# ERISA'S 50TH ANNIVERSARY: THE VALUE OF EMPLOYER-SPONSORED HEALTH BENEFITS

## HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

OF THE

## COMMITTEE ON EDUCATION AND THE WORKFORCE

## U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

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QUESTIONS FOR THE RECORD

# ERISA'S 50TH ANNIVERSARY: THE VALUE OF EMPLOYER-SPONSORED HEALTH BENEFITS

**Tuesday, September 10, 2024**

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

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

Present: Representatives Good, Walberg, Allen, Bean, Burlison, Chavez-DeRemer, Foxx, DeSaulnier, Courtney, Norcross, Wild, Mrvan, McBath, Manning, and Scott.

Staff present: Annmarie Graham, Deputy Communications Director, Mindy Barry, General Counsel; Sheila Havenner, Director of Information Technology, Alex Knorr, Legislative Assistant; Georgie Littlefair, Clerk; CJ Mahler, Professional Staff Member; Hannah Matesic, Deputy Staff Director; Audra McGeorge, Communications Director; Carson Middleton, Staff Director; Jacob Pletcher, Staff Assistant; Kelly Tyroler, Professional Staff Member; Seth Waugh, Director of Workforce Policy; Maura Williams, Operations Manager; Gavin Anderson, Intern; Illana Brunner, General Counsel; Ni'Aisha Banks, Staff Assistant; Nikita Chellani, Intern, Daniel Foster, Senior Health and Labor Counsel; Carrie Hughes, Director of Health & Human Services Policy; Cira Vera, CHCI Intern; Jessica Schieder, Economic Policy Advisor; Dhrtvan Sherman, Research Assistant; Raiyana Malone, Press Secretary; Madeline McBride, Grad Intern; Brashanda McCoy, CBCF Intern; Marie McGrew, Press Assistant; Veronique Pluviose, Staff Director; Isabella Sanchez, Intern and Banyon Vassar, Director of IT.

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

I thank everyone for being here today. I hope our members enjoyed, and our staff a particularly long district work period over the last 6 weeks. I have heard a lot from my constituents about the issues that impact their everyday lives. High gas prices, housing, utility costs, food inflation, and fears of an economic downturn, all top of the list, and give working Americans a real concern about their economic insecurity.

With costs for everything rising under the policies of the Biden Harris administration, it is important for Congress to look at ways to lower costs for American families. With constituent concerns top of mind, we meet today to discuss the bedrock law that helps provide economic security, stability and protection to a majority of the people we serve because it protects employee benefits.

Specifically, we will discuss the value of employer sponsored healthcare benefits under the Employment Retirement and Income Security Act of 1974, or ERISA. In the 50 years that ERISA has been the law of the land, it has helped incentivize employers to offer healthcare benefits that cover over 153 million Americans, or roughly half the population.

ERISA works because of its preemption clause. As a conservative, you will not often hear me say I support Federal preemption of State law, but in this instance, ERISA's effect is to alleviate the burden of government on employers, which actually helps workers.

Without ERISA preemption of State law, the patchwork of State regulations would hamper a business's ability to offer uniform coverage options. Imagine being relocated within the same company to a different State. It happened to me several times, and having to navigate an entire new system of healthcare regulation.

Thanks to ERISA we can avoid that disaster. Employers can simply comply with the protections outlined in ERISA and provide healthcare to employees around the country. According to a Society for Human Resources Management Survey, 90 percent of workers consider healthcare to be an extremely important, or very important benefit.

Another survey, by Protecting Americans Coverage Together found that 93 percent of Americans are satisfied with their employer sponsored coverage. With stats like that, it seems hard to believe that there are politicians who want to dismantle ERISA in favor of government run healthcare.

Private health insurance is at risk due to the push of the left for Medicare for All. The Biden Harris administration wants to make private healthcare unaffordable and unattainable, so that Americans think that they have no choice but to support government run plans. They have saddled employer sponsored healthcare with more regulations and have removed viable coverage options like association health plans and short-term, limited-duration plans.

The Democrats misnamed, Inflation Reduction Act, shifted billions of Medicare dollars to fund failing Obamacare plans. Now, Democrats plan to extend expanded premium tax credits beyond 2025 at a cost of 335 billion dollars. I do not think they understand that using tax dollars to pay for certain American's healthcare costs is robbing Peter to pay Paul, and actually makes healthcare less affordable for everyone.

It costs the government over $1,000.00 more per patient per year to place someone on an Obamacare plan, than on employer sponsored insurance plan. Beyond Obamacare, the proposal from this administration Democrat nominee, Kamala Harris, are somehow even more radical.

Vice President Harris has explicitly endorsed Medicare for All, a plan which calls for the elimination of private health insurance. This would prevent over half of America from keeping the plans

they have now, and that they overwhelmingly prefer. A single payer system would mark the end of ERISA as we know it, and cost taxpayers an estimated 32 trillion dollars.

Worse, her plan provides taxpayer funded healthcare for illegal immigrants. If the government has any legitimate responsibility in healthcare, it should at least be to benefit its own citizens. Before I close, I want to take a moment to play a video from the Washington Post that highlights just how real this threat to ERISA is.

[Video playing]

Mr. DESAULNIER. Mr. Chairman, a point of order here please. Mr. Chairman, point of order please.

Chairman GOOD. Thank you to our staff. It is interesting—we just had the Vice President in her own words without any commentary. For some reason, some members did not want anybody to hear that. It is very interesting. What she said——

Mr. DESAULNIER. Okay, a point of order please.

Chairman GOOD. The gentleman is not recognized. She says under my plan of Medicare for All, private insurance companies will be able to provide coverage if they play by our rules. Although she tries to moderate and disguise her position by acting like private insurance companies can keep functioning as normal, does anyone really think they will get better healthcare when they are playing by Kamala Harris' rules.

The Democrat plan is to make private healthcare unaffordable, and ultimately non-existent. One way to do this is to provide artificially, and temporarily lower cost government provided healthcare to drive providers out of the market, but everything the government does ultimately costs more, especially with the initial costs of the exploding debt that causes higher taxes and higher inflation.

Every government expenditure either causes higher taxes, higher inflation, or debt exploding to the taxpayers. At a time when many Americans are living paycheck to paycheck, and personal savings rates are near historic lows, rising healthcare costs are driven by government interventions are unmanageable. Permitting ERISA plans room to expand and innovate is the solution.

Now it is time for Congress to work to strengthen ERISA and employer sponsored health benefits for the next 50 years and beyond. With that, I now yield to the Ranking Member for his opening statement.

[The Statement of Chairman Good follows:]

STATEMENT OF HON. BOB GOOD, CHAIRMAN, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

Over the last six weeks, I heard a lot from my constituents about the issues that impact their everyday lives. High gas prices, housing and utility costs, food inflation, and fears of an economic downturn all top the list and give working Americans a real concern about their economic insecurity. With costs for everything rising under the policies of the Biden-Harris administration, it is important for Congress to look at ways to lower costs for American families.

With constituent concerns top of mind, we meet today to discuss the bedrock law that helps provide economic security, stability, and protection to a majority of the people we serve, because it protects employee benefits. Specifically, we will discuss the value of employer-sponsored health care benefits under the *Employee Retirement Income Security Act of 1974* (ERISA).

In the 50 years that ERISA has been the law of the land, it has helped incentivize employers to offer health care benefits that cover over 153 million Americans—roughly half the population. ERISA works because of its preemption clause. As a

conservative, you will not often hear me say I support federal preemption of state law. In this instance, ERISA's effect is to alleviate the burden of government on employers, which actually helps workers. Without ERISA preemption of state law, the patchwork of state regulations would hamper a business's ability to offer uniform coverage options. Imagine being relocated within the same company to a different state and having to navigate an entire new system of health care regulations. Thanks to ERISA, we can avoid that disaster. Employers can simply comply with the protections outlined in ERISA, and provide health care to employees around the country.

According to a Society for Human Resource Management survey, 90 percent of workers consider health care to be an extremely or very important employee benefit. Another survey by Protecting Americans Coverage Together found that 93 percent of Americans are satisfied with their employer-sponsored coverage.

With stats like that, it seems hard to believe that there are politicians who want to dismantle ERISA in favor of government-run health care. Private health insurance is at risk due to the push of the Left for Medicare-for-All.

The Biden-Harris administration wants to make private health care unaffordable and unattainable, so that Americans think they have no choice but to support government-run plans. They have saddled employer-sponsored health care with more regulations and have removed viable coverage options like Association Health Plans and short-term, limited-duration plans. The Democrats' misnamed "*Inflation Reduction Act*" shifted billions of Medicare dollars to fund failing Obamacare plans.

Now, Democrats plan to extend expanded premium tax credits beyond 2025 at a cost of $335 billion. I do not think they understand that using tax dollars to pay for certain Americans' monthly health care costs is robbing Peter to pay Paul, and actually makes health care less affordable for everyone. It costs the government over $1,000 more per patient per year to place someone on an Obamacare plan, than on an employer-sponsored insurance plan.

Beyond Obamacare, the proposals from this administration and Democrat nominee Kamala Harris are somehow even more radical. Vice President Harris has explicitly endorsed Medicare-for-All, a plan which calls for the elimination of private health insurance. This would prevent over half of America from keeping the plans they have now and overwhelmingly prefer. A single-payer system would mark the end of ERISA as we know it—and cost taxpayers an estimated $32 trillion.

Worse, her plan provides taxpayer funded health care for illegal immigrants. If the government has any legitimate responsibility in health care, it should at least be to the benefit of its own citizens.

Before I close, I want to take a moment to play a video from the Washington Post that highlights just how real this threat to ERISA is.

She says: "Under my plan of Medicare-for-All, private insurance companies will be able to provide coverage if they play by our rules." Although she tries to moderate and disguise her position by acting like private insurance companies can keep functioning as normal, does anyone really think they will get better health care when they are playing by Kamala Harris's rules?

The Democrat plan is to make private health care unaffordable, and ultimately non-existent. One way to do this is to provide artificially and temporarily lower cost government-provided health care to drive private providers out of the market. Everything the government does ultimately costs more, especially with the initial hidden cost of the exploding debt that causes higher taxes and higher inflation.

At a time when many Americans are living paycheck to paycheck, and personal savings rates are near historic lows, rising health care costs driven by government interventions are unmanageable. Permitting ERISA plans room to expand and innovate is the solution.

Now, it is time for Congress to work to strengthen ERISA and employer-sponsored health benefits for the next fifty years and beyond.

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Mr. DESAULNIER. Just a question to the point of order is a question of the relevance of the video in particular. It is more of a political statement, and I know that there is some license here in Congress for that, but that was extreme in the 10-years I have been here in Congress.

Mr. Chairman, it is unfortunate there are—there is work we can do with ERISA, clearly, but being as partisan as you just introduced this, and using absolutes about every time there is a tax in-

crease, every time the government spends money it leads to all of these horrible things.

This is a mixed market economy, capitalistic economy, and it requires rules and guidance that we all come to agreement on to make it work, including unfortunately, some of the worst aspects of human nature's greed, and lack of ethics, and we are going to talk about that a little bit today, for instance with MultiPlan.

In the spirit I think we have had for the last 4 years when we have been on this Committee, I appreciate our differences, but that was a rather extreme opening comment in my perspective.

To the witnesses, thank you for being here. All of your perspectives are valuable. We appreciate it at this important hearing on ERISA. When ERISA was enacted in 1974, Congress made its intent clear. The law's primary purpose is to "protect the interest of participants in employee benefit plans, and their beneficiaries."

To that end, ERISA established crucial consumer protection standards, provided remedies to workers whose claims are denied, or whose plans are mismanaged, and required fiduciaries to act solely in the best interest of the plan participants. As our Subcommittee discusses ERISA today, it's vital to keep this fundamental purpose at the forefront.

It is about consumers. We must also keep in mind the urgent need to improve the efficiency of our health care system. Our country currently spends more than 17 percent of our gross domestic product, over 4.5 trillion on health care, far more than our peer countries.

Workers and consumers are increasingly shouldering their costs through rising premiums and deductibles. Our health outcomes are among the worst in the developed world. In the other developed countries, they have a form of universal health care, so everyone can get quality health care. Different versions in different countries allow for the private sector to participate in it.

They have better outcomes, longer lifespans. The healthcare system is plagued by numerous challenges and inefficiencies, including, excuse me, the lack of price transparency, the excessive fees charged by self-dealing third-party administrators and pharmacy benefit managers, and the escalating cost of medical care and prescription drugs.

As the New York Times has documented, companies like MultiPlan and major third-party administrators make huge profits by charging high fees to employers, short-changing health care providers, and leaving workers on the hook for exorbitant medical bills, and yes, frequently their actions lead to death.

This is not an efficient use of our health care dollars, which is why Ranking Member Scott and I have written to the Department of Labor in support of their oversight on these practices, and more funding for them so they can do a reasonable job.

I sincerely hope my Republican colleagues will consider joining us to address these issues, including by supporting adequate funding for the vastly under-resourced Employee Benefit Security Administration and extending the bipartisan No Surprises Act implementation fund, which expires at the end of the year.

Despite the challenges we continue to face, it is also important to acknowledge the significant progress we have made in recent

years. The Affordable Care Act has provided preventative health services at no cost, protected tens of millions of Americans with pre-existing conditions, and allowing young people to remain on their parents' health plans until they turn 26.

The American Rescue Plan Act, and the Inflation Reduction Act, strengthened ACA premium tax credits. The tax credits reduced monthly costs for low-income individuals and provided premium relief to millions affected by the subsidy cliff, particularly self-employed, small businesspeople.

Just yesterday the Biden administration, Biden-Harris administration, finalized landmark new rules that will benefit compliance with the Mental Health Parity and Addiction Equality Act, and ensure that behavioral health needs are treated fairly by insurers and in health plans.

While these reforms have strengthened workers' benefits, and improved the efficiency of our health care system, I am concerned by the proposals to take us backward. For instance, one of our biggest recent successes in that Biden-Harris administration, for the first time recently completed negotiations under the Inflation Reduction Act, to reduce drug prices for nearly 9 million Medicare beneficiaries, while slashing seniors' out of pocket costs by 1.5 billion dollars in 2026 alone.

Despite these historic savings, the Republicans' extreme Project 2025 policy agenda proposes to repeal this program, and instead put billions in the pocket of big pharma. I am a recipient of one of those ten drugs. When I first got it to save me from stage 4 cancer, it cost as much as $500.00 a day. Now, next, thanks to this, and the pressure we put on them, it is close to what the European Union charges of under $90.00 a day.

In Australia it costs $37.00 a day. American taxpayers are subsidizing lower costs in other developed countries. Rather than roll back our historic progress, this Committee should move forward with House Democrats' legislation to extend drug price negotiations beyond Medicare and save billions for workers and businesses with private health insurance.

While we may not agree on every issue, I hope that today will be a robust discussion of the future of employer-sponsored coverage, and how we can collaborate across the aisle to address the challenges we face and get rid of the inefficiencies and the greedy profit-taking by some of private sector entities. I yield back.

[The Statement of Ranking Member DeSaulnier follows:]

STATEMENT OF HON. MARK DESAULNIER, RANKING MEMBER, SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

As a point of order, I question the relevance of that video in particular. It was more of a political statement. I know that there is some license here in Congress for that, but that was the most extreme in the ten years I have been here in Congress.

Mr. Chairman, there is work we can do with ERISA, clearly. Being as partisan as you just introduced us, in using absolutes about "every time there's a tax increase, every time the government spends money, it leads to all of these horrible things." This is a mixed market economy, a capitalist economy, and it requires rules and guidance that we all come to an agreement on to make it work—including, unfortunately, some of the worst aspects of human nature—greed and the lack of ethics. We will talk about that a little bit today, for instance, with MultiPlan.

In the spirit that we have had for the last four years we have been on this committee, I appreciate our differences. That was a rather extreme opening comment from my perspective.

To the witnesses, thank you for being here. All of your perspectives are valuable, and we appreciate it during this important hearing on ERISA.

When ERISA was enacted in 1974, Congress made its intent clear: the law's primary purpose is to "protect the interests of participants in employee benefit plans and their beneficiaries." To that end, ERISA established crucial consumer protection standards, provided remedies to workers whose claims were denied or whose plans were mismanaged, and required fiduciaries to act solely in the best interest of the plan participants.

As our Subcommittee discusses ERISA today, it is vital to keep this fundamental purpose at the forefront. It is about consumers.

In addition, we must also keep in mind the urgent need to improve the efficiency of our health care system.

