana also has a dynamic ballot initiative process, and I am certain that great strides can be made toward covering the uninsured through this process in 2008. However, the specter of ERISA preemption curbs some of the innovative possibilities.

Finally, ERISA preempts states from applying mandated coverages to self-funded employer plans. Most of those mandates provide important preventative health care, such as mammograms, di-

abetic services and supplies and other things. The cost of those kinds of care, when not covered, get shifted on to the narrowing slice of employers and individuals that do have insurance.

From Maine to Montana, states are starting to get serious about ending the health-care crisis. While there are many challenges that require national authority and resources, we hope your approach to health care will empower the states so that we can get out of the wagon and help you pull it over the hill.

[The statement of Mr. Morrison follows:]

Prepared Statement of John Morrison, J.D., Montana State Auditor and Commissioner of Insurance and Securities

Good afternoon. My name is John Morrison, I am the Montana State Auditor, and have served as the Commissioner of Insurance and Securities for the State of Montana since 2001.

I want to thank the committee for inviting me to testify and for being willing to examine this issue of how ERISA may be an obstacle that prevents state-based health care reform.

Like other states, Montana is clearly taking the bull by the horns and attempting to find new, innovative solutions to solve the health care crisis. In the 2007 legislative session, the state Senate and the House passed a joint resolution to create an interim committee to study ways to create "a system of universal, portable, affordable health insurance coverage for all Montanans that involves private health insurance issuers and that incorporates existing public programs." The bill directs the interim committee to specifically examine the concept of a health insurance exchange and the way that such a connector or exchange could be implemented in Montana. In addition, it directs the committee to study the advantages and disadvantages of mandating private universal coverage for all Montanans. [HJ 48]

In addition, in 2005 my office prepared legislation that created the Insure Montana Program. Governor Schweitzer joined me in requesting introduction of the bill and signed it into law that year. This program, administered by the insurance department, creates a voluntary purchasing pool for small employers with 2 to 9 employees and provides premium assistance to both the employees (variable based on income) and the employers. In addition, there are tax credits for other small employers who sponsor small employer group health plans. Insure Montana now makes health coverage affordable for nearly 10,000 Montana small business employees and their families.

Montana is a very rural state, with many small employers and a 19% uninsured rate. The existing health care crisis spreads across this entire country, but the best solutions for addressing this common problem vary widely from state to state because of widely varying demographics. Solutions that work in Massachusetts or in California may not work in Montana, and that is why state-based health reforms may be the most expeditious solution to a growing national problem. States can experiment with reforms on a smaller scale, so that the effectiveness of those reforms can be tested.

ERISA preemption of state regulation has been an obstacle to state-based health care reforms and will continue to be an obstacle to some future reforms now being contemplated by many states. For instance:

1. In 2007 the Montana legislature passed a new law that requires health insurance plans to allow parents to continue to insure their children under the parent's health insurance policy until age 25, even if the child is not a full-time student. This is a simple, but important reform because the age group between 19 and 30 years old typically has the highest uninsured rates. Continuing to cover those young adults on their parents' policies is a cost-effective way to provide health coverage for those individuals. Dependents who lose coverage under their parents' health plan often end up in public insurance programs or subsidized clinics, or incur unreimbursed medical care.

This new law cannot be applied to self-funded employer health plans because of ERISA, and therefore can only be a partial solution.

2. Some years ago, Montana created the Montana Comprehensive Health Association, which offers high-risk pool coverage to individuals who are unable to get coverage in the individual market because of their health status. It also offers coverage to individuals who are federally eligible for portability coverage pursuant to HIPAA. Both of those risk pools are funded by a 1% assessment on all private health insurance premiums written in this state, as well as the premium collected from the indi-

vidual participants. Because of ERISA preemptions, self-funded employer plans do not contribute to the funding for this program, even though their employees are able to take advantage of the portability pool when they lose their employer coverage. The financial viability of this program has been increasingly threatened since the passage of the HIPAA portability requirements. Access to coverage for persons losing employer coverage is a very important consumer protection provided by federal HIPAA law, but the states were left to shoulder the burden of the cost of that reform. ERISA prevents the states from assessing self-funded employer plans, and the entire burden is shifted to persons who pay private health insurance premiums and other state funding sources. Experience in Montana has shown that portability pool participants also tend to be high-risk individuals, and the pool cannot be maintained by premiums alone. Assessments or other funding sources are necessary.

We work hard to keep premiums affordable in this program and, to that end, we instituted a premium-assistance program for individuals who are 150% or below the FPL. We sought federal funding for this initiative in 2001 and Montana became a successful pilot project for the broader federal effort to assist state high-risk pools. However, the only steady source of funding for the program has come from the state because continued funding for the federal grant program for high-risk pools has not been reauthorized.

3. As we in Montana begin to study new reforms to address the health care crisis, we must do so tentatively, always testing the ERISA waters. Critics of health reforms may bring ERISA challenges (valid or not) against state laws, causing uncertainty, significant delay and significant litigation costs, even if the state ultimately prevails. If the states had the ability to apply to the Secretary of Labor for a waiver of preemption in advance of attempting certain reforms, most of that uncertainty, delay, and expense could be eliminated.

The new Montana joint resolution [HJ 48] proposes to study the advantages and disadvantages of mandating private universal coverage: for instance, perhaps a pay-or-play system, as well as the concept of a health insurance exchange. A health insurance exchange could make coverage more affordable and portable by allowing employees to choose their coverage from an exchange offering an array of products, and then carry that coverage with them if they leave that employer. Both of these ideas are significantly different from the current method of delivering health insurance coverage. All of the reform ideas emerging from the states, no matter how promising, must be subject to intense legal scrutiny and are sometimes discarded, simply because the risk of ERISA preemption is too great.

4. As with any study, the HJ 48 interim committee will need to collect data about health plans, benefits offered, number of individuals covered, amount of claims paid, and costs of coverage. ERISA generally prevents states from collecting data from self-funded health plans, and therefore states are left in the position of trying to find solutions for a problem when they have only half the information. State data collection should be saved from ERISA preemption.

5. Montana also has a dynamic ballot initiative process and I am certain that great strides can be made toward covering the uninsured through this process in 2008. I have talked to many stakeholders and found widespread interest in this approach. As we consider different policy options, the specter of ERISA preemption curbs the innovative possibilities.

6. The Insure Montana program has not encountered any direct ERISA challenges. However, the plans offered through the purchasing pool are privately insured and have higher cost premiums because of premium tax and high-risk pool assessments. That means that the cost of supplementing those premiums is higher. Self-funded employer plans are able to maintain lower costs because they do not pay these taxes and assessments and also because those plans do not include state mandates. But the cost savings achieved on the self-funded ERISA side are simply shifted onto the narrowing slice of the market covered by private carriers, including Insure Montana.

7. ERISA preempts states from enforcing mandated coverages as to self-funded employer plans. Most of those mandates provide important preventative health care such as mammograms, diabetic services and supplies, immunizations and well-child care for young children, newborn coverage and maternity coverage. Many individuals, who do not have coverage for these types of important preventative care items, cannot afford to obtain them on their own. Serious health problems can occur and result in costs of uncompensated health care being shifted to the rest of the population that pays for health insurance, both private and self-funded, or some of these individuals may end up in public programs like Medicaid, which all taxpayers must pay for.

From Maine to Montana, states are starting to get serious about ending the health care crisis. The laboratories of democracy are on the march, pioneering re-

forms. While there are many challenges that require the national authority and resources of Congress, we hope that your approach to health care will empower the states so that we can get out of the wagon and help you pull it over the hill.

Chairman ANDREWS. Thank you, Mr. Auditor.

Mr. Covert, welcome to the subcommittee.

STATEMENT OF KEVIN COVERT, VICE PRESIDENT AND DEPUTY GENERAL COUNSEL FOR HUMAN RESOURCES, HONEYWELL INTERNATIONAL, INC.

Mr. COVERT. Thank you, Mr. Chairman, Ranking Member Kline, members of the subcommittee.

I am pleased to have the opportunity to share my views about the importance of ERISA preemption in making it possible for my company and thousands of other employers around the country to offer and administer a comprehensive health benefit plan to our employees.

I am going to spend my time talking less about the theoretical and more about the practical, real-world implications of eroding ERISA preemption to those of us who sponsor employer plans.

Honeywell is a diversified manufacturing company with approximately 120,000 employees worldwide. We have approximately 60,000 employees in the United States, and we operate in all 50 states. We provide our employees with a comprehensive benefits package, including medical coverage that includes core health coverage, prescription drugs, vision and dental care.

We will spend in excess of $500 million in 2007 to provide health coverage to almost 135,000 employees and dependents. We will also spend in excess of $200 million this year to provide health coverage to another 60,000 retirees and their dependents.

By far, health care is the most valued benefit we provide to our employees, and the provision of a comprehensive benefits package is absolutely critical to our ability to attract and retain talent in an ever-increasingly competitive world.

Our employees do not have to go to work every day with the specter of catastrophic financial ruin caused by serious illness hanging over their heads. Moreover, we found that a healthy workforce is a productive workforce. While we have not attempted to quantify it, there is no doubt in our minds that the comprehensive health coverage that we provide to employees accounts for significant annual productivity savings for Honeywell.

Thus, this truly is an example of a win-win proposition. By investing in our people, our employees and their families have the security that a robust health-care package provides, while Honeywell benefits from the resulting productivity that a healthy workforce engenders.

Nevertheless, as health-care costs continue to skyrocket, Honeywell and other employers are increasingly challenged to find creative ways to provide quality care at manageable costs. ERISA preemption is the cornerstone of our ability to offer a comprehensive, affordable health-care package across all 50 states in which we operate. ERISA preemption provides administrative simplicity, business flexibility and cost containment, all of which were part of the

critical balance that Congress struck when ERISA was passed in 1974.

Before the enactment of ERISA, employee benefit plans were regulated by a patchwork of state and local statutes. Employers like Honeywell that provide a benefit to a national workforce encountered tremendous administrative difficulties and extraordinary expense complying with these rules. These rules differ from state to state and sometimes from locality to locality.

If we retreat to that pre-ERISA environment, employers will once again be subject to myriad mandates and regulations that Congress sought to avoid when ERISA was originally enacted. Even if one state's rules impose relatively modest requirements, when viewed from the perspective of an employer's multi-state health plan, such modest variations and requirements will impose significant costs and burdens, and I submit that the financial administrative resources consumed by efforts to comply with a patchwork of local laws will be better spent providing benefits to our employees and their families.

Now, as you all know, we live and operate in a very dynamic global economy. The ability to react quickly and efficiently to changing circumstances, both in the United States and around the world, is crucial to our ability not only to thrive, but to survive as a company. Flexibility is the hallmark of ERISA preemption. It allows employers to tailor their benefit programs to the needs of their own workforces as opposed to the rigidity that a one-size-fits-all state-mandate solution would inevitably foster.

Moreover, large employers have been the vanguard of innovation and cost containment in the health-care arena. Because ERISA preemption allows us to experiment and pilot plan designs, we have been able to mitigate cost increases and affect behavior for the positive.

For example, in 2002, we implemented disease management programs to target high-risk conditions, including asthma, heart disease and diabetes. In 2004, we began a multi-year campaign to educate employees about their own role in their health-care decision-making, providing them with a plethora of decision-making support tools and resources.

And just last year, we instituted a $500 incentive program to encourage our employees with one of eight different conditions that are known to have significant treatment variations—for example, hip replacement, knee replacement, hysterectomy, heart surgery—to seek out quality health information before making that treatment decision.

As a result, while health-care costs have on average increased 10.8 percent over the past 5 years, Honeywell has been able to constrain health-care cost increases to 8.9 percent annually over that same period. Without the flexibility borne of ERISA preemption, that cost containment would not be possible.

