FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

March 22, 2024

The Honorable Virginia Foxx
Chairwoman, Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515-6100

Dear Chairwoman Foxx:

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to the Committee on Education and the Workforce's *Request for Information: ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage*.[1] Central to Families USA's mission is a commitment to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage and care that improves overall health. We share the Committee's concern with rising health care prices and strongly support exploring additional ways to increase the affordability of health care coverage options and ultimately access to high-quality health care.

The United States is in the midst of a severe health care affordability and quality crisis.[2] High and rising health care prices, particularly hospital and drug prices, as well as high and rising health insurance premiums are putting Americans' health and financial security at risk. More than 100 million Americans are saddled with medical debt; half of all Americans forgo medical care due to cost; and a third of Americans indicate that the cost of medical services interferes with their ability to secure basic needs like buying groceries and paying rent.[3,4]

High and rising hospital and drug prices have a significant impact on all families and individuals, but particularly concerning is the impact on working people and their families, including the approximately 99 million workers and their family members who rely on self-funded employer-sponsored insurance (ESI) plans for their health care.[5] Importantly, these rising health care prices are a major driver of skyrocketing health insurance costs, which ultimately come directly out of workers' paychecks as annual increases in ESI premiums and cost sharing.[6]

The total cost of a family ESI plan increased a staggering 272% in the past two decades, rising from $6,438 in 2000 to $23,968 in 2023.[7] As a result, the median U.S. family of four is estimated to have lost more than $125,000 in wages over that time.[8] To make matters worse, workers are increasingly subjected to health insurance plans with larger cost-sharing requirements, including higher-deductible health plans, in an effort to contain

rising health care spending and costs.[9] Deductible-related costs for workers have grown significantly, with the average deductible for an individual employee's coverage nearly doubling in just a decade, from $1,025 in 2010 to $2,004 in 2021.[10]

Workers and employers alike recognize that rising health care costs have become unsustainable. Nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years.[11] At the same time, workers with ESI increasingly cannot access the care they need, with more than a quarter putting off or postponing needed medical care due to the high cost.[12]

In the Committee's request for information, there are four areas that Families USA believes are particularly important and relevant to improving the affordability and quality of health care coverage and delivery, including for people with ESI plans regulated under the *Employee Retirement Income Security Act* (ERISA). These include: Preemption, Reporting Requirements, Medical Loss Ratio, and COBRA and Portability. We offer our suggestions and feedback on each of them as detailed below.

Clarifying ERISA Preemption

Enacted in 1974, ERISA is a federal law that sets minimum standards for most employer-sponsored group health insurance plans, among other fringe employee benefits offered by private employers.[13] The purported goal of ERISA is to allow for the creation of uniform benefit offerings, including health related benefits, so employers operating in multiple states need not offer multiple state-specific benefits as a result of differing state laws and regulations. To facilitate this, ERISA explicitly disallows states from enacting laws and regulations that "relate to" employee health plans, including self-funded health insurance plans, even if they do not directly conflict with federal requirements.[14] Notably, this represents one of the broadest areas of federal preemption in law and significantly diminishes the extent to which states can adopt commonsense reforms that improve health care quality, access and affordability even in circumstances that would not disrupt multi-state benefit design.[15]

For example, due to ERISA preemption, states cannot require self-funded group health plans to report health care utilization and cost data to their all-payer claims databases (APCDs).[16] APCDs represent a critical tool for states to achieve meaningful health care transparency and ultimately to hold the health care system, particularly providers, accountable to delivering the high quality and affordable care that their state residents deserve.[17] **Therefore, FUSA urges the Committee to consider reforms that strengthen states' ability to promote affordable care and rein in rising health care costs involving ERISA self-funded plans, to the benefit of the 99 million people who rely on self-funded plans for their health care.[18] For example, Congress could allow the U.S. Departments of Labor and Health and Human Services to grant state-based waivers that allow additional state action(s) aimed at reining in rising health care costs, such**

as through enactment of APCDs that include claims and other data from ERISA self-funded plans.

