

**“ERISA, THE FOUNDATION OF EMPLOYEE
HEALTH COVERAGE”**

HEARING

BEFORE THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE
COMMITTEE ON EDUCATION AND
THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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**HEARING ON “ERISA, THE FOUNDATION OF
EMPLOYEE HEALTH COVERAGE”**

Tuesday, June 12, 2001

U.S. House of Representatives
Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:32 a.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, Fletcher, Boehner, Roukema, Ballenger, Tiberi, Andrews, Kildee, and Rivers.

Staff present: David Connolly, Jr., Professional Staff Member; Dave Thomas, Legislative Assistant; Jo-Marie St. Martin, General Counsel; Peter Gunas, Director of Workforce Policy; Dave Schnittger, Communications Director; Patrick Lyden, Professional Staff Member; Ben Peltier, Professional Staff Member; Heather Valentine, Press Secretary; Michael Reynard, Deputy Press Secretary; Deborah L. Samantar, Committee Clerk; Heather Valentine, Press Secretary; Brian Compagnone, Minority Legislative Aide; Michele Varnhagen, Minority Labor Coordinator/Counsel; and Camille Donald, Minority Legislative Associate.

Chairman Johnson. Good morning. Thank you all for being here. A quorum being present, the Subcommittee on Employer-Employee Relations will come to order. We are expecting more Members. As you know, the House is not in session until later today. Here is Mr. Ballenger. Thank you for being here. He knows about ERISA.

We are meeting today to hear testimony on ERISA and its impact on employee health coverage. Under committee rule 12(b), opening statements are limited to the Chairman and Ranking Minority Member of the Subcommittee. If other Members have statements, they may be included in the record.

With that, I ask unanimous consent for the hearing record to remain open 14 days to allow Members' statements and other extraneous material referenced during the hearing to be submitted for the official hearing record. Without objection, so ordered.

I am glad to see that we have a quorum in the audience. Thank you all for being here.

***OPENING STATEMENT OF CHAIRMAN SAM JOHNSON,
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS,
COMMITTEE ON EDUCATION AND THE WORKFORCE***

Good morning and welcome to the first health-related hearing of the Subcommittee on Employer-Employee Relations. Today's hearing focuses on the role of the Employee Retirement Income Security Act, or ERISA, and how employers voluntarily improve and provide health insurance to millions of the nation's workers under ERISA.

This hearing is designed to help educate the Members of the Subcommittee as we examine what works as well as the problems facing our employer-sponsored health insurance system.

Thanks to ERISA, the largest number of Americans, 129 million Americans, receives health insurance through their employer. I anticipate additional hearings in the coming months to examine such important topics as: 1) increasing the number of insured, especially employees of small businesses; 2) the effects of claims regulations released by the Department of Labor, as well as other regulatory burdens on employer-provided health plans; 3) ensuring medical privacy; and 4) granting greater protection to workers enrolled in managed care plans.

Over the past 26 years the ERISA preemption of state law has played a key role in providing health insurance to millions of Americans. ERISA covers nearly 80 percent of all workers in this nation. ERISA allows employers and employees alike to agree on a vast array of benefits without significant government interference driving up the cost of health insurance.

Of the estimated 43 million Americans without health insurance, 60 percent are small business owners and their families as well as their employees and their families. Affordable and accessible health insurance for small business enterprises is a priority for this Subcommittee.

When you run a small operation it is absolutely critical that employees and their families are healthy. People perform better when they have peace of mind, knowing their loved ones are healthy, safe and protected.

The same goal of a healthy employee also applies to the nearly 12 million American workers and their families who receive health coverage through multiemployer health plans. Over the past 20 years these plans have been on the cutting edge of providing quality to hard-working Americans and we all learned from their experience.

I look forward to the witness discussion of the role of ERISA in providing health coverage to our 129 million workers. The Subcommittee must be responsive to shortcomings in the health care system, but we must also insist on workable solutions that do not erode coverage or make cost unaffordable.

We need to expand access to more affordable health insurance and reduce the number of uninsured.

Finally, like some of our colleagues in the Senate, we will meet with health professionals, hospitals and other policymakers to study some of the major problems in our health care system, including medical errors.

I hope this hearing will launch this effort in the right direction. This Subcommittee intends to examine improving quality and reducing costs in the coming months and I look forward to working with my colleague Mr. Andrews to address these issues, along with my Vice Chairman, Dr. Fletcher, and the other Members of the Subcommittee.

WRITTEN OPENING STATEMENT, CHAIRMAN SAM JOHNSON,
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON
EDUCATION AND THE WORKFORCE – SEE APPENDIX A

After I recognize Mr. Andrews for an opening statement, I look forward to hearing what these witnesses have to say. Thank you for coming today. We appreciate your presence.

Mr. Andrews, you are recognized for an opening statement.

***OPENING STATEMENT OF RANKING MEMBER ROBERT
ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE
RELATIONS, COMMITTEE ON EDUCATION AND THE
WORKFORCE***

Thank you, Mr. Chairman. Good morning. I look forward to hearing from the four very knowledgeable and talented witnesses we will hear from this morning. I

thank you for charting this course that we are setting off on today to examine and listen to different points of view about some very serious health care issues in the country. I think you deserve credit for initiating this series, and I look forward to continuing to work with you as we go forward in it.

There are three major issues facing the American health care system. None of them is caused by the ERISA statute, but the solution to each issue must be found, I believe, somewhere within the ERISA statute.

The first issue is the question of cost. I have met with hundreds of employers and individuals in my district in this calendar year, and unfortunately we have seen the return of double-digit inflation in health care premiums, at least in my part of the country, and I think around the country. This is unsustainable. It leads us right back to the precipice that we confronted in the early 1990s. We didn't really get it right then, and we haven't gotten it right now. Dealing with the issue of somehow managing to control these costs is an issue for private individuals, private employers, and certainly for the public treasury as well.

A second issue is the issue of quality. There is certainly a strong feeling among many in our country that quality decisions are being interfered with in the area of health care, that decisions about what care a patient needs, what course of treatment should be followed, or what kinds of devices or prescriptions should be used. Too often these are being second-guessed by those who have a financial responsibility and a legitimate financial responsibility, but whose loyalty to that financial responsibility may override the best medical judgment on behalf of the patient and the family.

This has given rise to an intense debate in this Congress in the last three or four years over various versions of patient protection legislation. It is anticipated that the other body will take up one version of that patient protection legislation as early as next week. I hope and anticipate that similar debates will take place on the floor of the House either this summer or this fall. This is an issue that is not going to go away, because it is so deeply felt and perceived by so many Americans.

The third issue is coverage or lack of coverage. As we convene this morning there are 44 million Americans who do not enjoy the benefit of health coverage at all. This number has gone up, not down, despite a time of strong prosperity for most parts of the country.

In the early 1990s the unemployment rate exceeded 7 percent, the federal deficit exceeded \$350 billion a year, indices of economic activity were slumping, and the number of uninsured Americans was about 40 million. Since then the unemployment rate has fallen to below 4 percent at some times, slightly over right now. The federal budget has transformed itself from a deficit of several hundred billion dollars to a surplus of several hundred billion dollars, and by just about any measure the economy is qualitatively stronger than it was 10 years ago.

But the number of uninsured persons has gone up by about 10 percent during that period of time. This is not an accusation. I am making the statement as an observation, that we haven't figured out how to address this problem, and it is a very real, very serious everyday problem for 44 million persons living in this country.

So those are the three issues that I see in front of us. What do we do about the cost explosion that payers for health care are in fact experiencing around the country? What do we do to ensure that medical decisions return to a position of primacy in the relationship between a health care provider and a patient? And what do we do about the national scandal, as I see it, that 44 million of our residents in this country are not the beneficiaries of health insurance at all?

I think that the ERISA statute and its basic formula must be at the center of answering these questions. I don't think that the statute causes any of these problems, but I think that our mutual effort to find a solution will have to be through this statute. About three-quarters of American employers provide some kind of health insurance to their employees. It is a model that works.

I favor its continuation, and I think the starting point for this discussion should be how to take that principle of employer-sponsored health insurance and build on it, so that costs are moderated, quality is improved, and coverage is broadened.

Mr. Chairman, I look forward to the thoughts of the witnesses on these subjects and I thank you for the time.

Chairman Johnson. Thank you, Mr. Andrews. Now I would like to introduce our panel of witnesses.

Our first witness is Gary Ford, who is Managing Principal for Groom Law Group in Washington, D.C. Mr. Ford has over 20 years experience in dealing with ERISA. Next would be Thomas Harter, the Senior Vice President and Consultant of The Segal Company in Washington, D.C. He has over 28 years' experience in compensation and employee benefits. Following him will be Mr. James Klein, President of the American Benefits Council. The Council is a Washington D.C.-based association representing a broad spectrum of employee benefit systems. The last witness on this panel will be Alice Weiss, Director of Health Policy, National Partnership for Women and Families.

I want to thank all of you for coming today. Let me remind you that under our Committee rules oral statements are limited to five minutes. We have a light system down there. I hope you all are familiar with it. It will come on green and then turn yellow when you have one minute left, and then go red.

Your entire written statement can and will appear in the record.

I thank my colleagues on the Republican side for being here with me today. We have a lot of states represented. Kentucky, two Members from New Jersey actually, North Carolina, and Ohio just showed up. So we have a broad section of the United States represented up here to listen to you today.

And with that said, Mr. Ford, will you please begin your testimony?

**STATEMENT OF GARY M. FORD, ESQ., PRINCIPAL, GROOM
LAW GROUP, CHARTERED, WASHINGTON, D.C.**

Thank you, Mr. Chairman. As you mentioned, I am Gary Ford. I am from Groom Law Group. We are an employee benefits specialty firm also known as “ERISA nerds.” We spend our day working on ERISA issues. It should not come as a surprise to you that that is what we do given our field, and I am sure you are not envious of us for that.

This Committee has had a long history in this area and it is a pleasure to be here. Since before ERISA was enacted, this Committee has had an active jurisdiction in the regulation of health care back with John Dent and John Ehrlenborn continuing through COBRA and HIPAA and up to the present day. So it is an honor to be here with a Committee that has had such a pivotal role in crafting ERISA and its provisions.

My assignment, as I understand it, is to talk about some of the legal background very briefly. As you mentioned, almost 130 million Americans are in ERISA-covered plans, so it is hard to overemphasize how important this discussion is.

Let me start by talking about a controversial area in ERISA and that is preemption. Back in 1974 Congress chose the broadest language it could find to preempt state laws that regulate ERISA-covered plans. It said any law that relates to such a plan is preempted.

It then added something called the “savings clause”, which said nonetheless, state laws that regulate the business of insurance are saved from preemption. Then there was concern that that could be a loophole for indirectly regulating ERISA plans and it had the so-called “deemer clause” which said that states can’t use that insurance authority to indirectly regulate ERISA plans, so it is a very broad rule.

There have been 15 to 20 Supreme Court cases alone on the preemption provisions, and I think the state of the law today, while it’s impossible to describe it succinctly, is in summary that laws that conflict with ERISA are preempted. However, there may be some state laws of general applicability that don’t conflict with ERISA and if that is in an area of traditional state regulation, and if there is no evidence Congress intended to preempt them, and if they don’t affect an ERISA plan’s benefits structure, benefit administration, claims processing or enforcement, it may be held, depending on the facts of the case, that they are not preempted but generally, very broad preemption.

So ERISA clears the decks, and then it imposes federal regulation.

The fiduciary rules are one of the key sources of these regulations, and the ERISA fiduciary rules boil down to a requirement of two things; care and loyalty. By “care” we mean that in dealing with issues of the plan you basically need to behave as a diligent expert. You have to be both careful and knowledgeable, as if you were dealing with your own affairs in an informed way.

The other side of the fiduciary rules is “loyalty.” You must have an undivided loyalty when you are acting as a fiduciary to the participants in your plan. One court said you have to have “an eye single” to the interests of the participants, and look at no other factors.

ERISA goes on to add prohibited transaction rules. These are very complex rules that prohibit in advance a whole host of transactions and actions relating to an ERISA-covered plan such as loans and other transactions, self-dealing, kickbacks and the like. These prohibited transaction rules operate in advance and unless there is an exemption granted, they prohibit a whole host of actions before they ever occur.

ERISA also has broad reporting and disclosure requirements. Relevant particularly to Members who answer to their constituents, ERISA requires that a plain English, detailed description of the plan and its provisions, its claims processing rules, and so on, be provided to the individual participants. Then there are voluminous filings made with the government, which are publicly available as well.

On claims processing, ERISA basically contemplates that the participant will make the claim. The plan administrator will then make an initial determination on that claim. If he denies the claim, there is an internal appeal within the plan. If that is denied, then the participant has a right to go to court. Under current law they go to federal court. A judge, not a jury, hears the case. There is some deference given to the decision made by the plan; some weight given to it.

If the participant wins he or she is awarded the benefit that was denied plus, in the discretion of the court, attorney's fees. An area of controversy is if this is enough of a remedy if a benefit has been wrongfully denied.

As I mentioned, this Committee has had an active role in some of the other substantive regulations such as COBRA, which provides continuation health care, HIPAA, which dealt with preexisting condition limitations and enabled workers to move from job to job, and various benefit mandates.

WRITTEN TESTIMONY OF GARY M. FORD, ESQ., PRINCIPAL, GROOM LAW GROUP, CHARTERED, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Johnson. Thank you, sir. We appreciate your testimony.

Mr. Harter.

STATEMENT OF THOMAS R. HARTER, SENIOR VICE-PRESIDENT, THE SEGAL COMPANY, WASHINGTON, D.C.

Thank you, Mr. Chairman.

I am with the Segal Company, which is a consulting firm that for over 60 years has served the greater share of the multiemployer market, which covers approximately 12 million American workers. We believe that we represent more of these types of plans than all of the other consulting firms combined.

The Multiemployer Health and Welfare Funds basically have a number of unusual characteristics. First of all, they operate under the Taft-Hartley Act, where the benefits are operated through a trust fund with equal trustee representation from management and union workers. They are held together by collective bargaining agreements. They cover multiple employers with full portability when employees move from one employer to another. This most typically occurs in the construction, entertainment, transportation, and maritime industries, where an employee might work for a week or a month or even part of a day with one employer and then move to another. Yet all of these employers contribute to a common trust fund.

One of the characteristics is that the contribution rates for these plans are not directly tied to the eligibility of the participant. Rather, they will be represented by cents per hour, dollars per hour of contribution based on hours worked, or perhaps even some production units, such as a ton of coal or something like that. And this money then flows into the trust fund and the trustees are responsible for taking the stream of contributions and providing the best possible plan of benefits that can be provided under this stream of contributions.

Individual employers may not be aware of the details of the plan or even which of their employees are eligible. All of that administration is done through the trust fund, which will either have its own employees administering the plan or contract with a third party administrator to do that work.

The financial structure of a trust fund is quite complicated, because the trustees are obligated to not only collect and enforce contributions under the collective bargaining agreements, but they need to finance the benefits claims for the plans that have been established, whether it be medical, dental, vision, or short term disability.

They need to reserve for their large claims exposure, and for their claims fluctuations exposure. They need to reserve for their eligibility rules, which typically allow people to maintain eligibility even when there are short periods where there is no work, so that eligibility can be maintained. They also need to reserve against economic cycles, because there can be periods where construction is very high. A lot of contributions are coming in. And then there can be periods of years where contributions are much lower.

Finally, they need to concern themselves with any new legal or administrative requirements of law because any added expenses essentially subtract from the money that is available to provide benefits to the participants.

All multiemployer plans are unique, but if you look at their eligibility rules, you will see that they have some unusual features. In the construction industry when there is no work, for example, it is very common to have an employee travel to another state or, say, Houston. Contributions under a collective bargaining agreement would flow into a multiemployer plan in Houston and be transferred back to his home fund in the Washington area. Therefore the worker would be able to maintain eligibility for himself and his dependents.

Another characteristic of multiemployer plans is that the various work histories give rise to rules such as "hour banks" that allow people to bank hours in high periods and then maintain eligibility.

There's usually automatic coverage of dependents. Benefits are usually noncontributory as far as employee contributions through the payroll, although there will be deductibles and co-payments, and there are usually high levels of retiree coverage.

The ERISA framework basically works well for these plans because they operate on a multistate basis. They receive contributions from employers in various states. Their participants are mobile. They move where the work is. It is important to be able to offer a common plan of benefits for the union members nationwide. It is important to be able to reserve for liability without local or state jurisdictional concerns, and it is important to be able to operate a uniform appeal structure on a national basis to properly serve these participants.

WRITTEN TESTIMONY OF THOMAS R. HARTER, SENIOR VICE PRESIDENT,
THE SEGAL COMPANY, WASHINGTON, D.C. – SEE APPENDIX C

Chairman Johnson. Thank you very much. I appreciate those comments.

Mr. Klein, you may begin your testimony, sir.

***STATEMENT OF JAMES A. KLEIN, PRESIDENT, AMERICAN
BENEFITS COUNCIL, WASHINGTON, D.C.***

Thank you, Mr. Chairman, and Members of the Subcommittee. I am James Klein. I am the president of the American Benefits Council. As you may know, the Council represents companies that either directly sponsor or provide services to health and retirement plans that cover more than 100 million Americans.

Although members of our organization are overwhelmingly Fortune 500 companies, and I appear today obviously on their behalf, I hope that you will indulge me if I speak in personal terms. I also speak from the perspective of a small employer since I have the responsibility for overseeing and providing health care insurance for my 11 colleagues who are employees of the Council, myself and all of our family members.

We applaud you for holding today's hearing because despite the fact that ERISA has been around for nearly 27 years and despite the fact that millions of Americans receive their health coverage under plans that are regulated by the law, there really are several myths and misunderstandings about the statute.

Now in addition it appears quite likely that some version of the Patient's Bill of Rights will pass Congress this year and that will necessarily involve modifications to ERISA. It is extremely important that whatever passes does not do irreparable harm to ERISA's framework which, currently makes it possible for employers to provide coverage in a fair and consistent fashion.

Another way of saying it is to echo Congressman Andrews' comments, and that is that Congress focus on the number two issue, equality, and that it not do irreparable harm or exacerbate the problems of cost and coverage.

As the chart that I brought along displays, employers in general are already trying to cope with more than 12 percent annual increases in health care costs. I would argue that amending the law in a way that would include expansive liability provisions will only worsen the problem of cost and coverage and worsen the situation for those who lack coverage altogether.

I think it is important to note that one situation today that differs very substantially from when ERISA was enacted concerns how employers bear the burden of health coverage cost increases. The days when employers would simply absorb cost increases are clearly over and many companies now have very explicit benefit cost-sharing policies that make it quite clear that any additional expenses are shared equally between employer and the plan participants.

In the time that I have here today I would like to address two of the common myths and misunderstandings about ERISA.

The first is the claim that ERISA was really never intended to cover health benefits. Perhaps this myth is understandable given the use of the word "retirement" in the formal name of the law. But I think that a review of both the statute itself and its legislative history makes it quite clear that it is applicable to health benefits and that was very, very much intended from the outset.

