A HEALTHY WORKFORCE: EXPANDING ACCESS AND AFFORDABILITY IN EMPLOYER-SPONSORED HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

OF THE

COMMITTEE ON EDUCATION AND WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 2, 2025

Serial No. 119–7

Printed for the use of the Committee on Education and Workforce

Available via: *edworkforce.house.gov* or *www.govinfo.gov*

U.S. GOVERNMENT PUBLISHING OFFICE
61–401 PDF WASHINGTON : 2025

COMMITTEE ON EDUCATION AND WORKFORCE

TIM WALBERG, Michigan, *Chairman*

JOE WILSON, South Carolina
VIRGINIA FOXX, North Carolina
GLENN THOMPSON, Pennsylvania
GLENN GROTHMAN, Wisconsin
ELISE M. STEFANIK, New York
RICK W. ALLEN, Georgia
JAMES COMER, Kentucky
BURGESS OWENS, Utah
LISA C. MCCLAIN, Michigan
MARY E. MILLER, Illinois
JULIA LETLOW, Louisiana
KEVIN KILEY, California
MICHAEL A. RULLI, Ohio
JAMES C. MOYLAN, Guam
ROBERT F. ONDER, Jr., Missouri
RYAN MACKENZIE, Pennsylvania
MICHAEL BAUMGARTNER, Washington
MARK HARRIS, North Carolina
MARK B. MESSMER, Indiana
VACANCY

ROBERT C. "BOBBY" SCOTT, Virginia,
Ranking Member
JOE COURTNEY, Connecticut
FREDERICA S. WILSON, Florida
SUZANNE BONAMICI, Oregon
MARK TAKANO, California
ALMA S. ADAMS, North Carolina
MARK DESAULNIER, California
DONALD NORCROSS, New Jersey
LUCY MCBATH, Georgia
JAHANA HAYES, Connecticut
ILHAN OMAR, Minnesota
HALEY M. STEVENS, Michigan
GREG CASAR, Texas
SUMMER L. LEE, Pennsylvania
JOHN W. MANNION, New York
VACANCY

R.J. Laukitis, *Staff Director*
Véronique Pluviose, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

RICK ALLEN, Georgia, *Chairman*

ROBERT F. ONDER, Jr., Missouri
JOE WILSON, South Carolina
VIRGINIA FOXX, North Carolina
JAMES COMER, Kentucky
BURGESS OWENS, Utah
LISA C. MCCLAIN, Michigan
MICHAEL A. RULLI, Ohio
RYAN MACKENZIE, Pennsylvania
MICHAEL BAUMGARTNER, Washington

Mark DeSaulnier, California,
Ranking Member
JOE COURTNEY, Connecticut
DONALD NORCROSS, New Jersey
LUCY MCBATH, Georgia
JAHANA HAYES, Connecticut
GREG CASAR, Texas
SUMMER L. LEE, Pennsylvania
JOHN W. MANNION, New York
MARK TAKANO, California

C O N T E N T S

QUESTIONS FOR THE RECORD

A HEALTHY WORKFORCE: EXPANDING ACCESS AND AFFORDABILITY IN EMPLOYER-SPONSORED HEALTH CARE

Wednesday, April 2, 2025

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS,
COMMITTEE ON EDUCATION AND WORKFORCE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:15 a.m., in Room 2175 Rayburn House Office Building, Hon. Rick Allen (Chairman of the Subcommittee) presiding.

Present: Representatives Allen, Onder, Foxx, Mackenzie, Walberg, DeSaulnier, Courtney, Casar, Lee, and Scott.

Staff present: Vlad Cerga, Director of Information Technology; Libby Kearns, Press Assistant; Katerina Kerska, Legislative Assistant; Trey Kovacs, Director of Workforce Policy; Campbell Ladd, Clerk; R.J. Laukitis, Staff Director; Georgie Littlefair, Investigator; C.J. Mahler, Professional Staff Member; Danny Marca, Director of Information Technology; John Martin, Deputy Director of Workforce Policy/Counsel; Audra McGeorge, Communications Director; Daniel Nadel, Legislative Assistant; Ethan Penn, Deputy Press Secretary and Digital Director; Kane Riddell, Staff Assistant; Sara Robertson, Press Secretary; Ann Vogel, Director of Operations; Ali Watson, Director of Member Services; James Whittaker, General Counsel; Jeanne Wilson, Retirement Counsel; Ariel Box, Minority Intern; Ilana Brunner, Minority General Counsel; Daniel Foster, Minority Senior Health and Labor Counsel; Jo Howard, Minority Grad Intern; Carrie Hughes, Minority Director of Health & Human Services Policy; Amanda Lee, Minority Grad Intern; Jessica Schieder, Minority Economic Policy Advisor; Dhrtvan Sherman, Minority Research Assistant; Raiyana Malone, Minority Press Secretary; Marie McGrew, Minority Press Assistant; Ben Noenickx, Minority Intern; Eleazar Padilla, Minority Staff Assistant; Véronique Pluviose, Minority Staff Director; Banyon Vassar, Minority Director of IT.

Chairman ALLEN. The Subcommittee on Health, Employment, Labor and Pensions will come to order. I note that a quorum is present. Without objection, the Chair is authorized to call a recess at any time. Thank you to our witnesses for joining the Subcommittee to discuss today's topic, A Healthy Workforce, Expanding Access and Affordability in Employer-Sponsored Health Care.

As the Committee of jurisdiction over employer-sponsored health care, Educational Workforce Committee members understand that employers want what is best for their employees. Despite not being required to offer health coverage, small businesses often choose to do so in order to attract and retain top talent.

According to NFIB, 56 percent of small employers offer health insurance, and 89 percent of small businesses with more than 30 employees offer health benefits. As a small business owner myself, I learned that investing in the health of my employees paid long-term dividends, both in productivity and the morale of the company.

Unfortunately, it is getting more challenging for businesses of all sizes to offer competitive healthcare benefits to their employees. I have often said that competition is the only way to bring down cost. According to the Kaiser Family Foundation, premiums for family coverage for employees have increased 7 percent in each of the last 2 years.

Rising costs have a disproportionate impact on small businesses as they are less able to absorb the impact of rising healthcare costs. 94 percent of small employers find it challenging to manage the costs of their health plans, and 98 percent believe that the cost of their health plans will become unsustainable within this decade.

The Biden-Harris administration's inflationary agenda, intent on tying the hands of employers with costly and burdensome regulations contributed to the healthcare cost challenges that small businesses face today. Fortunately, President Trump and House Republicans have common sense solutions that give small businesses flexibility to expand access and affordability to their healthcare offerings.

The first solution is expanding access to associated health plans or AHPs. An AHP allows employers to band together to purchase health coverage. By combining purchasing power, small employers can negotiate more favorable rates the same way that larger employers do.

In 2018, the Trump administration finalized a rule that expanded AHP availability to more businesses and to self-employed individuals. However, this rule was regrettably tied up in the courts and ultimately reversed by the Biden administration. The results speak for themselves. While the Trump Rule was in effect, new AHPs produced savings of up to 29 percent on average, while realtor AHPs, like the one Ms. Shields will speak about today saw an average savings of up to 50 percent.

Congress should ensure that AHPs are a viable option for small businesses and self-employed individuals for years to come, which is why it is important for Congress to pass Chairman Walberg's Association Health Care Plans Act. Businesses of all sizes can use stop loss or reinsurance to insulate themselves from unexpected high medical claims.

However, Democratic led states have sought to overregulate self-insured health plans using reinsurance by artificially classifying these plans as fully insured with the intended result to removing small businesses' ability to innovate and contain cost. Under Self-Insurance Protection Act would clarify that self-insured plans with reinsurance are still self-insured health plans.

As we will hear in testimony today, the COVID–19 pandemic created an opportunity for small businesses to innovate by expanding telehealth coverage options. Chairman Walberg's Telehealth Benefit Expansion for Workers Act would return to employers this important tool used to expand coverage options and lower cost.

Employers have also innovated by participating in direct contracts with providers, removing middlemen, and bureaucracy, and allowing employers to customize their coverage options to meet their employees' healthcare needs.

This hearing will examine expanding businesses' ability to use innovative coverage models like direct contracts. Last, this Committee on a bipartisan basis has historically held ERISA preemption of State insurance law to be fundamentally important. ERISA preemption has allowed self-insured health plans the flexibility to design their plans in a way that works best for over 50 years.

We look forward to closely working with the Department of Labor to defend ERISA preemption. I am hopeful that our Democratic colleagues will work with us to get businesses more options, more flexibility and more opportunities to offer high-quality, affordable coverage to their employees.

I thank the Subcommittee members for joining this important discussion, and I look forward to our witnesses' expert testimony. Now, I yield to the Ranking Member for an opening statement.

[The statement of Chairman Allen follows:]

COMMITTEE ON EDUCATION & WORKFORCE
CHAIRMAN TIM WALBERG

COMMITTEE STATEMENT

Opening Statement of Rep. Rick Allen (R-GA), Chairman
Subcommittee on Health, Employment, Labor, and Pensions
Hearing: "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"
April 2, 2025

(As prepared for delivery)

The Subcommittee on Health, Employment, Labor, and Pensions will come to order. I note that a quorum is present. Without objection, the Chair is authorized to call a recess at any time.

Thank you to our witnesses for joining the Subcommittee to discuss today's topic: A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care.

As the Committee of jurisdiction over employer-sponsored health care, Education and Workforce Committee members understand that employers want what is best for their employees.

Despite not being required to offer health coverage, small businesses often choose to do so in order to attract and retain top talent.

According to NFIB, 56 percent of small employers offer health insurance, and 89 percent of small businesses with more than 30 employees offer health benefits.

As a small business owner myself, I learned that investing in the health of my employees paid long-term dividends, both in productivity and the morale of the company.

Unfortunately, it is getting more challenging for businesses of all sizes to offer competitive health care benefits to their employees. I have often said that competition is the only way to bring down costs.
According to the Kaiser [KAI-zur] Family Foundation, premiums for family coverage for employees have increased 7 percent in each of the last two years.

Rising costs have a disproportionate impact on small businesses, as they are less able to absorb the impacts of rising health care costs.

Ninety-four percent of small employers find it challenging to manage the cost of their health plans, and 98 percent believe that the cost of their health plans will become unsustainable within the next decade.

The Biden-Harris administration's inflationary agenda, intent on tying the hands of employers with costly and burdensome regulations, contributed to the health care cost challenges that small businesses face today.

Fortunately, President Trump and House Republicans have commonsense solutions to give small businesses flexibility to expand access and affordability in their health care offerings.

The first solution is expanding access to Association Health Plans, or AHPs.

An AHP allows employers to band together to purchase health coverage. By combining purchasing power, small employers can negotiate more favorable rates, the same way that larger employers do.

In 2018, the Trump administration finalized a rule that expanded AHP availability to more businesses and to self-employed individuals. However, this rule was regrettably tied up in the courts and ultimately reversed by President Biden.

The results speak for themselves. While the Trump rule was in effect, new AHPs produced savings of up to 29 percent on average, while realtor AHPs, like the one Ms. Shields will speak about today, saw average savings of up to 50 percent.

Congress should ensure that AHPs are a viable option for small businesses and self-employed individuals for years to come, which is why it is important for Congress to pass Chairman Walberg's Association Health Plans Act.

Businesses of all sizes can use stop-loss or reinsurance to insulate themselves from unexpected high medical claims.

However, Democrat-led states have sought to overregulate self-insured health plans using reinsurance by artificially classifying these plans as fully-insured, with the intended result of removing small business' ability to innovate and contain costs.

Dr. Onder's Self Insurance Protection Act would clarify that self-insured health plans with reinsurance are still self-insured health plans.

As we will hear in testimony today, the COVID-19 pandemic created an opportunity for businesses to innovate by expanding telehealth coverage options.

Chairman Walberg's Telehealth Benefit Expansion for Workers Act would return to employers this important tool used to expand coverage options and lower costs.

Employers have also innovated by participating in direct contracts with providers, removing middlemen and bureaucracy, and allowing employers to customize their coverage options to meet their employees' health care needs. This hearing will examine expanding businesses' ability to use innovative coverage models like direct contracts.

Lastly, this Committee, on a bipartisan basis, has historically held ERISA preemption of state insurance law to be fundamentally important. ERISA preemption has allowed self-insured health plans the flexibility to design their plans in a way that works best for them for over 50 years.

We look forward to working closely with the Department of Labor to defend ERISA preemption.

I am hopeful that our Democrat colleagues will work with us to give businesses more options, more flexibility, and more opportunities to offer high-quality, affordable coverage to their employees.

I thank the Subcommittee members for joining this important discussion, and I look forward to our witnesses' expert testimony.

I now yield to the Ranking Member for an opening statement.

Mr. DESAULNIER. Thank you, Mr. Chairman. I want to thank you for having this hearing. As you know, as soon as we both knew we were going to have these assignments again, I reached out and we had a wonderful conversation. As two former small business owners—or, I am a former, the gray hair and the white hair came from politics mostly.

Well, no, owning restaurants probably was worse. We have—we both met payrolls. We have paid for insurance. I want to really, and my hope is that while we go into our ideological approaches to this, there is an old saying, if you do what you have always done, you get what you have always got.

That we do it through this, we could work in a way that seems to me to be completely bipartisan. How do we improve efficiently with performance standards, the delivery of care, and the cost to these—this marketplace? For you and I, as you have stated, and for large employers, clearly if you are a business owner, you want to get value out of your insurance, and you do not want to have high denials.

You do not want to have, as you said, your employees not being as effective because they are not getting the support that they paid for. My concern is what is happening in the marketplace in this field. The previous session, the previous Chair and I, we had hearings on PBMs. What an inefficient part of the health care delivery system.

We have stories now about private equity companies going in and buying out rural hospitals, taking out all the assets and leaving, and having emergency response people have to take people an hour and 15 minutes to the next nearest hospital, as opposed to 15 minutes.

All of that is a structure that I do not know what the solution is. I have my own ideas, as you do, but it clearly for me is a level of urgency that this committee should really dive into. My respect for you, Mr. Chairman, and our collegiality over the years having been in the same class and our backgrounds, I think gives me hope that we can approach this in a way that we get good value for the employers, the employees, and the value includes the cost, but also the quality of care.

I do not think we are talking enough in this hearing, but hopefully in future ones, about the quality of care. Then, secondarily, you know my passion about behavioral health, making sure people have that access, but we have also had hearings in the previous session, bipartisan hearings about denials.

The facts about denials are just outrageous. I have had doctors tell me all over the country that claims they put in routinely for decades, they are now being denied. I have one example in my comments. Thank you for this. However, I have got to start out with the reality that the last 3 months with the current administration and DOGE and Mr. Musk, they have done irreparable harm without analysis to the health and safety of American workers.

This is the next part. The reckless closure of key offices within the Department of Health and Human Services, and firing of tens of thousands of essential workers is contrary to the administration's supposed enthusiasm for efficiency. You do not take years of

experience in any operation, private or public, and just indiscriminately get rid of them.

There is value that taxpayers lost by doing this. I am fine with greater efficiency. We can always look at that, but efficiency also requires us to look at the current positive sides of the delivery of services. To me that is the essence of owning a business, is problem solving without already—already assuming what the solutions are and being open-minded to how we achieve those solutions.

The Administration of Community Living or ACL, which is slated for closure, was formed specifically to streamline and bring under one umbrella, the various programs in the Health and Human Services Department.

I would like to submit for the record a letter signed by more than 450 organizations expressing their dismay over the plan to eliminate the ACL and split its functions across three other agencies. I would like to submit this. I would like unanimous consent at this time to submit it for the record.

Chairman ALLEN. Without objection.

[The information of Mr. DeSaulnier follows:]

AAPD
American Association of People with Disabilities

March 28, 2025

The Honorable Mike Johnson
Speaker of the House
H-232, The Capitol
Washington, DC 20515

The Honorable John Thune
Senate Majority Leader
US Senate SD-511
Washington, DC 20510

The Honorable Hakeem Jeffries
House Minority Leader
2267 Rayburn House Office Building
Washington, DC 20515

The Honorable Charles Schumer
Senate Minority Leader
322 Hart Senate Office Building
Washington, DC 20510

Speaker Johnson, Majority Leader Thune, Minority Leader Jeffries, and Minority Leader Schumer:

The American Association of People with Disabilities and the undersigned disability, civil rights, aging, mental health, and patient organizations were dismayed to learn of the plan to re-organize the Department of Health and Human Services (HHS), especially the plan to eliminate the Administration for Community Living (ACL) and split its functions across three other agencies, as well as the consolidation of the Office for Civil Rights (OCR) and Substance Abuse and Mental Health Services Agency (SAMHSA).

Formed in 2012, ACL was created to advance the fundamental principle that "older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities." ACL brought together aging and disability programs from across the federal government to efficiently administer similar programs that promote similar goals. Breaking up these programs across three other agencies is the opposite of promoting efficiency, program integrity, and optimization.

This plan also goes against the Workforce Innovation and Opportunities Act or WIOA, which was passed by Congress in 2014 and which transferred three programs to the ACL: Independent Living Services programs, programs related to The Assistive Technology Act, and The National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). WIOA gave the ACL Administrator statutory responsibilities for these programs that cannot just be erased without another act of Congress.

We are also concerned about the consolidation of the OCR into an agency to fight "waste, fraud, and abuse." OCR does critical work that should not be diluted into only waste, fraud, and abuse. For example, during the initial outbreak of COVID-19 in March 2020, OCR moved quickly to issue guidance and conduct enforcement against hospitals that were de-prioritizing people with disabilities for treatment. This civil rights enforcement action saved lives by ensuring that people with disabilities could access life-saving treatment that would otherwise be denied to them.

SAMHSA plays a critical role in promoting mental health and treating substance use disorders across the lifespan. Bipartisan leaders across the government have recognized that we are in the midst of a mental health and substance use disorder crisis. Now is not the time to make massive cuts to this agency.

These changes come amid the dismantling of the Department of Education and major cuts in staffing and services at the Social Security Administration. Together, these cuts will negatively impact disabled Americans' educational opportunities and the ability of disabled Americans and older adults who live in their communities to efficiently apply for and receive the Social Security benefits that they need to survive.

We urge Congress to use its oversight authority to halt this dismantling, hold hearings, and ensure that Americans with disabilities and older adults will not be harmed. For more information, please contact Michael Lewis at mlewis@aapd.com.

CC:
House Committee on Energy and Commerce
House Committee on Ways and Means
House Committee on Education and the Workforce
Senate Committee on Finance
Senate Committee on Health, Education, Labor and Pensions
Senate Committee on Aging

Sincerely,
American Association of People with Disabilities
3i Housing of Maine
Abilitree Center For Independent Living (CIL)
Ability360
Able South Carolina
AbleVoices
Access Central Coast
Access Living
Access to Independence
Access To Independence of Cortland County, Inc.
AccessAbility
ADA Watch/Coalition for Disability Rights & Justice
AdLib, Inc.
ADRC OF THE NORTH- IRON COUNTY
Advance Maryland
AFT: Education, Healthcare, Public Services
AgeWell Middle Tennessee
Alabama Lifespan Respite
Alexander Graham Bell Association for the Deaf and Hard of Hearing
All Wheels Up
Alliance Center for Independence
Alliance for Retired Americans
Aloha Independent Living Hawaii

ALS Association
American Academy of Pediatrics
American Association of People with Disabilities
American Association on Health and Disability
American Civil Liberties Union
American Cochlear Implant Alliance
American Council of the Blind
American Foundation for the Blind
American Macular Degeneration Foundation
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
American Therapeutic Recreation Association
Appalachian Independence Center
Arizona Developmental Disabilities Planning Council
Arizona Statewide Independent Living Council
Asian American Psychological Association (AAPA)
ASK Family Services
Assist To Independence
Association of Academic Physiatrists
Association of People Supporting Employment First (APSE)
Association of Programs for Rural Independent Living
Association of University Centers on Disabilities
Atlantic Center for Independent Living, Inc
Atlantis Community, Inc
ATTIC INC
Autism Society of America
Autism Society of Maryland
Autistic People of Color Fund
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network
Bazelon Center for Mental Health Law
Behavioral Health Research
Boston Center for Independent Living
Brain Injury Association of America
Brain Injury Association of South Carolina
Brooklyn Center for Independence of the Disabled
California Association of Area Agencies on Aging (C4A)
California Foundation for Independent Living Centers (CFILC)
California Resource Services for Independent Living
Cape Organization for Rights of the Disabled

Caring Across Generations
CASH Campaign of Maryland
CEAR
Center for Accessible Living
Center for Independence
Center for Independent Living of Central PA
Center for Independent Living Opportunities
Center for Law and Social Policy (CLASP)
Center for Living & Working, Inc
Center for Medicare Advocacy
Center for People With Disabilities
Center for Public Representation
Center on Aging and DIS-Ability Policy
Central Iowa Center for Independent Living
Child Neurology Foundation
Clinician Task Force
Coalition for Home Repair
Coalition on Human Needs
Colorado Developmental Disabilities Council
CommunicationFIRST
Community Access Center
Community Catalyst
Community Development Center
Community Development Network of Maryland
Community Legal Aid Society, Inc.
Community Resources for Independence, Inc.
Community Resources for Independent Living
Compass IL
Cornerstone Community Housing, Inc.
Count US IN Inc. (Count US Indiana)
Connecticut State Independent Living Council
DC Developmental Disabilities Council
Deaf Equality
Detroit Disability Power
DIAL-Center for Independent Living
Disabilities Network of Eastern CT
Disability Action Center (No. California)
Disability Belongs
Disability Community Resource Center
Disability Empowerment Center
Disability Law Center of Alaska
Disability Law Center of Utah
disAbility Law Center of Virginia

Disability Network Lakeshore
Disability Network Mid-Michigan
Disability Network Southwest Michigan
Disability Network Washtenaw Monroe Livingston
Disability Network Wayne County Detroit
Disability Network West Michigan
Disability Network/Michigan
Disability Options Network
Disability Policy Consortium
Disability Resource Center
Disability Rights @ Ogle Consulting
Disability Rights Arizona
Disability Rights California
Disability Rights Center - NH
Disability Rights Education and Defense Fund (DREDF)
Disability Rights Florida
Disability Rights Iowa
Disability Rights Maryland
Disability Rights Mississippi
Disability Rights NC
Disability Rights New Jersey
Disability Rights New York DRNY
Disability Rights Ohio
Disability Rights Pennsylvania
Disability Rights South Carolina
Disability Rights South Dakota
Disability Rights Vermont
Disability Rights Washington
Disability Rights WI
DMV Disability and Senior Community Group
Drug Policy Alliance
Dynamic Independence
Elderly Care Concepts
Empower Music Therapy
Empower Tennessee
Endependence Center
Epilepsy Foundation of America
Equality California
Eunice Kennedy Shriver Center, UMass Chan Medical School
Everybody Counts, Inc.
Exceptional Family Resources/ARISE
Falling Forward Foundation
Families On The Move of NYC, Inc.

Families USA
Family Support Organization of Essex County
Family Voices CO
Family Voices NJ
Family Voices of California
Family Voices of Tennessee
Family Voices, National
FiftyForward
FIRSTwnc
Foundation for Independent Living - Mountain State Centers for Independent Living
FREED Center for Independent Living
Frontier Group Idaho, LLC
Glens Falls Independent Living Center
Great Lakes ADA Center
Greater Springfield Senior Services Inc.
GWILLIAMS&ASSOCIATES,INC
Hand in Hand: The Domestic Employers Network
HASL
Hawaii Families As Allies
Huntington's Disease Society of America
Illinois Council on Developmental Disabilities
Illinois Iowa Center for Independent Living
IMPACT CIL
Inclusive Development Partners (IDP)
Independence Advocates of Maine
Independence Associates, Inc.
Independence First
Independence Now
Independent Living Center of the Hudson Valley
Independent Resources, Inc.
Indiana Disability Rights
Insight Enterprises, Inc. Peninsula Center for Independent Living
Institute for Community Inclusion (UCEDD)
Institute on Disability and Human Development, University of Illinois Chicago
Interfaith Disability Advocacy Coalition (IDAC)
InterFaith Works of Central New York
International Registry of Rehabilitation Technology Suppliers
Iowa Developmental Disabilities Council
J Badger Consulting Inc
Japanese American Citizens League
JCIL
John & Junes Mission
Junction Center for Independent Living, Inc.

Justice in Aging
Justice Policy Institute
Kelly's Kitchen
Kentucky Commonwealth Council on Developmental Disabilities
Kentucky Protection and Advocacy
Kentucky Statewide Independent Living Council
Lake County Center for Independent Living
Lakeshore Foundation
Lane Independent Living Alliance (LILA)
The Leadership Conference on Civil and Human Rights
Legal Action Center
Liberators for Justice (L4J)
Liberty Resources Inc.
Life and Independence for Today (LIFT)
LIFE Center for Independent Living (LIFE CIL)
LIFE Inc.
Linking Employment, Abilities & Potential
Little Lobbyists
Living Hope NGO
Long Island Center for Independent Living, Inc. (LICIL)
LVCIL
Maine Parent Federation
Marin Center for Independent Living
Mariposa Professional Services
Maryland Center on Economic Policy
Maryland Coalition of Families
Maryland Education Coalition
MDI Network/AAPI-OT
Mental Health Association in Michigan
MetroWest Center for Independent Living
Mid South Liver Alliance
Midstate Independent Living Choices, Inc.
Minnesota Statewide Independent Living Council (MNSILC)
Missouri Statewide Independent Living Council
MomsRising
Mongomery County Federation of Families for Children's Mental Health, Inc.
Mountain State Centers for Independent Living
Mountain State Centers for Independent Living - West Virginia
Movimiento para el Alcance de Vida Independiente
NAMI Huntington
NASILC - National Association of Statewide Independent Living Councils
National Academy of Elder Law Attorneys (NAELA)
National Adult Day Services Association

National Asian American Pacific Islander Mental Health Association (NAAPIMHA)
National Association for the Advancement of Orthotics and Prosthetics
National Association of Councils on Developmental Disabilities
National Association of Local Long Term Care Ombudsman
National Association of Social Workers
National Association of the Deaf
National Center for Pediatric Palliative Care Homes
National Consumer Law Center (on behalf of its low-income clients)
National Council of Asian Pacific Americans (NCAPA)
National Council of Jewish Women
National Council on Independent Living
National Disability Institute
National Disability Rights Network (NDRN)
National Disabled Legal Professionals Association
National Down Syndrome Society
National Federation of the Blind
National Health Council
National Health Law Program
National Mental Health Consumers' Self-Help Clearinghouse
National Multiple Sclerosis Society
National Organization of Nurses with Disabilities (NOND)
National Organization on Disability
National Partnership for Women & Families
National PLACE
National PLAN Alliance
National Respite Coalition
Native American Disability Law Center
NBJC
NC Statewide Independent Living Council
Network of Occupational Therapy Practitioners with Disabilities & Supporters
Nevada Disability Advocacy & Law Center
New Hampshire Council on Developmental Disabilities
New Horizons Disability Empowerment Center
New Horizons Respite Care Agency LLC
New Mexico Developmental Disabilities Council
North Country Independent Living DBA indiGO
North Dakota Center for Persons with Disabilities
North Dakota Protection & Advocacy Project
North Dakota State Council on Developmental Disabilities
Northern Nevada Center for Independent Living
Northwest Georgia Center for Independent Living
Occupational Therapy for Native Americans
Occupational Therapy Leaders and Legacies Society

Ocean State Center for Independent Living (OSCIL
Oklahoma Statewide Independent Living Council
Oklahomans for Independent Living
Openhouse
OPTIONS for Independence
Oregon Statewide Independent Living Council
OT Leaders &Legacy
PA ADAPT
Paralyzed Veterans of America
Paraquad
PAVE
PEAK Parent Center
Placer Independent Resource Services
Prevent Blindness
Progress Center for Independent Living
Project Freedom Inc.
Public Advocacy for Kids (PAK)
REACH, Inc.
Reentry Sisters
Reframe Health and Justice
Rehabilitation Associates
Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)
Religious Action Center for Reform Judaism
Resources for Independence Central Valley
Resources For Independent Living
Respite Care Association of Wisconsin
Rifton Equipment
Roads to Freedom Center for Independent Living of North Central PA
Rolling Start, Inc. Center for Independent Living
Rural Advocates for Independent Living
S.M.I.L.E
SAGE
SDAN
SEIU Local 500
Service Center for Independent Life (SCIL)
Service Employees International Union
Services for Independent Living, Columbia, Missouri
Show and Tell
Silicon Valley Independent Living Center
Silver State Equality
Society's Assets, Inc.
South Carolina Department of Social Services, Adult Protective Services
Southeastern MN Center for Independent Living, Inc.

Southern Illinois Center for Independent Living
Southern Maryland Center for Independent Living
Southern Nevada Center for Independent Living
Southwest Center for Independence
Spa Area Independent Living Services
SPAN Parent Advocacy Network
Special Education Equal Development Society (SEEDS)
Speech Garden
Spina Bifida Association
SPOKES Unlimited
Springfield Center for Independent Living
Statewide Independent Living Council of TN (SILCTN)
Statewide Independent Living Council, GA
Stavros Center for Independent Living, Inc.
Stone Soup Group
Summit Independent Living
Superior Alliance for Independent Living
Supermajority
TARP Center for Independent Living
Team Gleason Foundation
Tennessee Caregiver Coalition
Tennessee Disability Coalition
Tennessee Health Care Campaign
TEXCIL Association of Centers for Independent Living
The Advocacy Institute
The Arc - Jefferson, Clear Creek & Gilpin Counties
The Arc Michigan
The Arc of the United States
The Association of Oregon Centers for Independent Living
The Center for Disability Empowerment
The Center for Independent Living, Inc.
The Choice Program at UMBC
The Dance Centre
The Disability & Philanthropy Forum
The Disability Resource Center of the Rappahannock Area, Inc.
The Freedom Center for Independent Living, Inc.
The Kelsey
The Parents' Place of MD
The Partnership for Inclusive Disaster Strategies
The Pennsylvania Council on Independent Living
The Statewide Independent Living Council of Illinois
The Whole Person, Inc
TN Voices

Touch the Future Inc
Trans Maryland
Transitional Paths to Independent Living
Tri-County Independent Living (TCIL)
Tri-Lakes Center for Independent Living Inc.
UIC
Umpqua Valley disAbilities Network
United Church of Christ
United Spinal Association
University of Minnesota, Institute on Community Living
Vermont Center for Independent Living
Vermont Coalition for Disability Rights
Vermont Developmental Disabilities Council
Voices for Independence
Voices of Health Care Action
Walking Spirit
Walton Options
Well Spouse Association
Westchester Disabled On the Move
Wisconsin Board for People with Developmental Disabilities
Wisconsin Coalition of Independent Living Centers
Women Enabled International
Womxn Beyond Borders
World Institute on Disability
Wyoming State Independent Living Council

Mr. DESAULNIER. Thank you. Today we could discuss ways to improve access to care through employer-sponsored insurance by addressing exorbitant prescription drugs costs, or unjustified claims denials by large insurance companies. These are challenges we should tackle in light of the fact that last year alone 31 million Americans had to borrow an estimated 74 billion dollars to pay for health care for themselves or a family member.

Health care costs are the No. 1 reason for personal bankruptcy in the United States of America. That is completely unacceptable. Instead, against this backdrop, my congressional Republican colleagues are working to cut Medicaid based on their budget decisions, to pay for tax cuts for billionaires and corporations.

While we could partner on efforts to expand coverage for all Americans, including through employer-sponsored insurance, my colleagues unfortunately are, press—in my opinion, are pressing forward on efforts to eliminate health coverage, and make health care costs skyrocket for many people, without an analysis of the quality of care.

In February, House—the House majority approved a budget resolution that would give tax cuts to the richest 1 percent, with a price tag of over 1.1 trillion dollars. To help pay for this, Republicans directed the House and Energy and Commerce Committee to cut 880 billion dollars.

The non-partisan Congressional Budget Office, CBO, reported last month that there is no way for the majority party to meet their targeted cuts without forcing the most significant cuts to Medicaid in American history. I would—I would like to enter this report into the record, and I ask unanimous consent to do so.

Chairman ALLEN. Without objection.

[The information of Mr. DeSaulnier follows:]

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

March 5, 2025

Honorable Brendan F. Boyle
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Mandatory Spending Under the Jurisdiction of the House Committee on Energy and Commerce

Dear Ranking Member Boyle and Ranking Member Pallone:

In response to your request, this letter provides information about projections of mandatory spending for the 2025–2034 period for the list of programs, excluding Medicare, that you indicated are under the jurisdiction of the House Committee on Energy and Commerce.

In CBO's January 2025 baseline budget projections, mandatory outlays for the accounts you asked about total $8.8 trillion for the 2025–2034 period. Medicaid outlays account for $8.2 trillion, or 93 percent, of that amount (see Table 1).

You also asked for two subtotals of projected outlays in Table 1:

- Outlays other than for Medicaid total $581 billion through 2034.
- Outlays other than for Medicaid and CHIP total $381 billion over the 10-year period.

Table 1.
Outlays From Accounts Indicated to Be Under the Jurisdiction of the House Committee on Energy and Commerce

	By Fiscal Year, Billions of Dollars											
	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2029	2025-2034
Medicaid	656	695	738	767	803	837	871	910	948	986	3,658	8,209
CHIP	21	21	22	22	23	23	23	16	15	15	108	201
Other Listed Programs												
Risk Adjustment Program	12	15	16	15	15	15	16	17	18	18	73	158
Universal Service Fund	9	9	8	9	9	9	9	9	9	9	43	87
CHIPS	3	4	5	6	6	5	3	2	1	0	24	36
Offsetting Receipts[a]	-2	-4	-3	-3	-3	-3	-3	-2	-2	-2	-15	-27
Interest Earnings[a]	-3	-3	-3	-3	-3	-3	-3	-4	-4	-4	-15	-32
Other	25	21	19	20	18	14	12	10	10	10	103	159
Subtotal, Other	44	42	43	43	41	37	33	33	32	32	213	381
Total Outlays	**720**	**759**	**802**	**832**	**867**	**897**	**928**	**959**	**995**	**1,033**	**3,979**	**8,791**

Data source: Congressional Budget Office: *The Budget and Economic Outlook: 2025 to 2035* (January 2025), https://www.cbo.gov/publication/60870.

Components may not sum to totals because of rounding.

Outlays are for all programs except Medicare, which is under the jurisdiction of more than one Committee.

CHIP = Children's Health Insurance Program; CHIPS = Creating Helpful Incentives to Produce Semiconductors.

a. Offsetting receipts and interest earnings are classified in the budget as direct spending.

Among the largest programs other than Medicaid and CHIP are the risk adjustment program, in which health insurers make payments to the government or receive payments from it according to the health of their enrollees ($158 billion), and the Universal Service Fund ($87 billion). The risk adjustment program, however, is budget neutral with revenues offsetting spending. Spending from the Universal Service Fund is derived from fees that are classified as revenues on certain telecommunication services. Outlays for all other programs total $135 billion, on net, over the period, encompassing spending for a variety of federal activities.

I hope this information is helpful. Please contact me if you have further questions.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Jodey Arrington
Chairman
House Committee on the Budget

Honorable Brett Guthrie
Chairman
House Committee on Energy and Commerce

Mr. DESAULNIER. I might add that the CBO also did a report on the—on the tax cuts, and their analysis showed that over 85 percent of the benefits did not trickle down to Americans, it went to the top 1 percent, so in an age where we have the highest concentration of wealth in the history of the country, this tax cut actually made it worse. That is according to the CBO.

I challenge my colleagues from across the aisle to hold town halls and listen to what their constituents say. I have had four in 3 months say about how much they rely on Medicaid. Constituents like Alisa Rosillo who lives in my district, proud to represent, and is a parent to children with disabilities. She would be irreparably harmed, and her children by reckless cuts to Medicaid.

One in five Americans are covered by Medicaid, and they are understandably furious and afraid that their health is being sacrificed to pay for billionaires' tax cuts. Our priorities have never been clearer. Republicans are fighting to slash Medicaid for millions of people. I hope they change their mind, and I hope their constituents are telling them not to do that.

Raise taxes for consumers in ACA plans and dismantle Federal agencies that combat—combat corporate greed, all in order to fund 4 and a half trillion dollars in tax cuts for billionaires and large corporations. They have just cut the National Institutes for Health,

including serious cuts to the American Cancer Institute, which we will talk about further with Ms. Lilly.

On the other hand, Democrats have solutions to take on big pharma insurance companies and large corporations. Not all of them, we support corporations that have social responsibility and want to work with us and expect to profit from those contributions and their efficiencies.

Unfortunately, too many corporations are driving to the lowest common denominator in terms of return on investment without any kind of long-term strategy for the quality of the product they offer.

