April 5, 2024

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

Re: Employee Retirement Income Security Act (ERISA) 50th Anniversary Request for Information

Dear Chairwoman Foxx,

The 21 undersigned organizations, representing millions of patients and consumers facing serious, acute and chronic health conditions across the country, appreciate the Committee's interest in considering ways to build upon and strengthen the Employee Retirement Income Security Act (ERISA), the regulatory framework for employer-sponsored health plans. Though ERISA's pension and retirement plan provisions have long garnered the greatest attention, we believe it is appropriate and necessary to consider ways to strengthen the law to ensure health plans are providing true value for patients and employees.

In March of 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not a pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

ERISA provides employers broad flexibility to determine benefits and cost-sharing. Because employers often consider adequate health benefits to be a component of recruiting and retaining employees, employer health plans generally provide acceptable coverage for most enrollees. However, for the

[1] Consensus Healthcare Reform Principles https://www.protectcoverage.org/ppc-consensus-healthcare-reformprinciples

patients we represent, rising healthcare costs are increasingly translating to higher out-of-pocket costs, whether because of premiums, cost-sharing, or narrow networks that exclude critical providers.

Families with at least one member in worse health pay a larger share of their income toward healthcare costs compared to those in better health – 6.5 percent of income toward premiums and out-of-pocket costs compared to 3.8 percent, respectively. The differences are greater for those families with lower incomes. At 200 percent of poverty, families with at least one member in worse health pay 14 percent of income toward premium and out-of-pocket costs compared to 10 percent for those in better health.[2] Other groups of workers are also at greater risk of unaffordable premiums or cost-sharing, including older workers and those with low- and moderate income who are often priced out of coverage or can't afford to get care under their employer plan.[3,4]

We believe the Committee's Request for Information (RFI) provides an opportunity to consider ways in which employer-sponsored insurance (ESI) can be strengthened to ensure families struggling with high out-of-pocket costs aren't shouldering the burden of unchecked healthcare costs. At a minimum, we believe the Committee should prioritize additional resources for the Department of Labor (DOL) to oversee and enforce existing requirements for employer-sponsored plans, including protections against discriminatory benefits, fraud, and insolvencies, and the recently enacted provisions of the Consolidated Appropriations Act (CAA). The DOL Employee Benefits Security Administration (EBSA) has roughly 400 investigators and 100 benefits advisors to oversee more than 5 million health, pension, and other employee benefit plans - covering 150 million workers and their dependents. That stacks up to less than one investigator for every 12,500 plans.[5] It's difficult to have confidence that EBSA can effectively oversee compliance with existing requirements, let alone have the capacity to take on new responsibilities. In our view, additional funding is essential to any consideration of how to strengthen ERISA.

We are pleased to have the opportunity to offer the below comments for the Committee's questions as outlined in the Request for Information:

Preemption

While we recognize that ERISA preemption makes it administratively easier for large employers with workforces spanning multiple states to offer benefits, the sheer extent of the statute's preemptive reach, as interpreted by the courts, has long frustrated states' ability to regulate the most common way their residents access health coverage.

In addition, in practice, ERISA is often exploited to shield different kinds of coverage arrangements — those that cater to smaller firms without multistate workforces — from state oversight. An estimated 35 percent of covered workers in small firms (3 to 199 workers) are in a level-funded plan, a product that

[2]Claxton, G. et al. Peterson-KFF, Health System Tracker. March 10, 2022. 'How Affordability of Employer Coverage Varies by Family Income'.

[3] See, for example, Commonwealth's issue brief from August 10, 2023, titled 'Can Older Adults with Employer Coverage Afford their Health Care' and report from January 12, 2022, titled 'State Trends in Employer Premiums and Deductibles, 2010-2020'.

[4] Claxton, G. et al. Peterson-KFF, Health System Tracker. March 10, 2022. 'How Affordability of Employer Coverage Varies by Family Income'.

[5] U.S. Department Of Labor. 2020. Parity Partnerships: Working Together. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf

combines self-funding with a stop-loss policy.[6] Because they are exempt from most state insurance requirements, including solvency and consumer protection requirements, these products can be attractive to employers with younger and healthier workers. Stop-loss insurers can also use underwriting to weed out less healthy employer groups, leaving them to the insured market. The result is that premiums in the insured market grow with the increasingly costly pool of employees.