The law provides a very extensively developed framework for regulating health benefits that despite much well publicized criticism I think has really withstood the test of time very well.

The second myth, and perhaps an even more important one to address, is the one that contends that ERISA lacks remedies for those who, let's say, violate its terms. In fact, I would argue that one of the most severe penalties that ERISA prescribes is that

fiduciaries that violate the trust placed in them to administer the plan in the interests of the participants and beneficiaries may be relieved of their role as a fiduciary. For a health insurance company that is fundamentally in the business of providing health care products and services, that is an absolutely stunning penalty.

For someone like me, who oversees a small health plan for my colleagues on the staff and our families, the thought that I might be removed as a fiduciary with all the implications that that means for my future inability to attract and retain employees is clearly a substantial penalty which is designed to make sure that I always act in a consistent, fair and proper manner in administering that health plan.

It must be emphasized that ERISA is designed to encourage employers to sponsor benefit plans within the context of our nation's private, voluntary benefit system and then to establish very, very high standards by which those plans must operate. The law encourages efforts to resolve disputes in a way that hopefully ensures people get benefits they are promised without undermining the employer's ability or willingness to maintain plans for all participants and beneficiaries.

I guess one could say that that is another aspect of this balancing act that ERISA strikes between wanting to ensure that the individuals' promises are kept but that the plan is viable enough to continue for the benefit of all.

By contrast to the current framework and structure, I would say that much of the patient's rights debate would fundamentally alter the trust of the principles of law that underlie ERISA and have for nearly 27 years. Rather it encourages litigation instead of the expeditious resolution of honest disputes and exposes employer sponsors and health plans to the reality of enormous, enormous financial penalties.

This will certainly cause employers to question the prudence of sponsoring a benefit plan. In the past it has been an article of faith that it is prudent for an employer to provide health care coverage. More and more I see the likelihood that employers faced with the prospect of enormous liabilities will have to conclude that the prudent thing is not to be as actively involved in sponsoring benefits.

I would just like to say a brief word about ERISA preemption that both of my colleagues on the panel mentioned more extensively a moment ago but add an additional thought, if I may. ERISA's provisions that enable employers to provide a uniform and consistent benefit package wherever the employees may live, work, or receive their medical care, and again even for a small employer like our organization in the Washington metro area, it is a very vitally-important feature of the law. But I want to emphasize that it is really not just designed for the convenience of employers. It also exists for the protection of participants and beneficiaries, too.

It makes sure that the plans are administered in a consistent and an equitable fashion, which was not always the case in the days before ERISA. Its inclusion in the law was unquestionably one of the law's crowning achievements. I would argue that maintaining the federal preemption is of paramount importance, not just to employers but to participants as well. Therefore the possibility of being faced with different liabilities in different state courts is something to be approached with the greatest of caution.

Finally, if I may just echo Gary Ford's point about the historical role of this Subcommittee in the development of ERISA. Clearly the Subcommittee will play a crucial role in crafting whatever patients' rights legislation will emerge from Congress. In this immediate legislative effort and in the future I would certainly urge the Subcommittee to continue its historic role as the stalwart, champion, and protector of ERISA.

Thank you.

WRITTEN TESTIMONY OF JAMES A. KLEIN, PRESIDENT, AMERICAN BENEFITS COUNCIL, WASHINGTON, D.C. – SEE APPENDIX D

Chairman Johnson. Thank you, sir. We appreciate your testimony. We are going to approach this with vigor, I assure you.

Ms. Weiss, you may begin your testimony. I saw you taking a lot of notes. You still need to watch the light, please.

Ms. Weiss. Thanks.

Chairman Johnson. Thank you, ma'am. Go ahead.

STATEMENT OF ALICE M. WEISS, DIRECTOR OF HEALTH POLICY, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, WASHINGTON, D.C.

Good morning, Mr. Chairman, and other Members of the Subcommittee. Thank you for the opportunity to testify today on behalf of the National Partnership for Women and Families and its interest in advancing health care quality.

ERISA plays a critical role in our health care system and has had a number of positive effects for consumers. ERISA was passed to ensure individuals receive the benefits they are promised. Unfortunately, ERISA falls far short of the health protections consumers need. My testimony today will discuss ERISA's impact on our health care system and explain why federal legislation is needed to fulfill ERISA's promise for American families.

Contrary to Mr. Klein's assertion, ERISA was never intended to regulate health insurance. Enacted largely in response to employer pension fund abuses, ERISA created uniform federal standards for benefit plans while preserving states' traditional role regulating insurance.

Although it created detailed requirements for pension plans, its standards for health plans were minimal. In the quarter century since its enactment some new health

plan standards have been added, but they have done little to improve the quality of health care these plans provide.

ERISA's minimal regulation of health plans is problematic for the 129 million Americans covered by ERISA plans due to three important developments: the rise in self-insurance, the dramatic increase in managed care enrollment, and the Court's interpretation of ERISA preemption of state law. These changes have created a dire need for federal legislation.

First, in the decade since ERISA was passed there has been a substantial increase in the number of individuals covered by self-insured ERISA plans. Those covered by self-insured ERISA plans has risen from only four percent in 1976 to 43 percent today. Because ERISA preempts state regulation of these plans, 56 million Americans are without any protection from state insurance or managed care laws. This increase in self-insurance has undermined the drafters' intent, to protect ERISA enrollees under state insurance laws.

Second, the number of individuals enrolled in managed care has skyrocketed. Today, 92 percent of individuals covered by employer plans are enrolled in some form of managed care. Managed care has great potential. It can save money and provide better quality care. Women have much at stake and much to gain from managed care done right, but over the past few years managed care's potential has been eclipsed by concerns that for some it may do more harm than good.

ERISA was enacted during an era when fee-for-service insurance dominated the market. Today ERISA is badly in need of new protections to reflect managed care's inextricable link between medical treatment and coverage decisions.

The third development, which is discussed in greater detail in my written testimony, concerns the Court's interpretation of ERISA. Unlike other businesses, health plans covered under ERISA have become virtually immune from accountability for their decisions, even if individuals are hurt as a result.

If we agree that companies that make tires for our cars or toys for our kids should be accountable when people are hurt, then why should we treat health plans any differently? There are far too many examples of patients who are left without redress after the tragic results of a health plan decision. Although it is true, as Mr. Klein says, that fiduciaries may be removed from their duties that is cold comfort to those who are injured as the result of the managed care decision.

My written testimony discusses one recent example of a woman in Texas whose leg had to be amputated after her health plan repeatedly delayed and denied care. Adding insult to injury, when she tried to sue her health plan in state court, the court found she had no remedy due to ERISA's preemption.

Meaningful patient protections must ensure high quality health care and restore a sense of trust and accountability to our system. At a minimum, federal legislation must be the following principles:

First, it must apply to all Americans covered by private insurance, setting a federal floor and allowing states to enact more protective requirements.

Second, it must guarantee access to a fair, timely and unbiased independent review for health plan disputes.

Third, it must ensure meaningful remedies that do not roll back current protections or disrupt states' historic role in regulating health care.

Finally, it must guarantee strong, comprehensive patient protections without loopholes or opt-outs.

Some have argued that the cost of these protections is too high or that it would open the floodgates to litigation, but that is not the case. According to estimates prepared by the CBO, there would be only a minimal increase of 4.2 percent of a member's premium per month, less than a dollar. Practical experience in the states where there is now expanded liability shows that there will be no flood of litigation. Since the passage of legislation expanding HMO liability in the Chairman's home state of Texas, only nine suits have been brought.

ERISA needs these critical changes to ensure real protections for American families. At this time the only legislation meeting these principles is the bipartisan Ganske-Dingell Patient Protection Bill. This bill is the only one endorsed by a large and diverse number of groups representing consumers, health care providers, and working families.

We strongly encourage you to consider these principles and to pass a strong Bill of Rights without delay. The health of women and families hang in the balance.

Thank you. I look forward to the opportunity to answer any questions.

WRITTEN TESTIMONY OF ALICE M. WEISS, DIRECTOR OF HEALTH POLICY,
NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, WASHINGTON, D.C.
SEE APPENDIX E

Chairman Johnson. Thank you very much. We appreciate your testimony as well. I think in Texas there's been an increase in the number of suits, probably double that, but notwithstanding, I am going to reserve the right to question along with Mr. Andrews.

I recognize Mr. Tiberi.

Mr. Tiberi. Mr. Chairman, I don't have any questions at this time. Thank you.

Chairman Johnson. Nice going. Can you imagine a freshman coming in here and not having a question?

[Laughter.]

Chairman Johnson. Mr. Andrews.

Mr. Andrews. Mr. Tiberi is a person of great judgment and maturity. I can see that.

I would like to thank all the witnesses for their testimony. I think it's an excellent start for the hearings that we are beginning.

Mr. Klein, I wanted to ask you what your assessment of the present increases in health insurance premiums that we are experiencing.

I think it is a fair statement that as a general rule the liability that you mentioned in your testimony is not the law today, and the state statutes that have been enacted are rather narrow in their application. We can quibble over whether it is nine suits or 30 suits or whatever in Texas, but it isn't many.

Given the fact that the ERISA preemption that you favor is the law today, why are we having the kind of inflation in health care premiums that you have testified about?

Mr. Klein. It's a very good question, and I think that the answers are multiple.

Certainly the new medical advances that bring great success to the health care system also bring great cost. It is interesting though that for many, many years the medical community argued that medical malpractice activity was a large cost driver, and was something that the health insurance industry and we in the employer industry certainly always agreed with and still do agree with.

There seems to be a disconnect. I would not attribute all of the increase in health care costs to large medical malpractice awards.

Mr. Andrews. Could I just ask you a little further about that one?

Mr. Klein. I would have to say that increase in liability would exacerbate it.

Mr. Andrews. Well, that I think is a disconnect. It is indisputable that medical malpractice costs for providers have gone up, but isn't it also true that reimbursements to providers have gone down from the insurers, so would the providers be passing along the cost in medical malpractice increases to the insurers?

Mr. Klein. Well, of course, there's a limit to how much you can ratchet down health care costs in terms of provider reimbursements and so forth.

Mr. Andrews. My point is I think if you talk to just about any hospital or provider group they will tell you that in real dollar terms and sometimes absolute dollar terms payments to them by insurers have gone down in the last five or six years, so they are not in a position to pass along cost increases to anybody. So I don't think that increases in medical malpractice premiums are a cause.

What else might be?

Mr. Klein. Well, certainly the extent to which those of us who provide health care coverage to our employees and their families are bearing a portion of the cost of the 43 million uninsured to whom you quite appropriately referred, many of whom receive health care services but unfortunately don't have the means to pay.

Mr. Andrews. What thoughts do you have about dealing with the problems of those 43 or 44 million people?

Mr. Klein. Well, I guess in the truest form of the Hippocratic Oath, "First, do no harm."

I would say that those things that might worsen the problem should be avoided. I suppose we, like anybody else, struggle with the kinds of policy approaches that might help. Certain tax incentives that make it easier for individuals or smaller groups to purchase more effectively would be one way to help. There have been other discussions about ways in which people can collaborate in terms of their purchasing.

One of the things that we feel very positive about is that quality and cost need not operate at counter-purposes but rather one can assist the other. So much of the efforts that my members focus on are ways in which they can improve the quality returns for their workers in terms of insisting upon the best standards of practice as a way of not just achieving better health outcomes but in fact keeping people healthier and reducing cost.

Mr. Andrews. I think Mr. Klein has pointed out an important relationship and that is the relationship between the increasing costs of health insurance for those who do provide it and the fact that 44 million people do not have it at all. One of the key strategies for reducing health care costs for health insurers, buyers of health insurance, is to dramatically reduce the number of uninsured.

Very quickly, Ms. Weiss, I wonder if you could tell us about the Roark v. Humana case and what remedy you think would be appropriate for the plaintiff in that case?

Ms. Weiss. I'd be happy to do so, and thank you for the question.

The Roark v. Humana case was a case that was decided very recently in May, a case that involved a woman named Gwen Roark, whose medical treatment for an infection in her leg was repeatedly delayed or denied by her health insurer. As a result she had to have her leg amputated. I will speak briefly to the facts of the case and then talk a little bit about what I think it says about the need for changes in ERISA.

The patient, Gwen Roark, had a spider bite. It developed into a serious infection. Her doctor recommended treatment that he felt was medically necessary. Humana, her health plan, repeatedly delayed approval for the treatments that were needed or denied coverage. At one point, because of Humana's delay and outright denial of the treatment, her treatment stopped for a month and as a result she developed a serious infection, which developed into an injury, which ultimately required her leg to be amputated. Even after her leg was amputated, Humana continued to deny treatment for the services she needed to ensure she didn't have any further infections, and her leg needed to be amputated further.

In this case the Court found that even though the Texas liability law was available to her, this is a woman who lives in Texas, because her claim was being brought under her arrangement under ERISA as an employer-sponsored plan she would have no remedy under state law.

Essentially I think this case demonstrates very clearly why ERISA needs to be changed and while real accountability is needed. Otherwise health plans can avoid paying health benefits at will, and they have no accountability for the real world consequences of their actions.

Chairman Johnson. Mr. Ballenger, you are recognized for questions.

Mr. Ballenger. Thank you, Mr. Chairman.

Let me preface this on the fact that I own a manufacturing company that has 250 employees. Having been County Commissioner before, one of the major, explosive costs in medical expenses has been the under funding of Medicare and Medicaid. If you haven't asked your County Commissioners and your State Representatives about the additional cost in Medicare and Medicaid, you haven't asked the right question.

The cost of the uninsured is also a substantial increase. That cost is passed on to those of us that have health care plans for our employees.

Let me just say also that once upon a time I had a pension plan for my employees until I found out that ERISA and the federal government were going to be involved. So I did away with my health care plan just to get away from the federal government, and we put in an ESOP.

At the present time, now, we are talking about 44 million people that are uncovered by insurance. Generally speaking it doesn't take a very large company to self-insure. My company is large enough to self-insure and we cover 250 employees. Unless I am mistaken, and this is a point that I would love to have somebody really give me an answer to, if you choose the specifics of your health care plan and the manner in which the paperwork is done, doesn't this involve you in making medical decisions?

If it does involve you in making medical decisions, considering Dingell or whatever kind of plan you want to talk about, with the ability to sue anybody that happens to participate, it appears to me that any employer who picks a health care plan has to realize that you renegotiate these plans every year, as Mr. Klein said, because the costs are very explosive. They cut their costs to get your business and then the next year they measure what you did and increase your costs so you ask for bids again. You are making these medical decisions on a yearly basis for your employees and once you get involved in that, it appears to me that you are in a liable position for being sued.

Aside from the fiduciary responsibility and being removed as a fiduciary, what scares me to death is I have 250 employees and spend about \$4,000 a year on insurance for each one. That is a million dollars in free benefits that we give the employees and yet I have seen suits take place. The trial lawyers are getting rich from all of us and I think we are building a case where that little million dollars that I am paying for my employees puts me in a position to lose millions of dollars, and probably put my

company out of business if it was necessary.

And so the way I read this whole thing, if what I am saying is correct, and I am not a lawyer, so I am not really positive about it, but if I'm correct, then the simplest thing for me to do is give each of my employees the \$4,000 a year that we are spending on health insurance and have them buy their own insurance, and hope that they can find something. They obviously will not be able to get as good a health care plan because they are buying as individuals rather than groups.

I know I have talked an awful long time. First of all, I'd like Mr. Klein to field this question. You seem closer to my problem than the other guys that are all big wheels.

Mr. Klein. Yes. I don't think I could articulate it any better than you have, Congressman. I think that you hit the nail right on the head and I think that one additional point that I would make is that even if it turns out that you would prevail in demonstrating that your actions in selecting a health insurer, for example, did not constitute the kind of decision-making that would hold one liable, there could be enormous costs just in successfully defending yourself for that position.

In that regard I think the thing that worries me and certainly worries a lot of my very large company members is not just the 4.2 percent increase that is reflected in the chart that Ms. Weiss talked about. It is the reality that if you are the one who is held liable it could be an enormous financial catastrophe for your company.

If I may also answer your question by echoing Ms. Weiss and adding another dimension to a separate point that she made. She pointed out that if we hold people or companies liable for the tires on our cars or the toys for our kids, why not something like health care?

I guess my answer to that would be many of my Fortune 500 company members have gotten out of the business of manufacturing certain products on which they make money because of the fear of product liability. I don't think it is a stretch or Chicken Little saying "the sky is falling" to assume that the very rational decision of a lot of companies and certainly small companies providing health care, is that it isn't worth the risk.

Since this hearing is about ERISA, that is a fundamental change from the balance that was sought to be struck in crafting ERISA.

Mr. Ballenger. Mr. Ford, you're up on the legal end of this. Is that possible?

Mr. Ford. Let me just echo your concern that Congress look back at what it did in 1974, when it had the idea of a named fiduciary. It specifically identified people who had certain liability and responsibility and other people who didn't, so that it was clear who had to stand up to that obligation. That person could ensure against the liability that might flow from it.

Some versions of legislation that are now being considered would make people liable for, quote, "Any other duty under the plan." That is very broad and amorphous. It is hard for people to know whether they are acting under that provision or not.

Something that clarifies who is responsible for what would I think get a higher quality decision, because they will know they are on the line, and also avoid uncertainty and ambiguity about other people being responsible.

Chairman Johnson. Thank you.

Thank you, Mr. Ballenger. Your time has expired.

Mr. Kildee.

Mr. Kildee. Thank you, Mr. Chairman. ERISA was enacted I think two years before I came to Congress, and we have been dealing with it ever since.

It is a complicated law. It is a very important law. It protects a lot of people in my district and sometimes creates some problems for people in the district.

Ms. Weiss, is the preemption of state law ensuing beyond the actual cost of a benefit, is that explicitly written in ERISA, or is it implicitly there as interpreted by the courts?

Ms. Weiss. I would argue that it has been interpreted by the courts, that it is not explicitly there. There are some who have argued that the remedies that were provided under ERISA were intended to be much broader, but have been narrowed by the interpretation of the courts, both regarding what would constitute equitable relief under ERISA and in terms of the preemption of other state causes of action that might exist.

Mr. Kildee. But basically it was a court decision that ERISA preempted state law that nailed this down?

Ms. Weiss. Right. There was a case that the Supreme Court decided in 1987 called Pilot Life Insurance Company v. Dedeaux, which basically found that all of those state causes of action that an individual in a disability plan wanted to bring for injuries they had incurred as a result of a plan denial, were preempted because as the Court interpreted ERISA Congress had intended to occupy the field and therefore preempted any state regulation in this area.

Mr. Kildee. Let me ask you then, how does the Texas law work, because there is permission.

Ms. Weiss. Right.

Mr. Kildee. How does that work in light of ERISA?

Ms. Weiss. Right. Well, there has been an evolution of the Court's thinking in terms of ERISA preemption since the Pilot Life Insurance case was handed down, and there has been an evolution in understanding that there is a division between what are considered to be ERISA benefit decisions that involve the quantity of benefits that could be provided and the quality of medical care which has been traditionally a historic role for the states to regulate.