Our country currently spends more than 17 percent of our gross domestic product, over $4.5 trillion, on health care—far more than our peer countries. Workers and consumers are increasingly shouldering these costs through rising premiums and deductibles, yet our health outcomes are among the worst in the developed world. In other countries, they have a form of universal health care so everyone can get quality health care. Different versions in different countries allow for the private sector to participate in it. They have better outcomes and longer life spans.

The health care system is plagued by numerous challenges and inefficiencies, including:

- the lack of price transparency;
- the excessive fees charged by self-dealing third-party administrators and pharmacy benefit managers; and
- the escalating costs of medical care and prescription drugs.

As *The New York Times* has documented, companies like MultiPlan and major third-party administrators make huge profits by charging high fees to employers, shortchanging health care providers, and leaving workers on the hook for exorbitant medical bills—and yes, frequently, their actions lead to death. This is not an efficient use of our health care dollars, which is why Ranking Member Scott, and I have written to the Department of Labor to support their oversight on these practices and more funding for them so they can do a reasonable job.

I sincerely hope my Republican colleagues will consider joining us to address these issues, including by supporting adequate funding for the vastly underresourced Employee Benefits Security Administration and extending the bipartisan *No Surprises Act* Implementation Fund, which expires at the end of the year.

Despite the challenges we continue to face, it is also important to acknowledge the significant progress we have made in recent years. The *Affordable Care Act* has provided preventive health services at no cost, protected tens of millions of Americans with preexisting conditions, and allowed young people to remain on their parent's health plans until they turn 26. The *American Rescue Plan Act* and the *Inflation Reduction Act* strengthen ACA premium tax credits. The tax credits reduced monthly costs for low-income individuals and provided premium relief to millions affected by the subsidy "cliff," particularly self-employed small businesspeople. Just yesterday, the Biden-Harris Administration finalized landmark new rules that will benefit compliance with the *Mental Health Parity and Addiction Equity Act* and ensure that behavioral health needs are treated fairly by insurers and health plans.

While these reforms have strengthened workers' benefits and improved the efficiency of our health care system, I am concerned by the proposals to take us backwards.

For instance, one of our biggest recent successes—the Biden-Harris Administration, for the first time, recently completed negotiations under the *Inflation Reduction Act* to reduce drug prices for nearly 9 million Medicare beneficiaries while slashing seniors' out-of-pocket costs by $1.5 billion in 2026 alone. Despite these historic savings, the Republicans' extreme "Project 2025" policy agenda proposes to repeal this program and put billions in the pockets of big pharma.

I am a recipient of one of those ten drugs. When I first got it, it saved me from stage four cancer, and it cost me as much as 500 dollars a day. Now, thanks to this and the pressure we put on them, it is closer to what the European Union charges, 190 dollars a day. In Australia, it costs 37 dollars a day. American taxpayers are subsidizing lower costs in other developed countries.

Rather than roll back our historic progress, this Committee should move forward with House Democrats' legislation to extend drug price negotiations beyond Medi-

care and save billions for workers and businesses with private health insurance coverage.

While we may not agree on every issue, I hope that today will be a robust discussion on the future of employer-sponsored coverage and how to collaborate across the aisle to address the challenges we face and get rid of the inefficiencies and greedy profit-taking by some private sector entities.

I yield back.

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Chairman GOOD. Pursuant to Committee Rule 8-C, all members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically, in Microsoft Word format by 5 o'clock p.m., 14 days after the date of this hearing, which is September 24, 2024.

Without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous materials referenced during the hearing, to be submitted for the official hearing record. I note for the Subcommittee that some of our colleagues, who are not permanent members of this Subcommittee, may be waving on for the purpose of today's hearing.

I will now turn to the introduction of our distinguished witnesses. Our first witness is Ms. Ilyse Schuman, who is Senior Vice President for Health and Paid Leave Policy, for the American Benefits Council in Washington, DC. Welcome, Ms. Schuman.

Our next witness is Ms. Holly Wade, who is the Executive Director of the National Federation of Independent Business Research Center in Washington. Welcome, Ms. Wade.

Our third witness is Mr. Anthony Wright, who is the Executive Director of Families USA in Washington, DC. Welcome, Mr. Wright.

Our final witness is Dr. Paul Fronstin, who is the Director of Health Benefits Research for the Employee Benefit Research Institute, EBRI, am I saying that right, in Washington as well. Thank you, Dr. Fronstin.

We thank the witnesses for being here today, and we look forward to your testimony. Pursuant to Committee Rules, I would ask that you limit your presentation to a 5-minute summary of your written statement. I would also like to remind the witnesses to be aware of their responsibility to provide accurate information to this Subcommittee, and we will now recognize Ms. Shuman for 5 minutes.

**STATEMENT OF MS. ILYSE SCHUMAN, SENIOR VICE PRESIDENT, HEALTH AND PAID LEAVE POLICY, AMERICAN BENEFITS COUNCIL, WASHINGTON, D.C.**

Ms. SCHUMAN. Chair Good, Ranking Member DeSaulnier, and distinguished Subcommittee members, thank you for the opportunity to testify on behalf of the American Benefits Council. Employers play a critical role in the healthcare system, providing health benefits to nearly 180 million Americans.

In sponsoring these benefits, employers have made significant contributions not only to the health and well-being of working families, but to taxpayers, the economy, and the healthcare system as a whole. For 50 years ERISA, and ERISA preemptions specifically has been the cornerstone of the employer sponsored health benefits.

America's employers recognize that their investment in health coverage is an investment in their workforce, and in their business success, and working families and voters recognize its value too. According to polling data from the Winston Group on behalf of the Alliance to Fight for Healthcare, more than three-quarters of registered voters expressed satisfaction with their employer-sponsored health coverage, far preferring it to a stipend to shop in the individual market, and in even more stark preference over a system where employers do not provide health benefits at all.

Employer-sponsored health benefits yield a significant return on investment to the Federal Government and taxpayers. For every dollar of Federal expenditure for the tax exclusion of employer sponsored health benefits, employers pay more than $5.00 in benefits. It would cost said taxpayers substantially more to provide the same level of health benefits through a direct government program.

With a vested interest in securing the health and well-being of their employees, far from being mere payers that just sign checks for health benefits, our member companies employes have been innovators in market driven approaches to provide high value benefits. Our member companies also clearly understand that their innovation and ability to provide affordable, high-quality health coverage, are built on the foundation of ERISA, by enabling self-funded multi-State employers to offer uniform benefits to their employees nationwide.

However, ERISA preemption is under assault, as states seek to impose their own requirements on self-funded group health plans. Without ERISA uniformity, these plans will be extraordinarily difficult to administer, forcing employers to offer different benefits to their employees based on their location.

ERISA's 50th anniversary comes at a critical time to convey this important message. I also want to stress that employers are deeply concerned about overly burdensome Federal health plan regulations that add cost and complexity, but without commensurate value to either plan sponsors or employees.

I also want to stress that employers are deeply concerned about rising healthcare costs, fueled by a lack of transparency and competition. While employers continue their innovative efforts to lower cost, Federal legislative solutions are needed to create a more competitive and transparent healthcare marketplace.

90 percent of voters with employer sponsored coverage agree that it is important for Congress to take action this year to lower healthcare costs. There are solutions at hand. The Council strongly supports the lower cost, more transparency, including its PBM provisions, and more than 80 percent of voters agree that it should be a priority for Congress to pass price transparency legislation.

The Healthy Competition for Better Care Act is critical that with growing market power, large hospital systems are able to demand higher and higher prices and impose anti-competitive contracting restrictions that stifle competition. The Council urges the Committee to pass the Healthy Competition for Better Care Act.

Allowing hospital facility fees to be charged for telehealth appointments is precisely the type of payment distortion and obtuse billing practice that increases costs for patients and payers. Voters agree by an overwhelming margin of 8 to 1, that patients should

not be charged for this. The Council urges the Committee to approve the Transparent Telehealth Bill's Act to address the concern.

On this 50th anniversary of ERISA, the message is strong and clear from employers, employees and voters about the significant value of employer sponsored health coverage, that is built on their foundation—is the call for Congress to take action this year to lower healthcare costs.

These steps rely on and must be taken in concert with the uniformity ERISA preemption affords. 50 years after this landmark legislation was enacted, these provisions are even more important today. I appreciate the opportunity to testify.

[The prepared statement of Ms. Schuman follows:]


TESTIMONY OF

**ILYSE SCHUMAN**

SENIOR VICE PRESIDENT, HEALTH AND PAID LEAVE POLICY

AMERICAN BENEFITS COUNCIL

BEFORE THE

**UNITED STATES HOUSE OF REPRESENTATIVES**

**COMMITTEE ON EDUCATION & THE WORKFORCE**

**SUBCOMMITTEE ON HEALTH, EMPLOYMENT,**

**LABOR AND PENSIONS**

HEARING ON

# "ERISA AT 50: THE VALUE OF EMPLOYER-SPONSORED HEALTH BENEFITS."

**SEPTEMBER 10, 2024**

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

Chairs Foxx and Good, Ranking Members Scott and DeSaulnier and distinguished subcommittee members,

Thank you for the opportunity to testify on behalf of the American Benefits Council ("the Council") at this important hearing commemorating the 50th anniversary of ERISA and the value of employer-sponsored health benefits. I am Ilyse Schuman, the Council's senior vice president, health and paid leave policy.

The Council is a national association dedicated to protecting employer-sponsored benefit plans. The Council represents more major employers – over 220 of the world's largest corporations – than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or support health and retirement plans covering virtually all Americans participating in employer-sponsored programs.

Employers play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide health coverage to nearly 180 million Americans.[1] More Americans rely on their employers for health coverage than any other source. But the value of employer-sponsored health insurance extends far beyond just quantifying the number of people covered by this type of insurance. It also reflects the commitment of employers to their employees and to innovation. In sponsoring these benefits, employers have made significant contributions not only to the health and well-being of working families, but to taxpayers, the economy and the health care system as a whole.

The Council commends you for marking ERISA's golden anniversary with a hearing highlighting the value of employer-sponsored health benefits. Indeed, it is this half-century old law that is the foundation of employer-sponsored coverage and the fuel for employers' drive for lower-cost, higher-quality health care. Specifically, ERISA's federal preemption of state laws is essential to these efforts by enabling multi-state employers to offer uniform benefits to their employees, irrespective of their or their employees' location and tailored to meet the needs of employees and their families.

**Employer-sponsored health insurance brings tremendous value to working families, businesses, taxpayers, the economy, and the health care system as a whole.**

Employer-sponsored health insurance brings comprehensive health care within reach of working families in communities across America. And working families and voters recognize its value. According to polling data from the Winston Group on behalf

[1] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2022* (September 2023), Table 1

of the Alliance to Fight for Health Care,[2] more than three-quarters (78%) of registered voters expressed satisfaction with their employer-sponsored health coverage. In the same poll, by a margin of more than three to one (64% to 21%), voters with employer-sponsored health coverage preferred a system where companies provide comprehensive health coverage options, rather than a stipend for employees to shop for their own health insurance in the individual market. Notably, only 7% of voters with employer-sponsored health coverage preferred a system where employers do not provide health benefits at all.

America's employers recognize that their investment in health coverage for employees is also an investment in their business success. Employers make this substantial investment with the understanding that the health and well-being of the workforce has a measurable impact on virtually every aspect of their business. Moreover, an employer's ability to recruit and retain talent requires a commitment to offering high-quality, affordable health benefits to an ever-evolving workforce. A study by Avalere Health[3] estimated that employer-sponsored health insurance would provide a 47% return on investment to employers with 100 or more employees in 2022, projected to rise to 52% in 2026. This includes $275.6 billion from improved productivity in 2022 and $346.6 billion in 2026.

The tax-favored treatment for employer-sponsored health insurance also yields a significant return on investment to the federal government and taxpayers. The tax "expenditure" associated with employer-sponsored coverage is the estimate of the individual income tax imposed on workers that is forgone due to the tax-favored treatment of the health coverage they receive.

The value of the exclusion can be determined by looking at the amount employers spend for group health insurance and comparing it to the cost of the tax expenditure. According to the White House Office of Management and Budget, $225 billion in forgone revenue was attributable to the income tax exclusion for employer-provided health coverage in 2022.[4] Meanwhile, the Bureau of Economic Analysis (BEA) shows that employer group health insurance funds paid out $1.2 trillion that same year.[5] A back-of-the-envelope calculation of $1.2 trillion divided by $225 billion reveals that each dollar of federal expenditure yielded approximately $5.33 in benefits for covered employees and their families – a more than 5-to-1 return on investment. It would cost taxpayers substantially more to provide the same level of financial protection for health

[2] The Winston Group, *Alliance to Fight for Health Care National Survey* (September 2024)

[3] Avalere Health, *Return on Investment for Offering Employer-Sponsored Insurance* (June 28, 2022)

[4] White House Office of Management and Budget, *Analytical Perspectives - Budget of the U.S. Government, Fiscal Year 2024*, Table 19-2 (March 2023)

[5] U.S. Bureau of Economic Analysis, "Employer Contributions for Employee Pensions and Insurance Funds by Industry and by Type," Table 6.11 D (September 29, 2023)

expenses if it had to be provided through a direct government program rather than incentivizing the employer-sponsored system.


**Employers are at the forefront of innovation to lower health care costs and improve quality.**

The system of employer-provided health coverage has generated extraordinary health and economic benefits. With a vested interest in securing the health and well-being of employees coupled with a drive for innovation, employers are the key to lowering costs and increasing quality for employees and the health care system as whole.

Employers have long been pioneering initiatives to lower costs and improve quality through various value-based strategies. Far from being mere payors that sign the checks for health coverage and benefits, employers have been innovators in market-driven approaches to providing high-value health benefits. A report by the Council, *American Benefits Legacy: The Unique Value of Employer Sponsorship,*[6] describes the important contribution that employer-sponsored health insurance makes to the health and well-being of working families and the economy. Another report, the 2018 *Leading the Way: Employer Innovations in Health Coverage*[7] from the Council and Mercer, includes case studies depicting how employer providers of health coverage are lowering costs and improving quality through innovation.

Employers' commitment to the health and well-being of their employees and to innovation withstood the unprecedented challenges of the COVID-19 pandemic.

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[6] American Benefits Council, *American Benefits Legacy: The Unique Value of Employer Sponsorship* (October 17, 2018)

[7] American Benefits Council and Mercer, *Leading the Way: Employer Innovations in Health Coverage* (March 12, 2018)

During the pandemic, the Council reached out to scores of American employers to learn how they managed the unprecedented health and economic trials. The stories relayed in the Council's *Silver Linings Pandemic Playbook*[8] , such as expanding access to telehealth and mental health services to protect the physical and emotional health of workers, are reflective of this commitment.

Employers continue to lead the way on initiatives that lower costs, improve quality and help employees lead healthier and more productive lives. Examples of innovative payment reforms our member companies are implementing include:

- Recognizing the value of access to high-quality primary care, by moving away from fee-for-service to a per user, per month fee paid to advanced primary care clinics that meet the highest quality standards.
- Embarking on direct contracting with hospitals to direct employees to the right health system and thereby get a better discount in return.
- Leveraging price and quality data to help ensure that employees are using high-value providers who deliver appropriate care.

Employers have also been on the front lines battling the mental health and substance use disorder crisis. An informal survey conducted by the Council highlights the commitment of our large employer members to expanding access to mental health services. For an overwhelming percentage of respondents (87%), supporting and/or expanding access to mental health care for employees is a top overall priority for their organization. And employers have turned to telehealth and other point solutions to expand access to mental health care for workers and families in the face of a serious shortage of mental health providers.

**Nationwide uniformity under ERISA is the cornerstone of employer-sponsored health insurance.**

These and countless other examples are a testament to employer innovation and the importance of employer-sponsored coverage in addressing the nation's health challenges. The examples cited above and the commitment of employers to ensuring that working families have access to affordable, high-quality health coverage are built on the foundation of ERISA. Indeed, these innovations would not be feasible without ERISA's preemption provisions.

Following the passage of ERISA, one of its authors who was a member of this committee – Representative John Dent of Pennsylvania – cited preemption as the law's

[8] American Benefits Council, *The Silver Linings Pandemic Playbook* (October 13, 2021)

"crowning achievement." Not only was it important politically by enabling labor and management to come together in support of the legislation; but substantively he and his congressional colleagues recognized that nationwide uniformity under ERISA is the cornerstone of employer-provided benefits by enabling an employer to provide equitable benefits to its workers, wherever they live or work; and to more readily administer a benefit plan designed to provide that equitable coverage. Under ERISA's preemption provisions, employers that self-fund their health benefit plans can offer coverage across the 50 states that is consistent and tailored to the specific needs of their workforce. With ERISA's preemption provision, Congress protected such self-funded employers from a patchwork of state laws that would undermine these benefits to employers and employees alike.