We urge the Committee to consider the appropriate balance between maintaining flexibility for large employers under ERISA and commonsense state regulation on behalf of state residents. We recommend the Committee consider ways to allow for state regulation that would benefit plan participants. *Rutledge v. Pharmaceutical Care Management Association* opened a path for states to apply requirements that would improve affordability for those in ERISA-governed plans, but Congress can go further by revising the law to explicitly allow more state regulation aimed at cost control and data collection.[7] The Committee may also consider other options for giving states more tools to control healthcare costs.[8]

Fiduciary Requirements

The Committee seeks comment on the definition of fiduciary, its use, and fiduciary obligations under ERISA as they pertain to health benefits. Our organizations have a significant interest in the Committee's work on fiduciary obligations under ERISA. Plan participants, including patients, should be a primary focus of fiduciary obligations as plan employees who pay to participate in their employer group health plan have a reasonable expectation that their employer will use their payments and manage a plan (and its assets) with the goal of providing them adequate and affordable benefits. We believe it would be appropriate for Congress to clarify who is a fiduciary, building on the functional definition included in ERISA. To name specific entities only--for example, third-party administrators (TPAs) and Pharmacy Benefit Managers (PBMs)--risks inadvertently excluding an entity that performs fiduciary duties, and so should be bound by those obligations. Such a definition would capture the range of functions in which an entity may exercise discretion in administering and managing a plan and in controlling plan assets.

In applying the fiduciary obligations to act solely in participants' interest, to be prudent purchasers of health benefits, and to pay only reasonable plan expenses, we believe the Committee can help clarify expectations and tools included in the CAA and other laws enacted by Congress. Below, we offer comments on specific issues raised in the RFI.

Prohibited Transactions

Congress has made possible a significant step forward for healthcare price transparency in the U.S. with the enactment of broad authority for data collection under Section 2715A of the Affordable Care Act. Under the Transparency in Coverage requirements issued by the Trump Administration using their authority under 2715A, health insurance plans and issuers must publicly post their in-network provider reimbursement rates for all covered items and the allowed amounts and billed charges for out-of-network items and services. These disclosures can be a critical tool for understanding the drivers of health system costs and targeting strategies to lower cost growth. With that understanding, federal and state policymakers can better design policies to improve the affordability of coverage. But these are also critical tools for employers and other fiduciaries to be prudent purchasers of their health benefits and to

[6] KFF News, 2022 Employe Health Benefits Survey. October 27, 2022. Section 10: Plan Funding. https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/

[7] *Rutledge v. Pharmaceutical Care Management Association,* (US Supreme Court, 2020).

[8] See, for example, the proposals included in the Commonwealth's Issue Brief from February 2023 titled 'Reforming ERISA to Help States Control Health Care Costs'.

demand reasonable costs for care provided by both in- and out-of-network providers. But to date, compliance has been inconsistent, and the data are not yet in a usable form.

Congress can help improve meaningful compliance with these provisions by improving the accessibility, usability, and quality of the data reported, as has been under discussion in recent legislation. We urge you to continue this work. Congress can also consider options for holding all fiduciaries responsible for using this data to be more prudent purchasers of health benefits and to require reasonable costs for healthcare providers under contract with their service providers. Finally, Congress could also consider legislation that would require state departments of insurance to partner with enforcement entities, including making resources available for enforcement of key policies.

Data Sharing
Compliance with this provision of the CAA has also been mixed, largely because many vendors are still refusing to give employers access to claims data. Having access to this data is critical for employers acting as fiduciaries, and it is likely that many of the fees TPAs collect will be visible in claims data. We encourage Congress to help clarify that the claims data belong to the plan, giving employers access to de-identified claims data. Additionally, we urge the Committee to think through possible solutions that enhance data sharing while also maintaining patient privacy, which is critically important. Employers have little leverage with non-compliant TPAs other than to cancel their contracts, but they have few other options for TPAs, given the limited competition among those vendors.

Direct and Indirect Compensation
In DOL guidance, the agency advised that fiduciaries "must ensure that the compensation paid to a service provider is reasonable in light of the services provided." To do this, a fiduciary must have the information needed to make that assessment. Disclosure of fees and other compensation is essential to curbing unnecessary and inappropriate spending arising in and from contracts between employers and the various intermediaries they contract with, including brokers, benefit consultants, TPAs, and PBMs. As the Committee notes in the RFI, some vendors may have conflicts of interest that can drive up costs for plans. Misaligned incentives can also mean a TPA's interest may not always serve the employers with whom they contract.[9]

We appreciate the efforts the Committee has undertaken to improve compliance with these required disclosures, including the Committee's expressed intent that the requirement should apply broadly to covered service providers. We urge the Committee to continue that work.[10]

ERISA Advisory Council
Our organizations support expanding the role of the ERISA Advisory Council to include a work stream dedicated to health plans. With the current broad directive, the Council's work has largely been focused on pensions and retirement plans. We believe health plans warrant their own focus, particularly in light of the new opportunities and obligations created under the CAA and with the growing cost crisis in employer-sponsored coverage. Further, we believe the Council should have robust opportunities for consumer and patient groups to engage, beginning with the requirement that three seats on the Council

[9] Monahan, Christine. Georgetown University, Center on Health Insurance Reform. March 24,2023. 'Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators'. https://chirblog.org/questionable-conduct-allegations-insurers-acting-third-party-administrators/
[10] U.S. Committee on Education & Labor, Bipartisan Letter to Assistant Secretary Lisa Gomez. December 14, 2022. https://democrats-edworkforce.house.gov/imo/media/doc/bipartisan_scott-foxx_letter_to_ebsa_re_health_transparency.pdf

be set aside for representatives from such organizations. Finally, we ask that the Council be given sufficient funding to have the staff support to carry out their obligations.