In other ways, ERISA includes important federal protections that help to ensure workers across the country have access to high quality health coverage options, including: guaranteeing workers and their families access to basic information about their health benefits, rights to a grievance and appeals process, and ability to file a lawsuit if the plan breaches its fiduciary duties. It also provides certain federal financial oversight of their plans. Moreover, ERISA ensures workers can continue to be enrolled in their health plans for a time after leaving a job, after which they can move to another plan without facing denials or other exclusions for preexisting conditions. These rights are critical to protecting access to life-saving coverage for millions of workers and should be maintained, if not strengthened wherever possible. However, at the same time, ERISA lacks other protections that consumers with ESI urgently need: For example, large employer plans do not have to offer all essential health benefits that other plans such as ACA marketplace plans must cover.[19] Further, the extent of federal financial oversight of ERISA plans is dependent on federal agency staffing. States are in a strong position to augment federal oversight of ERISA self-funded plans and should be considered as partners in ensuring every American worker has high-quality and affordable health care coverage. **Therefore, FUSA urges the Committee to ensure that the Department of Labor has adequate staffing and financial resources for proper oversight of ERISA plans. FUSA also recommends the Committee consider allowing state regulators to partner with federal agencies to provide additional oversight of ERISA plans with a particular focus on plan quality and cost.**

While market forces help to ensure that most large employers provide competitive health benefits, increasingly, small employers are self-insuring, using level-funded arrangements (that is self-funding plus a stop loss policy),[20] or joining associations for purposes of being considered part of a large group. Neither small business owners nor their workers usually have the resources to thoroughly examine benefit arrangements, bargain for strong worker protections, or assure that third-party administrators and multiple employer welfare arrangements meet their fiduciary responsibilities. Moreover, self-insured plans are not part of wider risk pools: when healthier groups self-insure, it can therefore increase costs for groups who need and buy richer benefits.[21] **Therefore, it is essential that the Committee take steps to preserve state authority to regulate, ban or limit the sale of stop-loss insurance to employer groups below a certain size.**

FUSA urges the Committee to consider the following reforms:

- Disallow or limit level-funded arrangements, particularly in the small group and individual markets.
- Consider whether formal partnerships and funding arrangements with states could be used to enhance oversight of self-funded or level-funded arrangements.

- Enhance the minimum level of financial protection in ERISA and ACA compliant health plans. Currently, the Affordable Care Act limits cost-sharing in both individual and group plans. However, the annual limits on cost-sharing grow faster than families' buying power. They have increased from $12,700 for family coverage in 2015 to $18,900 for family coverage in 2024. (If these limits had instead followed the consumer price index, cost-sharing would have been limited to $16,628 in 2024, which is better though still a hefty burden). Out of pocket maximums, as determined in ERISA, should more closely follow and reflect changes in income (such as median income) and purchasing power to ensure that workers and their families are financially protected from high health care costs.
- Require third party administrators to disclose claims data, including negotiated rates and any adjustments made, while separately accounting for administrative fees.[22]

Reporting Requirements: Electronic Disclosures

Electronic disclosures are becoming increasingly common in all aspects of healthcare. Families USA is concerned that plan beneficiaries and patients are signing documents that they may not see or understand, and that they cannot easily retain copies of information important to their legal rights. For example, in hospitals and doctors' offices, patients may be asked to sign on electronic keypads to acknowledge that they have received information about their billing protections and responsibilities when they have not actually viewed these documents. Similar challenges may apply to communications between patients and their health insurers. At a minimum, people should receive either paper or electronic copies of information about their rights and benefits that they can retain and reference when they need it. **Therefore, Families USA recommends the Committee continue to strengthen certain disclosure requirements, particularly those around disclosure through electronic media, that ensure consumers are provided a simple, easy-to-read summary of their health benefit information up front, with any longer legal information in links or to follow.**

Relatedly, consumers will start receiving additional price information in advance of certain medical services as part of the advanced explanation of benefits under the No Surprises Act. It will be important for them to have clear and accessible records of this information that they can refer to as needed.

Medical Loss Ratio

Medical loss ratios (MLRs) are designed to ensure that the vast majority of insurance premium revenue received by a given insurer is used for medical care and health care quality improvement, as opposed to administrative expenses, overhead, and profits. Effectively, MLRs help to constrain insurer costs that are not directly related to providing

health and health care coverage. MLR standards provide significant financial protection for enrollees by constraining the prices at which insurers initially set premiums. Further, they require insurers to provide enrollees and consumers a rebate if premiums were set too high.[23] Each year, MLRs have resulted in significant rebates to enrollees. For example, in 2022, consumers received a total of $947,413,736 in rebates due to protections provided by medical loss ratios.[24]