Finally, an employer's ability to provide a national workforce with a uniform benefits package results in substantial savings to both the employer and employees. Approximately 70 million Americans receive health coverage under self-insured private-sector health plans. Without ERISA preemption, the complexity of trying to comply with a patchwork of state and local mandates would re-

sult in a massive shift in coverage from self-insured plans to the fully insured market.

According to a recent study by Hewitt Associates, fully insured plans cost on average 11 percent to 12 percent more than self-insured plans because of premium taxes, profit and risk charges, commissions, claims processing and administration charges.

Moreover, the cost of the actual mandates themselves, estimated to be 5 percent of health-care expenditures, would cause costs to spiral further out of control. These added costs would inevitably be felt by employees who are already being asked to shoulder an ever-increasing share of their health-care coverage.

Chairman ANDREWS. Mr. Covert, if we just could ask you to wrap up if you could.

Mr. COVERT. In summary, I think we can all agree that a number of the elements of state reform are laudable goals. However, we urge Congress to tread carefully here, as we need to be cognizant of the law of unintended consequences. By watering down ERISA preemption, we would be stifling the innovative quality improvement and cost-containment initiatives that employers have been leading.

Thank you, Mr. Chairman. I look forward to working with you and your committee to develop a plan that meets the needs of employers, employees and the uninsured alike.

[The statement of Mr. Covert follows:]

Prepared Statement of Kevin Covert, Vice President and Deputy General Counsel for Human Resources, Honeywell International, Inc.

My name is Kevin Covert and I am the Vice-President and Deputy General Counsel for Human Resources at Honeywell. I am a member of the Board of Directors of The American Benefits Council ("Council"), on whose behalf I am testifying today. We would like to thank the subcommittee for holding this important hearing on "Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives." Addressing the issue of uninsured Americans is a serious issue that deserves a thorough review by federal policymakers.

The Council's members are primarily major U.S. employers that provide employee benefits to active and retired workers and that do business in most if not all states. The Council's membership also includes organizations that provide services to employers of all sizes for their employee benefit programs. Collectively, the Council's members either directly sponsor or provide services to retirement and health benefit plans covering more than 100 million Americans.

The Council and its members have played a significant role on numerous health policy issues including supporting public and private initiatives to improve quality and transparency in our health care system, working to help stabilize the availability of retiree health care coverage as part of the Medicare Modernization Act, and serving as an important resource for policymakers on many other legislative and regulatory issues affecting employer-sponsored health coverage. The Council has also published a long-term public policy strategic plan—known as its Safe and Sound report—which lays out a broad agenda of specific improvements in benefits policy designed to achieve "personal financial security" for all Americans, including a range of recommendations intended to make health care coverage more accessible, more affordable and of higher quality.

Honeywell is a diversified manufacturing company with approximately 120,000 employees worldwide. We have approximately 60,000 employees in the United States and we operate in all 50 states. We offer our employees a comprehensive benefits package, including medical coverage that includes core health coverage, prescription drug coverage, dental coverage and a vision plan. We will spend in excess of $500 million this year to provide health coverage to almost 135,000 Americans, at per employee cost of approximately $10,000. We will also spend in excess of $200 million to provide health coverage to another 60,000 retirees and dependents.

Honeywell, like other large employers, has been at the forefront of healthcare innovation. The competitive global markets in which we compete have forced us to

think outside the box in the healthcare arena as we struggle to control costs, while at the same time competing for a limited supply of human capital. In 2002, we implemented disease management programs to target high risk conditions, including asthma, heart disease and diabetes. In 2004, we began a multi-year campaign to educate employees about their role in their own healthcare decision making, providing a plethora of decision support tools and resources. Just last year, we instituted a $500 incentive program to encourage employees with one of eight different conditions that are known to have significant treatment variations (e.g., hip replacement, knee replacement, back surgery, hysterectomy, heart surgery, etc.) to seek out quality health information before making a treatment decision. Thus, it is critical that Congress not do anything with respect to ERISA preemption that would stifle our health care innovation.

ERISA Preemption is Vital to the Voluntary Sponsorship of Health Plans

Employers have an enormous stake in addressing the problem of the uninsured and the rising cost of health care. Employers are directly affected by the costs of uncompensated care for the uninsured, which drives up costs for all health care payors, including private payors like Honeywell as well as government programs. Employers, like Honeywell, are on the frontline of addressing the rising cost of health care through the development of innovative plan designs, implementing wellness programs and promoting transparency in the costs and quality of health care services.

It is critical that federal or state reform efforts not undermine the crucial role that the Employee Retirement Income Security Act of 1974 (ERISA) and employers play in our health care system. ERISA "preempts" state laws that relate to employer sponsored employee benefit plans in order to promote the employer sponsorship of health plans and the uniform administration of benefits. Under ERISA, states retain the right to regulate insurance, however states may not deem ERISA plans to be insurance in order to subject such plans to state regulation.

Simply put, ERISA preemption is vital to the voluntary sponsorship of health plans. Over 70 percent of American workers age 18 to 64 have employer-based health coverage.[1] According to unpublished estimates by the Employee Benefit Research Institute (EBRI), roughly 70 million workers and dependents under age 65 are covered by private sector self insured plans.

Employers depend on ERISA preemption to ensure that coverage can be offered uniformly across the country and administered relatively efficiently. ERISA preemption also gives each employer the flexibility to design the terms of health plans to meet the changing needs of their unique workforce and to attempt to control spiraling health care costs. We strongly believe that legislative responses that affect employers must build on the current federal framework which preserves uniformity in plan design and administration.

State Reforms Raise Concerns for Employers

Although Congress has considered a variety of proposals over the years, states have now taken the lead in addressing the problem of the uninsured. Major initiatives were passed in Vermont, Maryland, Massachusetts and San Francisco, and numerous others are pending in states such as California, New Jersey and elsewhere. While the specifics of each proposal vary, they can be broadly categorized as follows:

• "Pay or Play" or "Fair Share" Laws: Pay or play laws require employers of a certain size to spend a set dollar amount or percentage of payroll for health care. Employers that fail to spend the required amount on health benefits typically must pay a penalty in the form of a tax or a mandatory contribution to state run health care programs. Maryland enacted the most publicized version of a pay or play law (the United States Court of Appeals for the Fourth Circuit found the Maryland law preempted under ERISA). Suffolk County, New York and San Francisco have adopted similar laws.

• Fair Wage Laws: Fair wage laws typically require employers to pay an overall hourly compensation package of a specified amount (e.g., $12/hr). Employers must pay a certain portion of the overall amount in cash (e.g., $9/hr) and the balance in either cash or health benefits. Employers who fail to offer a compliant hourly compensation package face monetary penalties. Municipalities are examining this approach as well.

• Comprehensive reform: Some states have adopted more comprehensive health care reforms, which may include (1) a play or pay assessment on employers that do not provide health coverage that meets a certain standard, (2) reforms of state

[1] See Employee Benefit Research Institute Databook on Employee Benefits, Ch 1at *http://www.ebri.org* (updated April 2007).

insurance markets, (3) a requirement that individuals obtain coverage (the "individual mandate"), (4) expansion of state and federal government health care programs, (5) premium assistance programs for lower wage workers to obtain private insurance, and (6) mandates on employers with uninsured employees to establish cafeteria plans to allow for pre-tax purchase of insurance. To date, Massachusetts and Vermont have adopted comprehensive proposals. A number of other states, including California, are considering proposals.

While a number of the elements of state reform are laudable, including expanding subsidies to purchase private insurance, helping consumers make better health care decisions by comparing health care costs and quality and giving states more flexibility over their use of federal funds to meet their health care needs, certain elements of state-based reform raise significant concerns for employers.

The Council is very concerned about proposals that have the effect of subjecting employers and health plans to a patchwork of state-by-state regulation. Even if one state's rules impose relatively modest requirements, when viewed from the perspective of an employer's health plan that covers employees in multiple states, the cumulative effect of such variations in requirements will impose significant costs and administrative burden.

A seemingly minimal employer mandate such as the requirement in Massachusetts that employers adopt and maintain a Section 125 "cafeteria" plan may create significant administrative burdens.[2] Cafeteria plans are benefit plans, adopted pursuant to Internal Revenue Code section 125, that employers may offer to allow employees to pay for health care coverage (or other qualified benefits) on a pre-tax basis. The Massachusetts reform law requires adoption of a Section 125 plan that satisfies both federal law as well as regulations established by the Commonwealth Connector. The Connector was created to help connect employers and employees with a choice of health care coverage options. Certain individuals, including individuals not eligible for coverage at their place of employment, such as those who work part-time, will be able to purchase insurance through the Connector using pre-tax dollars via cafeteria plans established by their employers.

If all 50 states were to require cafeteria plans, employers would have to establish or modify their cafeteria plans and set up payroll systems to satisfy requirements in each state where they had employees working. For example, we understand that the Massachusetts Connecter program will only receive payroll deductions once-per-month. However, most employers use a two-week pay period. As such, employers with operations in Massachusetts will have to create a wholly separate payroll deduction scheme to meet the Massachusetts requirement. This could be very burdensome if replicated in several states.

Another obvious concern with state reform efforts is with the pay or play or other employer assessments that accompany state law reforms. Because the proposals vary widely in each state, county or municipality, compliance would be extremely complex, if not impossible. Current proposals specify different amounts that must be spent on health benefits and the methods of determining the amounts vary widely. The proposals may include or exclude part-time workers, may use different definitions of employee or employer and count different types of coverage as qualifying coverage. The proposals also require distinct certification and reporting in each jurisdiction. Imagine the cost and difficulty of trying to comply with these rules if they varied in all 50 states (let alone 3,077 counties and 87,525 municipalities). Under this approach, employers would also need to be certain their plans remain in compliance with all future changes to these state and local requirements which would be an extraordinarily difficult challenge.

Employees also understand the importance of employer-sponsored health coverage and the employer's role in financing a large share of its expense. In a survey released earlier this month by the National Business Group on Health, two in three respondents (67%) consider their health plan to be excellent or very good. An even greater number (75%) said they valued it as their most important benefit from their employer and about three in every four respondents said they would prefer to get their health benefits through their employer rather than having a salary increase in order to purchase health coverage on their own.

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[2] One of the employer responsibilities under the Mass Health Care Reform Law is the requirement that employers with 11 or more full-time equivalent employees adopt and maintain a Plan that satisfies both Section 125 of the Internal Revenue Code and regulations established by the Commonwealth Connector. Helping Your Employees Connect to Good Health: Section 125 Plan Handbook for Employers. Version 1.0 (April 23, 2007) p. 2.

ERISA Preemption is Based on Sound Public Policy

We believe that ERISA preemption is based on sound public policy. Federal preemption fosters uniform administration and reduces the costly burden of state-by-state compliance and regulation. Without this essential framework, many employers, including the large employers that overwhelmingly provide health care coverage to their employees, will be forced to choose between increasing the employee share of health care coverage costs or eliminating coverage entirely. The complexity of administering a health care plan that treats workers differently based on the laws of each state (let alone each city) is inconceivable. ERISA preemption was enacted to solve this problem.

ERISA preemption also allows employers to provide uniform benefit packages across the workforce. Employers do not want to create disparities within the work force where employees have different benefits simply based on where they work or live. Instead, benefits need to be tailored to the specific needs of an employer's workforce across state lines.

ERISA preemption also helps mitigate the effect of health care costs as a factor in determining the advantages or disadvantages of operating in different states. Absent ERISA preemption, employers would have incentives to locate in states with less burdensome health care mandates. The high cost of health care already creates a competitive disadvantage for American employers relative to other countries. Allowing states and counties to encumber employers further would expand that gap.

