PARAGON HEALTH INSTITUTE

Testimony of Kev Coleman before the House Committee on Education & Workforce

"A Healthy Workforce:

Expanding Access and Affordability in Employer-Sponsored Health Care"

April 2, 2025

Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee, thank you for inviting me to speak on "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care." My name is Kev Coleman and I am a Research Fellow at Paragon Health Institute, an independent, non-partisan policy research organization that evaluates government health programs and develops solutions to improve policy and make life better for Americans. Prior to Paragon, I worked largely in technology startups including co-founding Association Health Plans, Inc. I am speaking today on my own behalf as a subject matter expert.

An AHP is a legal instrument by which a group of businesses can cooperatively sponsor a single large group health plan. There are many precedents in our nation's history for such a cooperative arrangement, such as group purchasing organizations, professional employer organizations, credit unions, and group captives. In each of these examples, organizations employ a similar strategy where demand for products/services is pooled among multiple businesses who voluntarily work together to secure lower prices from suppliers.

Big businesses use large group health insurance to cover employees at a lower cost per benefit than is often the case for the small group and individual health insurance markets.[1] One of the ways big businesses achieve savings through a large group health plan is scale. Large companies with thousands of employees are in a better position to negotiate with insurers, because large employers offer insurers a bigger risk pool over which health claims may be

[1] See "Realizing Health Reform's Potential: Jobs Without Benefits: The Health Insurance Crisis Faced by Small Businesses and Their Workers," The Commonwealth Fund, November 2012, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_oct_1640_robertson_jobs_without_benefits_small_businesses.pdf

spread and moderated. In some cases, these large companies can also negotiate lower rates with health care providers (because large employers offer providers a large volume of patients to utilize their services). Additionally, health insurance loads (i.e., the premium portion that exceeds expected medical expenditures paid by the insurer) are lower for large groups. Multiple studies have observed loads for businesses with 100 or more employees being less than half the expense compared to small businesses with fewer than 100 employees, with the savings growing for very large businesses.[2]

Through an AHP, small businesses can access large group health insurance by banding together. In the brief 2018 period when AHP reforms expanded small employers' ability to access to the large group market, new AHPs experienced both broad health benefits and double-digit savings. In my own research on nearly three dozen of these plans, the highest reported savings in a fully-insured AHP was 23 percent averaged across its members, and 29 percent at a self-insured AHP.[3] Separate research from the Coalition to Protect and Promote Association Health Plans found a Kansas City Regional Association of REALTORS AHP that averaged savings between 5 and 50 percent for its members while a Tennessee REALTORS AHP provided savings of 25 to 50 percent.

The 1974 Employee Retirement Income Security Act (ERISA) codified Association Health Plans (AHPs) as a type of Multiple Employer Welfare Arrangement (MEWA).[4] In the decades since ERISA's passage, the regulation of AHPs has evolved significantly both on the federal level as well as the state level. Most importantly, Congress amended ERISA's preemption provision in 1983 giving states the authority to regulate self-insured MEWAs operating within their borders. States, for their part, have further enacted numerous laws and regulations affecting AHPs since this

[2] See P. Karaca-Mandic, J. Abraham, and C. E. Phelps, "How Do Health Insurance Loading Fees Vary by Group Size? Implications for Healthcare Reform," International Journal of Health Care Finance and Economics 11 (2011): 181–207; and M. V. Pauly, Health Reform without Side Effects: Making Markets Work for Individual Health Insurance (Stanford, CA: Hoover Institution Press, 2010).
[3] Kev Coleman, "First Phase of New Association Health Plans Reveal Promising Trends," AssociationHelthPlans.com, January 30, 2019, https://www.associationhealthplans.com/reports/new-ahp-study/
[4] According to data from the Department of Labor, there were at least 82.8 million people covered by large group health plans in 2021. Since this data only included health plans with at least 100 participants, it omits millions of covered lives in plans that are large group by virtue of meeting most States minimum large group plan size of 51 employees. Daniel S. Levy and Yekun Zhou, "Self-Insured Health Benefit Plans 2024 Based on Filings through 2021," Advanced Analytical Consulting Group, Inc., September 30, 2023, https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2024-appendix-b.pdf

amendment. These rules ranged from benefit requirements (with which fully-insured AHPs must comply) to solvency and premium rating standards for AHPs that self-insure.