For 50 years, ERISA and the employer-sponsored health insurance system secured upon its foundation have withstood extraordinary challenges, including an unprecedented pandemic and dramatic changes in the workforce and economy. The importance of ERISA preemption for employers has only grown over this time as commerce has increasingly stretched across state lines. The pandemic, which resulted in an enormous growth in remote workers has resulted in more mid-sized and even small businesses finding themselves to be multi-state employers. Moreover, the need to innovate has become more paramount as employers continue to seek new strategies to lower costs, improve health outcomes, and meet the nation's health care challenges.

However, on its 50th anniversary, ERISA preemption is under assault on multiple fronts. As more fully explained in the Council's response to the committee's request for information on ERISA,[9] preemption is under attack in the states, threatening employers' ability to promote affordable, high-value health coverage to employees on a uniform basis nationwide. States are imposing their own requirements on self-funded group health plans. This includes procedural rules, reporting and disclosure requirements, benefit mandates, asserting what providers may (or in some cases must) be utilized by the plan, and/or restrictions regarding the type and nature of cost-sharing or coinsurance that may be applied to benefits. All of these requirements interfere with the fundamental policy goal of ERISA, which is to ensure that employers are able to offer uniform coverage to their employees, free from state regulation.

Without ERISA uniformity, employers would have to comply with a patchwork of varying and ever-changing state and local laws, making plans extraordinarily difficult to administer and causing employees performing the same job for the same employer, albeit in different locations, to receive very different benefits. Furthermore, in the absence of ERISA preemption, employers would not be able to leverage economies of scale that nationwide plan design, administration and negotiation affords.

[9] American Benefits Council, "Council Response to House Education and the Workforce Request for Information on ERISA (March 14, 2024)

This hearing comes at a critical time to convey to the committee the seriousness of the threat to ERISA preemption and the imperative to protect it Preemption is essential to employer-sponsorship of group health plans and to the value those plans bring to working families, businesses, taxpayers and the health care system as a whole.

**Burdensome federal regulations that add cost and complexity - but not value – undermine employer innovation and the ability to offer affordable, high-quality health coverage.**

Employers are deeply concerned about federal health plan regulations that add cost and complexity to group health plan administration without providing commensurate value to either plan sponsors or employees. For example, recently proposed regulations under the Mental Health Parity and Addiction Equity Act contain several provisions that will add burdens to plan sponsors, including a new fiduciary certification requirement, that are not necessary to support compliance and that do nothing to help consumers. While there is clearly an important role for federal regulations, overly burdensome and misguided requirements can instead undermine employer innovation.

**Employers are deeply concerned about rising health care costs fueled by a lack of transparency and competition.**

Employer-sponsored coverage remains a tremendous value for workers and businesses. Yet rising health care costs threaten this value. Employers are increasingly frustrated by fundamental failures in the health care marketplace that stifle competition, cloud line of sight to price and quality information, impede innovation and, ultimately, increase costs.

In 2022, private health insurance spending grew 5.9% to $1.3 trillion and is expected to grow an average of 5.6% over each of the next nine years.[10] According to a survey by the Kaiser Family Foundation, annual premiums for employer-sponsored health coverage reached $23,968 for family coverage in 2023, with workers, on average, paying $6,575 toward that cost, an increase of 7% from the prior year.[11] This trajectory is unsustainable for employers, employees and their families.

According to the Winston Group poll, health insurance costs are a key concern for voters, along with the economy and inflation. 70% of voters with employer-sponsored health insurance think that health care costs will increase over the next year. Asked to select from a list of which items concerned them the most about their health care, voters

[10] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), "CMS Releases 2023-2032 National Health Expenditure Projections" (June 12, 2024)

[11] Kaiser Family Foundation, *2023 Employer Health Benefits Survey* (October 18, 2023)

with employer-sponsored health insurance identified the cost of insurance premiums (29%) most frequently as the top concern, followed by the cost of co-pays/deductibles (24%). The only way to truly make health care more affordable for working families is to understand and address the root causes of rising spending, namely a lack of transparency and misaligned incentives that promote market consolidation and higher-cost care settings.

Health care prices – not greater utilization – are the primary cause of rising health care spending.[12] Hospital costs are the largest health spending category in the United States, accounting for almost one-third of all expenditures.[13] In 2022, according to the Centers for Medicare & Medicaid Services (CMS), hospital spending totaled $1.4 trillion.[14] It accounts for 44% of total personal health care spending for the privately insured and hospital price increases are key drivers of recent growth in per capita spending among these individuals .[15] Employer plans pay much higher prices for health care goods and services than public plans. According to a Rand Corporation report, in 2020, across all hospital inpatient and outpatient services, employers and private insurers paid hospitals 224% of what Medicare would have paid for the same services.[16] According to an analysis by the Congressional Budget Office (CBO), the main reason for the growth of per-person spending by commercial insurers—and why it differs from the growth of per-person spending by Medicare fee-for-service—has been rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services.[17]

It is therefore essential to examine the factors contributing to rising hospital care prices. The answer is that basic market dynamics are at play. When monopolistic hospital systems buy competing hospitals and physician practices, the resulting dominance in the local market allows them to raise prices and demand restrictive contracting terms with employer-sponsored health plans and the insurers who negotiate on their behalf. The 2020 report "Affordable Hospital Care Through Competition and Price Transparency" explains:

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[12] Gerard F Anderson, Peter Hussey and Varduhi Petrosyan, "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt," Health Affairs (January 2019)

[13] Matthew McGough, Aubrey Winger, Shameek Rakshit and Krutika Amin (Petersen-KFF Health System Tracker), "How has U.S. spending on healthcare changed over time?" (December 15, 2023)

[14] CMS Office of the Actuary, "National Health Expenditures 2022 Highlights" (December 13, 2023)

[15] Rand Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (2020)

[16] Rand Corporation, *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative* (2022)

17 Congressional Budget Office (CBO), *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (September 29, 2022)

> One of the greatest challenges to affordable health care is the high cost of American hospitals. The most important driver of higher prices for hospital care, in turn, is the rise of regional hospital monopolies. Hospitals are merging into large hospital systems and using their market power to demand higher and higher prices from the privately insured and the uninsured.[18]

Substantial economic literature has demonstrated that provider consolidation leads (on average) to "less bang for the buck": higher prices without higher quality or access.[19]

Many private hospital systems are also becoming vertically integrated with physician organizations. Hospitals and corporate entities owned half of America's physician practices and employed nearly 70% of physicians by the end of 2020.[20] After hospitals acquire physician practices, the prices for the services provided by acquired physicians increase by an average of 14.1%.[21] Also, after hospitals purchase physician practices, they are able to rename the practices as "hospital facilities" and thereby bill at higher hospital rates (that now include a "facility" fee) for the exact same service. This payment distortion incentivizes provider consolidation, in turn, fueling higher costs.

Competition and transparency are inextricably linked. In fact, a competitive health care market is predicated on transparency. Many employers that have had success decreasing the rate of health care spending have done so by analyzing data to better understand how much is being spent on specific services and then using plan design features to promote higher-value, relatively lower-cost providers. Despite important legislative and regulatory action to advance health care transparency, impediments remain to meaningful access and utilization of health pricing data. For example, the lack of standardized formatting and loopholes in the hospital price transparency regulatory requirements has impeded the use of such information.

**Employers and voters want Congress to take action *this year* to lower health care costs by increasing transparency and competition and by removing payment distortions that add cost but not value.**

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[18] The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* (January 31, 2020)

[19] The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market* (March 2020), pp 7

[20] Physicians Advocacy Institute, *COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020 [Prepared by Avalere Health]* (June 2021)

[21] Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physician practices on prices and spending," *Journal of Health Economics* (May 2018)

While employers continue their efforts to lower costs, federal legislative solutions are needed to create a more competitive, transparent health care marketplace and to remove payment distortions. According to the Winston Group polling, 90% of voters with employer-sponsored health insurance think it is important for Congress to take action ***this year*** to lower health care costs (54% of those voters say that this is very important). The good news is that there are legislative solutions that this committee has approved and/or plans to consider that represent important steps in lowering costs. Specifically, the Council strongly supports the following legislation:

- The Lower Costs, More Transparency Act
- The Healthy Competition for Better Care Act
- Transparent Telehealth Bills Act

**The Council strongly supports the Lower Costs, More Transparency Act**

The Lower Costs, More Transparency (LCMT) Act (H.R. 5378), which passed the House in an overwhelming bipartisan vote, represents an important step forward in lowering costs through increased transparency and competition. The Council applauds the committee for its work on the legislation and urges Congress to pass it this year.[22] The Council strongly supports policies in the LCMT Act that:

- ensure greater price transparency by codifying and improving price transparency for hospitals and group health plans,
- require greater transparency and oversight of Pharmacy Benefit Managers (PBMs),
- require hospital billing transparency to prevent practices that fuel consolidation and mask what should be the appropriate payment for care that is delivered in a lower-cost setting, such as off-site clinics or a physician's office, and
- expand site-neutral payment reform to eliminate higher payments for care that can safely be delivered in a physician's office but is being billed at higher hospital rates (including a facility fee) after the physician's practice is purchased by the hospital and rebranded as a "hospital outpatient department."

Employers understand the importance of these policies in fostering competition and keeping prices in check – and so do voters. According to the Winston Group poll, more than 80% of voters with employer-sponsored health insurance cited transparency of

[22] American Benefits Council, "Letter in Support of Lower Costs, More Transparency Act (H.R. 5378)" (December 7, 2023)

how much services cost as either the top priority (36%) or one of the high priority health care issues (45%) Congress should address.

By a 2-to-1 margin, voters are in favor of adopting site-neutral payment policies according to the Winston Group polling. Overwhelmingly, by a margin of 76% to 10%, voters said that patients should not be charged hospital facility fees for care received in an off-site doctor's office that is owned by a hospital system that is not located at a hospital. 52% of voters with employer-sponsored health insurance said that limits on such "facility fees" should be one of the top priorities of health care issues for Congress; and another 18% said it should be the top priority.

**The Council strongly supports the Healthy Competition for Better Care Act**

Healthy competition in the health care marketplace is essential for lower-cost, higher quality health care. Unfortunately, as large hospital systems have increasingly acquired other hospitals and physician practices, these health systems dominate the market and use their market power to push out lower-priced, higher-quality competitors – resulting in higher costs for employers and employees. A recent report from the National Bureau of Economic Research observed that hospital mergers that generated the largest price increases were the transactions that involved a more substantial lessening of competition.[23]

With growing market power, large hospital systems are able to demand higher prices and impose anti-competitive contracting terms on employer-sponsored health plans and the third-party administrators or insurers negotiating on their behalf. These restrictive terms that appear in contracts the hospital system negotiates with insurers, third-party administrators or group health plans further solidify the hospital system's dominance in the region, reduce competition, and ultimately increase costs. Large hospital systems in highly concentrated markets use their leverage in contract negotiations to include terms that limit access to lower-cost, higher-quality health care. These anti-competitive contracting terms come in several forms: (1) "anti-steering" or "anti-tiering" provisions that prevent employers from utilizing value-based designs to direct employees toward lower-cost, higher-quality providers, (2) "all-or-nothing" clauses that require the health plan to contract with all affiliated facilities and providers, including lower-quality ones, or (3) "most-favored nation" clauses that restrict other health plans that are not even a party to the contract from paying lower rates.

As hospital consolidation increases, these anti-competitive contracting provisions have become more prevalent and with more of a negative impact for more employers

[23] Zarek Brot-Goldberg, Zack Cooper, Stuart V. Craig, Lev R. Klarnet, Ithai Lurie and Corbin L. Miller "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers" (June 2024)

and workers. An estimated 117 million people live in a concentrated hospital market.[24] One study estimated that the vast majority (90%) of metropolitan statistical areas (MSAs) had highly concentrated hospital markets in 2016.[25]

With such contracting terms in place, the employer's hands are tied in their efforts to promote higher-value health care and employees are bound more tightly to higher-cost and/or lower quality providers. The Council urges Congress to address these practices that disrupt market dynamics and raise costs. The Council urges the committee to pass the Healthy Competition for Better Care Act (H.R. 3120) that would increase competition and promote lower costs by restricting such anti-competitive contract terms.

**The Council strongly supports the Transparent Telehealth Bills Act.**

Employers understand the importance of telehealth in expanding access to care, particularly mental health services. Accordingly, employers strongly support policies that allow them to increase access to affordable medical and mental health care via telehealth. However, allowing hospital "facility fees" to be charged for telehealth appointments is precisely the type of payment distortion and obtuse billing practice that increases costs for patients and employers. Voters agree by an overwhelming margin of 82% to 9% that patients should not be charged a hospital facility fee for care received via a telehealth appointment, according to the Winston Group polling. Accordingly, the Council urges the committee to approve legislation to prohibit increased facility fee payments for telehealth services furnished by providers located at hospital facilities.

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On this 50th anniversary of ERISA, the message is strong and clear from employers, employees and voters to Congress about the significant value of employer-sponsored health coverage that is built on ERISA's foundation. So is their call for Congress to take action ***this year*** to lower health care costs by addressing the root causes of rising costs that threaten this value. By passing legislation that increases competition and transparency and removes payment distortions leading to higher-cost care, Congress can unleash the power of employer innovation to improve the affordability and quality of health care for employees and their families. These steps rely on and must be taken in concert with the uniformity that ERISA preemption affords. Fifty years after this

[24] Urban Institute, *Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets* (March 2021)

[25] Brent D. Fulton, "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses" *Health Affairs* (September 2017)

landmark legislation was enacted, provisions crafted by its authors are even more important for employers to meet today's health care challenges and offer affordable, high-quality coverage to American workers and their families in the years ahead.

Thank you again for holding this hearing today and for the opportunity to testify.

Chairman GOOD. Thank you. I now recognize Ms. Wade for 5 minutes.

**STATEMENT OF MS. HOLLY WADE, EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF INDEPENDENT BUSINESS RESEARCH CENTER, WASHINGTON, D.C.**

Ms. WADE. Chairman Good, Ranking Member DeSaulnier, and distinguished members of the Subcommittee, on behalf of NFIB, I appreciate the opportunity to testify. Small businesses are the foundation of the U.S. economy, but unfortunately in recent years, the small business half of the U.S. economy has been significantly impacted by inflation, along with significant challenges in attracting qualified applicants for open positions.

Operating a business in these conditions is particularly difficult for small business owners. Most small business owners compete for talent by offering competitive wages and attractive benefits. Health insurance is one of the most popular, but costly benefits offered by about 30 percent of small employers.

However, escalating health insurance costs add to the inflation pressures many business owners face. These higher costs limit their ability to compete in the marketplace. The relationship between small businesses and health insurance has been a longstanding challenge for owners, whether they offer or do not offer the benefit to their employees.

63 percent of all employers believe that providing health insurance to recruit and retain employees is very or moderately important to them. Almost all, 94 percent of small employers find it challenging to some degree to manage the costs of providing employer-sponsored health insurance.

The cost of health insurance continues to rank as the most burdensome issue for small business owners, a ranking it has held since 1986. Currently, 41 percent of small business owners reported as a critical issue in operating their business. The average cost of individual health insurance plan has increased 112 percent in the last 20 years for small employers.

The average deductible for those policies has increased by 194 percent. Small businesses are not only paying significantly more for their health insurance, but their deductibles are more costly as well. In response to these escalating costs, the offer rate among small businesses has declined from 42 percent in 2004 to 30 percent in 2023.

Lack of insurance options, and affordability issues create significant headwinds for small business owners, and that most of them find the benefit important in retaining current employees and recruiting applicants. Broken down by employers who do and do not currently offer health insurance, 94 percent of owners who currently offer, believe that it is important, and 58, over half, percent

of owners who do not currently provide health insurance find it important in those aspects of retaining and retention of employees.

Almost two-thirds of non-offering small employers say that the health insurance is too expensive for them to offer it as a benefit. Most small business owners are offering health insurance purchase fully funded plans in the small group market. However, the small group market has experienced a sharp decline in issuer participation, and overall membership.