ERISA Waivers are Not the Solution

We believe that any new initiatives at either the state or federal level that address the problem of the uninsured must be pursued in a manner that continues to ensure uniformity in plan design and administration. This will ensure that that employers can continue to be innovators in plan design and cost control.

We are also very concerned that one response would be for federal policymakers to pare back ERISA preemption, or grant states "waivers" from ERISA preemption. Waivers might be tempting because states are already acting and it may be difficult for federal policymakers to develop a consensus for a federal solution.

ERISA waivers raise concerns as to both the mechanics and the efficacy of such a program. Moreover, it is not an easy solution—ERISA waivers will involve a tremendous amount of federal policymaking and oversight. Here are just some of the key issues that would have to be addressed:

• Will the states that are the subject of the waiver be named in federal law? If so, which standards would be used to protect certain state laws and not others?

• Will the process be administered on a case-by-case basis by a federal agency pursuant to federal standards? Is this a full-blown administrative proceeding?

• If an agency is granted authority to issue waivers, what standards would apply to limit the agency's authority or the future scope of state actions? Will states be limited to certain types of mandates or experimentation? Will states be free to force employers to pay for state health care reform?

Needless to say, if the standards for waivers are set in federal law, as they would have to be, then federal policymakers will have to resolve most, if not all, of the policy questions that would have to be addressed in fashioning a uniform, federal approach.

Conclusion

In conclusion, we recognize that the issue of uninsured Americans is a serious problem that requires a careful examination of every policy option. Moreover, the Council believes that changes to the nation's health care system are needed and has put forth in our long-term strategic plan several proposals to dramatically improve the health care system. We think the best approach is a federal solution that builds on ERISA and promotes uniformity and cost containment. The solution must complement, not undermine, the important role that private sector employers play in voluntarily sponsoring self-insured health plans that cover approximately 70 million American workers and dependents.

Again, thank you for the opportunity to share our perspectives.

Chairman ANDREWS. Thank you, Mr. Covert, very much.

There is another series of five votes here. What I would propose to do would be to try to get the statements of Ms. Moore and Commissioner Goldman in. Mr. Kline and I will stay to hear them, and then we will come back.

Unfortunately, it is going to be maybe an hour because of this series of votes. If people have to leave, we understand. Members will come back to ask questions.

So, Ms. Moore, we will proceed with you, and then Mr. Goldman, and we appreciate your patience.

STATEMENT OF AMY MOORE, PARTNER, COVINGTON & BURLING, LLP

Ms. MOORE. Sure. Good afternoon, Mr. Chairman and Ranking Member Kline, members of the subcommittee.

I represent a number of large employers who do business in multiple states and who are struggling with many of the same issues that the states are struggling with and that this committee is concerned about. So I very much appreciate the opportunity to be here this afternoon and speak with you about those issues.

I am happy to be able to affirm that 33 years ago Congress got something right. The thing that Congress got right was the preemption provision of ERISA. It has worked well all of these years. It has made it possible for employers to create uniform health programs that meet the needs of their workforce, and they can be administered efficiently across the country.

It has made it possible for employers to use their purchasing power to keep costs in line, and it has made possible the kind of employer innovation and improvement in health care that you heard Kevin Covert describe at Honeywell and that is also being implemented at large employers across the country.

A sort of urban myth has arisen that the breadth of ERISA's preemption provision was an accident and that the members of Congress at the time did not really foresee the effect that this preemption provision would have on states' efforts to reform health-care plans.

In fact, though, that is not the case. In large part, ERISA's preemption provision was a response to state efforts to reform their health-care system once they had enacted comprehensive health-care reform.

Other states were contemplating it, courts were entering decisions that health plans could be regulated as if they were insurance arrangements, and employers and organized labor were extremely concerned that the effect that these kinds of inconsistent state laws would have on their nationwide health programs.

Congress at the time carefully considered those concerns, weighed the competing interests of the state and the federal system and concluded that a broad ERISA preemption provision was essential to promote the health and vitality of employment-based health care, and I believe that experience has shown over the last 33 years that that judgment was correct.

Individual state mandates might seem like they are not terribly burdensome for an employer to comply with, but each mandate requires an employer to first figure out what the law requires. Does it apply to employees who live in one state and work in another? How does it apply? Who does it apply to?

They have to amend their health plans. They have to renegotiate their agreements with their providers. They have to create a special set of employee communications for the employees in that par-

ticular state, and that can be especially problematic for employers who are trying to post uniform communications on a Web site.

They have to train people who answer hotlines and who communicate with employees to answer questions about the new benefits or the new coverage. They have to revise their claims forms and claims procedures, and because, like the states, they do not have infinite resources, they have to make judgments about whether they need to cut back on other benefits in order to finance these new mandates.

So a seemingly small, seemingly benign state law can have a significant impact on employment-based plans.

There is a great deal that the states can do in the context of ERISA without ERISA waivers to reform access to health insurance, to reform individual and small group markets, to enact individual mandates. There is also a great deal that the states can do to finance health-care reform within their borders.

A great many people, I think, including myself, would love to discover that ERISA prevents the states from taxing corporate income or personal income to finance health reform, but, sadly, I fear that even I do not believe that ERISA preemption is that broad.

So I think that there are opportunities for the states to reform their health systems. The employers would like to work with them, but I think as this subcommittee considers how to address these very serious problems, we would ask that it remember that 160 million Americans under the age of 65 are receiving very good, very affordable health insurance from their employers, and we hope that you will approach this problem as a doctor approaches his patients, with the maxim in mind of first do no harm.

Thank you very much, and I will be happy to answer questions.

[The statement of Ms. Moore follows:]

Prepared Statement of Amy N. Moore, Covington & Burling LLP

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.

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, 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 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, 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]

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] 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:

- 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]

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 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.

ENDNOTES

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

Chairman ANDREWS. Thank you, Ms. Moore.
Commissioner Goldman, welcome.

STATEMENT OF STEVEN GOLDMAN, COMMISSIONER, NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

Mr. GOLDMAN. Thank you. Good afternoon, Chairman Andrews, Ranking Member Kline and members of the subcommittee. I thank you for giving me the opportunity to address you today.

As the chief insurance regulator in New Jersey, I am acutely aware of the crisis our country faces with regard to health insurance coverage. Of nearly 45 million Americans without health insurance in 2005, 8 million were children and 1.3 million live in New Jersey.

But there is some good news because there is an increased level of engagement and innovation at the state level on health reform issues. Just in the past year or so, we have seen major legislation adopted in seven states and reform work under way in six more.

A fundamental principle of insurance is to spread the risk as widely as possible. That principle is undermined by the increasing segmentation of the marketplace into smaller and smaller risk pools. Therefore, a guidepost to New Jersey's reform efforts is the creation of larger risk pools.

The Corzine administration has as a priority reducing the number of uninsured through a comprehensive examination of the current health-care delivery system and its funding mechanisms. The administration's health reform strategy is to expand health coverage in three ways: increase affordability and availability of commercial coverage for individuals and small groups, expand Medicaid and family care to cover people for whom commercial coverage is unaffordable, and strengthen the existing system of reimbursing hospitals for uncompensated care.

At present, this strategy does not require employers or individuals to purchase or contribute to coverage.

A working group chaired by State Senator Joseph Vitali has outlined a plan that would reduce by at least 50 percent the number of uninsured by replacing the New Jersey individual market with a government-sponsored program that would be mandatory for all people not eligible for employer coverage or Medicaid.

The plan would have premiums and other cost-sharing requirements based on income. So it should be affordable for every person required to purchase it. A major obstacle is its cost, estimated in excess of $1 billion, of subsidizing the premiums of low-income enrollees.

The administration continues to share Senator Vitali's goals and to work with him on health-care reform.

These approaches probably require an assessment on both insured and self-funded health benefit plans. Some argue that ERISA preemption precludes such assessments which will leave the burden on insured plans only.

In June of 2006, New Jersey, as part of the National Association of Insurance Commissioners, worked to identify promising state reform proposals and ways in which the federal government could encourage continued innovation and reform at the state level. As a part of that effort, the NAIC created the State Innovations Working Group and the Federal Relief Subgroup which I co-chaired with Commissioner Steve Orr of Maryland.

The groups gathered testimony from many sources and examined ERISA preemption and its effects upon state reform efforts. The subgroup conducted a survey of the states regarding potential preemptive effects of federal laws on innovations related to making health insurance or alternative health-care financing mechanisms more affordable.

One important issue noted was that ERISA complicates the ability of states to implement premium assistance programs as part of their Medicaid and SCHIP programs. Due to ERISA preemption, states cannot require employers to participate in these programs.

States also find it difficult to obtain information about employer coverage because they cannot compel employers to report this information or inform lower-income employees about the opportunity to enroll in a public program.

Thus, preemption undermines what would otherwise be a very effective strategy for helping working families afford the coverage already offered by their employers.

Importantly, in several areas, the states believe they are not actually preempted by federal law, but uncertainty regarding what is permissible has created a threat of protracted legal action to resolve the question and has effectively discouraged the states from acting in theses areas.

The NAIC used the results of the survey to formulate a four-point proposal for federal action that would help encourage more states to undertake innovative reform measures, allowing them to act as the laboratories of democracy. We selected items for inclusion in the proposal to maximize flexibility to confer upon the states and minimize impact on sponsors of multi-state self-insured plans.

New Jersey supports the NAIC proposals, and they are as follows:

Adopt an amendment to ERISA clarifying that data collection requirements are saved from preemption. To minimize the administrative burden of this change, it would not be unreasonable to limit states to collecting the same information from self-insured plans that they collect from fully insured plans.

Two, adopt an amendment to ERISA to clarify that pay-or-play requirements that are neutral as to whether an employer pays an assessment or offers health benefits and makes no requirement regarding the form of benefits offered to employees are saved from preemption.

Three——

Chairman ANDREWS. Commissioner, if you could just briefly wrap up, thank you.

Mr. GOLDMAN. Yes.

Amend ERISA to give the secretary of labor authority to grant waivers.

And, four, create a federal grant program to provide qualified states startup and operating funds.

[The statement of Mr. Goldman follows:]

Prepared Statement of Steven M. Goldman, New Jersey Commissioner of Banking and Insurance

Good morning Chairman Andrews, Ranking Member Kline and members of the subcommittee. Thank you for holding this important hearing and for providing me with the opportunity to present my views on the coordination of state and federal health reform initiatives. My name is Steven M. Goldman, and I am the New Jersey Commissioner of Banking and Insurance. While I testify today in my capacity as Insurance Commissioner, my testimony will also touch on my experience as Co-Chair of the National Association of Insurance Commissioners' Federal Relief Subgroup.

The problem is clear

As the chief insurance regulator for the state of New Jersey, I am acutely aware of the crisis our country faces with regard to health insurance coverage. Nearly 45

million Americans went without health insurance coverage in 2005.[1] Eight million of them were children[2] and 80 percent were from working families.[3] One million, three hundred thousand of these uninsured Americans live in New Jersey, and of these, 230,000 are children. When someone without health insurance needs extensive medical treatment the financial consequences can be devastating and the health consequences are even worse. In 2004 the Institute of Medicine estimated that every year 18,000 deaths in America can be attributed to a lack of health insurance coverage.[4] The challenge before us is great and it is growing every year.

States are leading reform efforts

In the face of these daunting and discouraging statistics, there is some good news. The level of engagement and innovation at the state level on health reform issues has never been higher. Just in the past year or so, we have seen major reform legislation adopted in seven states (Indiana, Massachusetts, Pennsylvania, Rhode Island, Tennessee, Vermont, and Washington) and reform work is underway in at least six more (California, Illinois, Kansas, Maine, Minnesota, and Oregon).