Last week, we celebrated the 15th anniversary of the Affordable Care Act, which dramatically expanded millions of Americans' access to affordable healthcare. Congressional Democrats continued to build on this progress with the American Rescue Plan Act and the Inflation Reduction Act.

Much more work needs to be done to improve health care in this country, and make it more affordable. However, axing the services and coverage that so many people, so many Americans rely on is not the way to accomplish those goals. I look forward to us working together to increase efficiency, and the quality of care in our health care system.

Nothing, I think, should be more bipartisan. In spite of our differences of our approach, in order to extend people's lives and the quality of lives for all Americans, irrespective of where they live, or what their party affiliation is. Thank you Mr. Chairman, I yield back.

[The statement of Ranking Member DeSaulnier follows:]

ED & WORKFORCE DEMOCRATS

OPENING STATEMENT

House Committee on Education and Workforce
Ranking Member Robert C. "Bobby" Scott

Opening Statement of Ranking Member Mark DeSaulnier (CA-10)
Subcommittee on Health, Employment, Labor, and Pensions
A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care
Wednesday, April 2nd, 2025 | 2:00 p.m.

Thank you, Mr. Chairman. I want to thank you for having this hearing.

As you know, as soon as we both knew we were going to have these assignments again, I reached out and we had a wonderful conversation. As two former small business owners — well, I'm a "former," the grey and white hair came from politics, mostly — well, no, owning restaurants probably was worse — so we've both met payrolls, we've paid for insurance. My hope is that while we go into our ideological approaches to this — there's an old saying that "if you do what you've always done, you get what you've always gotten" — that when we get through this, we can work in a way that seems to me to be completely bipartisan.

How do we improve efficiently, with performance standards, the delivery of care and the cost to this marketplace? For you and I, as you've stated, and for large employers, clearly, if you're a business owner, you want to get value out of your insurance. You don't want to have high denials. You don't want to have, as you said, your employees not being as effective because they're not getting the support that they paid for. So, my concern is what's happening to the marketplace in this field.

In the previous session, the previous Chair and I had hearings on Pharmacy Benefit Managers (PBMs) – what an inefficient part of the health care delivery system. We have stories now about private equity companies going in and buying out rural hospitals, taking out all the assets and leaving, and having emergency response people having to take people an hour and fifteen minutes to the next nearest hospital instead of fifteen minutes. All of that is a structure that, while I don't know what the solution is — I have my own ideas, as you do — but it clearly, for me, is a level of urgency that this committee should really dive into.

And my respect for you, Mr. Chairman, and our collegiality over the years, being in the same class and our backgrounds, gives me hope that we can approach this in a way that we get good value for the employers and the employees, and that value includes the costs but also the quality of care. I don't think we're talking enough, in this hearing, but hopefully in future ones, about the quality of care. And then, secondarily, you know my passion about behavioral health — making sure people have that access. But we've also had hearings in the previous session, bipartisan hearings about denials. The facts about denials are just outrageous. I've had doctors tell me, all over the country, that claims they put in routinely for decades are now being denied. I have one example of that in my comments. So, thank you for this.

However, I have to start with the reality that the last three months with the current administration, DOGE, and Mr. Musk, have done irreparable harm, without analysis, to the health and safety of American workers, and this is the next part.

The reckless closure of key offices within the Department of Health and Human Services (HHS) and the firing of tens of thousands of essential workers is contrary to the Administration's supposed enthusiasm for efficiency.

You don't take years of experience in any operation, private or public, and just indiscriminately get rid of them. There is value that taxpayers lost by doing this. I am fine with greater efficiency, we can always look at that, but efficiency also requires us to look at the current, positive sides of the delivery of services. To me, that's the essence of owning a business: problem-solving without already assuming what the solutions are and being open-minded as to how we achieve those solutions. The Administration for Community Living (ACL), which is slated for closure, was formed specifically to streamline and bring under one umbrella the various programs in the Health and Human Services Department. I'd like to submit for the record a letter, signed by more than 450 organizations, expressing their dismay over the plan to eliminate the ACL and split its functions across three other agencies.

I would like unanimous consent at this time to submit this to the record. Thank you.

Today, we could discuss ways to improve access to care through employer-sponsored insurance by addressing exorbitant prescription drug costs or unjustified claims denials by large insurance companies. These are challenges we should tackle in light of the fact that last year alone, 31 million Americans had to borrow an estimated $74 billion to pay for health care for themselves or a family member. Health care costs are the number one reason for personal bankruptcy in the United States of America. That is completely unacceptable. Instead, against this backdrop, my Congressional Republican colleagues are working to cut Medicaid, based on their budget decisions, to pay for tax cuts for billionaires and corporations.

While we could partner on efforts to expand coverage for all Americans, including through employer-sponsored insurance, my colleagues are unfortunately, in my opinion, pressing forward on efforts to eliminate health coverage and make health care costs skyrocket for many people without an analysis of the quality of care. In February, the House majority approved a budget resolution that would give tax cuts to the richest one percent, with a price tag of over $1.1 trillion. To help pay for this, Republicans directed the House Energy and Commerce Committee to cut $880 billion. The nonpartisan Congressional Budget Office (CBO) reported last month that there is no way for the majority party to meet their targeted cuts without forcing the most significant cuts to Medicaid in American history. I would like to enter this report into the record, and I ask for unanimous consent to do so.

I might add that the CBO also did a report on the tax cuts, and their analysis showed that over 85 percent of the benefits did not trickle down to Americans — it went to the top percent. So, in an age where we have the highest concentration wealth in the history of our country, this tax cut *actually* made it worse, according to the CBO.

I challenge my colleagues from across the aisle to hold town halls and listen to what their constituents say — I've had four in three months — about how much they rely on Medicaid. Constituents like Alisa Rosillo, who lives in my district I am proud to represent and is a parent to children with disabilities. She and her children would be irreparably harmed by reckless cuts to Medicaid.

One in five Americans are covered by Medicaid — and they're understandably furious and afraid that their health is being sacrificed to pay for billionaires' tax cuts.

Our priorities have never been clearer: Republicans are fighting to slash Medicaid for millions of people — I hope they change their mind, and I hope their constituents are telling them not to do that — raise taxes for consumers in ACA plans, and dismantle federal agencies that combat corporate greed, all in order to fund $4.5 trillion in tax cuts for billionaires and large corporations. Also, they've just cut the National Institute for Health, including serious cuts to the American Cancer Institute, which we'll talk about further with Ms. Lilly. On the other hand, Democrats have solutions to take on Big Pharma, insurance companies, and large corporations — and not all of them. We support corporations that have social responsibility and want to work with us and that expect a profit from those contributions and their efficiencies. But unfortunately, too many corporations are driving to the lowest common denominator in terms of return on investment without any long-term strategy for the quality of the product they offer.

Last week, we celebrated the 15th anniversary of the *Affordable Care Act*, which dramatically expanded millions of Americans' access to affordable health care. Congressional Democrats continued to build on this progress with the *American Rescue Plan Act* and the *Inflation Reduction Act.*

Much more work needs to be done to improve health care in this country and make it more affordable. However, axing the services and coverage that so many Americans rely on is not the way to accomplish those goals. I look forward to us working together to increase efficiency and the quality of care in our health care system. Nothing, I think, should be more bipartisan, in spite of our differences of approach, in order to extend people's lives and the quality of life for all Americans, irrespective of where they live or what their party affiliation is.

Thank you, Mr. Chairman. I yield back.

Chairman ALLEN. Thank you, Mr. DeSaulnier. Pursuant to Committee Rule 8-C, all members who wish to insert written statements into the record may do so by submitting them in Microsoft Word format to the Committee Clerk within 14 days of the date of this hearing.

Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous materials noted during the hearing to be submitted for the official hearing record.

Now, I would like to introduce our witnesses. I will now turn to the introduction of our three distinguished witnesses. Our first wit-

ness is Ms. Angela Shields, the Chief Executive Officer for Tennessee REALTORS in Nashville Tennessee, a great State and a great city. Ms. Shields is testifying on behalf of the National Association of REALTORS.

Our second witness is Ms. Bethany Lilly, Executive Director for public policy at the Leukemia and Lymphoma Society in Washington, DC. Our last witness is Ms. Marcie Strouse, a Partner with Capitol Benefits Group in Des Moines, Iowa. Ms. Strouse is testifying on behalf of the National Federation of Independent Businesses.

We thank the witnesses for being here today, and we look forward to your testimony. Pursuant to Committee rules, I would ask that you each limit your oral presentation to a 3-minute summary of your written statement. The clock will count down for 3 minutes, as Committee members have many questions for you, and we would like to spend as much time as possible on those questions.

Pursuant to Committee Rule 8D and Committee practice, however, we will not cutoff your testimony until you reach the 5-minute mark. I would also like to remind the witnesses to be aware of their responsibility to provide accurate information to the Subcommittee. I will first recognize Ms. Shields for your opening statement.

STATEMENT OF MS. ANGELA SHIELDS, CHIEF EXECUTIVE OFFICER, TENNESSEE REALTORS, ON BEHALF OF THE NATIONAL ASSOCIATION OF REALTORS, NASHVILLE, TENNESSEE.

Ms. SHIELDS. Thank you, Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee. Thank you for the opportunity to testify on behalf of the National Association of REALTORS. My name is Angela Shields, and I am CEO for the Tennessee REALTORS.

In 2019, Tennessee and other realtor associations created an association health plan to provide high-quality, low-cost health coverage options to our members. We succeeded. Realtor AHPs offered comprehensive health coverage for preexisting conditions in all ten ACA essential health benefits.

Our AHPs also had lower deductibles, and broader provider networks than the ACA. We did not negatively affect the ACA markets. Our members are generally older, and most do not obtain their health insurance from the ACA, so there was no competition. Of the few who did leave the ACA, most were older, less healthy individuals, seeking the lower deductibles and broader networks our AHP offered.

Unfortunately, a Federal District Court overturned the regulation, allowing our associations to offer the AHP. Forcing us to discontinue our plan. We were devastated. My leadership team and I cared deeply about our members and their families. For the past 5 years, I have fielded hundreds of calls and emails from members, many with serious preexisting conditions.

I had to explain why we took away their affordable comprehensive healthcare plans. Chairman Walberg has introduced The Association Health Plan Act, which would allow our realtor associations to once again have comprehensive and affordable coverage.

We support this bill because it provides a choice, which allows self-employed individuals and small businesses to shop around and decide which works best, the ACA or AHPs. I would like to end by saying this. The ACA has helped many of our members, and we will continue to support the ACA, but high deductibles and limited networks made the ACA unworkable for most NAR members.

AHP health coverages offers a viable insurance option for those members who find the ACA does not work. We urge Congress to work together and build on the AHP Act to provide a choice to self-employed individuals and to small businesses. Once again, I would like to thank you for your time and your consideration, and I would be happy to answer any questions that you would like to ask.

[The statement of Ms. Shields follows:]

NATIONAL ASSOCIATION OF REALTORS®

ADVOCACY GROUP
Shannon McGahn
Chief Advocacy Officer

HEARING BEFORE THE
HOUSE EDUCATION AND THE WORKFORCE SUBCOMMITTEE
ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

ENTITLED

"A HEALTHY WORKFORCE: EXPANDING ACCESS AND AFFORDABILITY ON EMPLOYER-SPONSORED HEALTH CARE"

WRITTEN TESTIMONY OF
ANGELA SHIELDS

ON BEHALF OF
THE NATIONAL ASSOCIATION OF REALTORS®
APRIL 2, 2025

nar.realtor (800) 874-6500 500 New Jersey Ave., NW Washington, DC 20001

Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee. My name is Angela Shields. I am CEO of the Tennessee REALTORS®. Thank you for the opportunity to testify on the challenges faced by small businesses in offering affordable health coverage to employees, as well as the difficulties of independent contractors – including REALTORS® and many other self-employed individuals – when trying to obtain affordable and comprehensive health coverage.

I am here today representing the National Association of REALTORS® (NAR) whose members are engaged in all facets of both residential and commercial real estate sales, brokerage, leasing, property management, and investment. Most NAR members are not employees of the real estate brokerages with which they are affiliated. They are "small businesses of one" – i.e., self-employed individuals with no employees paying for their business and health care expenses out of their own pockets. As CEO of the Tennessee REALTORS®, I have personally witnessed the many challenges and struggles of our members as they search for health plans with adequate medical provider networks and reasonable deductibles and co-pays.

Based on our member experience, REALTORS® urge Congress to work together and pass legislation that allows small businesses and self-employed individuals to obtain comprehensive and affordable coverage through an Association Health Plan (AHP). An AHP is an employment-based health plan that offers the same type of health coverage provided by large employers and unions. While we support the Affordable Care Act (ACA), we also advocate for giving people the choice to select the health coverage that best meets their needs. By allowing small businesses and self-employed individuals to access AHPs, we can help ensure that more Americans have the flexibility to choose affordable, high-quality health coverage options, fostering a healthier and more productive workforce.

REALTOR® Health Coverage Challenges

For decades, NAR has been working with Congress to offer a range of comprehensive and affordable health coverage options to its members.[1] While the ACA helped,[2] 15 percent of NAR members remain uninsured, with the majority citing premiums and deductibles as too expensive.[3] Most other NAR members today

[1] For example, NAR has supported legislation to allow bona fide trade associations to create AHPs, including the Small Business Health Fairness Act of 2003; the Small Business Health Fairness Act of 2005; the Marketplace Modernization and Affordability Act of 2006; the Small Business Health Options Program Act in 2008; and the Small Business Health Fairness Act of 2017. Most recently, NAR and many other trade associations have expressed support for Chairman Walberg's Association Health Plans Act.
[2] Before the ACA, NAR surveys consistently showed that 28-33 percent of REALTORS® were uninsured.
[3] NAR Research Division, 2023 Health Insurance Survey (Nov. 2023).

obtain their health coverage through their spouse's employer-based health plan or Medicare,[4] while 12 percent opt to buy coverage from the ACA's "individual" insurance marketplaces.[5]

The ACA's individual market offers comprehensive health coverage of medical services which can be affordable if subsidized by the federal government.[6] However, most ACA plans have high deductibles that must be met before a policyholder can begin enjoying their health coverage. For example, in 2024, the deductible for the most popular "silver" level individual market plan averaged $5,200 for single coverage and $11,000 for family coverage.[7] ACA's cost-sharing reduction subsidies are intended to help defray the out-of-pocket costs due to the deductibles. However, two-thirds of NAR members do not qualify for these subsidies and the other third may or may not qualify depending on how much real estate business they transact each year.[8]

While NAR members have benefitted from many ACA provisions, including the protections for pre-existing conditions, the ACA also created financial burdens and uncertainties, leaving many NAR members with little choice but to either go without health coverage altogether or pay at least $11,000 for a family before accessing their health coverage under an ACA plan.

Another challenge with obtaining coverage in the ACA individual, and "small group," market is the limited number of medical providers in ACA plan networks. According to the experts, ACA individual and small group market plans primarily have "narrow

---

[4] *Id.*
[5] *Id.*
[6] In 2020, Congress increased the ACA's premium subsidies for individual market plans purchased through an ACA marketplace and eliminated the income eligibility requirement. These "enhanced premium subsidies" reduced the up-front premium costs for an ACA individual market and allowed more individuals to access a premium subsidy. As the Centers for Medicare & Medicaid Services (CMS) reported, "four out of five enrollees [in a subsidized 'individual' market plan were] able to find a plan for $10 or less [per] month after premium tax credits, and over 50% [were] able to find a Silver plan for $10 or less." *See* CMS Newsroom, *American Rescue Plan and the Marketplace*, March 12, 2021. Importantly, these "enhanced premium subsidies" expire at the end of 2025 unless extended by Congress.
[7] *See* Kaiser Family Foundation, *Deductibles in ACA Marketplace Plans*, Dec. 22, 2023 at https://www.kff.org/private-insurance/issue-brief/deductibles-in-aca-marketplace-plans/.
[8] NAR Research Division, 2023 Health Insurance Survey (Nov. 2023).

networks,"[9] while employment-based plans, which include AHPs, have much broader provider networks.[10]

How Association Health Plans (AHPs) Can Help

Federal law currently limits self-employed individuals and most small employers to the ACA's individual and small group insurance markets, where, as discussed above, out-of-pocket costs are significantly higher and access to medical providers is limited. By adding an AHP option that offers the same health coverage as large employers and unions, Congress could help provide both small businesses and the self-employed with a choice, empowering them to shop around and decide which health coverage option fits best: AHPs, ACA plans, or other alternatives.

For decades, large employers and unions have enjoyed high-quality, low-cost health coverage because they bring larger and more sustainable risk pools to the negotiating table with commercial insurance companies. Larger risk pools are attractive to insurers because the healthcare utilization of healthier workers participating in the plan is more predictable and helps balance out the higher medical utilization of a few. This, in turn, helps insurers better manage healthcare spending for all plan participants and translates into better coverage and lower costs for the employees.

AHPs would provide the same options to employees of many small businesses and self-employed individuals by allowing them to group together to create larger and more sustainable risk pools. These larger, more sustainable risk pools would help them to achieve large employer coverage terms and prices, including lower deductibles[11] and broader provider networks, relative to ACA individual and small group plans.

---

[9] *See* Avalere Health, *Plans With More Restrictive Networks Comprise 73% of Exchange Market,* Nov. 30, 2017 *at https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market*.

[10] The Congressional Budget Office (CBO) has explained that "individual" market plans have narrower provider networks than employment-based plans. *See* Congressional Budget Office, *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, April 2021, page 7-8 at https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.

[11] According to the Kaiser Family Foundation, the average deductible for a "large group" market plan, including AHPs, was $1,787 for single coverage and about $4,000 for family coverage in 2024). *See* Kaiser Family Foundation, *2024 Employer Health Benefits Survey*, Oct. 9, 2024 at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey-Summary-of-Findings.pdf.

THE REALTOR® AHP Experience

In 2019, the Tennessee REALTORS®, along with several other state and local REALTOR® associations, established an AHP to offer a higher quality, lower-cost coverage option to our members. REALTOR® AHPs offered our members:

1. **Comprehensive health coverage**, including coverage for pre-existing conditions and voluntary coverage of all ten of the ACA's "essential health benefits."
2. **Affordable high-quality coverage** with lower premiums and deductibles. For example, participants of the Tennessee REALTOR® plan saved 30-40 percent.
3. **Broader coverage options and networks** so participants could choose and keep their own doctors year after year.

According to our data and experience, REALTOR® AHPs did not adversely affect ACA insurance markets. Most NAR members are older with mixed healthcare utilization, and many obtained their health coverage outside of the ACA risk pools. Therefore, joining our AHP could not impact the ACA because our members were never part of ACA pools in the first place. Even for those who were part of the ACA market before enrolling in our AHP, we observed no adverse impact. REALTOR® AHPs offered comprehensive coverage with broad provider networks and lower deductibles, attracting older members from the ACA market, many of whom had serious pre-existing conditions and other major medical needs. For more detail on REALTOR® experiences with AHPs, see Appendix A below.

Unfortunately, a federal district court overturned the U.S. Department of Labor's (DOL) rule that allowed REALTOR® AHPs. It was devastating. We had invested considerable time and resources in establishing an AHP, putting our reputation on the line, and we were thrilled that we had succeeded in helping our members. However, when the court overturned the DOL rule, our members felt like a rug had been pulled from under them.

Since then, our members have continually asked why our association cannot offer affordable and comprehensive health coverage. I have personally fielded hundreds of phone calls, emails, and in-person inquiries from our members, sharing their major medical needs and expressing their concerns about the loss of essential health care that they cannot access elsewhere.

As leaders of a REALTOR® association, my fellow Leadership Team and I not only have a fiduciary responsibility to our members, but we also care deeply about their health and well-being, as well as that of their families. We cannot go through this again.

We urge Congress to stand up and lead. Our members need legislation that ensures all small businesses and sell-employed individuals can access affordable and comprehensive health coverage through an AHP.

Recommendations:

1. **Permanently Restore Access to AHPs:** NAR strongly supports the enactment of Chairman Walberg's Association Health Plans Act. Congress must permanently restore the ability for small businesses and self-employed individuals to access comprehensive and affordable health coverage through AHPs.

2. **Consider AHP Data:** REALTOR® plans and other AHPs provide an important base of actuarial experience and data to help assess the validity of assertions about AHPs contributing to "adverse selection" or only offering "skinny plans." We disagree with these assertions, and we urge policymakers to consider our data as Congress develops legislation.

3. **Update Regulatory Authority for Independent Contractors:** In the 21st century, more U.S. workers are moving away from traditional jobs (where they traditionally worked for an employer) to becoming self-employed with no employees.[12] The 50-year-old Employee Retirement Income Security Act (ERISA) and DOL's case-by-case approach to applying rules for self-employed individuals have not kept pace with the shift to a gig economy. Not recognizing that these self-employed individuals are part of the workforce means ignoring that we now live in a competitive, global economy that no longer relies on traditional jobs. We need to update and clarify the rules to support the gig economy and bring back affordable health coverage options for self-employed individuals with no employees.[13] Regulatory reforms should also not dilute or compromise the ability of workers to be classified as independent contractors and support the self-employed.

Conclusion

Thank you for the opportunity to testify. I would be happy to answer your questions.

---

[12] See Small Business Trends, Key Trends at Sole Proprietorships Over the Past 30 Years (Dec. 2015) at https://smallbiztrends.com/2014/09/key-trends-sole-proprietorships-past-30-years.html.

[13] The DOL has acknowledged that Supreme Court precedent gives the Department the authority to address marketplace developments and new policy and regulatory issues. *See Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016); *see also*, *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92 (2015) and *National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967 (2005).

APPENDIX A: REALTOR® AHP EXPERIENCES

Background

- The Tennessee REALTORS® established a fully insured Association Health Plan (AHP) in accordance with U.S. Department of Labor (DOL) regulations in effect for plan year 2019. The Baldwin REALTORS® in Alabama, the Greater Las Vegas Association of REALTORS®, the Kansas City Regional Association of REALTORS®, and the Nevada REALTORS® also established an AHP.

- REALTORS® AHPs covered all ten of the Affordable Care Act's (ACA's) "essential health benefits" (EHBs) through the insurance contract and through a stand-alone product that provided coverage for pediatric dental and vision (one component of the tenth EHB [pediatric services]).

- REALTORS® AHP participants averaged savings between 5 and 50 percent, depending on the state or local market. (In Tennessee, the average savings were closer to 30-40 percent.) All participants also enjoyed significantly lower deductibles and co-pays, allowing access to benefits with lower out-of-pocket costs and broader networks.

Specific Stories

- REALTOR® AHP participants were asked: (1) If the AHP health coverage goes away on account of a Federal District Court ruling overturning the DOL regulation that allowed REALTOR® AHPs, how would it affect you? and (2) Please share a short story about how your AHP has helped you and your family?

- The Tennessee REALTORS® reported that many REALTOR® participants were previously uninsured or enrolled in non-ACA-compliant plans that did not cover pre-existing conditions. Because the Tennessee REALTORS® AHP provided coverage for pre-existing conditions, these real estate agents gained access to the major medical care that they needed. One real estate broker was especially thankful for being able to provide ACA-compliant and affordable coverage to their employed staff, which was much more attractive when compared to what was available in the small group market or other alternatives. The broker noted that before AHPs, many affiliated REALTORS® were only able to obtain short-term health plans, which did not cover diseases or illnesses that happened outside of the effective date of the policy.

- The Greater Las Vegas Association of REALTORS® reported that real estate professionals between ages 55 to 64 experienced lower overall premiums, richer overall benefits, and access to a broader network. The savings in premiums for this age cohort averaged 11 percent, and out-pocket savings average 12 percent. Additionally, thanks to increased education on health savings accounts tied to the AHP options, enrollees in those plans will save $3,600 annually.

- Prior to losing the Baldwin REALTORS® AHP, one participant explained, "If our AHP coverage goes away, it would cost more money for health insurance, and I would be less likely to use it due to higher deductibles and co-pays. What I have through the AHP is better coverage at a better price." Another Baldwin AHP participant stated, "I would have to pay $450 more for a "silver" plan instead of the equivalent "gold" plan I have now through the AHP." In response to the second question, a Baldwin AHP participant also explained, "I've been struggling with some chronic health issues, but have been unable to afford to go to a specialist and pay for the tests. I work two jobs, and I am a caregiver to a 94-year-old woman. Even with two jobs, I could not afford useful insurance on my own without this AHP. With this insurance, I've made some appointments and look forward to seeing what I can do to slow down the progression of the health issues I struggle with Fibromyalgia and inflammatory arthritis."

- A REALTOR® in the Kansas City AHP reported that as a newly self-employed individual, with a wife who recently retired, "[f]inding a long-term plan had been more difficult than I imagined... We have been making do with short-term plans, but not comfortable with the limited coverage.... The KCRAR plan has solved our health insurance problem." Another AHP participant discussed the limited marketplace options available in Kansas City and how the AHP offered by KCRAR enables the freedom to continue being a real estate professional. "This policy through KCRAR gives me the ability to step away from the uncertainty of the ACA Marketplace. The phenomenal work you have done to add major medical insurance for agents allows me to continue ... without a worry ... my career."

- Lastly, a participant from the Nevada REALTORS® AHP relayed:

  > "My wife and I are currently on the Nevada REALTORS®AHP health care plan and saved about $500 per month from our previous Obamacare plan. My wife paid the penalty for 4 years [when the individual mandate penalty tax was in effect] and had no coverage until we got an Obamacare plan. I am diabetic so going without health coverage is not an option for me as I have many doctor visits and high prescription costs. When we got coverage through the AHP, we upgraded our coverage and now have a deductible which is much lower, and the overall coverage is much better. In other words, we went from the worst plan under Obamacare to the best plan under Hometown Health for Northern Nevada and still saved money on the monthly costs. In addition, we are also able to go to the best hospital in Northern Nevada as well as have a network of local providers that were not covered under our previous plan. As we live in a remote area at Lake Tahoe, we would normally have to drive an hour or more to go to preferred providers under the previous Obamacare plan and now we can use local providers."

Chairman ALLEN. Thank you, Ms. Shields. I now recognize Ms. Lilly for your testimony.

STATEMENT OF MS. BETHANY LILLY, EXECUTIVE DIRECTOR, PUBLIC POLICY, THE LEUKEMIA AND LYMPHOMA SOCIETY, WASHINGTON, D.C.

Ms. LILLY. Thank you and thank you for inviting me to be here today, Chairman Allen and Ranking Member DeSaulnier. It is also wonderful to see you, Chairman, Chairman Walberg and Ranking Member Scott. I am delighted to join you today to talk about health insurance, and how it does and does not work for patients with blood cancer.

My name is Bethany Lilly, and I serve as the Executive Director of Public Policy at the Leukemia and Lymphoma Society where our mission is to cure blood cancers and improve the quality of life for patients and for their families. No one knows when they or someone they love will be diagnosed with a blood cancer.

Once a diagnosis occurs, our patients must often immediately start treatment. For some, every additional day of delay can reduce their chances of long-term survival. For—unfortunately, this is often the moment when our patients discover that their insurance is far more limited than they expected it to be.

The last thing anyone with cancer should have to think about while undergoing treatment is whether their insurance will or will not cover the health care that they need. It is also no longer tenable to ignore the unsustainable growth in the cost of care in this country. Regardless of whether someone has been diagnosed with cancer or not, the cost of health insurance is significantly impacting American pocketbooks.

Costs that patients do not pay directly, in co-pays or deductibles are too often passed back to them in the form of higher premiums. Insurance companies and public officials respond to efforts to reduce costs by inventing new ways to shift costs back onto the patients who receive care.

Higher deductibles, additional noncovered care, more prior authorizations and denials, increased coinsurance, rising premiums and more red tape. At LLS, we have focused on identifying ways to drive down the cost curve for blood cancer care without eroding the underlying quality of health insurance coverage, including policies mentioned in my written testimony that have been before the Committee in this and previous Congresses.

We are excited to work with the Committee to address issues related to denials and appeals, to prevent anti-competitive contracting practices, to advance site neutral reforms, and to limit facility fees. I would be remiss if I did not mention two additional and deeply impactful issues related to coverage before Congress this year.

The reauthorization of the ACA's enhanced premium tax credits, and preserving access to the Medicaid Program. LLS urges the Congress to take action to extend the tax credits that make ACA coverage more affordable, and similarly we are deeply concerned about proposals to cut the Medicaid Program that will result in coverage losses.

Now is the time for policymakers to stand up for patients, survivors, and caregivers by advancing solutions that bend the cost curve without sacrificing patient care. We need bold action in order to make the system sustainable for patients today and in the future. We need to ensure that every one of the approximately 188,000 people who will be diagnosed with a blood cancer this year, and every year after that, have access to comprehensive, high-quality and affordable health coverage.

Thank you all for your time and attention to these important issues today. LLS looks forward to working with all of you to improve health care coverage for blood cancer patients, and I look forward to taking your questions.

[The statement of Ms. Lilly follows:]

Testimony of Bethany Lilly
Executive Director, Public Policy, The Leukemia & Lymphoma Society

Committee on Education and Workforce
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"

April 2, 2025

Thank you, Chairman Walberg, Ranking Member Scott, Chairman Allen, Ranking Member DeSaulnier, and Members of the Subcommittee. I am delighted to join you today to talk about health insurance and how it does and does not work for patients with blood cancer. My name is Bethany Lilly and I serve as the Executive Director of Policy and Research at The Leukemia & Lymphoma Society (LLS), where our mission is to cure blood cancers and improve the quality of life of patients and their families.

No one knows when they or someone they love will be diagnosed with a blood cancer. But once a diagnosis occurs, our patients often must immediately start treatment and, for some, every additional day of delay can reduce their long-term survival. Unfortunately, this is also often the moment when our patients discover that their insurance is far more limited than they expected. This can be because they have, sometimes unknowingly, purchased a low-quality plan that does not provide coverage for the services they need or because they encounter unnecessary bureaucratic barriers to accessing the care they need.

At LLS, we have had patients call our information and referral center who have what they thought was high-quality insurance but, after closer inspection, turned out not to cover their needed drugs, tests, or treatments. Others call later in the treatment journey when a particular treatment or drug is denied by their health insurer. The last thing anyone with cancer should have to think about while undergoing treatment is whether their insurance will or will not cover the healthcare they need.

Layer on top of this the cost of cancer care. A patient diagnosed with acute lymphoblastic leukemia can expect their treatments to cost just under half a million dollars within the *first twelve months* of their treatment.[1] That number is almost a decade old now, and we know that costs have only grown. There are also new treatments for blood cancer, cell and gene therapies that will dramatically extend patients' lives for a high price.

It is no longer tenable to ignore the unsustainable growth in the cost of care in our country. Regardless of whether someone has been diagnosed with cancer or not, the cost of health insurance is significantly impacting American pocketbooks. Costs that patients don't pay directly in co-pays or deductibles are too often passed back to them in the form of higher premiums. Insurance companies and public officials respond to efforts to reduce costs by inventing new ways to shift costs back onto the patients receiving care: higher deductibles, additional "non-

covered" care, increased co-insurance, rising premiums, more red tape, and stricter eligibility criteria for insurance.

At LLS, we have focused on identifying ways to drive down the cost curve for blood cancer patients without eroding the underlying quality of that coverage. For example, we support policies included in the Lower Cost, More Transparency Act—passed by the House last Congress-which would reduce the cost of cancer care for seniors and other patients. We've also supported policies considered before this committee in this and previous Congresses that would help address anticompetitive contracting practices, control costs associated with insurance middlemen like pharmacy benefit managers and third-party administrators, and limit facility fees associated with basic services like telehealth.

Now is the time for policymakers to stand up for patients, survivors, and caregivers by advancing solutions that bend the cost curve without sacrificing patient care. We need bold action in order to make the system sustainable for patients, today and in the future. And we need to ensure that every one of the 188,000 people who are diagnosed with a blood cancer this year – and every year after – have access to comprehensive, high-quality, and affordable health coverage.

Today, I will discuss how the Committee can address these issues and ensure that blood cancer patients and all Americans have affordable and high-quality health insurance.

Addressing Problems in Employer Coverage

Cancer patients frequently experience barriers and delays within their insurance – even when it is comprehensive. Patients also often reach out to LLS because they have encountered utilization management barriers—most often, the denial of a prior authorization request or a flat-out denial of coverage for a particular service. These denials are all too common with breakthrough cell and gene therapies, especially for CAR-T,[2] which is often a last resort for patients who have come out of remission or for whom other treatments have not worked.[3] But even basic cancer treatment can often require multiple prior authorizations or other bureaucratic hoops. For example, we were contacted by a patient who's treatment plan included receiving chemotherapy 12 times. Rather than review and approve the entire course of treatment, her plan required prior authorization for each individual chemotherapy visit. You can just imagine the stress and anxiety she felt, wondering if each time she might be told no and have to stop treatment.

A recent KFF survey found that adults who had more than 10 physician visits or who needed at least one prescription medication faced more prior authorization problems in the past year — unfortunately, most blood cancer patients meet both of these criteria.[4] And those patients who experience prior authorizations report that those administrative barriers resulted in significant delays, higher costs, or inability to receive services at all.[5] Speed is of the essence with many blood cancers and even minor delays can result in drastic changes to the likelihood of survival or even ability to access treatment. A report released by LLS in 2023 includes the story of a 9-year-old blood cancer patient who was found to be a candidate for a clinical trial. However, insurance denials for needed air transport led to a delay in his enrollment: by the time he arrived at the

trial center, his liver enzyme levels had increased and rendered him ineligible for participation.[6] Similarly, press reporting highlighted the story of Forrest VanPatten, who passed away as he fought with his insurer to cover CAR T,[7] - an unacceptable outcome of delays in our insurance system.

Denials are also common for blood cancer survivors living in long-term remission—they will need additional monitoring and surveillance that might appear odd or unnecessary to a new insurer who might not have their medical history. Many cancer treatments are toxic to the heart, requiring survivors to get regular cardiac monitoring that isn't usually recommended until later in life, often leading to coverage denials for recommended care.

Both the first Trump Administration and the Biden Administration took steps to address the overuse of denials in public programs, but there is evidence from KFF's survey of adults with health insurance that denied claims are "somewhat more common amount people with employer-sponsored insurance (21%) and marketplace insurance (20%), less so among people with Medicare (10%) or Medicaid (12%)."[8] An oncology-focused study in the Journal of the American Medical Association last year determined that over 95% of denied claims were from commercial payers[9]—while this is only one major cancer center, the anecdotal reports to our Information and Referral Center also suggest that denials are a major issue for commercial insurers.

It is difficult to provide specifics because there is extremely limited data available on denials by ERISA-regulated plans. Last year, LLS testified before the US Department of Labor's ERISA Advisory Council and urged the consideration of several policies that would address this gap in transparency. This testimony is not yet available on the Advisory Council's website so I have included a copy with my testimony. We urge the Committee to review our recommendations and to consider addressing this hugely challenging problem for our patients and all health insurance consumers.

Non-comprehensive Insurance

While insurance issues exist regardless of the source of coverage, LLS knows firsthand that there are categories of insurance and "insurance-like products" that put not only our patients – but everyone who enrolls in them – at significant risk. This category of products can often openly discriminate against patients, charge more to people with pre-existing conditions, retroactively refuse to pay for care that has already been provided, and charge women more just for being women.

LLS strongly supports Congressional action to regulate or prohibit insurance that fails to adequately protect patients, including plans that discriminate against people with pre-existing conditions, offer no meaningful coverage in the case of a cancer diagnosis, or neglect to cover essential healthcare services like prescription drugs, mental health services, and maternity care.

Short-Term, Limited-Duration Insurance

For example, short-term plans are an insurance product that was originally intended to be a short-term bridge between coverage such as when a young adult graduates from college, but their employer coverage hasn't kicked in yet.[10] However, these plans are exempt from many important federal consumer protections. When left unchecked, these plans inappropriately marketed themselves as an alternative to traditional health insurance while discriminating against patients – including after they have received a life-threatening diagnosis – and refusing to cover even simple services like prescription drugs.[11] One blood cancer patient was sold a short-term plan, despite asking his broker for a higher quality plan--is subsequent non-Hodgkin lymphoma diagnosis left him with more than $800,000 in medical debt.[12] The evidence is clear: when these plans are allowed to proliferate, they not only put patients at risk, but they also drive up premiums for those purchasing comprehensive health coverage.[13]

Association Health Plans

Our organization has similar concerns related to another non-comprehensive form of coverage. A bill considered by this committee last Congress allowed for the expansion of a type of multiple employer welfare arrangements (MEWAs), called an association health plan (AHP).[14] These plans may charge patients higher premiums based on factors (such as gender, location, or occupation) and are not required to provide Essential Health Benefits (meaning that they can exclude coverage necessary for cancer or other necessary care, such as prescription drugs), and remain outside the individual and small group markets (even while marketing to individuals and small businesses).[15] Because they don't have to play by the same rating rules or provide needed benefits, these plans can undercut the upfront cost of high-quality insurance, raising costs for people who depend on comprehensive coverage.[16]

LLS and other patient groups were also very concerned by the amount of fraud and mismanagement seen in the MEWA industry, concerns shared by the state insurance regulators who described them as "notoriously prone to insolvencies."[17] These concerns are borne out by the data—the Department of Labor has brought civil and criminal enforcement against 21 MEWAs since 2018, recovering more than $95 million in just the last six years.[18]

LLS strongly supported the rescission of the 2018 final regulation that would have expanded AHPs in a similar way to the proposed Act because we believe the rule would only cause the proliferation of low-quality coverage options and potentially destabilize the individual market risk pool.[19] For the same reasons, we opposed the bill last Congress[20] and would urge the Committee to find solutions to address healthcare costs that do not promote low-quality coverage.