Down 7.4 percent from 2022 to 2023, ending the year with 8.5 million participants. This decline is driven primarily by the escalating cost of insurance. The coverage options in this market have declined. Alternatives, like those provided under ERISA framework become vital.

Recent reports point to an increase in the percentage of small firms offering health benefits through a level funded plan, for instance. As we mark the 50th anniversary of ERISA, it is an opportune time to reflect on the rule that employer provider coverage has played in the U.S. and on small businesses. While most small firms remain fully insured, ERISA protections have been crucial in ensuring that even the smallest businesses can offer health benefits to their employees, while having the flexibility and predictability to design benefits in a way that works best for them.

Moving forward, ERISA should be protected and strengthened to empower those small businesses with greater coverage choices under this framework, enabling them to offer valuable benefits that will contribute to their growth, stability and success in the U.S. economy.

Some policy solutions to strengthen small firm's coverage choices; allowing small businesses and self-employed individuals to band together to achieve savings through economies of scale, protect small business's access to stop loss insurance, re-evaluate and right size mandates that drive up premium costs, and promote price transparency and price certainty.

We thank the Committee for its vital work in the past year, expanding coverage choices for small businesses under ERISA, and look forward to partnering with you to continue building on this law's success. Thank you for allowing me the opportunity to testify for you today.

[The prepared statement of Ms. Wade follows:]

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

**NATIONAL FEDERATION OF INDEPENDENT BUSINESS**


Statement for the Record of Holly Wade
Executive Director, NFIB Research Center

Before the

**United States House Committee on Education and the Workforce**
**Subcommittee on Health, Employment, Labor, and Pensions**

**Hearing on: "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**

Tuesday, September 10, 2024

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

Dear Chair Good, Ranking Member DeSaulnier, and distinguished Members of the Subcommittee on Health, Employment, Labor, and Pensions, my name is Holly Wade, and I serve as the Executive Director of the National Federation of Independent Business (NFIB) Research Center.

On behalf of NFIB, I appreciate the opportunity to testify before the House Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions hearing entitled, "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits."

NFIB is the nation's leading small business advocacy association, representing members in Washington, D.C., and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB proudly represents approximately 300,000 members nationwide from every industry and sector.

The NFIB Research Center promotes a greater understanding of small businesses and the conditions that impact them. The Center produces and disseminates various surveys and studies on small businesses, focusing on areas related to business operations and the effects of public policy.

Small businesses are the foundation of the U.S. economy, employing nearly half (46%) of the private sector workforce and responsible for 44 percent of our gross domestic product (GDP).[1] Unfortunately, in recent years, the small business half of the U.S. economy has been significantly impacted by inflation, along with significant challenges in attracting qualified applicants for open positions. Operating a business in these conditions is particularly difficult for small business owners. Most small business owners compete for talent by offering competitive wages and attractive benefits. Employer-provided health insurance coverage is the largest source of health coverage in the U.S., covering over 160 million people.[2] It is the most popular but costly benefit offered by about 30 percent of small employers.[3] However, escalating health insurance costs add to the inflation pressures many business owners face. These higher costs limit their ability to compete in the marketplace.

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[1] Small Business Administration, Office of Advocacy, Frequently Asked Questions About Small Business, 2024. 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] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 2023.

The relationship between small businesses and health insurance has been a long-standing challenge for small business owners whether they offer or don't offer the benefit to their employees. Health insurance is a primary benefit for many employees and job seekers, and small employers compete for talent by offering competitive compensation packages. Sixty-three percent of all employers believe that providing health insurance to recruit and retain employees is very or moderately important. Almost all (94%) of small employers find it challenging, to some degree, to manage the cost of providing employer-sponsored health insurance.[45]

The cost of health insurance continues to rank as the most burdensome issue for small business owners, a ranking it's held since 1986.[6] Currently, 41 percent of small business owners report it as a "critical" issue in operating their business. The average cost of an individual health insurance plan has increased 112 percent in the last 20 years for small employers. The average deductible for those policies has increased by 194 percent. Small businesses are not only paying significantly more for their health insurance but their deductibles are more costly also. In response to these escalating costs, the offer rate among small businesses has declined from 42 percent in 2004 to 30 percent in 2023.[7]

There is tremendous value in employer-provided coverage and in small businesses being able to provide robust, affordable health benefits to their employees. Unfortunately, almost all (98%) of small employers offering health insurance are concerned that the cost of providing health insurance to their employees will become unsustainable in the next 5-10 years. Over half of them (58%) were very concerned. The lack of insurance options and affordability issues create significant headwinds for small business owners in that most of them find the benefit important in retaining current employees and recruiting applicants for open positions. Broken down by employers who do and do not currently offer health insurance, 94 percent of owners who currently offer health insurance believe it is important, and 58 percent of owners who do not currently provide health insurance.[8]

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[5] Wade and Oldstone, 2023 Small Business Health Insurance Survey, NFIB Research Center. https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf

[6] Wade and Oldstone, NFIB Small Business Problems and Prioroties, NFIB Research Center, 2024. https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf

[7] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 2004-2023.

[8] Wade and Oldstone, 2023 Small Business Health Insurance Survey, NFIB Research Center.

Small business owners who do not offer health insurance are often at a competitive disadvantage in attracting talent, but they overwhelmingly cite the cost of health insurance as the main reason they do not provide the benefit. Almost two-thirds of non-offering small employers say that health insurance is too expensive for them to offer it as a benefit.

The financial burden of health insurance on small businesses is significant and growing, creating an uneven playing field between small and large companies. According to a recent JPMorganChase Institute report on health insurance costs, the median health insurance payroll burden for small firms with less than $600,000 in annual revenues is nearly 12 percent, compared to just 7 percent for firms with revenues over $2.4 million.[9] The businesses that provide health insurance coverage face tough choices, having to pass the rising costs along to their customers: Nearly half of small employers (46%) report raising their prices to keep up with rising health insurance costs. To make matters worse, half of small employers (49%) now earn less due to health insurance premium increases over the last five years.[10] This disparity highlights how smaller firms are disproportionately affected by rising health insurance costs.

Most small business owners offering health insurance purchase fully funded plans in the small group market. However, the small group market has experienced a sharp decline in issuer participation and overall membership, down 7.4 percent from 2022 to 2023, ending the year with 8.5 million participants.[11] This decline is driven primarily by the escalating costs of health insurance. As coverage options in this market decline, alternatives like those provided under the ERISA framework become vital. Recent reports point to an increase in the percentage of small firms offering health benefits through a level-funded plan, for instance.[12]

As we mark the 50th anniversary of ERISA, it's an opportune time to reflect on the role that employer-provided coverage has played in the U.S. and on small businesses. While most small firms remain fully insured, ERISA protections have been crucial in ensuring that even the smallest businesses can offer health benefits

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

[10] Wade and Oldstone, 2023 Small Business Health Insurance Survey, NFIB Research Center.

[11] https://www.markfarrah.com/mfa-briefs/an-analysis-of-profitability-for-the-individual-and-small-group-health-insurance-markets-in-2023/ from NAIC Supplemental Health Care Exhibits (SHCE).

[12] KFF 2022 Employer Health Benefits Survey https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/

to their employees while having the flexibility and predictability to design benefits in a way that works best for them.

ERISA has played a vital role for half a century in ensuring robust healthcare coverage for workers in the U.S. Moving forward, ERISA should be protected and strengthened to empower more small businesses with greater coverage choices under this framework, enabling them to offer valuable benefits that will contribute to their growth, stability, and success in the U.S. economy.

We thank the Committee for its vital work this past year expanding coverage choices for small businesses under ERISA and look forward to partnering with you to continue building on this law's success.

Sample Policy Solutions to Strengthen Small Firms' Coverage Choices

**Allow Small Businesses and Self-employed individuals to Band Together to Achieve Savings Through Economies of Scale.**
Association Health Plans (AHPs) are one option for small businesses to offer more affordable insurance to employees. AHPs level the playing field between large employers and small businesses subject to more regulation and benefit mandates in the small group market. By pooling their resources and leveraging the purchasing power of larger groups, small businesses can reduce premiums and increase their bargaining power, resulting in health insurance at a more affordable price with better networks. Congress should enact legislation such as provisions included in H.R. 3799, the CHOICE Arrangement Act, to protect and expand small businesses' ability to participate in AHPs. Lawmakers should improve existing regulations to allow for industry-based and non-industry-based small businesses to establish an AHP, including self-employed individuals. Additionally, lawmakers should push back against rules that restrict or limit the use of AHPs.

**Protect Small Businesses' Access to Stop-loss Insurance.**
In many instances, self-insurance can offer employers more flexibility in designing coverage, leading to more affordable coverage. Stop-loss insurance enables self-insured employers to mitigate risks, protecting employers and employees from catastrophic losses. An increasing number of group health plan sponsors are utilizing level-funded arrangements. Thirty-eight percent of small firms reported offering health benefits through a level-funded plan in 2022. Level-funded plans provide small employers with potential cost savings, predictability, and customization. As small businesses' average premiums in the small group market

continue to increase alarmingly, self-funding can be an attractive option for small employers looking for an alternative. Policymakers should protect and expand small businesses' access to stop-loss insurance.

**Re-evaluate and Right-Size Mandates That Drive Up Premium Costs.**
The ACA implemented a complicated employer mandate system called the Employer Shared Responsibility Provision. This provision requires all small businesses with 50 or more full-time employees (including "full-time equivalent" employees (FTEs)) to offer health insurance to 95% or more of their full-time employees or face significant fines.

The employer mandate presents serious challenges for small businesses. It is a one-size-fits-all approach with severe market distortive consequences and fails to account for industry revenue differences. This mandate holds back small business growth as businesses face massive changes in their operations if they get close to the 50-FTE threshold. Eliminating the mandate or raising the FTE threshold would remove an arbitrary barrier to growth. Furthermore, the mandate has proven ineffective, as only 1% of the initially projected revenue has been collected from this mandate. Congress should reform the employer mandate and, at minimum, adjust the threshold to 100 or more full-time employees to provide small firms with more room for growth, define full-time work under the mandate as 40 hours per week, and remove unnecessary, burdensome paperwork requirements.

In addition to providing employers with increased coverage choices it is essential to tackle the root causes of rising health care costs by promoting greater access to quality, affordable healthcare through innovation, transparency, and competition.

**Promote Price Transparency and Price Certainty.**
Small businesses support price transparency. In a recent NFIB member ballot, more than three-quarters (77%) of small business owners supported requiring insurers to provide price information for healthcare services. Small businesses can greatly benefit from greater price transparency. When healthcare providers and insurers disclose the costs of their services and treatments, small businesses can make more informed decisions about which plans and providers to choose. This enables them to negotiate better rates with insurers and avoid overpaying for healthcare services. Lawmakers must codify and strengthen the rules for hospitals, Pharmacy Benefit Managers (PBM), and insurer price transparency.

For half a century, ERISA has played a key role in empowering businesses of all sizes to offer valuable benefits that contribute to a healthy workforce and to the growth and success of the economy. To truly extend these benefits to all, small businesses and their employees must be empowered with more choices and control over their health care coverage decisions. Expanding coverage options will enable small firms to remain competitive, and more fully support their local economy.

Thank you for allowing me the opportunity to testify before you today.

Chairman GOOD. Thank you. I will now recognize Mr. Wright for 5 minutes.

**STATEMENT OF MR. ANTHONY WRIGHT, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, D.C.**

Mr. WRIGHT. Thank you. Good morning, Chairman Good, Ranking Member Scott, Ranking Member DeSaulnier, and members of this Committee. My name is Anthony Wright. I serve as the Executive Director of Families USA, a national health care consumer advocacy organization.

I appreciate the opportunity to testify on behalf of consumers and workers on the 50th anniversary of ERISA, which is an excellent excuse to have some cake, but also to reflect on the employer-sponsored coverage, and its State, which is the pillar of our healthcare system that covers 60 percent of the Nation, 164 million Americans, including two-thirds of them in self-insured plans under ERISA.

Workers with on-the-job benefits often consider themselves lucky to have group coverage, having a large employer share in the cost of coverage, and negotiate for the best quality and cost. They increasingly need help to access basic benefits, or key consumer protections, and most of all on affordability.

Only Congress can provide that help. Since ERISA's broad State preemptions significantly diminish states' ability to innovate and improve healthcare quality, access, and affordability. Limiting states from even enacting modest efforts, like requirements to contribute to State health payment data bases for greater price transparency.

Therefore, it is Congress that needs to be vigilant and proactive in updating ERISA, and other Federal laws, to improve health access and affordability. That is why Families USA, over the last many decades, has supported the many congressional actions to improve ERISA, such as COBRA, HIPAA, mental health parity and the Affordable Care Act. The most recent example is the No Surprises Act, which bans surprise bills.

Prior to that, 33 states passed their own protections, but they did not apply to millions of their residents in self-insured plans. Congress should continue to take steps that supplement State action, whether on the unfinished work on surprise ambulance bills, or on filling holes on ERISA's standards and patient protections.

For example, should all large employers be required to provide the same essential health benefits that small employers give their

workers? Some states are now working to update and improve their essential health benefit standards to better meet consumers' needs. The Federal Government should follow.

Similarly, only Congress could provide relief to those in self-insured plans who need more comprehensive remedies for denials of medically necessary care. Another issue, when consumers have these or other problems, no one knows where to go for help. I mean no one. While 40 percent of the Nation are in these self-insured plans, in a recent KFF survey, zero percent of respondents guessed that their plan was regulated by the Federal Department of Labor.

Congress should ensure that the Department has the adequate staffing and resources to ensure proper oversight of ERISA plans and their finances, to take complaints, and to support consumer assistance programs to help people navigate our complex health care system.

Ultimately, the biggest issue for ERISA plans is the biggest issue in all of health care: affordability. No one is insulated from high health care costs, not even large employers and their workers. Inflated and irrational health care prices are putting Americans' health and financial security at risk.

More than 100 million Americans are saddled with medical debt. Half of all Americans report foregoing medical care due to cost, and a third of Americans indicate that the costs of medical services interfere with securing basic needs, like groceries and rent.

Over the past 25 years, the cost of family employer-based plan has increased from $6,500.00 to almost $24,000.00. The worker's share of premium and out-of-pocket costs has risen dramatically as well. In 2007, 60 percent of individuals in employer-based coverage had minimal deductibles under $500.00. Now 60 percent have deductibles over $1,000.00.

For most low-wage workers, that means they have to pay more than what they have in the bank before most of their coverage even kicks in. For workers and employers alike, as we see today, rising healthcare costs have become unsustainable.

Fortunately, Congress has the opportunity to take action to improve health care affordability, including addressing the underlying market failures that drive rising health care costs, ensuring price transparency, site-neutral payments, and other reforms advanced by this Committee in the Lower Costs, More Transparency Act. Broadening the prescription drug cost containment policies in the Inflation Reduction Act into the commercial market, so that we have more discounts for more drugs for more people.

Taking timely access to extend enhanced tax credits to prevent dramatic premium spikes if they are allowed to expire next year and instituting and updating caps on out-of-pocket costs, both for prescription drugs and generally.

Thank you again, for the opportunity to join in today's discussion on the ways to build on the foundation of ERISA to improve access to affordable coverage to everyone, including workers and their families. I yield back.

[The prepared statement of Mr. Wright follows:]


**Testimony of Anthony Wright**
**Executive Director**
**Families USA**

Before the House Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

*"ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"*

September 10, 2024

Families USA
1225 New York Avenue, NW
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Washington, DC 20005

Chair Good, Ranking Member DeSaulnier, members of the Committee, thank you for the opportunity to testify at this hearing on the value and current state of employer-sponsored health benefits, 50 years after the enactment of the Employee Retirement Income Security Act of 1974 (ERISA). It is an honor to be with you today, and to represent the perspective of health care consumers in this important discussion.

My name is Anthony Wright, and I serve as the executive director of Families USA. For more than 40 years, Families USA has been a leading national, non-partisan voice for health care consumers working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. Central to Families USA's mission is a commitment to guaranteeing that families and individuals throughout the nation have access to high-quality, affordable, comprehensive health coverage.

We appreciate this opportunity to reflect on the progress we have collectively made in securing and improving coverage for the 164 million Americans[1] who rely on employer-sponsored insurance (ESI) for their health care. And we look forward to continuing to work with you to build on the foundation of ERISA to improve access to affordable coverage for everyone, including America's workers and their families.