So I guess in the mid-1990s a number of circuit courts started deciding cases that distinguish between what they refer to as quality of care cases versus benefit administration or quantity cases. Following that line of thinking, which has largely been established now, the fifth circuit in a recent decision decided that the Texas HMO liability law was safe from preemption as relating to the quality of medical care that is provided by the HMO, not with respect to the benefit administration.

The Pegram case, which the Supreme Court decided last year, affirmed that understanding and actually in the opinion the Supreme Court, in a unanimous opinion I should say, the justices suggested that the idea of what is a quality of care case is actually broader than we originally thought. It is not just strictly medical malpractice cases but it is cases like the one I was describing that involved both mixed treatment, medical treatment, issues, and plan administration issues, and so if there is any element of medical judgment, the Supreme Court reasoned, these cases should stay in state court.

Mr. Kildee. So an attorney representing a client has to look at ERISA, state law, and court decisions, and perhaps a Patient's Bill of Rights could clarify all of this, make it nice and clean and clear what the rights of the patient are?

Ms. Weiss. Right. The Ganske-Dingell bill provides clear lines of avenues of relief that would be created, basically. It would clarify that with respect to these medical treatment decisions and the mixed treatment and eligibility decisions, those would be eligible for relief under state law, existing state laws, and states could pass whatever laws they like.

With respect to the pure coverage or eligibility decisions, whether or not a member is an individual member of the plan, and whether or not the individual has exhausted their waiting period, those decisions would go to federal court and there would be some expanded remedies available.

Mr. Kildee. Thank you very much.

Ms. Weiss. Thank you, Mr. Kildee.

Chairman Johnson. Thank you, Mr. Kildee.

Mrs. Roukema.

Mrs. Roukema. Thank you.

Let me first state that I am a strong supporter of the Patient's Bill of Rights or whatever we are calling it these days, Ganske-Dingell, and I was an original co-sponsor of Norwood-Dingell and I don't hear anything that has been said thus far that would change my mind. But I also want you to know, aside from that, that for a number of years I was the ranking Republican on the Subcommittee on Labor-Management, which had jurisdiction over ERISA, so I am quite familiar and have been strongly supportive of ERISA over the years.

I have been listening carefully and I haven't heard anything said here today that would firmly state that somehow the Patient's Bill of Rights would be in specific conflict with ERISA as written both in the law or as Ms. Weiss has just pointed out,

subsequent court cases. So I have heard nothing that would contradict what my convictions were before.

Now if one of the other three members on the panel would like to respond to what Ms. Weiss just said, as well as the fact that in her testimony she said ERISA may be adjusted? She didn't go into any explanation as to how it might be adjusted. I don't believe it has to be.

I believe that anything that is in the law now is consistent with dealing with the managed care explosion and the question of accountability. If it isn't, if there is something incontrovertible in ERISA, tell me about it. I didn't hear it. If so, then this is the modern age and ERISA would have to be adjusted. But I haven't heard anything that contradicts that.

Would anyone like to comment on that?

Chairman Johnson. Mr. Ford, can you respond?

Mr. Ford. I would be happy to, Mr. Chairman, and thank you, Mrs. Roukema, for your service on the ERISA front for all of these years.

All of the Patient's Bills of Rights that are pending amend ERISA, one way or the other in major ways.

Mrs. Roukema. But it is not a fundamental rewriting of ERISA. It is only a modification.

Mr. Ford. I think the degree of change depends on the portions of which bill one is talking about.

One thing that they fundamentally differ on is whether ERISA should remain a statute that is focused on a nationally uniform federal set of remedies and claims procedures. Some do that. Some attempt to meld new and additional federal remedies with the opening of additional access to state courts and state remedies at the same time.

I will say as a lawyer, and I guess that's what I bring to the table today if I bring anything, that the ones that combine the state and federal regulation systems so that one really has 51 different systems operating at the same time, are for us a Rubik's cube or a three-dimensional chess game. They are going to be fascinating legal work, and involve, being in federal and state courts one after the other. It's going to be much slower. It's going to be much more expensive. It's going to be much more complicated.

Those of us who run law firms are already looking at expanding our space and hiring more people to accommodate it. That is good for us. Going back to Mr. Andrews' three goals I would suggest that the question for the Congress is the one area you can save. One of them isn't to pay more lawyers and overhead.

Mr. Andrews. I didn't say that.

Mr. Ford. That was not his fourth principle. I was listening carefully, and I think this is one area where one version or another could be more efficient and cheaper and faster. That is not only good for the employers and unions who put these plans together, but it would also be good for the participants because a system that is slow and expensive is daunting. It is hard to enter and it's hard to get out of, and hard for the participants to get justice.

Mrs. Roukema. Excuse me, Mr. Ford, but isn't that fundamental to ERISA in that we can deal with the uniform appeals process on a national scale. That is consistent, is it not?

Mr. Ford. Yes, you certainly may and I would suggest that the ERISA platform is the right platform to legislate on.

Mrs. Roukema. There is nothing contradictory in the Patient's Bill of Rights that would conflict with that procedure.

Mr. Ford. Some versions would introduce state processes at the same time, and one would not necessarily, as you now do, go to the plan, exhaust your administrative remedies, and then go to federal court. You could go to state court. You could be in federal and state court at the same time. You could not exhaust your remedies within the plan. So some versions of the Patient's Bill of Rights would be a fundamental departure from the approach, which ERISA has taken for 25 years.

Mrs. Roukema. I guess my time has run out, but if Ms. Weiss would like to submit something for the record please, I would appreciate it. Thank you.

Chairman Johnson. Well, Mrs. Roukema, I think you have hit at the core issue here, and I would like to offer each of the other witnesses a chance to respond to that question if you desire.

Mr. Klein. Well, without belaboring the point, I would just echo Mr. Ford's comments about it being a dramatic departure to insert this idea of different results arising in state courts. I think the point that Congresswoman Roukema was probably going to make, at least as I interpreted it, is the question of how do we then address the real problems, like the case, for example, that Ms. Weiss cited.

I think that the way it can be done without a dramatic departure from ERISA but within the ERISA framework is to follow exactly the formula that the federal government uses for the health plans that it provides. It serves as the sponsor, for the nine million people who are covered by the Federal Employee Health Benefit Plan or the 12 million people who are within the managed care features of the Medicare system. When there is a dispute it automatically goes through an external review approach. All of the Patient's Bills of Rights that have been introduced would provide that a patient that faces the kind of serious situation that Ms. Weiss spoke about would be able to get a decision on coverage within 72 hours.

Resolving these issues upfront, rather than the cold comfort of a huge damage award that comes after the fact and after the tragic amputation of a leg is a point that Chairman Boehner championed last year in the last Congress when the Patient's Bill of Rights was being talked about.

So I think that there are ways in which this can be accomplished by addressing these questions through an independent external review. I would note that the federal government protects itself against any liability for the Federal Employees Health Plan and the Medicare system. I don't see why it should be imposed on private employers without a commensurate opportunity for resolving these matters through external review.

Ms. Weiss. If I might respond? Thank you.

Chairman Johnson. Yes.

Ms. Weiss. Chairman Johnson, obviously I would agree with Mr. Klein's suggestion that external review is especially important and will help reduce the number of injuries that could ultimately result.

However, I would argue that the case that I described actually provides an excellent example of why external review is not enough and why some further accountability and some redress is needed.

In the case I described there were repeated delays and denials and even after approval there were additional delays and denials. The delay and denial that caused a gap of a month in treatment where the woman's infection was already so serious and so detrimental that she would have required an amputation to cure her and to save her life. In those cases external review provides no meaningful relief, and it provides very few protections in terms of the fairness of the process.

It provides a quick, independent medical judgment as to whether or not medical care is needed. It doesn't provide the sort of accountability that health plans obviously may need to ensure that they provide the treatment that they are supposed to be covering.

Chairman Johnson. Thank you. Mr. Fletcher is recognized.

Dr. Fletcher. Thank you, Mr. Chairman. I appreciate you having this hearing.

Chairman Johnson. Excuse me, Mr. Harter. Did you have a comment to make on that subject?

Mr. Harter. I would just like to add that again when you are dealing with small employers that are participating in multiemployer plans the ability for these people to even deal with variations in state law is virtually nonexistent.

If they are operating a plan in one jurisdiction the legal support that they have knows the local law but it is not cognizant of what is going on nationally. Claims coming in from other parts of the country will embroil them in involved legal cases.

It is not going to take more than a couple of these before the employers and unions that are running these plans are going to simply throw up their hands and say, you know, this won't work.

Chairman Johnson. Puts the unions in a bind, doesn't it?

Mr. Harter. Certainly does.

Chairman Johnson. Thank you. Mr. Fletcher.

Dr. Fletcher. Thank you, Mr. Chairman I appreciate the testimonies. Let me first just make a few brief comments.

One, I guess it's pretty clear the increases in the costs of health care is driven more by the new treatments, technology and pharmaceutical agents that we have. Certainly a litigious environment substantially increases the costs of health care, not primarily but secondarily.

There's cases and estimates by the medical associations that show the number of tests that are done that are probably not needed, while the number of MRIs that are done for headaches increase substantially.

As a practicing physician I know that there were a number of MRIs I ordered particularly because of the concern about frivolous lawsuits, even though it was very, very unlikely that there was an early tumor involved or other pathology.

There is no question that HMOs have certainly earned to some extent, the ire of the public because of the hassle factors. But getting away from anecdotes, although I know a particular case is very important, let me ask Ms. Weiss. When we are dealing with science and dealing with quality of health care we shouldn't be legislating on anecdotes, and yet I do believe that if there is an egregious case there needs to be appropriate redress.

Let me ask you if you have seen any studies of quality of care by the self-insured versus individual markets, particularly regarding women's issues, such as the number of Pap smears that are performed, the percentage of mammograms that are performed, C-section rates, or hysterectomies?

Ms. Weiss. Well, actually, I don't believe that I have seen any studies dealing with that, but I would want to respond to your suggestion, with all due respect, that legislation is being done by anecdote.

There was a recent study by the Kaiser Family Foundation, actually it was just released I believe last week that showed that 51 percent, a majority of the people who are enrolled in managed care report that they are experiencing real problems, and that these problems have real consequences, including lost time at work.

Dr. Fletcher. Ms. Weiss, let me interrupt you.

We were looking for academic studies that are done on the quality of care, because even though I certainly as a practicing physician find managed care very difficult to deal with, there are some changes that are needed. I think internal-external review would help. But actually the studies from academic centers on quality of care have not shown a difference between fee-for-service and managed care. There have been studies on both sides, but I don't think we have seen a distinction.

In my experience the other thing that managed care has brought, is that we do see more preventive care coverage than we have seen in the past. I think we will find an increase in the percentage of mammograms that we are getting, the percentage of immunizations for children, the percentage of Pap smears that I was doing, which I didn't previously get and do not get under strictly fee-for-service. So I think we need to realize that there are some benefits to managed care, even though I think we need some legislation, a Patient's Bill of Rights.

I think it is also inappropriate to try to compare Texas law with our attempts here to open up state litigation, and you have made our point very well that the trial lawyers are probably not going to invest a great deal in court. Where there is a question of whether it would go forward anyway, and/or saying that we could predict the number of cases that would be filed if open litigation under state courts would be passed here is like comparing apples and oranges.

Let me ask Mr. Ford his opinion. Mr. Ford I have two questions. My time is slim. Let me ask them both and you can respond.

First, where are the courts going regarding ERISA cases, and second, maybe Mr. Klein, you will contribute to this one after he answers, if litigation was opened up with a designated decision-maker particularly for the self-insured, how would that work regarding ERISA?

Mr. Ford. Thank you. On the first question there are two or three areas, and I will try to be very brief. One area is where the courts are active right now. This is the Pegram decision, which Ms. Weiss alluded to. Pegram was a Supreme Court decision that basically said that the kind of mixed decision of medical and plan eligibility or coverage made by a managed care physician who had made a mistake in making a medical necessity determination, and who had delayed a particular treatment by eight days and done it in network instead of ordering it immediately, was not an ERISA fiduciary decision.

The Court noted that medical malpractice law exists under state law to deal with it, and wondered whether the Congress would want the courts to invent a federal medical malpractice law.

I don't agree with what Pegram decided that any kind of eligibility decision made by a managed care organization and anyone in that organization is therefore not preempted and is subject to state suit. It was dealing with medical malpractice and a physician in a treatment setting, and that is a much narrower finding.

I think at least in answer to where it's going it leaves a number of question marks that haven't been resolved.

The second area is on this issue of state external review laws. To cut to the chase, the Texas law requiring external review was preempted because it interfered with ERISA's claims process. On the other hand, a seventh circuit decision in a case called Moran found that an external review law in Illinois was not preempted, that it could continue, so there is disagreement there.

I expect that to go to the Supreme Court and expect the Supreme Court to say that external review, the laws on the state level as opposed to what the Congress might do, are preempted by ERISA.

The third major area is disclosure. There is a lot of disagreement in the courts over what ERISA requires by way of disclosure. It has these detailed disclosure rules that are set out in Sections 102 and 104, but some courts are finding that there is a general fiduciary duty to perform disclosures. Now clearly a fiduciary has a duty not to mislead a participant or a patient, but does the fiduciary have an additional duty to give individualized advice and disclosure to people, say on the tax consequences of a particular decision or about the internal medical incentives, or financial incentives in a managed care organization? The courts disagree on that.

I think ultimately the decision will be that ERISA disclosure has been legislated in detail. The Department of Labor has detailed disclosure regulations, new ones, and that is where the disclosure rules ought to be, not in some generalized, ill-defined fiduciary duty. But it is not resolved yet.

On the designated decision-maker point, I think that making clear who is responsible for what is very important. That will get better conduct by people who are making the decisions. It will let the participant know who is accountable. It will enable the insurance and the cost process to be refined and it will be much more efficient and I think cost effective.

Mr. Klein. You asked me to follow that up, and I guess I would characterize the designated decision-maker provision that though a well-meaning effort to try to limit the scope and the circumstances under which there might be liability, I think that two points need to be noted.

The first is the potential for chilling effect that that could have on the current very active and positive role that employers and other designated decision-makers play in terms of being advocates for the participants in their plans, alluding back to the dialogue I had before with Congressman Ballenger in terms of what kind of vulnerability that there might be for those like me. Would I be held liable at some point for having directed the decisions about what kind of coverage was selected?

The other point, more Ganske-Dingell legislation or Kennedy-McCain legislation in the Senate, is the extent to which there still is liability under class actions, notwithstanding a designated decision-maker feature that might be added into that kind of a framework at some point down the road. So I think that one has to make sure that it would be crafted in such a way as to provide protections for all different kinds of liability for different kinds of claims.

Chairman Johnson. Thank you. You didn't want to respond?

Ms. Weiss. I would love the opportunity to respond. Thank you very much, Chairman Johnson.

In terms of the concept of making clear who is responsible for what, I think a point that was made earlier by Mr. Klein was that the Ganske-Dingell bill could subject employers to extensive liability; there would be no way for them to control it and that merely setting up the plan would subject them to liability.

I wanted to respond in kind and say, you know, the Ganske-Dingell bill does include specific protections for employers and clarifies that employers shouldn't be held liable unless they are in the business of basically what is effectively making medical decisions for their employees.

To the extent that they are, they should be held liable, as other health plans are, and the Ganske-Dingell bill does also include a specific protection against employers being held liable merely for setting up the plan.

Apart from that, in terms of the appropriate role of the states and the federal government in regulating health care, I would just respond to Mr. Ford's comments in regard to the direction the Court is going in. In looking at the Supreme Court's likely decision in the fifth circuit case involving preemption of external review it is possible that the federal judiciary does not want to interfere in states' regulation of health care and managed care.

I think the unanimous opinion of the Court in Pegram alluded to this, but I think it was also reiterated in a letter that Chief Justice Rehnquist recently wrote to Senator Nickles where he states that he doesn't believe the federal judiciary is the appropriate place for these types of lawsuits and other regulation he wants to defer to the states' traditional role in regulating health care. Thank you.

Chairman Johnson. Thank you. Mr. Boehner.

Mr. Boehner. Mr. Chairman, thank you, and let me congratulate you and Mr. Andrews on having this hearing and the timeliness of it.

As we all know, employers and unions cover some 129 to 130 million American workers. It is the foundation of the health care insurance system in our country and there's certainly some turmoil in the marketplace with these tremendous cost increases, and tremendous concerns on the part of employers, their employees and others about how they are going to continue to afford quality health insurance.

What is happening around America is that employers and their employees are getting increasingly concerned about whether they can continue to do what they have been doing. As we here in the Congress begin to consider the legislation that would offer new mandates, open up new liability, I think that we have to be very, very careful that we don't kill the goose that is laying the golden egg in terms of providing the foundation of our health insurance system.

Mr. Klein, you know that there are proposals kicking around Congress that would subject employers and/or insurers to liability both in federal court, which is already allowed under ERISA, and open ERISA and ERISA plans up to state rights of action.

Mr. Ford made earlier comments about the fact that it is going to be expensive, and it is going to subject employers or their agents to be hauled into state or federal court. What is the likely impact if you are an employer? What are you likely to do?

Mr. Klein. Well, you know, I was at an event this morning, Chairman Boehner, with some other business groups, and we were talking about this issue. I was saying that throughout the course of this very vigorous debate over the last couple of years I have been an advocate for major employers. I have also thought of this in very personal terms, in the context of what would I do for the health care that I am responsible for providing for my colleagues on the staff and their family members, and for myself, for that matter?

I have to say that as an organization dedicated to the promotion of the employer-sponsored health care system and in fact we provide a very generous plan for my colleagues, we would be among the last out the door in terms of saying we would give it up.

But I would have to very seriously consider whether the prudent business thing to do, would be to sponsor a health plan and to take as active a role as we like to take in terms of insuring good care. Would I in the process expose our small organization and potentially myself as a fiduciary to enormous liabilities?

I looked around the room because this event this morning was held over at the National Federation of Independent Business, and I thought that if I am seriously considering that I might have to re-evaluate that in a post-Ganske-Dingell world of that being the law. What about those companies whose pictures were shown up on the wall of the NFIB, such as the small bicycle shop, or the music shop where benefits is not a fundamental core of what they do?

I think that it would be a very serious evaluation that one would have to draw.

Mr. Boehner. Mr. Harter, how many employees are covered under multiple employer welfare arrangements?

Mr. Harter. Approximately 12 million employees.

Mr. Boehner. And what do you think the reaction of a board of trustees would be to the possibility of being held personally liable, because each of those trustees, as I understand, are in fact fiduciaries under ERISA?

Mr. Harter. That's correct. Of course they have that liability today and they are able to insure it, so part of the answer is whether in fact insurance protections can be put in place so that they feel comfortable with assuming any new responsibility.

Mr. Boehner. Now those boards of trustees are made up of both employer representatives and union representatives, is that correct?

Mr. Harter. That is correct. Multiemployer plans by law require 50-50 representation.