Telehealth as an Excepted Benefit

LLS strongly supports patient access to telehealth. A second opinion from a hematologist-oncologist specialist from across the country should not need to be in person. However, telehealth must be a part of a broader package of healthcare services

that will meet the needs of employees or other enrollees. Last Congress, the Committee considered the Telehealth Benefit Expansion for Workers Act which we are concerned would create a new excepted benefit for telehealth services. Excepted benefits, importantly, are not comprehensive health coverage and are often not allowed to coordinate with other insurance coverage.[21] Like AHPs, they are often exempted from federal regulations and allowed to discriminate against people with pre-existing conditions.[22]

Fundamentally, an excepted telehealth benefit is insufficient on its own—if you see a nurse practitioner via a telehealth visit who provides a diagnosis and a prescription, and then your insurance does not cover the prescription when you reach the pharmacy counter, what is the value of that benefit? Similarly, if the telehealth visit determines that the patient must seek in-person care, a common outcome, then the patient would have to turn to another form of insurance. This would require navigating two different sets of paperwork, two different sets of prior authorization, and two sets of cost-sharing obligations. If the telehealth provider is in one network or health system and the in-person provider is in another, it is highly likely that the in-person provider would have limited access to the medical history of the patient, increasing systemic costs.

LLS and other organizations have also seen a concerning trend in the past several years: excepted benefits have been marketed and sold, sometimes as a bundle of policies, as if they are comprehensive coverage.[23] This is false and misleading. Allowing for more health insurance-like products will only add to consumer confusion and misinformation. As we and partner organizations wrote when this proposal was first being considered, "we are concerned [this policy] would be harmful to patients and consumers, and we encourage the Committee to instead consider approaches that would promote consumer access to integrated telehealth benefits within a comprehensive health plan."[24]

Stop Loss

Stop loss insurance is intended to be used as a tool to protect a health plan sponsor—typically an employer—from unpredictably high losses due to unexpected claims. As such, it can be an important tool to promote stability for sponsors of health insurance plans.[25]

Last Congress, the committee considered the Self-Insurance Protection Act, which proposed major changes to the structure and the regulation of stop loss insurance. In particular, we were concerned that the proposal eliminates the ability of states to exercise oversight of stop-loss plans. State insurance regulators play an important role in the health insurance marketplace and removing states' ability to regulate stop-loss coverage would lead to less oversight of these plans. The National Association of Insurance Commissioners has a history of proceedings, a white paper, and a model act to aid states on appropriate regulation of these plans.[26] We are concerned that removing state regulation would increase the likelihood of misleading marketing and other

fraudulent practices that would prove harmful to employers purchasing stop-loss coverage as well as their employees.

Ensuring Access to Comprehensive Health Insurance for All

Finally, I want to touch on the current broader debates in Congress over health insurance and how those debates impact workers, employers and patients.

Extension of the ACA Premium Tax Credits

Congress has not yet extended the advance premium tax credits that expire at the end of 2025. Failure to act will result in premium increases, quite dramatic ones in some places: in Michigan's 5th District, premiums for a 60 year-old couple making just over $80,000 would increase $13,500.[27] In California's 10th District, the same couple would see a premium increase of $23,486.[28] As I speak to you today, insurers in the ACA marketplaces across the country are preparing rates for the 2026 plan year. These costs are unaffordable for small business owners and self-employed workers who rely on these tax credits to afford high-quality insurance. And because ACA coverage does provide the high-quality coverage that blood cancer patients and others with chronic conditions and disabilities need, those costs may price out those who want to start small business or pursue their dream careers. Estimates by the actuarial firm OliverWyman show that 2 million people (almost 1 in 4) with chronic conditions like cancer will lose their health insurance coverage if the tax credits are not extended.[29]

Congress must act to extend the premium tax credits as soon as possible. The rates will be finalized in August and without action, those final rates will reflect premium increases. The confusion and sticker shock over these increased premiums will lead to market upheaval and estimates suggest that 4 million people may lose coverage entirely.[30]

Cuts to Medicaid

Congress is also considering major cuts to the Medicaid program, which covers 72 million people across the United States, including 1 in 10 adults with a history of cancer and 1in 3 children diagnosed with cancer.[31] Medicaid also provides comprehensive health insurance coverage to many people diagnosed with cancer or other acute diseases who lose employer coverage during cancer treatment and people with disabilities who wish to work, but require home and community-based supports.

After being diagnosed with multiple myeloma, DeAnna from North Carolina lost her job and her insurance. "I wanted to work, [but] if your head's hurting from chemo and steroids or if you've had no sleep, you can't be a dependable employee." When her state expanded Medicaid under the Affordable Care Act, she was able to enroll in Medicaid and get the stem cell transplant that saved her life. The savings target set for the Energy and Commerce Committee by the recently passed FY25 budget resolution is impossible

to achieve without making deep cuts to the Medicaid program, jeopardizing the care that people like DeAnna need.

In addition, many of America's most labor-intensive jobs don't provide insurance, leaving Medicaid as the only option for millions of workers. With Medicaid cuts, industries like agriculture, construction, senior and disability care, and manufacturing would have dramatic increases in uninsured workers.[32] Without access to maintenance medications, physical therapy, and other treatments through Medicaid, many workers with chronic health conditions would be unable to continue working.[33] Medicaid is also virtually the only health insurance that provides long-term care services that allow people with disabilities to live and work in their communities.[34]

Medicaid's important role supporting the workforce cannot be understated, nor can its importance to state budgets. As Nevada Governor Joe Lombardo wrote recently about one proposal to reduce the matching funding for the Medicaid expansion, "This change alone could result in a $1.85 billion loss in federal funds over the next two years […]. Nevada could not absorb a federal funding loss of this magnitude without major cuts to Medicaid and other state programs."[35] Federal cuts like enacting per capita caps or work reporting requirements, reducing the Medicaid expansion match, curtailing provider taxes, and eliminating state-directed payments don't target fraud and waste—they target state budgets. While such cuts wouldn't get us any closer to rooting out fraud and abuse, they would make it impossible for states to maintain benefits for current Medicaid enrollees. Just one example: in Michigan, KFF estimates that 740,000 people would lose Medicaid coverage if Congress reduced the federal match for the expansion population and the state couldn't fill the $64.3 billion budget gap.[36]

Thank you for your time and attention to these important issues today. LLS looks forward to working with all of you to improve healthcare coverage for blood cancer patients and I look forward to taking your questions.

---

[1] Gabriela Dieguez, Christine Ferro; Milliman; *The Cost Burden of Blood Cancer Care*; 2018; https://us.milliman.com/en/insight/the-cost-burden-of-blood-cancer-care.

[2] CAR T stands for "chimeric antigen receptor T-cells" and, in this context, refers to a class of immunotherapy treatments for cancers that modify an individual patient's T-cells in order to produce an immune response to their cancer. The FDA has approved a number of CAR T therapies to treat several blood cancers. More information is available at: https://www.lls.org/treatment/types-treatment/immunotherapy/chimeric-antigen-receptor-car-t-cell-therapy.

[3] ProPublica, *Insurance Executives Refused to Pay for the Cancer Treatment That Could Have Saved Him. This Is How They Did It.* (2023), https://www.propublica.org/article/priority-health-michigan-cart-insurance-vanpatten-denials; ProPublica, *Health Insurers Have Been Breaking State Laws for Years* (2023), https://www.propublica.org/article/health-insurance-denials-breaking-state-laws.

[4] KFF, *Consumer Problems with Prior Authorization: Evidence from KFF Survey* (2023), https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/.
[5] *Id*.
[6] The Leukemia & Lymphoma Society, *Vital Access: How Policymakers Can Streamline the Cancer Care Journey*, 2023, https://www.lls.org/sites/default/files/2023-01/vital_access_2023.pdf.
[7] *Supra* note 3.
[8] KFF, *Consumer Survey Highlights Problems with Denied Health Insurance Claims*, 2023, https://www.kff.org/affordable-care-act/issue-brief/consumer-survey-highlights-problems-with-denied-health-insurance-claims/.
[9] Jacob Y. Shin, Fumiko Chino, John J. Cuaron, et al; *Insurance Denials and Patient Treatment in a Large Academic Radiation Oncology Center*; JAMA Network Open, 2024; https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2819911.
[10] Dania Palanker, JoAnn Volk, Kevin Lucia; The Commonwealth Fund; *Short-Term Health Plan Gaps and Limits Leave People at Risk*; 2018; https://www.commonwealthfund.org/blog/2018/short-term-health-plan-gaps-and-limits-leave-people-risk.
[11] *Id*.
[12] The Leukemia & Lymphoma Society, et al; *UNDER-COVERED: How "Insurance-Like" Products Are Leaving Patients Exposed*; 2021; https://www.lls.org/sites/default/files/National/undercovered_report.pdf.
[13] *Id*.
[14] Timothy Jost, The Commonwealth Fund, *The Past and Future of Association Health Plans*, 2019, https://www.commonwealthfund.org/blog/2019/past-future-association-health-plans.
[15] *Id*.
[16] Kevin Lucia, Justin Giovannelli, Sabrina Corlette; *The Commonwealth Fund; In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets*; 2018; https://www.commonwealthfund.org/blog/2018/initial-state-approaches-association-health-plans.
[17] National Association of Insurance Commissioners and The Center for Insurance Policy and Research NAIC 03062018, Comment 623, 2018, https://www.regulations.gov/comment/EBSA-2018-0001-0611.
[18] Department of Labor, *Proposed Rule: Definition of "Employer" - Association Health Plans*, Footnote 38; 2023; https://www.federalregister.gov/documents/2023/12/20/2023-27510/definition-of-employer-association-health-plans#p-75.
[19] The Leukemia & Lymphoma Society, Comment on EBSA-2023-0020, 2024, https://www.regulations.gov/comment/EBSA-2023-0020-0027.
[20] Partnership to Protect Coverage, Letter re: patient community concerns about the detrimental impact of policies included in HR 2868, the Association Health Plans Act; HR 2813, the Self-Insurance Protection Act, and HR 3799, the CHOICE Arrangement Act; https://www.protectcoverage.org/siteFiles/43074/06%2021%2012%20PPC%20Letter%20to%20House%20re%20noncompliant%20plans%20concerns.pdf.
[21] Dania Palanker, Kevin Lucia; The Commonwealth Fund; Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk; 2021; https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk.
[22] *Id*.
[23] *Supra* note 21.

[24] Partnership to Protect Coverage; Letter re: patient community concerns about the detrimental impact of policies included in HR 2868, the Association Health Plans Act; HR 824, the Telehealth Benefit Expansion for Workers Act; and HR 2813, the Self-Insurance Protection Act; 2023; https://www.protectcoverage.org/siteFiles/43073/06%2006%2023%20PPC%20Letter%20to%20EW%20re%20Healthcare%20Affordability%20Markup.pdf.
[25] National Association of Insurance Commissioners, *White Paper: Stop Loss Insurance, Self-Funding and the ACA*, 2015, https://content.naic.org/sites/default/files/inline-files/SLI_SF.pdf.
[26] *Id*.
[27] Keep Americans Covered, Fact Sheet for Michigan's 5th District, 2024, https://americanscovered.org/wp-content/uploads/2025/02/202502_KAC_1P_Enhanced_Tax_Credit_District_Michigan-05-1.pdf.
[28] Keep Americans Covered, Fact Sheet for California's 10th District, 2024, https://americanscovered.org/wp-content/uploads/2025/02/202502_KAC_1P_Enhanced_Tax_Credit_District_California-10-1.pdf.
[29] Ryan Schultz, Peter Kaczmarek, James Bao, John Rienstra; Oliver Wyman; *How ACA Tax Credits Impact Patients With Chronic Conditions;* 2024; https://www.oliverwyman.com/our-expertise/insights/2024/sep/premium-tax-credit-ending-chronic-conditions-at-risk.html.
[30] *Id*.
[31] American Cancer Society Cancer Action Network, *The Facts About Medicaid and Cancer*, 2025, https://www.fightcancer.org/policy-resources/facts-about-medicaid-and-cancer.
[32] Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz, Alice Burns; Understanding the Intersection of Medicaid and Work: An Update; 2025; https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-an-update-appendix/.
[33] Wikle, S. (2017). Work requirements in Medicaid would add more red-tape and barriers to health coverage. Center for Children and Families, Georgetown University Health Policy Institute.
[34] Maiss Mohamed, Alice Burns, Molly O'Malley Watts; KFF; *What is Medicaid Home Care* (HCBS)?; 2025; https://www.kff.org/medicaid/issue-brief/what-is-medicaid-home-care-hcbs/.
[35] Tabitha Mueller, The Nevada Independent, *Nevada Republican Gov. Lombardo speaks out against GOP's proposed Medicaid cuts*, 2025, https://thenevadaindependent.com/article/nevada-republican-gov-lombardo-speaks-out-against-gops-proposed-medicaid-cuts.
[36] Elizabeth Williams, Alice Burns, Rhiannon Euhus, Robin Rudowitz; KFF; *Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates*; 2025; https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/.

Chairman ALLEN. Thank you, Ms. Lilly. I now recognize Ms. Strouse for your testimony.

STATEMENT OF MS. MARCIE STROUSE, PARTNER, CAPITOL BENEFITS GROUP, ON BEHALF OF THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS, DES MOINES, IOWA

Ms. STROUSE. Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee, thank you for the opportunity to testify today. My name is Marcie Strouse. I am a small business owner and benefits consultant in Des Moines, Iowa, but more importantly, I am a mom of three amazing kids, including two who were diagnosed with a neuromuscular disease.

That diagnosis turned my world upside down, and it changed how I see healthcare. It is just not policy issue for me, it is personal. It is about ensuring that people can access the care they need when it matters most. For over 20 years, I have worked directly with small employers across Iowa. I sit across from family run businesses, hearing their fears and frustrations.

They want to take care of their people. They want to be competitive, but they are drowning in rising costs and limited choices. In Polk County where I live, family premiums for small group plans have gone up 85 percent in just 8 years. For my own family of five, we pay $1,100.00 a month for a pre-ACA plan.

A comparable ACA plan today would cost my family more than $2,100.00 a month, almost double. That is simply not sustainable, and I can tell you I am not the exception. Most small business owners are feeling the strain of rising costs and thinking to themselves, how can we stay competitive, retain and attract employees, and support our teams when we are paying more for less coverage every day.

According to the latest NFIB job survey, 38 percent of small employers could not fill open jobs this February. Offering health benefits is one of the only ways we can compete with big companies, but 94 percent of owners say it is getting harder to afford. What can Congress do?

Small business owners are resilient and innovative, they just need the tools to succeed. Congress should empower small businesses with more choices, greater flexibility and better tools to support healthier teams and stronger communities. Pass the Self-Insurance Protection Act. Self-insurance gives small businesses the freedom to design smarter plans.

Over the last 3 years, one of my two person clients saved $17,500.00 by moving to a level funded plan. Congress should protect small business access to vital tools like stop loss insurance, expand association health plans, letting small businesses pool together, regardless of industry, levels the playing field with big employes and provides more options.

Promoting innovative models, such as direct primary care and reference-based pricing. I have employers who have saved over 40 percent by switching to a plan with DPC and reference-based pricing. The models lower costs and put consumers back in the driver's seat. Preserve and expand telehealth. Telehealth is a lifeline, especially in rural communities, and it saves time and money.

Congress should pass the Telehealth Benefit Expansion for Workers Act to make this a permanent option under ERISA. Protect ERISA preemption and cut red tape. We need clear, uniform rules so we can focus on our people, not paperwork.

Finally, promote transparency, market consolidation and hidden costs have driven prices up. Small employers deserve to know what they are paying and why. We want to take care of our teams, offer strong benefits, and build businesses we can be proud of, but we need Washington to give us the tools to do that.

I look forward to working with the Committee to accomplish these goals. Thank you for the opportunity to testify today.

[The statement of Ms. Strouse follows:]

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Statement of Marcie Strouse
Partner, Capitol Benefits Group

United States House of Representatives
Committee on Education and Workforce
Subcommittee on Health, Employment,
Labor, and Pensions

A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care

April 2, 2025

National Federation of Independent Business
555 12th Street NW, Suite 1001
Washington, DC 20004

Chairman Allen, Ranking Member DeSaulnier, and Members of the House Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions:

Thank you for the opportunity to testify today on behalf of the millions of small business owners across America who, like me, are passionate about building stronger and healthier communities. My name is Marcie Strouse. I am a benefits consultant, a small business owner in Des Moines, Iowa, and—most importantly—a mom to three wonderful kids, including twins who were diagnosed with a neuromuscular disease at age seven.

That personal experience changed everything for me. It made health care not just a professional concern but a mission. For over 20 years, I've worked with small employers across Iowa, helping them build benefit packages that meet their employees' needs and align with their budgets. I've seen firsthand the difference that good coverage can make and the heartbreak when options are out of reach.

The Health Care Crisis on Main Street

Small businesses are the foundation of the American economy.[1] They are also community builders, supporting schools, sponsoring local events, and offering their employees not just a paycheck but a pathway to financial stability, health, and well-being.

At the heart of that promise is employer-sponsored health care. For decades, it has been the most valued benefit in attracting and retaining talent. Most Americans receive their health coverage through an employer[2]; however, that promise is now slipping out of reach for many small business owners.

For nearly 40 years, the number one concern for small business owners has been rising health insurance costs.[3] Today, it's not just a concern; it's a crisis. **Ninety-eight percent of small business owners fear they will be unable to afford coverage in the next few years.[4]**

The small group insurance market is in a free fall, resulting in fewer options, higher costs, and untenable trade-offs.[5] Family premiums for small businesses have increased by 129%

[1] https://advocacy.sba.gov/2024/07/23/frequently-asked-questions-about-small-business-2024
[2] https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-why-is-employer-sponsored-health-insurance-so-dominant
[3] Holly Wade & Madeleine Oldstone, Small Business Problems and Priorities, 2024 NFIB Research Center, 2024 https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf.
[4] Health insurance survey - 2023 - https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf
[5] Concentration in Small Group Health Insurance Markets Increased from 2011 through 2020 from an average of 13 issuers in 2013 to only 5 in 2020. See page 15 www.gao.gov/assets/gao-23-105672.pdf.

over the last two decades.[6] In Polk County, where I live and work, the average family premium for a small group plan has risen by 85% in the last eight years. For context, my family is currently enrolled in an individual grandmothered plan through Blue Cross & Blue Shield (BCBS). We have a $2,500 deductible, and our monthly premium is $1,135.45 for a family of five. A similar Affordable Care Act group plan in 2025 would have monthly premiums of $2,161. Despite almost doubling in cost, these ACA plans don't offer more value or quality, and in some instances, they come with narrower networks.

That's simply unsustainable, and it is why we must advance bold, practical policy changes that give small business owners more access and better options.

Today's small business outlook remains shaky, driven by high costs, workforce shortages, and economic uncertainty. For small employers trying to recruit and retain talent, the inability to offer competitive and affordable health insurance is a serious disadvantage. According to the latest NFIB jobs report, 38% of small business owners reported job openings they could not fill, the highest reading since August 2024.[7]

Despite relentless challenges, small business owners still believe in the power of offering health care. Sixty-three percent say it is vital to attracting and retaining talent. However, 94% find managing the cost increasingly difficult.[8] The disparity between small and large employers is stark: small firms pay nearly twice as much for health insurance as large businesses.[9] That uneven playing field puts Main Street businesses at a competitive disadvantage—and America's workforce at risk.

Empowering Employers Under ERISA

The ERISA framework has long enabled employers to offer affordable, high-quality health benefits. The following recommendations would be important steps toward giving the same access to small employers.

1. Expand Access to Self-Insurance and Stop-Loss Protections.

Self-insurance is one of the most effective ways for small employers to manage costs and improve plan design. But today, far too many are locked out due to regulatory uncertainty and limited access to stop-loss coverage. Congress should pass the *Self-Insurance Protection Act* (SIPA) to ensure that small employers can continue to rely on stop-loss insurance. This protection is critical. **Just last year, a two-employee client of mine saved over $3,500 annually by transitioning to a level-funded plan. Those savings helped them lower employee cost-sharing and improve coverage.**

---

[6] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 2003 - 2023.

[7] https://www.nfib.com/wp-content/uploads/2025/03/NFIB-Feb-2025-Jobs-Report.pdf

[8] https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf

[9] https://www.jpmorganchase.com/institute/all-topics/business-growth-and-entrepreneurship/small-business-health-insurance-burdens

2. Strengthen Association Health Plans (AHPs) and Pooling Arrangements
Allowing small businesses to band together across industries to purchase health coverage, whether through AHPs or other ERISA-regulated pooling arrangements, would give them the same negotiating power that large employers enjoy. This can result in lower premiums, stronger networks, and better plan options. We should level the playing field by removing outdated restrictions that prevent small businesses from pooling together, simply because they operate in different industries.

3. Increase Flexibility for Direct Primary Care and Reference-Based Pricing
Innovative models, such as direct contracts, Direct Primary Care (DPC) and reference-based pricing, are showing great promise in lowering costs and improving care. These arrangements promote transparent pricing, eliminate intermediaries, and restore decision-making authority to employers and employees. Congress should remove ERISA barriers that discourage small employers from adopting these models. Congress should also encourage plan designs that prioritize prevention and value over volume.

4. Expand Access to Telehealth
The COVID-19 pandemic demonstrated that telehealth is not merely a convenience but a lifeline to greater access, improved outcomes, and lower costs. Expanding employer flexibility to offer telehealth benefits, including as a standalone option, would give small businesses a practical and affordable way to expand access for their employees. Congress should ensure telehealth remains a permanent, flexible benefit option under ERISA by passing the *Telehealth Benefit Expansion for Workers Act*.

5. Protect ERISA Preemption and Reduce Red Tape
Congress must protect ERISA preemption from state-level patchwork mandates that drive up administrative costs and limit plan innovation. Lawmakers should reduce burdens on employers by streamlining and eliminating unnecessary reporting requirements. Some of the smallest businesses are already struggling to comply and lack resources and time. This is a commonsense way to relieve small business owners from burdensome red tape and allow them to focus on what they do best: Serving their customers, supporting their employees, and contributing to their communities.

6. Address Market Consolidation and Promote Transparency
Finally, we must increase transparency and accountability within the health care system. Market consolidation among hospitals and pharmacy benefit managers (PBMs) has left small employers at the mercy of monopolistic pricing with little access to information. This has been driven in part by misaligned incentives. Lawmakers should examine the policies—some of which originated from the ACA—that have contributed to this consolidation.

Greater transparency and better incentives in hospital pricing and pharmacy benefit manager practices would bring much-needed competition to the system, providing

employers and patients with the information they need to make more informed decisions. It's time for every player in the system —hospitals, insurers, and pharmacy benefit managers (PBMs)—to compete fairly and be transparent.

Give Us a Fighting Chance

Small business owners aren't asking for a handout; we're just asking for a fighting chance. We want to take care of our employees. We want to offer generous, flexible, and affordable benefits. But we need Washington to stop tying our hands.

The people I serve every day are not Fortune 500 CEOs. They are café owners, HVAC repair shops, and family-run manufacturers. They're part of the fabric of America, and they're being priced out of the system.

If we want a healthier and stronger workforce, we must empower employers who are willing to invest in their people.

Thank you for the opportunity to testify today.

Chairman ALLEN. Thanks to all the witnesses. Under Committee Rule 9, we will begin questioning the witnesses under the 5-minute rule. I will start with my questions first, and before I do, I would like to clarify just a few things for the witnesses and for everyone attending the hearing today. First, at least in my meetings with Elon Musk and his team, and our conference meetings, his team has no authority to hire and fire a single Federal employee.

What they are doing is what I would do in my business. They are going in, they are analyzing it, they are running the algorithms, they are looking at production, how many people it should take, and what it takes to run the government. I would think that any organization would want someone to take a look at that.

Unfortunately, Congress had not been able to do that, and that is seriously our responsibility, but for whatever reason politics gets in the way. He is providing a very valuable service to this country, and I think, you know, we should be ashamed of demonizing somebody that actually wants to help us get out of a serious, serious situation.

The other thing I would say is this, there are two things that have to happen for us to sustain this country. First, is we have to—and all the analysts say this, we have to reduce government spending by 3 percent and grow the GDP by 3 percent. If we do not do this, it is unsustainable.

We have run 2 trillion-dollar deficits long after COVID. COVID has been over for 3 years, and we are still running 2 trillion-dollar deficit. That is unsustainable. No country can—our interest on our debt is a trillion dollars. The American people need to wake up to this fact. There is a way to deal with it.

First, you have to have incentives. We have been told by analysts if we do not pass and extend the tax credits, that there will be, you know, we will lose incentives for businesses to grow their business and to hire more people. You have to have incentives to grow GDP.

These are just business principles that I learned in my business, and I am sure other folks who have learned in business, this is the way to do business. Now, Ms. Shields, getting back to you and self-employed individuals. Like the realtors you represent that often struggle to find affordable healthcare coverage, what options do realtors have to obtain coverage?

Ms. SHIELDS. Thank you, Mr. Chairman. My members, when we were offering our healthcare plan, they had some options available, obviously. They had the ACA. They did have our plan at the time that they no longer have. Many of them that were married were able to obtain through their spouse, and then frankly, we have 15 percent nationwide that are not insured at all.

That is our biggest concern. What we did find was that when we offered our plan, they were comparing our plan to the ACA, so some did stay in the ACA. The ones that we attracted were the ones that the ACA was just too expensive for them, they could not afford it. We were able to save them some cost. They also found our deductibles were a little better, and so they made the change for that particular reason.

Again, back to the spouses, they were able to save money sometimes because they were having to pay for their spouse that might not have been insured as well.

Chairman ALLEN. Why are AHPs so important for self-employed individuals like realtors?

Ms. SHIELDS. Thank you again for that question. It is so important because, for many reasons and I can talk to you all day about it, but the ones I would highlight is again, the deductible savings. In many cases we are able to keep them with the doctors they are already using.

We do take preexisting conditions, and it just gives them good, high-quality coverage. We are a plan that was ACA compliant. We had all ten of the key essential programs that is required by ACA, so we were offering them good coverage.

Chairman ALLEN. Yes. I cannot understand why anybody would object to that. Ms. Strouse, if all employers with fewer than 50 employees are not required to offer health coverage to their employees, but many choose to do so. Can you discuss the reasons why small employers choose to offer health coverage?

Ms. STROUSE. Yes, that is a great question, and one that I get a lot. It is because they want to take care of their people. They want to take care of their communities. They want to be also competitive to the large employers that are out there. Right now, they pay twice as much as a large employer does for healthcare costs, however, they are employing the people that they see at church on Sundays, that they see on the soccer field, and so these are not just employees to them, they are their community.

They want to make sure that they have that opportunity to provide benefits, and just as mentioned, you know, the ACA in Iowa specifically limits the access to network. We only have HMO options within our marketplace in Iowa, which is like most states. In order to offer a group plan you have more flexibility, and you can offer more of those national PPO networks that then have that broader network, so people are not losing their coverage.

Chairman ALLEN. Right. You know there was a promise made in ACA that your premiums would go down. What we have done, employer-based health insurance has become so expensive it is actually driving people to Medicaid.

Ms. STROUSE. Yes.

Chairman ALLEN. Which is, you know, the problem we have with the mandatory spending issue. If we can customize it, make it more affordable obviously, we can get these people on great plans and obviously the company has—and the impact of this coverage has got to be positive.

In other words, the idea is it is coming from the employer and not from the Federal Government. Would that be a—yes?

Ms. STROUSE. Absolutely, yes.

Chairman ALLEN. Your written testimony, and I have got about a minute, notes how innovative coverage models, such as direct contracts and direct primary care allow businesses to lower costs, and improve quality. What barriers do small employers face in using these innovative models? What can Congress do to make it easier for small employers to use these models?

Ms. STROUSE. Yes, so currently when you use direct primary care, there is a subscription or a membership fee that is included for access for those plans, and they are not HSA qualified, so if you have an FSA plan in, or an HAS plan in, you do not receive those tax benefits on those plans.

Direct primary care also has a huge impact on outcome of healthcare, so typically those employees that are using direct primary care have a much higher level of direct access to their provider, and so in the case of maybe diagnosing a chronic disease earlier, those things are going to be caught.

There is a lot more advocacy on that side of things, so that, for me, is a big piece of it is just making sure that those employees and employers can afford to offer those direct primary care options.

Chairman ALLEN. Right. Thank you so much, and I yield my time now, and I recognize Mr. Courtney for your questions.

Mr. COURTNEY. Thank you, Mr. Chairman, and thank you to the witnesses for your thoughtful testimony. Again, I am also somebody who can say that I spent 20 years as a small employer, and like the Chairman and the Ranking Member, you know, definitely acknowledge that there are realities there in terms of that end of the market that we should always be focused and working on.

Last Congress, as Mr. DeSaulnier mentioned, you know, we actually came together on a bipartisan basis to have the transparency in the pharmacy benefit managers, which again, small business communities supported strongly because that black box of how prescription drugs are negotiated, is unacceptable in terms of really trying to make sure that the customer, which is businesses who are buying these health plans understand, you know, where their dollars are going.

Large companies like Boeing, as part of their contracts with PBMs, required full transparency. Because of that, a lot of them did not bid on their offering, and as a—but the ones that did, Boeing saved millions of dollars because of just the fact that they could be able to see what happened.

Unfortunately, the bill was pulled during the lame duck session at the behest of the Trump transition team, and again, Speaker Johnson had signed off in terms of the legislation and unfortunately it got withdrawn.

We are going to start again because that is—getting to the core costs of health care has got to be part of the plan here in terms of how you lower premiums. If you do not do that, then you know, everything you are doing is just cost shifting. It is whack-a-mole, and that is just not going to work.

Speaking of moles, Mr. DeSaulnier mentioned the 880 billion dollar cut to Medicaid, which is not a mole, that is like a gorilla that is going to again, have ripple effects to the employer community.

Mr. Chairman, I have a list of the 50 major health care provider groups that have come out opposed to the 880 billion dollar cut, and again, it deals with the high end providers, the American Hospital Association, Catholic Hospital Association, Children's Health Association, physician groups, patient groups that have all come forward and recognize the devastating impact this is going to have for access to care.

I ask that this list be unanimous consent to be added to the record.

Chairman ALLEN. Without objection.

[The information of Mr. Courtney follows:]

Groups Opposed to Medicaid Cuts:

50 State Medical Associations

AARP

AFSCME

Alliance for Aging Research

Alliance for Childhood Cancer

America's Essential Hospitals

American Academy of Family Physicians

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

American College of Physicians

American Psychiatric Association

American Association of Pediatric Ophthalmology and Strabismus

American Cancer Society Cancer Action Network

American Hospital Association

American Lung Association

Association for Community Affiliated Plans

Community Catalyst

Families USA

First Focus Campaign for Children

National Alliance on Mental Illness

Association of American Medical Colleges

California Children's Hospital Association

California Hospital Association

Catholic Health Association of the US

Children's Hospital Association

Coalition for Whole Health

Coalition of Child Health Groups

Coalition of Local Government Organizations

Coalition of Medicaid Stakeholders

Coalition of National Faith Organizations

Coalition of Nurse Practitioners

Coalition of State Ambulance and Emergency Medical Services Associations

Coalition of Survivors of Domestic Violence and Sexual Assault

Diabetes Patient Advocacy Coalition

Disability and Aging Collaborative

Federal AIDS Policy Partnership

Federation of American Hospitals

Justice in Aging

National Bleeding Disorders Foundation

National Multiple Sclerosis Society

National Rural Health Association

SEIU

The Arc

Southern Poverty Law Center

UnidosUS

National Coalition of Patient Advocacy Organizations (a group of 30 patient groups)

Mr. COURTNEY. Again, if that goes through, you know, we are looking again at, you know, a program that provides 40 percent of the live birth coverage in America for babies and mothers. Again, it is about 40/45 percent of children are covered. Some are actually working families because Medicaid provides for coverage.

Again, Ms. Lilly, maybe you can talk about that, that you know, that is part of the solution in terms of helping with small, with employers to have options.

Ms. LILLY. I will say just to start off that I think having cancer is incredibly expensive. Anyone in our community who has had cancer can tell you that, and for a lot of kids as you have said, Medicaid is one, either their source of coverage, or it comes in as a secondary source of coverage when their parents realize exactly how expensive this is going to be.

Children's hospitals across the United States, I am sure they are on your list because they are one of the largest recipients of Medicaid funding. When our kids end up in these children's hospitals

that have the necessary specialized care, Medicaid is often the program that is picking up the tab there.

I will say, you know, I also think a lot about caregivers. If you are, say, a mom or a dad who has had a kid diagnosed with cancer, and that kid is in the hospital for months or weeks on end, you may not be able to maintain your job. You may not have access to paid leave, you may not be able to do that.

You also need health insurance. If something additionally awful were to happen you would also need that health insurance, and Medicaid also picks up those families. Medicaid is also incredibly important for people with disabilities, and many people deal with the long-term implications of having a cancer.

For instance, I know you have personal experience with this, sir, but if you have been through that chemo, if you have been through that radiation, if you have been through frankly the treatments that we still need to develop better options for, those can have really long-term implications on your health, and you may need access to long-term services and supports, which are only available through the Medicaid Program.

Really, Medicaid kind of comes around all cancer patients, and really helps all of that. I will add that I think in addition to caregivers and kids, and people with disabilities, you also have a lot of older adults on Medicaid, and that is actually one of the biggest populations of people with blood cancer are older adults.

Mr. COURTNEY. 60 percent, right. Thank you. I yield back.

Chairman ALLEN. Next, we turn to the Chairman of the Committee, Mr. Walberg.

Mr. WALBERG. Thank you, Mr. Chairman, and I want to say thank you to you, and Ranking Member DeSaulnier for your flexibility and continuing this hearing today, starting a little earlier than we had planned as the schedules changed, but thank you. I think it is an important hearing.

I would also say I look forward to the apologies that will come out from my Democrat colleagues when we find it all worked out that there were no Medicaid benefit cuts. The unfettered, fear mongering that is going on that the people with cancer and everyone else are concerned with unnecessarily.

I look forward to that, and again, the conscious effort to try to declare before the American people that 880 billion dollars for cuts, which will cut the entire Medicaid funding is intended, so we will see.

I look forward to that when in fact the President and leadership and Congress have said no Medicaid cuts. I hope that gets out. Ms. Shields, thank you for being here. The Congressional Budget Office estimates that expanding association health plans will result in 400,000 uninsured individuals gaining coverage.

What are the additional advantages of allowing small businesses to band together to offer coverage to AHPs?

Ms. SHIELDS. Thank you. Again, there are many benefits to allowing these programs. One, you do pick up additional people who had not been insured. We have had—not to repeat myself, but 15 percent that were uninsured across the entire nation with NAR, so we are picking them up.

Second, we have a comprehensive plan that is offering great benefits to our members that they were otherwise unable to get. The cost savings, the deductible that is lower, and we were able to lower the deductibles for our members where they were paying for a family $11,000. We were able to bring that down significantly anywhere from $4,000 to $6,000, depending on which plan they picked.

These are high-quality plans that were ACA compliant and had all ten essential pieces in it. They are able to keep their doctors. We were allowing them to choose—these plans allowed them to choose their doctors. We also had where we were allowing pre-existing conditions.

It was everything that we were able to provide. It was as if you were going to work for a large employer, but it was a plan that they were able to do as self-employed, which for us, our job is to offer our members benefits. This was one of the biggest benefits they were asking for.

Mr. WALBERG. Yes. The disruption of the Tennessee REALTORS AHP ultimately put people on the Unaffordable Care Act again.

Ms. SHIELDS. Absolutely, or uninsured.

Mr. WALBERG. Or uninsured, which was basically the same in many cases. You had an insurance policy under the Unaffordable Care Act, but you could not use it in so many cases.