New Jersey experience

New Jersey passed comprehensive health reform legislation in the early 1990s. Almost 15 years of history provides some guidance. We consider our small group market (2-50 employees) very successful. About 900,000 people, over 10% of our population, are covered in this market. This market provides affordable coverage even though eligibility and rates cannot be based on health conditions. Rates can only depend (to a limited extent) on age, gender, and geography. Many of us in New Jersey consider this market to be an easily replicated template for gradual reform.

Our individual market, on the other hand, has not been as successful. In this market, the combination of guaranteed issue, pure community rating (prohibition of rating based on age, gender, and territory as well as health status), and the absence of any rating subsidy has led to increasing rates and decreasing enrollment. Currently, only about 80,000 people, or less than 1% of our population, are enrolled in this market. That being said, changes have been made in this market, including the offering of Basic and Essential policies with rating by age, gender, and territory, that have stabilized enrollment to some extent.

In addition, while the New Jersey individual market is often characterized as having the highest average premiums, these "average" premiums are available to any eligible person. Currently, an eligible individual in New Jersey can purchase a comprehensive HMO policy for about $435 a month, regardless of health condition. Various reform proposals being considered in New Jersey seek to reduce this cost, but no proposal currently being considered does so at the price of creating separate coverage pools or rating for "healthy" and "unhealthy" individuals.

Another interesting initiative in New Jersey is our "Dependent Under 30 Law", which allows unmarried, childless dependents to continue on their parent's coverage by paying the cost of the coverage. This program, which became effective over the past year, has about 7,000 young people enrolled. A number of states have enacted, or are considering enacting, similar laws.

We think that a problem with the current health insurance market is the increasing segmentation of that market into smaller and smaller risk pools. We think a fundamental principle of insurance is to spread risk as widely as possible. A guidepost of our reform efforts is the creation of larger risk pools. The reinsurance of higher cost enrollees in our reform markets would be an example of this principle.

Governor Corzine is a strong supporter of universal health care. In the absence of federal action to address the issue, his administration is proposing significant state reforms to make health care more accessible and affordable.

The Corzine administration's near term health reform strategy is to expand health coverage in three ways: 1) increase the affordability and availability of commercial coverage for individuals and small groups; 2) expand Medicaid and Family Care to cover people for whom commercial coverage is unaffordable; and 3) strengthen the existing system of reimbursing hospitals for uncompensated care to provide a safety net for those who remain uninsured.

In the commercial market, we think it makes sense to combine our individual and small group markets, and develop a reinsurance system to cover the largest claims

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[1] De-Navas-Walt, Carmen, Bernadette. D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, Income Poverty and Health Insurance Coverage in the United States: 2005, Table C-2

[2] Ibid.

[3] Institute of Medicine, Committee on the Consequences of Uninsurance, Insuring America's Health, 4 Principles and Recommendations (Washington, National Academic Press, 2004 p. 163

[4] Ibid. p. 8

in these markets. We estimate that this will reduce individual rates significantly for younger people, reduce small group rates slightly, and reduce the number of uninsured by over 100,000.

Our Medicaid/Family Care initiatives include enrolling the many Medicaid eligible who are not currently enrolled, increasing the coverage of parents in low income families, and a buy in program for high income families to insure their children by paying the full cost of Family Care coverage.

However, this near term strategy still leaves a vast number (over 1 million) NJ residents uninsured, and does not require employers or individuals to purchase or contribute to coverage. A working group chaired by State Senator Joseph Vitale has developed a plan that would reduce, by at least 50%, the number of uninsured. The Vitale plan would replace the New Jersey individual market with a government sponsored plan that would be mandatory for all people who were not eligible for employer coverage or Medicaid. This plan would have significant cost savings (perhaps 10%) compared to commercial coverage. Most important, the plan would have premiums and other cost sharing requirements based on income, so it should be affordable to every person required to purchase it. A major obstacle for this plan is the cost (estimated in excess of $1 billion) of subsidizing the premiums of low income enrollees. Governor Corzine shares Senator Vitale's goals and is committed to working with him.

Both the administration initiative and the Vitale plan probably require, for their success, a broad-based assessment on both insured and self-funded health benefit plans. As discussed below, some argue that ERISA pre-emption precludes such assessments, which will leave the burden of such assessments on insured plans only.

Massachusetts innovation

In Massachusetts, a Republican governor and Democratic legislature were able to bridge the partisan divide to reach agreement on one of the most innovative new programs in many years. This program may merge the small group and individual health insurance markets into a single market operating under a single set of rules, creates a "health insurance connector" that facilitates the purchase of policies by individuals and small businesses, requires all state residents to enroll in health coverage and provides subsidies to those who cannot afford it.

Montana innovation

In 2005, Montana created the Insure Montana program, which assists very small businesses with the purchase of health insurance by providing tax credits to those that already provide coverage to their employees and by providing monthly assistance to obtain coverage through a purchasing pool to those that have not been able to it. Currently the pool provides coverage to 5,100 people from 735 small businesses in Montana, while the tax credits assist an additional 3,800 people from 655 small businesses.

New York innovation

In operation since 2001, the Healthy New York program provides private market coverage for small businesses, sole proprietors, and uninsured workers. Healthy New York reduces premiums through a reinsurance program that reimburses participating carriers for 90 percent of claims between $5,000 and $75,000 for each enrollee. Since its inception, over 300,000 New Yorkers have obtained health insurance coverage through the program, which has reduced premiums by 40 to 70 percent compared to the overall market, depending on the coverage purchased.

Vermont innovation

Almost one year ago today Vermont enacted a new health reform law. Beginning on October 1, the new Catamount Health Plan will provide uninsured state residents with a low-cost health insurance product with an emphasis on preventive care and chronic care management. The state will provide subsidies for low-income individuals to purchase coverage either through the Catamount Health Plan or through employer-provided coverage and will also make significant new investments to improve the quality and cost-effectiveness of care for those with chronic conditions and to create a statewide health information infrastructure to facilitate the sharing of information between health care providers, patients, and payers.

While these programs I have mentioned have all received substantial coverage in the press, many other state efforts have not received as much attention. The National Association of Insurance Commissioners (NAIC) has compiled a catalog of innovative state programs to modernize health insurance and extend coverage to the uninsured, which runs some 90 pages in length.

NAIC efforts to promote state reforms

In June 2006, the NAIC embarked upon an effort to identify promising state reform proposals and ways in which the federal government could encourage continued innovation and reform at the state level. The NAIC's Health and Managed Care (B) Committee held a public hearing to take testimony from state officials, health policy scholars, consumer groups, and insurance industry representatives on promising reform strategies, and created a State Innovations Working Group ("Working Group") to concentrate on the issue and hold further hearings. Since then, the State Innovations Working Group has held two additional hearings to gather testimony, including one in which we examined ERISA preemption and its effects upon state reform efforts.

Noted ERISA expert Patricia Butler testified before the Working Group in September 2006 on the state of ERISA preemption with regard to health reform legislation on the state level. She detailed two key areas in which ERISA complicates the states' abilities to implement innovative health reform plans. First, she told the Working Group, the status of "pay-or-play" assessments on employers was uncertain. A federal district court had recently invalidated a Maryland statute that required all private employers with more than 10,000 employees in the state to spend at least 8 percent of its payroll on health benefits or pay the difference to help fund the state Medicaid program. A federal appeals court later upheld that verdict in a 2-1 decision.[5]

However, she believed a broad-based "pay-or-play" assessment would be likely to withstand an ERISA challenge. To do so, the assessment would have to remain neutral regarding whether employers offer coverage or pay an assessment to the state, could not set standards to qualify for the credit against the assessment, or otherwise refer to ERISA plans.

Ms. Butler also noted that ERISA complicates the ability of states to implement premium assistance programs as part of their Medicaid and SCHIP programs. Due to ERISA preemption, states cannot require employers to participate in these programs. States also find it difficult to obtain information about employer coverage (benefits, premium sharing, employee qualifications, work status, and waiting periods) because they cannot compel employers to report this information or inform lower-income employees about the opportunity to enroll in a public program. Thus, preemption undermines what could otherwise be a very effective strategy for helping working families afford the coverage that is already offered by their employers.

Recommendations

In light of this testimony, the Working Group created a Federal Relief Subgroup, which I co-chaired with Commissioner Steven Orr of Maryland, and directed it to identify areas in which states could use additional flexibility to more effectively pursue reforms that would reduce the number of their citizens without health insurance coverage. The Federal Relief Subgroup conducted a survey of the states, asking them if they had considered the preemptive effect of federal laws on innovations related to making health insurance or alternative health care financing mechanisms more affordable, particularly with respect to the small group market in which small businesses purchase coverage. Fully two-thirds of responding states had encountered situations where federal law preempted, or threatened to preempt, health reform proposals. The remaining third either had not kept track of the preemptive effects of federal laws upon reform proposals or had not encountered any.

It should be noted that in several areas the states believe that they are not actually preempted by federal law, but uncertainty regarding what is permissible has created a threat of protracted legal action to resolve the question, and thus has effectively discouraged the states from acting in these areas.

States reported a wide range of areas in which federal preemptions interfered with their ability to pursue reforms, including the ability to:

- Broadly spread assessments to fund high risk pools across fully-insured and self-insured plans ;
- Broadly pool risk across fully-insured and self-insured plans ;
- Collect data on coverage, benefits, premiums, and utilization from self-insured plans;
- Apply minimum standards to stop-loss insurance to ensure that it is not used to evade state insurance regulation by smaller businesses that lack the funds and expertise to self-insure ;
- Craft reforms that target very small businesses with 10 or fewer employees or persons with high medical costs ;

[5] Retail Industry Leaders Association v. Fielder, 4th Cir. January 17, 2007

• Require employers to provide minimum levels of health benefits ;
• Require self-insured plans to promptly reimburse providers for covered services ;
• Apply state law consumer protections to self-insured plans; and
• Implement a statewide chronic care management and health promotion programs; and
• Create statewide health information networks .

The NAIC used the results of the survey to formulate a four-point proposal for federal action that would help encourage more states to undertake innovative reform measures, allowing them to act as the "laboratories of democracy," testing and fine-tuning different approaches and customizing them to fit different situations in each state. We selected items for inclusion in this proposal in order to maximize the flexibility they confer upon the states, while minimizing the impact upon the sponsors of multistate self-insured plans. It is my belief that Congress could best help the states to make progress by:

• Amending ERISA to clarify that states may require self-insured plans to submit data regarding coverage, premiums, cost-sharing arrangements, and utilization;
• Amending ERISA to clarify that "pay-or-play" assessments that meet specified criteria are not preempted by federal law;
• Granting the Secretary of Labor the authority to grant waivers from ERISA to states that implement comprehensive health reform proposals; and
• Creating a federal grant program to provide grants to states pursuing new and innovative reform ideas.

Data collection

Good data is an essential prerequisite of successful reform. Currently, state policymakers cannot gain a complete picture of health insurance and health care markets, including accurate and comprehensive data on benefits, premiums, cost-sharing requirements, and utilization of care. While state regulators routinely collect this data from licensed carriers providing fully insured plans, it is not clear that they can require sponsors of group health benefit plans and third party administrators to provide it. To get an approximate picture of the benefits, premiums, cost-sharing arrangements, and care utilization associated with self-insured plans in their states, legislators and regulators must rely upon groups such as the Kaiser Family Foundation and the Employee Benefits Research Institute to conduct surveys and supply aggregate data. This data is vital to state policymakers, both in crafting reforms and in administering Medicaid and SCHIP premium assistance programs.

Congress should remedy this situation by adopting an amendment to ERISA clarifying that data collection requirements are saved from preemption. To minimize the administrative burden of this change, it would not be unreasonable to limit states to collecting the same information from self-insured plans that they collect from fully-insured plans.