Obviously if they feel that the liability is excessive, the first situation is going to be that you are going to have difficulty finding people willing to assume responsibility for being trustees. They do not receive compensation for that responsibility and it could be very, very difficult to simply have people assume these roles.

The second situation basically is that in collective bargaining it's very, very easy to take these employee contributions and in effect return them to the participant's paycheck, to simply stop the fund. It would be a very simple operation to do if the parties decided to do it.

The balancing act is essentially whether the tax consequences to the participants, who now will have to buy benefits themselves with after-tax money in many cases, will justify the action that they are taking.

Mr. Boehner. But if multiple employer plans were subjected not only to increased federal liability but potential liability in each of the states in which they operate, how would a multiple employer plan try to adjust rates and costs given this uncertainty?

Mr. Harter. Well, that would be answered over time. Do the requirements in a particular state cause identifiable additional costs to be factored into the rates for all participants working in that state? Variations in benefit plans or the way the insurance protection is being provided in effect insulates a group so that their coverage is fundamentally different from the rest of the group is going to undercut the basic relationships that are going on in a multiemployer plan.

The unions are operating from the perspective that they are providing uniform benefits to all of their employees, and to the extent they can't do that, the whole union relationship will break down.

I really don't know how multiemployer plans would tackle that issue, other than dealing with insurance companies on a state by state basis to identify the protections and the costs associated with them and then trying to incorporate that into their rate structure.

Mr. Boehner. Thank you, Mr. Chairman.

Chairman Johnson. Thank you, Mr. Boehner.

Mr. Harter, earlier you said that you would have to adapt to the costs state by state, but really wouldn't that affect the overall cost for everyone in your plan?

Mr. Harter. Basically, under the current structure all assets of the plan have to be available for all liabilities.

Chairman Johnson. Right.

Mr. Harter. So there is really nothing in today's structure that isolates assets for particular participants and particular localities. That doesn't mean that if you have an unraveling of the ERISA exemption that we couldn't be going in that direction.

If states set up specific reserve requirements for participants working in their state, it may in fact require assets to be allocated to particular groups in order to reserve and provide the benefits for that group.

Chairman Johnson. The overall cost is going to go up?

Mr. Harter. The overall cost is going to go up. In fact, under today's regulations you essentially would have to set up multiple plans with multiple filings and all of the work associated with a multiple employer being duplicated on a state-by-state basis. It would have a tremendous impact on cost.

Chairman Johnson. Thank you. Let me ask Mr. Ford a question. In your testimony you mentioned that ERISA overrides the patchwork of state laws and would subject multistate plans to inconsistent regulation. From your experience, can you give us some examples of different types of regulations one of your clients might experience without ERISA?

Mr. Ford. Yes, Mr. Chairman, and it picks up some on what Mr. Harter just said.

Imagine you are running a plan, whether as an employer or as a multiemployer plan that has operations in 40 or 50 states. There are going to be different benefit mandates in each of those states. I think right now half the states have a list of 10 benefit mandates.

There would be different claims timing rules. There would be different appeals rules and the number of appeals and whether an appeal can be raised orally or must be in writing. There would be external review in some states but not in others. There would be different reporting and disclosure, different damages and so on.

I thought about could a multistate plan, whether it is a multiemployer or corporate plan, address this by saying we are going to go through the rules and try to do the most generous thing in each area and automatically comply with all of these. It doesn't really work, if you think about it. What is more generous is having three levels of appeal that are slower or two levels that are faster? And you are not going to be able to get a uniform approach to benefits even if you are willing to bend over backwards to do the most liberal of all the state rules.

So to go to your question, in either a multiemployer plan or in a corporate plan, there's going to be more overhead as you expand the number of staff and lawyers who are busy trying to comply with 51 sets of rules instead of one set of rules.

Chairman Johnson. Well, that is a "lawyer protection plan."

Mr. Ford. It is.

Chairman Johnson. I can't believe that you stated you are already hiring extra people in your law firm to take care of this problem.

Mr. Harter, in your statement for the record, you mentioned the fact that many multiemployer plans, like in the Washington, D.C. area for example, which isn't a state, cover participants who live in a number of states around here. How does ERISA help that situation?

Mr. Harter. Well, essentially ERISA sets a framework for operating a plan and there is no requirement to conform again to state mandates.

Even if a plan decides to provide coverage through an insurance carrier for part or all of its coverage, generally the only state mandates that apply are for the state where the fund is located. Basically you are able on either an insured or a self-funded basis to offer a uniform plan, whether employees are working in the District, Maryland or Virginia.

As I indicated earlier, even if they move to other states because work isn't available in this area, and funds flow back, there are no consequences as far as the plan design. The trustees prepare a plan document of uniform provisions and make them available to all participants and essentially establish eligibility rules that combine the hours worked in any of the states in order to establish eligibility.

Chairman Johnson. Thank you, sir.

Mr. Andrews, I believe you had one follow-up.

Mr. Andrews. I do. I think it is very important, given some of the statements that are on the record, that we refer to the language of the Ganske-Dingell proposal, identical to the McCain-Kennedy proposal in the Senate, and that is this.

The ERISA preemption is lifted but the ERISA preemption is not lifted against employers unless the employers fit into a very narrow exception that is defined in Section 302 of the Dingell-Ganske bill. A claim is still preempted against an employer unless the employer is involved in direct participation in a decision to deny or a decision that impacts on a participant.

The phrase "direct participation" is specifically defined in the bill as the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure to do something. The purpose of that language is to specifically disclaim vicarious liability. It is to specifically disclaim principal agent liability. It is to specifically disclaim anything short of the actual active participation by an employer in a decision.

The second point I would like to make is we heard a reference to legislating by anecdote. I don't think we are legislating by anecdote. I think we are legislating based on a growing national consensus that there is a real problem here.

That problem is manifested in litigation that has nothing to do with ERISA, and is trying to get around ERISA. There are lawsuits being filed today throughout the country in state and federal courts for unauthorized practice of medicine against managed care organizations. There are lawsuits being filed for medical malpractice against managed care organizations. There are lawsuits being filed under the civil RICO statutes for interstate conspiracy to deny someone of life or property.

I think that we need to consider here, amidst all this testimony that there already is a flood of litigation, and I would be interested in the panelists' comments on this proposition, and I ask it as a question.

Do you think there will be more litigation or less litigation if something like Ganske-Dingell is adopted? Now I know your first impulse is to say, 'Well, of course there will be more litigation because we'll have state tort liability.'" But given the flood of litigation that already exists, based upon medical malpractice, based upon unauthorized practice of medicine, based upon civil RICO, based upon lots of new theories, many of which as a lawyer I think are rather bizarre, what do you think of the argument that it is better to legislate it and have a finite and clear set of standards than it is to simply let a multitude of trial courts across the country and a multitude of trial lawyers determine which theory is the one that hits the jackpot? What do you think of that?

Mr. Klein. I could take a crack at that one.

I think it is a very thoughtful question, certainly, but I want to first just clarify one important point that you made about the direct participation issue in the context of answering your question.

It should be noted that that direct participation feature, you know, may exist in sort of a narrow class of actions initiated under the new remedies prescribed under ERISA in the Ganske-Dingell bill, but there is no limit on class actions for other provisions of ERISA or, as you pointed out, the RICO statutes.

So it is not as complete a protection to the employers that some folks might otherwise think, and it is also important to note that what is offered up as a defense by somebody being sued is of a different nature than something that just prescribes what one's liability is, because you can expend a great deal of effort and resources defending yourself against liability.

You know, naturally I can't sit here and predict whether there will be more or less litigation but I think that even if the point that you note is correct, we are certainly not likely to see less litigation under a scenario whereby people can sue in both federal and state court.

Clearly, as we have discussed today, it goes against the whole nature of the federal framework of ERISA. It is quite a different matter to say that one can go to court to enforce the decision of a properly structured independent external review decision that a benefit should have been provided, and to enforce that through litigation than it is to invite litigation at the front-end and not even require one to exhaust the independent external review process, as unfortunately is the case under the Ganske-Dingell bill.

Mr. Andrews. Anyone else? That is my last question.

Mr. Ford. Mr. Andrews, excuse me, I might just add to that.

I think there really may be two parts to the question: first, will there be more litigation, and second, will it cost more?

On the first question, I think there will be more litigation if there are states remedies available in addition to federal remedies. There will be more litigation of a particular type. That is the kind that offers a potential big judgment at the end and is a very expensive system. You can look at the medical malpractice system. It is a very expensive system to work one's way through so smaller medical malpractice claims often don't get compensated. I think the more moderate and smaller claims cases probably won't balloon, but the ones that portend a bigger payoff in the state system probably will.

The second point is whether I am right that abandoning the notion of a uniform federal forum in federal court for ERISA claims for parallel state actions is necessarily going to be more complicated. Some of the bills propose a stay in federal court and action in state court, then on to federal court if you lose all the way up through appeals, and then back to state court if you lose on appeal. It's going to be slower.

That is not only a cost factor for people who sponsor plans. It is a major disincentive to people who have been harmed to take their claim into that system unless they get a big dollar payoff at the end.

Mr. Andrews. I'm sure Ms. Weiss would like to respond.

Ms. Weiss. Thank you. I have just a couple of points for clarification of the record.

Mr. Klein suggested that the Ganske-Dingell bill does not include any protections against class action litigation, but I would refer him to Page 168, Section 303 of the Senate version of the bill, which includes a provision called "limitation on actions" and does specifically limit the types of class actions that could be brought under the bill with respect to the new protections that are created.

Mr. Klein. That's what I said.

Ms. Weiss. May I? Thanks.

The bill does not, however, include the types of broad-based preemption or barring of class actions that might exist as Mr. Klein was suggesting with respect to the other rights that exist under ERISA or with respect to the RICO actions. I would respectfully submit, following on your wise comments, Congressman Andrews, that after the creation of a more meaningful remedy for individuals there would be less of a need for class actions.

And the second point of clarification that I wanted to make was in response to a point that Mr. Ford had made before regarding the concerns about ERISA plans being subject to inconsistent regulation under the 50 states. I would just suggest that with respect to fully-insured plans, these are already indirectly subject to state regulation in the 50 states, and they are managing just fine.

Under the Supreme Court's decision in 1985, *Metropolitan Life Insurance v. Massachusetts*, the Supreme Court clarified that state insurance benefit mandates do apply to the insurance companies that are providing benefits to ERISA covered, fully-insured, employer-sponsored plans. Thanks.

Chairman Johnson. Thank you.

Mr. Boehner, do you have a follow-up question?

Mr. Boehner. Yes, Mr. Chairman, thank you.

Mr. Andrews, my good friend and colleague from New Jersey, pointed out the alleged employer carve-out in the Ganske-Dingell bill. He did in fact read it correctly, that if you directly participate in a decision that you are in fact held liable.

Any one or all four of you can take a crack at this, but explain how to preserve your fiduciary duty to protect all beneficiaries in the same manner. How do you do that without directly involving yourself, other than the case of a fully insured plan? Do you just lay it off on someone else? Under the fiduciary duty outlined in ERISA, no self-insured plan would ever be carved out by the language that currently exists in that bill. Am I correct or wrong?

We'll start with you, Mr. Ford.

Mr. Ford. I'll try to be brief.

The "directly participates" language reflects an effort to make it clear, but I don't think it is there yet. It is pretty amorphous as to what constitutes direct participation in a decision. One doesn't have to be a fiduciary, Mr. Boehner.

The question for the Committee and Congress is do you want a rule that sends people running in the other direction from that responsibility? I think what one would have to do as a business person is get out of that role and totally hand it to someone else to make those decisions for fear of the potential liability.

Mr. Harter? Mr. Klein? Ms. Weiss?

Mr. Harter. I guess I would comment that there's really two parts to the decision-making process that an employer goes through.

One is simply the contractual arrangement that's been set up. The plan document that has been established on which claims are being paid is seldom specific enough to deal with every situation that might arise.

Experience shows that when appeals come to boards of trustees or to employers, they are frequently appalled with the decision that they are faced with under the plan document that has been drafted. They in fact look for opportunities to correct the situation, either by approving the appeal, although the plan document did not clearly approve it, or immediately amending the plan of benefits so that the circumstance is covered.

It raises a lot of questions in my mind, as I'm sure it does yours then, as to the extent they suddenly start participating in medical decisions? They are really deciding coverage issues and unless these categories are very clearly separated, you are always faced with a situation where someone else in another situation is filing suit.

I think again the complexity of this situation is mind-boggling.

Mr. Klein. I can answer it just very briefly, echoing both of those points, of course, by saying that we often get immersed in this discussion with the premise in mind that the decision to grant the coverage of the benefit is necessarily the right decision. You ask how one balances the responsibilities under ERISA as a fiduciary, and we have to recognize that sometimes of course the right decision under the terms of the plan or under the terms of even the medical judgment provided may be to not cover something. That is a very difficult position for anyone to be in.

I think what we can all agree on, whatever else we might disagree on is that what we want to achieve is a situation whereby if a mistake is made in making that determination that it can be dealt with and rectified quickly.

I just can't underscore enough that I think the way that you envisioned it in your legislation of the last Congress, whereby through a properly and fairly structured external review process that is dealt with at the front end, we can overcome what will be natural human mistakes that will happen. This will allow people who are qualified to make those decisions, to render the final judgments. Then whoever refuses to provide the coverage, if in fact the right decision was that something should have been covered, can go to court to enforce the external review decision, but not deal with it at the front end by inviting litigation and not providing a mechanism to deal with what is obviously are very difficult questions.

Ms. Weiss. In response to your question, Chairman Boehner, I basically think that many have suggested that fiduciary responsibility would necessarily subject health plans to being involved and directly participating under the language of Ganske-Dingell.

I think that to the extent that the fiduciary responsibility flows to all plan participants and the interests of the entire plan as opposed to the individual participants, I think employers could very persuasively argue that unless they directly participated under the language of the bill that they would be protected from liability.

But I would just want to make a larger point about fiduciary liability generally, because I think there has been some suggestion that fiduciary liability under ERISA is so strong and so protective of ERISA participants. I would respectfully submit that it has done very little to protect the interests of participants and beneficiaries in the managed care plans that are currently suffering from the problems caused by a wrongful delay or denial where they have no redress. Thanks.

Mr. Boehner. Thank you, Mr. Chairman.

Chairman Johnson. Thank you, and I want to thank the witnesses for their valuable time and testimony. I think this is kind of a good summary at the end, and I appreciate the fact that in America we can agree to disagree sometimes. Isn't this a great nation?

Thank you all for being here. If there's no further business, the Committee stands adjourned.

Whereupon, at 12:19 p.m., the Subcommittee was adjourned.

***APPENDIX A - WRITTEN OPENING STATEMENT, CHAIRMAN
SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE
RELATIONS, COMMITTEE ON EDUCATION AND THE
WORKFORCE***

Committee on Education and the Workforce

**STATEMENT OF THE HONORABLE SAM JOHNSON
CHAIRMAN
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS**

June 12, 2001 Hearing On:

**"ERISA: THE FOUNDATION OF EMPLOYEE
HEALTH COVERAGE"**

GOOD MORNING. WELCOME TO THE FIRST HEALTH-RELATED HEARING OF THE SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS. TODAY'S HEARING FOCUSES ON THE ROLE OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, KNOWN AS ERISA, AND HOW EMPLOYERS VOLUNTARILY PROVIDE HEALTH INSURANCE TO MILLIONS OF THE NATION'S WORKERS UNDER ERISA.

THIS HEARING IS DESIGNED TO HELP EDUCATE THE MEMBERS OF THE SUBCOMMITTEE AS WE EXAMINE WHAT WORKS, AS WELL AS THE PROBLEMS FACING OUR EMPLOYER-SPONSORED HEALTH-INSURANCE SYSTEM.

THANKS TO ERISA, THE LARGEST NUMBER OF AMERICANS, 129 MILLION AMERICANS, RECEIVE HEALTH INSURANCE THROUGH THEIR EMPLOYER.

I ANTICIPATE ADDITIONAL HEARINGS IN THE COMING MONTHS TO EXAMINE SUCH IMPORTANT TOPICS AS: 1) INCREASING THE NUMBER OF INSURED, ESPECIALLY EMPLOYEES OF SMALL BUSINESSES; 2) THE EFFECTS OF CLAIMS REGULATIONS RELEASED BY THE DEPARTMENT OF LABOR, AS WELL AS OTHER REGULATORY BURDENS ON EMPLOYER-PROVIDED HEALTH PLANS;

3) ENSURING MEDICAL PRIVACY; AND 4) GRANTING GREATER PROTECTION TO WORKERS ENROLLED IN MANAGED CARE PLANS.

OVER THE PAST 26 YEARS, THE ERISA PREEMPTION OF STATE LAW HAS PLAYED A KEY ROLE IN PROVIDING HEALTH INSURANCE TO MILLIONS OF AMERICANS.

ERISA COVERS NEARLY 80 PERCENT OF ALL WORKERS IN THE NATION. ERISA ALLOWS EMPLOYERS AND EMPLOYEES TO AGREE ON A VAST ARRAY OF BENEFITS WITHOUT SIGNIFICANT GOVERNMENT INTERFERENCE DRIVING UP THE COST OF HEALTH INSURANCE. ...

OF THE ESTIMATED 43 MILLION AMERICANS WITHOUT HEALTH INSURANCE, 60 PERCENT ARE SMALL-BUSINESS OWNERS AND THEIR FAMILIES, AS WELL AS THE EMPLOYEES, AND THEIR FAMILIES. AFFORDABLE AND ACCESSIBLE HEALTH INSURANCE FOR SMALL BUSINESS ENTERPRISES IS A PRIORITY FOR THIS SUBCOMMITTEE.

WHEN YOU RUN A SMALL OPERATION, IT IS ABSOLUTELY CRITICAL THAT EMPLOYEES AND THEIR FAMILIES ARE HEALTHY. PEOPLE PERFORM BETTER WHEN THEY HAVE PEACE OF MIND, KNOWING THEIR LOVED ONES ARE HEALTHY, SAFE AND PROTECTED.

THE SAME GOAL OF A HEALTHY EMPLOYEE ALSO APPLIES TO THE NEARLY 12 MILLION AMERICAN WORKERS AND THEIR FAMILIES WHO RECEIVE HEALTH COVERAGE THROUGH MULTI-EMPLOYER HEALTH PLANS.

OVER THE PAST 20 YEARS, THESE PLANS HAVE BEEN ON THE CUTTING EDGE OF PROVIDING QUALITY BENEFITS TO HARD WORKING AMERICANS AND WE CAN ALL LEARN FROM THEIR EXPERIENCE.

I LOOK FORWARD TO THE WITNESSES' DISCUSSION OF THE ROLE OF ERISA IN PROVIDING HEALTH COVERAGE TO 129 MILLION WORKERS. THE SUBCOMMITTEE MUST BE RESPONSIVE TO SHORTCOMINGS IN THE HEALTH CARE SYSTEM, BUT WE MUST ALSO INSIST ON WORKABLE SOLUTIONS THAT DO NOT ERODE COVERAGE OR MAKE COSTS UNAFFORDABLE.