Alongside these state regulatory efforts, other federal laws passed in the same period, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), introduced additional obligations on AHPs. Under HIPAA, an employee seeking coverage from his or her employer's large group AHP may not be denied eligibility or continued eligibility based on health factors. Specifically, an AHP is prohibited from denying coverage based on:

- Health status (e.g., obesity, a physical disability, etc.)
- Pre-existing medical conditions (e.g., diabetes, high blood pressure, etc.)
- Pre-existing mental illnesses (e.g., depression, bipolar disorder, etc.)
- Medical claims history (e.g., expensive health care bills resulting from an accident)
- Medical history
- Genetic information
- Disability

The Affordable Care Act (ACA) further requires group health plans – including AHPs offering major medical coverage[5] – to comply with the law's group health plan requirements. These requirements include no cost-sharing for certain preventive services, and no annual and lifetime limits imposed on certain benefits covered by the AHP.[6]

[5] ERISA section 733(a)(1) and PHSA section 2791(a)(1) provide that a "group health plan" is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents…directly, or through insurance, reimbursement, or otherwise.

[6] As discussed later in this preamble, ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA, requiring an AHP to, among other things, Eliminate all pre-existing condition exclusions for all plan participants [PHSA section 2704]; Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan [PHSA section 2711]; Provide coverage for certain preventive health services with no cost-sharing [PHSA section 2713]; Cover "adult children" up to age 26 [PHSA section 2714]; Stop rescinding coverage absent fraud or misrepresentation [PHSA section 2712]; Include new internal and external appeals processes (and provide notice) [PHSA section 2719]; Allow participants a choice of primary care physician/pediatrician/OB/GYN [PHSA section 2719]; Provide direct access to emergency services [PHSA section 2719A]; Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information [PHSA section 2705]; Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014 [PHSA section 2707(b)]; Eliminate waiting periods that exceed 90 days [PHSA section 2708]; Provide participants with a summary of benefits and coverage [PHSA section 2715].

AHPs are urgently needed as a coverage option given the decline in small businesses offering health insurance. In the year 2000, 47.2 percent of small employers offered coverage. By 2023, that percentage declined to 30.1 percent.[7] According to data from the National Association of Insurance Commissioners (NAIC), there were 13,685,860 covered lives[8] (with comprehensive medical insurance) in the small employer health insurance market in 2014, the first year of small group coverage under the Affordable Care Act. Covered lives in this market fell to 9,562,174 by 2022, roughly a 30 percent decline in less than a decade.[9] During that same period, the average cost of single employee health coverage among small employers went from $5,886 annually to $7,513 annually,[10] a 28 percent increase. Premiums for family coverage rose even higher. Family coverage among small employers rose from an average of $15,575 in 2014 to $20,406 in 2022, a 31 percent increase.[11] Ultimately the entire premium of small business health insurance is borne by employees, including the employer share as those premiums represent foregone wage compensation.[12]

These increases were accompanied by an escalation in employee premium and deductible contributions. Employees enrolled in single coverage at a small business had their insurance contribution increase 58 percent, from an average of $1,035 in 2014 to $1,635 in 2022.[13] The increase for family coverage was even more severe at

[7] AHRQ, “MEPS IC,” "Percent of private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[8] National Association of Insurance Commissioners, "2014 Accident and Health Policy Experience Report," 2015.
[9] Covered lives apply to employees with comprehensive medical insurance within U.S. small employers. "Small group health plan means a health plan offered in the small group market as such term is defined in state law in accordance with the federal Public Health Service Act (PHSA). The Proctecting [sic] Affordable Coverage for Employees Act as Public Law 114-60 (PACE Act) amended section 1304(b) of the ACA and section 2791(e) of PHSA on October 7, 2015, to revise the definition of small employer for the purposes of the market reforms under title 1 of the Affordable Care Act and title XXVII of the Public Health Service Act. The PACE Act generally defines a small employer as an employer who employed an average of 1-50 employees on business days during the preceding calendar year, but provides States the option of extending the definition of small employer to include employers with up to 100 employees." National Association of Insurance Commissioners, "2022 Supplemental Health Care Exhibit Report," 2023, https://content.naic.org/sites/default/files/publication-hcs-zb-supplemental-health-report-2022.pdf
[10] AHRQ, “MEPS IC,” “Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[11] AHRQ, “MEPS IC,” “Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[12] "New research shows that increasing health insurance costs are eating up a growing proportion of worker’s compensation, and have been a major factor in both flattening wages and increasing income inequality over the past 30 years." Jen A. Miller, "Cost of Employer-Sponsored Health Insurance is Flattening Worker Wages, Contributing to Income Inequality," Tufts University, January 16, 2024, https://now.tufts.edu/2024/01/16/cost-employer-sponsored-health-insurance-flattening-worker-wages-contributing-income
[13] AHRQ, “MEPS IC,” “Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.