ERISA is landmark legislation focused on addressing the safety and integrity of pension and welfare plans by establishing requirements for fiduciary responsibility, plan administration, and participant rights, and creating greater accountability and transparency for employers and other plan sponsors.[2] While a longstanding pillar of health law, ERISA has appropriately been amended several times to address the evolving retirement and health care needs of employees and families. As it stands today, ERISA provides a critical floor for minimum standards for most employer-sponsored group health insurance plans. ERISA also includes important federal protections that

help to ensure workers across the country have access to high-quality health coverage options, including guaranteeing workers and their families access to basic information about their health benefits, rights to a grievance and appeals process, and ability to file a lawsuit if the plan breaches its fiduciary duties. It also provides certain federal financial oversight of their plans.

Over the last several decades, Families USA has worked in partnership with Congress to improve and expand ERISA, through amendments such as the Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows workers and their families to continue to be enrolled in their health plans for some time after leaving a job, and the Health Insurance Portability and Accountability Act (HIPAA), which ensures they can move to another plan without facing denials or other exclusions for preexisting conditions.[3] During times of economic hardship, including the Great Recession from 2007-2009 and the COVID-19 crisis that hit in 2020, Families USA worked with members of this Committee to enact COBRA subsidies to help laid-off workers maintain access to care.[4] Additional improvements to ERISA were made through the Mental Health Parity Act and the Affordable Care Act (ACA), the latter of which included bans on harmful practices such as preexisting condition exclusions, excessive waiting periods for coverage, prior authorizations for emergency care or care provided by an OB/GYN, lifetime and annual limits on essential benefits, and coverage rescissions when workers needed to access their benefits most. The ACA allowed for dependent coverage up to age 26 and broad coverage of preventive services, in addition to requiring plans to provide summaries of benefits and coverage and to maintain clear processes for internal and external claims, reviews, and appeals.

The 50th anniversary of ERISA is an essential time not only to assess how far we have come and how the law can and should continue to evolve, but also to look at the state of employer-based coverage in America in general. And what we hear from employers and workers alike is

deep and pervasive concern about the cost and value of care and coverage. In fact, 93 percent of Americans agree that our country is paying too much for the quality of health care we receive, and more than half of adults in that same poll said that their most recent health care experience was not worth the cost.[5] Put simply, consumers are clamoring for action to address health care affordability.

Thankfully, this Committee and your colleagues in the 118th Congress have taken critical steps to advance bipartisan bills to improve health care affordability for America's workers and their families. We share the Committee's concern with rising health care costs and strongly support your efforts to explore additional ways to increase the affordability of health care coverage options and improve access to high-quality health care. This work is urgently needed, as the United States is entrenched in a severe health care affordability and quality crisis.[6]

**The U.S. Health System in Crisis**

High and rising health care prices, particularly hospital and drug prices, as well as high and rising health insurance premiums are putting Americans' health and financial security at risk. More than 100 million Americans are saddled with medical debt; half of all Americans report forgoing medical care due to cost; and a third of Americans indicate that the cost of medical services interferes with their ability to secure basic needs like buying groceries and paying rent.[7,8]

High and rising health care prices have a significant impact on all Americans, including the approximately 100 million workers and their family members who rely on self-funded employer-sponsored insurance (ESI) plans for their health care.[9] Importantly, these rising health care prices drive skyrocketing health insurance costs, which ultimately come directly out of workers' paychecks as annual increases in ESI premiums and cost sharing – crippling the ability of working

people to earn a living wage.[10] Today's real wages (wages after accounting for inflation) are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[11] The total cost of a family ESI plan increased a staggering 272% in the past two decades, rising from $6,438 in 2000 to $23,968 in 2023.[12] As a result, the median U.S. family of four is estimated to have lost more than $125,000 in wages over that time.[13] A recent analysis by Families USA found that if policymakers do not take action to rein in high and rising hospital prices and the harmful business practices of large health care corporations, low- and middle-income workers, a group that disproportionately includes people of color, could lose nearly $20,000 in wages by 2030.[14]

To make matters worse, workers are increasingly subjected to health insurance plans with larger cost-sharing requirements, including higher-deductible health plans, as a result of desperate attempts by employers to contain rising health care spending and costs.[15] Deductible-related costs for workers have grown significantly, with the average deductible for an individual employee's coverage nearly doubling in just a decade, from $1,025 in 2010 to $2,004 in 2021.[16]

Workers and employers alike recognize that these rising health care costs have become unsustainable. Nearly 90% of large employers say that rising health care costs threaten their ability to provide health care benefits to employees over the next five to 10 years.[17] At the same time, workers with ESI increasingly cannot access the care they need, with more than a quarter putting off or postponing needed medical care due to the high cost.[18]

Notably, the excessive cost of health care does not generally buy Americans higher quality care or even higher volumes of care. In fact, the opposite is true. Despite spending two to three times more on health care than other peer countries, the United States has some of the worst health outcomes, including some of the lowest life expectancy and highest infant mortality rates.[19]

These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[20]

**Building on the Foundation of ERISA**

ERISA regulates most of the private insurance market, specifically health plans in which employers directly take on the liability for their employees. These self-insured plans are solely regulated at the federal level, whereas other private insurance plans are also subject to state insurance regulation. So, while state laws can add patient protections and other regulations on insurers, such as requiring that they provide additional benefits beyond those mandated under federal law, self-insured plans governed by ERISA are not subject to these state regulations.[21] Notably, this is one of the broadest areas of federal preemption in law, and significantly diminishes the extent to which states can fully adopt reforms that protect patients and improve health care quality, access, affordability, and transparency – even in circumstances that would not disrupt multi-state benefit design.[22]

This is particularly challenging given that 65 percent of people who rely on employer-sponsored insurance for health care coverage are in a self-funded health plan.[23] For example, due to ERISA preemption, states cannot require self-funded group health plans to report health care utilization and cost data to their all-payer claims databases (APCDs).[24] APCDs represent a critical tool for states to achieve meaningful health care transparency, and can help to unveil critical trends in health care costs, service utilization, and health care quality that are essential in being able to effectively drive towards higher value health care and holding the health care system, particularly providers, accountable to delivering the high-quality and affordable care that their

state residents deserve.[25] But they are far less impactful if they don't have comprehensive data from across all payers.

**Given these real limitations for states to innovate and improve health benefits, it is even more critical that Congress be vigilant in enacting federal laws that improve affordability and access to health care and rein in the rising health care costs that impact ERISA self-funded plans and the people they cover.** This includes providing for more comprehensive remedies and compensatory damages for inappropriate denials than those that currently exist under ERISA – an issue Families USA testified about before Congress in 1998, but which has yet to be addressed.[26] Another example is evidenced by recent state and federal efforts to ban surprise medical billing. Prior to passage of the No Surprises Act in December 2020, 33 states had taken steps to ban balance billing in fully insured health plans.[27] But they were prohibited from applying those protections to self-insured plans, leaving millions of people in those states and in those plans vulnerable to balance billing until federal legislation amended ERISA to protect them as well. Congress was right to act on surprise medical bills and should continue to take steps to supplement state action to improve consumer protections for patients, filling in holes in ERISA's standards and protections. For example, large employer plans are not required to offer all essential health benefits that other plans such as ACA marketplace plans must cover.[28] Some states are working to update and improve their essential health benefit standards to better reflect current evidence-based medical standards and better meet consumer needs, and the federal government should follow suit.

Further, while ERISA's structure has benefits for multi-state employers, it can also make it harder for patients and the public to understand who has oversight over their insurance or where to appeal denials or file a complaint. Most consumers have no idea whether they are enrolled in a

plan regulated by ERISA, and understandably assume their state department of insurance is the place to file complaints against employers or other plan sponsors about their coverage. In fact, a recent KFF Survey of Consumer Experiences with Health Insurance found that of U.S. adults with health insurance, 76% of respondents said they don't know which government agency to contact for help dealing with their insurance, including 83% of people with private health coverage.[29] And of those who did say they knew which agency to contact, *zero percent* of people in self-funded plans were aware that their coverage was actually regulated by the federal Department of Labor (DoL).[30] This underscores how critical it is for the Department of Labor to be well-resourced to educate consumers about where and how to exercise their rights, ask questions, and file complaints – including by utilizing DoL's Benefits Advisors[31] – and to have the resources and tools needed to conduct meaningful investigations and oversight activities, including around fiduciary issues or denials of care. **Families USA therefore strongly urges the Committee to ensure that the Department of Labor has adequate staffing and financial resources to ensure proper oversight of ERISA plans and robust support for consumers who are enrolled in them.**

Additionally, states are in a strong position to augment federal oversight of ERISA self-funded plans and should be considered as partners in ensuring every American worker has high-quality and affordable health care coverage. There are good models of state and federal consumer assistance partnerships that demonstrate what it looks like to effectively meet the needs of privately insured people who are seeking redress for insurance issues and concerns. One such example is the tri-agency and state partnership to address consumer complaints via the No Surprises Help Desk. The No Surprises Act applies to all ERISA plans as well as to individually purchased plans. Consumers and advocates who call the Help Desk with balance billing problems are seamlessly routed to the proper regulator to address their concerns. For example, the

Community Service Society of New York recently had a case in which a consumer in a self-insured plan received a bill for $2,592 for care she received from an out-of-network specialist. She believed the doctor was in-network because she received written information from her plan assuring her as such. Yet her internal appeal was denied. Without assistance, she would not have known her next appeal should be to the federal Department of Labor. Luckily, her outreach to NY Community Health Advocates resulted in them filing a complaint with the No Surprises Help Desk, and as a result, her claim was reprocessed through the proper regulatory channel. Ultimately, she was only held responsible for her in-network cost sharing, saving her thousands of dollars.[32]

This story also underscores **the need for robust consumer assistance and ombudsman programs to help people navigate complexities within our health care system**, including issues that arise around ERISA exemptions. Importantly, Congress authorized Consumer Assistance Program funding in section 1002 of the Affordable Care Act but has not appropriated funding for several years. Some programs still exist with state funding alone, including the above-referenced Community Health Advocates run by the Community Services Society in New York, but Congress should provide federal support to make such programs available in every state.

**It is also essential that the Department of Labor have sufficient resources to oversee Multiple Employer Welfare Arrangements (MEWAs) and other self-funded arrangements, and that Congress preserve state authority to regulate, ban or limit the sale of stop-loss insurance to employer groups below a certain size.** While market forces help to ensure that most large employers provide competitive health benefits to attract and retain workers, there are some employers – including those in low-wage industries – where oversight is needed to ensure basic benefits and patient protections. Also, Families USA is concerned that small employers are increasingly self-insuring, using level-funded arrangements (that is self-funding plus a stop loss

policy),[33] or joining associations for purposes of being considered part of a large group. Neither small business owners nor their workers usually have the resources to thoroughly examine benefit arrangements, bargain for strong worker protections, or assure that third-party administrators and multiple employer welfare arrangements meet their fiduciary responsibilities. These arrangements could be abused without proper oversight and should not be used to circumvent key patient protections and financial oversight. Moreover, the proliferation of self-insured plans can have a negative impact on wider risk pools: when healthier groups self-insure, it can therefore increase costs for groups who need and buy richer benefits.[34]

**Improving Health Care Affordability for Working Families**

Ultimately, the biggest issue for ERISA plans is the biggest issue in health care: affordability. There are several essential steps that Congress can take to improve health care affordability for people with private insurance, including workers and their families who access their care through employer-sponsored insurance:

Enhance the Minimum Level of Financial Protection in ERISA and ACA-Compliant Health Plans

Currently, the Affordable Care Act limits cost-sharing in both individual and group plans. However, the annual limits on cost-sharing grow faster than families' buying power. They have increased from $12,700 for family coverage in 2015 to $18,900 for family coverage in 2024. (If these limits had instead followed the consumer price index, cost-sharing would have been limited to $16,628 in 2024 – better, though still a hefty burden). Out of pocket maximums, as determined in ERISA, should more closely follow and reflect changes in income (such as median income) and purchasing power to ensure that workers and their families are financially protected from high health care costs. While the ACA eliminated outright discrimination due to pre-existing conditions,

rising out-of-pocket costs continue to disproportionately burden families dealing with chronic conditions or major medical issues.

Lower Prescription Drug Costs for People in the Private Insurance Market

The impact of high prescription drug costs on individuals and families who rely on medications is clear, with almost 30% of adults not taking their medications as prescribed in the past year — rationing their medications, skipping doses, or not filling their prescriptions at all.[35,36,37] Being forced to make those decisions directly results in poorer health outcomes: rationing or skipping needed medication causes an estimated 125,000 deaths a year.[38,39] Not only do high and rising drug prices drive up health care costs for people at the pharmacy counter, but they also drive up health care premiums and deductibles and are often experienced in the form of reduced wages.[40,41,42] Drug companies set the list price for their drugs long before they are purchased by the consumer. These underlying prices are paid by insurance providers who in turn pass those high and rising costs along to families and employers in the form of higher insurance premiums. The problem of costs being pushed onto the consumer is particularly pronounced for people with employer-sponsored insurance, because the premium and deductible structure in these private plans are particularly vulnerable to drug pricing increases as compared to the more standardized structure of Medicare or Medicaid.[43,44] The increased prices charged by drug companies become part of the costs analyzed by actuaries to establish updated health insurance premiums, and those increased premiums accrue to all people within an insurance pool, regardless of whether those enrollees take prescription drugs. In fact, almost 20% of health insurance premiums are driven by the rising cost of prescription drugs.[45]

Recently, Congress took important steps to systemically bring down drug prices and rein in the rate of skyrocketing price increases. The Inflation Reduction Act (IRA) of 2022 is landmark legislation that includes several key provisions to address the underlying prices of certain medications and control the rate of price increases for drugs in Medicare. The IRA gave the Centers for Medicare & Medicaid Services (CMS) the ability to negotiate drug prices in Medicare for the first time in our nation's history, and implemented inflationary rebates for any drug whose price rises faster than the rate of inflation in one year, meaning drug companies have to pay back to Medicare the difference between the new increased price and what the price would have been at the rate of inflation.[46]

**Congress should broaden the impact of the IRA to the commercial market to better protect all consumers from inflated and irrational drug costs, including by expanding the number of drugs eligible for negotiation in Medicare and allowing commercial insurance to voluntarily adopt the Medicare negotiated rate.** The IRA limits the number of drugs that are subject to government negotiation each year, and the negotiated prices are not automatically available to consumers with private health insurance. This leaves millions of consumers with private coverage, including ESI, vulnerable to continued high prescription drug prices. The Secretary of the Department of Health and Human Services should be authorized — and required — to expand the list of drugs subject to negotiation and to extend all negotiated prices to private sector health insurance, should insurance plans want to adopt the Medicare negotiated price.

**Similarly, Congress should extend the IRA's inflationary rebate protections into the commercial market**. The IRA requires that drug manufacturers pay a rebate when they increase prices faster than the rate of inflation for some drugs covered under Medicare Part B and almost all covered drugs under Medicare Part D. Drug manufacturers that do not pay the rebate would

face a significant monetary penalty. These inflation rebates should be extended to include drugs covered in the commercial market to better protect individuals in employer-sponsored plans and other private plans from drug manufacturers' high prices and exorbitant yearly increases. This would also protect those in the commercial market from potential cost shifting by drug companies attempting to make more off all other payers when their prices drop in Medicare.[47]

Address Underlying Causes of High and Rising Health Care Costs

At its core, our country's health care affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer or patient health outcomes. Broken incentives encourage providers to get bigger, not better. Our current system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, wellbeing and financial security of families and communities.[48] What's more, health care is one of the only markets in the U.S. economy in which consumers are blinded to the price of a service until they receive a bill after the services are delivered.[49] The House of Representatives – in large part due to the Leadership of this Committee – has already advanced well-vetted, bipartisan, and commonsense legislation that would remedy some of the most obvious health system failings that lead to high and irrational health care prices. The *Lower Costs, More Transparency Act*, which passed the House in an overwhelming bipartisan vote in December 2023, would make crucial progress toward making health care more affordable for people with ESI and all types of health insurance in several essential ways:

- **Codifying and strengthening price transparency rules** to make clear, without any exception, that all hospitals and insurers are required to post the underlying price of

health care services, in a machine readable and consumer-friendly format. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses.[50]

- **Expanding site neutral payments for drug administration services in Medicare to help ensure consumers pay the same price for the same service regardless of where that service is performed**. Since commercial insurance and Medicaid often adopt Medicare payment policies, the broken payment incentives in Medicare are amplified across payers. Site-of-service payment differentials drive care delivery from physician offices to higher-cost hospital outpatient departments,[51] a major driver of higher spending on health care services which require lower resources such as office visits and minor procedures.[52] Payment differentials further propel consolidation by providing a financial incentive for hospitals to buy physician offices and rebrand them as off-campus outpatient hospital departments (HOPDs) and facilities in order to receive higher payments,[53] resulting in an increasingly anticompetitive market where hospitals increase market power to demand even higher prices from commercial payers.[54] These higher commercial prices are then passed on to American families and come directly out of workers' paychecks, typically as monthly health insurance premiums.[55] The Committee for a Responsible Federal Budget projects that comprehensive site neutral payment policy could reduce health care spending by $153 billion over the next decade including lowering premiums and cost-sharing for Medicare beneficiaries by $94 billion and for those in the commercial market by $140 - $466 billion.[56]
- **Advancing billing transparency reforms** so that off-campus hospital outpatient departments are required to use a separate identifier when billing to Medicare or commercial insurers to ensure large hospital systems do not overcharge for the care they deliver in outpatient settings.