Ms. SHIELDS. Right. We heard terrible stories from members, particularly when we had to tell them that we had to cancel the program. I had a member who, unfortunately, has passed since that time, who had everything from heart conditions to diabetes, and ended up dying from Lou Gehrig's disease.

To have to tell somebody like that that we finally got you on a plan, and then have to tell him we are so sorry, but now we have to take it away.

Mr. WALBERG. Yes, the cruelty of the Courts in the Biden administration, taking people off of plans that worked for them, which provides insurance coverage when you figure across the Nation, for 85 percent potentially of our workforce in small business. Thank you.

Ms. SHIELDS. Thank you.

Mr. WALBERG. Ms. Strouse, use of telehealth drastically increased during the pandemic, and as a result we saw new and innovative ways of delivering care. What feedback did you receive from workers about increased access to telehealth benefits?

Ms. STROUSE. Yes, the telehealth benefit was actually pretty significant during that time, and then going forward people got used to it, and the access to care through telehealth. For us, what we saw in the State of Iowa was more access to behavioral health providers during that time because Iowa, like many states, have challenges with providers and access to providers, especially in rural communities like Iowa has.

That telehealth piece actually helps to keep people from running into the doctor for things and incurring a cost—a claims cost to that. A lot of these things can be done at no cost to the employee, depending on plans, and how these are set up. What also happened was it actually encouraged people to actually seek that care be-

cause maybe that barrier of getting in to see a provider face to face is gone, so telehealth is very significant.

We would love to see that continue forward, especially on the health savings account qualified plans.

Mr. WALBERG. Right, which saves costs as well, and helps healthcare. Thank you.

Ms. STROUSE. Absolutely.

Mr. WALBERG. I yield back.

Mr. ONDER [presiding]. The Chairman yields back. The Chair next recognizes Ms. Lee from Pennsylvania.

Ms. LEE. Thank you, Mr. Chair. I think I might take just a slightly different route, and I would like to start by saying that I do not think that we should have health care that is tied to employment in the first place. The United States has the largest economy on Earth, but we are one of the only wealthy countries where getting sick can bankrupt you and your access to care depends on what kind of job you have, or whether you have one at all. Our current health care system tells people that their worth and their health depends on their specific employment status. In the wake of the Trump administration and DOGE's reckless mass firings across the Federal Government, it is now clearer than ever why trying something as, or excuse me, as tying something as essential as health care to a paycheck is harmful.

We are hearing heartbreaking stories after heartbreaking story about the tens of thousands of people who are waking up one day suddenly unemployed, and also suddenly without health care. A woman about to give birth to twins, a man in the middle of chemotherapy. We have heard from a senior desperately needing hip surgery.

Let us also not forget, even those with employer-sponsored insurance can still struggle with health care access and affordability. Often, I hear from working families who are underinsured, burdened by high out-of-pocket costs, skipping appointments, or drowning in debt for care that barely meets their needs.

If they even have coverage, it often does not go far enough, and many are forced to choose between rent and groceries or paying thousands for their life-saving medication. Ms. Lilly, based on what you have seen in the blood cancer community, can you speak to the personal and financial effects on patients when they are denied coverage for lifesaving care, not because of medical judgment, but because it is being too costly or not profitable?

Ms. LILLY. Yes. I would say that this is unfortunately a call we often get to our information and referral center is, hi, I have insurance, but they are saying they are not going to cover this particular service. Unfortunately, you know, the U.S. has led in biomedical research. We have amazing cell and gene therapies, and those therapies are probably the calls we get the most now, is folks being unable to access these services because they are so expensive.

I will also add that this is one of the reasons why Medicaid is so important. If we look at Deanne, who was diagnosed with blood cancer many years ago, she ended up on Medicaid because she could no longer work. A similar situation for Amanda, who lives in Michigan. Many of our patients end up not being able to work, not

being able to maintain the coverage, and then end up accessing the Medicaid Program because they are literally too sick to work.

Ms. LEE. Thank you. Unfortunately, being denied life-saving care based on cost is not an exception, it is baked into the system. Investigations have uncovered troubling practices by health plans and their corporate service providers to conduct arbitrary, improper and mass denials of claims.

A ProPublica investigation found that Cigna built a system allowing doctors to instantly reject claims without opening the patient's file. Another investigation found how EviCore a company contracted by insurers that cover over 100 million Americans, uses a secretive algorithm to drive up denial rates.

One employee described executives directing staff to keep a closer eye on guidelines because we are not showing savings. Ms. Lilly, since private insurers often have a duty to maximize profit for shareholders, would you agree that a health system designed to maximize care and access for the public would help prevent these kinds of abusive denial practices, and better protect patients?

Ms. LILLY. I think it would, and I think having that transparency that has really been a theme of this hearing so far, around what algorithms are being used? What are they based on? Are they being doublechecked? Is there a human actually reading the results and saying OK, no, this is all right, this makes sense?

Does that human have the right expertise? Are they, for my patients, an oncologist, or are they someone else?

Ms. LEE. I—just to say, I think this is exactly why we need universal health care. We have spent decades trying to patch a broken system. The Affordable Care Act expanded access and curbed some of the worst abuses, but to be honest, it was a compromise.

Since then both Democratic and Republican administrations have doubled down on market-based models that hand over more power and profit to corporate actors, allowing private equity firms and hospital conglomerates to tighten their grips on the health care system.

Where do these profits go? Straight into lobbying and political campaigns that block meaningful reform. That is exactly why we know this Republican Congress, this administration, and the billionaires and corporate lackeys will not support the policies working people actually need.

That is why, instead of seeking to bolster our health system, they are seeking to cut at least 800 million in funding for Medicaid, a lifesaving program for our most vulnerable populations, including those who found themselves, or find themselves recently unemployed. We do not need more tweaks. We need a system that treats health care as a human right, not a job perk.

One that prioritizes savings lives, not shareholder values, we deserve universal, guaranteed health care for all. I thank you all so much for your time today, and I yield back.

Mr. ONDER. The gentlelady yields back. The Chair next recognizes himself for 5 minutes. You know, we have been hearing a lot today about Medicaid. That was not the purpose of this hearing, but Id like to echo the sentiments of Chairman Walberg.

Our Democratic colleagues insist on mis—and repeating their misrepresentations about Medicaid. There are no Medicaid cuts.

Where do they get the 880 billion dollar figure they keep repeating? They get that because that is the total amount that the Energy and Commerce Committee is tasked with savings, as we desperately attempt to get our Federal budget deficit and debt under control.

Not all of that savings will come, of course, from the Medicaid Program, much of it will come from the EV mandate, and so on. Even if, even if 800 billion dollars came from savings from reforming Medicaid, according to the CBO instead of Medicaid spending over the next decade increasing by 2.5 trillion dollars, it would increase by 1.7 trillion dollars, only in this city. Only in Washington, DC, is a 1.7 trillion dollar increase a cut.

In many ways—there are many ways, without cutting coverage, that we can save money on the Medicaid Program, and we do badly need to do so. We can check eligibility, that alone can save hundreds of billions of dollars. Work requirements can save over 100 billion dollars.

We know the Democrat states spend twice as much per capita on Medicaid as Republican states. We could reform gimmicks used by states to juice their take from the Medicaid dollar. We can eliminate some of these gimmicks. No, there are no Medicaid cuts, but if we are to preserve Medicaid for the most needy, and the most vulnerable, we badly need to reform the Medicaid Program.

Ms. Strouse, I appreciated your testimony in support of the Self-Insurance Protection Act to self-insurance, it allows employers to offer an alternative to costly, one size fits all traditional insurance plans and Obamacare plan. It can produce long-term financial savings for employers, give flexibility to tailor coverage to the needs of their employees, and invest in employee wellness programs.

Reinsurance, or stop loss insurance, which empowers self-insured employers to enter into these agreements is critical. Reinsurance is a financial risk management tool that protects self-insurance employers from catastrophic expenses. We know that in 2022, 103 million Americans relied on self-insurance for their healthcare coverage.

Since the Obama administration, this alternative has been under attack at the State and Federal levels. That is why this week of course, I introduced the Self-Insurance Protection Act. This bill will protect self-insurance by clarifying that Federal regulators cannot define stop loss insurance as traditional health insurance, which common sense dictates it is not.

It also prohibits states from regulating stop loss insurance if those regulations make it inaccessible to employers. Essentially, it prevents the regulation of self-insurance out of business. Ms. Strouse, in your written testimony you mentioned that a two-employee small business was able to save over $3,500 annually by transforming—or, transitioning to a level funded plan by purchasing stop loss insurance.

How does this work and how does this lead to cost savings?

Ms. STROUSE. Yes. Again, through innovation what we are seeing here is new opportunities coming to the table. When you look at the small group market, that self-funded space is a little different than it would be for these large employers that, you know, essentially are hundreds of employees.

There are a lot more protections built around the small employer, so then that way, you know, if for some reason they come into a self-funded plan, and let us say they do have situations where they have multiple employees dealing with cancer or chronic diseases that might increase those costs, they still have protections so there is no run out.

There is nothing that is going to catch them on the back end. These have really been put together to make sure that it not only protects those employers and employees, but it does also put them in the driver's seat for their healthcare. These plans, typically what they can do is lower deductibles, out of pocket maximums, lower those cost shares for office visits.

It also again gives those employees the opportunity to drive their own health experience and their own health journey. When you have skin in the game and it directly impacts your paycheck, you tend to be a little bit more engaged with what is going on, so we are seeing, you know, things being diagnosed a lot sooner, and better outcomes for employees in these situations.

Mr. ONDER. Well, thank you, Ms. Strouse. I yield back. The Chair recognizes Ranking Member Scott of Virginia.

Mr. SCOTT. Thank you, Mr. Chairman. Mr. Chairman, we have heard a lot about the deficit. I would just point out that the Republican budget increases the deficit, and adds on to the debt as opposed—compared to doing nothing, and remind people that every Democratic president since Kennedy has improved the deficit that they inherited, compared to what they handed over to the Republicans.

Every Republican president since Nixon has handed over to the Democrats a worse deficit than the one, they inherited all without exception. For fearmongering, CBO said you cannot cut Energy and Commerce 880 billion dollars, programs under that Committee, without touching Medicaid. If they want to end the fearmongering, all they have to do is identify 880 billion dollars within the jurisdiction of that Committee that does not include Medicaid, and that would put an end to the discussion.

Ms. Shields, you indicated that under your plans you covered all of the essential benefits that were required under the Affordable Care Act. Is that right?

Ms. SHIELDS. Yes, sir.

Mr. SCOTT. That is not required for associated health plans? Is that right?

Ms. SHIELDS. We made a point of making sure that we were covering everything, so that we wanted to be——

Mr. SCOTT. It was—it was not required under associated health plans?

Ms. SHIELDS. I honestly would have to defer that to my consultant, so I could get back to you on that.

Mr. SCOTT. Your plan—it is not required under associated health plans, but you did voluntarily. Now, your plans were done before the—before the American Rescue Plan Act eliminated the cliff at four times poverty that eliminated any subsidies after I guess about $60,000 income for an individual.

When we eliminated that cliff, what did that do to the competitiveness of your plans?

Ms. SHIELDS. Congressman Scott, I am not sure that I have the information available to answer that.

Mr. SCOTT. What was the typical policy premium under your plan?

Ms. SHIELDS. The typical—again, they had several plans that they could pick from, so it might range $1,200 a month, depending on if they were getting family added to it. It might add just a little bit more to it, but I am going to say average they were probably around $1,000 to $1,100, $1,200 depending on which plan they picked.

Mr. SCOTT. That would be over $10,000, $12,000 a year. That—when we eliminated the cliff it meant that the maximum you would pay for a family policy would be 8 and 1/2 percent of your income, which at $100,000 would be $8,500.00, which would be very difficult for you to compete with.

I think the problem we had was that cliff, which we eliminated in the American Rescue Plan, and extended in the Inflation Reduction Act, which made insurance much more affordable for the people in the income range that realtors would probably find themselves in, the 60,000 to 100,000, maybe a little more, would be much more affordable.

Can—could—could businesses buy into the Affordable Care Act, Ms. Shields?

Ms. SHIELDS. Again, I am not familiar with the Affordable Care Act, and as far as could businesses buy in, but I am happy to get the information that you need and get that back to you.

Mr. SCOTT. Can anybody on the panel answer that?

Ms. Strouse.

Ms. STROUSE. Can you just repeat it really quick, so I can make sure I am understanding it?

Mr. SCOTT. Can businesses buy into—small businesses buy into the Affordable Care Act?

Ms. STROUSE. Yes.

Mr. SCOTT. How does that work, because I—we understand most businesses do not take advantage of that.

Ms. STROUSE. There was the shop market opportunity, and it was not sustainable in most situations, and so what was happening was employers were looking at that as an option and recognizing that they have better options outside of that.

Those subsidies that have been increased, some of these people that have—coming from employer plans to get into the marketplace with those subsidies are recognizing that in that case they actually have less access to providers in the marketplace, so they are giving something up to get lower premiums.

The premiums have significantly increased from the very beginning of the market, the marketplace.

Mr. SCOTT. Mr. Chairman, the—Ms. Shields indicated that the benefits—essential benefits were not required. I would ask unanimous consent to enter into the record a Washington Post article entitled, "He Had Short Term Health Insurance. His Colonoscopy Cost Him $7,000" because it was not included.

A statement on behalf of members of a partnership, a coalition of organizations who are opposing the association health plans, the

telehealth benefit expansion, and the Self-Insurance Protection Act for the record.

Mr. ONDER. Without objection, so ordered.

[The information of Mr. Scott follows:]

He had short-term health insurance. His colonoscopy bill: $7,000.

The policies don't have to follow rules established under the ACA and can set caps on certain types of care – sometimes far below what it costs.

March 28, 2025

By Julie Appleby

Tim Winard knew he needed to buy health insurance when he left his management job in manufacturing to launch his own business.

It was the first time he had shopped around for coverage, searching for a plan that would cover him and his wife, who was also between jobs at the time.

"We were so nervous about not being on a company-provided plan," Winard said.

After speaking with an insurance agent, he decided against enrolling in an Affordable Care Act plan because he was concerned about the potential cost. Instead, he chose a short-term policy, good for six months.

Bill of the Month

A crowdsourced investigation by KFF Health News that dissects and explains medical bills.

Do you have a confusing or outrageous medical bill you want to share? Tell us about it!

Six months later, Winard was still working on starting his business, so he signed up for another short-term policy with a different insurer that cost about $500 a month.

When he needed a colonoscopy, Winard, 57, called his insurance company. He said a representative told him to go to any facility he wanted for the procedure.

Early last year, he had the colonoscopy at a hospital in Elmhurst, Illinois, not far from his home in Addison.

The procedure went well, and Winard went home right afterward.

Then the bill came.

The medical procedure

Periodic colon cancer screening is recommended for people at average risk starting at age 45 and continuing until age 75, according to the U.S. Preventive Services Task Force. In addition to those for preventive purposes, doctors may order colonoscopies to diagnose existing concerns, as was the case for Winard.

There are several ways to screen, including noninvasive stool tests. A colonoscopy allows clinicians to examine and remove any polyps, which are then tested to see whether they are precancerous or malignant.

The final bill

$10,723.19, including $1,436 for the anesthesia and $1,039 for the recovery room. After an insurance discount, his plan paid $817.47. Winard was left owing $7,226.71.

The billing problem: A short-term plan

Short-term, limited-duration insurance policies do not have to follow rules established under the ACA because they are intended to be only temporary coverage.

Benefits within the plans can vary, with some setting caps on certain types of care — sometimes far below what it costs. What's covered can be hard to parse, and the insurer generally gets the last word.

While some short-term policies look like comprehensive major medical policies, all come with significant caveats. Most have limits that people accustomed to work-based or comprehensive ACA plans may find surprising.

All short-term insurance carriers, for example, screen applicants for health conditions and can reject them because of health problems or exclude those conditions. Many do not include drug coverage or maternity care.

The fact that short-term plans can cover fewer services, conditions and patients is why they are generally less expensive than an unsubsidized ACA plan.

Stunned that he owed more than $7,000 for his colonoscopy, Winard contacted his insurance company, Companion Life Insurance of Columbia, South Carolina.

An insurance representative told him in an email that it classified the procedure and all its costs, including the anesthesia, under his policy's "outpatient surgery facility" benefit.

That benefit, the email said, capped insurance payment "within that facility" to a maximum of $1,000 per day.

That definition surprised Winard, who said he read his policy to mean that there was a cap on what could be charged for the facility itself — not for all the care he received there.

"I interpreted it to be a facility like a recovery room or surgery room," he said. "They defined it to include any services at an outpatient facility."

His plan says it covers colon cancer screening at 80 percent after patients meet their deductible. It also covers 80 percent of the cost of drugs provided in an outpatient setting.

Winard, who had met his deductible, said he expected he would pay only 20 percent toward the cost of his colonoscopy.

Short-term plans have been sold for decades. But in recent years, they've become a political football.

Out of concern that people would choose them over more comprehensive ACA insurance, President Barack Obama's administration limited short-term plans' terms to three months. Those rules were lifted in President Donald Trump's first term, allowing the plans to again be sold as 364-day policies.

President Joe Biden, calling such plans "junk" insurance, restricted the policies to four months — a change that took effect one month after Winard's procedure. Trump is expected to reverse Biden's reversal and again make them available for longer durations.

The resolution

In December, Winard hired an advocate, Linda Michelson, to help him parse his bill. They wrote to the hospital, offering to pay $4,000 if it would settle the entire bill — an amount Michelson said is about four times what Medicare would pay for a colonoscopy. Winard said the hospital declined the offer.

Spencer Walrath, an Elmhurst spokesperson, wrote in an email to KFF Health News that the hospital's prices "reflect the value of the services we deliver."

Companion Life did not respond to requests for comment. Scott Wood, who identified himself as a program manager and co-founder of Pivot Health, which markets Companion Life and other insurance plans, said in an interview that there was room for interpretation in the billing and that he had asked Companion Life to take another look.

Shortly after Wood's comment to KFF Health News, Winard said he was contacted by his insurer. A representative told him that, upon reconsideration, the bill had been adjusted — although he was given no specific explanation as to why.

His new bill showed he owed only $770.

The takeaway

Short-term plans can be appealing for some people because of the relatively low cost of their premiums, but consumers should read all the plan documents carefully before enrolling. Understand that the plans often won't cover a full range of benefits, and check to see which services are covered and which are excluded. Check whether a policy includes per-day or per-policy-period dollar caps on coverage or other payout limits.

The federal government offers subsidies based on household income for ACA plans, which can make them comparable in cost to cheaper, short-term plans — but with a wider range of benefits.

In hindsight, Winard said he had not understood the difference between ACA policies and short-term plans.

His advice? Don't rely solely on marketing materials, and always get a cost estimate, preferably in writing, before a nonemergency procedure like a colonoscopy.

Bill of the Month is a crowdsourced investigation by KFF Health News that dissects and explains medical bills. Since 2018, this series has helped many patients and readers get their medical bills reduced, and it's been cited in statehouses, the U.S. Capitol and at the White House. Do you have a confusing or outrageous medical bill you want to share? Tell us about it!

What readers are saying

The comments express strong criticism of the U.S. healthcare system, particularly focusing on the inadequacies of short-term health insurance plans. Many commenters highlight the high costs and lack of coverage associated with these plans, contrasting them with universal... Show more

This summary is AI-generated. AI can make mistakes and this summary is not a replacement for reading the comments.

Statement on Behalf of Members of the Partnership to Protect Coverage
House Committee on Education and the Workforce
Health, Employment, Labor, and Pensions Subcommittee
Hearing on: "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"
April 2, 2025

The 27 undersigned organizations represent more than 120 million people living with a pre-existing condition in the US. Collectively, we have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that are critical components of any discussion aimed at improving or reforming our healthcare system.

Our organizations share three principles that we use to help guide our work on healthcare to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.[i] These principles state that healthcare must be adequate, affordable, and accessible.

With these principles at the forefront, we write to convey our concerns about policies that could negatively impact the quality and affordability of healthcare for patients, including three bills that have previously been considered by the Committee and may be before you again or amended for your consideration: the Association Health Plans Act; the Telehealth Benefit Expansion for Workers Act; and the Self-Insurance Protection Act. In the report, "Under-covered: How 'Insurance-Like' Products Are Leaving Patients Exposed," many of our organizations documented our concerns with health insurance products that are not required to comply with the patient protections enacted in the Affordable Care

Act.[ii] We are especially concerned that the bills above, or other similarly crafted proposals, would decrease the number of consumers enrolled in comprehensive health insurance plans and threaten access to quality, affordable health care for the patients and consumers we represent.

We urge the Committee to oppose bills that would limit comprehensive coverage options for these individuals including the policies detailed below.

The Impact of Association Health Plans

Current law allows employers to work together to form a multiple employer welfare arrangement (MEWA) to provide certain benefits to their employees. An Association Health Plan (AHP) — a health benefit plan sponsored by an employer-based association — is one type of MEWA.

AHPs do not constitute adequate coverage because AHPs:

- Can be classified as large employers and are therefore not subject to critical patient protections and state insurance regulations.
- Are not required to provide comprehensive coverage or cover the Essential Health Benefits (EHB) and may also charge higher premiums based on occupation or even health status in some cases.
- Pose risks to the many consumers who do not enroll in them. AHPs can siphon away healthy individuals from state individual and small-group markets by leveraging the regulatory advantages they enjoy. This leaves the individual and small group markets smaller and with a larger proportion of individuals with pre-existing conditions, leading to higher premiums and fewer plan choices for those who depend on those markets to access affordable, comprehensive coverage.

We believe additional enrollment in AHPs by small employers and the self-employed, like proposed in the Association Health Plans Act, will weaken patient and consumer protections and lead to higher costs for consumers who rely on comprehensive insurance. As the Committee contemplates improvements to the healthcare system, we urge you to oppose legislation that would promote additional enrollment in AHPs and partner with us to set common-sense restrictions that protect patients, consumers, and employers – limiting low-value plans rather than allowing them to proliferate further.

Telehealth as an Excepted Benefit

Telehealth has long been a vital care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. Our organizations believe that telehealth can and should be used to increase patient access to care and we have issued principles to aid lawmakers in setting appropriate policies to achieve that goal.[iii]

Nothing prevents an employer or health insurance carrier from offering telehealth coverage in conjunction with their health coverage, and many do. However, we are concerned with any proposals that would create a new excepted benefit for telehealth services. Excepted benefits are a category of coverage exempt from most federal and state standards that apply to health insurance. This means that a telehealth excepted benefit could discriminate against patients with a pre-existing condition by refusing to cover certain treatments, charging more for coverage, or denying coverage altogether.

Excepted benefits coverage can take many forms, including disease-specific policies like cancer-only, dental, and fixed indemnity plans. These plans are designed to supplement a major medical insurance plan. They are *not* comprehensive coverage and, in many cases, they are not allowed to coordinate with

other coverage. These products are often exempted from federal regulation and primary regulation authority lies at the state level. While telehealth is an important coverage, it is insufficient on its own without major medical health insurance.

With telehealth as a new excepted benefit, employers would be able to offer the stand-alone benefit as an alternative to a comprehensive health insurance plan. Low-wage workers, in particular, would be at risk of enrolling in the lower-cost telehealth plan, thinking it will provide comprehensive coverage when it won't.

Lastly, we want to draw the committee's attention to a concerning trend. In recent years, excepted benefits have been marketed and sold – sometimes bundled – as replacements for traditional health insurance.[iv] This can lead to significant consumer confusion and a false sense of security for people who believe they've purchased high-quality coverage, only to find substantial gaps and higher out-of-pocket costs when they use their plan.

We are concerned that bills like the Telehealth Benefit Expansion for Workers Act, or others that are similarly formulated, would be harmful to patients and consumers. We encourage the Committee to instead consider approaches that would promote consumer access to integrated telehealth benefits within a comprehensive health plan.

Stop-Loss Coverage

Stop-loss insurance is intended to be used as a tool to protect a health plan sponsor—typically an employer—from unpredictably high losses due to unexpected claims. As such, it can be an important tool to promote stability for sponsors of health insurance plans, particularly sponsors providing coverage for small numbers of insured individuals, whose unique health needs sometimes necessitate very expensive health services.

We are concerned with proposals, like the Self-Insurance Protection Act, that would remove an important level of consumer and patient protection by eliminating the ability of states to exercise oversight of stop-loss plans. State insurance commissioners play an important role in the health insurance marketplace. Removing states' ability to regulate stop-loss coverage would lead to less oversight of these plans, which would increase the likelihood of misleading marketing and other fraudulent practices that would prove harmful to employers purchasing stop-loss coverage as well as their employees.

Conclusion

We urge the Committee to reject the bills referenced above and, instead, partner with organizations like ours to identify opportunities to expand affordable, accessible, and adequate healthcare coverage for patients and their families. If you have questions or would like to discuss this further, please contact Katie Berge (Katie.Berge@lls.org), Jelani Murrain (Jelani.Murrain@cancer.org), and Ashleigh Tharp (atharp@cff.org).

Sincerely,

AiArthritis
Alpha-1 Foundation
American Cancer Society Cancer Action Network
American Heart Association

American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cancer*Care*
Crohn's and Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Muscular Dystrophy Association
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart: The National Coalition for Women with Heart Disease

---

[i] Consensus Healthcare Reform Principles. https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/PPC-Coalition-Principles-FINAL.pdf.
[ii] Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed. https://www.lls.org/advocate/under-covered-how-insurance-products-are-leaving-patients-exposed.
[iii] Principles for Telehealth Policy. https://www.lung.org/getmedia/ac136df2-5984-46b6-9503-8523f71f5425/FINAL-Principles-for-Telehealth-Policy-_8_27_2020-(003).pdf.
[iv] Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk. https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leavingconsumers-risk.

Mr. ONDER. The Chair recognizes Mr. Mackenzie of Pennsylvania.

Mr. MACKENZIE. Thank you, Mr. Chair. For Ms. Shields, participants in your program had a choice to enter into these plans. Is that correct?

Ms. SHIELDS. That is correct. They would do their research to determine if our plan fit them best, or if they wanted to go to the ACA or anywhere else.

Mr. MACKENZIE. What they experienced was lower premiums and deductibles in this option?

Ms. SHIELDS. That is correct. They had better prices, lower deductibles, and as pointed out earlier, it may not be necessarily that the price was lower, but they had a better plan that fit their needs.

Mr. MACKENZIE. What you are saying is that they were satisfied with their access to the care through their use programs?

Ms. SHIELDS. Absolutely, especially the fact that they were able to come in. We covered the previous existing conditions that they had, or that they were able to keep their doctors, or for whatever the necessary reason was.

Mr. MACKENZIE. What I am hearing is that this is a choice that these individuals are choosing. They were potentially able to get lower premiums and deductibles, and they were satisfied with the care that they were receiving?

Ms. SHIELDS. 100 percent. Our whole point was to offer it as a benefit, so that they had options because many of them again, were not insured, and did not feel that they had anywhere that they could get the insurance that they needed.

Mr. MACKENZIE. When you see that pattern, it is astounding that people would be opposed to giving people a choice to get lower cost healthcare that they are satisfied with. That is astounding to me that somebody would go on the record and say I want to take away choice from people to get low-cost healthcare that meets their needs.

I will just leave it right there. The next thing is I want to talk to Ms. Strouse, and ask about small businesses, a particularly challenging environment for healthcare in our economy today is making sure that small businesses can offer affordable healthcare to their individuals.

Can you tell me about additional innovative options that you are seeing in this space that meet those needs?

Ms. STROUSE. Yes, so we routinely talk about the level funded, which is the self-funded plans in that small group market, with most of our groups. There is a little bit more flexibility in that. However, there are things coming into the market around direct primary care that actually again, puts those employees in the driver's seat.

We have a program that we can offer to employers at a minimum, just a minimal fee on a monthly basis, and employees have direct access to a provider team that they can call, text, email at any time. This team not only advocates for them in situations where maybe a claim has been denied, which agents do all the time. I just had one of those this week.

Sometimes those denied claims are lack of documentation that needs to just be put together. When we look at these things, the whole experience, which I think Mr. DeSaulnier had mentioned, the quality of care, is very challenging.

A lot of times somebody might get diagnosed with something, and just accessing the next step is very difficult. When you have these advocacy programs in place, you actually have a team that is not only helping you to navigate that process.

A lot of times they have success in getting appointments sooner for these people. They have the ability to look at prescriptions, and so they can look at a wide variety of prescriptions in case somebody got prescribed something that is very expensive or not covered.

They can do that medical management with them, and they also just have a little bit more of a person in their corner, so they know that they can contact this provider team, and that team already knows them. They know their family members, and they do not have to take the time out to go to a doctor that they might only see for 15 minutes, to then be sent to a specialist, or you know, just out into the healthcare system.

Again, these are providing that really high level of touch to the employees, and it is bringing the claims cost down because these programs do not run then through the insurance program.

For these basic needs that they have, those claims do not run through. When you partner that with a level funded plan, or a

high-deductible health plan, the out-of-pocket costs go down significantly for those members that are participating in that.

Mr. MACKENZIE. Great. Well, thank you for sharing that with me. What I would like to close on is that we know we have a broken healthcare system in this country. I think everybody up here agrees with that. The question is where do you go next? For me, the clear answer is that we want people to innovate.

We want new options, more options available for these individuals. It could be association health plans. It could be self-insurance. It could be telehealth. It could be direct primary care, it could be anything that we are not even aware of at this time, but the way that we are going to get those solutions is by getting government out of the way.

Instead of having a one size fits all approach, which is failing people in many instances, I think we need to allow the free market to innovate, allow these new options to come online, and they can work in tandem with things like Medicare or Medicaid. It is not a one size fits all option.

I think we need an all of the above solution here, and so I again, thank you for your testimony today and these new alternatives that you have presented that I think we should be in support of. Thank you, and I yield back.

Chairman ALLEN. The gentleman yields. I now recognize Mr. DeSaulnier, our Ranking Member for his questions for 5 minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. I hope we are still friends, and the comments that have been made by my colleagues about Medicaid, I—I welcome. We can stop talking about it if we all have an agreement that what is in the Republican approved budget, in terms of the number, is not going to happen the way it is described in that.

I think apologies are not the right word for my friend, Mr. Walberg. I think there is a recognition that the end product hopefully will be what we can all agree on, much like the starting product was from the Senate and through the budget process until a certain point, we were reaching consensus.

Ms. Lilly, I am a survivor of stage 4 chronic lymphocytic leukemia. I like to tell my friends that I was perfectly healthy until I became a Member of Congress when I was diagnosed with stage 4 cancer.

Then after that because of my decreased immune system, just running on the mall I took a freak fall 5 years ago at the beginning of COVID, was rushed to George Washington, and my doctors there told my kids when they flew out from California that I would die in the next 48 hours. I am—have some expertise, not because I chose to, but because I am a survivor of the American health care system.

We do agree that the United States has—we pay the most of any developed country for our health care, a fifth of the economy. Looking at people who help pay for that, and from a business perspective, clearly this is broken, and we have the worst outcomes of any developed country.

I mean that is a simple statement. If I ran a restaurant, I was losing money, and I kept borrowing money to prop it up, I would not be in business very long. If I said I was going to cut my prices

by 25 percent, and I was also going to cut a third of my kitchen staff, I do not think people would believe me.

Ms. Lilly, denials first, and then I want to talk about the cuts at NIH and ACI. I have got an example that is not an anomaly where a gentleman, and again, as a consumer, I could not have done this without help as you have said, Ms. Strouse.

Having been a small business member, I was a member of NFIB back when I was a Republican, many years ago, I can barely remember sometimes. Having had—trying to negotiate that. There are denials, and as you alluded to, there are the denials before the denials, just trying to negotiate the system, which is not just conspiracies, or incompetence.

I had a friend who used to say I used to believe in conspiracies until I discovered incompetence. In this instance I think it was a combination of both, that you alluded to. In the case of denials, one case that stands out to me is a gentleman named Tracy Pike from Illinois, father of three, he had stomach cancer stage 4.

He had all kinds of cases and precedents and let us see Blue Shield of Illinois and Blue Cross of approving the operation. Then when he was getting ready to go, they denied his—the approval. He died because he was denied. Is that an anomaly, or is that what we are seeing more and more?

Ms. LILLY. Unfortunately, it is not. I think it is something that we are seeing more and more as the cost of health care is increasing. I will add that, you know, I think we had a—we testified before the ERISA Advisory Committee on this exact issue around denials recently, and that is part of my written testimony, so I would refer everyone to that.

I will say I think we do not know how many denials occur in employer-sponsored insurance. We do not have a lot of information, and that transparency is kind of the first step in that direction. The Office of Inspector General has looked at denials in both Medicaid Managed Care and in Medicare Advantage, where they are incredibly high.

Folks do not know they can appeal denials. I mean, I think that the lack of consumer knowledge is also an incredibly important piece of this. Kaiser Family Foundation, KFF, does sponsor a regular survey of health consumers, and more than 50 percent of people had no idea they could appeal a denial.

Mr. DESAULNIER. I want to ask you about the cuts to NIH and ACI. I, as a survivor of leukemia, I would not be here if it was not for investments over the last 70 years in research in the Department of Defense first off, and at NIH and ACI. What is going to happen, chronic—CLL is the most common leukemia, affects everyone.

Doctor told me if I was diagnosed with this 15 years ago, I would be dead. Now, I have a normal life expectancy, times hundreds of thousands of Americans. What will these cuts that the administration has just done to the department and NIH, how will that affect life expectancy?

Ms. LILLY. Half of cancer treatments in use today were developed by the NCI, the National Institute of Cancer. We need that research to advance the ball to make sure that we have new treatments. With cuts to that, we do not know. America has led in bio-

medical research for decades and decades, and that is why, sir, you are still alive with us today, and I do not know what will happen.

We are monitoring this very carefully and very concerned.

Mr. DESAULNIER. The pill I have in my pocket that I will take at 3 in the afternoon was paid for from American taxpayers. It is now covered by Johnson & Johnson. They charge $500 a pill in this country. In Australia it was 37, in the EU it was 90. When the Biden administration with us in leadership negotiated those prices, it is now $90.

Free market is great, but there has got to be some parameters to free market. We live in a mixed market. Thank you, Mr. Chairman, I yield back.

Chairman ALLEN. The gentlemen yields, and now I will recognize our former Chairman and current Chairman of the Rules Committee, Ms. Foxx, for her questions.

Mrs. FOXX. Thank you, Mr. Chairman. Ms. Strouse, we often talk of ERISA preemption as being important for large employers to avoid the complexity of dealing with a patchwork of different insurance regulations across State lines. Why is ERISA preemption also important for small employers?

Ms. STROUSE. Yes, that is a great question. Again, it comes down to being treated equally, so small employers are already at a disadvantage. Offering them plans that are regulated by ERISA, like the self-funded plans, those are just crucial. It is just another option, another opportunity for them, again, to be innovative.

We do not want regulations to get in the way when something is working, which ERISA has worked for a long time.

Mrs. FOXX. Thank you very much. Ms. Strouse, last Congress the House passed the Lower Cost More Transparency Act, which among other things, would have required hospitals and insurance companies to publicly list the prices they charge patients.

How would additional price transparency allow agents in the benefits industry like you, to better assist employers and employees as they make healthcare coverage decisions?

Ms. STROUSE. Transparency is vital. I think we all can agree on that, and right now the healthcare system has gotten so complicated that it makes it very hard for people to actually be able to manage their healthcare journey. PBMs continue to get brought up, and I will tell you it is not only PBMs in the pharmacy space. There are quite a few stakeholders that actually impact pharmacy costs.

We need to make sure that we are not only targeting one situation and asking for them to be transparent. We need transparency across the board.

When we look at things like site neutral payments, you know, those are the things that we are looking at in that space as far as the hospitals and all of the consolidation that has happened in the rural communities across the country.

Mrs. FOXX. You know, it is intriguing to me that there is this battle not to have transparency, price transparency. Obviously, we must be on to something if the people who should be giving us transparency are not giving us transparency because it is the right thing to do.

Ms. Shields, as you mentioned in your testimony, you were responsible for setting up the association health plan for the realtors. Can you discuss in more detail the participation in the AHP you set up, and how did this participation compare to the participation in ACA plans?

Ms. SHIELDS. Thank you for that question. Our members were participating in the ACA. We had many that were not insured at all, and then we had many members that were getting their insurance from their spouses. If that person happened to be working, and of course, we did have some on Medicare or Medicaid.

When we offered the plan, we had done many, many surveys, and this is something that was a benefit that our members had asked us to offer to them. When we set up the plan, we did not find that it took away necessarily from the ACA. What we found is it was a choice that our members were able to look at to see if it was a benefit for them and their family.

We did have a lot that came to our program because they found that it was either saving them money, it was a better deductible rate for them, or they were able to have a pre-existing condition that was covered, or they were able to keep their doctors, or for any other number of reasons.