"Pay-or-Play" Assessments

As noted above, a "Pay-or-Play Assessment" is one which requires an employer to fund employee health benefits to a specified level, or pay an assessment (usually intended to otherwise fund coverage.) States have long held that a properly crafted pay-or-play initiative is not preempted by ERISA, so long as it remains neutral on the question of whether an employer would choose to pay the required assessment or provide health benefits to its employees. Nevertheless, legislative clarification that these programs are permissible within ERISA's regulatory framework would obviate the need for states to defend these programs in court each time they are proposed. I believe Congress should adopt an amendment to ERISA to clarify that pay-or-play requirements that are neutral as to whether an employer pays an assessment or offers health benefits and make no requirements regarding the form of benefits offered to employees are saved from preemption.

Many experts, such as Patricia Butler, believe ERISA already allows for pay-or-play programs, as long as they are structured in a way that does not require self-insured plans to provide a defined benefit package. However, experts also agree that any pay-or-play program could be challenged in court and that a specific allowance in federal law would avoid uncertainty, legal wrangling, and wasted time and money, all of which would impede a state's reform efforts.

Impediment waivers

In addition to the two flexibility proposals above, it is my hope that additional ideas will continue to be developed at the state level, some of which may require additional flexibility from the federal government. We therefore recommend that Congress amend ERISA to grant the Secretary of Labor the authority to grant waivers from that statute for the purposes of encouraging and facilitating innovative

state initiatives to expand health insurance coverage, contain health care costs, and to improve the quality and efficiency of health care. This authority would help states that are crafting as yet unforeseen solutions to the problem of the uninsured and would encourage further creativity at the state level.

Federal assistance

Finally, new and innovative health reforms are costly to develop and implement, and a federal grant program to encourage and assist the states in this process would be very helpful. I believe that a new federal grant program that provides qualified states both start-up and operating funds to develop and implement innovative health insurance reforms that address access and the affordability of health insurance and health care would be an extraordinarily useful and wise use of federal resources. I have reviewed H.R. 506, the Health Partnership Through Creative Federalism and S. 325, the Health Partnership Act and believe that legislation along the same general lines as these bills would be very helpful.

Conclusion

Thank you again for the opportunity to share my thoughts on this important issue. I look forward to working with Congress and this Committee on ways to help the states craft new, innovative, and successful initiatives to ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Please do not hesitate to call upon me if I can be of any further assistance. This concludes my testimony, and I would be happy to answer any questions from the committee.

Chairman ANDREWS. Thank you very, very much.

We will briefly adjourn to go cast some votes. I hope it will be about 45 minutes. It could be longer. Again, if someone has a pressing engagement and must leave, we fully understand, but the members will return after that period to ask questions.

Thank you.

The committee stands in recess.

[Recess.]

Chairman ANDREWS. The subcommittee will resume deliberation.

I want to, again, thank this extraordinarily patient panel of witnesses for what you have endured today. The vagaries of the congressional schedule are sometimes difficult to predict. Thank you very, very much for your patience.

The statements were outstanding. We are very pleased with the contribution that each of you has made to our dialogue and discussions, and we hope that today will not be your last contribution to this discussion, although, given the schedule, you may wish that it would be. But we would invite you to continue speaking with the committee as the process goes on.

I have a few questions.

Mr. Covert, I just wanted to say I know that Honeywell has a well-deserved reputation as an exemplary provider of employee benefits. You treat your employees very, very well, and it is good business to do so, and it is also what the corporate ethic is. I understand that.

About how much does Honeywell spend on health benefits each year as a percentage of its payroll?

Mr. COVERT. Mr. Chairman, I am not sure as a percentage of payroll. It is a little over $500 million on actives and dependents, another $200 million or so on retirees. That is a little over $700 million on sales of $31 billion. I am not sure exactly, but I am quite sure that it is more than 8 percent. We satisfy the Maryland law.

Chairman ANDREWS. Yes. You sort of anticipate my question.

Mr. Colmers, so, if the Maryland law had been upheld by the Fourth Circuit and were on the books today, the what I will call pay-or-play provision would not apply to an employer that had expended more than 8 percent of its payroll. Is that correct?

Mr. COLMERS. Eight percent for for profit; 6 percent for nonprofit.

Chairman ANDREWS. Now, in Maryland, when an uninsured person goes to a hospital, does the person get care?

Mr. COLMERS. Absolutely. Maryland actually is unique in the country in that regard. Maryland is the only state in the country that has an all-payer hospital rate-setting system. New Jersey used to have one. In Maryland, all payers help contribute to fund the funding of uncompensated care.

Chairman ANDREWS. So the person would get care, and because he or she could not pay their bill, am I correct in assuming that other payers who do pay would, in effect, pay that bill, would——

Mr. COLMERS. Absolutely. It is an explicit adjustment to the rates that hospitals charge other payers, and those payers, including Medicare and Medicaid pay for it.

Chairman ANDREWS. So if an employer that has more than the threshold number of employees, which is 10,000, under the Maryland plan, and that employer, let's say, provides less than 8 percent of payroll to health care, if that employer's employees go to the hospital, they get cared for, correct?

Mr. COLMERS. That is correct.

Chairman ANDREWS. And to what extent does that employer participate in paying for that care?

Mr. COLMERS. That the employer contributes? Well, if they are not providing coverage, they are not contributing at all.

Chairman ANDREWS. They are not contributing at all.

Mr. COLMERS. Not directly, no.

Chairman ANDREWS. So if I have 15,000 employees and I do not provide health benefits to most of them or all of them, so I am below the 8 percent threshold, and one of my employees gets into an auto accident, has a brain stem injury, and that person runs up a huge bill, my contribution as an employer is zero to that?

Mr. COLMERS. Yes. Although I would say, with all due respect to the insurance commissioners around here, because it is an automobile accident, it might be a little bit different than——

Chairman ANDREWS. Okay. Let's say the person just has an aneurism. This person just has an aneurism then.

Mr. COLMERS. Yes.

Chairman ANDREWS. Mr. Morrison, in Montana, one of the provisions that you have talked about was the 1 percent premium levy in order to fund a fund designed, as I understand it, for people who are difficult to insure, who are high risk. If one of those uninsured people goes to a hospital in Montana, an uninsured person with an aneurism, do they get care?

Mr. MORRISON. They do, and, as you know, Mr. Chairman, the EMTALA federal law requires across the country a certain level of care in an emergency setting. Montana Hospital Association estimates that they spend over or they provide over $100 million a year in our small population state in uncompensated care. They

then figure that into the rate base, and those rates then affect the reimbursement rates for the insured plans.

Chairman ANDREWS. So what happens is that payers who do pay their bill are cross-subsidizing payers who do not under that system.

Mr. MORRISON. Exactly.

Chairman ANDREWS. Ms. Moore, who should pay that bill? What do you think we should do about that problem?

Ms. MOORE. Well, I think that for employers, we have a voluntary health system. Employers choose how to compensate their employees, and they choose whether to provide health benefits or to provide compensation in some other form.

Chairman ANDREWS. Right.

Ms. MOORE. As long as we have a voluntary system, some employers are going to choose not to provide health coverage at the level that we might think appropriate, but, interestingly, I think 96 percent of employers with more than 100 employees do provide comprehensive health care and are covering those expenses.

Chairman ANDREWS. Okay. My time has expired, but I guess I would ask you to supplement for the record the specific answer to the question I asked, which is who you think should pay the bill, and I think I just heard you say whoever volunteers to pay it.

Ms. MOORE. Yes, I think that is right.

Chairman ANDREWS. Okay. I would yield to the ranking member, Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman.

I, too, would like to thank the witnesses for their incredible patience. Unfortunately, one thing in this place that trumps everything else are votes on the floor, and there is simply nothing we can do about that. So I apologize, and I appreciate your understanding.

Dr. Boustany has to leave, and so what I would like to do now is yield to him so that he can ask his questions.

Dr. BOUSTANY. I thank the gentleman.

I have some simple yes-no questions. Let me start with you, Ms. Moore. Does the ERISA preemption prevent states from subsidizing coverage for low-wage workers or small employers?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Thank you.

What about increasing the transparency of information on health quality and price to give consumers more objective information on where to go for needed health care? Does the ERISA preemption prevent states from doing that?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Does the preemption clause prevent reallocating federal Medicaid matching funds for expanding health coverage to state residents?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Does it prevent regulating insurance premiums charged for health coverage offered to small employer groups and individuals?

Ms. MOORE. No.

Dr. BOUSTANY. Does it prevent enacting an individual coverage mandate for higher-income workers?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Does it prevent expanding coverage under SCHIP or Medicaid?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Does it prevent forming insurance pools for offering more affordable coverage to small employers?

Ms. MOORE. No.

Dr. BOUSTANY. Does it prevent forming insurance pools for high-risk, high-cost individuals who are otherwise unable to afford health coverage on their own?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. Does it prevent states from enacting medical liability reform to lower the cost of defensive medicine and litigation expense?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. And finally, does it prevent reducing or eliminating state-mandated benefits on health insurance coverage?

Ms. MOORE. No, it does not.

Dr. BOUSTANY. I think it is important, as we look at this debate, to understand what the fundamental issue is here, and it is clear that states have many tools. I just mentioned 10. States have many tools to make coverage and medical care more affordable and available for families.

But one tool they do lack is the ability to tax employer-sponsored plans, and my sense of it is that the movement on the part of the states to chip away with ERISA waivers is basically to get their hands on the money. I believe that ERISA waivers are perhaps a thinly veiled attempt to create new taxes, and no one can guarantee that these new costs will not be passed on to the working families.

So, before we open the Pandora's box, why not ask whether new taxes on employers or employer-sponsored health care would actually lower health costs. I think that is a legitimate question to ask.

And I think we have to wonder and ask what happens if we inadvertently dismantle the employer-based health-care system and make it more cumbersome and more expensive to administer. What are the consequences of that because, clearly, it is a system that is working for a segment of our population?

So I think we need to be very clear as we go forward in this debate how we move on this because we all share the same concerns. We all want to make health care more affordable. We want to include the uninsured into the rolls being insured, and there are many tools out there that currently exist.

So I think we have to be honest about what is at stake here.

If anyone wants to comment further, I am certainly happy to entertain your answers or comments.

Yes?

Ms. KOFMAN. Thank you.

I completely agree with you that we certainly do not want to jeopardize or in any way adversely impact the comprehensive benefits that many self-insured large employers offer. The problem is that not all large employers do that, and when they do not, it is the state taxpayers that end up subsidizing the profits of those large employers that do not pay for their workers. So the idea here

is one of equity and fairness in how we finance medical care and coverage.

And the problem for states that I have observed is that even though you have a simple answer from one of the witnesses here that states can and cannot do certain things, it is not so simple when states are challenged using ERISA and, as I mentioned earlier, both Maryland and Massachusetts laws were carefully crafted by many experts to avoid ERISA challenge, and many people thought that they were okay under ERISA, and it turned out that they were not. So there is a whole lot of risk. States are not certain as to how far they can go to develop good mechanisms.

Dr. BOUSTANY. I think the states do have a number of tools that they could use, and we are only starting to see some creative responses. For too long in health care, there has been a lack of creativity in how to deal with this.

I know. I am a heart surgeon. I also was on the board of a community hospital. I also worked in the county hospital system in Louisiana. So we have looked at a number of creative ways on how to deal with this.

And so I think too often the states have not been creative and have just simply looked for more money to throw at a problem without trying to devise a real solution to dealing with this healthcare crisis that I think has continued to grow.

Chairman ANDREWS. Mr. Goldman?

Dr. BOUSTANY. I know my time is up.

Chairman ANDREWS. I think Mr. Goldman just wanted to say something, and then we will go to Mr. Kline.