We further urge the Committee to augment the reforms set forth in the *Lower Costs, More Transparency Act* by continuing to **develop and advance legislation that addresses anticompetitive practices and clauses in health care contracting agreements that lead to limited**

**networks and high prices for patients**. Such legislation must be comprehensive and carefully constructed to prevent industry gaming of exemptions or other legislative loopholes. Specifically, Congress should prohibit the use of "all-or-nothing," "anti-steering," and "anti-tiering" clauses in contracts between health care providers and insurers. "Anti-tiering" and "anti-steering" clauses restrict the plan from directing or incentivizing patients to use other providers and facilities with higher quality and lower prices; and "all-or-nothing" clauses require health insurance plans to contract with all providers in a particular system or none of them. These contracting terms too often limit consumers from accessing higher-quality and lower-cost care.[57]

Additionally, **Families USA urges the Committee to continue to explore opportunities to improve transparency around the ownership interest of health care corporations, including with regard to private equity (PE)**. Without insight into how profits from health systems are ultimately being funneled, it is very difficult to identify potential abuses, leaving private equity firms free to purchase health systems in order to drive profits through upcoding, surprise billing, and other questionable business practices.

Extend Enhanced Premium Tax Credits for People Who Purchase their Insurance in Marketplaces

While Congress works to address the core drivers of high health care costs, consumers need direct relief from the immediate impacts of our unaffordable system and the financial security of knowing that they won't have to spend significant portions of their income on health coverage. For millions of people across the country, that guarantee comes in the form of advance premium tax credits (APTCs), recently enhanced by Congress but set to expire next year without Congressional action.

Currently, 19.7 million people across the United States get help paying for their health coverage through APTCs which they can use to purchase a plan through the health insurance marketplaces. People seeking to purchase health insurance may qualify for APTCs if their household income is at least $14,580 for an individual or $30,000 for a family of four, they buy a plan offered on healthcare.gov or a state marketplace, and they do not have other options for affordable health coverage.[58]

Congress bolstered the amount of assistance available to people in recent years, increasing the premium tax credit amounts under the American Rescue Plan Act and extending those enhancements under the Inflation Reduction Act. And it guaranteed that people who buy insurance without an employer's help can access benchmark coverage that costs no more than 8.5% of their income. These actions provided a lifeline for people who would otherwise not be able to afford their health coverage or access health care, including people who received unaffordable offers of insurance through their employer. But those enhancements are set to expire at the end of 2025, and if Congress does not act to extend them, millions of people will face significant premium spikes and risk losing their health insurance altogether, forcing families to choose between delaying or skipping needed health care or taking on medical debt they cannot afford. **Families USA urges Congress to take timely action to extend and make permanent the enhanced APTCs well before the deadline to protect consumers from dramatic increases in health care premiums that will jeopardize their health and financial wellbeing.**

Thank you again for holding this hearing today and for your leadership in working to lower health care costs and improve affordability for consumers, including the vast majority of Americans who get their health care through employer-sponsored insurance. The journey to fully transform our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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Chairman GOOD. Thank you. I will now recognize Dr. Fronstin for 5 minutes.

**STATEMENT OF DR. PAUL FRONSTIN, DIRECTOR, HEALTH BENEFITS RESEARCH, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, D.C.**

Mr. FRONSTIN. Chairman Good, Ranking Member DeSaulnier, and distinguished members of the Subcommittee, my name is Paul Fronstin. I am the Director of Health Benefits Research at the Employee Benefit Research Institute. Established in 1978, EBRI is committed to data dissemination, and policy research in education on financial security and employee benefits.

Consistent with our mission, EBRI does not lobby or advocate specific policy recommendations. Thank you for the opportunity to appear before you today. Employers' commitment to worker health established its roots in the late 1800's. Examples of health programs include the mining, lumbering and railroad industries. Employers had a practical interest in their workers' health.

During World War II, employers began to offer more formal health insurance. Because employer contributions to insurance did not count toward wage controls, health insurance became an attractive means to recruit and retain employees.

Employers today offer health coverage because of their belief that offering has a positive impact on the overall success of the business, and ERISA's preemption of State law has created an environment of national uniform standards for employee benefit plans, thus giving employers the regulatory means to continue to offer health benefits as they do today, yet there have been questions along the way as to whether employers have reached the tipping point with health benefits.

Predictions have been made that employers would stop offering coverage. In this testimony, I examine how the availability of employment-based health coverage has been changing, by examining employer sponsorship of coverage, as well as employee eligibility for coverage.

There is no comprehensive dataset that allows us to go back to the days of ERISA. However, the percentage of the population with employment-based health benefits can be tracked. It was at or near 70 percent between 1970 and 1989, between 1989 and 2007 it varied between 62 and 68 percent. Since then, it has varied between 58 and 62 percent, with 61 percent in 2022.

The declines in coverage often coincided with relatively high increases in premiums, though there were years when the correlation was far from perfect. The more recent stability in premiums coincided with stability in the percentage to population with employment-based health coverage.

In 2022, employment-based health coverage continued to be the most common source of health coverage. When examining data since 1996, the percentage of employers offering health benefits was at a near record low in 2023. However, it is important to put this in context. Small employers are in large part responsible for the decline in coverage, and most employers in the U.S. are small.

Just about every employer with 100 or more employees offer health benefits today. Despite the overall decline and the percent-

age of employers offering health coverage, the percentage of workers eligible for health benefits has been mostly constant since 1996. The eligibility rate has not changed much because the majority of workers are employed by large firms.

Workers have historically rated their health coverage as favorable and continue to do so. Just over one-half are extremely, or very satisfied with their current plan, and one-third is somewhat satisfied. Only 12 percent say they are not at all satisfied, and these figures are essentially unchanged since the late 1990's.

ERISA effectively preempts State and local regulation of self-funded health benefits. The scope of this has generated some degree of debate. Proponents of ERISA preemption point to the creation of a uniform and predictable regulatory environment for employers, while detractors believe that State and local governments ought to have a great role in pursuing healthcare reform, beyond their current ability to regulate health insurance.

On Thursday, EBRI is releasing the findings from a series of focus groups, with benefits decisionmakers of large employers. Three main themes emerged from these discussions. First, under ERISA preemption, there is a uniform landscape of regulations, rather than a patchwork of different State level regulations, which makes it possible for an employer operating in more than one State to administer and offer benefits equitably to their employees.

Second, ERISA preemption reduces administrative costs, thus enabling employers to deliver richer benefits and lower cost coverage to their workers. Third, ERISA preemption fosters innovation that would otherwise be stifled by different states requiring different coverages or administrative rules.

Employers remain committed to providing health benefits to employees and their families. If ERISA preemption were eroded, however, benefits executives worry about higher costs for providing health benefits.

Chairman Good, thank you again for the opportunity to appear before the Committee today. My colleagues and I look forward to working with you and members of the Committee in the future. Thank you.

[The prepared statement of Dr. Fronstin follows:]

# Testimony to the House Committee on Education and the Workforce on behalf of the Employee Benefit Research Institute

Statement of Paul Fronstin
Director, Health Benefits Research
Employee Benefit Research Institute, Washington, DC

**United States House of Representatives**

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

## ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits

September 10, 2024

EBRI EMPLOYEE BENEFIT RESEARCH INSTITUTE

Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, I am Paul Fronstin, Director of Health Benefits Research at the Employee Benefit Research Institute (EBRI). I am pleased to appear before you today to testify on ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits. Established in 1978, EBRI is committed exclusively to data dissemination, policy research, and education on financial security and employee benefits. Consistent with our mission, EBRI does not lobby or advocate specific policy recommendations: The mission is to provide objective and reliable research and information. All of EBRI's research is available on the internet at www.ebri.org.

Employers' commitment to worker health established its roots many years ago. Early examples of employment-based health programs include the mining, lumbering, and railroad industries during the late 1800s (Institute of Medicine, 1993). Employers in these industries provided company doctors funded by deductions from workers' wages. Employers had a practical interest in providing health services to injured or ill workers, who often worked in remote geographic regions.

It was during World War II that employers began to offer more formal health coverage. Because the National War Labor Board (NWLB) froze wages, employers sought ways to get around the wage controls to attract scarce workers (Helms, 2008). In 1943, the NWLB ruled that employer contributions to insurance did not count as wages and thus did not increase taxable income, and they were not subject to the wage freeze. As a result, health insurance became an attractive means to recruit and retain workers. Employers began to offer health coverage to their workers to be competitive in the labor market, and the number of persons with employment-based health coverage started to increase. By the end of the war, health insurance coverage in the United States had tripled (Weir, Orloff, and Skopol, 1988).

It has also been suggested that the tax-preferred status of employment-based health coverage led to the rise in its prevalence and comprehensiveness (Gabel, 1999) and that the tax-exempt status of health coverage has encouraged employers to offer it and to provide more comprehensive coverage than they otherwise would have (Sheils and Haught, 2004).

Employers today offer health coverage because of their belief that offering it has a positive impact on the overall success of the business. And it can be argued that the Employee Retirement Income Security Act of 1974's (ERISA's) pre-emption of state law has created an environment of national uniform standards for employee benefit plans, thus giving employers the regulatory means to continue to offer health benefits as they do today.

There were questions as to whether employers had reached a tipping point with health benefits in 2007 (Fronstin, 2007). At the time, there were numerous references to the "death" of employment-based health benefits. Not long after, the Patient Protection and Affordable Care Act of 2010 (ACA) was passed, and similar debate ensued on whether employers would stop offering coverage. There were also contrary views at the time.

In this testimony, I examine trends in the availability of employment-based health coverage. I also examine employer sponsorship of coverage and employee eligibility for coverage, as well as other questions.

## Employment-Based Health Benefits System Most Common Source of Health Coverage

There is no comprehensive dataset on employment-based health benefits that allows us to go back to the days around the passage of ERISA. However, two data sources allow us to track one data point — the percentage of people under age 65 (the non-Medicare population) going back to 1970. The percentage of the nonelderly population with employment-based health benefits was at or near 70 percent from 1970 to 1989 (Figure 1). Between 1989 and 2007, it varied between 68 percent and 62 percent. Since 2007, it has varied between 62 percent and 58 percent, and it was 61 percent in 2022.

The declines in coverage that occurred in the 1990s and early 2000s coincided with relatively high increases in health insurance premiums, though there were years, such as 1997–2000, when the correlation was far from perfect.

The more recent stability in premiums coincided with stability in the percentage of the nonelderly population with employment-based health coverage. In 2022, employment-based health coverage continued to be the most common source of health coverage, whether examining the entire population (55 percent covered) or the population under age 65 (61 percent covered) (Figure 2). Among the population under age 65, 21 percent had Medicaid, while 8 percent had private, non-group coverage, which includes marketplace coverage.

## Employer Sponsorship of Health Benefits

When examining the period of 1996–2023, the percentage of employers offering health benefits was at a near record low in 2023, with less than one-half of employers offering health benefits at that point (Figure 3). However, it is important to put this number in context. During the same period, 2000 was the year with the greatest percentage of employers offering coverage — 59 percent. And the percentage has ebbed and flowed over time.

The overall percentage of employers offering coverage is heavily influenced by the fact that small employers are in large part responsible for the decline in coverage. Most employers in the United States are small, while most employees work in large firms (Figure 4).

The diminishing percentage of employers offering health coverage has been limited to small employers. Between 1996 and 2023, among employers with fewer than 10 employees, it decreased from 34.2 percent to 22.5 percent. It decreased from 64.9 percent to 51.8 percent among employers with 10–24 employees, and it decreased from 80.8 percent to 76.7 percent among employers with 25–99 employees (Figure 5). In contrast, when we look at larger employers, we find that the percentage with 100–999 employees offering health benefits

increased from 92.7 percent to 95.6 percent. Similarly, the percentage of employers with 1,000 or more employees offering health benefits increased from 96.7 percent to 97.6 percent.

## Worker Eligibility for Health Benefits

Despite the overall decline in the percentage of smaller employers offering health coverage, the percentage of workers employed by private-sector employers who were eligible for health benefits (the eligibility rate) has been mostly constant since 1996, varying from a low of 75.4 percent in 2014 to a high of 81.3 percent in 1996 (Figure 6). The eligibility rate has not changed much because of the distribution of workers skewing toward larger employers.

The percentage of workers eligible for health coverage by establishment size is shown in Figures 7 and 8. While eligibility rates trended downward in all firm sizes between 1996 and 2013 (Figure 7), they have been trending upward since (Figure 8). Workers in large firms were most likely to be eligible for health benefits. However, even though small employers were least likely to offer health benefits, workers in smaller firms were almost as likely as workers in large firms to be eligible for health benefits when they were offered. This phenomenon is due to historical minimum participation and minimum contribution requirements in the states. States generally require that a minimum percentage of workers offered coverage must enroll or have coverage from another source. As a result, it is common for small employers to offer coverage to all workers, and it is also more common than in larger firms for the employer to pay the entire premium for employee-only coverage.

## Worker Opinions About Health Coverage

Workers have historically rated their own health coverage as favorable and have continued to do so through 2023. Just over one-half (55 percent) of those with health coverage were extremely or very satisfied with their current plan in 2023, and 33 percent were somewhat satisfied (Figure 9). Only 12 percent said they are not too satisfied or not at all satisfied. These figures are essentially unchanged since the late 1990s.

## Generosity of Health Coverage

EBRI explored trends in actuarial value (AV) — or relative generosity of health plans — in the employment-based health coverage market since 2013 (Fronstin, Hagen, et al., 2021). The ACA required employers with 50 or more full-time-equivalent employees to offer health plans that provided a minimum value of at least 60 percent. In other words, these employers had to provide health plans with at least a 60 percent AV.

When the ACA passed, there was concern that the requirement for employers offering health coverage to provide plans with at least 60 percent AV would incentivize employers to reduce the generosity of their plans to the 60 percent floor. Using data from mostly the large group market, EBRI research showed that, as of 2019, this has not happened. Both the average and median AV were about 83 percent in each year from 2013–2019.

As opposed to group coverage, health insurance purchased in the individual market tends to be somewhat less generous. Plans purchased in the individual market average an actuarial value of 76 percent (Fronstin, Hagen, et al., 2021).

Several factors may explain the slightly lower AV typically seen in the individual market. First, consumers may have more choices in the individual market than would typically be offered by an employer, including benefit offerings with lower actuarial values. Second, while the tax credit is linked to the consumer's income, it is also based on the second lowest cost silver policy, meaning that it is a fixed number of dollars. Consumers can use their tax credit to purchase a policy of any metal tier, and while many choose silver, a sizable number purchase bronze, because the premium after applying the tax credit is often zero or close to it. Third, because the tax credit is based on a silver policy with an actuarial value of 70 percent, it is typically the case that the consumer purchases either a silver or a bronze policy and only rarely trades up to a gold policy. Fourth, even under the American Rescue Plan Act (ARPA) credits, but certainly under the original ACA tax credit income levels, some people simply did not qualify for a tax credit and had to pay the entire premium amount. They have been more likely to purchase a lower AV policy.

## ERISA at 50

ERISA effectively preempts state and local regulation of self-funded, employer-provided health benefits. The scope of this has generated some degree of debate. Proponents of ERISA preemption point to the creation of a uniform and predictable regulatory environment for employers concerning their ERISA-governed benefit offerings, while its detractors believe that state and local governments ought to have a greater role in pursuing health care reform beyond their current ability to regulate health insurance.