WE NEED TO EXPAND ACCESS TO MORE AFFORDABLE HEALTH INSURANCE AND REDUCE THE NUMBER OF UNINSURED.

FINALLY, LIKE SOME OF OUR COLLEAGUES IN THE SENATE, WE SHOULD MEET WITH HEALTH PROFESSIONALS, HOSPITALS AND OTHER POLICY MAKERS, TO STUDY SOME OF THE MAJOR PROBLEMS IN OUR HEALTH CARE SYSTEM, SUCH AS MEDICAL ERRORS. THIS HEARING WILL BE A STEP IN THE RIGHT DIRECTION.

I HOPE THIS SUBCOMMITTEE WILL EXAMINE IMPROVING QUALITY AND REDUCING COSTS IN THE COMING MONTHS.

I LOOK FORWARD TO WORKING WITH MY COLLEAGUE, MR. ANDREWS, TO ADDRESS THESE ISSUES, ALONG WITH MY VICE-CHAIRMAN DR. FLETCHER, AND THE OTHER MEMBERS OF THE SUBCOMMITTEE.

***APPENDIX B - WRITTEN TESTIMONY OF GARY M. FORD, ESQ.,
PRINCIPAL, GROOM LAW GROUP, CHARTERED,
WASHINGTON, D.C.***

Committee on Education and the Workforce

June 12, 2001

Testimony of Gary M. Ford, Esq.
Groom Law Group, Chartered
Hearing Before the Subcommittee on Employer-Employee Relations
House Education and the Workforce Committee

Good morning. My name is Gary Ford. I am Managing Principal of Groom Law Group, a law firm here in Washington, D.C. We are the largest employee benefits specialty firm in the United States, so you will not be surprised to learn that we spend our days focused on the regulation of pension and health plans under ERISA, the Employee Retirement Income Security Act of 1974. I appreciate the opportunity to comment on the very important role that ERISA plays in our health care system.

ERISA provides the legal framework for the private, employer-based portion of the nation's health care system. Over 120 million Americans participate in ERISA-covered group health and retirement plans, all of which are voluntarily sponsored by employers, or employers and labor unions jointly. ERISA does not apply to governmental plans or church plans, nor does it apply to individual insurance policies, which are subject to state regulation. The provisions of ERISA that govern group health plans are administered and enforced principally by the Department of Labor.

Many employers have employees in numerous states, so ERISA begins by overriding or preempting the patchwork of state laws that might otherwise subject these plans to inconsistent regulation. Indeed, one of the hallmarks of ERISA was Congress's intent to ensure uniformity in the administration of multi-state benefit programs. To this end, ERISA includes an express preemption provision that provides that title I of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This broad statement, known as the "relates to" clause, is qualified by a "savings" clause providing that "nothing in this title of ERISA shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). The savings clause, however, is further qualified by the "deemer clause," which effectively bars states from directly regulating the ERISA plan itself under the guise of state insurance law.

Applying these provisions, a State law that "relates to" an ERISA plan is generally preempted, while a State law that "regulates insurance" may be "saved" from preemption despite its relation to an ERISA plan. ERISA's provisions preserve the traditional role of the states in regulating the business of insurance, while preempting non-insurance laws that relate to employee benefit plans. Notably, the application of these provisions has led to the current regulatory dichotomy between self-insured group health plans and insured plans. Where plans are self-insured, states may not regulate the content of such plans. Where plans are insured, states may regulate the content of the insurance policies the plans purchase. Thus, insured plans are generally subject to greater regulation than self-insured plans, and they are generally more

expensive to maintain as they are subject to state mandated benefit laws and state premium taxes.

In terms of substantive rules, ERISA strictly regulates the conduct of persons, businesses and unions that exercise discretionary control over health plan assets or over the management or administration of an ERISA-covered health plan. ERISA § 3 (21) (defining fiduciary). These "fiduciaries" are subject to the highest duties of loyalty and care known to American law. They must follow the written documents governing the plan (so long as they are legal), they must make decisions with care, skill, diligence and prudence, and they must act with "an eye single" to the interests of the employees and retirees covered by the plan. ERISA § 404(a)(1).

But ERISA requires more. Fiduciaries and others who deal with health plan matters must obey ERISA's "prohibited transaction restrictions." These rules broadly prohibit and regulate a wide array of transactions (e.g., loans, sales of property, transfers of plan assets) with parties related to the health plan and prohibit a fiduciary from using plan assets for his own interest, acting in a plan transaction on behalf of a party whose interests are adverse to the plan, or taking kickbacks. ERISA § 406.

ERISA also imposes what the Supreme Court has called an "elaborate scheme" of reporting and disclosure rules, requiring plan administrators to file annual reports with the government and provide each participant with a Summary Plan Description ("SPD") that includes detailed disclosures to health plan participants. The Department of Labor recently has greatly expanded the list of information required to be included in the SPD. In addition to describing plan benefits, SPDs must also include detailed descriptions of the procedures participants must follow to make a claim for benefits under the plan.

Since ERISA's enactment, Congress has repeatedly revisited ERISA to expand the regulation of health plans. In 1986, Congress added to ERISA and the Internal Revenue Code a comprehensive set of rules -- the so-called "COBRA" rules -- that require plans and employers to make continuation health coverage available, for example, to employees who lose their jobs, beneficiaries of employees who die, or retirees who otherwise would lose coverage because of their employer's bankruptcy. Then, in 1996, Congress passed HIPAA, the Health Insurance Portability and Accountability Act, which amended ERISA, the Code and the Public Health Service Act to add rules intended to enable employees to change jobs without sacrificing their health coverage, including rules that restrict the use of preexisting condition limitations. ERISA § 702. Finally, in recent years, Congress has added to ERISA several health benefit mandates, including benefits for mothers and newborns, mental health parity, and reconstructive surgery for mastectomies. ERISA §§ 711-13.

In terms of processing of health claims, ERISA contemplates that the participant file his or her claim with the plan and, if it is denied, appeal the decision within the plan and then, if that appeal is denied, take the plan to court. ERISA § 503. In court, a judge, not a jury, decides the matter, the plan administrator's decision generally is entitled to deference, and the participant is awarded his benefit and may be awarded attorney's fees if he or she prevails.

ERISA provides a "reticulated" scheme of public and private enforcement to ensure compliance with its substantive requirements. ERISA § 502. ERISA specifically enumerates who may bring any of nine causes of action and what relief may be granted. The private parties to a plan, such as participants, beneficiaries and fiduciaries, may enforce rights under these provisions. In addition, however, the Secretary of Labor is authorized to bring suit to ensure that participants' rights are protected.

The courts have consistently characterized ERISA's remedy scheme as "exclusive." Thus, even where a state law cause of action arises under a state insurance law that may fit within the savings clause, the cause of action is nonetheless preempted.

In view of ERISA's structure and history, it is not surprising that all of the major Patients Bill of Rights proposals now pending before Congress would, if enacted, make most of their proposed changes through direct or indirect amendments to ERISA, including requiring new patient protection provisions (e.g., emergency room coverage, specialty care), new claims procedures (internal and external) and remedies.

***APPENDIX C - WRITTEN TESTIMONY OF THOMAS R. HARTER,
SENIOR VICE PRESIDENT, THE SEGAL COMPANY,
WASHINGTON, D.C.***

Committee on Education and the Workforce

Committee on Education and the Workforce, U.S. House of Representatives

Statement by Thomas R. Harter, Senior Vice President, The Segal Company

June 12, 2001

My comments are on behalf of The Segal Company, but more specifically with respect to our client Multiemployer Health and Welfare Plans. Multiemployer Benefit Plans cover roughly 10 million American workers and their families. For more than 60 years, The Segal Company has served as actuary and consultant to this market place, with a greater share of this business than all other consulting firms combined.

Each multiemployer plan is unique, reflecting the characteristics of the industry and the collective bargaining patterns that have developed over time. The political and financial stability of these plans derives from the simple fact that the sponsoring employers and unions intend these plans to be permanent. As collective bargaining agreements are renewed over time, the compensation package is adjusted to allow the required contributions to be directed to the multiemployer plan to maintain the appropriate level of benefits.

ERISA provides the essential framework to protect the individual participant, dealing with the fundamental direction that all decisions be made in the best interests of plan participants. Requirements for written plan documents, the reporting and disclosure of plan information, and an open appeals structure supports this concept.

Of equal importance is the ability under ERISA to operate a common benefit plan on a national basis, with financial risk sharing not restricted by the location of participants in state or local jurisdictions. A change in this relationship would cause many of these plans to reassess their ability to continue operations.

The attached article explains multiemployer health plans and how they work. It was written by Judith F. Mazo, the Director of Research for The Segal Company, and first appeared in the Benefits Law Journal in 1997.

Multiemployer Health Plans: Why and How Do They Work?

JUDITH F. MAZO

Multiemployer health plans cover a large segment of the American population, but many employers and practitioners are unfamiliar with how these plans are structured and operated and the special legal requirements applicable to them. In this article, a multiemployer plan expert explains how these plans work and the rationale for some of the rules applicable to them. The author maintains that a combination of factors has made multiemployer plans successful for 50 years and that, while not all of these factors can be easily applied to other situations, the experience of these plans in providing portable coverage can be instructive.

Multiemployer health and welfare plans provide health, life insurance, and related coverage to roughly 10 million workers, retirees, and their families, but to those outside their ambit they are probably even more mysterious than multiemployer pension plans. Yet, within the perimeters of their operations, they have succeeded in providing the kind of "portable health coverage" that Congress and the President have been promising for years. What are they doing right? The answer is: Nothing magical; their structures and operations have evolved to fit the special circumstances of the people and industries they serve, and some care has been taken to make sure that government requirements have not gotten in their way.

A key aspect of multiemployer plans is that they are held together through collective bargaining agreements, which carry with them a tradition of collective action for mutual support. Where employees are not represented by unions or something like them, it may not be possible to replicate this commitment to pooled financing in the interest of the group as a whole, absent legislation compelling it. But the multiemployer plan experience with coverage portability for a mobile work force can be instructive, whether or not it points the way to a more universal solution.

Judith F. Mazo, an attorney based in Washington, D.C., is Senior Vice President of The Segal Company. She is a member of the Editorial Advisory Board of Benefits Law Journal.

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A PRIMER ON MULTIEMPLOYER PLANS

No one aspect of multiemployer plan operations can be appreciated in isolation. Without a broader context, a discussion of what a multiemployer plan does in specific circumstances could leave the reader even more puzzled than before.

"Multiemployer Plan" Defined

A multiemployer plan could be defined, simply, as a plan sponsored by more than one employer. But nothing is simple in employee benefits law, in which much of the language—including the key words "plan," "sponsored," and "employer"—has a special technical meaning. In this article, we will look at multiemployer plans as they are defined in Section 3(21) of ERISA, which is the most common popular-sense concept: plans to which more than one unrelated employer (i.e., more than one controlled group) contributes pursuant to collective bargaining agreements. These are almost always set up under Section 302(c)(5) of the Taft-Hartley Act as stand-alone trusts, administered by a board of trustees on which—as Taft-Hartley requires—the employees and employers are equally represented. Because the benefit programs start with these Taft-Hartley trusts, multiemployer plans are often also called "funds," a term that is used almost interchangeably with "plan" in this article as well.¹

A vital distinction is drawn under ERISA between "multiemployer plans," as defined in Section 3(37) of that law, and "multiple employer welfare arrangements" (MEWAs), which are defined in Section 3(40). MEWAs are subject to state regulation, typically as insurance companies; as employee welfare benefit plans, multiemployer plans are exempt from state regulation (to the extent Section 514 of ERISA continues to shield employee welfare benefit plans, in the wake of recent Supreme Court rulings). MEWAs are defined as, among other things, plans to which more than one employer contributes, but the definition specifically excludes *collectively bargained plans*.

In the Internal Revenue Code, multiemployer health benefit plans are not generally considered separately from other collectively bargained plans, for which special rules are sometimes prescribed. For tax purposes, a plan is not considered collectively bargained if more than half of the sponsoring union's members are owners, officers, or executives of the employer.²

Distinctive Features of Multiemployer Plans

While there are tremendous variations—and very few things that a person under oath could say are common to "all," rather than

"virtually all," multiemployer plans—some characteristics are not only typical, but significant, to the plans' special character.

Collective Bargaining

Multiemployer plans cover people who work for a number of employers under one or more collective bargaining agreements (CBAs) with the same union, or with locals of the same international union. In some areas, a group of unions may band together to sponsor a single fund. The fact that the plans are a product of, and constantly subject to monitoring through, collective bargaining is crucial to an appreciation of what the plans are designed to achieve, including harmonious labor relations. However, although the plans are negotiated and co-sponsored by labor unions, they provide health coverage for all employees who are covered by the relevant CBAs and meet the plan's eligibility standards, not just those who belong to the union.

Typical Plan Jurisdiction and Coverage

Multiemployer health funds typically cover people working in a single city or metropolitan area, but some are regional, statewide, or even national in scope. They are common in industries with many small employers, such as trucking or garment manufacturing, and where employment is mobile and workers move frequently from job to job, as in construction, entertainment, and longshore work. In those situations, few employers have the resources to offer health coverage on their own, and employment is often so transitory that few employees would qualify if the employers did sponsor their own plans. Multiemployer plans also cover union-represented workers in the retail, hotel, bakery, maritime, building maintenance, hospital, mining, and other industries, in which employment is not necessarily as sporadic, and more of the employers are substantial in size.

In addition to the individuals covered by bargaining agreements, almost all multiemployer plans cover a small complement of non-bargained workers, such as the employees of the health plan itself and related funds and, very often, the employees of the sponsoring union. Some multiemployer plans (mainly, but not exclusively, in the construction industry) allow employers to cover their managers and office workers along with their union-represented employees. These are typically small businesses that may have three or four employees aside from those in the bargaining unit. Often the owner is a former union worker who went into business for him- or herself and may still, in fact, be a union member. These people could not obtain

decent, affordable coverage outside of the plan. Plans that cover non-bargained participants typically require contributions at the same rates that the employer is paying on its bargained participants and specify a set number of hours—say 40 a week—for which contributions must be paid, so that the employers do not just “buy in” for themselves at the minimum needed to establish eligibility.

Autonomous, Self-Supporting Plan Administration

A hallmark of multiemployer plans is that they are managed by labor-management boards of trustees, who hire their own staff or contract directly with a third-party administrator to run the program and administer the benefits. Thus the operations are independent of, and separate from, each of the employers. This saves the employers the burden and expense of trying to operate a benefit plan (the “ultimate outsourcing” as one observer put it). It also means that it can be much more difficult for a multiemployer plan to communicate with its participants because it is not located at their workplaces and that payroll-deduction is rarely a feasible mechanism for collecting employee contributions.

The funds' stand-alone status also makes it difficult to collect all but the most basic data about the participants. It would inevitably be inconvenient to try to get information that is lodged in many employers' separate systems. But that difficulty is compounded for multiemployer plans: Because they are run by an equal number of employer and employee representatives, contributing employers are understandably reluctant to furnish information about their businesses' ownership, compensation, and staff complements to their competitors and to those who represent their workers in pay and benefit negotiations.

On the other hand, because many of the participants are themselves often on the move, trying to keep in touch with them can be equally difficult. Some multiemployer plans regularly have a third or more of their standard participant mailings (SPDs, benefit announcements, etc.) returned because the individual is no longer at that address. Often the only reliable way to communicate with a participant is in connection with the payment of a claim.

In addition to determining eligibility and paying or adjudicating claims, multiemployer plan administrators also bill, collect, and account for the employer contributions that finance the benefits. All expenses of plan administration are met out of the plan contributions (which are negotiated as part of the wage package) and any accumulated reserves, so increased administrative costs directly affect the

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plans' financial status in the same way as other increased benefit costs.

The tradeoff between wages and benefits is explicit in the multiemployer environment, where it is clear that an extra dollar for health coverage means one dollar less for wages or pensions, because that is the focus of the collective bargaining. A comment along the lines of "I paid in all those years ..." is not unusual from multiemployer plan participants, even if there were no official pre-tax or post-tax employee contributions paid to the plan.

Plan Financing

Typically, employers contribute at flat rates, set in the bargaining agreement and usually based on covered work, such as \$1.50/hour for each hour of covered service. Differences in the rates at which different employers contribute to a given plan may or may not affect their employees' benefits, depending on plan rules.³ Employer contribution rates are calculated to fund the plan as a whole and are rarely linked directly to the cost of coverage for a specific group or individuals within it.⁴ Pooled funding on a uniform basis, regardless of the specific experience of an individual or a subgroup, helps keep labor costs predictable and eliminates demographics as a differentiating factor when contributing employers compete for jobs. This, in turn, promotes the mobility of covered workers, since they all carry the same benefit costs as they move from signatory employer to signatory employer.

In the majority of cases, employers' contribution rates are fixed for the term of the CBA, which is commonly two or three years and sometimes as long as five years. Absent renegotiation of the labor agreement, plans must make advance arrangements to cover both expected and unexpected cost increases that materialize during the bargaining cycle. Some CBAs provide for scheduled annual or periodic increases; some have scheduled increases that can be allocated to wages, pensions, or health benefits as the union sees fit; a few include "maintenance-of-effort" provisions that authorize the plan trustees to increase contribution rates without additional bargaining, if necessary to maintain the current benefit schedule. Most anticipate the plans' needs in the later years of the agreement by setting a constant rate of contributions that is expected to be a little high at the beginning, building up a reserve to cover the likelihood that it may be a little low at the end.

Actual contribution income fluctuates, of course, with the level of covered work during the term of the agreement. Perversely, health

plan costs tend to rise when work availability slumps; because that is when participants have time to go to the doctor. Although multi-employer health plans are "funded" in the ERISA sense because they have earmarked assets that are held in a trust, they tend not to *prefund* future liabilities through the maintenance of significant reserves. However, given the inherent uncertainty of their contribution streams, they often try to maintain some reserves as a cushion—or are forced to do so, if claims for a period turn out to be lower than expected. The exemption for collectively bargained plans from the qualified asset reserve limits of Code Section 419A is, therefore, essential for multiemployer plans.

Multiemployer plans rarely require active employees to contribute toward coverage for themselves or their dependents. By contrast, retiree coverage is often contributory,⁵ and participants who would lose coverage because they are not working intensely enough to maintain eligibility may be offered the opportunity to "self-pay," at a cost that is below COBRA rates.

Benefits

Multiemployer plan benefit packages are, typically, designed by the plan's trustees, rather than negotiated by the employers and union and set out in the CBA itself. However, in many cases, the trustees and the bargaining parties consult not only on the contribution rates needed to maintain the current coverages but also on what additional amounts would be needed to support particular benefit enhancements.⁶ Large national or regional funds that cover a broad array of groups often offer a "menu" of benefit packages corresponding to stated contribution rates, so that local bargainers know in advance what a contribution increase will provide.