65 percent. In 2014 an employee with family insurance coverage paid an average of $4,426 annually. By 2022, that average contribution swelled to $7,324.[14] On top of employee insurance costs rising, there was also an increase in the amount of money paid out-of-pocket for medical care before insurance payments began. For individuals, deductibles rose from $1,777 for individuals in 2014 to $2,499 in 2022[15] while families saw average deductibles increase from $3,810 to $4,854.[16]

The National Federation of Independent Business (NFIB) has found affordability a central obstacle for small firms wishing to offer health coverage to their employees. The 2024 edition of their quadrennial survey "Small Business Problems & Priorities" reported that health insurance costs "continues to be the number one small business problem, a position it has held since 1986."[17] This same study revealed that the cost of health insurance was the top reason given for not offering coverage to employees. Expanded AHPs are an essential tool in addressing the problem of health insurance affordability for small businesses and permitting more employers to offer health insurance to their workers and their workers' dependents.

AHP opponents seek to restrict large group coverage from small businesses, but they are oddly silent regarding why this coverage may be successfully used by big businesses, including their own universities and nonprofits. Congress and federal policymakers should permit small businesses and their employees' access to the same coverage large organizations already enjoy. This is a matter of fairness and equity. Aside from the previously mentioned advantages of lower load charges as well as the leverage of scale in negotiation, there are three additional cost reductions that large group health insurance provides an AHP.

[14] AHRQ, "MEPS IC," "Average total employee contribution (in dollars) per enrolled employee for family coverage at private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2023," Firm size: fewer than 50 employees.
[15] AHRQ, "MEPS IC," "Average individual deductible (in dollars) per employee enrolled with single coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2023," Firm size: fewer than 50 employees.
[16] AHRQ, "MEPS IC," "Average family deductible (in dollars) per employee enrolled with family coverage in a health insurance plan that had a deductible at private-sector establishments by firm size and selected characteristics, 2002 to 2023," Firm size: fewer than 50 employees.
[17] Survey results based on 2,873 business owners with membership in the NFIB. Holly Wade and Madeleine Oldstone, "Small Business Problems & Priorities," National Federal of Independent Business, 2024, https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf

First, there is the percentage of premiums that can legally be used for profit and administration by a commercial health insurer. Small group plans devote 20 percent of their premiums to profit and overhead. Large group health plans, in contrast, are restricted to 15 percent for the same items, giving them a 5 percent savings advantage in comparison.[18]

Second, large group plans derive efficiencies from the absence of a "user fee" expense. This fee, ranging from 1.2 percent to 1.5 percent of premiums, is charged to insurers selling "individual" coverage on an Affordable Care Act (ACA) exchange to self-employed businesses.[19] In the state-based exchange Covered California for Small Business, there is a similar "Participation Fee of 5.2 percent of the premium due by each Covered California Enrollee."[20]

Third, large group health plans are able to unbundle supplemental benefits such as vision and dental care into separate group plans. Accordingly, those who do not desire such coverage do not pay for it, while those with such preferences still benefit from group rate savings.

[18] National Association of Insurance Commissioners, "Medical Loss Ratio," last updated October 26, 2022, https://content.naic.org/cipr-topics/medical-loss-ratio

[19] Centers for Medicare & Medicaid Services, "HHS Notice of Benefit and Payment Parameters for 2025 Final Rule," April 2, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule

[20] Covered California, "2025 PLAN YEAR AMENDMENT to the COVERED CALIFORNIA FOR SMALL BUSINESS QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2023 – 2025 FOR THE SMALL GROUP MARKET," August 1, 2024, https://hbex.coveredca.com/stakeholders/2025-Amend_QHP-CCSB_Model-Contract_8-1-24_Clean-Final.pdf