On Thursday, September 12, 2024, EBRI is releasing the findings from a series of focus groups with benefits decision makers at large employers (Spiegel and Fronstin, forthcoming). Three main themes emerged in the roundtable discussions. First, under ERISA preemption, there is a uniform landscape of regulations, rather than a patchwork of state-level regulations, which makes it possible for an employer operating in more than one state to administer and offer benefits equitably to their employees. Employers view the consistent benefits made possible by ERISA preemption as a tool for increasing work force mobility. If a worker for a firm with operations in multiple states moves from a satellite office in one state to the company headquarters in another, they know they will have access to a similar menu of benefits. Second, ERISA preemption reduces administrative costs and burdens, thus enabling employers to deliver richer benefits and lower-cost coverage to their workers. Third, ERISA preemption fosters innovation that would otherwise be stifled by different states requiring different coverages or administrative rules.

Employers remain committed to providing health benefits to employees and their families. If ERISA preemption were eroded, however, benefits executives would worry about higher costs

for providing health benefits and would likely closely watch their competitors to determine next steps.

## Conclusion

The commitment of employers to worker health was initially driven by practical needs. The formalization of health coverage during World War II, facilitated by wage controls and subsequent tax regulations, set the stage for the widespread adoption of health benefits by employers. This framework was reinforced by the passage of ERISA, which provided a consistent regulatory environment for employee benefit plans.

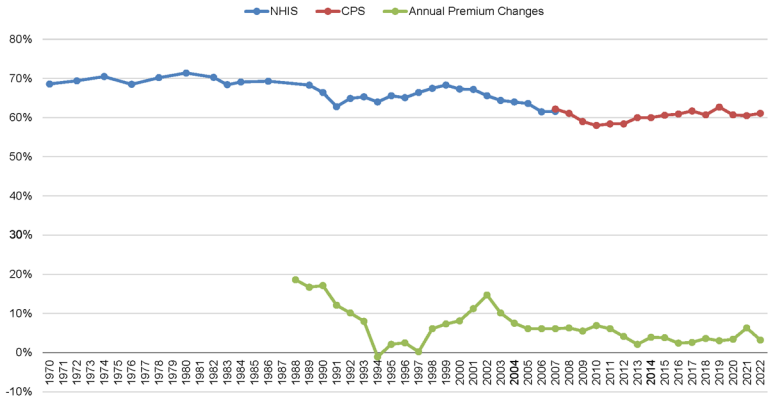
Despite predictions of a decline, the employment-based health coverage system has demonstrated continued resilience. The ACA prompted a debate about its potential impact, yet predictions that employers would reduce their health benefits offerings have not fully materialized. The recent data indicate that, although the percentage of employers offering health benefits has declined, the eligibility rates for coverage among workers have remained relatively stable. This stability is largely due to the continued prominence of large firms, which are more likely to offer health benefits.

While the landscape of employment-based health benefits is evolving, it remains a cornerstone of the American health insurance system.

Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, thank you for the opportunity to appear before you today.

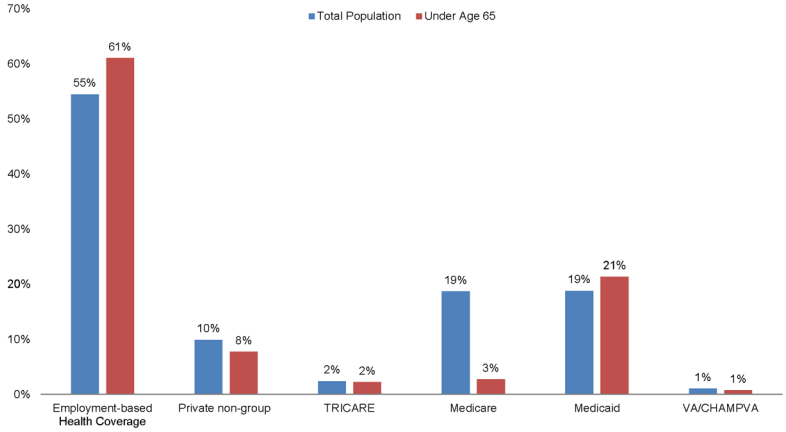
## Appendix: Figures

Figure 1
**Percentage of Persons Under Age 65 With Employment-Based Health Coverage, 1970–2022**



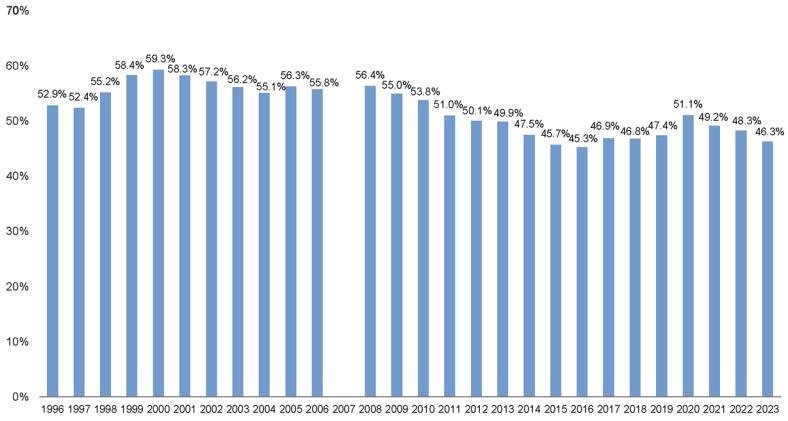

Source: www.cdc.gov/nchs/data/nhsr/nhsr017.pdf and Employee Benefit Research Institute estimates from the Current Population Survey.

Figure 2
**Percentage of Population, by Health Insurance Source, 2022**



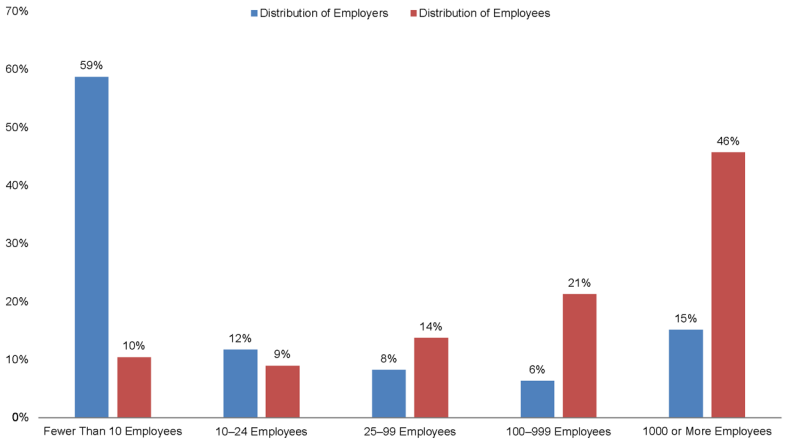

Source: Employee Benefit Research Institute estimates from the Current Population Survey.
Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Figure 3
**Percentage of Private-Sector Establishments That Offer Health Insurance, 1996–2023**



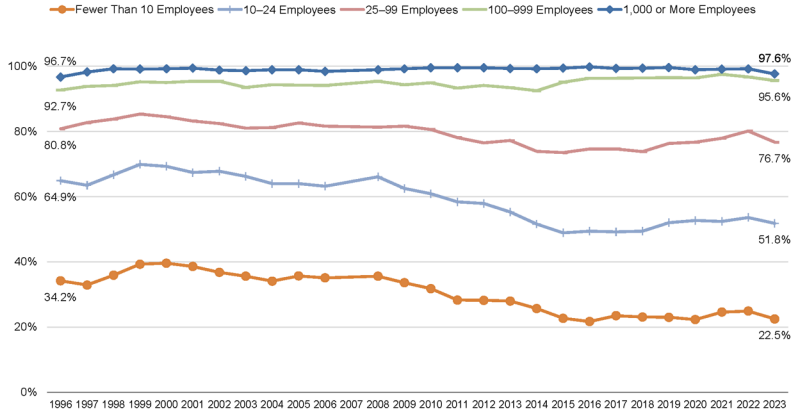

Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 4
**Distribution of Private-Sector Establishments and Their Employees, 2023**



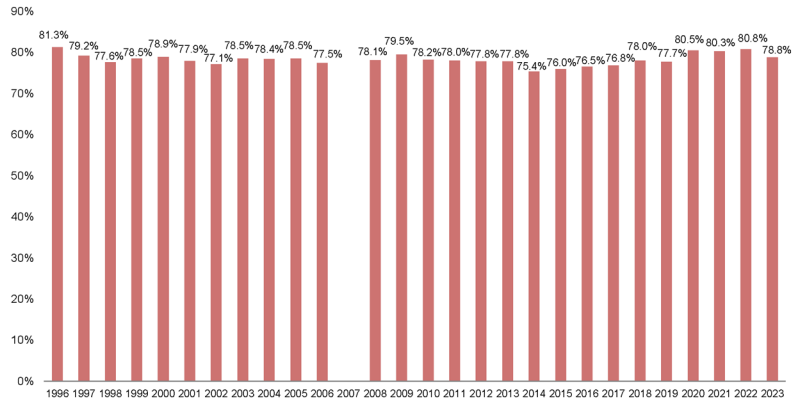

Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 5
**Percentage of Private-Sector Establishments That Offer Health Insurance, by Establishment Size, 1996–2023**



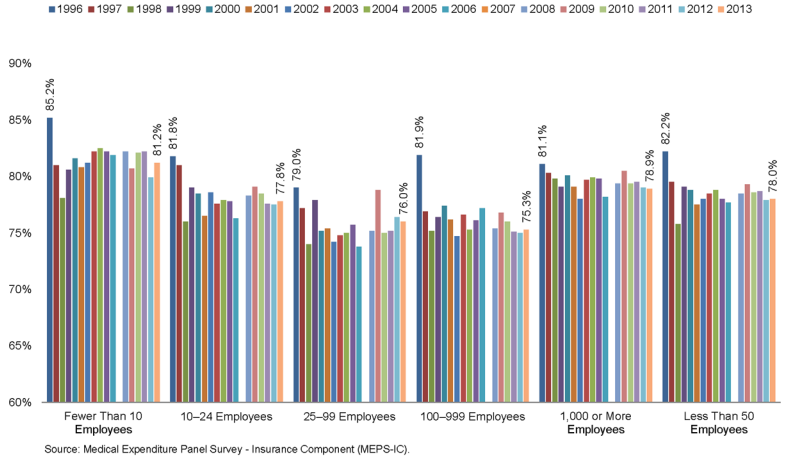

Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 6
**Percentage of Private-Sector Workers Eligible for Health Coverage, 1996–2023**



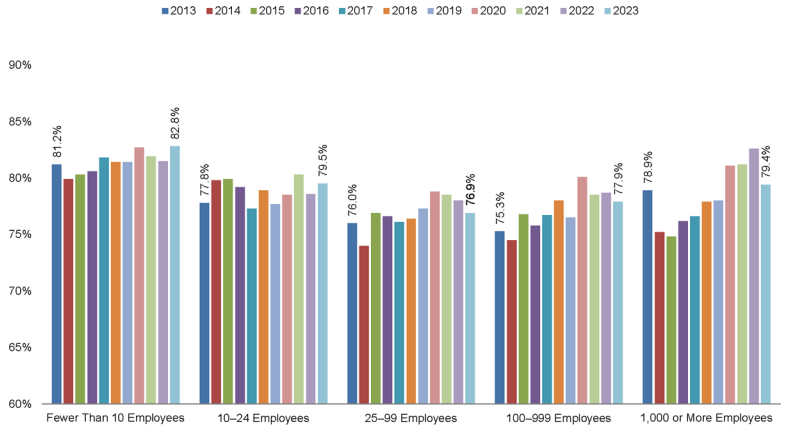

Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 7
**Percentage of Private-Sector Workers Eligible for Health Insurance, by Establishment Size, 1996–2013**



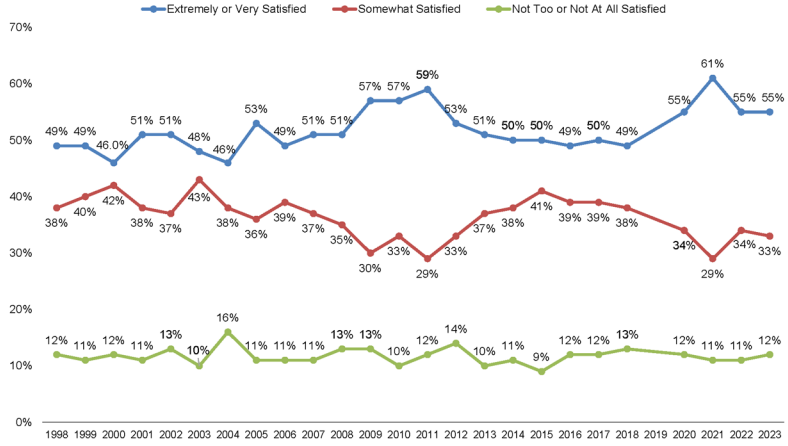

Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 8
**Percentage of Private-Sector Workers Eligible for Health Insurance, by Establishment Size, 2013–2023**




Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Figure 9
**Overall Satisfaction With Current Health Insurance Plan, 1998–2023**




Source: Various Employee Benefit Research Institute surveys.

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Chairman GOOD. Thank you. Under Committee Rule 9, we will now question witnesses under the 5-minute rule, and I will wait to ask my questions at the end, and therefore, recognize Mr. Walberg from Michigan for 5 minutes.

Mr. WALBERG. Thank you, Mr. Chairman, and thanks to the panel for being here. The Employer Retirement Income Security Act, ERISA, enacted in 1974 is a cornerstone of American labor law that has profoundly shaped the landscape of employer sponsored insurances we have all mentioned today.

ERISA has played a vital role in elevating the quality of employer sponsored insurance over the past 50 years. It has empowered workers, retirees, and others to make informed decisions about their health and retirement benefits, ensuring that their needs are met throughout their careers, and into retirement.

ERISA has not only contributed significantly to the stability and security of millions of working families, but also brings tremendous values to taxpayers and the economy overall. Thank you to the witnesses for being here to help commemorate ERISA's 50th anniversary.

Mr. Chairman, I do not see any balloons in the room, but we probably should have had some, though we do have some hot air, I guess, in the room. Ms. Schuman, thank you for being here. In what key ways has the healthcare industry changed since the passage of ERISA in 1974?

Ms. SCHUMAN. Thank you, Congressman, for that question. The healthcare industry has changed dramatically in the past 50 years. It has certainly become more complex and consolidated, but it has also become more innovative, and a lot of this innovation has been enabled and fueled by ERISA, and the employer innovation that that enables and fuels.

Mr. WALBERG. Let me jump on that and ask you to suggest some top recommendations that you might give to Congress on how ERISA can continue to protect employer's ability to offer high-quality and affordable health benefits.

Ms. SCHUMAN. Well, first of all let me thank you by recognizing the connection between ERISA and the ability of employers to offer affordable, high-quality coverage. That is predicated on ERISA and ERISA preemption, and the ability to offer affordable high-quality coverage to their employees nationwide.

My top recommendation for you on how ERISA can continue to protect employer's ability to do so, is to protect ERISA preemption, mindful of expanding efforts at the State to erode that. Congress does need to do more to address the lack of transparency and competition in the healthcare marketplace that are driving higher costs for employer sponsored coverage, and those two can and must be taken in step, protecting ERISA and ERISA preemption, and at the same time taking action to lower healthcare costs. Thank you.

Mr. WALBERG. Thank you. Ms. Wade, could you discuss the challenges small employers face when they try to offer coverage to their employees, and what kinds of innovative coverage models would make it easier for small businesses to offer health coverage, and also if you would comment on how expanding access to association health plans would help small businesses to offer coverage?

Ms. WADE. Certainly. Thank you for the question. For small firms, they are challenged in a whole myriad of ways, one of which is whether they offer health insurance at the beginning of operating their business as an employer firm. The challenge of costs and affordability is impacting their ability to construct competitive packages to attract talent, to retain their current employees.

One of the key components for small business in the affordability aspect, is allowing a diverse array of plans and structures and the benefit to offer their employees that makes sense to them. More transparency in the cost part of it but offering more plan designs that makes sense for them to offer to their employees.

Association health plans, the way it is constructed is very specific and confined, and restricted to a lot of small business owners currently. Expanding the availability of Association health plans to a larger population would allow them to purchase in economies of scale that are more afforded by large firms and will give them a competitive leg up from their current status right now in being able to afford.

As I mentioned in my statement, those who are not able to afford health insurance and offering currently are looking to do that. They want to be able to compete for talent and retain current employees, so many of them are hoping that in the future the affordability will be more manageable, and that they will be able to offer the benefit to their employees because they know that that is the second most valuable, outside of wages, for competitive structure of that.