Coverage for active employees' families is, typically, automatic and noncontributory. In part because of the difficulty of administering payroll deduction and benefit elections for a transitory population, with which officials of the fund are not in regular contact, few multiemployer welfare plans offer cafeteria-style choices under IRC Section 125. From their genesis as bare-bones "cents-per-hour" coverage pools, multiemployer plans have a long tradition of self-insuring for benefits, although insurance, managed care organizations, and other intermediaries are also used to provide benefits when that is cost-effective and acceptable to the participants. While HMO, PPO, point-of-service, and other managed care approaches are common as options, it is still unusual to see them as the only or primary coverage format in a multiemployer plan in most parts of the country.

A 1992 Segal Company study reported that a majority of multi-employer health plans—68 percent of the 483 plans reviewed—provided retiree coverage.⁷ One illustration of the extent to which combining forces through a multiemployer plan can make benefits feasible and affordable is the fact that over 80 percent of the construction industry funds surveyed, and 50 percent of those in the retail industry, provided retiree coverage. This is virtually the only retiree health coverage provided for rank and file workers in those industries.

Most multiemployer funds that provide health coverage also provide other types of welfare benefits, such as life insurance, short-term disability benefits, AD&D, etc. On the other hand, the standard pattern is to meet employees' need for long-term disability income through the multiemployer pension plan. Ordinarily, an employer's welfare fund contributions entitle its employees to the whole package of benefits, although modular options—with or without group term life, for example—may be available on some of the larger funds' benefit menus.

Eligibility

Multiemployer plans' reputation for coverage portability is based on their eligibility rules: They allow workers to establish and maintain coverage by working for a number of employers, not just one.

Pooled Service Credit

A multiemployer plan participant can move from job to job among employers that contribute to the plan without losing the benefit of eligibility credits built up at earlier jobs. For example, a painter or electrical worker may work for five or six different building contractors in the course of a year, without interrupting his or her family's health coverage.

Typically, an employee establishes eligibility for health coverage by working during a fixed period at least a minimum number of hours⁸ for which employer contributions are made. It does not matter how many employers contribute or when, during the eligibility measuring period, the person works. For example, a fund may require 300 hours of covered service during a calendar quarter to qualify for welfare fund coverage starting on the first day of the next calendar quarter. An employee working for covered employers has the full three-month period in which to accumulate the necessary 300 hours, from one-day assignments to one-month projects to year-long engagements. An individual could start on January 1, work substantial

overtime, and accumulate 300 hours by early February; or he or she could work 100 hours in January, zero hours in February, and 200 hours in March; or the person could work 100 hours in each of the three months. Whatever the route to accumulating the 300 hours, health plan coverage will start on April 1 and continue in force through at least June 30, under this scenario, whether or not the person has any more covered service.⁹

An individual's job with any one employer that contributes to the plan may be very brief—at the extreme, for example, longshoremen may work for several different employers in the course of a single day. But the multiemployer plan looks to continuity of employment *among contributing employers*, rather than with individual employers. In some instances, the concept of "continuous service" extends beyond local boundaries to include service for employers throughout the country who contribute to health plans co-sponsored by affiliates of the same international union. All hours of service for which contributions are received are added together in determining whether the employee earns or retains health coverage for the following period.

In some ways it might be fair to say that, for a multiemployer plan, the "employer" is the industry that collectively sponsors the plan.

Maintaining Coverage Without Current Service

In addition to basing eligibility on total service during a specified period, whether or not the person worked continuously during that period, several other devices to span gaps in covered service are common among multiemployer plans: reciprocity agreements, "hour banks," specially designed short-term coverage extensions, and self-pay options.

Reciprocity agreements, promoted and coordinated by international unions that represent a large proportion of the workers covered by multiemployer plans, make it possible for a participant to maintain health coverage under his or her "home" plan while working elsewhere in the country under a different bargaining agreement. Often called "money-follows-the-man" agreements, the typical arrangement is for the plan that receives the contributions with respect to an individual's work (the "away" plan) to forward those funds to the employee's home plan, where they are recognized as continued employer contributions and the person receives the corresponding amount of service credit, adjusted as needed for cost differentials. So, for example, an electrician who lives in Boston might go to Toledo

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for several months to work on a project there; the Toledo fund would send the contributions attributable to that person's work back to his "home" plan in Boston, so that family health coverage back home is maintained and there is no need to re-qualify for coverage in Toledo.¹⁰

"Hour banks" or, sometimes, "dollar banks" are another device that many multiemployer plans use to help their participants bridge gaps in covered work. These enable people who work substantially more than the minimum needed for eligibility in a given period to "bank" some of that extra service, and then draw on it when work drops off. Take, for instance, the hypothetical plan promising three months' coverage for someone who works at least 300 hours in covered service in the preceding three months. An individual who worked, say, 600 hours in a calendar quarter might have 150 of those hours "banked" to be applied to maintain eligibility if, in the future, he or she is not able to achieve the 300-hour minimum from current work. Service credit in eligibility banks may be subject to expiration or forfeiture.

This hour bank example also illustrates how, although they resemble premiums, employer contributions are not designed to pay the discrete cost of covering the specific individuals with respect to whom the contributions are made. That is, the minimum test for eligibility is usually not based on a determination that the contributions paid for someone who works that much will add up to the cost of providing health care for that person (and his or her family, if there is one). Rather, the assumption is that, while some people will qualify for coverage by working the *minimum* number of hours required, others will generate a surplus by working far more than would be needed, on a per capita basis, to meet the total cost of the plan. And, since employer contributions typically start with the first hour that an employee performs in covered service, in very high turnover industries multiemployer plans can often afford to set fairly low eligibility thresholds because of the contribution income they will receive on the people who will not qualify for coverage.

In effect, the group supports all of its members. That is why those who work more than the minimum can only receive eligibility-bank credit for part of the excess that they generate. The rest is needed to meet the plan's current costs.

Many multiemployer plans have a variety of other special provisions aimed at maintaining uninterrupted health coverage for people who are "in the industry" although between covered jobs. For example, a plan may use a concept similar to a break in service, which allows an employee who has met the minimum eligibility test and

been covered for a certain period to remain covered until his or her service drops below a level that is much lower than what is needed for initial eligibility: 300 hours of covered service is needed to qualify for health coverage, but it continues in effect as long as the person has at least 150 hours of service in each subsequent quarter. Others simply extend coverage for a given period of time automatically, without additional payment, if the person is available for work under the jurisdiction of the collective bargaining agreement (and is not working for competitors of the contributing employers).

Finally, a common mechanism multiemployer plans offer employees for the preservation of health coverage is the opportunity to "self pay"—to make up for any shortfall in employer contributions on their behalf by paying in the extra amount themselves. The cost of coverage on a self-pay basis is less, sometimes considerably less, than COBRA premiums, because the self-pay rates are usually derived from employer contribution rates, while COBRA premiums are more of a true premium-equivalent. The self-pay opportunity is usually intended as a temporary bridge rather than a means of continuing health coverage over the long term; if the former participant does not recover eligibility based on employer contributions after a period such as three or six months, self-pay coverage ripens into COBRA, which the family may or may not keep in force, given the higher cost.

Retrospective Determinations

Regardless of the specifics of multiemployer health plan eligibility rules, virtually all of the plans share one administrative characteristic that may become pertinent as the federal government moves more deeply into regulating health plan operations: The beginning and end of an employee's multiemployer plan health coverage are both determined retrospectively. Until a plan has received the employer contributions and reports on employees' covered service for a period, it cannot determine who has established or lost eligibility during that period. Since the deadline for these employer filings may be ten days to a month after the close of the reporting period, a family's health coverage may be in effect before either the employee or the plan knows about it.¹¹ To mitigate this, some plans build a delay, or "lag period," into their eligibility rules so that coverage does not start until a month or two after the period in which the person earned enough service to become eligible. For example, if the measuring period is the calendar quarter and there is a one-month lag period, someone who first meets the eligibility test in the quarter ending March 31 will have coverage starting May 1.

SPECIAL RULES FOR MULTIEMPLOYER HEALTH PLANS

When proposed laws and regulations call for actions that are incompatible with the way multiemployer plans must operate, Congress and regulation drafters try to adapt their rules to the special circumstances of multiemployer plans—if they remember and can be persuaded to do so. There are fewer such special rules for health plans than there are for retirement plans, probably because there have generally been fewer rules for health plans that needed to be adapted to multiemployer plans. Here is a quick survey of some of the more important areas in which the laws and regulations bend a little to give multiemployer plans some breathing room.

Effective Dates

Ordinarily, if compliance with a statutory change will cost money or compel changes in employee benefits that may be covered by a bargaining agreement, the effective date for collectively bargained plans is set at the first day of the first plan year beginning after expiration of the current bargaining agreement. Sometimes these are open-ended, but more often the law goes into effect after three years, even if the bargaining agreement has longer to run. When there is more than one collective bargaining agreement, as is frequently the case for multiemployer plans, the effective date is linked to the expiration of the *longest-running* agreement that had been ratified by the date of enactment of the law.¹²

ERISA Preemption

Many multiemployer plans operate multistate, and even those that do not do so directly often end up with multistate operations through their participation in reciprocity agreements. Beyond that, ERISA preemption is of great importance to multiemployer plans because their operations are already so complex, and subject to so many controls under federal law (i.e., Taft-Hartley and the National Labor Relations Act, as well as ERISA, the Code, and the rest), that having to confront state regulation as well could prove backbreaking. Thus, perhaps the most important ERISA special rule for multiemployer health plans is their carveout from MEWA status in Section 3(40), which preserves their ERISA preemption shield.

VEBAs

Under the Taft-Hartley Act, multiemployer health and welfare funds must use a trust. In light of this, the regulations under IRC Section 501(c)(9) for tax-exempt voluntary employee beneficiary

associations (VEBAs) include several provisions that help multi-employer plans and other collectively bargained funds qualify as VEBAs so that federal income taxes do not add to their costs.

Employment-Related Common Bond
(Treas. Reg. Section 1.501(c)(9)-2(a)(1))

Explicit examples of participants joined by the "employment-related common bond" that is necessary for VEBA status include those covered under one or more collective bargaining agreements related to their benefits and members of a given labor union or members of locals affiliated with the same national or international union. Employees of the sponsoring union and of the fund itself are also cited as examples of those eligible to participate along with the union members.¹³

Employee
(Treas. Reg. Section 1.501(c)(9)-2(b)(1)(ii), (2))

Individuals who are considered employees for purposes of a collective bargaining agreement are considered employees for VEBA purposes; those who are intermittently employed by different employers in an industry characterized by short-term employment are treated as employees even during gaps between jobs.

Life, Sick and "Other Benefits"
(Treas. Reg. Section 1.501(c)(9)-3(e))

The "other benefits" that VEBAs can provide, in addition to health and life insurance-type benefits, include certain enumerated examples plus any benefit (other than those specifically singled out in the regulation as nonqualifying) that is provided through a Taft-Hartley trust.

Welfare Benefit Fund Reserve Limits

As should be apparent from the earlier discussion, since the flow of contributions to multiemployer health plans is fairly unpredictable and directly dependent on the economic fortunes of the covered workers,¹⁴ it is essential that all of the parties be allowed a great deal of flexibility to accept whatever is available when times are good and to maintain adequate reserves to sustain coverage and benefits during the lean periods. If there is any danger that employers may not be able to deduct the full amount of what they are required to contribute, they will negotiate for very low contribution rates. If there is any danger that earnings on fund reserves will be taxable, which

would have the effect of raising the cost of benefits, the union may well negotiate for extra-high contribution rates to prevent possible benefit cuts. This kind of conflict and uncertainty would make it extremely difficult for multiemployer health funds to continue as a reliable source of stable health coverage for mobile workers and their families.

The law and regulations governing welfare plan deductions and the taxability of their reserves make allowances for multiemployer plans that are designed to avoid that unhappy result.

Asset Account Limits

Under Section 419A(f)(5)(A) of the Code, no qualified asset account limits apply to welfare benefit funds maintained under collective bargaining agreements, so the limits on deductible employer contributions in Section 419, and on tax-exempt fund reserves in Section 512(a)(3)(E), do not apply to multiemployer and other collectively bargained plans. Many, but not all, multiemployer plans would also be exempt from those limits as a result of the 10-or-more-employer exception in Section 419A(f)(5)(B).

Funding for Retiree Health Coverage

Because collectively bargained plans are exempt from the asset account limits, employer contributions used to pre-fund retiree health coverage under multiemployer plans are deductible even if anticipated future inflation in the cost of that coverage is taken into account in determining the funding, despite the general rule that allows tax-favored pre-funding on the basis of current costs.¹⁵ And, unlike other types of welfare benefit funds, the earnings on retiree health reserves in multiemployer and other collectively bargained funds are tax-exempt, under Temporary Regulations Section 1.419A-2T, Q&A 1, which provides that "neither contributions to nor reserves of ... a collectively bargained welfare benefit fund shall be treated as exceeding the otherwise applicable limits of section ... 512(a)(3)(E)" until the adoption of final regulations on this subject.

On the other hand, since Code Section 420(a) excludes multiemployer pension plans from the application of Section 420, excess multiemployer pension assets cannot be transferred to a multiemployer health fund to meet current retiree health costs.

Definition of Collectively Bargained Plan

Under the governing temporary Treasury regulations, a welfare benefit fund that was in existence before July 1, 1985, is considered

to be collectively bargained for purposes of Sections 419, 419A, and 512 if at least 50 percent of the participants are covered by collective bargaining agreements. However, if the number of non-bargained participants later increases "by reason of an amendment, merger, or other action of the employer or the fund," the plan will lose its special status as collectively bargained.¹⁶

This is intended, of course, to prevent employers from taking advantage of the fact that some of their employees are union-represented and sheltering large amounts of funding for their non-bargained workforces. But, if it were read literally, the language would clearly go too far. At the extreme, it might, for example, prevent a robust 10,000-participant multiemployer health fund from absorbing a financially troubled fund with 100 participants if any of them were not covered by a collective bargaining agreement. Even if the percentage of non-bargained workers covered by a plan were to go up a few points because, for example, a multiemployer plan is amended to allow contributing employers to cover themselves and their office staffs along with their union-negotiated employees, the reasoning is highly questionable. The temporary regulation recognizes plans established after July 1, 1985, as collectively bargained if at least 90 percent of their participants are covered by bargaining agreements. So it should not matter if the covered population in a pre-existing plan goes from 95 percent to 93 percent collectively bargained, just as it should not matter if the percentage of non-bargained people stays the same or drops even if their absolute number increases.

Asset Allocation

Another feature of the Section 419A temporary regulations could potentially be quite troubling if misunderstood or misapplied. Section 1.419A-2T, Q&A 2(3) warns that

only the portion of the fund (as determined under allocation rules to be provided by the Commissioner) attributable to employees covered by a collective bargaining agreement, and from which benefits for such employees are provided, is considered to be maintained pursuant to a collective bargaining agreement.

If put into effect, a requirement that health fund assets be allocated between collectively bargained and non-bargained participants could create recordkeeping problems and costs that would be difficult for funds to handle. But that would be the least of it.

For example, if separate reserves had to be maintained for the non-bargained participants' benefits because they are subject to lim-

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its, how could their claims experience be pooled with that of the bargaining-unit workers? Would the contributions required on behalf of non-bargained individuals have to be calculated like true insurance premiums, in an attempt to make sure that the assets earmarked for them would be adequate to cover their claims? What could the fund do in the case of an unanticipated catastrophic claim for a non-bargained person? Under these circumstances, would the bargained and non-bargained employees really be in the same "plan"? Would an allocation requirement effectively deny the non-bargained workers access to the multiemployer plan's large risk pool, relegating them to the same fairly helpless position as other small groups seeking health coverage that is both adequate and affordable?

If the answer to those questions is yes, the obvious response is: Why do that? What tax or other policy objective would be advanced by making good health coverage inaccessible to even more people?

On the other hand, if partitioning the plans' reserves does not interfere with their ability to cover a reasonable number of non-bargained as well as bargaining-unit workers, that may be because purporting to earmark assets would be an empty gesture for most plans. Take, for example, a multiemployer plan with 5,000 bargaining-unit participants and 150 non-bargained participants. Assume that guidelines are issued, and the plan is allowed to maintain unlimited reserves for its bargaining unit participants (as the law clearly provides), but virtually no reserves for the others. The plan therefore pays all claims incurred by non-bargained participants from its current contribution income, drawing down on the reserves if necessary to meet the expenses of care for the bargaining-unit people. No extra taxes are paid and everyone gets adequate health coverage, although the exercise of creating separate reserves has cost the fund some money. Again, why bother?¹⁷

These arguments are aimed at possible future allocation requirements. Because the language of the temporary regulation may seem imprecise, it is important to note that at present there is no requirement to split reserves or other assets between bargained and non-bargained groups. It anticipates that allocations will be required under "rules to be provided by the Commissioner," but does not compel anything until those rules are issued. Happily, no attempt has been made to do so, in the 12-plus years since the temporary regulation was adopted.

Nondiscrimination Rules

ERISA amended the qualified plan provisions of the Code to make it clear that people covered by collective bargaining agree-

ments can be disregarded, in applying the nondiscrimination rules, if benefits were the subject of good-faith bargaining.¹⁸ This enables collective bargaining to focus on the workers covered by the agreement, without affecting what the employer is permitted to do for its other employees (including what it is allowed to do under agreements with other unions). The pension nondiscrimination regulations build on that, and a related provision in IRC Section 413(b)(2), to establish a rule that essentially exempts people considered covered by a collective bargaining agreement from the general nondiscrimination and minimum coverage rules.¹⁹

Whether and, if so, how the income-related nondiscrimination rules for health plans apply to multiemployer plans is less clear—probably because health plans were given so little consideration at the time ERISA was passed, and because since the demise of Section 89, so much less attention, has been given to the details of the nondiscrimination rules for health plans. Code Section 505(b) expressly exempts VEBAs associated with multiemployer and other collectively bargained plans from the nondiscrimination rules of Section 505. However, there is no equally express exception from the Section 105(h) nondiscrimination rules for self-funded multiemployer health plans, although Section 105(h)(3)(B)(iv) includes the standard exclusion for people covered by collective bargaining agreements when testing other plans. In practice, this has not been an issue, perhaps because of the egalitarian nature of most multiemployer plans' coverage and eligibility rules.

A principle underlying the "automatic pass" for collectively bargained participants under the qualified-plan nondiscrimination rules was the policy makers' sense that unions are responsible for seeing to it that those they represent are treated fairly in the design of wages and benefits, so the imposition of additional tax code nondiscrimination rules is not necessary or appropriate. That reasoning holds as true for health and welfare benefits as it does for retirement plans.

COBRA

Despite the many devices that multiemployer plans deploy to try to keep their participants' health coverage in force, people do lose eligibility and become entitled to continue their coverage under COBRA.

Applicability

Although plans maintained by employers with fewer than 20 employees are exempt from COBRA and many employers that contribute to multiemployer plans fit that category, the exemption ap-

plies only if *all* employers contributing to a plan meet the small-size test.²⁰ That might be the case for a few multiemployer plans, but it would be difficult to document. The exemption looks at the employers' total workforces, not just those covered by any one plan, and multiemployer plans do not have enough information about the total workforces of contributing employers and their controlled groups. Moreover, the exemption would be lost if *any* of the employers grew past the 20-employee mark, and no multiemployer plan would want to be in the position of offering COBRA one year and not offering it the next, as individual contributing employers grow and shrink.

