COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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To the Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education & the Workforce

On "Reducing Health Care Costs for Working Americans and Their Families"

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Introduction

Chairman Good and Ranking Member DeSaulnier, I appreciate the opportunity to testify today regarding America's health cost problem that is leading to an affordability challenge for many Americans. My name is Joel White, and I am the President of the Council for Affordable Health Coverage. CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care so that all Americans have access to affordable coverage. Our membership reflects a broad range of interests, including organizations representing small and large employers, patient groups, consumers, and insurers. Collectively, our members provide benefits to tens of millions of Americans and work tirelessly to offer affordable coverage to their workers.

Employers are the largest source of coverage in the US, representing more than half of all covered lives. Employees love their health benefits, and, according to our recent polling, want Congress to strengthen their health coverage.[1] Unfortunately, policies adopted in the last decade, in addition to rising health costs, inflation, a tight labor market, regulatory red tape, and taxes make it difficult, if not impossible, for businesses of all sizes to provide affordable coverage. Worse, some in Congress want to take away private employer insurance. I encourage the Committee to reject that approach and instead strengthen employer coverage by clarifying and expanding ERISA protections.

Congress should make health coverage more affordable and accessible in three ways: 1) expand options for employers and their employees; 2) provide financial incentives to ensure employer coverage remains viable; and 3) enact policies to lower the cost of health services and drugs to reduce premiums and out-of-pocket costs.

The Value of Employer Coverage

Most people have health coverage – 92 percent of Americans.[2] Although it is often masked in today's health care debate by discussions around Obamacare, employer provided coverage is by far the largest source of health insurance for Americans, exceeding coverage through ACA's

[1]CAHC Polling available here
[2] US Census Bureau data - https://www.census.gov/library/publications/2022/demo/p60-278.html

exchanges, Medicare, and Medicaid combined. For example, just 4 percent of Americans get coverage through ACA exchanges, but 160 million get coverage through work. [3]

And people like their coverage – a lot. According to a survey by Protecting Americans' Coverage Together (PACT), of which CAHC is a member, health insurance is the most important benefit an employer can offer workers and their families. [4] In fact, 96% of Americans believe it is important that a job offer health insurance. Additionally, by nearly a two-to-one margin, respondents said they would not accept a job that does not offer health insurance. Finally, 95% of poll respondents believe employer-sponsored health plans are more convenient than looking for coverage on the open market. This is perhaps the most important finding – people like employer coverage because the employer helps resolve problems and deals with a confusing and expensive market. For example, during COVID mental and behavioral health issues became more prevalent and more severe, especially as we became more isolated by working from home and attending school virtually. Many large employers responded by enhancing virtual care via telehealth and digital app solutions. Stand-alone health benefits played an important role in these strategies and filled a significant gap for the workforce.

People do not want to fend for themselves in the individual market and are ill-equipped to do so because they lack scale to negotiate better prices. They also do not want Congress to put them in an inflexible, one-size-fits some government program that only changes when a law is passed, or a bureaucrat changes a rule. Government is slow to keep up with medicine, science, and benefit innovation and the changing needs of a dynamic workforce.

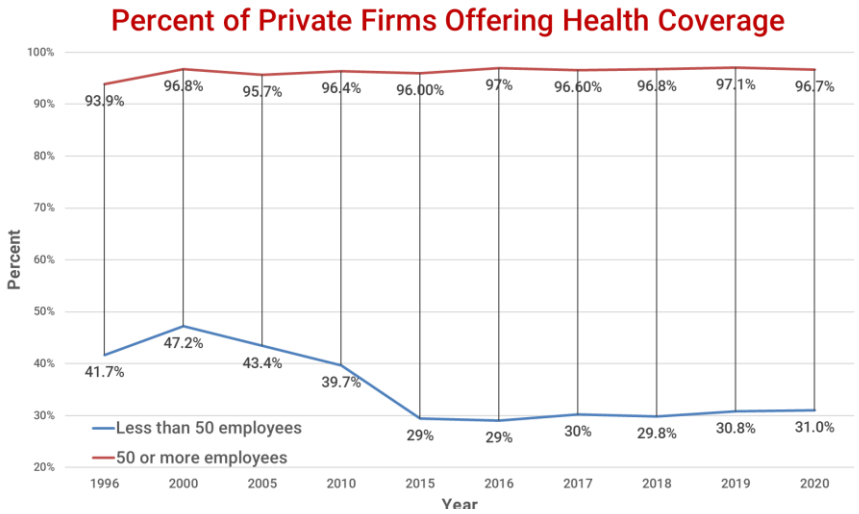
Challenges

Health coverage is expensive because health care is expensive. Premiums buy coverage that pays for medical services and drugs. As health costs increase, so do premiums and out-of-pocket costs like deductibles. The cost of an average family employer plan right now is about $22,000[5], which is roughly equivalent to the all-in one-year cost of an in-state 4-year public institution, including

[3] https://www.kff.org/report-section/ehbs-2022-summary-of-findings/
[4] https://www.uschamber.com/assets/documents/Final-PACT-Public-Opinion-Survey.pdf
[5] https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/

tuition, room, board, and fees.[6] Over the last decade, the cost of employer plans increased nearly 50 percent, twice as fast as wages, reducing the affordability of coverage.