Medical Loss Ratio

The Medical Loss Ratio (MLR) requirements of the ACA provide meaningful protection for plan enrollees by requiring that a fair portion of their premiums be spent on healthcare claims and not plan administration and profits. Insurers who fail to provide a minimum level of benefit for each premium dollar paid must issue rebates to enrollees. In 2022, the average rebate per person for the small group market was $169; for the large group market, the average rebate was $110 per person.[11]

There is some evidence that plans can manipulate MLR definitions to their advantage, for example, by purchasing services from related businesses such as an insurer-owned PBM or by artificially inflating provider payments to avoid having to pay rebates.[12] We urge the committee to review how MLR definitions can be gamed to circumvent the MLR, as we strongly oppose any efforts to weaken this important quality measure.

COBRA Continuation Coverage

Prior to the enactment of the ACA, patients relied almost exclusively on COBRA continuation coverage when their employer coverage ended, often because they had to cut back hours or take a leave from work in order to manage their chronic condition. The pre-ACA individual market wasn't an option for them, and high-risk pools, where available, had premiums that were typically twice the premiums for individual market coverage and imposed pre-existing condition exclusions that meant coverage was meaningless. The ACA has given them another, more reliable option: guaranteed coverage that can't discriminate based on pre-existing conditions, including a comprehensive set of benefits, rating rules, a prohibition on dollar limits on covered benefits, and other important consumer protections. Subsidies for those eligible based on income make that coverage more affordable.

At the same time, we recognize that COBRA continues to be an important option for patients who need the continuity of their provider network and coverage approvals as they navigate complex conditions like cancer. We believe COBRA should continue to be an option for those who need it, and we ask the Committee to consider ways to defray the high cost of COBRA premiums, as has been done in the past.

Specialty drug coverage

Specialty drugs can be a lifeline for people with chronic and acute conditions, yet high cost-sharing can put them out of reach for many people, especially where patients must take multiple prescription drugs to manage and treat their conditions. A recent survey found that affordability is particularly an issue for those taking four or more prescription medicines: nearly four in ten say they have difficulty affording their prescriptions. Further, three in ten people report cutting back on prescribed medication, including those who report not having a prescription filled, taking an over-the-counter drug instead (21%), or cutting pills in half or skipping a dose (12%).[13]

---

[11] Ortaliza, J. et al. KFF News, 2023 Medical Loss Ratio Rebates. May 17, 2023. https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/

[12] See, for example, Brooking's 'Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation' by Richard Frank and Conrad Milhaupt. March 24, 2023 and Georgetown Univeristy's Center on Health Insurance Reform's 'Questionable Quality Improvement Expenses Drive Proposed Changes to MLR Reporting', by Karen Davenport. February 22, 2022.

[13] Kirzinger, A. et al. KFF News, Public Opinion on Prescription Drugs and Their Prices. August 21, 2023. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

Unfortunately, some employers are exploiting the flexibility they have in applying the annual limit on out-of-pocket costs to services that would be considered essential health benefits. They are using this flexibility to restrict access to certain specialty drugs from coverage by designating them as "non-EHB" to avoid complying with the annual limit requirements, while ostensibly still providing coverage to employees. These policies constrain coverage and access to specialty drugs and leave patients to rely on external funding such as patient assistance or charity care.[14] We were very supportive of the proposal finalized in the 2025 Notice of Benefit and Payment Parameters to address this "EHB-loophole" for individual and small group plans[15] and eagerly await the promised future rulemaking to extend this policy to ERISA plans.[16] We urge the committee to support these policies so that that any drug covered by a health plan is considered part of their EHB package, and thus, cost-sharing for these must be counted towards patients' annual cost-sharing limits.

Conclusion

Our organizations thank the Committee for this opportunity to provide comment on the ERISA request for information. We look forward to working with the Committee to pursue policies that control costs and better arm employers with the tools they need to be prudent purchasers of healthcare. If you have any questions or would like to discuss our comments further, please contact Katie Berge, Director of Federal Government Affairs at katie.berge@lls.org.

Sincerely,

ALS Association
American Cancer Society Cancer Action Network
American Kidney Fund
American Lung Association
Arthritis Foundation
Cancer*Care*
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Eczema Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.

Cc: The Honorable Bobby Scott, Ranking Member

[14] From A to AFP – The Cancer Patient's Journey. ACS CAN & The Leukemia & Lymphoma Society. https://lls.org/sites/default/files/2024-03/from_a_to_afp.pdf

[15] Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS); Department of the Treasury. Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, CMS-9895-F. Released April 2, 2024.

[16] Department of Labor. FAQ about Affordable Care Act Implementation Part 66. Released April 2, 2024. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66