COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

March 15, 2024

Virginia Foxx
Chairwoman,
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, D.C. 20515-6100

Dear Chairwoman Foxx:

The Council for Affordable Health Coverage (CAHC) is pleased to respond to the ERISA Request for Information issued by the Committee on January 22, 2024. CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care so that all Americans have access to affordable coverage. Collectively, our members, which include large employers offering ERISA plans, provide benefits to tens of millions of Americans.

Employers are the largest source of coverage in the U.S., representing more than half of all covered lives, mostly thanks to ERISA and the protections it provides. Employees love their health benefits, and, according to our recent polling, want Congress to strengthen their health coverage.[1] Unfortunately, policies adopted in the last decade, in addition to rising health costs, inflation, a tight labor market, regulatory red tape, and taxes make it difficult, if not impossible, for businesses of all sizes to provide affordable coverage. Worse, some in Congress want to take away private employer insurance.

CAHC believes Congress should instead strengthen ERISA by 1) expanding options for employers and their employees; 2) providing financial incentives to ensure employer coverage remains viable; and 3) enacting policies to lower the cost of health services and drugs to reduce premiums and out-of-pocket costs.

Request for Information: ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage

Americans primarily finance their health care through health insurance plans offered through their workplace. Most of that work-related coverage is provided through ERISA plans. The focus of ERISA is on large employers, but unions and some smaller businesses also use ERISA's structure to provide valuable benefits to their workers. Indeed, on its 50th birthday, we find ERISA plans evolving and innovating to meet the demands of the modern workforce. As state and federal policies drive more people out of private, fully insured coverage and into public coverage through subsidies and mandates on employers, we encourage the Committee to assess the challenge and strengthen ERISA.

[1]CAHC Polling available here

Assess the Impact of Mandates on ERISA Plans

Often – too often, we believe – Members of Congress tout the benefits of any approach to expanding coverage, addressing access, and improving quality without also seriously considering the costs and trade-offs inherent in almost all policy approaches. Advocates of new benefit mandates and expanded tax subsidies for health coverage often downplay the costs borne by employers, insurers, and ultimately, taxpayers and consumers. For example, the ACA mandated large employers to cover preventive benefits without cost sharing, adopt a medical loss ratio, and set limits on maximum out-of-pocket costs and annual and lifetime limits. More recently, the President's budget proposes to require a $2,000 cap on out-of-pocket costs for prescription drugs. Most would say those changes are beneficial, but they all come at a cost. Without an independent and unbiased understanding of how these benefit mandates impact premiums, we cannot understand how policy changes may drive people out of private coverage and onto public programs.

We urge the Committee to pass legislation to assess the impact current and proposed benefit mandates may have on costs, premiums, and coverage in ERISA. Such an analysis should be conducted by an unbiased entity qualified to make such an assessment, such as the GAO or CBO. Additionally, it would be helpful for CBO to include in all cost estimates for legislation impacting coverage a premium assessment so that Members of Congress might weigh the benefits and costs associated with new policy ideas.

Preemption

State encroachment on ERISA plans continues to be an issue. States have proposed new regulations that would limit employer access to ERISA plans or the stop-loss insurance necessary to mitigate risk. Some states have proposed to ban access to ERISA plans for the small employer market, while others have tried to adopt high minimum stop-loss rules that effectively ban access to ERISA plans for many employers. States have also tried to promulgate rules that include extensive administrative requirements.

Recent litigation surrounding pharmacy benefit managers and the application of certain requirements to ERISA plans have emboldened some states to consider new actions that will further infringe on employer ERISA protections. Those decisions were narrowly applied but states are taking advantage of the ambiguity. ERISA still needs to be protected from state efforts to limit pre-emption.

CAHC believes the Self Insurance Protection Act (SIPA) strikes the appropriate balance. SIPA codifies ERISA protections for employers by barring states from setting policies that would make ERISA plans or stop loss insurance unavailable to employers. This narrow and targeted approach ensures that states can still set appropriate standards that protect employers without creating burdens that will negatively impact the availability of coverage.

Level Funded plans are one type of ERISA plan that has been targeted for regulation by some states. These are plans that reduce risk and streamline administration by offering a fixed monthly price that covers the cost of administration and reinsurance and fully funds the claims' risk for

the year. Employers have plan flexibility and design their plans, and they can shop for the best deals on reinsurance (based on attachment points that make sense) and administrative costs.[2] Some states have started limiting small employers' ability to offer self-funded plans. While states lack jurisdiction over self-funded plans directly (which fall under ERISA and outside of state law in most circumstances), several states have effectively eliminated small employer access to self-funded plans by attempting to make the sale of reinsurance to small employers illegal, banning the sale of level-funded plans to certain size groups, or making the sale of low attachment point plans (which are needed by most small employers seeking a level-funded plan arrangement) illegal.