Most large firms offer coverage to their employees. And while small business accounts for more than 60 percent of new jobs, the smaller the company, the less likely they are to offer health insurance. A full 97 percent of firms with more than 50 employees provide coverage for their workers. But for those companies with less than 50 employees, the offer rate is just 31 percent,



Source: MEPS/AHRQ Data

which represents a significant decline since the enactment of Obamacare. This is by design, as the law created significant new costs for small businesses and new incentives to drop coverage because workers could obtain subsidized coverage through Exchanges.

The biggest challenge small firms face? More than half (55%) of small business leaders cite high costs of health insurance as a barrier to offering health coverage.

Small businesses are also challenged to find relevant health care benefit packages. According to a recent survey from the Small Business Entrepreneurship Council, only 1 in 5 (17%) small business leaders strongly agree that the employer health care solutions available to them have kept up with changing market conditions. In addition, small firms do not have large pools of employees to

[6] https://educationdata.org/average-cost-of-college#:~:text=The%20average%20cost%20of%20attendance,or%20%24218%2C004%20over%204%20years.

spread risk across broad populations or to reduce the administrative costs associated with offering coverage. One sick person at a small business can blow a hole in profits and potentially sink the enterprise.

Government Policies

Congress has enacted laws that make it more difficult for employers to offer coverage, and that create incentives for people to leave employer coverage and join government programs. Chief among these is the Affordable Care Act, which significantly changed market rules for the individual and small group markets. The table below shows the mandates that apply to small firms but not large enterprises. Keep in mind, individual coverage is heavily subsidized, shifting the costs of the mandates onto taxpayers.

ACA Market Reform	Individual Market	Small-group Market*	Large-group Market*
Guaranteed issue	Yes	Yes	Yes
Pre-existing condition exclusions prohibited	Yes	Yes	Yes
Out-of-pocket maximums	Yes	Yes	Yes
Annual and lifetime limits prohibited	Yes	Yes	Yes
Preventive services covered without cost-sharing	Yes	Yes	Yes
Essential health benefits	Yes	Yes	No
Rating rules	Yes	Yes	No
Single risk pool	Yes	Yes	No
Risk adjustment program	Yes	Yes	No
Medical loss ratio	80%	80%	85%

*Applies to fully insured products. The small-group market is defined in most states to be groups of up to 50 employees, with large group defined as groups with 51 or more employees.

Source: New Rules to Expand Association Health Plans, American Academy of Actuaries Magazine, May 2, 2018

While Congress talked up the benefits of these reforms, the cost of imposing these changes were rarely discussed and created several important dynamics that are playing out in the market today. First, mandated benefits and new market rules increased the cost of coverage and shifted those

costs onto taxpayers via premium subsidies. Second, small businesses got most of the mandates that increased costs, but none of the benefits of premium reduction subsidies. Third, Congress created a tax credit for small businesses to offset these costs, but the credit was structured so poorly, just 7,000 firms (out of 30 million) took the tax incentive in 2016, the last year data from the IRS is available. Lastly, small businesses have no mandate to provide coverage. As Congress increased their costs and limited their choices, the authors of the ACA created powerful incentives for small businesses to drop coverage.