Families USA would oppose any efforts to weaken medical loss ratios as part of reforming ERISA. In fact, FUSA would strongly support improvements to current MLR standards through further examination of how insurers define their quality expenditures, and how plans distinguish between medical and administrative expenses that entail several layers of contracting. Improvements to MLR are especially critical as insurers continue to vertically integrate across the health care system, such as by buying up independent doctors' offices, which may make it easier for insurers to game MLR requirements.[25]

COBRA and Portability

Former employees often elect to retain their employer-provided health insurance, rather than enrolling in a marketplace plan, when they are in the midst of treatment and are unable to change providers or formularies or reset deductibles. **Therefore, Congress should consider additional special enrollment opportunities that would allow a COBRA enrollee to switch to a marketplace plan after completing a course of treatment.[26]**

Further, for most former employees, the cost of COBRA coverage is simply unaffordable. COBRA premiums often represent the full cost of both the employer and employee share of premiums plus a 2% administrative fee.[27] In fact, on average, the total annual cost of employer-sponsored health coverage offered by firms with 20 or more employees in 2019 was $7,012 for single coverage and $20,599 for family coverage.[28] As a result, the vast majority of recently unemployed people do not elect COBRA coverage; only about 130,000 unemployed non-elderly adults had health coverage through COBRA in 2017, out of more than 11.5 million non-elderly adults who were unemployed that year.[29] **In order to make COBRA a more effective tool in preventing coverage losses, Congress should take additional steps to put in place federal subsidies to offset the high cost of COBRA premiums paid by unemployed workers, particularly during times of high unemployment and economic recession, as included most recently as part of federal COVID-19 relief packages. More affordable COBRA coverage would promote continuity of care, especially among patients with complex and ongoing conditions under treatment.**

Families USA applauds the Committee on Education and the Workforce for exploring additional ways to increase the affordability of health care coverage options and ultimately improve access to high quality health care for our nation's workers and their families. We appreciate the opportunity to respond to the Committee's request for information and stand ready to work with you to ensure families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage and care that improves overall health.

Thank you again for the opportunity to provide comment. Please contact Ben Anderson, Deputy Senior Director of Health Policy (banderson@familiesusa.org) at Families USA with any questions.

Sincerely.

Yael Lehmann

Interim Executive Director

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[5] Kaiser Family Foundation, *Employer Health Benefits: 2023 Annual Survey. https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf*

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healthcare-costs; Prescription Drug Spending in the U.S. Health Care System: An Actuarial Perspective (Washington, DC: American Academy of Actuaries, March 2018), https://www.actuary.org/content/prescription-drug-spending-us-health-caresystem; Benjamin N. Rome, Alexander C. Egilman, and Aaron S. Kesselheim, "Trends in Prescription Drug Launch Prices, 2008- 2021," JAMA 327, no. 21 (2022): 2145–2147, https://jamanetwork.com/journals/jama/article-abstract/2792986.

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[9] Sam Hughes, Emily Gee, and Nicole Rapfogel, "Health Insurance Costs Are Squeezing Workers and Employers," Center for American Progress. November 29, 2022, https://www.americanprogress.org/article/health-insurance-costs-are-squeezingworkers-and-employers/.

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[14] In 1990, the United States Supreme Court interpreted ERISA's language to "exempt self-funded ERISA plans from state laws that 'regulat[e] insurance." For more information, see, Commonwealth Fund, *Reforming ERISA to Help States Control Health Care Costs,* February 9, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2023/feb/reforming-erisa-help-states-control-health-care-costs

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[16] "ERISA: A Bipartisan Problem for the ACA And The AHCA", Health Affairs Blog, June 2, 2017. DOI: 10.1377/hblog20170602.060391

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[19] ERISA plans must cover some newborn and maternity care, preventive services, and certain cancer services, and their coverage of mental health and substance use treatment must be at parity with other services. 29 U.S. Code §1185, §1185a.

[20]In 2020, 14.4% of groups with less than 50 employees were in self-insured plans. Medical Expenditure Panel Survey, AHRQ, https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&prfricon=yes&searchText=insured&subcomponent=2&tableSeries=2&year=-1. Thirty percent of employees in those plans also had stop-loss coverage. https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/tiib2b1b.pdf

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[22] Christine Monahan, Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators | CHIRblog, March 24, 2023

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[28] Ibid.

[29] Ibid.