The problem that we found back to Mr. Scott's point with the ACA was that the ones that were in there were the realtor, we were talking earlier about people that are unemployed. Well, if you know a realtor, they are going to tell you they are unemployed every day. They have to get up every day and go find their work.

With that, you might have an average price, or an average income that they make, but it is not necessarily something they are going to keep year after year after year. They do not get raises like an employee does. What happens is that their income is fluctuated.

The subsidies we were being told is that they would take a subsidy maybe and then end up having to pay it back at the end of the year. They do not necessarily always qualify for those subsidies. The costs of the ACA did not always fit them with the lower cost.

Mrs. FOXX. Well, thank you very much. I think you have done a great job of describing that situation with realtors from ones I have talked to. Mr. Chairman, I have a question for Mr. Coleman that I will enter into the record.

Chairman ALLEN. Thank you. The gentlelady yields back, and now I will call on Mr. Casar from Texas for his questions for 5 minutes.

Mr. CASAR. Thank you. I want to focus my time today on something you will not hear much about from my Republican colleagues, and frankly, I do not think we are hearing enough about in the news, but it is what I believe is Donald Trump's most dangerous attack on the rights of working people thus far.

Last Thursday night President Trump signed an executive order that fundamentally undercuts union and labor rights that Americans have counted on for 100 years. The executive order strips the rights to organize and to bargain away from one and a half million Federal employees, and that is just where he wants to start.

For over 100 years, Americans have joined together in unions to fight to win everything from child labor laws to the minimum

wage, to the 40-hour work week. For over 100 years, unions have protected their members and lifted up all American workers.

For more than 100 years, our unions have empowered Americans to stand up against the greedy and the ultra-rich that tried to use our government to take away your money.

They have stood up against people like Elon Musk who think everyone else was put on Earth to just make them richer. Again, Donald Trump at the behest of the ultra-rich, has signed this executive order robbing one and a half million Americans of the fundamental right to come together alongside their coworkers to fight for better wages and better working conditions.

If the President is allowed to exploit a loophole in order to end the Federal right to bargain, that is not where he is going to stop. He will be coming for your right to bargain and to organize next. This attack will not end with these Federal workers unless we put a stop to it.

Let us discuss who Donald Trump is starting with by trying to take away their rights. These Federal workers are people dedicated to serving the public, doctors at the VA, food safety inspectors at the Department of Agriculture, IRS employees who go after corporations who cheat on their taxes.

This includes our janitors, food service workers, administrative employees, all losing the right to organize and bargain that workers have fought and bled for and marched for, for over 100 years. This executive order is illegal, full stop. Trump does not have the authority to take bargaining rights away from these workers, and it is already being challenged in court.

The president is trying to see what he can get away with after stacking the Supreme Court with not just right-wing Justices, but Justices picked by some of the richest people and biggest corporations in the country. This committee should be talking about this.

It should really be the only thing that this committee on "The Workforce" is discussing this week. Right now, instead, we have had kind of a business as usual committee hearing on health care, so let us talk about how Trump taking away collective bargaining rights impacts health care.

Federal employees will continue to be fired without due process because they do not have union representation. They will lose their health care. CDC employees that are protecting us from the next pandemic can be fired without the security of a collective bargaining agreement.

Justice Department lawyers prosecuting things like health care fraud could lose their jobs because they are not Trump's political lackeys, but they have lost protections in collective bargaining. These are real impacts, and we should be talking about them.

My question, Mr. Chairman, is whether we can hold a hearing on President Trump's executive order to strip bargaining rights away from 1.5 million Americans?

Chairman ALLEN. This hearing is about employer healthcare plans. We will take your question under consideration.

Mr. CASAR. I appreciate that. It would be good for us to talk about since we are the folks here that talk about education and the workforce, one and a half million Americans losing their right to bargain. I cannot think of another moment in American history

where in just 1 day that many Americans have lost that basic labor right.

I would request that we have that hearing. If we can have it at the next meeting, or we can have a hearing about how a Trump executive order has gotten rid of the minimum wage for Federal contractors, or the firing of Equal Employment Opportunity Commissioners who are tasked with stopping discrimination in employment.

Mr. Chairman, thank you for taking it under consideration, and I will continue to bring up this issue if we do not have a hearing on the fact that one and a half million Americans just lost their bargaining rights.

I will be interested in whether the Republican majority is trying to take away bargaining rights from even more union workers, or whether they are thinking about giving those bargaining rights back.

We know union members vote both Democratic and Republican, as they always have, and I just think it is really important for those union members to know whether the Republican majority and President Trump wants to take away their bargaining rights that they have had for over 100 years. Thank you.

Chairman ALLEN. The gentleman yields. Now I will—let us see, yes, OK. I now call Mr. DeSaulnier for a closing statement, yes.

Mr. DESAULNIER. All right. I want to thank the Chairman, and I really look forward to—I am happy to work with my colleagues. Clearly, the system has worked. I think if we as people, those of us who have owned businesses, really looked at this in private, we could find a solution, we could—if we were driven by efficiency.

As I said, it is very clear we pay the highest cost in terms of a percentage of GDP, a fifth of the U.S. GDP compared to the rest of the developed world with worse outcomes, life expectancy, and that is in spite of these huge investments. We know there are inefficiencies. We know that PBMs no longer serve as any kind of efficient delivery of services.

We know that taking over hospitals and closing them so that we are restricting competition does not help with the quality of care. If we want competition, we have got to help incentivize to have that hard infrastructure. We need to get young people to be able to go into the field.

All of those things I really have hope. On the Medicaid, I take—I take my friends at their word. However, I have to say that in addition to CBO, the Kaiser Foundation did an analysis of CBO's analysis and let me just read some of what they said.

This is from Kaiser Family Foundation, a nonprofit, probably the most respected nonprofit when it comes to health care in the United States, and I am proud of the fact that Henry Kaiser started it in the East Bay of California as a major employer during World War II because he wanted—he was really the starter of employer-employee based health care.

Kaiser Family Foundation, "The math is conclusive. Major cuts to Medicaid are the only way to meet the House's budget resolution requirements." The analysis goes on to say, "The CBO letter confirms early expectations, finding that over the next 10 years 93

percent of Non-Medicare spending in the Energy and Commerce jurisdiction is from the Federal share of Medicaid spending.

8.2 trillion out of 8.9 trillion. An additional 200 billion of Federal spending comes from the Children's Health Insurance Program, CHIP. Some of the committee's remaining spending in budget neutral, and there is—and therefore won't cut toward deficit reduction, even if Energy and Commerce eliminated all Non-Medicaid and CHIP spending, the committee would need to cut Federal spending on Medicaid and CHIP by well over 700 billion dollars."

Mr. Chairman, I would like to ask unanimous consent to submit the Kaiser Family Foundation analysis for the record.

Chairman ALLEN. Without objection.

[The information of Mr. DeSaulnier follows:]

KFF

The independent source for health policy research, polling, and news.

Timely insights and analysis from KFF staff

Workforce Reductions at Social Security Could Affect Medicare and Medicaid Coverage

The Math is Conclusive: Major Medicaid Cuts Are the Only Way to Meet House Budget Resolution Requirements

Alice Burns
Mar 7, 2025

The House passed a budget resolution instructing the House Energy & Commerce Committee (E&C) to reduce the federal deficit by at least $880 billion over 10 years. Although the budget resolution does not mention Medicaid, it was widely expected that most of those cuts would come from Medicaid given E&C's area of jurisdiction. On March 5, the Congressional Budget Office (CBO) published a letter detailing the non-Medicare mandatory spending under E&C's jurisdiction to identify what programs could be cut to meet the $880 billion target. (Medicare was excluded because cuts to Medicare are believed to be off-the-table.)

The CBO letter confirms early expectations, finding that over the next 10 years, 93% of non-Medicare spending in the E&C jurisdiction is from the federal share of Medicaid spending: $8.2 trillion out of a total $8.9 trillion. An additional $200 billion of federal spending comes from the Children's Health Insurance Program (CHIP). Some of the committee's remaining spending is budget-neutral, and therefore, won't count towards deficit reduction. Even if E&C eliminated all non-Medicaid and CHIP spending, the committee would need to cut federal spending on Medicaid and CHIP by well over $700 billion, nearly 10% of projected spending; and most agree that E&C is unlikely to eliminate all other sources of non-mandatory spending.

The math is conclusive: Major cuts to Medicaid are the only way to meet the House's budget resolution requirements. There are a myriad of options available for cutting Medicaid, but all of them would leave the states facing difficult choices to raise revenues or cut spending. Cuts to Medicaid spending could mean dropping coverage for some people, eliminating coverage of high-cost optional benefits such as prescription drugs, or cutting payment rates to health plans and providers. Different policies would have different implications for states, with policies such as a per capita cap having widespread effects across all states and policies such as cuts to the federal share of funding for the Affordable Care Act (ACA) expansion disproportionately affecting the red and blue states that have expanded Medicaid. Other policies, such as limiting supplemental payments to hospitals, could have disproportionate effects on the health care industry, with the consequences being larger in states with greater reliance on such payments.

Cutting HIV Prevention Funding at CDC: What Would it Mean?

Mr. DESAULNIER. If I could continue just briefly, in terms of efficiencies, as two people who met payrolls. If we were interested in efficiencies, I have often sat here and thought if we just, on a bipartisan level, followed the recommendations of the Inspector Generals, how much more efficient would government be?

We pay for them. They are experts. They are bipartisan. They have come in with great recommendations. What did this administration do as one of its first acts? It fired the Inspector Generals. Why would we not just listen to them, and act with the seriousness of implementing those plans?

The problem is not the analysis of the IG, it is our failure to act, the Congress, on efficiencies. Elon Musk, I have known for a good deal of time. 20 years ago, I was visiting the Palo Alto campus talking to the people who ran Tesla. I thought it was a good idea. I was a Republican appointed by Governor Pete Wilson regulator.

In those days we wanted to improve under the California waiver, the Clean Air Act signed by Richard Nixon, and then the California Clean Air Act signed by Governor Ronald Reagan. We wanted to incentivize this kind of delivery of services. The original conception and the brilliant minds behind Tesla, the computerized system and the battery, was not Elon Musk.

If you want to read a good analysis of this, read Ludicrous, it is a book about how Tesla got formed. I have met with Mr. Musk. He once asked me when I was a Chair of the Transportation Committee in the State Senate, he wanted to know why in California we could not be like Oregon and not have a sales tax on cars that cost $100,000, so he could get more of it out.

At the time, I was Chair of the Budget Committee on Health and Human Services. We were—during the recession we were cutting our social safety net by billions of dollars, Democrats, with Republicans. I told him, it was a funny exchange, I said I cannot comprehend of writing a bill like that.

I have had long relationships, off and on with the company. The plant—is many of the people who work in Fremont work, live in my district. I have been there multiple times. There is a genius, I suppose, to what is happening there, but you have to look under the hood so to speak, to the corporate culture.

The corporate culture does not work. The companies that are coming online internationally, Ford, GM, who are providing that product are doing it in a competitive way. They were late, and I wish they had been earlier, but in terms of efficiency, just because somebody has a lot of money does not mean they are the messenger of efficiency, particularly when you are coming from a business model like that to a completely different model.

I am completely committed to working with my colleagues to look at efficiencies. There is no excuse for the Federal Government to have inefficient delivery of services. With that, Mr. Chairman, for all of our differences, for you and the chairman of the full committee, it is in our best interest to respect one another, and I know we do, even when we get heated about some of these things.

I think we can fix this system in this subcommittee if we take that approach. The cuts to Medicaid, putting it in the budget where responsibility goes, inevitably, since you are in the majority, what the final numbers are I will respect that division, but I think it is completely accurate for us to bring the subject up aggressively because it is in the budget. Thank you, Mr. Chairman, and I yield back.

Chairman ALLEN. I thank the Ranking Member. gain, I agree with Chairman Walberg. I cannot wait to shine a light on it and show the people of this country where the money is going. You know, I served on the Healthy Future Task Force, and I asked all the experts to give me a breakdown of where every healthcare dollar is going.

They could not give it to me. You know, we have talked about how complex healthcare is, they could not give it to me. We spend 4 trillion dollars in this country on healthcare. If you think about what Elon Musk said, he said we are sending money out that we do not know—that there is no characterization on it is what he calls it. I call it code. OK, what is this for?

I am talking about here we are talking about B's and T's, not millions. I am talking about billions. Who actually approved this, or appropriate this to be spent? Maybe that is the reason the Inspector Generals got fired. Maybe they were not, you know, doing their job. You know, I mean we have all—we are all seeing the list of waste, fraud and abuse that is coming out of this exercise.

We should be embarrassed about it, not defend it. I mean we are dealing, I mean a public company would not get away with this. Their shareholders—are the taxpayer's shareholders in the Federal Government. They have got the stock. They have got ownership.

That is the reason they pay taxes is to be secure, and to make sure that their dollars are being spent in a wise way, which is frankly the only way we are going to survive. Like I said earlier, we are running 2 trillion-dollar deficits after COVID. If we were at pre-COVID spending today, we would have a balanced budget.

Like CBO said, revenues would not increase under our Tax and Jobs Act, or revenues are up a trillion dollars. You grow the economy, you grow revenues. You grow GDP, you grow revenues. Folks, there is a way to do this, and there is a way not to do it, and somehow, we have got to convince each other that OK, this is how you get the job done.

I am looking forward to that. I really am. We have learned a lot today. You know, one thing is small businesses need flexibility and as many tools as possible to combat years of rising healthcare costs, to continue to offer high-quality and affordable healthcare benefits to their employees.

You know, a former President promised the American people if we pass this, your premiums are going to go down. What happened? There should be alarm about that, and we are just sitting here paying the bill. Guess who is paying the bill? Our children and our grandchildren, and future generations.

We should be ashamed of that. Democrats and Republicans can share the goal of expanding assets to the affordable and high-quality healthcare to all Americans, and there is a way to do it. Have you heard from our witnesses doubling down big government healthcare is the wrong approach because it takes away choices and increases healthcare costs for employers and employees.

The government is not the answer. The people are the answer. We give this to the people, they will fix it. I look forward to continuing to work with all the members of the Committee on the innovative free market care solutions we discussed today, and with that, this hearing is adjourned.

[Whereupon, at 11:49 a.m., the Subcommittee was adjourned.]

[Additional submissions from Chairman Allen follows:]

Business Group on Health

STATEMENT FOR THE RECORD BY

BUSINESS GROUP ON HEALTH

TO THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON EDUCATION & THE WORKFORCE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

"A HEALTHY WORKFORCE: EXPANDING ACCESS AND AFFORDABILITY IN EMPLOYER-SPONSORED HEALTH CARE"

April 2, 2025

Chairman Allen, Ranking Member DeSauliner, and Members of the subcommittee, Business Group on Health appreciates the opportunity to submit this statement for the record on behalf of our members regarding the subcommittee's April 2, 2025, hearing: "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care." We appreciate the subcommittee's focus on finding ways to enhance health care access and affordability for employers and employees. Business Group on Health shares this focus, and we are pleased to share our perspective on some of the ideas that arose during the hearing.

As the nation's leading voice for large employers dedicated to advancing the quality and affordability of health care, the Business Group represents a vibrant community of more than 440 of today's most forward-thinking employers and industry partners including 72 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries. Business Group members – innovative employer plan sponsors – are leading the way and encouraging others by providing strong health plan offerings, adopting alternative payment models, managing the total cost of care, promoting customized health care coverages, furthering population health, and keeping people well.

Employer-sponsored coverage remains the backbone of the U.S. health care system, providing access to care for more than 170 million Americans. Large employers take this responsibility seriously and are committed to delivering comprehensive, affordable benefits

20 F Street, NW
Suite 200
Washington, DC 20001

202-558-3000
info@businessgrouphealth.org

Visit us at:
www. businessgrouphealth.org

to their workforce. While satisfaction with employer-sponsored insurance remains high, employers are increasingly navigating a complex landscape of rising costs, evolving care models and shifting policy proposals. As the subcommittee considers opportunities to strengthen access and affordability, we encourage a focus on advancing transparency in health care markets, preserving access to virtual care and protecting ERISA preemption as the foundation for uniform and innovative plan design.

I. Transparency

Transparency for plan sponsors into cost and quality of items and services paid for by the plan and its members, and promoting competition and fair dealing are fundamental to expanding access and affordability. By ensuring that employers have access to comprehensive and actionable data, they are better able to make informed decisions, negotiate more affordable rates, and incentivize high-quality care. This, in turn, drives market competition, fosters a culture of continuous improvement, and ultimately benefits employees, their families and the broader health care system.

While health care costs generally continue to escalate, prescription drug costs in particular are increasing substantially, leading employer plan sponsors to face significant challenges in maintaining affordable and comprehensive prescription drug benefits for employees and their families. Our 2025 Employer Health Care Strategy Survey reveals that, between 2021 and 2023, the median percentage of health care dollars spent on pharmacy has jumped from 21% to 27%, suggesting that nearly all of the increased health care costs that employers are absorbing is related to pharmacy cost.[1] Therefore, it is not surprising that nearly all large employers cite patient and plan affordability as paramount concerns, with 94% specifically troubled by the unsustainable pharmacy cost trend.[2]

Rising drug costs are propelled by long-standing market structures and practices and exacerbated by the lack of transparency within PBM arrangements and a rebate- dominated contracting model that often limits plan sponsors' ability to obtain or consider clear, upfront pricing for needed medications. The lack of transparency in contracting and rebates and the opaqueness of the pharmacy supply chain are some of employers' biggest concerns relative to pharmacy benefits; Business Group on Health's 2025 Employer Health Care Strategy Survey shows that 97% of employers seek greater transparency in their vendor partnerships.[3]

Provisions requiring PBMs to provide health plans data on rebates, fees, benefit design parameters and other essential information would strengthen employers' crucial insights

[1] Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024.
[2] Ibid.
[3] Ibid.

into drug costs and utilization that would help empower employers to better evaluate PBM performance and design more cost-effective benefits. Thus, the Business Group views transparency and accountability as vital reforms and supports increased reporting and disclosures to plan sponsors to better inform decision-making, contracting, and plan design. For these reasons we urge Congress to enact PBM transparency requirements so that all stakeholders can have clear directives and standards for employer access to this critical information.

While the Business Group supports transparency and accountability in PBM arrangements, we are seriously concerned about existing proposals that would impose new civil monetary penalties (CMPs) or other amendments to ERISA Section 502 or made otherwise applicable to employer sponsored health and welfare plan arrangements. We believe that ERISA's current requirements, including fiduciary responsibilities and enforcement provisions, are adequate and appropriate to support and ensure compliance with any new statutory provisions.

Adopting CMPs into ERISA would be a significant and negative departure from long-standing enforcement practices, harmful to employer's authority and fiduciary oversight, unnecessary and overly burdensome. ERISA's current Section 502 provisions are adequate and appropriate to handle the enforcement of any new requirements and should not be amended. Moreover, provisions that would apply CMPs (or other penalties) through the Public Health Service Act (PHSA) or the Internal Revenue Code (IRC) would misalign accountability, create confusion, increase administrative burden, and have similar deleterious effects on employer health plans as any ERISA Section 502 amendments.

We believe the imposition of CMPs would disrupt plan sponsors' ability to negotiate effectively and manage relationships with PBMs and other stakeholders. Instead of facilitating greater transparency and cost management, we believe CMPs or other penalties in this circumstance would lead to higher costs, increased litigation risks, and reduced flexibility and control for employer-sponsored plans.

For these reasons, we urge Congress to remove the previously proposed CMP and excise tax provisions from the relevant sections of any proposed amendments to ERISA, PHSA, and IRC. The proposed transparency provisions, without the disruptive penalty provisions, will be an important improvement that allows employers to work in furtherance of their fiduciary responsibilities without overreaching into counterproductive government interference or other undesirable consequences.

II. Telehealth & Other Health Savings Account Qualified Plan Improvements

Though telehealth services had been widely offered prior to COVID-19, its adoption and utilization were accelerated because of the pandemic. Even after the end of the COVID-19 public health emergency, telehealth services are still widely utilized and valued as a benefit by employers and employees. According to our *2024 Large Employer Health Care Strategy Survey*, nearly all employers who responded will offer telehealth for some services, with 97% offering virtual care options for acute care. Telehealth, telemental health, and mental well-being (e.g., resiliency, mindfulness) will be offered by nearly all employers by 2026 – while our *2025 Employer Health Care Strategy Survey* indicated that 69% of employers will offer virtual primary care services beyond traditional telehealth by 2027.

One critical policy introduced during the pandemic and subsequent rise in telehealth usage was the flexibility to allow high-deductible health plans (HDHPs) to cover telehealth visits pre-deductible without jeopardizing beneficiaries' health savings account (HSA) eligibility. The Business Group and employer community at large resoundingly supported this policy, leading the flexibility to be extended twice since it was first permitted. Unfortunately, this widely popular flexibility was allowed to lapse at the end of the 118th Congress. The Business Group urges Congress to restore and make permanent the telehealth flexibility for HDHPs.

There are other potential policies at the intersection of telehealth and HDHPs that would provide great benefit to employees. Since their inception, health savings accounts (HSAs) paired with HDHPs have grown to play an important role in the plan designs offered by employers. HSA funds, including employer contributions, help employees and their families afford their out-of-pocket health care expenses and save for future health care needs, including for retiree health expenses.

While the current HSA/HDHP design works for many, employers are also interested in investing in certain HSA improvements beyond pre-deductible telehealth to help ensure employees and their families can access and afford support for early and long-term chronic needs. Specifically, we support codification of the flexibility provided in IRS Notice 2019–45, as provided in the Chronic Disease Flexible Coverage Act (H.R. 919 (119th)) and the Primary Care Enhancement Act of 2025 (H.R. 1026 (119th)). Additionally, outside of the health plan we support granting employers additional flexibility to offer stand-alone telehealth coverage so that even those who decline employer health plan coverage can have additional support and access. To that end, we supported the Telehealth Benefit Expansion for Workers Act of 2023 in the 118th Congress, which does not appear to have been reintroduced yet in the 119th – but would expect to support it if and when it is.

III. ERISA Preemption

The Business Group applauds the subcommittee's recognition of and inquiry regarding the importance and primacy of ERISA preemption. No substantial work can be done to build upon access and affordability in employer-sponsored coverage without ensuring that ERISA preemption remains strong and reliable as it has for over 50 years.

ERISA preemption is a key component upon which self-insured employer-sponsored benefit plans are built. This provision is essential for eliminating the confusion and administrative and cost burden of conflicting and inconsistent state and local regulations, thereby supporting the efficient and effective delivery of robust, customized benefits. The Business Group is unequivocal in our view on the importance of ERISA preemption and will continue to engage across the spectrum of stakeholders to help educate on and protect the heart and foundation of ERISA plans. (See Business Group on Health: Position Statement on Preserving ERISA.)[4]

Without ERISA preemption, employers would be forced to comply with an untenable patchwork of state and local mandates, which would lead to skyrocketing costs and threaten the ability of employers to provide high-quality health and welfare benefits to their employees. This is why the vast majority of employers surveyed by Business Group on Health in our 2025 Employer Health Care Strategy Survey report that ERISA preemption is very important/important to their organization, with a definitive majority ranking protecting and affirming ERISA preemption as the highest priority for Congress and the administration with respect to ERISA health and welfare plans.[5] This clear and urgent priority of protecting ERISA preemption recognizes its vital role as the foundation of uniform, tailored health and welfare benefits, empowering employers to design and provide health care and other plans that meet the needs of employees and their families.

We acknowledge the unfortunate reality that ERISA preemption has been and continues to be explored for gaps, weaknesses or opportunities to assert fragmented and burdensome non-federal authority over self-insured plans. However, those efforts have largely to-date yielded more crisp contours of preemption's boundaries and not fundamental erosion of its purpose and effectiveness for self-insured plans. Indeed, it is a testament to ERISA preemption's strength that after 50 years of near continuous inquiry and scrutiny it continues to provide a basis for plans to design and administer uniform coverage nationwide. For these reasons we believe legislation on ERISA preemption is unnecessary at

[4] Business Group on Health. Position Statement on Preserving ERISA.
[5] Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024.

this time, and we urge the subcommittee to defend the principle that ERISA preemption is strong and must be protected and affirmed in all instances.

While additional legislation on preemption itself is not desirable, Congress should recognize that preemption is the instrument through which federal policymaking and legislation can and should drive requirements for self-insured employer plans and programs. From our comments here and the Business Group's broader policy pursuits,[6] we believe action for employers and self-insured plans is appropriate at the federal level to ensure administrable, effective and fair benefits and programs are provided across an employer's workforce. We encourage Congress to continue its focus on federal standards and to pursue federal legislation that is supportive and sustaining for employer-sponsored self-insured plans.

Thank you to the subcommittee for your consideration and attention to these important issues, and we would welcome the opportunity to discuss this submission or any other matters impacting access and affordability in employer-sponsored health care.

[6] Business Group on Health. Policy Position Statements.

ERIC | THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION & WORKFORCE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

"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 the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled "*A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care*." We appreciate the subcommittee's attention to the impacts of rising health care costs on employers and their workforce and look forward to working with you to find solutions that will make quality health care more affordable and accessible.

ERIC is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

ERIC member companies offer comprehensive health coverage for employees, their families and retirees through self-insured plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). They do so to attract and retain employees, to be competitive for human capital, to improve health and productivity, and to provide peace of mind. Large employers, like ERIC member companies, roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and a myriad of other innovations that improve quality, reduce costs, and drive value for working families.

Below, we highlight ERIC's topline policy proposals to consider as you examine the rising costs of health care for employees, their families, retirees, and employers. More than 160 million Americans receive health insurance from their employers, and employers can and should be important partners to help forge affordability solutions. ERIC looks forward to working with you on the following policy proposals identified by our member companies as key to this shared goal.

I. Transparency and Accountability Reforms

ERIC member companies believe transparency is integral both to reduce health care costs and improve quality of care. Health care costs for employers continue to rise at an unsustainable rate. To help mitigate these costs, Congress should significantly strengthen transparency in the health care system, thus giving rise to better care for patients, more competition, greater value, and improved quality and safety.

ERIC applauds the House's work on the "*Lower Costs, More Transparency Act"* (LCMT, H.R. 5378 – 118th Congress) as an important step in addressing the need for greater health care transparency. Too many hospitals are still failing to meaningfully comply with the U.S. Department of Health and Human Services (HHS) regulations requiring them to make public standard charges, including negotiated rates. Notably, the legislation would enshrine in statute the requirement that hospitals publicly post the negotiated price for health care items and services in a machine-readable format and increase compliance with and enforcement of this requirement. In addition, the legislation strengthens group health plan Transparency in Coverage requirements and makes important changes to facilitate better access by plan sponsors to much-needed data so they can offer better benefits to their employees.

While these policies are significant and necessary, we urge Members of Congress to continue to push forward on additional reforms to ensure optimal transparency. This includes extending transparency requirements to pharmacy benefit managers (PBMs) along with commonsense reforms that would hold PBMs accountable to fair market practices when partnering with employers. To that end, we strongly urge Congress to enact the bipartisan, bicameral health care package that was agreed upon in December but failed to make it onto the final continuing resolution. Additionally, we implore the Committee to push for inclusion of Title IV of the LCMT, which provides desperately needed clarifications and enhancements to the Consolidated Appropriations Act (CAA), as well as implementing new data sharing and transparency requirements to improve employer-sponsored health benefits.

The more accurate, complete, accessible, and up-to-date the data is when shared with employer-sponsored health plans, the more plan sponsors may do to ensure not only their own compliance with current law and regulations, but also to improve affordability and quality for the millions of workers enrolled in these plans. If Congress wants employers to be active purchasers who make changes and advocate on behalf of employees throughout the plan year, then employers need information about costs throughout the plan year – not just in an end-of-the-year summary.

II. Provider Consolidation and Unfair Pricing Practices

Health care provider markets continue to consolidate, including the mass purchase of provider practices by hospital systems. With such widescale consolidation comes great market power to demand higher prices. ERIC member companies are seeing the impact of this through enhanced pressures regarding provider contracting, as well as significant price increases for services in provider offices and clinics.

There is no case for a laissez-faire approach to such egregious market failures. Immediate intervention is needed to preserve free markets in health care as they continue to spiral out of control, leading to affordability and access concerns for employers and their workforce.

Congress should enact legislation banning hospitals from charging facility fees for telehealth services, along with facility fees at hospital-purchased physician offices. This could be achieved by promoting transparency via honest billing requirements, requiring a unique identifier for billing at every site of care. Legislation was introduced last Congress that would do just that -- the "*Facilitating Accountability In Reimbursement (FAIR) Act*" (H.R. 3417 – 118th Congress) and the "*Site-Based Invoicing and Transparency Enhancement (SITE) Act*" (S. 1869 – 118th Congress). Furthermore, Congress should enact legislation advanced by the Committee last Congress that would rebalance the lopsided market power of providers and promote fairness in contracting practices. We encourage the subcommittee to promote competition and reduce network consolidation by advancing the "*Healthy Competition for Better Care Act*" (H.R. 3120 – 118th Congress) through the legislative process.

III. Telehealth

ERIC member companies are pioneers in offering robust telehealth benefits. Telehealth enables individuals to obtain the care they need, when and where they need it, affordably and conveniently. Telehealth visits are generally less expensive than in-person visits and significantly less expensive than urgent care or emergency room visits. Telehealth visits allow individuals who may not have a primary care provider and are experiencing medical symptoms an affordable alternative to an otherwise unnecessary emergency room visit. Access to telehealth benefits saves individuals significant money and reduces the cost to the plan, which ultimately lowers health insurance premiums.

Telehealth benefits reduce the need to leave home or work and risk infection at a physician's office, provide a solution for individuals with limited mobility or access to transportation, and have the potential to address provider shortages, especially related to mental health, and improve choice, competition, and reduce costs in health care.

ERIC's member companies continue to innovate in their benefit designs to reflect telehealth improvements – held back only by various federal and state government barriers. This includes overly restrictive provider licensing, unnecessary barriers such as banning store-and-forward communications, or specific technology requirements. Additionally, ERIC member companies are interested in offering telehealth to certain sectors of their workforce who currently cannot be offered these services. We encourage Congress to pass the "*Telehealth Benefit Expansion for Workers Act of 2023*" (H.R. 824 – 118th Congress). This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled in the employer's full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and others, by removing barriers presented under current law, such as the *Affordable Care Act* (ACA).

Conclusion

Thank you for this opportunity to share our views. ERIC is committed to helping forge solutions that result in improved health care access, affordability, quality, transparency, and safety for all Americans. We are confident that our policy recommendations can provide meaningful changes to our health care system. We look forward to working with the subcommittee to further help in policy development and enact legislation.

Charles Crain

Managing Vice President, Policy

April 2, 2025

The Honorable Rick Allen
Chair
Subcommittee on Health, Employment, Labor, and Pensions
House Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

The Honorable Mark DeSaulnier
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
House Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Chair Allen and Ranking Member DeSaulnier,

On behalf of the National Association of Manufacturers and the 13 million people who make things in America, thank you for holding today's hearing on the importance of access to and affordability of employer-sponsored health insurance (ESI).

The NAM is the largest manufacturing association in the United States, representing small and large manufacturers in every industrial sector and in all 50 states. Manufacturers have a deep commitment to providing health benefits to their workers, even as rising health care costs remain a top challenge for the industry. More than 58% of manufacturers, and 68% of small and medium-sized manufacturers, cited health care costs as their primary concern in the NAM's most recent Manufacturers' Outlook Survey.[1] Despite this challenge, 93% of manufacturing employees are eligible for health insurance benefits, which underscores the urgent need for action to reduce health care costs for manufacturers and manufacturing workers alike.[2]

ESI is the bedrock of the United States' health care system—in 2024, 154 million people were covered through ESI.[3] In 2023, the NAM released a study, *Manufacturers on the Front Lines of Communities: A Deep Commitment to Health Care*, which took an in-depth look at the progress made by manufacturers in offering ESI, as well as the challenges they continue to face.[4] The study found that manufacturers provide health care benefits so they can effectively attract and retain employees, to maintain a healthy and productive workforce, and because they believe it is the right thing to do for their workers. Manufacturers are committed to continuing to offer health insurance to their employees, but there are steps Congress can take to ease the burden they face.

---

[1] National Association of Manufacturers, Q1 2025 Manufacturers' Outlook Survey (March 6, 2025). Available at https://nam.org/2025-first-quarter-manufacturers-outlook-survey/.
[2] Kaiser Family Foundation, *2024 Employer Health Benefits Survey* (Oct. 9, 2024). Available at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf
[3] *Id.*
[4] National Association of Manufacturers, *Manufacturers on the Front Lines of Communities: A Deep Commitment to Health Care* (July 2023). Available at https://documents.nam.org/IIHRP/2023%20Health%20Care%20Reportsingles.pdf.

To increase access to and affordability of ESI, manufacturers recommend the following:

- Strengthening ERISA: ERISA underpins manufacturers' ability to provide health insurance to their employees. The law allows manufacturers to provide uniform, yet tailored, benefits to workers across multiple states. However, the complexities and bureaucracy of the health care system are major challenges for manufacturers. These challenges can be addressed through improvements to the current public-private health care system. Reforms that ease regulatory burdens would lower costs and improve the quality of care for manufacturers and manufacturing workers.

- Protecting ERISA's Federal Preemption: ERISA's federal preemption of state and local laws and regulations is essential to the operation of ESI, as it allows multi-state employers to design and administer uniform benefits to all employees, regardless of their states of residence. Eroding or eliminating preemption would force manufacturers to comply with a patchwork of cumbersome and potentially conflicting state-based rules, a costly and untenable situation.

- Improving Data Transparency and Accessibility: Administering high-quality, affordable health plans requires the collection and analysis of massive amounts of data, a task to which manufacturers dedicate significant resources. It is thus important that employer plan sponsors have user-friendly access to their complete data in order to make informed choices about their plan's operations. Transparency also benefits manufacturing employees' experience in the health care system and enables them to make more informed decisions. Additional transparency mechanisms would improve beneficiaries' experiences.

- Preserving the ESI Tax Exclusion: The ESI tax exclusion is critical for the success of ERISA health plans. The individual tax exemption and employer deduction for ESI must be maintained in their current forms. Any deviation would jeopardize employers' ability to offer and employees' ability to utilize ESI.

- Reforming Pharmacy Benefit Managers: PBMs are underregulated middlemen that design, negotiate, and administer prescription drug benefits on behalf of health insurance companies and employers that self-fund health insurance plans for their employees. PBMs contribute to the skyrocketing cost of health care by tying patient cost-sharing to list prices, pocketing manufacturer rebates, and obscuring their concerning business models. Necessary reforms include increased transparency, the delinking of PBM compensation from the list price of medicines, and full rebate passthrough to the plan and its beneficiaries in the commercial market.

Manufacturers appreciate the Subcommittee's timely consideration of ways to increase access to and drive down costs for ESI. The NAM looks forward to continuing to work with the Subcommittee to strengthen the ESI system so manufacturers can continue to offer employees health insurance.

Sincerely,

Charles Crain
Managing Vice President, Policy


HRPA HR POLICY ASSOCIATION®
CONNECT INFORM EMPOWER
Advancing the American Workforce
ALIGNING POLICY SOLUTIONS & BEST PRACTICES
SPOTLIGHT ON
Employer-Sponsored Health Benefits Vital to Productivity & Growth
CHROs are committed to maintaining employer-sponsored health insurance as an essential benefit for employees, recognizing the value of high-quality, low-cost coverage for working Americans and their families.
By Margaret Faso

About this Series

HR Policy Association (HRPA) represents nearly 400 of the largest companies worldwide. Members employ more than 10 million individuals in the U.S. This report articulates the perspectives of our members regarding the trajectory of work in the U.S. and the need for specific changes in both corporate and public policies to effectively advance the future of the American workforce.

HR Policy Association's "Advancing the American Workforce" series equips policymakers and business leaders with insights from Chief Human Resource Officers (CHROs) of major companies. The profound changes employers and society have experienced over the past five years have transformed the way large employers and their employees think about work, the workforce, and the workplace and how each needs to be structured for long-term success. HR Policy provides the perspective, not only from employers, but from CHROs who bridge the goals of their companies with the talents and needs of its greatest asset: employees.