Congress should protect access to level-funded plans and reinsurance (including low attachment point reinsurance) policies by ensuring they remain available for sale and purchase in all states. This would involve clarifying ERISA preemption with respect to self-funded arrangements for small businesses.

Additionally, lawmakers should strengthen Association Health Plans in their efforts to expand health coverage options, lower premiums, and reduce out-of-pocket costs, especially for employees of small businesses. These plans allow flexibility for a community of employers to offer enhanced benefits that better reflect the needs of the member employers and their employees.

Medical Loss Ratio

Medical loss ratios exist to protect consumers or employers from potentially inflated administrative expenses from the insurer. An MLR requires minimum spending on direct patient care. The employer is taking on the risk as a stand-in for the insurer and essentially paying all medical expenses. Many ERISA plans pay a third-party administrator (TPA) to run their plan, and the administrative expenses are negotiated by the employer. Adding an additional layer of government bureaucracy to the process will provide no value to the union or employer. The stop-loss policies purchased by the employer to mitigate risk do not pay for direct medical care, the policies reimburse the employer for losses outside the expected claims costs. The use of a medical loss ratio makes little sense in the self-funded ERISA market.

ERISA Advisory Council

ERISA may be the most important and complicated health insurance law, but unlike Medicare, it is not run by the federal government. Tens of thousands of employers running their health insurance plans for millions of employees and families will not be well served by more advice and red tape from Washington bureaucrats. Employers choose to self-insure to control their own benefits and usually provide significantly richer benefits than fully insured plans and exceed federal minimum standards.

[2] In Misunderstanding Level-Funded Health Insurance Plans, Is The Administration Missing An Opportunity? | Health Affairs

We do not support expanding the Advisory Council to provide recommendations to Congress at this time. We would support creating an independent entity under the legislative branch, similar to MedPAC, so that oversight is vested in Congress, and responses and recommendations speak primarily to what Congress can and should do, versus what regulators might do. This will help ensure the statute is protected, and that activist regulators are kept in check.

Direct and Indirect Compensation

We believe the changes that required new disclosures are working well and see no reason to revisit this issue. Employers remain free to contract with a variety of self-insured models or to purchase fully insured coverage.

Specialty Drug Coverage

Employers struggle to pay for new and expensive, but massively beneficial therapies. High up-front costs are borne immediately, but savings from reduced hospitalizations and physician office visits accrue over time. As science and medicine advance, this challenge and opportunity will accelerate.

For example, in 2023, four gene therapies, each costing approximately $3 million per treatment, were approved. CAHC's Campaign for Transformative Therapies (CTT) estimates as many as 60 gene therapies will be approved by 2030. These costly treatments provide durable cures for patients suffering from debilitating and painful conditions, but the cost of these miracles taken together may be unaffordable for many employers.

One way to address this challenge is through value-based payment (VBP) arrangements, which generally tie payment for a therapy to realized patient outcomes. As our recent paper[3] on VBPs points out, prescription drugs have been largely left out of the transition to value-based care as government-initiated reforms have focused on services, with drugs being an afterthought or specifically carved out. This has left pharmaceutical manufacturers (manufacturers) and payers (both public - i.e., state Medicaid programs - and private - i.e., commercial plans) on their own to develop value-based care models.

Despite several legal and economic barriers, several states have adopted value-based payment arrangements in Medicaid, which include:

- SUBSCRIPTION-BASED MODELS: State pays a flat fee to a drug manufacturer for unlimited access to a specific drug. In turn, the state must agree to let that manufacturer be the sole provider of said drug.
- OUTCOMES-BASED AGREEMENT MODELS: Manufacturers provide the state supplemental rebates if agreed-upon clinical outcomes are not met.

[3] https://cahc.net/wp-content/uploads/2023/09/CTTVBAWhitePaperv2023FIN-3.pdf

- WARRANTY AGREEMENTS: Some manufacturers are developing alternative models like warranty agreements, whereby third parties other than the manufacturer may make payments to states when patients do not meet predetermined outcomes.

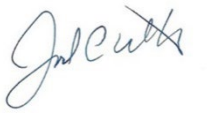
At the same time, the Centers for Medicare, and Medicaid Innovation (CMMI) has proposed a model where states could benefit from pooled risk via reinsurance to help manage drug costs for products included in outcomes-based arrangements.

CTT has supported the use of value-based payment arrangements which help ensure health plans – including Medicaid – pay for value. However, several well-intentioned laws, including the anti-kickback and Stark statutes, make the process more difficult. Based on these experiences and proposals, we believe a number of policy options should be explored to expand value-based payment programs in the commercial sector to address the high costs of innovative therapies similar to what states have already done in Medicaid.

Conclusion

ERISA is vital to keeping 150 million Americans healthy. Congress must ensure its endurance by strengthening and protecting it from state overreach and erosion. As the Committee considers the future of ERISA, CAHC stands ready to serve as a resource.

Sincerely,



Joel White
President