Accordingly, it is fair to say that multiemployer plans, as a class, are subject to the COBRA provisions of ERISA and the Code. Two aspects of the COBRA rules have been specially tailored to fit multiemployer situations.

Accountability

Multiemployer health plans are, of course, administered by the plans' trustees, not by individual contributing employers. Because service with all contributors is pooled to determine plan eligibility, employers contributing to multiemployer plans often may not know which of their employees are in fact covered and which of their former employees actually lost health coverage when their jobs ended. Few contributing employers, other than those with a seat on the board of trustees, probably know what the multiemployer plans' benefits are or what they actually cost. Contributing employers cannot supervise the way COBRA is administered by a multiemployer plan, but, under the law's original provisions, employers were the ones penalized (by a loss of tax deductions for all of their health plan contributions) if a mistake was made.

Before the employer community could become too concerned about the prospect of incurring severe tax penalties for the actions of an unrelated party over which they have no control, the situation was corrected. When the tax sanctions for COBRA violations were overhauled in 1988 and scalable excise tax penalties were substituted for the previous all-or-nothing denial of deductions, liability for the taxes in the case of multiemployer plans was placed on the plan. This change was supported by multiemployer plan advocates, to assure contributing employers that they were not at risk if they continue to provide health coverage through multiemployer plans. However, the hope is that, when and if a COBRA excise-tax collection campaign is launched, the IRS will recall that the assets in multiemployer plan trusts are all that is available to pay for the par-

ticipants' and beneficiaries' health care. An aggressive effort to collect COBRA penalty taxes from the plans will just diminish their ability to provide coverage.

Another side to the question of accountability under COBRA was not as carefully addressed during the statutory rewrite. While the multiemployer plan is responsible for honoring the COBRA rights of people associated with a contributing employer (as current or former employees or as members of those employees' families), when an employer stops contributing to the multiemployer plan it is not clear that the plan's responsibility to that employer's current or former workers must or should continue.

For example, the law provides that a change in the coverage of active plan participants must be applied as well to similarly situated COBRA participants.²¹ The great majority of advisors to multiemployer plans assumed this meant that, if an employer shifted its active employees from a multiemployer plan to a single employer plan, this was a change in coverage that had to be applied to any former employees of that employer who had elected COBRA under the multiemployer plan. In *In re Appletree Markets*, 19 F.3d 969 (1994), the Fifth Circuit disagreed. Whether or not *Appletree Markets* is correct, the answer probably would have been different if the employer had gone completely out of business rather than changing the media through which it provided health coverage, since the law says specifically that COBRA coverage terminates when "the employer ceases to provide any group health plan to any employee."²²

Notices

COBRA generally requires the employer to notify the plan administrator when an employee has a qualifying event—usually, termination of employment or reduction in hours—that will lead to termination of his or her health coverage. However, in most multiemployer situations, what is important is termination of employment or decline in hours with all contributing employers, rather than with any one of them. To avoid a blizzard of unnecessary notices, multiemployer plans are permitted to dispense with this employer-notice requirement.²³ If they do not want to go that far, multiemployer plans can extend the deadline for employers to report qualifying events so that those notices can be included with the employers' regular remittance reports.²⁴

CONCLUSION

Multiemployer health plans are surprising institutions to those who are not familiar with them. An academic analysis might conclude that

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they cannot work, since their income and expenses are each subject to so many variables and, given the decisive role of collective bargaining, no single entity can control the key decisions.

But not only do multiemployer plans work, they have been doing so—to the great benefit of millions of Americans and their families—for fifty years. Like most relationships among people, multiemployer plans work when, and because, all concerned want them to work and are willing to cooperate toward that end. Before ERISA, multiemployer plans depended on goodwill and cooperation among the employers and unions that sponsor the plans and the trustees that manage them. In recent decades, they have increasingly come to need the understanding and cooperation of federal policy makers and regulators to make sure that rules aimed at the more familiar single-employer model do not inadvertently choke off the ability of multiemployer plans to fulfill their mission.

It is safe to predict that the coming years will see an even greater need for that kind of willingness to listen, learn, and accommodate. Otherwise, a lot of working families could lose their health coverage.

NOTES

1. Multiemployer plans are also often called Taft-Hartley funds. The great majority of Taft-Hartley funds are multiemployer plans, but there also are some jointly administered single-employer funds set up under the Taft-Hartley Act.
2. IRC §7701(a)(46).
3. Most often, a group that negotiates higher contribution rates is entitled to extra benefits. However, note that a higher contribution rate will not generate more contribution income for the plan unless the group in fact has as many hours of service on which contributions are made as others in the plan.
4. However, underwriting of some sort is not uncommon when a new group is admitted to a fund or a merger is contemplated, so that the trustees can have an idea of how future costs are likely to be affected.
5. To avoid cutting retiree benefits, multiemployer plan trustees have tended to prefer imposing contribution requirements on the retirees. Increases in the cost of retiree health coverage are often coordinated with benefit increases under the companion multiemployer pension fund.
6. Actually, in most cases the people who serve as trustees are also those who conduct the negotiations, but wearing different hats.
7. The Segal Company, *Survey of Multiemployer Postretirement Health Care Plans* (1992).
8. For convenience, this article discusses eligibility based on hours worked. For any given plan, eligibility may be based on some other service measurement, such as day or weeks, which fits work patterns in the industry. In the Screen Actors Guild and other entertainment-industry multiemployer funds, eligibility is based on covered earnings.

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Residuals — fees paid when a movie, TV show, commercial, or other product of the participant's talent is reissued or re-exhibited — count as covered earnings, so a person can maintain eligibility as an active participant long after he or she has stopped working, or even stopped living.

9. In less transitory employment situations, such as the hotel and restaurant industry, eligibility may be measured from the first day of employment in a job category for which employer contributions to the health fund are required.

10. Each plan's board of trustees decides whether or not to join a reciprocal agreement, but once they do they are expected to honor it with respect to all eligible workers. Participation is also voluntary on the part of the individual, who could choose to try for eligibility in the jurisdiction where he or she is working.

11. And, of course, not all employers pay on time. Delinquent contributions may qualify an employee for health coverage months after the period to which they relate.

12. The granddaddy of these was the deferred effective date of ERISA's minimum standards, which set an outside compliance date for collectively bargained plans of January 1, 1981, ERISA §1017(c)(1).

13. See also Treas. Reg. §1.501(c)(9)-2(a)(2)(ii)(B), (C).

14. Even if employers are prosperous, the plan will not receive contributions unless the participants are working.

15. See IRC §419A(c)(2)(A).

16. Treas. Reg. §1.419A-2T, Q&A 2(4).

17. This discussion assumes the IRS rules would not require a separate allocation of current contributions, as well. If they require an allocation of both contributions and reserves between bargained and non-bargained participants, they would effectively be saying that the two cannot be covered under the same plan. At least that would moot any further concern with the acceptable proportion of non-bargained people that can be covered without losing "collectively bargained" status.

18. See, e.g., IRC §410(b)(3)(A), (B).

19. See Treas. Reg. §§1.401(a)(4)-1(c)(5), 1.410(b)-2(b)(7).

20. See IRC §4980B(d)(1).

21. ERISA §602(1), IRC §4980B(f)(2)(A).

22. ERISA §602(2)(B), IRC §4980B(f)(2)(B)(ii).

23. ERISA §606(b).

24. ERISA §606(a)(4)(B), IRC §4980B(f)(6)(B).



***APPENDIX D - WRITTEN TESTIMONY OF JAMES A. KLEIN,
PRESIDENT, AMERICAN BENEFITS COUNCIL, WASHINGTON,
D.C.***

Committee on Education and the Workforce

Statement by
James A. Klein
President
American Benefits Council
on the
Employee Retirement Income Security Act (ERISA) and Employer-Sponsored Health
Coverage
Subcommittee on Employer-Employee Relations
House Committee on Education and the Workforce

June 12, 2001

INTRODUCTION

Good morning, I am James A. Klein, President of the American Benefits Council. The American Benefits Council is a national trade association whose members include Fortune 500 companies and other organizations that provide benefit services to employees and their dependents. Collectively, the Council's members either sponsor or administer health and retirement plans covering more than 100 million Americans.

I appreciate this opportunity to present our views on the importance of the Employee Retirement Income Security Act (ERISA) to employers such as our members who voluntarily sponsor health benefits through the workplace. ERISA is of crucial importance to employers who sponsor health benefit plans and provides an effective framework to ensure these benefit plans are operated efficiently and responsibly.

THE EMPLOYERS' PERSPECTIVE

Employers must compete for one of their most valuable assets: a skilled, committed and productive workforce. The primary reason employers provide health benefit plans is to attract and retain talented employees by offering them an attractive and competitive total compensation package. However, employers offer health coverage not only because employees highly value this benefit, but because helping to protect employees from the financial loss associated with illnesses and accidents enhances workforce productivity, especially when the benefit is well managed. Once a plan is established, employers share with their employees a strong and mutual interest in maintaining a high quality, affordable set of benefits that are administered consistently and fairly for all plan participants.

Employers highly value the framework provided by ERISA because it offers the tools they need to structure a health benefit plan that best meets the needs of their workforce and manage it efficiently. Under ERISA, state laws are preempted if they "relate to" an employee benefit plan. This was not an inadvertent outcome when ERISA was enacted in 1974. In crafting ERISA's preemption provisions, Congress made a very conscious choice by opting for a uniform Federal framework for employer-sponsored health plans

rather than regulation by fifty different states. In addition, the fact that ERISA imposes more detailed standards on pension plans than it does on health plans is evidence of where Congress perceived the more urgent concerns to be at the time of its enactment, not evidence -- as many wrongly assume -- that ERISA was not intended to fully apply to the health benefit plans sponsored by employers.

We believe ERISA strikes a careful balance that affords meaningful protections for plan participants while encouraging employers to establish and maintain valuable health benefit plans by giving them the flexibility to design and administer their benefit plans consistently regardless of where their employees might live and work. For most of our members, this is an essential issue since all of them have employees residing in nearly every state.

Even in those cases where an employer elects to provide health coverage through an insurer or health maintenance organization regulated by each different state, ERISA still has important advantages to employers and employees. The most significant of these is that ERISA provides for the resolution of coverage determination disputes through a uniform federal framework.

Every day, millions of health benefit claims are reviewed, decided, and issues are resolved. In very few instances, some health claims are then litigated and, when they are, ERISA's uniform legal framework then applies to the courts' decisions. This framework is extremely important for two reasons. First, it leads to a much more consistent interpretation by the courts of what should or should not be covered by a health plan than would be the case if conflicting decisions were being made by fifty different state jurisdictions. Second, it provides a much more cost-effective approach to conflict resolution and therefore preserves scarce plan assets for the payment of benefits of all plan participants.

For employees, there are also distinct advantages of the uniform ERISA framework. It means an employee's legal rights, remedies, and obligations do not depend on where he or she happens to reside. Prior to ERISA, it was not unusual for courts to have difficulty resolving which state had jurisdiction over a benefit issue when the plan participant, the employer, the plan, and other service providers could all be located in different states. This situation frequently left employees with no real resolution of their concerns while attorneys argued at length over relatively arcane legal concepts and procedural issues.

ERISA recognizes that employers make an entirely voluntary decision when they elect to offer health, pension or other similar benefit plans to their employees. However, once an employer makes the decision to establish a benefit plan to provide coverage, ERISA places a set of strict obligations on the fiduciaries of these plans in order to protect plan participants and hold the plan accountable for proper administration. Among the most fundamental of these are the duties of care and loyalty imposed by ERISA on plan administrators, employers, and other fiduciaries. These standards are designed to assure those involved in the administration of a benefit plan act prudently and solely in the interest of plan participants. Breach of these standards can subject the administrator to serious financial penalties -- including loss of business and personal

assets -- and therefore provide meaningful protections to all plan participants.

ERISA's protections also rely on a scheme that emphasizes the resolution of problems at their earliest possible stage through an appeals process, rather than one that encourages costly and unnecessary litigation. Many large employers, such as our members, are directly involved in their plan's appeals process because it allows them to have a direct say over the interpretation of the terms and conditions of coverage when ambiguities must be resolved. What we hear over and over again is that employers work hard at the appeals process to make sure all cases receive a fair and prompt review. And they tell us they look for ways to say "Yes", rather than "No" whenever it is possible and try to instill that same mindset with their business partners who may share plan administrative responsibilities with them.

It should come as no surprise, then, that we have major concerns about the many different versions of the Patients' Bill of Rights that would subject employers to fifty different state interpretations of their obligations as plan sponsors and expose them, both individually and as corporations, to the constant threat of unlimited damages. This approach would be guaranteed to increase the numbers of uninsured families in America, escalate health care costs, reward aggressive litigation behavior, and result in more expensive and more restrictive health benefits for those still fortunate to retain coverage at all.

It is our view that we need to encourage, not punish, employers and health plans that take their responsibilities seriously when they decide to offer health benefits through the workplace. Making informed, consistent and appropriate decisions about what is covered under a health benefit plan is serious business and needs to be undertaken by those with a commitment to making the best decisions possible. But, if we are honest with ourselves, we also must recognize that in many cases, the job of making health benefit coverage decisions involves some tough judgement calls based on the best information available at the time. It is extremely important that a public policy framework exists that recognizes our common interests in seeing these difficult, but essential decisions are made properly. We are convinced the best way to proceed is to build on the foundation of ERISA's remedial scheme by improving the existing appeals procedures and adding a further stage of independent external review for health care claims where a coverage decision judgment call must be made based on medical facts and evidence.

We also need to be clear that the increased exposure of a health plan to legal risk would be a development no employer sponsors of these plans could or would ignore. Among small employers, the additional exposure to legal risk would undoubtedly cause many to drop their health benefit plans entirely. For new start-up companies, unlimited legal exposure would certainly be a strong impediment to additional plan formation for health coverage so sorely needed to tackle the problems of uninsured Americans. And for large employers, like our members, additional legal risk and the potentially unpredictable litigation costs would directly contribute to higher out-of-pocket costs paid by employees and would lead to more restrictive and more limited coverage.

Many companies now have benefit cost-sharing policies that make explicit how increases in health care expenses -- whatever the source of the increase might be -- are shared between the company and plan participants. For example, where there is a 50/50 cost-sharing policy, any additional expenses to the plan, including the costs of expanded court-awarded financial damages, would mean that all plan participants would pick up 50 percent of the added expense. This is a very important reality to keep in mind because employees who cannot afford health coverage when it is available are just as uninsured as those who have no benefit plan options to choose from in the first place.

In summary, employers take seriously their fiduciary responsibilities under ERISA. Coverage determinations are made under the terms and conditions of the plan with every effort made to see the right decision is made in each individual case. They work hard to select health plans able to meet demanding standards -- from our members and from the private accreditation organizations that employers were instrumental in establishing -- and work closely with health plans to make necessary changes when areas for improvement are identified. All of this is made possible under ERISA, which allows employers the flexibility to design and manage a health plan that responds to the needs of their workforce, holds them accountable for seeing it is managed fairly and consistently, and provides an incentive for offering and maintaining a high quality set of health benefits in an increasingly competitive global marketplace

CONCLUSION

The private health plan system owes much of its success to ERISA. How we address ERISA issues will have a profound effect on millions of Americans whose security depends on the continued availability of health plans that are voluntarily sponsored, and largely paid for, by employers. Few issues could affect these decisions as much as the question of legal liability and increased legal risk.

We urge that you proceed cautiously in this area and continue down the path of encouraging the right coverage decisions to be made at the earliest possible stage through a fair and improved appeals process, rather than one that would increase the incentives for litigation, the costs of which would be broadly shared. This subcommittee, in particular, has a long and distinguished record of finding and striking the appropriate balance between the desire for improved protections for benefit plan participants and the need to keep employers encouraged to take the voluntary act of sponsoring benefit plans that meet essential needs of more than 100 million Americans. Your continued leadership to find that balance once again as Congress struggles to enact a Patients' Bill of Rights is now needed more than ever.

Mr. Chairman, that concludes my statement. We welcome the opportunity to continue to work with you and the members of this committee as you address these important issues and I thank you for the opportunity to present our views to you today.

***APPENDIX E - WRITTEN TESTIMONY OF ALICE M. WEISS,
DIRECTOR OF HEALTH POLICY, NATIONAL PARTNERSHIP FOR
WOMEN & FAMILIES, WASHINGTON, D.C.***

Committee on Education and the Workforce

TESTIMONY OF THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES
BEFORE THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
OF THE
HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE
ON
"ERISA – The Foundation of Employee Health Coverage"

Statement of Alice M. Weiss, Director of Health Policy
National Partnership for Women & Families

June 12, 2001

Good morning, Mr. Chairman and other members of the Subcommittee. I am Alice M. Weiss, Director of Health Policy for the National Partnership for Women and Families. Thank you for the opportunity to testify today about ERISA's role in our health care system.

The National Partnership is a nonprofit, nonpartisan organization that uses public education and advocacy to promote fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership has grown from a small group of volunteers into one of the nation's leading advocates for women and families. One of the Partnership's key priorities is ensuring that American women and their families receive the highest quality health care, including care provided through private employer-sponsored health plans regulated by the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA plays a critical role in our health care system. Employer-provided health plans covered under ERISA provide health insurance for an estimated 129 million Americans, representing about two-thirds of all Americans with private health insurance. Enacted on Labor Day of 1974, ERISA was intended to establish uniform national standards to ensure that individuals receive the benefits promised by their employers. ERISA's federal standards have had a number of positive effects for consumers, encouraging many employers to offer job-based coverage and providing important protections regarding continuation and portability of health insurance coverage when individuals leave their jobs. However, in the health care context ERISA often falls far short of the protections consumers need. Rather than providing greater security, ERISA has become a barrier to meaningful regulation and a shield enabling bad actor HMOs, insurers, and employers to wrongfully deny or delay benefits with impunity.

My testimony today will discuss ERISA's impact on our health care system and explain why federal legislation is needed to ensure it will fulfill its promise for American families.

ERISA's Impact in the Health Care Arena

ERISA was never intended to regulate health insurance. ERISA was enacted in 1974 to establish uniform national standards to ensure that workers and their families received the benefits that they were promised. In order to encourage employers operating in multiple states to offer benefits to their workers, ERISA preempted state regulations that "relate to" the employer-sponsored benefit plan. However, ERISA preserved state laws that regulate insurance, leaving the state insurance commissioners with authority to regulate health insurers who provided coverage for employer plans. Thus, states retained the ability to regulate ERISA-covered health plans indirectly, through their regulation of insurers.