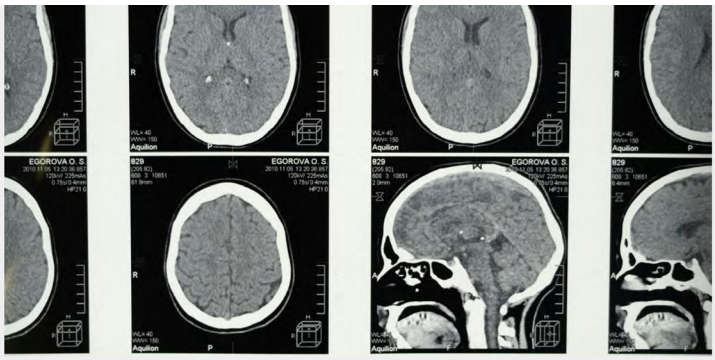
New technologies, evolving demographics, and shifting political winds demand a strategic approach to HR. Chief Human Resource Officers are at the forefront of navigating these changes, and their perspective provides invaluable insights for policymakers. This multi-part series offers practical experiences and perspectives on the critical trends shaping the future of work, and suggests policy approaches to ensure the American workforce remains at the vanguard of global excellence in the years to come.

Executive Editor: Timothy J. Bartl

Series topics include:

- Artificial Intelligence (AI)
- Diversity, Equity & Inclusion
- Employee Voice & Unionization
- Global
- *Health Care & Wellness*
- Human Capital Metrics
- Immigration
- Non-Compete Agreements
- Pay Transparency & Equity
- Retirement
- Workplace Flexibility

HRPA



EXECUTIVE SUMMARY

Employer-Sponsored Health Benefits Vital to Productivity & Growth

Chief Human Resources Officers are committed to maintaining employer-sponsored health insurance (ESI) as an essential benefit for employees, recognizing its value to working Americans and their families.

More than half of Americans, 179.8 million people, receive health care coverage via an employer.[1] Employers are in a unique position to provide the best possible benefits to American workers. Unlike others in the health care supply chain, employers seek to both lower health care costs and keep employees and their families healthy. To improve company culture and business growth, it is in the best interest of employers to provide high-quality, low-cost health care benefits so they can have a healthy, productive workforce.

However, employers and employees are facing serious affordability challenges that if not addressed, threaten the viability of the U.S. health care system. The National Health Expenditure report, released by the Centers for Medicare & Medicaid Services, expects national health spending to reach nearly $6.8 trillion by 2030.[2] Further, the annual per-employee cost of employer-sponsored health benefits rose by 5.2% in 2024 after a decade of average annual cost growth of 3%.[3] To sustain the employer-sponsored health care market, federal policy address rising costs through increased health care price and data transparency while eliminating the legislative and regulatory barriers which inhibit employer flexibility and innovation.

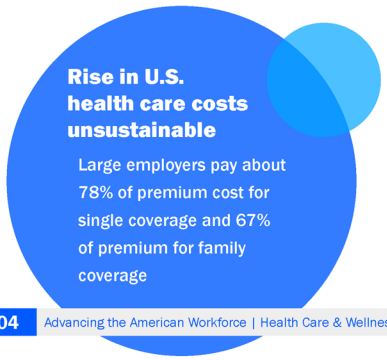
HRPA

Access to Health Coverage Benefits Both Employer & Employee

Health insurance is a driving force in employee retention and vital to securing a robust workforce.

Employers recognize that health coverage not only attracts employees, it keeps them healthy and productive on the job, benefiting both the employer and its employees. The Employee Benefit Research Institute's 2023 Workplace Wellness Survey found that 70% of employees report health insurance as the most important factor in deciding whether to stay with an employer.[4]

To attract and retain talent, employers seek to innovate and build on the competitive benefit packages they offer. As the needs and expectations of employees change, employers adjust their benefits offerings to positively impact the health and wellbeing of employees and their dependents. Employers have long been innovators in the health care space, implementing changes to meet the evolving needs of employees and their families, including changes that support inclusion and diversity. In fact, 75% of Association members stated that their company evaluated health care and wellbeing benefits as part of their strategy to improve the inclusion and diversity of their workforce.[5]



CHROs expect the following health care trends to continue over the next decade:

- Employee focus on workplace mental health and wellbeing programs
- Telehealth expansion
- Personalized or add-on health and wellness programs
- More aggressive negotiations with pharmaceutical companies and PBMs, and investment in pharmaceutical management programs as the use of specialty drugs increases.

The future of employer-sponsored health care and wellbeing benefits will be shaped by several factors—most importantly cost pressures, changes in technology, evolving employee expectations, and the federal policy landscape. As the health care system continues to evolve, employers need a policy and regulatory landscape that allows them to be flexible and innovative in response to the needs of their employee population. In fact, 55% of HR Policy members stated that they can lower health care costs "to some extent, but not enough to make a difference" without federal policy changes."[6] Recognizing the importance of health benefits to employees, employers will continue to offer core benefits but will likely look to supplement health plan offerings with additional wellbeing benefits.

Plan Offerings and Cost

Large employers offer a variety of plan options to their employees, allowing employees to make plan decisions that best suit them. Preferred Provider Organizations or PPOs continue to be the most common plan type, with 47% of workers enrolled in a PPO, 29% in a high-deductible health plan, 13% in Health Maintenance Organizations, and 10% in Point Of Service plans.[7] (See figure 1.)

Health care costs continue to rise at an unsustainable rate in the U.S. The average annual premium for employer-sponsored health coverage was $8,435 for an individual and $23,968 for family coverage, increasing 7% between 2022 and 2023.[8] While large employers pay about 78% of premium cost for single coverage and 67% of premium for family coverage, employees still struggle with financial stability and wellbeing. In fact, over 80% of workers have high or moderate concern for their household's financial wellbeing[9] and one in four workers don't feel they can afford their health care needs without causing financial hardship — increasing to about half of workers among those making $30,000 or less.[10] To address the impact of financial stressors on wellbeing and utilization of services, many employers are taking a more holistic approach to wellbeing. Employers have implemented financial wellbeing programs ranging from financial literacy courses to offering emergency savings accounts.

While employers take many steps to address rising costs, the fundamental affordability problem with the U.S. health care system continues to be prices.[11] One 2019 meta-study that reviewed 43 original studies and 18 reviews covering 341 studies on the effectiveness of cost containment policies, found that cost sharing, managed care competition, reference pricing, generic substitution and tort reform show promise for cost containment.[12] However, there are limits to how much cost can be shifted to plan participants. In addition, cost shifting generally has the unintended consequence of reducing the amount of necessary care that plan participants utilize.

FIGURE 1

- ***Health Maintenance Organization (HMO):*** Limits coverage to care from providers that contract with the HMO; generally, does not cover out-of-network care except in an emergency. Focus on wellness and preventive care.
- ***Preferred Provider Organization (PPO):*** The predominate managed care design for employer plans. A group of medical providers contracts with the plan to provide services, offering discounted pricing in exchange for an anticipated volume of business. Providers are typically paid on a fee-for-service basis.
- ***Point of Service Plan (POS):*** The plan contracts with health care providers or a managed care company to provide services through a PPO arrangement.
- ***High Deductible Health Plan (HDHP):*** Intended to encourage consumers to be more proactive with their medical care through higher deductibles and lower premiums. Can be utilized with Health Savings Accounts (HSAs) which allow individuals to set aside pre-tax dollars to be used for medical expenses.

Recent Legislative & Regulatory Actions Place Burden on Employers

One of the most significant barriers to employers administering health care plans is the administrative burden caused by legislative and regulatory policy.

While employers understand the need for and appreciate guidance, recent policy decisions have placed significant pressure on employers without spreading the risk across all stakeholders in the health care system.

For example, the proposed mental health parity rules place a significant burden on employers to demonstrate network adequacy for behavioral health providers. While an important step in addressing access gaps with behavioral health services, employers rarely have control over the composition of the networks they contract with or whether providers will choose to join the networks employers are in.

Separately, the Inflation Reduction Act, which allows Medicare to negotiate the price of prescription drugs with pharmaceutical manufacturers, did not include any provisions related the private market. Many employers are concerned that Medicare drug negotiation will result in cost shifting to their plans as pharmaceutical manufacturers seek to make up lost revenue. In this case, policies that address market reform and transparency in the health care system would be more effective at controlling costs than legislation only aimed at one portion of the insurance market.

Current policy poses significant barriers for employers

Policies that address market reform and transparency would be more effective at controlling costs than narrowly-tailored legislation

HR Policy Association Supports the Following Reforms:

1 Preserve and Strengthen ERISA[13]

For employers to be able to continue to provide affordable and accessible high-quality health care coverage, federal health care policy must uphold ERISA. Enacted in 1974, ERISA provides national standards for employee benefits and generally preempts "any and all state laws" regarding employee benefits. Nearly all Association members operate in more than one state and are self-insured. ERISA's preemption provisions enable self-insured businesses to offer uniform, tailored, and valued health benefits to their employees. Without this framework, employers would be subject to a patchwork of state requirements, making it increasingly difficult to design and uniformly administer health, welfare, and retirement benefits for employees and families. Any attempts to weaken the federal restriction through state-by-state regulation of self-insured employers should be rejected.

- An increasing number of states have enacted or are considering laws that regulate pharmacy benefit managers (PBMs) in response to the Supreme Court's 2020 decision in *PCMA v. Rutledge* which found that a PBM law in Arkansas was not preempted by ERISA. As a result, employers are increasingly concerned that without federal PBM legislation, they will have to navigate a patchwork of state laws.
- ERISA's national framework allowed large employers to adapt their benefits in response to the COVID-19 pandemic. While many of these adaptations were in response to changes in health care delivery, they also reflected a focus on employee expectations, with 87% of Association members altering their approach to health and wellbeing benefits to meet those changing expectations.[14] For example, during the pandemic, HR Policy members quickly acted to provide crucial health care services, like telehealth visits, to their benefit design. Without the current federal framework under ERISA, employers would not have been able to implement the additional high-quality benefits employees not only expected but needed.

2 Protect the tax deductibility of employer-sponsored insurance

Proposals to cap the income tax exclusion for employer sponsored health coverage are one example of policy that would further financially squeeze employers and employees. Proponents of these proposals, often part of budget and tax reform proposals, argue the employee tax exclusion prevents competition in the market and locks employees into jobs. However, taxing health insurance as income would increase the tax burden of employees and limit private sector innovation. Rather than addressing the factors causing rising prices in the health care market, these proposals would likely reduce the number of employers offering employer-sponsored insurance.

3 Promote transparency and market innovation

The opaque nature of our health care system is due to the mix of private and public payers, varied coverage plans, and diverse networks of providers, and significantly limits the ability of employers to manage their costs. As plan fiduciaries, employers have a responsibility to make sure they are paying "fair prices" for the health services received by company employees. To get to a "fair price," all stakeholders need to comply with transparency requirements. In terms of drug price transparency, HR Policy Association supports the *Lower Costs, More Transparency Act* and other efforts to increase reporting requirements of Pharmacy Benefits Managers (PBMs) by mandating disclosure of different forms of compensation expected to be received from pharmaceutical manufacturers.

- Reforms should enable employees to be prudent consumers of health care by fostering patient and employer access to appropriate health care price and quality data while protecting individual privacy and security. Our members recognize the importance of increased price transparency for consumers but believe the biggest impact will come from making data available that self-insured employers can use to improve their networks, increase quality, negotiate lower prices on behalf of their plan participants, and better implement value-based plan designs.
- There is some degree of consensus that employees are suboptimal health care consumers and do little shopping or price comparison for their health care. Engaging employees to be health care consumers along all stages of an individual's health care continuum is a challenge facing all employers. Health care quality and price transparency is a crucial piece of educating employees on the value of health care services.

4 Focus reporting requirements on the correct entities

The *2021 Consolidated Appropriations Act*, mental health parity rules, and Transparency in Coverage rules, while all important efforts, place a significantly higher reporting burden on employers than any other entity in the health care system. Future policy solutions should recognize that employer plans often do not have access to the claims data the current rules and statutes require them to report. Policies should require reporting from the actual entities that directly hold the information rather than compel employer plans to obtain the data from third, fourth or fifth parties down the various health care supply chains.

5 Expand telehealth

During the COVID-19 pandemic, Congress and federal agency guidance provided for increased flexibility regarding telehealth benefits. Current *Affordable Care Act* rules do not allow employers to extend telehealth benefits to several classes of employees including part-time and seasonal employees. Amending the excepted benefit and eligibility classifications under federal law will allow telehealth to be treated like any other add-on benefit and enable employers to continue to provide access to telehealth services for all employees.

6 Modernize health savings accounts (HSAs)

Employers have looked to federal policy to modernize HSAs for many years to mitigate out-of-pocket financial costs for employees. Several key improvements to HSAs would allow HDHPs and HSAs to be paired with direct primary care arrangements; allow an individual to have an HSA even if his or her spouse has a flexible spending account (FSA); and allow employers to offer free or lower cost care to employees under HDHPs. These provisions would help control health care costs for both employers and employees as well as incentivize preventive care. To that end, HR Policy supports the *HSA Improvement Act of 2023* (H.R. 5688) and the *HSA Modernization Act of 2023* (H.R. 5687).

7 Increase access and affordability of behavioral health services

Behavioral health conditions are among the most common health conditions in the U.S. and have a significant impact on an individual's productivity and success in the workplace. Nearly 25% of the nation's workers have depression, and these workers miss twice as much work and have five times as much lost productivity as those without depression.[15] To address the significant access and affordability issues associated with behavioral health services, federal policy should:

- Improve access to in-network behavioral health specialists through increased funding to encourage behavioral health providers to practice in Professional Shortage Areas and require more frequent provider notifications to group health plans or issuers on whether they are accepting new patients.
- Expand screening and monitoring through measurement-based care by establishing incentives with carriers and providers to increase the use of screening and measurement tools.
- Expand integrations of behavioral health care into primary care settings by providing grant funding to provide technical assistance and remove the barriers that primary care practices face when trying to implement integrated models, like the Collaborative Care Model.

Endnotes

1 Health Insurance Coverage in the United States: 2022, Census Bureau, https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf

2 "CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures," CMS.gov, https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures#:~:text=The%20report%20finds%20that,over%20the%20same%20period

3 Survey on health & benefit strategies for 2025, Mercer, https://www.mercer.com/assets/us/en_us/shared-assets/local/attachments/pdf-2024-us-survey-on-health-and-benefits-strategies-for-2025.pdf

4 EBRI 2023 Workplace Wellness Survey, https://www.ebri.org/docs/default-source/wbs/wws-2023/wws-2023_short-report.pdf?sfvrsn=f55f062f_2

5 HR Policy Association CHRO Survey, June 2022 https://www.hrpolicy.org/insight-and-research/resources/2022/hr-workforce/public/09/2022-mid-year-chro-survey-results/

6 HR Policy Association CHRO Survey, February 2020

7 Kaiser Family Foundation. 2023 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/

8 Kaiser Family Foundation. 2023 Employer Health Benefits Survey, https://www.kff.org/report-section/ehbs-2023-summary-of-findings/

9 EBRI 2023 Workplace Wellness Survey, https://www.ebri.org/docs/default-source/wbs/wws-2023/wws-2023_short-report.pdf?sfvrsn=f55f062f_2

10 Commonwealth: https://www.axios.com/2023/10/26/health-care-unaffordable-insurance

11 Gerard F. Anderson, et. al., It's Still The Prices, Stupid, Why The US Spends So Much On Health Care, RAND, October 17, 2019. Also see: PwC Health Research Institute, Medical cost trend: Behind the numbers 2022, 2021; and Audrey Kearney, et. al., Americans' Challenges with Health Care Costs, Kaiser Family Foundation, December 14, 2021

12 Niek Stadhouders, et. al., Effective healthcare cost-containment policies: A systematic review, Health Policy, January 2019

13 Employee Retirement Income Security Act of 1974

14 HR Policy Association CHRO Survey, June 2022, https://www.hrpolicy.org/insight-and-research/resources/2022/hr-workforce/public/09/2022-mid-year-chro-survey-results/

15 https://news.gallup.com/poll/163619/depression-costs-workplaces-billion-absenteeism.aspx#:~:text=who%2C%20at%20some%20point%20in,productivity%20annually%20to%20U.S.%20employers

Series Authors

Timothy J. Bartl
President and CEO
HR Policy Association

Chatrane Birbal
Vice President, Public Policy & Government Relations
HR Policy Association

Wenchao Dong
Senior Director and Leader, HR Policy Global
HR Policy Association

Margaret Faso
Senior Director, Public Policy, HR Policy Association
Executive Director, American Health Policy Institute

Nancy B. Hammer
Vice President, Communications
HR Policy Association

Gregory Hoff
Associate Counsel, Director of Labor & Employment
Law and Policy, HR Policy Association

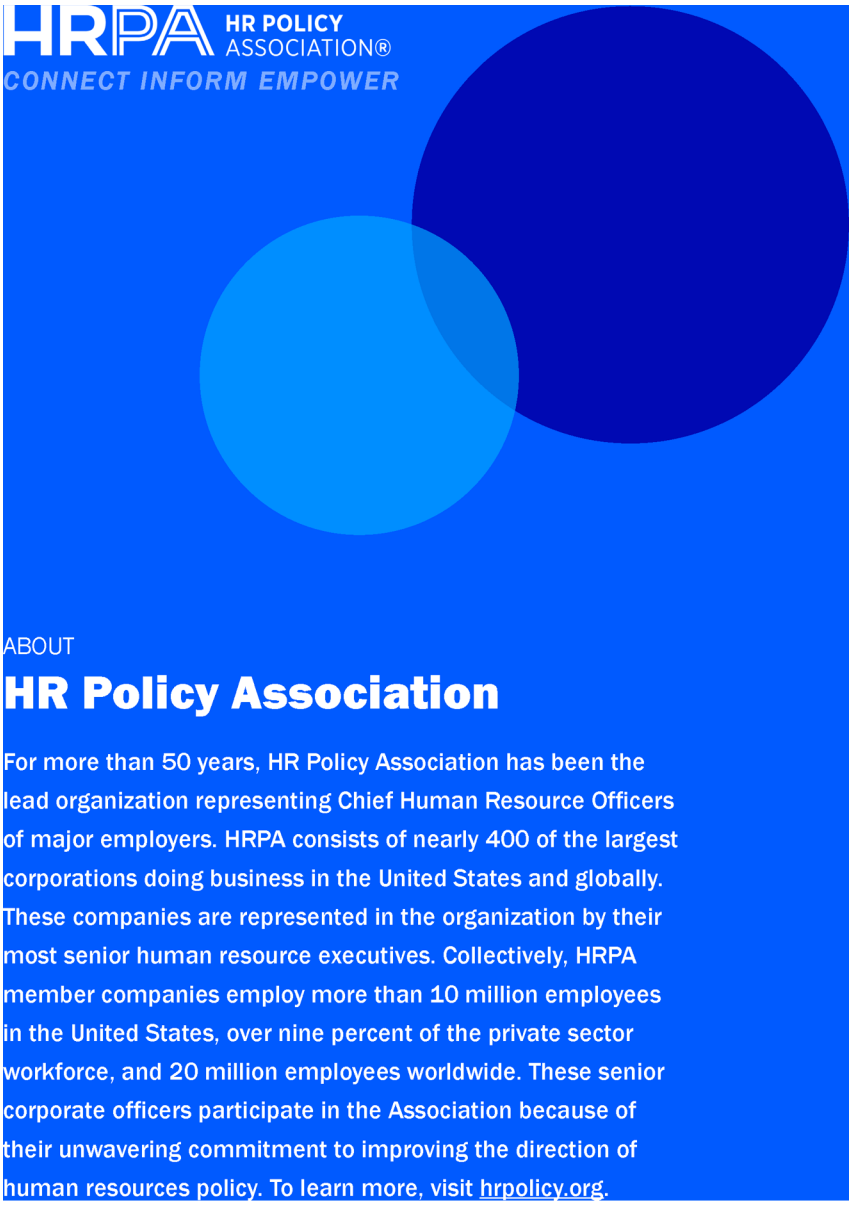
Ani Huang
Senior Executive VP, Chief Content Officer, HR Policy Association
President and CEO, Center On Executive Compensation

Megan Wolf
Director, Practice
HR Policy Association, Center On Executive Compensation

Daniel V. Yager
Senior Advisor, Workplace Policy
HR Policy Association

HRPA's Board of Directors

HRPA


HRPA
HR POLICY
ASSOCIATION®
CONNECT INFORM EMPOWER
ABOUT
HR Policy Association
For more than 50 years, HR Policy Association has been the lead organization representing Chief Human Resource Officers of major employers. HRPA consists of nearly 400 of the largest corporations doing business in the United States and globally. These companies are represented in the organization by their most senior human resource executives. Collectively, HRPA member companies employ more than 10 million employees in the United States, over nine percent of the private sector workforce, and 20 million employees worldwide. These senior corporate officers participate in the Association because of their unwavering commitment to improving the direction of human resources policy. To learn more, visit hrpolicy.org.

April 1, 2025

The Honorable Rick W. Allen
Chair
House Education and Workforce Committee
Subcommittee on Health, Employment, Labor, and Pensions
Washington, DC 20515

The Honorable Mark DeSaulnier
Ranking Member
House Education and Workforce Committee
Subcommittee on Health, Employment, Labor, and Pensions
Washington, DC 20515

Re: ATA Action Statement for the Record in Response to Upcoming Education and Workforce Subcommittee Hearing

On behalf of ATA Action, the advocacy arm of the American Telemedicine Association, we thank you for holding this crucial hearing to explore ways to expand access to affordable employer-sponsored healthcare and support a healthy workforce. Telehealth has become an essential tool in our healthcare system, relied upon by providers, patients, and employers for affordable, efficient, and safe care delivery. ATA Action's top priority is to make permanent the telehealth flexibilities implemented during the COVID-19 pandemic including first dollar coverage of telehealth in high-deductible health plans (HDHP) coupled with health savings accounts (HSAs) and telehealth as an excepted benefit. ATA Action applauds Congress for extending the Medicare telehealth flexibilities and the Acute Hospital Care at Home Program but unfortunately, both telehealth flexibilities for employers have expired leaving millions of Americans without access to virtual care services. We urge Congress to reinstate these flexibilities as soon as possible until a permanent pathway forward is implemented.

First Dollar Coverage of Telehealth in HDHP-HSAs

In 2020, Congress allowed employers to offer employees enrolled in HDHP-HSAs to receive telehealth services pre-deductible. Over 30 million Americans took advantage of this flexibility as it removes the barriers of high deductibles, increases access to convenient and affordable care, encourages preventative health practices, and makes the healthcare experience smoother and more predictable. However, this waiver expired on December 31, 2024, leaving many individuals without the immediate access to telehealth services that had previously been available to them.

In response, ATA Action has called on Congress to reinstate the first-dollar coverage for telehealth in HDHP-HSAs in any upcoming legislative package. The **Telehealth Expansion Act**

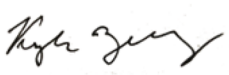
of 2025, introduced by Representatives Jodey Arrington (R-TX) and Susie Lee (D-NV), seeks to make this flexibility permanent, ensuring that individuals with HDHPs and HSAs can continue to receive pre-deductible telehealth services. The bill has received bipartisan support and represents a crucial step toward maintaining and expanding access to telehealth services for millions of Americans. We understand this legislation is not in the Education and Workforce Committee's jurisdiction but want to relay the importance of this employer flexibility that we hope Congress writ large will support to reinstate. See here for a stakeholder letter signed by over 300 organizations urging Congress to act on this provision.

Telehealth as an Excepted Benefit

On June 23, 2020, the Labor, HHS and Treasury Departments jointly issued an FAQ pertaining to the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security Act (CARES) and other health coverage issues. Specifically, it stated that the agencies would take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan for the duration of the PHE. This flexibility was not extended and expired at the end of calendar year 2023. Therefore, ATA Action urges the Committee to prioritize action on this issue and swiftly work alongside the rest of your colleagues to reinstate this policy immediately. Given the tremendous support for telehealth services, reinstating this policy would restore access to convenient and affordable healthcare options for individuals who need them most, while reducing the strain on both the healthcare system and individuals' financial burdens.

Thank you for your work on these important issues. We look forward to working with the Committee to ensure the appropriate telehealth policies are implemented and reinstated that will increase access to affordable and safe healthcare services. ATA Action is here as a resource and would be happy to answer any questions.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR THE RECORD BY

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE (P4ESC)

TO THE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND THE WORKFORCE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

"A HEALTHY WORKFORCE: EXPANDING ACCESS AND AFFORDABILTY IN EMPLOYER-SPONSORED HEALTH CARE"

April 2, 2025

Chairman Allen, Ranking Member DeSaulnier, and Members of the Subcommittee, thank you for the opportunity to submit a statement on the record on behalf of the Partnership for Employer-Sponsored Coverage (P4ESC) for the hearing entitled "*A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care.*" We commend the subcommittee's focus on this topic. We look forward to working with you to help build progress toward these shared goals.

P4ESC is a nonpartisan advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and sectors, and the millions of Americans and their families who rely on employer-sponsored coverage every day. Employer-sponsored health insurance is the single largest source of coverage in our nation.

Employer-sponsored coverage has been the backbone of our nation's health system for more than eighty years. Businesses of all sizes contribute vast financial, administrative, and other resources to employees and their families through the employer-sponsored system and have a vested interest in health care quality, value, and system viability.

Moreover, employer-sponsored group coverage holds a distinct advantage over coverage sold in the individual market. Workplace-based coverage groups together employees without regard to their health status. These pools tend to be more stable over time and more predictable leading to lower premium trends than other pooling arrangements. Controlled entry and exit from the plan,

employer contributions, and the ability of younger healthier employees to offset the cost of older or less healthy employees helps keep coverage more affordable across the entire workforce.

We urge Congress to find ways to strengthen employer-sponsored coverage rather than to search for alternatives to it. To that end, P4ESC urges your attention to the following principles that are important to ensure that employment-based coverage thrives into the future:

- Uphold the current tax treatment of employer-sponsored coverage
- Preserve ERISA preemption – the vital backbone of employer-sponsored coverage
- Address rising medical costs and market dysfunctions to help keep care and coverage more affordable

Uphold the tax treatment of employer-sponsored coverage

The Federal Tax Code has long favored employer-sponsored coverage. The value of coverage provided to employees and their dependents is not recognized as income to the employee. This tax code preference has been challenged by some policy makers interested in funding other priorities or shifting our health care system to an individual-based system. P4ESC strongly cautions Congress not to disrupt what has worked so well through the years.

The exponential growth in our nation's employment-based health coverage system can be traced back to a cap on wages initiated during World War II to help stifle inflation. Employers began offering fringe benefits – such as health insurance – to offset the limit on wages and attract employees. This approach has supported coverage for more than 80 years. The direct benefits and federal spending offsets of employer-provided coverage result in an annual net social impact of $1.5 trillion, driven by increased labor participation, business formation, increased health coverage, and reduced federal health subsidies[1]. Each dollar of federal expenditure – the tax revenue foregone for employer-provided coverage – yields approximately $5.34 in benefits for covered employees and their families[2].

Policymakers and regulators will face great difficulty in constructing a cap on the tax exclusion. A cap approach based on a regionally adjusted national average would not work for larger groups which are almost universally experience-rated. Some of the larger groups have older or less healthy employees with higher rates of utilization, and consequently, more expensive plans. Smaller employers with older employees with higher utilization might also be disproportionately affected. A cap would hit employees covered by these plans more harshly than others. All

---

[1] National Bureau of Economic Research working papers https://www.nber.org/system/files/working_papers/w28590/w28590.pdf
[2] Joint Committee on Taxation's Estimates of Federal Tax Expenditures For Fiscal Years 2019-2023; The Bureau of Economic Analysis' National Income and Product Accounts (Table 6.11).

employers and employees would see their FICA contributions increase with higher recognized wages due to a cap on the tax exclusion.

Taxing health insurance benefits is not just impractical, it is unjust. Employees are already shouldering substantial tax burdens. Taxing their health insurance as income would further burden employees, effectively amounting to a new and unappreciated tax hike.

Preserve ERISA Preemption

The *Employee Retirement Income Security Act (ERISA)* was enacted in 1974 to encourage voluntary employee benefit plans (particularly retirement and health benefits) and to promote uniformity in these plans across state boundaries. ERISA preempts the application of state laws that "relate to" these employer-sponsored plans. ERISA does not preempt the states from regulating health insurers or health insurance products. ERISA also does not preempt state laws of general applicability, such as taxes. In its 50-year history, ERISA has worked well and effectively to the benefit of employees and employers. ERISA is the foundation of employer-based coverage. P4ESC commends both this Subcommittee as well as the full Committee for their bipartisan stewardship of ERISA.

Multistate employers seek to build an equitable workplace culture by providing uniform and affordable benefits to their employees regardless of where they live. Employers also want to be able to administer these benefits in an efficient, consistent manner. Uniform design and administration of benefits promotes substantial efficiencies and significantly reduces health care costs for employees and employer plan sponsors.

P4ESC urges Congress to ensure that ERISA's preemption principle remains strong and intact, particularly given the growing number of state laws in recent years that challenge ERISA preemption. Congress must stand firm against these state inroads against ERISA preemption.

Address the Rising Cost of Health Care

Health care costs are simply out of control. The United States spent $4.5 trillion on health care in 2022, fully 17.3 percent of our national gross domestic product. Hospitals routinely charge employer plans more than two-and-one-half times what Medicare pays[3]. Employers of all sizes long have been concerned by increases in the cost of medical care, not fully explained by population growth and population aging[4]. Small business owners have cited this as a leading

[3] Rand, May 13, 2024. https://bit.ly/4bUf0I6
[4] Peter G. Peterson Foundation, 2023, Why are Americans Paying More for Healthcare?, https://www.pgpf.org/blog/2024/01/why-are-americans-paying-more-for-healthcare

challenge for more than 30 years[5]. Greater congressional and regulatory oversight of high health care costs and the failing market for medical care is long overdue.

According to the Centers for Medicare and Medicaid Services (CMS), health care spending can be broken down into 10 categories[6] (hospital care 31%, physician services 20%, prescription drugs 10%, other personal healthcare costs 5%, dental services 4%, home healthcare 3%, other professional services 3%, other non-durable medical products 2%, durable medical equipment 2%). Significantly, the top three categories (hospital care, physician services, and prescription drugs) account for more than 60 percent of total health care spending. No other category of spending tops five percent.

Additionally, P4ESC and businesses of all sizes long have been concerned by health sector consolidation. P4ESC strongly supports transparency across the health care system and congressional oversight over hospital and physician practice consolidation. This would include greater price transparency across all stakeholders, including pharmacy benefit managers (PBMs), health plans, and hospitals. P4ESC also supports uniform application of site neutral payment policies and honest billing requirements to deter location-based gaming of coverage. P4ESC has actively opposed benefit mandates and regulatory proposals that would add cost or costly complexity to benefit administration.

Conclusion

P4ESC is the leading defender of employer-based coverage. We are especially vigilant against the three biggest threats to employer-sponsored coverage: threats to the tax treatment of employer-sponsored coverage; threats to ERISA uniformity; and the rising cost of health care and benefits. We respectfully ask that lawmakers consider the effect on employer-sponsored coverage as they consider health care legislation.

Employers have a significant stake in developing and implementing health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout the 119th Congress. If you or your staff would like to meet with members of P4ESC, please contact P4ESC's Executive Director Neil Trautwein[7].

---

[5] National Federation of Independent Business, www.nfib.org.
[6] CMS, https://www.cms.gov/files/document/highlights.pdf
[7] Neil Trautwein, neil@trautweinstrategies.com, (703) 517-3692

STATEMENT FOR THE RECORD

SUBMITTED TO THE

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

Hearing on A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care

April 2, 2025

SUBMITTED BY THE

The Coalition to Protect and Promote Association Health Plans

I. *Overview*

The Coalition to Protect and Promote Association Health Plans (the "AHP Coalition") respectfully submits this Statement for the Record.

Ever since its formation in August 2018, the AHP Coalition has been working tirelessly to correct-the-record.[1] Specifically, contrary to what critics are saying, Association Health Plans ("AHPs") are ***not*** an "end-run around" the Affordable Care Act ("ACA"). Quite to the opposite. AHPs that offer major medical health coverage are currently offering ***better coverage*** than ACA-compliant "small group" and "individual" market plans.

How do they do that?

AHPs are ***voluntarily covering all ten of the ACA's "essential health benefits" (EHBs)***, including pediatric major medical coverage. AHPs also cover pediatric dental and vision services either through their AHP insurance contract or through a stand-alone product. In addition, AHPs offer ***broader health care provider networks*** relative to many existing ACA "small group" and "individual" market plans.

AHPs are also ***priced at an "actuarially fair premium"*** for both young and old AHP participants. Doing so encourages more young and healthy individuals to enroll in AHP health coverage, which in turn benefits older and less healthy AHP participants by increasing the size of – and balancing out – the risk pool.

AHPs are also subject to the specific rules under the Affordable Care Act ("ACA"), the Employee Retirement Income Security Act ("ERISA"), and the Health Insurance Portability and Accountability Act ("HIPAA") that prevent these arrangements from discriminating against individuals/employees based on a health condition. Most importantly, AHPs are ***prohibited from denying people coverage if they have a pre-existing condition***.

To date, at least 37 States allow small employers in the ***same industry*** to establish an AHP that is regulated like a "large employer health plan."[2] In addition, at least 30 States have signaled that they want to allow AHPs to (1) cover small employers in ***different industries*** and (2) cover ***self-employed individuals with no employees***.[3] Note, 13 States currently do not allow employers in the ***same industry*** to establish an AHP that is regulated like a large employer plan,[4] while other States prohibit self-insured AHPs from operating in their State.[5]

---

[1] *See* Amicus Brief submitted by The Coalition to Protect and Promote Association Health Plans to the Court of Appeals for the District of Columbia Circuit at https://www.thepowerofa.org/wp-content/uploads/2019/06/Amicus-Brief-The-Coalition-to-Protect-and-Promote-Association-Health-Plans-and-AssociationHealthPlans.com_.pdf.

[2] These States include: AL, AK, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NC, ND, OH, OK, OR, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY.

[3] *See* Bloomberg Tax, Tax Management Compensation Planning Journal, *Association Health Plans (AHPs) and States' Rights: An Accounting of How States Want to Regulate AHPs,* Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

[4] These States include: CA, CT, DE, ID, MD, MA, NH, NJ, NM, NY, PA, RI, VT.

[5] For example, CA and WA refuse to grant a self-insured AHP a "license" to operate in their States.

II. AHPs Do Not Offer "Skinny Coverage"

Opponents of AHPs continually say that AHPs are "junk plans" or AHPs offer "skinny coverage." Even the Department of Labor ("DOL") under the Biden Administration adopted this refrain, asserting that AHPs offer "skinny coverage" because AHPs are not subject to the Affordable Care Act's ("ACA's") "essential health benefits" ("EHB") requirement.[6]

Contrary to these assertions, there is ample evidence that AHPs do ***NOT*** offer "skinny coverage." Rather, AHPs offer coverage that is ***equally*** – and in some cases ***more comprehensive*** – than ACA "individual" and "small group" market plans.[7]

How do AHPs do this:

- They voluntarily cover the ACA's EHBs.
- They offer broader provider networks relative to ACA "individual" and "small group" market plans.
- They offer lower deductibles relative to ACA "individual" and "small group" market plans for coverage that is equal to – if not better than – ACA plans.

A. AHPs Voluntarily Cover the ACA's EHBs

With respect to EHB coverage, AHPs – just like large employer- and union-sponsored health plans – are voluntarily covering the ACA's EHBs. Why? To meet employee demand and to attract and retain talented workers.

More specifically, regardless of whether an employer is large or small – and regardless of whether an employer is offering their own single-health plan or offering health coverage through an AHP – the employer chooses to offer health benefits to attract and retain talented workers. Why? Because both large and small employers recognize the need to offer comprehensive health coverage as an employee benefit, especially in a tight labor market.

How do AHPs voluntarily cover the EHBs?

In some cases, fully-insured and self-insured AHPs cover all ten EHBs – including coverage for pediatric dental and vision care – in the AHP insurance contract or self-insured health plan itself. In most other cases, however, a fully-insured or self-insured AHP will cover all ten EHBs, while covering pediatric dental and vision care through stand-alone products. In ***both*** cases, ***all*** ten of the EHBs are covered.

---

[6] *See* 88 Fed. Reg. 87981, 87974 (Dec. 20, 2023).

[7] *See* Office of Management and Budget, EO 12866 Meeting 1210-AC16, S*ubmission by the Coalition to Protect and Promote Association Health Plans*, Oct. 2, 2023 at https://www.reginfo.gov/public/do/viewEO12866Meeting?viewRule=true&rin=1210-AC16&meetingId=223574&acronym=1210-DOL/EBSA.

It is important to note that those AHPs that cover pediatric dental and vision care through stand-alone products choose to do so because the Board governing the AHP determined that pediatric dental and vision benefits can be provided through a stand-alone product at a lower cost, while providing the same – if not a better – level coverage than if these services were offered through the insurance contract or self-insured plan itself.