Mr. GOLDMAN. Yes. Briefly, Congressman, one aspect that is totally nonfinancial is just data collection. It is very difficult to assess the health-care status in your state in its entirety if you cannot collect data from a large segment of the population that is having health care provided for it in a different way, and so that is clearly nonmonetary.

With respect to the monetary aspect, there is a monetary aspect to it. There is no doubt about it. But I do not think the monetary aspect is designed as necessarily the principle driver. There is an effort to bring some fairness across the system because, as was acknowledged, not every employer is Honeywell. Lots of employers are not Honeywell and do not pay a fair share and basically are laying off the same dollars to the state taxpayers, and that is not fair either.

Chairman ANDREWS. The gentleman's time has expired.

The gentleman from Minnesota, the ranking member, is recognized for 5 minutes.

Mr. KLINE. Thank you, Mr. Chairman.

And I am mindful of the fact that it is late. Some of you have made new plane reservations, but even those will run out here shortly.

Just a couple of things for Mr. Covert—and Ms. Moore, for that matter. This issue of data collection that Mr. Goldman has raised. Have you got some position or comment on that? What is the problem with what he is talking about, either one of you, both of you?

Mr. COVERT. I mean, from my perspective, I mean, we really do not have a problem with the data collection and sharing of data.

We would be just as happy to get the information that the states have as well.

From our perspective, what we would ask for, though, is that, you know, the federal regulating agency tell us what you want to know, as we do in the 5500s in the pension area. Tell us what you want disclosed. We are happy to disclose it.

What we do not want to have to do is go out and spend millions of dollars with auditors because every state decides they have a different idea of what it wants to know and how it wants it to be reported. If the federal government were to determine that they would like us to report and share this data, from my perspective, we do not have an issue with that.

Ms. MOORE. And I think that is generally true of large employers. They are already reporting a lot of data because they are required to under federal law. They are willing to report more if more data would be useful. They are very interested in getting data on health-care outcomes to improve their own programs, but their principle concern is that they not be exposed to the 50 different requirements in 50 different states.

Mr. KLINE. Okay. Thank you.

Let's talk about the 50 different states and the 50 different requirements. I am very impressed. Honeywell, as we have discussed a couple of times today, has employees in all 50 states, and so the regulation of each state would be of some importance to you.

If the regulations got too complex and passed some or all of the states, you could choose, could you not, to just get fully insured plans or purchase them for your employees, and if you did that, what would the impact be?

Mr. COVERT. Yes, we could, Congressman Kline. The problem with that approach from our perspective and from our employees' perspective is that once you go state by state to the individual or the group fully insured market, you are basically locked into the various mandates of each of those states which means we have less flexibility.

So, if we are in New Jersey, we have to comply with whatever New Jersey has mandated in terms of its insurance products. Minnesota is something different; Texas, something different. So we end up with, you know, a fair degree of difference among the 50 states as they decide on an individual basis what they think is important and what should be covered under the policy.

So we do not have the ability to structure some of the, you know, tools and the cost saving and, you know, innovative ideas that we have come up with to help provide better benefits at lower cost.

It is also a lot more expensive. I mean, if we have to go to Prudential to buy insurance, Prudential is in business to make money. There is a profit load in there. There is a retention piece in there just in case their actuaries are wrong on how much risk and loss they are going to have.

As I noted in my statement, the estimate from Hewitt Associates is that it is 11 percent to 12 percent more expensive to go into the fully insured market than self-insurance because you have all those minimal man costs carved out. You know, if you are paying $10,000 like we are per employee for health care, you add 12 percent on top of that, that is $1,200 more.

Employees are already stretched to the limits. If you add another chunk of that $1,200 on top of them just because we went from self-insured to fully insured, I am not sure that they are going to think that was a great deal.

Mr. KLINE. Okay. Thank you.

Mr. Chairman, I see the light is starting to turn on me as well, and it is late. So I will yield back again with my thanks to the witnesses. You have just been great.

Chairman ANDREWS. Let me reiterate my appreciation for the quality of the testimony, the thoroughness of the analysis.

I did want to say to Commissioner Goldman, we are especially glad you could be with us today. I know this is a very busy time in our state, and I find the NAIC proposals very encouraging as a place to start.

This will be an ongoing dialogue. We welcome your continuing participation.

We are again very grateful for your patience through a very long day, and we thank you very, very much.

The committee will now stand adjourned.

[Additional submissions from Mr. Kline follow:]

[Letter from an employment community follows:]

May 18, 2007.

Hon. ROBERT E. ANDREWS, *Chairman,*
Hon. JOHN KLINE, *Ranking Member,*
Subcommittee on Health, Employment, Labor and Pensions, U.S. House of Representatives, Washington, DC.

DEAR CHAIRMAN ANDREWS AND RANKING MEMBER KLINE: We welcome the opportunity to share the views of the employer community in advance of your upcoming hearing on efforts to cover uninsured Americans. Roughly 160 million Americans are insured—primarily through the offering of voluntary employer-provided health benefits. We support efforts to expand health care coverage and access, but we strongly encourage you to recognize the importance of the Employee Retirement Income Security Act (ERISA) and the role played by its preemption clause in ensuring the ability of employers to maintain uniform national health care plans.

The states are doing significant work on the problem of the uninsured—we applaud those that are approaching this in a responsible manner working closely with all of the stakeholders to seek solutions that expand coverage without overburdening employer-sponsored plans. The uniformity across state lines ensured by ERISA preemption helps protect affordable, uniform coverage for tens of millions of Americans; we believe it is critical that states address the health care crisis in a way that does not violate the ERISA preemption clause.

ERISA provides a crucial framework for offering benefits to American workers. An important provision requires that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *" Referred to as "the crowning achievement of this legislation" by its principal House sponsor Rep. John Dent (D-PA), the provision aims to "round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation * * *"

In a health care system that has many glaring flaws, one of the true victories since the enactment of ERISA has been the success in enabling nationwide plans to cover millions of employees in multiple jurisdictions. This is far more than just a convenience; when employers negotiate contracts with vendors using a standard approach, they have maximum leverage in ensuring the lowest possible premium costs, which greatly benefits plan beneficiaries. It also lowers administrative and compliance costs, which means that more of a company's benefits expenses are spent on the provision of benefits to employees and their dependents than on benefit administration. These advantages would be lost if employers had to negotiate and set up separate plans to comply with the unique rules of each jurisdiction.

We look forward to working with you and your colleagues on these important issues.

AMERICAN BENEFITS COUNCIL,
NATIONAL BUSINESS GROUP ON HEALTH,
BUSINESS ROUNDTABLE,
NATIONAL BUSINESS COALITION ON HEALTH,
CORPORATE HEALTH CARE COALITION,
NATIONAL RETAIL FEDERATION,
THE ERISA INDUSTRY COMMITTEE,
RETAIL INDUSTRY LEADERS ASSOCIATION,
HR POLICY ASSOCIATION,
SOCIETY FOR HUMAN RESOURCE MANAGEMENT,
NATIONAL ASSOCIATION OF MANUFACTURERS,
U.S. CHAMBER OF COMMERCE,
NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS.

[Statement of the ERISA Industry Committee follows:]

Prepared Statement of the ERISA Industry Committee

Mr. Chairman, Ranking Member Kline and Committee Members: Thank you for the opportunity to voice the point of view of major employers that directly sponsor voluntary health care benefit plans for tens of millions of Americans. Today's hearing addresses the issue of state and federal initiatives to expand access and coverage, and the importance of ERISA protections for national health care plans. The ERISA Industry Committee (ERIC) is a non-profit trade association committed to the advancement of employee health, retirement, and compensation plans of America's largest employers. We represent exclusively the employee benefits interests of major employers. ERIC has a strong interest in economic policy affecting our members' ability to deliver those benefits, their cost and their effectiveness, as well as the role of those benefits in America's economy.

Members of ERIC directly sponsor health care and pension plans that cover tens of millions of Americans, providing them the freedom to pursue career opportunities without fear of financial ruin from health care expenses. The employer-sponsored health care system, specifically with support of the national uniformity provisions in ERISA, has allowed American employers to provide workers with the best retirement and health benefits in the global market.

ERISA has played a vital role over the course of the past decades in protecting the health care coverage of American workers and their families, whose employers provide quality health care benefits. Over 160 million Americans have enjoyed the financial security provided by quality, voluntary health care benefits sponsored by major employers across the country.

Heath care costs have persisted in rising in the double-digit for many years, significantly higher than the costs attributable to most companies' core operations. The driving force behind important innovations that have slowed this rise, increasing quality of health care and health insurance for workers while simultaneously controlling costs, has been major employers. Through strategies like drug therapy, disease management and prevention, the medical home model, voluntary mental health coverage, advances in health information technology and personal health records, consumer-driven health plans, value-based purchasing and pay-for-performance initiatives, transparency programs, and myriad other innovations, major employers have brought competition, openness, and improvement to the United States' health care market. This has resulted in vast increases in quality for patients and purchasers, while at the same time helping to curb rising costs.

The erosion of ERISA preemption protections would threaten the affordable and accessible health insurance coverage provided to American workers. Major employers, not legislators or government, have been responsible for the most important improvements in health care in the United States. An employer is attuned to the specific needs of its own workforce, and can better design plan offerings that will meet the needs of its workers, regardless of where they are employed, where they live, or where their medical providers are located.

Rather than the drastic and possibly disastrous proposition of removing ERISA protections from national employer-sponsored health care plans, Congress should consider being proactive in some of the areas that American health care is severely lacking:

We lag behind other countries in implementation of health information technology and electronic health records. American citizens, on average, have no medical home

or primary care physician—driving them to unnecessary emergency room care and inflating the costs of treatments. Health plans in the United States, especially those sponsored or managed by the government, place little emphasis on prevention and disease management, which are the best methods to improve health and control costs. Individuals do not have tax parity with employers in the purchasing of health insurance. Small businesses may not band together to create more powerful purchasing pools. The health care market in the US is misaligned—it is easier to find information on the cost and quality of televisions and MP3 players than on doctors and hospitals.

With all of these (and many other) glaring flaws in the US health care system, there is much to be done that can positively impact access and coverage without threatening the health insurance already provided to more than half of Americans. ERISA has made providing coverage to employees spread across the country affordable and practical, allowing major employers to adhere to rules made by Congress and the Department of Labor—not forcing them to construct a different plan in every state, or worse, every county or city.

Encroaching state and local health care mandates have threatened employers' ERISA protections, raising the specter of vastly increased administrative costs, severely decreased bargaining leverage for plan sponsors, and a balkanized system of coverage. When employers negotiate rates for uniform plans to cover thousands of employees across the country, it allows them to secure the lowest possible premium costs and ensure the most affordable coverage for plan beneficiaries.

While we applaud the efforts of this Committee to explore options that may expand much-needed access and coverage to the more than 40 million uninsured Americans, ERIC members urge you to avoid actions that could jeopardize the positive aspects of our current system. There are many proven ways to expand access, lower the barriers of high costs, and increase coverage for uninsured Americans that will not threaten the affordable and comprehensive coverage offered by major employers.

ERISA preemption of conflicting state regulations has been an invaluable tool in safeguarding the coverage currently provided to more than 160 million American workers and their families, and we urge you to take this into account when evaluating options to bolster state initiatives. We look forward to working with Congress to further efforts that will bolster the voluntary employer-sponsored benefits system, expand coverage for the uninsured, and improve the quality of health care in the US.

Thank you for considering the views of America's largest employers, who sponsor health insurance for so many American workers.