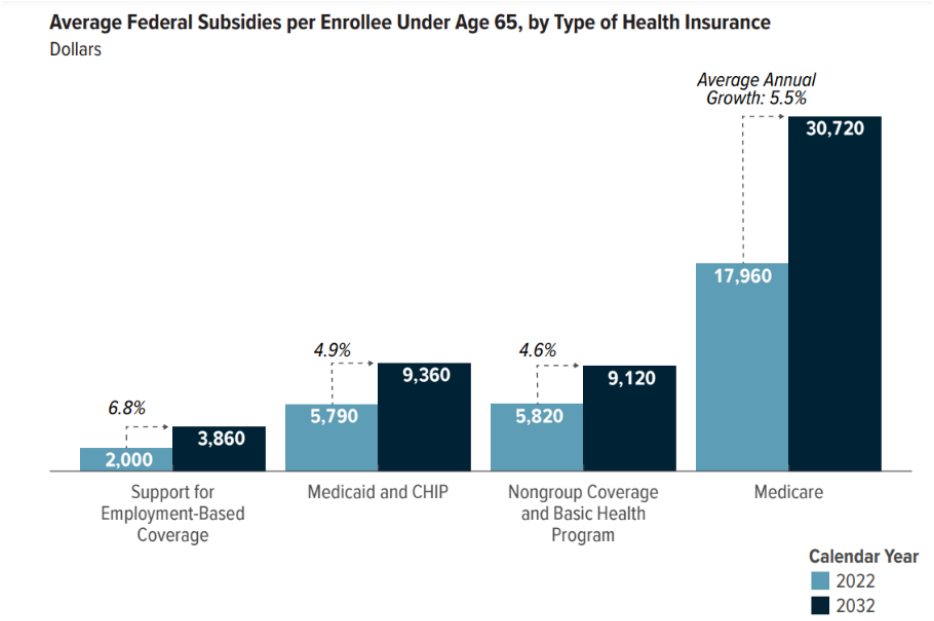
And they did. As a result, some hardworking Americans' only options are programs like ACA, where they struggle with higher deductibles and less access to care. Or they are enrolling in Medicaid, which has little access to doctors and drugs. It is estimated as many as 12 million people who work for small firms get coverage in ACA and Medicaid.

We need strong safety nets, but ACA and Medicaid are not a good deal for enrollees or taxpayers. In 2021, deductibles were twice as high in Obamacare than in small business plans ($4,500 versus $2,000), and access to care is often restricted by very narrow networks.[7] In Medicaid, doctors are increasingly unavailable.[8] So, while people may have a coverage card, they have limited access to doctors, and as a result, many seek care in high-cost settings like the hospital. Subsidies in both the ACA and Medicaid are three times more expensive than in employer coverage, according to CBO. Taxpayers pay the bill for higher costs and less access.[9] Those taxpayers include small business employees already struggling with the high cost of healthcare.

[7] https://www.gao.gov/assets/820/814141.pdf

[8] According to a November 2021 MACPAC report, "Adults with Medicaid coverage were significantly less likely to report having a usual source of care than adults with private coverage. They were also significantly more likely to report not receiving or delaying medical care, prescriptions, and dental services compared to adults with private coverage."

[9] https://www.cbo.gov/system/files/2022-06/57962-health-insurance-subsidies.pdf



Increasing Choices and Lowering Costs

Considering the challenges faced by all employers, including government policies that are not working well, Congress should take steps to: 1) expand options for employers and their employees; 2) provide financial incentives to ensure employer coverage remains viable; and 3) enact policies to lower the cost of health services and drugs to reduce premiums and out-of-pocket costs. These include:

1. **Level the playing field:** Give small businesses the same benefit design options available to large businesses;
2. **Make a good thing better:** Allow more people to form and join Association Health Plans; and
3. **Extend telehealth flexibilities:** Continue allowing employers to offer standalone telehealth benefits.

Level the Playing Field

Kaiser Family Foundation (KFF) reports that 65 percent of workers are covered by a self-funded plan[10], meaning that the employer directly funds the health plan benefits. Self-funded employers are able keep premiums low and exercise greater control over plan benefits. The ability to self-fund is at the disposal of big business, but for small businesses this attractive option is often out

[10] https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/

of reach due primarily to cost and availability.[11] Kaiser estimates that large firms cover more workers under self-funding arrangements than small business (82 percent versus 20 percent), but small firms are increasingly using self-funding as an emerging strategy to better manage costs and innovate benefits.[12]

A level-funded plan is a type of self-funded plan that is an exception to that rule, offering a self-funded model that is more accessible to small business because it reduces risk for small employers. Level-funded plans have three parts:

- Administration (processing of claims, estimating premiums),
- Claims costs (payment of actual employee medical expenses), and
- Stop-loss (insurance coverage for excess losses).

Level-funded plans reduce risk and streamline administration by offering a fixed monthly price that covers the cost of administration and stop-loss, and fully funds the claims' risk for the year. Employers have flexibility to design their plans, and they can shop for the best deals based on attachment points that make sense. Recognizing the savings and benefits of this model, 36 percent of covered workers at small firms reported enrollment in a level funded plan in 2022.[13]

Some states have started limiting small employers' ability to offer self-funded plans. While states lack jurisdiction over self-funded plans directly (which fall under ERISA and outside of state law in most circumstances), some states have effectively eliminated small employer access by banning the sale of level-funded plans to certain size groups or making the sale of low attachment point plans illegal.