It is also important to point out that the "control test" applicable to an association establishing an AHP imposes a fiduciary duty on the Board governing the AHP,[8] requiring the Board to "act in the best interest" of the AHP participants, while also keeping plan costs low.[9] The requirement to adhere to these fiduciary duties drives the Board's decision to cover pediatric dental and vision care through stand-alone products because the coverage is (1) just as – if not more – comprehensive than the type of coverage that can be offered through the insurance contract or plan itself (thus, acting in the best interest of plan participants) and (2) less costly than the type of coverage that can be offered through the insurance contract or plan itself (thereby keeping plan costs low for participants).

B. AHPs Have Broader Provider Networks Than ACA "Individual" and "Small Group" Market Plans

Another litmus test for "skinny coverage" is the health plan's provider network.

It is well-established that ACA "individual" and "small group" market plans primarily have "narrow networks."[10] In fact, the Congressional Budget Office ("CBO") has explained that "individual" market plans generally have narrower provider networks than employment-based plans.[11]

AHPs – which are employment-based plans that offer the same type of coverage offered by large employers and unions – have broad provider networks which, unlike ACA "individual" and "small group" market plans, does not force participants to drive hours to and from a physician's office or a hospital that is in-network to receive medical treatment or to even get a routine medical check-up. Although the Biden Administration has undertaken efforts to strengthen the ACA's "individual" market "network adequacy" rules,[12] the provider networks for ACA "individual" and "small group" market plans pale in comparison to the breadth of employer-based health plan provider networks offered through an AHP.

---

[8] The Department of Labor ("DOL") developed the "control test" through decades worth of Advisory Opinions, providing that to be considered a "bona fide group or association of employers" – and thus, an "employer" under Employee Retirement Income Security Act ("ERISA") section 3(5) – the employer members of the group participating in the AHP must control the functions and operations of the AHP through a governing Board. Such control must be present in both form and substance [*see, e.g.*, DOL Adv. Op. 2012-04A (May 25, 2012), DOL Adv. Op. 2005-25A (Dec. 30, 2005), DOL Adv. Op. 96-25A (Oct. 31, 1996)].

[9] The Board governing an AHP is considered a fiduciary under ERISA, and as a fiduciary, the Board is required to (1) act for the exclusive purpose of providing benefits to plan participants and (2) defray the reasonable expense of administering the plan [*see* ERISA sections 3(21) and 404(a)(1)(A)].

[10] *See* Avalere Health, *Plans With More Restrictive Networks Comprise 73% of Exchange Market,* Nov. 30, 2017 *at* https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

[11] Congressional Budget Office, *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, April 2021, page 7-8 at https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.

[12] *See* Notice of Benefit and Payment Parameters for 2024 at https://www.govinfo.gov/content/pkg/FR-2023-04-27/pdf/2023-08368.pdf.

C. AHPs Offer Lower Deductibles Compared ACA "Individual" and "Small Group" Market Plans

AHP opponents – and even the Biden Administration's DOL – suggest that AHPs "underinsure" plan participants.[13] However, when it comes to making claims that a particular type of health plan "underinsures" participants, these critics and the DOL *need to look no further* than ACA "individual" and "small group" market plans.

For example, although ACA "individual" market plans are heavily subsidized by the Federal government (such that monthly premium payments for ACA "individual" market plans may only amount to $10 per month for particular policyholders),[14] ACA "individual" market plans have extremely high deductibles that must be met before any policyholder can even begin enjoying their health plan's coverage.

Let's look at the facts: The deductible for a "bronze" level plan – which, according the ACA, is allowed to have the highest deductible – averaged $7,258 for single coverage and about $15,000 for family coverage for the 2024 plan year.[15] The most popular "individual" market plan (a "silver" level plan, which is the benchmark plan for determining the value of the premium subsidy) had an average deductible of $5,241 for single coverage and about $11,000 for family coverage for the 2024 plan year.[16]

This means that while it may be affordable for a family of four to ***purchase*** a subsidized ACA "individual" market plan (because premiums are low…around $10 per month for certain families), this family must spend $11,000 to $15,000 out their own income ***BEFORE*** any insurance coverage begins. That is ***the definition of*** being underinsured.

AHPs – which, as stated, are employment-based plans that offer the same type of coverage offered by large employers and unions – offer health plans that range from a relatively low deductible plan of about $1,000 for single and $2,000 for family coverage to a High-Deductible Health Plan ("HDHP") with deductibles ranging from $2,500-$5,000 for single coverage and $4,000-$8,000 for family coverage.

Based on this fact alone, AHP coverage is better coverage than ACA "individual" market plans. Add in the fact that AHPs voluntarily cover the EHBs and offer broader provider networks (as discussed above), AHPs provide comprehensive coverage that is ***superior*** to ACA "individual" market plans.

Similarly, the average deductible for a "small group" market plan was $2,757 for single and $7,000 for family coverage for the 2024 plan year, while the average deductible for a "large group" market plan – which AHPs are – was $1,787 for single coverage and about $5,000 for family coverage in 2024.[17] This is merely additional verifiable evidence illustrating that AHPs provide comprehensive coverage that is ***superior*** to ACA "small group" market plans.

---

[13] 88 Fed. Reg. at 87974-75 (Dec. 20, 2023).
[14] *See* Centers for Medicare & Medicaid Services ("CMS") Newsroom, *American Rescue Plan and the Marketplace*, March 12, 2021, explaining that "four out of five enrollees [in a subsidized 'individual' market plan] will be able to find a plan for $10 or less [per] month after premium tax credits, and over 50% will be able to find a Silver plan for $10 or less."
[15] *See* Kaiser Family Foundation, *Deductibles in ACA Marketplace Plans*, Dec. 22, 2023 at https://www.kff.org/private-insurance/issue-brief/deductibles-in-aca-marketplace-plans/.
[16] *Id.*
[17] *See* Kaiser Family Foundation, *2024 Employer Health Benefits Survey*, Oct. 9, 2024 at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey-Summary-of-Findings.pdf.

Based on the foregoing, it is also reasonable to ask the following question: Even in cases where a health plan covers the ACA's EHBs, if a planholder is required to pay $11,000 or more out-of-their-own-pocket ***before any coverage of the EHBs even begins***, isn't that by definition "skinny coverage"? So it stands to reason that while ACA "individual" and "small group" market plans cover the EHBs, ACA "individual" and "small group" market plan offer "skinny coverage," unlike AHPs that are voluntarily covering the EHBs while also offering lower deductibles for such coverage.

III. AHPs Are Required to Protect People With Pre-Existing Conditions

Some critics of AHPs go so far as to say that AHPs can discriminate against people with pre-existing conditions. This assertion is ***patently FALSE***.

AHPs – as a "group health plan" under the law[18] – ***CANNOT*** deny coverage for people with a pre-existing condition.

More specifically, and as discussed more fully below, the ACA's "group health plan coverage requirements" apply to AHPs.[19] Chief among these "group health plan coverage requirements" is the prohibition against denying coverage for a person with a pre-existing condition.[20]

It is also important to point out that virtually all States that allow AHPs to operate include a State law requirement that ***prohibits*** an association sponsoring an AHP from refusing to allow an employee (or their dependent) to participate in the AHP because of a health condition (i.e., a pre-existing condition).[21]

In addition, according to State law, an association sponsoring an AHP ***cannot*** condition membership in the group on any health-status related factor relating to any individual.[22] This means that AHPs ***CANNOT*** prevent people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.

IV. AHPs Are Subject to Robust Consumer Protections and Coverage Requirements

A. AHPs Are Subject to the ACA's "Group Health Plan Coverage Requirements"

As discussed above, AHPs – as a "group health plan" – ***are*** subject to the ACA's "group health plan coverage requirements,"[23] which means that a fully-insured ***and*** self-insured AHP ***must***:

---

[18] ERISA section 733(a)(1) and Public Health Service Act ("PHSA") section 2791(a)(1) provide that a "group health plan" is 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.

[19] ERISA section 715 incorporates by reference the ACA's coverage requirements applicable to a "group health plan" into ERISA.

[20] *See* PHSA section 2704. As stated, PHSA section 2704 is incorporated by reference into ERISA through ERISA section 715 and thus is applicable to "group health plans," including AHPs.

[21] *See, e.g.*, Virginia Insurance Code section 38.2-3521.1.E.1.f.

[22] *See, e.g.*, Virginia Insurance Code section 38.2-3521.1.E.1.e.

[23] As stated above, ERISA section 715 incorporates by reference the ACA's "group health plan coverage requirements" into ERISA.

- Eliminate all pre-existing condition exclusions for all plan participants.[24]
- Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan.[25]
- Provide coverage for certain preventive health services with no cost-sharing.[26]
- Cover "adult children" up to age 26.[27]
- Stop rescinding coverage absent fraud or misrepresentation.[28]
- Include new internal and external appeals processes (and provide notice).[29]
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.[30]
- Provide direct access to emergency services.[31]
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.[32]
- 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.[33]
- Eliminate waiting periods that exceed 90 days.[34]
- Cover the cost of clinical trial participation.[35]
- Provide participants with a summary of benefits and coverage.[36]
- Provide annual reports describing the plan's quality-of-care provisions.[37]

B. AHPs are Subject to the Consumer Protections Under ERISA, HIPAA, and COBRA

Under ERISA, there are specific notice and disclosure requirements that a fully-insured and self-insured AHP must comply with.[38] In addition, ERISA's fiduciary responsibilities apply, requiring the Board governing the AHP and, if applicable, service providers to the AHP, to act in the best interest of the plan participants.[39] AHP plan participants have a private right of action to sue the AHP, the Board, and any other fiduciaries if there is wrong-doing,[40] and there are detailed procedures for filing health claims.[41]

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,[42] and according to HIPAA, premiums for an AHP participant ***cannot*** be developed based on the participant's health condition and a participant's individually identifiable health information *must* be protected.[43]

---

[24] *See* PHSA section 2704.
[25] *See* PHSA section 2711.
[26] *See* PHSA section 2713.
[27] *See* PHSA section 2714.
[28] *See* PHSA section 2712.
[29] *See* PHSA section 2719.
[30] *Id.*
[31] *See* PHSA section 2719A.
[32] *See* PHSA section 2705.
[33] *See* PHSA section 2707(b).
[34] *See* PHSA section 2708.
[35] *See* PHSA section 2709.
[36] *See* PHSA section 2715.
[37] *See* PHSA section 2717.
[38] ERISA, Title I, Subtitle B Part 1.
[39] ERISA, Title I, Subtitle B Part 4; *see also*, ERISA section 404(a).
[40] ERISA section 502.
[41] ERISA section 503.
[42] ERISA, Title I, Subtitle B Part 6.
[43] ERISA section 702.

C. State Benefit Mandates Apply to Fully-Insured "Large Group" AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured "large group" AHP is subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured "large group" plans in most States are as good as the ACA's EHBs. Even in States where their benefit mandates may not cover all of the ten medical services that make up the EHB requirement, the drafters of the ACA observed that most if not all fully-insured "large group" plans cover the EHBs, which is why Congress chose to exempt fully-insured "large group plans" from the EHB requirement entirely.

D. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a "multiple employer welfare arrangement" ("MEWA").[44] In the case of a self-insured MEWA, Congress (back in 1983) specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.[45] Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

V. AHPs Will Not Segment the Insurance Markets

A. AHPs Will Draw High-Medical Utilizers Out of the Existing Markets

Opponents of AHPs suggest that if AHPs are allowed to cover employees of industry-based and non-industry-based small employers and/or self-employed individuals with no employees then this will destabilize the "individual" and "small group" markets.[46] However, there is ***no*** verifiable data justifying this claim. Only theoretical assumptions that have never been corroborated.

For example, AHPs that cover employees of industry-based small employers have been operating for decades now. And never – not once – has there been a study indicating that these industry-based AHPs have adversely affected the insurance markets.

It is true that some reports have identified issues relating to insolvencies and plan mis-management with respect to self-insured MEWAs that occurred decades ago. But, none of those reports ever claimed or illustrated that these self-insured MEWAs have ever adversely affected the insurance markets. More importantly, none of those reports ever claimed or illustrated that fully-insured AHPs ever adversely affected the insurance markets.

---

[44] *See* ERISA section 3(40).
[45] *See* ERISA section 514(b)(6)(A)(ii).
[46] 88 Fed. Reg. at 87974 (Dec. 20, 2023).

As described above, AHPs have – and will continue to – offer comprehensive coverage. And, in most cases, such comprehensive coverage will be offered at a lower cost relative to the "individual" and "small group" market plans. Based on these facts, we believe that in cases where AHP coverage is offered to employees of industry-based or non-industry-based employees and/or self-employed individuals with no employees such offers will actually ***help stabilize*** the "individual" and "small group" markets, or at a minimum, AHPs will have ***no*** substantive impact on the existing insurance markets.

More specifically, it is well-established that employees and individuals shop for health insurance based on price, as well as the comprehensiveness of the health coverage. The health status of a particular employee or individual also drives their behavior.

In cases where an employee or individual is healthy, they will most likely gravitate toward health coverage with a lower cost, although the comprehensiveness of coverage is important even to healthier employees and individuals. If, however, an employee or individual is less healthy (and thus a "high-medical utilizer"), they are more likely to seek out comprehensive coverage, although price remains an important factor as well.

As stated, AHPs offer comprehensive coverage at a lower cost relative to ACA "individual" and "small group" market plans. As a result, healthy employees and individuals will gravitate toward AHPs based on their cost, but also comprehensiveness. Also, less-healthy/high-medical utilizers will gravitate toward AHPs based on their comprehensiveness, and also lower cost.

The end result, ***both*** healthy people ***and*** less healthy/high-medical utilizers are going to be attracted to AHP coverage. And, this will result in less healthy/high-medical utilizers exiting the "individual" and "small group" markets to enroll in an AHP (because such plans offer comprehensive benefits at a lower cost), which means that the availability of AHP coverage will actually ***benefit*** the "individual" and "small group" markets from a health risk perspective – or at a minimum, AHPs will have ***no*** substantive impact on the existing insurance markets – by drawing less healthy/high-medical utilizers out of the current risk pool.

B. If "Lives" Are Not In the Risk Pool In the First Place, Markets Cannot Be Impacted

Predictions of market destabilization are not just theoretical, they are also incomplete because they fail to account for the number of employees and individuals who are currently ***not*** covered by any form or health insurance. If, for example, these uninsured employees and individuals enroll in an AHP, the current ACA insurance markets will ***not*** be affected because these "lives" were ***never*** in the risk pools in the first place.

It is important to point out that since the enactment of the ACA, health coverage offered by small employers with fewer than 50 employees has declined by roughly 20 percent.[47] Only about 50 percent of small employers with fewer than 50 employees actually offer health coverage today, as compared to 99 percent of large employers.[48] If small employers who are not currently offering health insurance coverage to their employees are attracted to AHPs (because AHPs offer comprehensive coverage at lower prices), their enrollment in AHPs will ***not*** – by definition – impact the existing "small group" market because the employees of these small employers are ***not*** a part of the ACA's market in the first place.

---

[47] *See* Kaiser Family Foundation, *Employer Health Benefits: 2022 Annual Survey*, Oct. 27, 2022 at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.
[48] *Id.*

Same is true for the "individual" market. While a record number of individuals have enrolled in a subsidized "individual" market plan through an ACA Exchange for the 2024 plan year, there are still millions of individuals who have opted against enrolling in an "individual" market Exchange plan for personal and/or financial reasons. If these uninsured individuals enroll in an AHP, the existing "individual" market will ***not*** be impacted because these individuals were ***never*** a part of the risk pool.

C. Generous Premium Subsidies Drive Behavior

Related to whether AHPs will adversely affect the "individual" market, one must also take into account the financial incentives available to, for example, self-employed individuals who are eligible for a premium subsidy relative to self-employed individuals who may choose to purchase AHP coverage out-of-their-own-pocket.

More specifically, AHP coverage is not subsidized for a self-employed individual. It is true that a self-employed individual is eligible to take an above-the-line deduction for the premium costs associated with AHP coverage,[49] but in the vast majority of cases, the tax benefit flowing from the above-the-line deduction will be much less than any premium subsidy a self-employed individual may be entitled to access, especially in, for example, 2024 and 2025 when (1) the premium subsidies are available to any individual irrespective of their income and (2) the value of the premium subsidy is higher than pre-2020 law.

The reality is this: If it is not in a self-employed individual's best financial interest to purchase coverage through an AHP – because, for example, this self-employed individual may be eligible for a generous premium subsidy that covers much of the premium cost of an "individual" market Exchange plan – this self-employed individual is *not* going to exit the "individual" market. This is a behavioral response that even the Biden Administration's DOL recognized.[50]

However, there may be instances where a self-employed individual does not find the premium subsidy to be meaningful (because, for example, this self-employed individual is a high-income earner). Here, this self-employed individual may indeed exit the "individual" market for AHP coverage.

There may also be non-financial reasons that account for why a self-employed individual may opt against purchasing a subsidized "individual" market Exchange plan (e.g., the individual is not comfortable with the very high deductible associated with the benchmark-"silver" plan).

In these instances, the self-employed individual should have the freedom and the flexibility to enroll in an AHP. Forcing self-employed individuals into the "individual" market is not only arbitrary, it is inequitable. ***Individuals should have the right to choose***.

Most importantly, even if certain self-employed individuals (like the ones discussed above) exit the "individual" market for superior AHP coverage, this does not – in and of itself – mean that the existing market will be adversely affected. As stated, AHP coverage will be equally attractive to ***both*** healthy self-employed individuals ***and*** self-employed individuals who are high-medical utilizers. As a result, even if healthy self-employed individuals may exit the "individual market," less healthy/high medical-utilizers will ***also*** exit the individual market, thus having a positive impact on the existing risk pool.

---

[49] *See* Section 162(l) of the Internal Revenue Code ("Code").
[50] *See* 88 Fed. Reg. at 87974 (Dec. 20, 2023).

VI. Congress Must Pass Chairman Walberg's Association Health Plan Act

Chairman Walberg has introduced the Association Health Plan Act which sets forth a legal framework that would allow employees of small employers and self-employed individuals with no employees to access the same type of health coverage offered by large employers and unions. The Association Health Plan Act increases access for these employees and self-employed individuals without lessening restrictions on the formation of AHPs. For example, relative to regulations relating to AHP issued by the DOL in 2018,[51] the Association Health Plan Act strengthens restrictions on the formation of AHPs, while also ensuring that AHPs offer affordable and comprehensive coverage.

The following provides a detailed explanation of the various requirements set forth under the Association Health Plan Act, along with justifications as to why these requirements should be passed by Congress and signed into law by the President.

A. Industry-Based and Non-Industry-Based Associations That Meet Certain Conditions Can Establish a Fully-Insured "Large Group" AHP or Self-Insured Plan AHP

Chairman Walberg's Association Health Plan Act (hereinafter referred to as "the Act") would confirm in Federal statute that ***both*** industry-based ***and*** non-industry-based associations that meet certain conditions can establish (1) a fully-insured "large group" AHP or (2) a self-insured AHP that would be considered a "Plan MEWA" (hereinafter referred to as a "self-insured Plan AHP"). Importantly, the Act does ***NOT*** preempt State law in any way, shape, or form.[52]

The conditions that must be met before an industry-based or non-industry-based association can establish (1) a fully-insured "large group" AHP or (1) a self-insured Plan AHP include a "control test," which mirrors the "control test" developed by the DOL through decades of Advisory Opinions, which is a key ingredient to being considered an "employer" under ERISA section 3(5). In addition, the Act maintains the "business purpose standard," requiring the association to have been organized and maintained in good faith for purposes other than that providing health coverage.

The Act also includes the State law requirements discussed in Section III above, namely (1) that an association establishing an AHP is prohibited from conditioning membership in the association on any health-status related factor relating to any individual ***AND*** (2) the AHP must make coverage available to all employer members (including self-employed individuals) of the association regardless of any health status-related factor relating to the employer members' employees or dependents. In other words, an AHP ***CANNOT*** discourage people with pre-existing conditions, or those who are otherwise anticipated to have higher health care costs, from joining AHPs.

There are also a number of conditions that are currently set forth in State law governing the types of associations that can permissibly operate an AHP in the State so as to be consistent with State law consumer protections.

---

[51] *See* Definition of Employer Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018).
[52] For example, if a State does not want to follow a portion – or all – of the Act's framework, a State is permitted to enact its own State law on the matter.

- ***Justification for Codifying These Conditions In Federal Statute***

Satisfying These Conditions Produces a True Employee Benefit Plan, Not a Commercial Insurance-Type Arrangement

- The conditions set forth in the Act that must be satisfied ***before*** an industry-based or non-industry-based association can establish an AHP is proof that the established AHP is a true employee benefit plan that is the product of a genuine employment relationship. In other words, AHPs established by associations that satisfy ALL of these conditions are ***not*** artificial structures marketed as employee benefit plans, and they are ***not*** commercial insurance-type arrangements, but instead, are true employee benefit plans.

The Act's Conditions Are Consistent With State Law Consumer Protections

- The conditions set forth in the Act are designed to be consistent with the applicable insurance regulations that State insurance regulators are familiar with and enforce every day. These conditions are narrowly tailored and place the appropriate guardrails around what types of associations can establish an AHP, which ensures that those associations that satisfy ALL of these conditions do *not* have some hidden objective of attempting to sidestep otherwise applicable insurance regulations or misdirect State insurance regulators. The Act's conditions prevent such bad actors from entering the market.

B. Aggregation Rule

According to the Act, if an industry-based or non-industry-based association satisfies ALL of the conditions discussed above, ALL of the employees (including self-employed individuals) of ALL of the employer members (including self-employed individuals) of this association shall be aggregated and counted together for purposes of determining whether this aggregated group includes 51 or more employees. In cases where an industry-based or non-industry-based association includes at least 51 employees, this group will be considered a "large employer" that is sponsoring a "large group" health plan under the ACA, and thus, States shall regulate this fully-insured AHP as a "large group" plan, unless a State enacts a State law providing otherwise (again, the Act does ***not*** preempt State law).

- ***Justification for Codifying the Aggregation Rule In Federal Statute***

This Will Confirm That Associations Can Offer "Large Group" Health Plan Coverage

- Codifying this aggregation rule in Federal statute is paramount on account of CMS's "look-through rule," which ever since 2011, has governed whether a fully-insured AHP can be considered a fully-insured "large group" plan.[53] Currently, CMS's "look-through" rule is merely memorialized in sub-regulatory guidance (i.e., a CMS Insurance Standards Bulletin). Codifying this aggregation rule in Federal statute is necessary to ensure legal certainty for State insurance regulators, Federal regulators, and stakeholders on both sides of the AHP issue, including associations interested in establishing a fully-insured "large group" AHP and opponents of AHPs that continue to advance inaccurate claims on how AHPs are regulated under the law.

---

[53] *See* CMS Insurance Standards Bulletin, Sept. 1, 2011 at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

- It is important to note that "large group" AHPs are ***not*** less regulated health plans, as many AHP opponents contend. As discussed in Section IV above, fully-insured "large group" AHPs are not only subject to the ACA's "group health plan coverage requirements," ERISA, COBRA, HIPAA, and other Federal laws such as the Women's Health and Cancer Rights Act, and the Newborns' and Mothers' Health Protection Act, fully-insured "large group" AHPs are subject to State benefit mandates that in most if not all States require coverage of benefits and services that are just as good if not better than the ACA's EHBs.

C. Codifying the Practice of Varying Premiums By Employer Member

The Act codifies the practice of varying premiums by each employer member of an association that (1) satisfies the above stated conditions and (2) offers health coverage through a fully-insured "large group" AHP or self-insured Plan AHP.

More specifically, the Act sets forth specific requirements for developing premium rates for AHPs sponsored by (1) associations that ONLY include employers with at least 1 common law employee, (2) associations made up SOLEY of self-employed individuals with no employees, and (3) "mixed associations" that include BOTH employers with at least 1 common law employee and self-employed individuals with no employees.

1. Associations That ONLY Include Employers With At Least 1 Common Law Employee

In the case of an AHP established by an industry-based or non-industry-based association that ONLY includes employers with at least 1 common law employee, this AHP shall develop a "base" premium rate based on the collective health claims experience of ALL of the employees and their dependents participating in the AHP. Then, at the election of the association, the AHP may vary this "base" premium rate up or down for each employer member based on the collective health claims experience of all of the employees employed by each respective employer member who are participating in the AHP.

2. Associations Made Up SOLEY of Self-Employed Individuals With No Employees

In the case of an AHP established by an association made up SOLELY of self-employed individuals with no employees, the AHP shall develop a "base" premium rate based on the collective health claims experience of ALL of the self-employed individuals and their dependents participating in the AHP. Then, the AHP shall charge this "base" premium rate to ALL self-employed individuals and their dependents participating in the AHP. In other words, any variation based on the health claims experience of a particular self-employed individual is prohibited.[54] The only type of variation that can occur may reflect the different "type" of health plan (e.g., a PPO vs. an HDHP) and "type" of coverage (e.g., single, employee +1, and family coverage). But again, the premium rate for the "type" of health plan and "type" of coverage shall be the SAME "base" premium rate for ALL self-employed individuals enrolled in the respective "types" of health plan and coverage.

---

[54] As discussed in Section IV, HIPAA prohibits a "group health plan" from charging different premium rates based on the health status of an individual participant [ERISA section 702(b)].

3. "Mixed Associations" of Employers and Self-Employed Individuals

If there is a "mixed association" that includes BOTH employers with at least 1 common law employee AND self-employed individuals with no employees, this AHP shall develop a "base" premium rate based on the collective health claims experience of ALL of the employees and their dependents AND the self-employed individuals and their dependents participating in the AHP. Then, at the election of this "mixed association," the AHP may vary this "base" premium rate up or down for each employer member with at least 1 common law employee based on the collective health claims experience of all of the employees employed by each respective employer member who are participating in the AHP.

For purposes of varying the "base" premium rate for self-employed individuals with no employees, ALL of the self-employed individuals who are members of the "mixed association" shall be aggregated together into one, single group of self-employed individuals. This aggregated group of self-employed individuals would effectively stand alongside all of the employer members that employ at least 1 common law employee. In other words, the aggregated group of self-employed individuals would themselves operate as their own group within the larger group, just like the employer member groups.

It is important to emphasize that the AHP ***CANNOT*** vary premiums for EACH self-employed individual participating in the AHP. As stated, HIPAA currently prohibits a "group health plan" from varying premiums for an individual participant based on health status. The approach here would allow the AHP to vary the "base" premium rate for the ***entire*** aggregated group of self-employed individuals up or down based on the collective health claims experience of ALL of the self-employed individuals who are a part of this aggregated group and who are participating in the AHP.

In other words, the AHP shall be permitted to vary the "base" premium rate for the aggregated group of self-employed individuals as if this aggregated group were their own group standing side-by-side with those employers with at least 1 common law employee that are members of this "mixed association" and offering health coverage through the AHP.

Note, a "mixed association" MUST have at least 20 self-employed individual members that can be aggregated into a single group of self-employed individuals with no employees. If this "mixed association" does ***not*** include at least 20 self-employed individuals that can be aggregated together, this group may ***NOT*** establish an AHP that covers self-employed individuals. However, this association could still establish an AHP for its employer members with at least 1 common law employee just like groups that ONLY include employers with at least 1 common law employee can, as described above.

- ***Justification for Codifying These Requirements In Federal Statute***

Varying Premiums By Employer Member Is a Long-Standing Practice Which Is Permitted By States and the Federal Government

- Fully-insured "large group" AHPs and self-insured AHPs have a ***long history*** of (1) developing a "base" premium rate for ALL of the plan participants based on the collective health claims experience of ALL of these participants – and then – (2) varying this "base" premium rate up or down for each employer member based on the collective health claims experience of all of those employees employed by a particular employer member participating in the AHP.

- In the 37 States that allow fully-insured AHPs to operate as a "large group" plan, every Department of Insurance allows the fully-insured AHP to vary premiums in the above described manner. Same is true in those States that allow self-insured AHPs to operate (both Plan and Non-Plan MEWAs). The Federal government – including the Obama Administration, Trump Administration, and Biden Administration – have allowed this practice to exist as well, deferring to States and how States want to regulate their own insurance markets. States may choose to enact a State law codifying this practice (as Virginia did in 2023)[55] or a State may choose to enact a State law prohibiting this practice. Once again, the Act does ***not*** preempt State law.

Varying Premiums By Employer Members Is a Fiduciary Obligation

- As discussed above, one of the most important factors for qualifying as an "employer" under ERISA section 3(5) is the "control test," which requires an association sponsoring an AHP to establish a governing Board to operate and manage the health coverage offered through the AHP. As also discussed above, the Board – as an ERISA fiduciary – must "act in the best interest" of the AHP plan participants and undertake efforts to keep health plan costs low. Importantly, electing to vary the premium rates for each employer member based on the collective health claims experience of all of the employees employed by the respective employer members who are participating in the AHP is driven by the duty to "act in the best interest" of AHP plan participants. If the AHP ***did not*** develop different premium rates for particular employer members, the solvency of the AHP ***could be*** called into question, which ***could*** adversely affect the health coverage offered to plan participants, which ***would be counter*** to the participants' "best interest."

- As a result, to ensure that comprehensive and affordable health coverage is consistently made available to employees of the sponsoring employer members, the Board ***has a fiduciary obligation*** to elect to vary premiums by employer member to maintain the AHP's long-term solvency. In other words, engaging in practices that would ensure the long-term solvency and viability of the AHP (like varying premiums by employer member) is by definition "acting in the best interest" of plan participants because without engaging in this practice, the association sponsoring the AHP – and by extension, the association's employer members – may no longer be able to offer health coverage.

D. Self-Employed Individuals With No Employees Would Be Considered an "Employer," "Employee," and "Participant" for the Sole Purpose of Participating In an AHP

The Act confirms in Federal statute that if a self-employed individual with no employees satisfies a specified definition, this self-employed individual would be considered (1) an "employer," (2) an "employee," and (3) a "participant" under ERISA for the **SOLE** purpose of participating in an AHP.

In other words, even if a self-employed individual with no employee satisfies the specified definition, this self-employed individual **WOULD NOT** be considered (1) an "employer," (2) an "employee," and (3) a "participant" for ***any other purposes*** under ERISA (although Congress and/or the DOL may consider allowing this self-employed individual to be considered (1) an "employer," (2) an "employee," and (3) a "participant" for purposes of participating in an Association Retirement Plan, consistent with regulations that were finalized in 2019).[56]

---

[55] *See* Virginia Insurance Code section 38.2-3521.1.E.5.

[56] *See* 29 C.F.R. 2510.3-55; *see also*, Definition of "Employer" Under Section 3(5) of ERISA—Association Retirement Plans and Other Multiple-Employer Plans, 84 Fed. Reg. 37508 (July 31, 2019).

It is important to note that the Act is ***not*** endeavoring to treat a self-employed individual with no employees as an "employer" and "employee" under the PHSA or the ACA. Instead, a self-employed individual with no employees would be treated as an "employer" and "employee" for purposes of ERISA ***only***. And ***only*** for the sole purpose of being considered an "employer member" and an "employee" of an association that satisfies the above stated conditions.

In this case, it is the ***association*** that stands as the "employer" under the PHSA and ACA, ***not*** the self-employed individual with no employees. In addition, the self-employed individual – as an "employee" of the association that satisfies the above stated conditions – would be aggregated and counted together with other self-employed individual members of the association (in the case of an association made up SOLELY of self-employed individuals) and/or other employees of employers with at least 1 common law employee that are members of the association (in the case of a "mixed association") for purposes of determining whether this group includes at least 51 employees, and thus, can be treated as a "large employer" sponsoring a "large group" AHP.

- ***Justification for Codifying These Requirements In Federal Statute***

This Will Confirm That Self-Employed Individuals With No Employee Can Be an "Employer," "Employee," and a "Participant" Solely for Purposes of Participating In an AHP

- Confirming in Federal statute that ERISA allows a self-employed individual with no employees to participate in an AHP is grounded in the DOL's sub-regulatory guidance relating to "working owners" (i.e., self-employed individuals with no employees). Specifically, in 1999, the DOL issued Advisory Opinion 99-04, concluding that a self-employed individual with no employees (i.e., a working owner) may have dual status as an "employer" and an "employee," and thus, permissibly be considered a "participant" in an ERISA-covered plan.[57] This conclusion was based on the DOL's opinion that multiple sections of ERISA (e.g., ERISA section 402(a)(2), ERISA section 403(b)(3)(A), ERISA section 408, ERISA section 4001(b)(1), ERISA section 4021(b)(9), and ERISA section 4022(b)(5)(A)) all served as an indication that self-employed individuals may be considered "participants" for purposes of ERISA coverage. This opinion led the DOL to explain that "there is a clear Congressional design to include [self-employed individuals with no employees] within the definition of participant for purposes of Title I of ERISA."[58]

- Confirming in Federal statute that a self-employed individual with no employees has dual status as "employer" and "employee" for purposes of participating in an AHP is consistent with the flexible approach the DOL has taken when seeking to give individuals access to workplace benefits. In addition, codifying this requirement is consistent with this DOL's current efforts to re-classify certain independent contractors so they may have access to workplace benefits.[59]

---

[57] DOL Adv. Op. 99-04A (Feb. 1999); *see also* DOL Adv. Op. 2006-04A (April 27, 2006).
[58] *Id.*
[59] *See* 89 Fed. Reg. 1638 (Jan. 10, 2024).

An Employment Relationship Exists Even for Self-Employed Individuals With No Employees

- A self-employed individual with no employees provides services to the self-employed individual's own trade or business by providing services to a third-party entity, which itself is traditionally a trade or business or a third-party consumer. This self-employed individual generates revenue for its own trade or business through the provision of these services for these third-parties, and the Internal Revenue Code treats this revenue generated as "income," which is taxed for both income and employment tax purposes, just like "wages."

- While these self-employed individuals with no employees do not act in the capacity of employees of an employer in the traditional employment sense, these self-employed individuals continue to provide services just like an employee, and these self-employed individuals generate income that is taxed just like wages. A failure to recognize that these revenue generating, taxpaying self-employed individuals operate in an employment setting is a failure to recognize that we now live in a competitive, global economy that no longer relies on a workforce made up of the traditional employee employed by a traditional employer. In other words, accepting the notion that "one does not have an employment relationship with oneself" fails to recognize changing market dynamics and is rooted in economic theory of the 1970s when ERISA was first enacted into law.

- It is important to emphasize that over the past three decades, our nation's economic environment has evolved into a competitive, global economic environment. Our nation's workforce has similarly evolved from a traditional employment-based setting where "employees are employed by an employer," to a non-traditional employment-based setting where a growing number of workers are self-employed individuals with no employees.[60] With the continued growth of the "gig economy," and more and more millennials working as self-employed individuals – by choice or by circumstance[61] – Congress can no longer ignore the needs of these types of workers. In our view, it is incumbent upon Congress to develop new policies that not only reflect current market dynamics, but that provide access to meaningful workplace benefits that self-employed individuals with no employees so glaringly lack solely because they choose – or are forced – to work without a traditional employer.

---

[60] *See* Small Business Trends, *Key Trends at Sole Proprietorships Over the Past 30 Years*, Dec. 4, 2015 at https://smallbiztrends.com/2014/09/key-trends-sole-proprietorships-past-30-years.html, reporting that the Internal Revenue Service found that sole proprietorships nearly doubled from 1980, when there were 39.2 for every thousand Americans to 76.7 sole proprietors for every thousand Americans in 2007.

[61] *See* McKinsey Global Institute, *Independent work: Choice, Necessity, and the Gig Economy*, October 2016, page 4 at https://www.mckinsey.com/featured-insights/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy.

[Additional submission from Rep. Foxx follows:]

PARAGON HEALTH INSTITUTE

Written Answers to Questions for the Record from Kev Coleman, Research Fellow Paragon Health Institute
For the House of Representatives Committee on Education & Workforce
Hearing Entitled
"A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"

April 22, 2025

Questions put forth by Rep. Virginia Foxx (R-NC)

1. Mr. Coleman, as health care costs for small businesses rise, how do stop-loss or reinsurance options protect employers and employees from insurance price increases?

Stop loss reinsurance (also known as "excess insurance") is an insurance instrument used by self-funded health plans to financially protect the plan from insolvency due to catastrophically high medical expenses that exceed the plan's actuarial predictions. The same stop loss protection can be employed by a partially self-funded health plan, sometimes referred to as "level funded," where the plan is under management of a third-party insurer instead of the entity whose employees are being insured.

In both scenarios, the stop loss reinsurance allows a health plan (and the employer sponsoring it) to reduce the premiums it charges enrollees by limiting the maximum expense of medical claims within a given year. This predetermined limit where a stop loss policy begins to pay an employer/health plan for excess medical claims is known as the "attachment point." Additionally, the health plan's premiums incorporate the lower cost of the stop loss insurance rather than the higher cost of a catastrophic financial expense against which it protects.

