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

THE PROBLEM IS CLEAR

As the chief insurance regulator for the state of New Jersey, I am acutely aware of the crisis our country faces with regard to health insurance coverage. Nearly 45 million Americans went without health insurance coverage in 2005[1]. Eight million of them were children[2] and 80 percent were from working families[3]. One million, three hundred thousand of these uninsured Americans live in New Jersey, and of these, 230,000 are children. When someone without health insurance needs extensive medical treatment the financial consequences can be devastating and the health consequences are even worse. In 2004 the Institute of Medicine estimated that every year 18,000 deaths in America can be attributed to a lack of health insurance coverage.[4] The challenge before us is great and it is growing every year.

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[1] De-Navas-Walt, Carmen, Bernadette. D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, *Current Population Reports, P60-231, Income Poverty and Health Insurance Coverage in the United States: 2005, Table C-2*
[2] *Ibid.*
[3] Institute of Medicine, Committee on the Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations* (Washington, National Academic Press, 2004 p. 163
[4] *Ibid.* p. 8

STATES ARE LEADING REFORM EFFORTS

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

New Jersey Experience

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

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

In addition, while the New Jersey individual market is often characterized as having the highest average premiums, these “average” premiums are available to any eligible person.

Currently, an eligible individual in New Jersey can purchase a comprehensive HMO policy for about $435 a month, regardless of health condition. Various reform proposals being considered in New Jersey seek to reduce this cost, but no proposal currently being considered does so at the price of creating separate coverage pools or rating for "healthy" and "unhealthy" individuals.

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

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

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

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

In the commercial market, we think it makes sense to combine our individual and small group markets, and develop a reinsurance system to cover the largest claims in these markets. We estimate that this will reduce individual rates significantly for younger people, reduce small group rates slightly, and reduce the number of uninsured by over 100,000.

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

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

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

Massachusetts Innovation

In Massachusetts, a Republican governor and Democratic legislature were able to bridge the partisan divide to reach agreement on one of the most innovative new programs in many years. This program may merge the small group and individual health insurance markets into a single market operating under a single set of rules, creates a "health insurance connector" that

facilitates the purchase of policies by individuals and small businesses, requires all state residents to enroll in health coverage and provides subsidies to those who cannot afford it.

Montana Innovation

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

New York Innovation

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

Vermont Innovation

Almost one year ago today Vermont enacted a new health reform law. Beginning on October 1, the new Catamount Health Plan will provide uninsured state residents with a low-cost health insurance product with an emphasis on preventive care and chronic care management. The state will provide subsidies for low-income individuals to purchase coverage either through the Catamount Health Plan or through employer-provided coverage and will also make significant

new investments to improve the quality and cost-effectiveness of care for those with chronic conditions and to create a statewide health information infrastructure to facilitate the sharing of information between health care providers, patients, and payers.

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

NAIC EFFORTS TO PROMOTE STATE REFORMS

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

Noted ERISA expert Patricia Butler testified before the Working Group in September 2006 on the state of ERISA preemption with regard to health reform legislation on the state level. She detailed two key areas in which ERISA complicates the states' abilities to implement innovative health reform plans. First, she told the Working Group, the status of "pay-or-play" assessments on employers was uncertain. A federal district court had recently invalidated a Maryland statute that required all private employers with more than 10,000 employees in the state

to spend at least 8 percent of its payroll on health benefits or pay the difference to help fund the state Medicaid program. A federal appeals court later upheld that verdict in a 2-1 decision.[5] However, she believed a broad-based "pay-or-play" assessment would be likely to withstand an ERISA challenge. To do so, the assessment would have to remain neutral regarding whether employers offer coverage or pay an assessment to the state, could not set standards to qualify for the credit against the assessment, or otherwise refer to ERISA plans.

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

RECOMMENDATIONS

In light of this testimony, the Working Group created a Federal Relief Subgroup, which I co-chaired with Commissioner Steven Orr of Maryland, and directed it to identify areas in which states could use additional flexibility to more effectively pursue reforms that would reduce the number of their citizens without health insurance coverage. The Federal Relief Subgroup conducted a survey of the states, asking them if they had considered the preemptive effect of federal laws on innovations related to making health insurance or alternative health care financing mechanisms more affordable, particularly with respect to the small group market in which small businesses purchase coverage. Fully two-thirds of responding states had encountered situations where federal law preempted, or threatened to preempt, health reform proposals. The remaining

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

third either had not kept track of the preemptive effects of federal laws upon reform proposals or had not encountered any.

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

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

- Broadly spread assessments to fund high risk pools across fully-insured and self-insured plans ;
- Broadly pool risk across fully-insured and self-insured plans ;
- Collect data on coverage, benefits, premiums, and utilization from self-insured plans;
- Apply minimum standards to stop-loss insurance to ensure that it is not used to evade state insurance regulation by smaller businesses that lack the funds and expertise to self-insure ;
- Craft reforms that target very small businesses with 10 or fewer employees or persons with high medical costs ;
- Require employers to provide minimum levels of health benefits ;
- Require self-insured plans to promptly reimburse providers for covered services ;
- Apply state law consumer protections to self-insured plans; and
- Implement a statewide chronic care management and health promotion programs; and
- Create statewide health information networks.

The NAIC used the results of the survey to formulate a four-point proposal for federal action that would help encourage more states to undertake innovative reform measures, allowing them to act as the “laboratories of democracy,” testing and fine-tuning different approaches and customizing them to fit different situations in each state. We selected items for inclusion in this proposal in order to maximize the flexibility they confer upon the states, while minimizing the

impact upon the sponsors of multistate self-insured plans. It is my belief that Congress could best help the states to make progress by:

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

Data Collection

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

Congress should remedy this situation by adopting an amendment to ERISA clarifying that data collection requirements are saved from preemption. To minimize the administrative

burden of this change, it would not be unreasonable to limit states to collecting the same information from self-insured plans that they collect from fully-insured plans.

"Pay-or-Play" Assessments

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

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

Impediment Waivers

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

would help states that are crafting as yet unforeseen solutions to the problem of the uninsured and would encourage further creativity at the state level.

Federal Assistance

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

CONCLUSION

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