ERISA's health plan standards are minimal. ERISA was enacted largely in response to workers' complaints about employers' pension fund abuses. As a result, while ERISA originally included a number of detailed requirements for pension plans, it included only a handful of general requirements that also applied to health plans, dealing with information reporting and disclosure, benefit dispute resolution, and fiduciary rules for individuals who control plan assets. In the mid-1980s and late-1990s, ERISA was amended several times to add some new specific requirements for health plans, including COBRA continuation of coverage, portability and non-discrimination rules under HIPAA, mental health parity requirements, hospital stay requirements for newborns and mothers, and reconstructive surgery standards following breast cancer. Although these newer requirements have created some minimal standards for ERISA's regulation of health care, none of these provide the oversight that has developed in the state health insurance market or require plans to improve the quality of health care they provide.

ERISA's inadequate regulation of health care plans has become increasingly problematic for consumers due to several important developments since ERISA was enacted: the rise in the number of individuals covered by self-insured ERISA plans; the dramatic increase in managed care enrollment; and the courts' interpretation of ERISA's preemption of state law. These changes have created a dire need for federal legislation to fix the problems arising from ERISA's impact on the health care arena.

Rise in Self-Insured Thwarts State Insurance Regulation

One important change has been the rise in self-insurance among employer-sponsored plans. When ERISA was enacted, most people received health insurance coverage through insurance contracts regulated by the states. There was a general consensus that states should continue to regulate insurance contracts, so they were carved out of ERISA's general preemption of state law in what became known as the "savings clause." Under the savings clause, state insurance laws continue to apply to insurers who contract with employers to provide insurance for the employer-sponsored health plans. In the decades since ERISA was passed, there has been a substantial increase in the number of individuals covered by "self-insured" ERISA plans, where the employer bears some or all of the risk for paying for benefits. Among all individuals covered by ERISA plans, the number of individuals covered by self-insured plans has risen from only 4 percent of all ERISA covered individuals to 43 percent of individuals, totaling

nearly 56 million Americans nationwide.

This increase in those covered by self-insured plans has seriously eroded states' ability to effectively regulate insurance for individuals covered by ERISA. Under ERISA, states are barred from regulating ERISA plans directly. This leaves 56 million individuals without any state protections, including important patient protections and access to help from the insurance commissioner when they have problems with their health plan. Instead, they are subject only to ERISA's minimal standards, and are only able to turn to one of the Department of Labor's 10 regional offices nationwide, which are woefully short-staffed to deal with the volume of complaints that would arise, if individuals knew where to turn to for help.

And, because ERISA does not include solvency requirements or a guarantee fund for health benefits, individuals enrolled in self-insured plans are always at risk of their health plan being unable to pay claims and leaving individuals without coverage or payment for health claims they have already incurred. By contrast, state insurance laws regulate insurers for solvency and require annual licensing to ensure health insurers meet these requirements.

ERISA's preemption of state law for self-insured plans and absence of meaningful protections denies individuals covered by self-insured plans the full range of protections ERISA was intended to provide.

Dramatic Increase in Managed Care Enrollment Undermines ERISA's Protections

The number of individuals covered by ERISA employer health plans who are enrolled in managed care arrangements, including HMOs, PPOs, and Point-of-Service (POS) Plans, has skyrocketed since ERISA was enacted. In 1988, only 27 percent of all workers covered by employer-sponsored plans were enrolled in managed care plans. Today, the vast majority of individuals covered by employer plans, 92 percent, are enrolled in some form of managed care.

Managed care plans raise questions about the need for regulation that were not anticipated when ERISA was enacted in 1974. ERISA was premised on a traditional fee-for-service or indemnity insurance model, in which individuals received treatment first and later dealt with payment issues. Managed care plan's efforts to control costs through utilization review and other incentives have created an environment in which medical treatment decisions and coverage decisions are now blended and virtually inseparable. As a result, ERISA's models for information disclosure and dispute resolution are outdated and insufficient. Although the Department of Labor has issued final rules that are an important first step in updating ERISA's requirements for today's managed care world, more meaningful regulation is needed to address consumers' needs for protection against potential managed care abuses.

Managed care has great potential. Its promise is to save money and provide better quality care through better coordination of services and a strong emphasis on preventive and primary care. Managed care plans are also uniquely positioned to educate millions of women and men about how to get and stay healthy. Women,

especially, stand to benefit from managed care done right. A quality managed care plan can make it easier for women to learn about and obtain services, such as mammograms, Pap smears, and prenatal care, and take advantage of health-promoting benefits, from smoking-cessation classes to discounted health club memberships. In addition, a good relationship with a well-trained primary care provider can give women a chance to get answers to health questions that might otherwise go unasked. But providing quality health care is about much more than just delivering preventive services.

Over the past few years, managed care's potential has been eclipsed by concerns that for some it may do more harm than good. The American people, including American women, have become increasingly worried that the legitimate interest in controlling costs could compromise the quality of care managed care plans provide. Recent studies have underscored these concerns, demonstrating that they are grounded in patients' experiences with managed care. According to a recent Kaiser Family Foundation survey, over half of all Americans in managed care plans have experienced some problem with their plan, including 17 percent who experienced a delay or denial in coverage. A substantial number of those who experienced a problem suffered adverse consequences as a result, including 38 percent who reported financial consequences, 21 percent reporting lost time at work, school, or another activity, and 21 percent reporting a decline in their health.

These and other concerns have helped to fuel the groundswell of public support for improved patient protections aimed at righting managed care's balance between quality and cost. Every state has passed some type of patient protection similar to those being considered at the national level. Forty states have enacted protections relating to access to emergency services. Thirty-six states have enacted laws providing direct access to ob-gyn providers for women. Forty states have enacted some external review program, allowing individuals to seek independent review of their benefit disputes with their health plan. And the Chairman's home state of Texas and 9 other states have enacted laws holding HMOs accountable for injuries caused by negligent decisions.

Even though many states have passed these protections, there is still a need for amendments to ERISA to ensure minimum federal protections. State protections will never apply to the 56 million individuals in self-insured ERISA plans, leaving out more than a quarter of all those with private health insurance. In addition, state laws vary and cannot ensure a strong threshold of patient protections. Federal patient protection legislation is needed to ensure that families covered under ERISA can also reap the protections of managed care reforms.

Court's Interpretation Narrows Remedies – Recent Trend Indicates Change

Another issue that has contributed to consumers' dissatisfaction with ERISA is the courts' broad interpretation of ERISA's preemptive reach, especially with respect to state law remedies. In 1987, the Supreme Court interpreted ERISA's preemption of state laws that "relate to" ERISA plans in the landmark decision, Pilot Life Insurance Co. v. Dedeaux, to find that ERISA preempted all state law remedies that had any relation to the ERISA benefit plan. Reasoning that Congress intended ERISA's

remedial provisions to "occupy the field" of regulation relating to remedies, the Court found that state law tort and contract remedies that would normally apply to insurance contracts would not apply for all individuals in ERISA plans. Under ERISA, individuals seeking redress for a plan's decision can only bring an action under ERISA for equitable relief, to get the benefit that should have been provided or to enforce the terms of the plan or the law. No legal remedies, including compensation for injuries that are caused by a plan's wrongful delay or denial of benefits, are available.

Since the mid-1990s, a trend in federal caselaw has developed that has carved out medical malpractice cases from ERISA's general preemption of state law. This trend began with the Third Circuit Court of Appeals' decision in Dukes v. U.S. Healthcare, in which the court found that a case involving medical malpractice was *not* to be preempted by ERISA. Dukes and the cases that followed it established a distinction between suits involving the quality of medical care and those involving a benefit decision – cases involving medical quality issues could now be brought in state court, but those involving a benefit decision or plan administration were still preempted under ERISA.

In its unanimous decision last year in the Pegram v. Herdrich case, the Supreme Court indicated that state law liability for medical cases involving ERISA plans may be broader than many thought. In Pegram, the Court indicated that cases involving so-called "mixed eligibility" decisions, those that involve both a benefit decision and medical treatment issues should be pursued under state law, not under ERISA. Under the Court's rationale, only cases involving what the Court referred to as "pure eligibility" decisions – decisions that involve strictly coverage issues (e.g., whether an individual was a member of the plan or whether a waiting period under the plan had elapsed) - were subject to ERISA's preemption of state suits. This is a major shift in the courts' view regarding ERISA preemption and one that greatly expands the types of cases that can now be brought against managed care plans in state court. The new legal baseline after the Pegram case allows individuals to hold most health plans accountable in state court for decisions involving any medical treatment issues.

Despite the Court's seeming expansion of remedies following Pegram, there is still a need for federal action to expand legal accountability. First, it is unclear how federal courts will interpret the Court's suggestion in the Pegram decision – settling this issue could take many years, depriving individuals of greater certainty. Second, the Court's decision did little to address the need for greater remedies for cases involving what the Court called a "pure eligibility decision" – a case that only involves the plan's interpretation of its own coverage policies.

Federal action is also needed because some courts may choose to disregard the Court's message in Pegram, as was the case in a recent decision by the Federal District Court for the Northern District of Texas, Roark v. Humana. In that case, the court found that an HMO that delayed and denied coverage for Gwen Roark's medical treatment for an infection in her leg, causing her to have her leg amputated, was not accountable under Texas' HMO liability law for its medical decisionmaking. Instead, the court held that her state law claim was preempted by ERISA, finding that her claim was "about administration of benefits, not quality of medical treatment." Without addressing this

area, individuals will have no real redress when their plan makes a mistake regarding enrollment or determining whether a benefits is covered, or wrongly interprets a waiting period requirements.

ERISA's preemption of most state law liability has created a situation in which health plans offered by private employers have become outliers in our legal system – unlike almost every other business entity, they are often immune from accountability for their actions, even if individuals are hurt by their actions. Other businesses in the health care industry and other companies are legally accountable for their actions as a generally accepted principle of public policy. If we agree that companies that make tires for our cars or toys for our kids should be accountable when people are hurt, then why should we treat those who are entrusted with our health, our most precious commodity, any differently?

In acknowledging ERISA's absence of meaningful remedies in his opinion in Andrews-Clarke v. Travelers Insurance Company, Judge Young aptly remarked that , although ERISA was "[e]nacted to safeguard the interests of employees and their beneficiaries, [it] has evolved into a shield of immunity that protects health insurers, utilization review providers and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits." This immunity from suit also further perpetuates an imbalance of power between patients and their plans – a real patients' bill of rights will tip the balance back to empower patients.

Federal Patient Protections Needed to Fulfill ERISA's Promise

ERISA's original intent was to ensure individuals receive the benefits they are promised and to provide needed federal standards to guarantee protections, while preserving states' traditional regulatory authority over insurance. Strong, enforceable patient protection legislation is needed to ensure that ERISA fulfills its promise of protection to American families.

The National Partnership for Women & Families leads a diverse group representing consumers, health care providers and workers supporting the passage of strong patient protection legislation. Meaningful patient protections must ensure high quality health care and restore a sense of trust and accountability to our system. At a minimum, federal legislation must meet the following principles: First, it must apply to all Americans covered by private insurance, setting a federal floor of protections that allows states to enact more protective requirements. Second, it must also guarantee access to a fair, timely, and unbiased independent external review for health plan disputes. Third, it must ensure meaningful remedies that do not roll back protections available under current law. Fourth, it must also include comprehensive consumer protections without loopholes or opt-outs that weaken the requirements.

Federal Floor, not Ceiling

Any patient protection bill must apply to all Americans with private health insurance. This includes those covered by private-sector group health plans, individual health plans, and fully-insured state or local government plans. Proposals that only cover

those in private job-based plans, or only those that are in self-insured job-based plans do not meet the mark – all Americans need and deserve the same protections. Some versions of these bills would apply key protections to only those in self-insured job-based plans, leaving out as many as seven in ten Americans with private health insurance coverage who need and deserve the same rights. Others leave out those in self-insured state and local government plans, leaving out state workers and their families in as many as 32 states.

Patient protections should apply a uniform federal floor of protection for everyone, regardless of what type of plan covers them. The certification of state laws that meet or exceed the Federal minimum standard should be determined and enforced by a federal body. States should not be provided with loopholes, such as having limited penetration of managed care in their state or allegations of premium increases, which allow them to easily opt out of the Federal minimum standard.

Timely and Truly Independent External Review:

Independent, external review procedures are an essential component to restoring consumers' trust in the health care system. Although ERISA's internal review protections that require the plan to conduct a timely and fair review of the dispute are also important, a timely independent review by a neutral third party outside of the plan is critical to ensure that an individual will get a fair decision that is based on specific medical needs. External review is now required in forty states, making it a firmly established principle of business for many health plans and insurers. Experience in the states also shows that consumers are not abusing these rights by overusing the system. Despite its prevalence in the states, a federal law is still needed to ensure that all consumers have access to these important protections.

Strong patient protection legislation must ensure that patients have access to a speedy and genuinely independent external review for all decisions involving any evaluation of medical facts. True independence from the plan means that the managed care plan cannot select the external review entity. It also means there must be ample standards to ensure the reviewer has no financial or business relationship with the plan or other parties involved in the appeal that could bias the decision. In addition, the external reviewer must be free to make its own determinations regarding medical necessity and should not be bound by the plan's definitions. No deference should be given to hidden plan policies or exclusions – only those that are explicit and unambiguous should be given full effect.

With respect to the appeal process, the external review process should be fair and open, without unnecessary barriers like short time frames to bring an appeal or financial thresholds that could keep consumers from exercising their rights to appeal. Also, plans should not be permitted to circumvent the internal or external review process through alternative dispute resolution or arbitration – only a qualified medical expert should make decisions regarding whether care is medically needed and covered under the terms of the plan.

Some important aspects of the external appeal process deal with the relationship

between the right of appeal and the right to judicial review. While individuals should be required to complete the internal and external appeal process before they may seek judicial review, consumers who have already been injured should not be required to complete the external review process before seeking review in court. This is the model that applies for Medicare beneficiaries and is consistent with general principles of administrative law, which do not require an individual to exhaust administrative remedies when it would be futile. In this context, the patient is no longer seeking the benefit she was denied, but is seeking redress for her injury, which cannot be given through the external review process. Finally, the external reviewer's decision should not be given the same weight as a judge's opinion, and should not foreclose a consumer's right to a full and fair review in court that includes all of the evidentiary rules and discovery protections.

The external review scheme should also build on, not replace, states' expertise in this area and allow states flexibility to provide a stronger appeal process where they choose. Any federal rights that are created should establish a floor, not a ceiling, of protections for consumers.

Expanded Legal Remedies that Ensure Accountability

Health plans are protected against liability for many of their decisions today because of ERISA's interpretation by the courts. A strong patient protection bill must restore meaningful accountability for HMOs, insurers and employer-sponsored health plans, without undermining existing rights consumers have to accountability in state court for mixed treatment and eligibility decisions under the Supreme Court's opinion in Pegram.

Meaningful accountability includes provisions that will ensure full redress for both coverage and medical decisions, without unreasonable caps on non-economic damages that disproportionately hurt women, children and the elderly, and deny appropriate compensation. Courts should be able to take a "fresh look" at these cases *de novo* – requiring courts to defer to plan decisions undermines the strength and purpose of creating accountability. Health plans should not be able to create a presumption against liability by blaming individuals or external review entities. Civil monetary penalties are no substitute for remedial relief.

Employers should be protected from liability unless they directly participated in the decision that caused the harm, as the Ganske-Dingell bill provides. Employers should be able to contract with insurers to provide insurance, without fear of retribution. However, when employers take on the responsibility for making benefit decisions, they must be held to the same standards as health plans. Employers and health plans should not be able to assign their liability for these decisions to treating physicians.

Real people are hurt by the absence of meaningful accountability. There are too many examples of those who are left without redress after the tragic results of a health plan's decision to delay or deny care. The parents who lost their baby after their health plan refused to authorize round-the-clock hospital monitoring during the mother's high-risk pregnancy despite two doctor's recommendations. The man who committed suicide

after his health plan denied him admission to a health plan's alcohol rehabilitation program, despite his desperate need for help and the plan's stated coverage of the services. These are the real faces behind the need for health plans to be accountable for these decisions, not only to address the inequity of these tragic losses, but to deter bad decisions that cause them.

The costs of expanding accountability are low. According to estimates prepared by the Congressional Budget Office evaluating the effect of the Bipartisan Patient Protection Act of 2001 (S. 283), the cost of expanding liability to codify the current bifurcation of liability in state and federal court is minimal - a total increase of eight-tenths of one percent of premium for job-based health plans per individual per month. On average, individuals will pay less than a quarter for these benefits, an extra cost of only \$.23 per month; families will pay a little more than a dollar, only about \$1.14 extra. And practical experience in the states where there is now expanded liability disproves the allegation that it will result in a flood of litigation – since the passage of legislation expanding HMO liability in the Chairman's home state of Texas, only nine suits have been brought.

Expanding accountability for managed care consumers is a practical, common sense answer that will neither break the bank nor disrupt our health care system – the majority of Congress has supported these rights in the past and the overwhelming majority of Americans support them as well. The time has come for them to be enacted.

Comprehensive Patient Protections without Loopholes

In addition to these other components, a strong patient protection bill must guarantee a variety of other comprehensive patient protections that are essential to women and families. These include access to emergency rooms, Ob/Gyns, prescription drugs, clinical trials, pediatricians and other medical specialists including those outside of the network if the network providers are not adequate. Patient protection legislation must also ensure that medical judgments are made by medical experts, patients with a special medical condition receive continuity of care, patients have a choice of a full range of health providers, and patients are provided with full and understandable information about their health plan. Health care professionals must be protected against retaliation when they advocate on behalf of patients' needs or to improve health care quality. And "gag clauses" that prevent medical professionals from providing patients with full information about their treatment, including reproductive health care services, should also be barred.

H.R. 526/S. 283 is Only Legislation Meeting These Principles

At this time, the only legislation that meets these principles is the Bipartisan Patient Protection Act of 2001, H.R. 526/S.283 sponsored in the House by Representatives Ganske and Dingell and in the Senate by Senators McCain, Edwards, and Kennedy. This legislation is also the only bill endorsed overwhelmingly by patients, nurses, psychologists, union workers, and many others. This bill represents a reasonable compromise based on the legislation that passed with a two-thirds majority in the

House in 1999. It provides the basic protections that American women and families need and ensures meaningful accountability.

A public opinion survey released last week demonstrates that public support for this legislation remains high, with 85 percent of all Americans supporting a bill. And support is bipartisan – surveys show that 79 percent of Republicans, 87 percent of Democrats and 85 percent of Independents support patient protection legislation, including the right to legal redress. Even if there is some additional cost, public opinion surveys gauging Americans' support for patient protections have consistently shown that a majority of Americans are willing to spend a little more to ensure they have these strong protections.

American families need ERISA to be amended to include these patient protections in order to keep pace with the changes in our health care system since it was enacted more than a quarter century ago. Congress has come a long way in its understanding of Americans' need for patient protections in the nearly seven years since the beginning of this debate. While we are heartened to know that many now agree that there is a need for this legislation, we will continue to advocate for strong and enforceable protections as this debate moves forward. We encourage members of Congress to consider these principles and to pass a strong patients bill of rights without delay – the health of women and families hang in the balance.

Thank you.

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