Stop loss further reduces the financial expense of maintaining appropriate operational funds in reserve. Since a health plan's premiums are normally collected monthly, its cash flow can be compromised if a high medical claim occurs earlier in the year. However, a health plan can use "individual stop loss" coverage alongside its aggregate stop loss (which covers the risk pool as a whole). Individual stop loss provides funds for a high expense individual medical claim even if the health plan's total aggregate attachment point has not been reached.

2. It's frustrating when a federal law, like ERISA, is distorted to make it more difficult for employers to provide health insurance coverage for their employees. When President Trump made it easier for small businesses to make association health plans more accessible in 2018, President Biden rescinded that rule. What impact has that rescission had on small businesses and employees?

The recission of the 2018 regulatory update for association health plans (AHPs) made certain that the approximately 30,000 individuals[1] who lost their 2018 AHP coverage did not have that

[1] Christopher E. Condeluci, "Association Health Plans

coverage reinstated. The recission, instead, further delayed reforms expanding small business access to AHP and the savings AHPs can provide though use of a large group health plan. The negative effects attending this continued lack of access are multiple. Foremost, it restricts an AHP's large group health plan savings from small businesses. Competing large businesses, in contrast, have no such restriction on the use of a large group health plan and, as such, they can use the operational savings from lower health coverage costs to more competitively price products that compete with the offerings of small businesses. Alternatively, they can provide richer benefits, making it harder for small businesses to contend for the best talent in hiring. Without the lower costs of a large group health plan (mediated through an AHP), small businesses may consider:

- Raising the prices of their products
- Forgoing employee raises or promotions
- Eliminating employee health coverage

For small businesses who do not offer health coverage, the market absence of an AHP's large group savings will likely perpetuate the poor insurance offer rate already observed among small firms. The latest 2023 data from the government's Medical Expenditure Panel Survey found only 30.1 percent of businesses with fewer than 50 employees offered health coverage.[2] The National Federation of Independent Business (NFIB) has identified affordability as the principal 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."[3] This same study revealed that the cost of health insurance was the top reason given for not offering coverage to employees.

(AHPs) and States' Rights: An Accounting of How States Want to Regulate AHPs," Bloomberg Tax, Tax Management Compensation Planning Journal, October 28, 2019, https://powerofassociations.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf

[2] 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. For a more detailed discussion see also Kev Coleman, "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care — Testimony of Kev Coleman," Paragon Health Institute, April 2, 2025, https://paragoninstitute.org/private-health/a-healthy-workforce-expanding-access-and-affordability-in-employer-sponsored-health-care-testimony-of-kev-coleman/ and Kev Coleman, Small Business Health Insurance Equity Through Association Health Plans," Paragon Health Institute, April 25, 2023, https://paragoninstitute.org/private-health/small-business-health-insurance-equity-through-association-health-plans/

[3] 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

[Additional submissions from Rep. Scott follows:]

AFSCME
We Make America Happen

#525-24

April 1, 2025

The Honorable Rick Allen, Chair
The Honorable Mark DeSaulnier, Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Allen and Ranking Member DeSaulnier:

On behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFSCME), I write to express our strong concern over efforts to expand the availability of health plans that are exempt from key consumer protections under the Affordable Care Act (ACA). This undermines access to comprehensive health coverage.

Specifically, proposals advanced in Project 2025 and the Republican Study Committee's FY 2025 budget seek to expand substandard coverage, including Association Health Plans (AHPs) and short-term, limited-duration insurance (STLDI). These plans lack many of the ACA's most essential safeguards—such as coverage for preexisting conditions and essential health benefits. As a result, such proposals risk siphoning younger, healthier individuals away from the ACA marketplaces and threaten to destabilize the insurance risk pool and drive up premiums for those who rely on comprehensive coverage.

We supported rescinding the deeply flawed 2018 AHP rule. At this time we urge Congress to stay the course. AFSCME strongly opposes H.J. Res. 181, which would use the Congressional Review Act to roll back the U.S. Department of Labor's April 2024 final rule restoring critical protections. Rescinding that rule would reinstate a regulatory framework that allowed "junk" plans with inadequate coverage and high out-of-pocket costs to proliferate—placing workers and families at significant financial and health risk.

AFSCME represents nearly 200,000 members working in the private sector, many of whom are employed by small businesses and would be directly impacted by the erosion of ACA protections. We cannot afford to return to a system that allows insurers to offer bare bones plans that fail to cover vital services like mental health care, maternity services or prescription drugs.

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 FAX (202) 429-1293 TDD (202) 659-0446 WEB www.afscme.org 1625 L Street, NW, Washington, DC 20036-5687

We urge you to reject H.J. Res. 181 and any legislation that expands AHPs or similar substandard plans. Instead, we call on Congress to protect and build upon the ACA's foundation and ensure all Americans have access to high-quality, affordable health care.

Sincerely,

Edwin S. Jayne
Director of Federal Government Affairs

ESJ/DH:lm

cc: U.S. House of Representative Education and the Workforce Subcommittee on Health, Education, Labor and Pensions

February 8, 2024

Joe Canary
Office Director
Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Re: RIN 1210–AC16; Definition of "Employer" – Association Health Plans

Dear Director Canary,

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write in response to the Employee Benefits Security Administration (EBSA) proposed rule titled "Definition of 'Employer' – Association Health Plans" published in the *Federal Register* on December 20, 2023 that would rescind its previously finalized 2018 final rule Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans (2018 AHP Rule). The AAFP supports policies which increase patient centered care, support family physician practices, and ensure that patients receive high-quality, evidence-based care that addresses health disparities.

The AAFP thanks EBSA for its continued interest in providing robust access to affordable health care coverage for all Americans. **We view this proposed rule as an important step to safeguard the comprehensive, meaningful health insurance coverage that Americans deserve.**

Rescinding the 2018 AHP Rule

The AAFP had serious concerns with the 2018 AHP rule, which was designed to expand the definition of "employer" to allow for expanded individual and employer purchase of AHPs. The 2018 rule allowed AHPs to be formed by groups of individuals solely for the purpose of providing health insurance, removing requirements for their association to have a common business interest or contain a genuine organizational relationship outside the provision of health insurance benefits, and adjusting requirements to allow for AHP owners to control details of the health plan.

As a result, the finalized rule allowed some individual employers and self-employed persons to create a single employee welfare benefit plan or group health plan operating in the large group market. This would have enabled newly formed AHPs to be treated as large employer plans, which have health coverage requirements that differ from requirements small businesses and individuals are subject to under the *Affordable Care Act (ACA)*. Through this type of formation, such AHPs would no longer be required to provide essential health benefits (EHBs) to enrollees.

The AAFP's primary concern with the 2018 AHP Rule was that, despite the possibility of expanded access to health insurance coverage, the coverage to be provided by AHPs was not subject to

important ACA consumer protections, and the plans would not provide meaningful health insurance coverage. Our comments on the 2018 AHP proposed rule highlighted the risks to consumers, as AHPs would have the option to reduce or eliminate certain essential health benefits under the ACA to avoid covering vulnerable, expensive patients. **While the AAFP supports efforts to improve access to high quality health care coverage for uninsured and underinsured Americans, we encourage regulators to ensure that the coverage options available do not compromise the comprehensive insurance benefits on which Americans rely.**

Despite litigation over the promulgation of the 2018 AHP Rule which set aside its requirements in a 2019 decision, and information from the Department of Labor noting that no existing AHPs were formed based on the expanded flexibilities in the 2018 AHP Rule, the AAFP still believes that concrete EBSA regulatory action is helpful in clarifying AHP formation requirements and reinforcing the Administration's view of the limitations of the 2018 AHP Rule.

2023 Proposed Rule

The AAFP applauds EBSA's proposed rule, which rescinds the 2018 AHP Rule in full. We agree with the statement that this rescission would "resolve any uncertainty regarding the status of the standards established under the rule, allow for a reexamination of the criteria for a group or association of employers to be able to sponsor an AHP, and ensure that guidance being provided to the regulated community is in alignment with ERISA's text, purposes, and policies."

As the proposed rule makes clear, prior to ERISA's passage, certain arrangements lacking the requisite connection to the employer had resulted in abuses leaving consumers both paying premiums and becoming responsible for unpaid medical services that should have been covered by the plan. The 2018 AHP rule increased the likelihood that such mismanaged plans and plans providing more limited coverage would be marketed to consumers. Thus, the full rescission of the proposed 2018 AHP Rule is necessary to ensure such plans are not brought to market. The AAFP firmly believes patients deserve access to meaningful coverage options. By repealing the 2018 AHP Rule, patients will be protected from plans that offer limited benefits and high out-of-pocket costs, coupled with the risk of plan mismanagement and limited EBSA oversight resources.

The protections provided through this proposed rule come during a pivotal time for millions of Americans, as state Medicaid programs complete Medicaid redeterminations as part of the COVID-19 Public Health Emergency (PHE) unwinding. The redetermination process has resulted in and will continue to mean millions of individuals transitioning off Medicaid coverage and assessing options for private health insurance. **The AAFP believes this rule is a critical step in providing protections against plans that would limit coverage, and potentially lack transparency in doing so.**

In addition to comments on rescission of the 2018 AHP Rule, EBSA also seeks comments on whether the Department should engage in additional rulemaking for group health plans that codifies and replaces the pre-2018 AHP Rule policies, issue additional guidance clarifying the application of the Department's pre-2018 AHP Rule standards, propose revised alternative criteria for multiple employer association-based group health plans, or pursue some combination of those or other alternative steps. **The AAFP encourages the Department to consider future rulemaking which will further clarify the pre-2018 AHP rule policies that were in place and solidify standards for AHP formation and operation in regulation.** The AAFP also urges the Department to consider other ways it can utilize oversight authority to further provide individual consumers with heightened transparency about plan options and conduct necessary oversight of plans that mismanage individual premiums and benefit administration.

Additional Comments

The proposed rule rescinding the 2018 AHP rule is an important step in ensuring consumer access to meaningful health insurance coverage, which is a key tenant of the AAFP's Health Care for All policy. Family physicians provide continuing and comprehensive medical care, health maintenance, and preventive services to patients across their lifespan. While many family physicians provide comprehensive, longitudinal primary care, many also practice in hospitals, emergency departments, urgent care centers, long-term care facilities, and other health care settings. As such, family physicians know firsthand that the implementation of essential health benefits (EHBs) requirements in the Affordable Care Act (ACA) have significantly benefited patients and population health outcomes. The AAFP strongly urges EBSA to work with federal partners to ensure patients can access coverage with comprehensive essential health benefits, based on latest clinical and scientific evidence.

We appreciate the opportunity to provide comments on this proposed rule. For additional questions, please contact David Tully, Vice President of Government Relations, at dtully@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

101 North Carson Street
Carson City, Nevada 89701-3713
Office: (775) 684-5670
Fax No.: (775) 684-5685

1 State of Nevada Way
Las Vegas, Nevada 89119-4339
Office: (702) 486-2500
Fax No.: (702) 486-2505

Office of the Governor

February 26, 2025

The Honorable Brett Guthrie
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Mike Crapo
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairmen Crapo and Guthrie:

I'm writing to address the potential impact of proposed changes to Medicaid funding on the State of Nevada. As the largest payer of health care in our state, Medicaid plays a critical role in both our budget and the well-being of our residents. This essential safety net program provides coverage for low-income individuals, children, seniors, and people with disabilities, ensuring access to necessary care. Its stability is vital not only for the health of Nevadans but also for preventing additional strain on an already burdened health care system, including providers and emergency rooms.

While reducing federal spending and taxes is essential to the nation's economic stability, critical programs like Medicaid require thoughtful consideration and a longer transition period for states to assess impacts and collaborate with the federal government. Medicaid not only provides care for the most vulnerable Nevadans but also drives significant economic activity within the state's health care sector. Sudden funding reductions would disrupt this balance, making it difficult for Nevada to responsibly plan for and manage these changes. While ultimate funding decisions rest with the Administration and Congress, it is imperative that federal policymakers fully consider the consequences for states if these proposals move forward.

Of the various proposals being contemplated at the federal level, the following would be most detrimental for Nevada.

Rolling Back Critical Expansion Population Funding: In the 2013 session of the Legislature, Nevada expanded Medicaid to help close the coverage gap for hundreds of thousands of Nevadans who could not afford the cost of private health insurance. This expansion has resulted in significant gains for Nevada's health care system, including reducing the state's uninsured rate, which, at that time, was the fifth highest in the nation.

If Congress rolls back enhanced federal funding for this expansion population, it will have serious consequences for Nevada's budget. This change alone could result in a $1.85 billion loss in federal funds over the next two years, putting at risk the state's capacity to maintain coverage for approximately 300,000 Nevadans. Nevada could not absorb a federal funding loss of this magnitude without major cuts to Medicaid and other state programs.

Limiting Federal Funding with a Per Capita Cap Model: Although the specifics of the proposal have not yet been formally released, an initial state analysis estimates that federal funding losses sourced to a per capita model could range from $590.2 million to $3.15 billion over the 2025-2027 biennium. This range depends on factors such as the base year and trend rate used to calculate federal spending. If this proposal is coupled with a reduction in enhanced federal funding for the expansion population, the projected losses would be significantly higher, ranging from $1.5 billion to $5.3 billion over the same two-year period.

Nevada has demonstrated that federal investment in the state's Medicaid program has improved both health outcomes and productivity, yet challenges remain. By leveraging federal funding, the state has expanded access to school health services, lowered the uninsured rate, and made significant progress in enhancing behavioral health care for both children and adults. As one of the fastest-growing states in the nation, Nevada must retain the flexibility to adapt to demographic and population shifts, and limitations on Medicaid funding would clearly hinder that ability.

Lowering the Safe Harbor for Provider Taxes for Hospitals: Hospitals across Nevada, especially in rural areas, are struggling with rising patient volumes and uncompensated care. A proposed reduction in the federal safe harbor for provider taxes from 6% to 4% would place a significant financial strain on more than 43 hospitals statewide. This change would directly limit the hospital tax revenues Nevada can leverage to supplement Medicaid payments through the state's hospital tax and payment program, resulting in a projected $693 million reduction in supplemental payments for Nevada hospitals during the 2025-2027 biennium.

Moreover, this change would diminish Nevada's capacity to comply with its recently signed settlement agreement with the U.S. Department of Justice for children with behavioral health disabilities. Currently, state law allows for a portion of hospital provider tax revenues to be used to finance new home and community-based services for this child population through Medicaid. An initial estimate indicate that this proposal would reduce tax revenues available for children's behavioral health care by approximately $30 million, which, when matched with available federal Medicaid funds, would result in a loss of $80 million in Medicaid coverage.

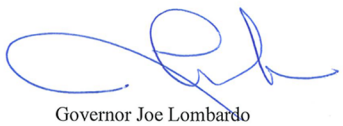
Beyond its role in providing care to vulnerable populations, Medicaid funding has also contributed to the growth and stability of Nevada's health care economy. Hospitals, clinics, and providers across the state depend on Medicaid reimbursements to sustain operations, maintain staffing levels, and invest in critical services. An abrupt reduction in federal funding would not only disrupt care for those who rely on Medicaid but would also destabilize public and private health care providers, leading to workforce reductions, service limitations, and financial strain on already overburdened hospitals. I would respectfully submit that any changes to Medicaid's funding structure must account for these broader economic implications to ensure continuity of care and the financial viability of Nevada's health care system.

As federal proposals to reform Medicaid continue to take shape, my office intends to remain actively engaged in discussions at both the state and federal levels. If enacted, these proposals would fundamentally alter Medicaid financing, leaving states – like Nevada – without the time or budget necessary to plan for responsible implementation. While I support a comprehensive review of federal spending and efforts to reduce reliance on government, I urge federal policymakers to take a measured and responsible approach to any changes in Medicaid funding. This includes implementing a phased-in timeline to minimize disruptions to state budgets, health care systems, and the vulnerable Nevadans who rely on Medicaid.

Nevada remains committed to being a constructive partner in efforts to ensure fiscal responsibility at the federal level, but funding cuts alone will not resolve the root causes of Washington's budgetary challenges or the rising cost of health care. The proposed reductions would put lives at risk in Nevada, and the state would be unable to absorb the impact without significant disruption. Rather than indiscriminate cuts, states need better tools and federal support to control costs, reduce waste, and enhance program quality. This includes advancing solutions to curb the escalating cost of prescription drugs, strengthen efforts to prevent fraud, waste, and abuse in Medicaid, and eliminating burdensome federal regulations that drive up costs for technology and vendor services. I welcome the opportunity to continue this dialogue as Congress considers policies to improve Medicaid's long-term sustainability.

If you have any questions or concerns about the items discussed in this letter, please do not hesitate to reach out to Chief of Staff, Ryan Cherry, at (775) 684 – 5670.

Sincerely,



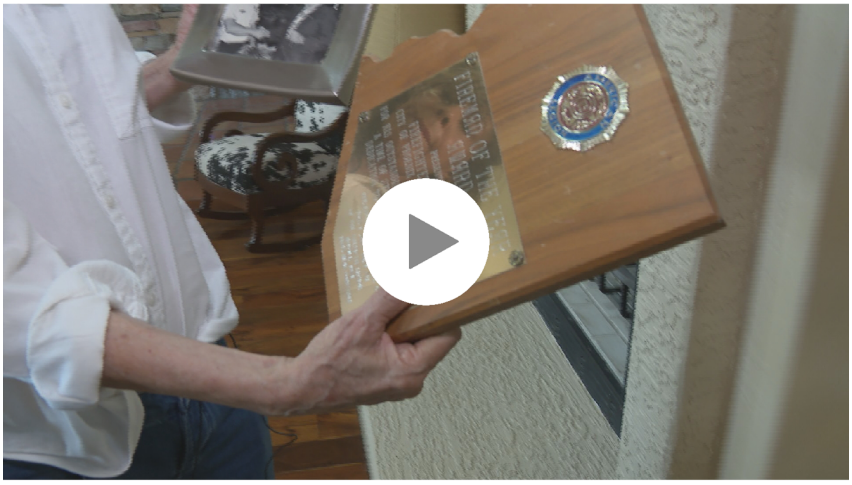
Governor Joe Lombardo
State of Nevada

Cc: The Honorable Catherine Cortez Masto
The Honorable Jacky Rosen
The Honorable Mark Amodei
The Honorable Dina Titus
The Honorable Susie Lee
The Honorable Steven Horsford

I-TEAM

$40,000 out of pocket: Retired Phoenix first responders want insurance to pay outstanding bills

Thin Blue Line Benefits Association offered affordable health plans for retired first responders. Now, some complain medical bills aren't getting paid.



Author: **Katie Wilcox**
Published: **5:00 PM PST February 23, 2025**
Updated: **3:19 PM PST February 24, 2025**

PHOENIX — Retired Phoenix firefighters, police officers and their families are raising alarms about their insurance plan after waiting months for payment for their medical bills.

Thin Blue Line Benefits Association, a limited liability company from Texas, started as an organization for first responders who were in an insurance gap: they retired before age 65 and did not yet qualify for Medicare.

The sales pitch was simple: these are plans only for first responders, who only deserve the best.

“I believe the reason most of these people went with Thin Blue Line is because they're geared toward retired police officers and retired firemen throughout the country,” said Susan Huff, a TBL member whose husband is a retired Phoenix firefighter.

“And they were a little bit cheaper,” Huff said.

How the plan worked

The company is an Association Health Plan, which describes itself as giving members access to benefits. Members pay premiums, have a deductible and copays, and are part of a coverage plan described in a summary of benefits and coverage document.

Members' records showed the plan used the Cigna provider network and Quilt Benefits and Kentucky Health Administrators to handle claims processing.

Then in December, those contracts were terminated.

Meanwhile, some members were complaining their medical bills were not getting paid.

$40,000 out of pocket

Last fall, Susan Huff’s daughter needed surgery.

“We had to take money out of our retirement to pay for it, thinking we were going to get reimbursed, you know, within a few months,” Huff said. “What we paid was $40,000.”

Huff said her plan amounted to about $2,000 per month in premiums. As the weeks and months wore on, she said she made multiple attempts to reach the company for payment.

“After the calling and calling, and it was like, this is so bizarre. I've never had anything like this happen before,” Huff said.

Huff began researching and noticing community groups on social media with dozens of other first responders and their families making similar complaints.

The I-Team spoke with multiple families of firefighters and police officers who also stated they have been paying premiums every month, but not getting the coverage they expect.

Letters to members

On December 2, Thin Blue Line management sent members an email to “address some concerns” about “plans, networks and provider issues.”

The email was not signed by a specific person, but Anna Reed is the CEO and sole manager, according to court filings.

The email alluded to reasons why Thin Blue Line would no longer work with Kentucky Health Administrators, Quilt Benefits or Cigna.

The email acknowledged delays in payment and said that the company made “some key changes in our executive management and eliminated those with ill intent from our company.”

“All claims will be paid correctly, and we are working rapidly to get them processed correctly and through the system,” the email stated. “Though these individuals have tried to make TBL insolvent this is not the case. TBL is fully intact and will stay that way despite these malicious actions.”

Thin Blue Line has not responded to multiple requests for comment from the 12News I-Team.

A few weeks later, members got a very different letter.

This time, from Paul Ford with Quilt Benefits.

“This letter is to inform you that, effective December 1, 2024, Quilt Benefits and its affiliate Kentucky Health Administrators… are no longer the claims administrator for the self-funded plan sponsor, Thin Blue Line, or any of its plans,” Ford wrote. “Cigna network access has also been terminated as of December 1, 2024.”

Ford offered a different reason for ending the agreement: a failure to pay claims.

“Please note that the unfortunate reason for the termination of this relationship is a result of Thin Blue Line failing to submit to Quilt timely funding of claim amounts due to providers… As a result of this failure to fund claims and after multiple notices and attempts to remedy the issue, Quilt rightfully terminated the administrative agreement with notice to Thin Blue Line on November 1, 2024.”

The lawsuit

On December 9, CEO Anna Reed and Robert Anderson filed a lawsuit against Matthew Clay accusing him of a breach of contract and disparagement.

Clay was an “initial member” of Thin Blue Line when it was established in 2020. Clay wanted to leave the company in 2024.

The lawsuit states Clay entered a “withdrawal” agreement with Thin Blue Line, but accuses him of violating the agreement and disparaging the company.

Clay denies the allegations. He filed a countersuit in response, accusing Thin Blue Line of fraud.

In his counterclaim, Clay contends that he is a retired law enforcement officer himself and that he joined Thin Blue Line as a member, “and paid significant monthly premiums,” but that some of his own bills were not paid.

“Clay, his family members and his medical providers have also submitted claims to TBL that were not paid,” Clay’s attorneys allege in the counterclaim.

Thin Blue Line and its attorneys did not respond to the I-Team’s request for comment but deny the allegations against the company in filings in federal court.

‘A history of fraud’ in Association Health Plans

“There's a long history of fraud in association health plans,” said Emeritus Professor Timothy Jost, of Washington and Lee University School of Law. “A lot of them have gone insolvent and left their members holding the bag.”

Healthcare advocates have compiled lists of reports over the years describing different companies that left members with millions of dollars in unclaimed medical bills.

A 2018 report from the United Hospital Fund showed a long history of insolvencies.

“Self-insured Association Health Plans are inherently less stable than state regulated insurance companies because solvency requirements are lower and AHP operations are higher risk operations compared to traditional insurers,” the report stated.

Thin Blue Line is a self-funded association health plan, according to its court filings.

The Arizona Department of Insurance and Financial Institutions said Thin Blue Line is not licensed to provide insurance in Arizona but added that self-funded plans are not regulated by the state.

“It was hard to know, in some cases, who's regulating these,” said Sarah Lueck, the Vice President for Health Policy with the Center on Budget and Policy Priorities. “If I'm a consumer enrolled in those plans and I find something's wrong, it could be confusing and difficult to know who is the cop on the beat, who is the person I'm supposed to call to help me figure out the problem that I'm having.”

Steps you can take

"I can't speak to the details of what this specific arrangement is or what exactly is going on right here, but if it were me, I would say to call the state insurance department and file complaints," Lueck said. "Also to go to the Federal Labor Department and file a complaint."

If you're concerned that your provider is not properly handling your medical claims, you can file a complaint with the Arizona Department of Insurance and Financial Institutions.

"One other possible remedy would be to complain to the Employee Benefit Services Administration, the federal agency that regulates employer plans," Jost said.

Here's how to contact the Employee Benefits Services Administration.

"I think it's really important that people make sure that they are buying licensed insurance," Jost said. "I would also start with going to a licensed insurance broker or agent who has a good reputation in the community and can guide me to find an insurance plan that is legitimate."

If you want new insurance, the Affordable Care Act has open enrollment every year beginning November 1, and continuing through the following January 15.

If you need insurance outside of open enrollment, you may be qualified for an exception to apply for a Marketplace plan. A licensed insurance agent may also be able to direct you to a private insurance plan.

Experts also recommend talking to your doctor or other healthcare provider about any unpaid medical bills. Many providers are willing to work with self-pay or low-income patients to avoid sending medical bills to collections.

For tips on this or any other story, email connect@12news.com or email Katie Wilcox at kwilcox@12news.com

[Additional submission from Rep. Walberg follows:]

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

[Questions and responses submitted for the record by Ms. Bethany Lilly follows:]

April 24, 2025

Bethany Lilly
Executive Director, Public Policy
The Leukemia and Lymphoma Society
10 G Street NE, Suite 400
Washington, DC 20002

Dear Ms. Lilly:

Thank you again for testifying before the House Committee on Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions at a hearing titled "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care." Enclosed are additional questions following the hearing. Please provide a written response no later than May 15, 2025, for inclusion in the hearing record. The response should be sent to Katerina Kerska of the Committee staff who can be contacted at (202) 226-9435 or Katerina.Kerska@mail.house.gov.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Rick W. Allen
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Questions for the Record from
REPRESENTATIVE ROBERT C. "BOBBY" SCOTT

Committee on Education and the Workforce
HELP Subcommittee hearing titled: "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"

Wednesday, April 2, 2025
10:15 A.M.

Representative Robert C. "Bobby" Scott (D-VA)
Question(s) for Bethany Lilly, *Executive Director, Public Policy*, Leukemia and Lymphoma Society

1. In February, House Republicans voted to approve a budget resolution that aims to cut over $800 billion from Medicaid in order to give $4.5 trillion in tax breaks to large corporations and billionaires. Not only will the Republican's draconian budget plan explode the federal deficit, but it is also threatening the health coverage of over 154,000 people in Virginia's Third Congressional District, including nearly 40,000 children in my district. Take for example, the story of one of my constituents from Norfolk, Virginia, named Angel Pye. Medicaid enabled Angel's son, who had Sickle Cell Disease, to afford the health care he needed to live for 10 years. He was in and out of the hospital with blood transfusions, which Medicaid covered. Medicaid also provided some funding when Angel left her job to work as a home care provider for her son. Sadly, Angel's son passed away a month ago. Angel is now sharing her story to highlight the importance of protecting Medicaid.
    a. What impact would the cuts proposed in the House Republican budget resolution have on people who rely on Medicaid?

2. Medicaid plays an outsized role when it comes to long-term care. Medicaid accounts for 61 percent of all long-term care spending in this country. This includes things like nursing home care, but it also includes home and community-based services that provide support to disabled individuals, including older individuals, to continue to live and work in their communities.
    a. If not for Medicaid, who would pick up the bill for long-term care in this country?

3. For 15 years, the Republican Party has waged a war on the *Affordable Care Act* and the landmark consumer protections it enshrined into law for millions of working people in this country. These consumer protections include protecting over 130 million Americans with pre-existing conditions, allowing young people to stay on their parents' insurance until age 26, prohibiting charging women higher premiums than men for the same coverage, and much more. In January 2025, 64 percent of the public had a favorable opinion of the ACA. Despite its sky-high approval and historic progress in decreasing

the uninsured rate, Republicans continue to push for the repeal of the ACA and expansion of "junk" health insurance plans that evade vital consumer protections.

a. Ms. Lilly, can you speak to the deficiencies of these substandard health plans—such as association health plans and short-term, limited duration insurance—for Americans? What benefits do these plans cover (or not cover)?

4. In March, the Trump Administration proposed a new regulation governing the ACA Marketplaces that would make it harder for people to get health coverage. Among many changes, the regulation would reduce the Open Enrollment period, end a monthly special enrollment period for Americans and allow insurance companies to offer health plans that cover less medical care. The Administration's own estimate is that 750,000 to two million Americans would lose their ACA health insurance in 2026 as a result of these changes.
    a. Ms. Lilly, how does the Trump Administration's proposal hurt Americans' ability to get quality health coverage?

5. The Trump Administration and DOGE have been carrying out mass firings of federal employees, including those at federal health care agencies, and have made cuts to federal funding and research grants.
    a. How do you expect these cuts will impact Americans' health?

Questions for the Record from
Representative Robert C. "Bobby" Scott (D-VA)

Committee on Education and the Workforce HELP Subcommittee hearing titled: "A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care"

Wednesday, April 2, 2025
10:15 A.M.

Answers to Questions from Robert C. "Bobby" Scott (D-VA) for Bethany Lilly, Executive Director, Public Policy, Leukemia and Lymphoma Society.

1. *In February, House Republicans voted to approve a budget resolution that aims to cut over $800 billion from Medicaid in order to give $4.5 trillion in tax breaks to large corporations and billionaires. Not only will the Republican's draconian budget plan explode the federal deficit, but it is also threatening the health coverage of over 154,000 people in Virginia's Third Congressional District, including nearly 40,000 children in my district. Take for example, the story of one of my constituents from Norfolk, Virginia, named Angel Pye. Medicaid enabled Angel's son, who had Sickle Cell Disease, to afford the health care he needed to live for 10 years. He was in and out of the hospital with blood transfusions, which Medicaid covered. Medicaid also provided some funding when Angel left her job to work as a home care provider for her son. Sadly, Angel's son passed away a month ago. Angel is now sharing her story to highlight the importance of protecting Medicaid.*
    a. *What impact would the cuts proposed in the House Republican budget resolution have on people who rely on Medicaid?*

As you highlighted in your question, we anticipate significant coverage losses. The Congressional Budget Office estimates that the proposals in the Budget Reconciliation bill, when combined with the expiry of the enhanced advance premium tax credits, would increase the number of people without health insurance by at least 13.7 million people. Medicaid provides a crucial safety net when people with blood cancer, as it did with DeAnne in North Carolina, mentioned in my written testimony, and for millions of others across the United States. The proposals would harm low-income working adults, Medicare beneficiaries, children, people with disabilities, and patients with complex health conditions. We urge Congress to reject these cruel and reckless policies.

2. *Medicaid plays an outsized role when it comes to long-term care. Medicaid accounts for 61 percent of all long-term care spending in this country. This includes things like nursing home care, but it also includes home and community-based services that provide support to disabled individuals, including older individuals, to continue to live and work in their communities.*
    a. *If not for Medicaid, who would pick up the bill for long-term care in this country?*

Long term services and supports (LTSS), also called long term care, are extremely expensive—"[o]n average, an American turning 65 today will incur $120,900 in future LTSS costs, measured in today's dollars."[i] Unfortunately, private insurance and Medicare generally do not cover LTSS, which leaves Medicaid as the only available insurance for these services.[ii] In 2022, Medicaid paid for 61% of the total $415 billion that was spent on LTSS and families paid for an additional 17% out of pocket.[iii]

Many people with blood cancer require access to LTSS because of the toll that cancer treatment can have on the body.[iv] If Medicaid stopped covering LTSS, suddenly millions of families would be unable to access the care they need. Private LTC insurance is unaffordable or unworkable for many, offering limited coverage.[v] This means even more families will not get the support they need.

An additional dynamic is the difference between more cost-effective home- and community-based services (HCBS) and institutional services.[vi] HCBS are "optional" Medicaid services, meaning that states are not required to cover them, while more expensive institutional services are mandatory.[vii] Unfortunately, this means that they are often targeted for reductions when state must balance Medicaid budgets, as happened following the early 2000s recession.[viii] Cutting at least $715 billion from Medicaid as the Budget Resolution proposes will force states to absorb costs or cut services and leaves people with LTSS needs facing an impossible choice—either institutionalization or loss of home care services.

3. *For 15 years, the Republican Party has waged a war on the Affordable Care Act and the landmark consumer protections it enshrined into law for millions of working people in this country. These consumer protections include protecting over 130 million Americans with pre-existing conditions, allowing young people to stay on their parents' insurance until age 26, prohibiting charging women higher premiums than men for the same coverage, and much more. In January 2025, 64 percent of the public had a favorable opinion of the ACA. Despite its sky-high approval and historic progress in decreasing the uninsured rate, Republicans continue to push for the repeal of the ACA and expansion of "junk" health insurance plans that evade vital consumer protections.*
    a. *Ms. Lilly, can you speak to the deficiencies of these substandard health plans— such as association health plans and short-term, limited duration insurance—for Americans? What benefits do these plans cover (or not cover)?*

While insurance issues exist regardless of the source of coverage, LLS knows firsthand that there are categories of insurance and "insurance-like products" that put not only our patients – but everyone who enrolls in them – at significant risk, both financially and in terms of their health. This category of products can often openly discriminate against patients, charge more to people with pre-existing conditions, retroactively refuse to pay for

care that has already been provided, and charge women more just for being women. This includes association health plans (AHPs); short-term limited-duration insurance (STLDI); and a variety of other products. While the rules of each differ, all lack some part of comprehensive coverage that the Affordable Care Act mandated. Importantly, because of the skimpy coverage offered by some of these products, patients and consumers can be disproportionately harmed financially when their coverage fails to meet their medical needs. LLS urges the committee to find solutions to address healthcare costs that do not promote low-quality coverage.

4. *In March, the Trump Administration proposed a new regulation governing the ACA Marketplaces that would make it harder for people to get health coverage. Among many changes, the regulation would reduce the Open Enrollment period, end a monthly special enrollment period for Americans and allow insurance companies to offer health plans that cover less medical care. The Administration's own estimate is that 750,000 to two million Americans would lose their ACA health insurance in 2026 as a result of these changes.*
    a. *Ms. Lilly, how does the Trump Administration's proposal hurt Americans' ability to get quality health coverage?*

LLS opposed several components of the rule and we are concerned to see several of the proposals from the rule incorporated into the Budget Resolution text. In addition to shortening the Open Enrollment period, eliminating the special enrollment period (SEP) for low-income people, and reducing the actuarial value of plans, the rule proposes implementing a premium for people who like their plan and stay enrolled in it, increasing the paperwork burden on those attempting to use an SEP, allowing insurers to deny coverage to those who the insurer says owe it or a related entity premiums, preventing the autoenrollment of some people into cheaper coverage, and several other harmful changes. We are extremely concerned that these changes would erode blood cancer patients' access to meaningful coverage. Our full comments to the agency are available on Regulations.gov.[ix]

In addition, we note that the best way of ensuring access to affordable premiums for comprehensive coverage would be to retain the enhanced premium tax credit. Congress needs to act and ensure that Marketplace coverage remains affordable.

5. *The Trump Administration and DOGE have been carrying out mass firings of federal employees, including those at federal health care agencies, and have made cuts to federal funding and research grants.*
    a. *How do you expect these cuts will impact Americans' health?*

LLS is deeply concerned about the cuts to already-committed funding from the NIH and to federal agency staffing that have happened at lighting speed and without full understanding of the implications. We recognize the need for efficiency and to ensure taxpayer money is spent wisely, but these decisions must be thoughtfully made and cannot jeopardize critical

government functions, like basic research and the operations of health and safety net programs on which some people with chronic conditions rely. NIH funding has contributed to 354 of the 356 drugs approved from 2010 to 2019 and every dollar in NIH funding generates $2.46 in economic activity, ranging from $47.6 million to $13.8 billion per state.[x] Most importantly, half of all cancer treatments used today were discovered or developed at NCI.[xi] We urge Congress to consider the long-term impacts and lasting harm to patients that could come from these cuts.

---

[i] https://aspe.hhs.gov/sites/default/files/documents/08b8b7825f7bc12d2c79261fd7641c88/ltss-risks-financing-2022.pdf.
[ii] https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.
[iii] https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.
[iv] https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/living-with-a-blood-cancer-in-later-life-the-complex-challenges-and-related-support-needs-of-adults-aged-75-and-older/19F78ABEE27081D425661C1C9EEE4662.
[v] https://kffhealthnews.org/news/article/dying-broke-why-long-term-care-insurance-falls-short/.
[vi] https://www.kff.org/medicaid/issue-brief/what-is-medicaid-home-care-hcbs/.
[vii] https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.
[viii] https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.
[ix] https://www.regulations.gov/comment/CMS-2025-0020-23132.
[x] https://www.lls.org/blog/balancing-fiscal-responsibility-saving-and-improving-lives.
[xi] https://www.lls.org/blog/balancing-fiscal-responsibility-saving-and-improving-lives.