[Statement of the HR Policy Association follows:]

Prepared Statement of the HR Policy Association

Mr. Chairman, Congressman Kline and Distinguished Members of the Subcommittee: We appreciate the opportunity to submit testimony to the Subcommittee on health care reform activity at the state and local level and the importance of ERISA to preserving health care benefits for those covered by group health insurance plans. We strongly believe that your examination of this subject should include recognition of the vital role that ERISA and its strong preemption language play in ensuring the ability of employers to offer uniform benefits nationwide.

HR Policy Association consists of chief human resource officers representing more than 250 of the largest corporations in the United States. From nearly every major industry sector, HR Policy members have a combined market capitalization of more than $8.2 trillion and employ more than 18 million employees world wide. Most of these corporations do business in more than one state and several do business in all fifty states. HR Policy seeks to ensure that laws and policies affecting employment relations are sound, practical, and responsive to the realities of the modern workplace. All of HR Policy's member companies provide health care benefits to employees.

There is no question that the most important domestic policy issue for employers is the current health care crisis. In the United States, employers' share of health insurance costs currently represents 6.8 percent of total employee compensation.[1] Employers' health care costs have increased more than 550 percent since 1981,

[1] Bureau of Labor Statistics, Employer Costs for Employee Compensation (ECEC) online database, *http://www.bls.gov/ncs/ect/home.htm*, series IDCMU2150000000000P, accessed May 2006.

while inflation has only doubled the price of goods and services in the economy during that same period. Rapidly rising health insurance premiums in the United States are damaging the ability of some companies, particularly longer-established ones, to compete in the domestic and international market. According to the Organization for Economic Cooperation and Development (OECD), the United States spent 15.2 percent of its Gross Domestic Product (GDP) on health care in 2003, 30 percent more than Switzerland, which ranked second, and 78 percent greater than the median for all 30 OECD countries.

Moreover, more than 45 million Americans are uninsured, which is injurious not only to those who lack coverage, but employers and society as a whole. The cost of uncompensated care delivered to uninsured individuals is shifted to payers raising premiums for the government, employers, and their employees. In 2005, premiums for family coverage provided by private employers were $922 higher and premiums for individual coverage were $341 higher due to the cost of care for the uninsured. A June 2003 Institute of Medicine study estimated that the uninsured cost the United States from $65 to $130 billion per year in lost earnings and output from absenteeism, chronic poor health, disability and early mortality.

Because of the severity of the problem—and its national character—we fully anticipate that Congress over the next few years will be actively seeking solutions. As the representative of those responsible for the employee benefits of 19 million Americans, HR Policy stands ready to work very closely with the Congress in that effort.

Achieving a national consensus in this area is critical but, thus far, elusive. It is not surprising, then, that the states have stepped into the void and are actively pursuing reforms designed to ensure that the maximum number of their own citizens is covered by health insurance. We generally applaud the energy and creativity of those states that are approaching this in a responsible manner, working closely with all of the affected stakeholders. As they proceed, we have no doubt that there will be many valuable lessons that can be applied to a national solution.

What is prompting the states to act is the very large number of individuals and families in each state who, for a variety of causes, are not covered by health insurance. Enactment of ERISA and the success of its preemption in enabling employers with employees in multiple jurisdictions to offer uniform nationwide plans has been one of the few strengths of our badly flawed health care system. At present, 61 % of employees with private health insurance receive it through employer sponsored health care. It is important that any policy changes made at either the federal, state or local level do nothing to jeopardize the coverage of those who are already insured through the employment-based system.

As you know, ERISA provides in 29 U.S.C. § 1144(a) that its provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *" Referred to as "the crowning achievement of this legislation" by its principal House sponsor Rep. John Dent (D-PA), the purpose of the provision was to "round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation * * *"[2]

Employers with operations throughout the United States seek to maintain uniform benefit policies for their employees for a variety of reasons including the inherent efficiencies for employers, and equity, cost and convenience considerations for their employees. One of the advantages large employers have in securing health insurance coverage for their employees is the size of the pool they bring to the carrier and the economies of scale in administering the program. Multi-state employers are able to offer the most affordable coverage to workers when they negotiate contracts with large vendors using a standard approach to get the maximum amount of leverage and the lowest costs. Employees within multi-state ERISA plans benefit directly from this reduced administrative cost in the form of lower premiums for their coverage. Employers would lose this leverage if they had to negotiate with vendors based on local and state rules rather than a single national standard, which would only exacerbate the challenge that employers face in maintaining affordable benefits.

Large companies employ the use of regional and national health care resources to provide benefits for their workers. For example, some medical centers in major urban areas have expertise in particular procedures, delivering care in a way that lowers costs and raises health care quality. Employers have supported a concentration in regional specialty practices or "centers of excellence" by directing their employee to use carefully selected facilities. ERISA facilitates employer plans to arrange for health care without being limited by the locations of their employees' health insurer, employment or residence.

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[2] 120 Cong. Rec. 29197 (1974).

Employers with self-insured plans have led efforts to promote consumer awareness and decision making about health care cost and quality in an effort to improve the care delivered and lower overall costs. Companies have supported improvements in data collection, patient satisfaction, treatment outcomes, and the use of patients using this data to select providers. ERISA has provided an incentive for employers to invest in quality improvements, measures, and adopt a uniform data standard nationwide. Furthermore, ERISA protects employers seeking these improvements from having to comply with a variety of state definitions for data reporting, which could significantly slow these efforts.

While ERISA permits employers to establish programs that serve their employees without variation across state, city and county lines, it also provides needed flexibility for employers to design their benefit plans. Companies retain the flexibility to vary health benefits for reasons related to the needs of their employees, rather than varying benefits based on an employee's state of residence.

Multi-state employers also want to maintain uniform benefits across state lines for equity reasons underlying a common principle that all similarly situated workers within one company should be entitled to similar benefits regardless of the state in which they reside. Uniform benefit policies facilitate understanding for employees and retirees who often travel across state lines during the course of their tenure with one employer. Employees receive the benefit of having consistent and clear plan choices, equitable treatment of like employees residing in different states, and continuous access to health care benefits across state lines.

Furthermore, ERISA remedies provide consistent rights for plan participants from state to state. This equity ensures plan assets are used exclusively to pay for benefits and are not consumed in paying a small number of high damage awards for the benefit of a limited number of beneficiaries.

An enactment by a single state or locality can disrupt this uniformity, resulting in additional administrative costs that simply add to the growing burden of providing health care benefits. If all fifty states act separately, not to mention the thousands of municipalities within those states, it could only make multi-employer plans far less efficient and far costlier for the employers as well as their employees.

Thus, we believe it is critical that, as the states continue to address the health care crisis, they do so in a way that does not violate the ERISA preemption clause. Within this framework, they can continue to pursue solutions to expand health insurance coverage of their residents without undermining the coverage that already exists.

Thank you for this opportunity to express our views.

[Statement of the Society for Human Resource Management follows:]

Prepared Statement of the Society for Human Resource Management

Chairman Andrews, Ranking Member Kline, and Members of the Subcommittee, thank you for holding this important hearing on federal and state initiatives to increase health care access and coverage. The Society for Human Resource Management (SHRM) appreciates the opportunity to submit this statement for the record to highlight our strong support for the Employee Retirement Income Security Act (ERISA).

SHRM is the world's largest association devoted to human resource management. Representing more than 217,000 individual members, the Society's mission is to serve the needs of HR professionals by providing the most essential and comprehensive resources available. As an influential voice, the Society's mission is also to advance the human resource profession to ensure that HR is recognized as an essential partner in developing and executing organizational strategy. Founded in 1948, SHRM currently has more than 550 affiliated chapters within the United States and members in more than 100 countries.

SHRM is well positioned to provide insight on the role of ERISA in the voluntary provision of health care benefits. HR professionals are responsible for designing and implementing health care benefit programs that meet the needs of workers and contribute to organizational success. SHRM's members strive to offer the right mix of benefits to attract and retain top performers while balancing the increasing costs of offering these benefits.

Since rising health care costs are a serious burden for both employers and employees, HR professionals are working to reduce health care costs by driving patient safety and quality improvement efforts through employer health plan purchasing power and employee education. HR professionals are helping to foster change in em-

ployee and provider behavior by educating employees about the cost of health care and how to make purchasing decisions based on quality. By ensuring that employees understand their health care benefits and know how to utilize them efficiently and to their best advantage financially, HR professionals can help control the future cost of employee health benefits.

Despite years of significant cost increases, the majority of employers continue to voluntarily offer health care insurance, providing important health care benefits to more than 160 million Americans. The preemption clause of the Employee Retirement Income Security Act is critically important to the employer-based health care system, providing a national framework for organizations to offer uniform health care plans.

Because ERISA preemption is fundamental in allowing employers to maintain affordable, uniform coverage for employees and their families, SHRM believes that ERISA preemption must be maintained and strengthened. While SHRM supports efforts to expand coverage to the uninsured, allowing ERISA preemption waivers would harm the employer-based health care system and could jeopardize the generous health care coverage of tens of millions of Americans.

While state efforts to increase coverage to the uninsured are laudable, SHRM has serious concerns and reservations with proposals that would violate ERISA by imposing health care spending or coverage mandates, such as the Maryland Fair Share Health Care Fund Act.

Because the Maryland proposal would require employers with a defined number of employees to spend a certain percentage of their payroll on employee health benefits or make a contribution to the state's insurance program, the United States Court of Appeals for the Fourth Circuit concluded that the Act would require employers to restructure their health insurance plans, which conflicts with ERISA's objective to permit the nationally uniform administration of employee benefit plans. SHRM filed an amicus brief in support of the Retail Industry Leaders Association's challenge of the Act, and believes this important decision sends a strong message that self-funded employer plans are governed by federal law.

As Members of the Committee know, the number of uninsured Americans is a serious issue that requires careful examination by policy makers and stakeholders. Major reform of our current health care system, to include expanded coverage, better quality, and lower costs, is a top priority for HR professionals. SHRM applauds the committee for convening this important hearing and looks forward to working with Congress to pursue important reforms that will strengthen the employer-based health care system.

[Letter from the Corporate Health Care Coalition follows:]

CORPORATE HEALTH CARE COALITION,
May 22, 2007.

Hon. ROBERT E. ANDREWS, *Chairman,*
Hon. JOHN KLINE, *Ranking Member,*
Subcommittee on Health, Employment, Labor and Pensions, U.S. House of Representatives, Washington, DC.

DEAR CHAIRMAN ANDREWS, RANKING MEMBER KLINE AND MEMBERS OF THE SUBCOMMITTEE: The members of the Corporate Health Care Coalition (CHCC) commend you for considering ways to address the health care crisis and the unacceptable number of Americans who lack health insurance. As you consider health care reform proposals, we ask that you recognize the importance of the Employee Retirement Income Security Act (ERISA) and the important role that its preemption clause plays in ensuring the ability of large employers to maintain uniform national health care plans.

CHCC is comprised of 17 large, multi-state, predominantly self-insured companies that operate health benefit plans for employees and their families as well as retirees. Our organization is distinguished by its focus on issues that are critical for employers who sponsor health benefit plans on a nationwide basis. Members of CHCC have been in the forefront of efforts to ensure quality and cost-effective benefits since its inception.

Enactment of ERISA and the success of its preemption in enabling employers with employees in multiple jurisdictions to offer uniform nationwide plans has been one of the few strengths of our badly flawed health care system. The benefits of ERISA preemption go beyond administrative convenience for employers. ERISA preemption provides equity, cost and convenience considerations for employees, ensuring that all employees of multi-state employers are treated consistently and fairly regardless of where they work.

When employers negotiate contracts with large vendors using a standard approach, they have the maximum amount of leverage in ensuring the lowest possible premium costs, benefiting employees in the form of lower out-of-pocket expenses for their coverage. This advantage would be lost if employers instead had to negotiate separate plans to comply with the unique rules of each jurisdiction in which they have employees. Eliminating ERISA preemption would ultimately result in higher costs for employers and their employees.

