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AMERICAN BENEFITS

COUNCIL

**Testimony of Kevin Covert, Honeywell
On Behalf of the
American Benefits Council**

**Hearing on Health Care Reform: Recommendations to Improve
Coordination of Federal and State Initiatives
House Education and Labor Committee
Health, Employment, Labor and Pensions Subcommittee**

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

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

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

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

ERISA Preemption is Vital to the Voluntary Sponsorship of Health Plans

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

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

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

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

State Reforms Raise Concerns for Employers

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

- **"Pay or Play" or "Fair Share" Laws:** Pay or play laws require employers of a certain size to spend a set dollar amount or percentage of payroll for health care.

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

Employers that fail to spend the required amount on health benefits typically must pay a penalty in the form of a tax or a mandatory contribution to state run health care programs. Maryland enacted the most publicized version of a pay or play law (the United States Court of Appeals for the Fourth Circuit found the Maryland law preempted under ERISA). Suffolk County, New York and San Francisco have adopted similar laws.

- Fair Wage Laws: Fair wage laws typically require employers to pay an overall hourly compensation package of a specified amount (e.g., \$12/hr). Employers must pay a certain portion of the overall amount in cash (e.g., \$9/hr) and the balance in either cash or health benefits. Employers who fail to offer a compliant hourly compensation package face monetary penalties. Municipalities are examining this approach as well.
- Comprehensive reform: Some states have adopted more comprehensive health care reforms, which may include (1) a play or pay assessment on employers that do not provide health coverage that meets a certain standard, (2) reforms of state insurance markets, (3) a requirement that individuals obtain coverage (the "individual mandate"), (4) expansion of state and federal government health care programs, (5) premium assistance programs for lower wage workers to obtain private insurance, and (6) mandates on employers with uninsured employees to establish cafeteria plans to allow for pre-tax purchase of insurance. To date, Massachusetts and Vermont have adopted comprehensive proposals. A number of other states, including California, are considering proposals.

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

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

A seemingly minimal employer mandate such as the requirement in Massachusetts that employers adopt and maintain a Section 125 "cafeteria" plan may create significant administrative burdens.² Cafeteria plans are benefit plans, adopted

² One of the employer responsibilities under the Mass Health Care Reform Law is the requirement that employers with 11 or more full-time equivalent employees adopt and maintain a Plan that satisfies both Section 125 of the

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

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

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

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

ERISA Preemption is Based on Sound Public Policy

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

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

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

ERISA Waivers are Not the Solution

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

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

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

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

- Will the process be administered on a case-by-case basis by a federal agency pursuant to federal standards? Is this a full-blown administrative proceeding?
- If an agency is granted authority to issue waivers, what standards would apply to limit the agency's authority or the future scope of state actions? Will states be limited to certain types of mandates or experimentation? Will states be free to force employers to pay for state health care reform?

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

Conclusion

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

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