To help small businesses across the country, Congress should protect access to level-funded plans and reinsurance (including low attachment point reinsurance) policies by ensuring they remain

[11] 2023 Small business Health Insurance Survey, NFIB. https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf
[12] https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/
[13] *Ibid*

available for sale and purchase in all states. This would involve clarifying ERISA preemption with respect to self-funded arrangements for small businesses.

Make a Good Thing Better: Association Health Plans

Congress created ERISA decades ago, and insurance sold through associations had long been an option for employers to purchase coverage that works for their employees. Millions have done so. The Department of Labor (DOL) allows a group or association of employers to sponsor a single multiple employer plan if it is a bona fide group that shares a commonality of interests and the benefit arrangement is controlled by the employer members.

Under current law, insurance coverage provided through an employer association to individuals and small employers is regulated by the rules of those markets unless the coverage is through a single ERISA covered plan. Unless the arrangement constitutes a single ERISA covered plan, the regulatory framework disregards the group in determining what rules apply (individual, small or large group), and then regulators apply those rules. The size of each employer participating in the association determines the regulations that apply. As a result, different members of the association will have different rules apply based on their circumstances. This makes association health insurance very difficult to administer and discourages employers from banding together to provide association coverage.

In 2018, DOL concluded the ERISA rules treated association arrangements as mere collections of individual plans, subjecting employer members to a complex and costly compliance environment where members may be simultaneously subject to large group, small group, and individual market rules. On June 21, 2018, the Department issued a Final Rule[14] to expand the availability of association coverage for small businesses and self-employed individuals. The final rule would have broadened the types of employer groups or associations that may sponsor a single group health plan under ERISA. It made it easier for more groups to form AHPs by establishing a more flexible "commonality of interest" test if their members were in the same trade, industry, line of business, or profession, or maintained their business in the same geography (same state or

[14] 29 CFR Part 2510

metropolitan area). It would also expand AHPs to self-employed individuals, former employees, and family members, creating important new coverage options for people who may slip between the cracks. Importantly, the rule allowed employer members to benefit from size to pool risk and be regulated under the ERISA framework. CBO estimated that almost 4 million more people would be covered by these arrangements, with nearly half a million newly insured, largely because premiums would be 30 percent less than in fully regulated small group market coverage.[15]

The rule was challenged in Federal District Court by 11 states and on March 28, 2019, was vacated, disrupting the market by creating legal and regulatory uncertainty. The Court's decision was appealed to the Court of Appeals for the D.C. Circuit where it sits to this day "in abeyance" due to the change in Administration. The Administration intends to propose rule changes to the 2018 AHP rules.

In the Memorandum Opinion, the Federal District Court found the Final Rule "…exceeds the statutory authority delegated by Congress in ERISA."[16] Congress must act to clarify the status of AHPs and expand AHPs as an option for the many businesses eager to lower costs.

A good start would be to pass Congressman Walberg's bill the Association Health Plan Act to ensconce AHPs in statute, clarify regulatory authority, and expand AHPs as an option for employers. The bill would also ensure AHPs cannot limit eligibility for coverage based on medical history or health status, fully insured AHPs must comply with state benefit mandates, and self-insured AHPs comply with state MEWA rules. It clarifies the definition of employer and removes the commonality of interest requirement, allowing more associations to form and pool risk to lower premiums. We expect premium reductions, and more people insured, a welcome relief to the status quo.

Don't Take Away Benefits: Continue Allowing Employers to Offer Standalone Telehealth Benefits

[15] https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf
[16] https://affordablecareactlitigation.files.wordpress.com/2019/03/5940153-0-12659.pdf

During the COVID-19 designated public health emergency (PHE), many employees have enjoyed access to telehealth services because employees who do not qualify for a group health plan offered by their employer, were able to access stand-alone telehealth benefits. On May 11th, the PHE is set to expire, and this flexibility will end. Seasonal and part-time workers will also lose access to telehealth services in many cases.

Congress should pass H.R. 824, the *Telehealth Benefit Expansion for Workers Act*[17], to change current law to allow employers to offer workers stand-alone telehealth benefits. Under the bill, stand-alone telehealth benefits would remain separate from traditional group health plans.

I. Conclusion

With the continued rise in health costs, CAHC is very concerned that we're dangerously close to a two-tier health system within the American workforce. If you work for a Fortune 500 company, University, or government agency – or anyone else with a large group plan – you get generous, high quality, private coverage. But if you're self-employed, work at a small business or earn working-class wages, you have to choose between two bad options – a high-deductible Obamacare plan or Medicaid, with a dearth of provider options. This is a disaster for those who believe in private healthcare and want to preserve government safety net programs for the truly needy. Workers deserve better access to private coverage and Congress needs to act.

Thank you for the opportunity to testify today, and I am happy to answer any questions.

[17] https://www.congress.gov/bill/118th-congress/house-bill/824