Several states are undertaking efforts to address the problem of the uninsured and other flaws in the system. We praise those that are doing so in a careful manner and working closely with all of the stakeholders to seek a solution that is economically responsible. However, as lawmakers focus on the problem of the uninsured, they should be careful to avoid jeopardizing the benefits of millions of Americans who receive their existing coverage through the employment-based system. ERISA preemption enables large employers to provide comprehensive benefits in a relatively cost-effective manner for millions of Americans. Our members believe that it is critical that, as the states continue to address the health care crisis, their efforts do not weaken the ERISA preemption clause.

Thank you for your attention in this matter.

MARISA L. MILTON,
Executive Director.

[Letter from the Business Roundtable follows:]

BUSINESS ROUNDTABLE,
May 21, 2007.

Hon. ROBERT E. ANDREWS, *Chairman,*
Hon. JOHN KLINE, *Ranking Member,*
Subcommittee on Health, Employment, Labor and Pensions, U.S. House of Representatives, Washington, DC.

DEAR CHAIRMAN ANDREWS AND RANKING MEMBER KLINE: On behalf of Business Roundtable, I commend you for your interest in health care reform and for seeking improvements in the coordination of federal and state initiatives. Our health care system is in need of transformation. We must ensure that all Americans have access to affordable, quality health care coverage, whether their coverage is provided in the private marketplace or through federal or state public programs.

Business Roundtable is an association of 160 chief executive officers of leading U.S. companies with over $4.5 trillion in annual revenues and more than 10 million employees. Counting employees and their families, Business Roundtable companies provide health care coverage for approximately 35 million Americans.

Health care coverage is of critical importance and value to our employees and their families. Employment-based health benefits are the most common form of health insurance for the non-poor and non-elderly according to the Employee Benefits Research Institute. The Employee Retirement Income Security Act (ERISA) is the foundation upon which most employers offer health coverage to their employees. Currently, more than 159 million Americans receive their health insurance benefits through the workplace. ERISA allows employers to create health plans that are tailored to the needs and desires of their employee workforce. Additionally, ERISA allows employers to provide wellness, fitness, disease prevention and management programs. Without ERISA, there would be significantly less health care coverage and less healthy workers in America's workforce.

We look forward to continuing to work with Congress to seriously reform and improve our nation's health care system without harming employee coverage.

Sincerely,

JOHN J. CASTELLANI.

[Statement of Faith Cristol follows:]

Prepared Statement of Faith Cristol, Vice President, Workforce and Tax Retail Industry Leaders Association

Chairman Andrews, Ranking Member Kline, and other Members of the Subcommittee, thank you for the opportunity to discuss retailers' continued support for the Employee Retirement Income Security Act ("ERISA") that encourages employers to voluntarily offer employees health care benefits.

I am Faith Cristol, Vice President of Workforce and Tax at the Retail Industry Leaders Association ("RILA"). RILA promotes consumer choice and economic free-

dom through public policy and industry operational excellence. Its members include the largest and fastest growing companies in the retail industry—retailers, product manufacturers, and service suppliers—which together account for more than $1.5 trillion in annual sales. RILA members provide millions of jobs and operate more than 100,000 stores, manufacturing facilities and distribution centers domestically and abroad. RILA is governed by a Board of Directors that includes the top leadership in some of the country's most innovative and successful companies, including Best Buy Co., Inc., Lowe's Companies, Inc., Target Corporation, The Home Depot, Inc., Wal-Mart Stores, Inc., and other retail leaders.

RILA members recognize that ERISA, in its current form, is crucial to the voluntary provision of health care benefits in this country. Accordingly, RILA applauds Congress both for the passage of ERISA more than 30 years ago and its ongoing oversight of this important area of health care policy, including today's hearing. By allowing multi-state employers to administer employee health care plans uniformly and efficiently on a nationwide basis, ERISA has created this country's system of voluntary, employer-provided health care benefits. As I discuss in further detail below, central to this system is ERISA's preemption of state and local health care spending mandates.

1. RILA Members Are Leaders in Providing Benefits to Employees

For members of RILA, offering competitive salaries and comprehensive benefits is not just good for employees; it is also good for business. Attracting and retaining a qualified and satisfied team of employees is one of the most significant challenges that our members face everyday. Throughout the country, competition for employees is robust, especially in times of low unemployment such as we are experiencing in today's economy.

As a result, RILA members on average pay their hourly employees nearly twice the federal minimum wage, and offer competitive benefit plans that often include health care benefits, employee discounts, profit sharing and retirement savings plans, stock option plans, disability insurance, training and educational opportunities, paid time off, life insurance and other benefits. RILA members want employees who are healthy, productive and satisfied with their jobs—and the competitive nature of their industry demands that they provide attractive employee benefits.

2. ERISA Encourages Employers to Provide Health Care Benefits

Given RILA members' strong economic and altruistic incentives for providing competitive employee benefits, they strongly support current policies that encourage employers to voluntarily provide health care coverage—of which ERISA is a key and indispensable component. When Congress enacted ERISA more than three decades ago, it created a system that encourages employers to offer employee health benefits by permitting them to administer health plans uniformly and efficiently. This is especially important to employers that operate in multiple states, such as RILA's members. Without such uniformity, these employers would be faced with a patchwork of complex and conflicting state regulations that would make providing health care benefits far more challenging.

The national regulatory framework afforded by ERISA gives companies the flexibility they need to meet and respond to the unique requirements of their workforce. This is especially important to retailers who employ a much younger workforce than most industries. In fact, one-third of all retail workers are under 24 years of age, as compared with only 14 percent for all industries. Retailers also have a high percentage of workers who choose to work part time or who work only seasonally, characteristics that lead to high turnover. Given the unique demographics of their workforce, retailers need flexibility in devising health plans that meet their distinctive characteristics and compensate similarly situated employees equivalently, and ERISA gives them that flexibility.

3. ERISA Should and Does Preempt State and Local Health Care Spending Mandates

Today, however, ERISA's uniformity and efficiency are under attack by those seeking to undermine it with a patchwork of state and local governments spending mandates—each imposing a unique set of regulations and costs on the health care benefit plans offered by employers. Specifically, lawmakers in more than 30 states have been lobbied to enact so-called "fair share" legislation to force large employers to spend a percentage of their payroll on employee health care benefits or else pay a fine, in effect, to a state health care fund.

The exact percentages and the size of the companies captured by these spending mandates vary from state to state, but the basic formula is the same: employers with a specific number of workers would be mandated to pay a specific amount or percentage on worker health benefits. To the extent an employer's spending falls

short of these mandated amounts, the difference would have to be paid to a state fund set up by the legislation for the supposed purpose of defraying state expenditures on health care.

By precluding the uniform and efficient administration of health care plans, these spending mandates threaten to undermine this nation's system of employee benefits voluntarily provided by employers. Federal courts have correctly held that these state and local health care spending mandates are preempted by ERISA.

As a result of a legal challenge by RILA, earlier this year the United States Court of Appeals for the Fourth Circuit affirmed a district court decision invalidating a Maryland "fair share" law that attempted to impose a health benefit mandate on employers. Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). This judicial ruling makes it clear that employer health plans are governed by federal law, not by a patchwork of state and local laws. RILA believes the Fourth Circuit's decision sends a strong message that bills containing "fair share" provisions that are under consideration in other states also are preempted by ERISA.

The circuit court held that "[b]ecause 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. We conclude therefore that the Maryland Act is preempted by ERISA."

The Fourth Circuit also recognized that this decision prevents the very type of "regulatory balkanization that Congress sought to avoid by enacting ERISA's preemption provision." Importantly, the Fourth Circuit specifically noted that if it had not affirmed the district court's decision "surely other States and local governments would follow" Maryland in passing laws that "clash[] with ERISA's preemption provision and ERISA's purpose."

This judicial ruling validates the position of the business community[1] that the U.S. Congress enacted ERISA, in part, to create uniformity in national health benefit plans. The single, national regulatory framework afforded by ERISA gives companies the flexibility they need to meet and respond to the unique requirements of their workforce. Businesses generally, and retailers in particular, need to be free to devise health plans that meet the distinctive characteristics of their employees, and ERISA gives them that freedom. This is especially important to employers that operate in multiple states, and ERISA encourages them to offer employee health benefits by permitting them to administer health plans uniformly and efficiently.

ERISA also allows large employers to take advantage of their nationwide purchasing power to help drive down the costs of health care for their employees—the same concept that allows large retailers to offer consumers lower prices on their products.

Supporters of state and local health care spending mandates argue that they are not preempted by ERISA because they do not mandate what benefits an employer must offer. The Fourth Circuit rejected this argument, as well. Maryland argued that its fair share provision was not mandatory because, inter alia, an employer could pay the state a tax in lieu of increasing health care benefits. Id. at 193-97 ("the Secretary relies most heavily on the argument that the Fair Share Act gives employers the choice of paying the state rather than altering their health care spending"). The Fourth Circuit concluded that "this argument fails," noting that "in most scenarios the Act would cause an employer to alter the administration of its health care plans." Id. at 197. "In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA health care benefit plans so as to meet the minimum threshold." Id. at 193. A fair share provision is effectively mandatory because it "leaves employers no reasonable choices except to change how they structure their employee benefit plans." Id. at 197.

In sum, ERISA is the lynchpin of our nation's system of voluntary employer-sponsored health care. If we allow ERISA to be eroded by "fair share" spending mandates or other state and local incursions operating under the auspices of an "ERISA waiver" or otherwise, then we are headed down a dangerous track that could jeopardize employer-sponsored health care in this country. Differing state and local health benefit mandates would only increase health care costs, create benefit disparity among similarly situated employees, and serve as a strong disincentive for employers to offer health coverage.

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[1] Notably, the United States Chamber of Commerce, the Maryland Chamber of Commerce, the Society of Human Resource Management, and the National Federation of Independent Businesses submitted "friend of the court" briefs supporting RILA's legal challenge of the Maryland law.

4. In Addition to Being Unlawful, Health Care Spending Mandates Also Are Unwise

RILA believes it is unwise to restrict the flexibility of businesses by dictating how they should structure their health benefit plans or how much should be spent on those benefits. For this reason as well, RILA members are strongly opposed to state health care mandates.

As noted above, these spending mandates represent a "one-size-fits-all" approach to health care coverage that make no sense for retail businesses that experience a high degree of turnover and employ a much younger workforce than most industries. Moreover, both common sense and economic research show that the burden of health care mandates might very well fall on the employees themselves. State and local spending mandates put pressure on employers to pass the cost of mandated health care benefits onto employees. The companies may look to cut jobs or move out of the jurisdiction altogether. The result is that employees could end up footing the bill for these newly mandated benefits. In the end, many of these employees could be forced to confront the bitter irony that legislation designed to provide employer-based health care leaves them with neither an employer nor health care.

In sum, health care spending mandates implicitly blame the business community for the state's health care problems by placing the burden of solving these problems on employers. They restrict employers' ability to be flexible, to respond to market conditions, and to react to the needs of their employees. Because these spending mandates would significantly complicate and frustrate employers' efforts to provide voluntary health care benefits, RILA opposes them as unwise policy in addition to their being unlawful.

5. Conclusion

ERISA is crucial to the voluntary provision of health care benefits in this country, and a key feature of ERISA is its preemption of state and local health care spending mandates. By barring the creation of a complex and conflicting patchwork of such state and local mandates, ERISA in its current form allows employers to administer employee health care plans uniformly and efficiently on a nationwide basis.

RILA appreciates this opportunity to submit a written statement, and thanks the Committee for addressing this important issue.

[Whereupon, at 5:23 p.m., the subcommittee was adjourned.]