Mr. WALBERG. Thank you. My time has expired. I yield back.

Chairman GOOD. Thank you. We will now recognize Mr. Courtney from Connecticut for 5 minutes.

Mr. COURTNEY. Thank you, Mr. Chairman. To the witnesses, you know, Mr. Fronstin I think did a really nice job about going back to the origins of employer-sponsored insurance that the World War II decision to make the value of those plans tax-exempt, really has been sort of foundational.

Again, I would just like to ask all the other witnesses, the simple question yes or no, do you think Congress should reduce the tax-exempt status of health care—employer-sponsored health plans?

Ms. SCHUMAN. Absolutely not.

Mr. COURTNEY. Ms. Wade.

Ms. WADE. Absolutely not.

Mr. COURTNEY. Mr. Wright.

Mr. WRIGHT. Given that it is a foundation for 60 percent of people to get coverage, no.

Mr. COURTNEY. Again, the reason, and as a former employer, is that if Congress made that move, it basically would add to the taxable income of all the employees of Ms. Wade's membership, as well as Ms. Schuman's membership. Unfortunately, this is a very relevant issue in 2024.

Project 2025, which is the document generated by the Heritage Foundation, with dozens of former Trump officials, Russell Vought, the former budget director of the Trump administration, also the Chair of the Republican National Committee's Platform Committee, again, in that package in Project 2025, it proposes to cap the tax

exclusion below 100 percent, which is a tax increase for workers of employee-based, employer-sponsored plans.

The Republican Study Conference, which again is closer to home here in the House, about 70 percent of the membership of the majority caucus issued their 2025 budget document earlier this year, which proposed the same thing. Again, if you look at the history surrounding this issue, Milton Friedman, the Godfather of conservative economics, wrote an essay.

Mr. Fronstin is probably familiar with it, How to Fix Health Care Costs, where he proposed eliminating the tax-exempt status of employer sponsored insurance. This year, in 2024, given the fact that we have Project 2025, which again, has got the fingerprints of the former President's former employees, as well as people working on his campaign, proposing to cap the tax exclusion, as well as the Republican Study Conference doing exactly the same thing.

When we are talking about threats to employer-sponsored insurance in 2024, that is really the elephant in the room in terms of making sure that the foundational cornerstone that created employer-sponsored insurance, back during World War II remains intact. I can say this as somebody who when we passed the Affordable Care Act, and Ms. Schuman knows this, it included a Cadillac tax, which we furiously were succeeded in terms of delaying the impact of that for 10 years after the law passed.

Then finally, in the House, with a bill that I was the lead sponsor, and had great bipartisan support, stripped that from the law by a vote of 419 to 6. There is strong bipartisan support for maintaining the tax-exempt status of employer-sponsored insurance. However, that is very much, very, very much at risk in terms of just the positioning of different forces, think tanks and other groups, that really want to go at this.

Which again, if you go back and read the Godfather, Milton Friedman's economic treatises on this, I mean that is a, you know, just a fundamental tenant of a lot of conservative economists in this country, which is that that's really the source of a lot of the problems for the costs of health care insurance.

Mr. Wright, you mentioned the fact that the Inflation Reduction Act last August 15th during the recess, announced the first ten medications, in terms of the negotiated prices. 80 percent cut in cost of some of those very high-cost, high-utilized medications in Medicare.

We have a bill, the Lowering Drug Costs for American Families Act, which would extend the benefits of that negotiation to employer-sponsored plans, or individual plans, optional. Do not have to do it if you do not want it, but can you, from Families USA, would that help small employers as well as individuals get the benefit of lower costs, which are driving higher premiums?

Mr. WRIGHT. The short answer is, yes, that individuals, businesses, insurers, other payers, are all struggling with the cost of high inflated and irrational health prescription drug prices. Using the authority of negotiation that is in the Inflation Reduction Act to extend those discounts, not just to the Medicare program, but more broadly in the commercial market, would be a big boon, and start to chip away at the affordability issues that people have at the pharmacy, and when paying premiums.

Mr. COURTNEY. Thank you. I yield back.

Chairman GOOD. Thank you. We will now recognize Mr. Allen from Georgia for 5 minutes.

Mr. ALLEN. Thank you, Mr. Chairman, and first, just quickly, my position on employer health insurance or ERISA. We can always have a government program in this country, but we need to give the business community the flexibility to provide the best coverage at the best value for their employees. The business community will figure this out.

My position is to give this coverage the same waivers that the Affordable Care Act gave to unions and the faith-based company—faith-based part of the healthcare industry, so that we can get totally away from Federal regulatory issues dealing with ERISA, as far as compliance, and all the costs, and everything that is being added to that.

I also want self-employed people to be able to participate in ERISA. We do not have time to discuss that today, but I would like your written response to that idea as far as going forward and how to solve the tremendous cost increase in health insurance.

In recent years, another matter is growing adoption of so-called alternative funding programs and employer sponsored plans. Some stakeholders have suggested that AFP vendors divert employees into their programs, and push employers to adopt discriminatory benefit designs that single out medicines that treat specific conditions.

They suggested this type of action could violate ERISA and HIPAA compliance. Representative McBath and I recently sent a letter urging the Department of Labor to investigate the prevalence of AFPs in the employer sponsored health coverage market, and asked the DOL to take action to prevent these predatory practices.

Ms. Schuman, how well do you think employers are aware of potential ERISA compliance risks with AFPs? Have you provided any education about compliance risk to member companies?

Ms. SCHUMAN. Thank you for that question, Congressman. The Council's membership typically rely on traditional PBM and drug payment models, so members have not raised AFPs as an issue that I am aware of, and the Council has not actively addressed AFP with its members. It does sound like this is certainly a concerning practice, but I said it has not been brought to our attention by our membership.

Certainly drug costs are a big concern for our members, and just want to take this opportunity to again offer my support for the great bipartisan work of this Committee already in the Lower Cost More Transparency Act, to bring more transparency and oversight of PMBs in an effort to do that.

Mr. ALLEN. Well, it is a long and frustrating fight to get your medications approved through the PBM step therapy process. It often results in missed days of work, and a worsening of their condition. The lack of transparency, as you mentioned, PMB practices makes it difficult for employers to assess whether the administration of drug benefits aligns with their employees' best interest and well-being.

Many people I represent in the Georgia's 12th District, experience these same frustrations, which is why I am proud to cosponsor

the Safe Step Act, which would ensure employer health plans, including their contracted PBMs, offer an expedient and medically reasonable step therapy exceptions.

Dr. Fronstin, how would legislation such as Safe Step Act help people with chronic conditions, who are covered by the ERISA plan?

Mr. FRONSTIN. I have not studied the Safe Step Act, specifically, but it sounds like it would streamline prior authorization process, and speed up the process again for certain medications, when all the medications are not working as expected.

Mr. ALLEN. What can be done to help employers navigate the complex benefit structures, pharmacy networks, and formularies that are obscured by the PBM incentives?

Mr. FRONSTIN. PMB incentives are complex, and I think building an employee benefit program is complex as well for many employers, even large employers, and sometimes beyond the expertise of many benefit managers. That is why they use consultants, use ERISA attorneys.

They often learn from each other at conferences. There are some purchasing coalitions that employers have joined to help them navigate a complex healthcare system, and provide them some leverage.

Mr. ALLEN. Thank you. I am out of time. I have additional questions I would like to submit for the record. With that I yield back.

Chairman GOOD. Thank you. Without objection.

[The information of Mr. Allen follows:]

Chairman GOOD. I now will recognize Ms. Manning from North Carolina for 5 minutes.

Ms. MANNING. Thank you. With regard to the antics at the top of this hearing, I did not realize we were playing campaign ads here. In fact, I thought there were ethics rules that separate our official acts from campaigning, and if I had known, I certainly would have brought a few campaign ads of my own to play.

I would like to turn to the actual subject of this hearing, and I want to start by thanking our witnesses for being here, to celebrate the anniversary of ERISA. It is the essential cornerstone of our Nation's health care policy, and the consumer protections Congress has passed to strengthen it, such as the Affordable Care Act, have ensured better outcomes for millions of Americans.

Sadly, for almost 15 years, the Republican Party has waged an all-out war on the ACA, and the landmark consumer protections it has enshrined into law for millions of working people in this country. These include protections for more than 130 million Americans with pre-existing conditions, requiring coverage of contraceptives, prohibiting charging women higher premiums than men for the same coverage and so much more.

In April of this year, 62 percent of the public had a favorable opinion of the ACA, and these protections are critical to my constituents and frankly, they are critical to my family. I have a daughter who has a serious pre-existing condition, a chronic illness that thankfully is successfully treated with a biologic that would cost her $23,000.00 every month, if not for the protections of the ACA.

I am grateful that we passed the IRA, which will finally allow our government to negotiate over some of the most expensive prescription drugs available, and I am also astonished that the Republicans continue to push for the repeal of the ACA. In fact, Project 2025, Trump's Project 2025, lays out a plan for undermining and destroying the ACA.

Project 2025 has a detailed plan from a right-wing think tank for the next Republican administration. Mr. Wright, let me ask you about this. One of the key policies of Project 2025 is to separate the subsidized ACA insurance market from the non-subsidized insurance market.

Can you explain what this would mean for Americans left out of the ACA's protections?

Mr. WRIGHT. I think the things that we would be concerned about is the loss of consumer protections and ultimately coverage for millions of Americans who depend on that coverage, that would have—losing those protections, and for some would be a problem. Losing the coverage would also have a destabilizing impact on the overall market because those who are no longer covered would be left in a smaller and sicker risk pool, and thus have ever increasing premiums as a result.

The loss of consumer protection would be broader than that, and that would be the concern, whether it is access to basic essential health benefits, or as you mentioned, an issue with regard to being able to get the care that you need, regardless of pre-existing condition.

Ms. MANNING. For example, it could cause the loss of protections for people like my daughter, who have a pre-existing condition, as do millions of Americans across the country. Is that correct?

Mr. WRIGHT. That is correct.

Ms. MANNING. Thank you. Overall, would this reduce American's health care costs, or increase them?

Mr. WRIGHT. As I mentioned, the destabilizing effect would not be just an impact on the people who would lose the subsidy, or lose the coverage, but also have a broader impact on the system as a whole, in terms of leaving people in a smaller and sicker risk pool, with higher premiums. Yes.

Ms. MANNING. To put it plainly, it could increase health care costs overall. Is that correct?

Mr. WRIGHT. Yes.

Ms. MANNING. Project 2025 also calls for keeping "anti-life benefits" out of benefits plans, including coverage for abortion care, and I assume, including coverage for contraception or birth control, and this is actually written in the plan, including costs for surrogacy. Mr. Wright, could you speak to the benefits that reproductive care coverage has had for Americans?

Mr. WRIGHT. It is critical that people have the ability to plan and start families when and how they want them, but also to get the prenatal and postnatal care to have healthy babies, and children, and adults. This is critical, especially now that we are in a maternal—we have a maternal mortality crisis, and so those kinds of services are incredibly important to make sure that we deal with both disparities and the overall quality of care.

Ms. MANNING. Thank you. I have more questions. I will submit them in writing. Thank you very much.

Mr. WRIGHT. Thank you.

Chairman GOOD. Thank you. We will now recognize Chairman Foxx from North Carolina for 5 minutes.

Mrs. FOXX. Thank you, Mr. Chairman, and I want to thank our witnesses for being here today. It is a very important issue to the majority of people in this country, particularly those who are covered by employer sponsored healthcare.

Ms. Schuman, your written testimony highlights anti-competitive contracting terms, such as all or nothing, and anti-steering clauses, which prohibit a plan sponsor from contracting with a business associate's competitors or using providers outside of a business association's network.

How did these restrictions affect plan benefit design and cost?

Ms. SCHUMAN. Well, thank you very much for that, for that question. As large hospital systems have increasingly acquired other hospitals and physician practices, these healthcare systems dominate the market, and they use their market power to push out lower priced, higher quality competitors. One of the ways that they can do that is through these anti-competitive contracting terms, that they demand are included in contracts with health plans, insurers and third-party administrators.

These anti-competitive contracting terms come in several forms, anti-steering, or anti-tiering provisions, that prevent employers from utilizing value-based design to direct employees toward lower cost, higher quality providers, or all or nothing clauses, for example, that would require the health plan to contract with all affiliated facilities and providers, including lower quality ones.

These contract provisions are designed to do one thing, to limit access to lower cost, high quality care, and to tie the hands of employers in their efforts to promote more value driven care. That is why the Council is so strongly supportive of the Healthy Competition for Better Care Act, that would restrict these anti-competitive provisions, and urges the Committee to approve it. Thank you.

Mrs. FOXX. Thank you very much. You just answered my second question. Ms. Wade, the Affordable Care Act does not require employers with fewer than 50 employees to offer health coverage to their employees, and yet NFIB reports that many employers still choose to offer coverage. Can you discuss the benefits for small employers, and their employees of offering employer-sponsored health benefits?

Ms. WADE. Certainly. NFIB, we have surveyed our members periodically over the years, and with the tight labor market that they are experiencing now, but have been for years, the ability to offer health insurance as the primary benefit outside of wages is incredibly important to many of them in attracting talent and retaining current employees.

The availability, the affordability, of this benefit for them being able to have a large choice of benefit structures to offer their employees is critical for them in those purposes of retaining talent and recruiting for open positions. This is one of the main hurdles that they face in offering the benefit, is cost.

We survey our members, and they tell us that in the next five to 10 years, most of them are very concerned about their ability to keep the affordability aspect of offering the benefit to their employees, and so they are concerned whether they are going to be able to offer the benefit going forward.

They are concerned about their ability to compete for talent in their workforce.

Mrs. FOXX. Thank you. Dr. Fronstin, your written testimony states that ERISA's preemption of State law created an environment of national uniform standards for employee benefit plans and allows employers to continue to offer health benefits. What would health benefits look like today without ERISA?

Mr. FRONSTIN. That is a really interesting question. I think if you go back before ERISA, employers offered coverage for business reasons, to be competitive in the labor force. Just about every large employer still does. Some small employers do, and if you ask the employers, small employers that do so, they are doing so for business reasons, to be competitive in the labor market.

They are concerned about employee health and their productivity. I do not know that if we did not have ERISA it would look any different than that. I think ERISA certainly has enabled employers, perhaps large employers to—made it easier to offer benefits across State lines, but I still think they believe in the reasons why they offered benefits to begin with, which is to be competitive in the labor market, and to invest in worker health.

Mrs. FOXX. Thank you very much. My time is expired. I yield back.

Chairman GOOD. Thank you. Pursuant to previous order, the Chair declares the Subcommittee in recess, such to the call of the Chair. We will plan to reconvene promptly in 5 minutes at 11:25. Thank you, so the Subcommittee stands in recess.

[Recess]

Chairman GOOD. The Subcommittee will now come to order following a recess. I will now recognize Ms. Hayes from Connecticut for 5 minutes.

Ms. HAYES. Thank you. Thank you to our witnesses for being here today. I also want to just thank my colleague, Ms. Manning, who left, for bringing up the idea about the ethics separation on Committee. I was in the back and saw how this Committee opened, and that is not the way we should be doing our work, and she brought up the ethics guidelines, which I think would be a real issue, except that the people of Virginia's 5th have already worked that out for us.

While hardworking American people are struggling to afford medications, drug companies are reporting billions in profits. According to Protect Our Care, in the first 3 months of 2024, 15 of the biggest drug companies reported nearly 173 billion in revenue, and nearly 29 billion in net profits.

In 2022, I voted to pass the Inflation Reduction Act, which empowered Medicare for the first time in history, to negotiate lower drug prices for millions of seniors. The ten drugs selected for the first round of negotiations accounted for over 55 billion dollars in total Part D gross prescription drug costs in 2023.

These negotiations resulted in a reduction of 38 to 79 percent on the selected drugs. Mr. Wright, in Project 2025, and what we have heard from many Republicans on this Committee, there have been calls for repealing the Medicare drug price negotiation program. What consequences will seniors face if the Inflation Reduction—if that portion of the Inflation Reduction Act is repealed?

Mr. WRIGHT. Thank you for the question. I think there will be impacts to both the individual beneficiaries, and to the program as a whole. Individual beneficiaries are getting the benefits in the Inflation Reduction Act of an overall cap on prescription drugs of $2,000.00, access to free vaccines, a cap on $35.00 for insulin, but more they are getting the benefit of getting the negotiated discount rate when they go to the pharmacy, especially if they are under insured.

If that was to be repealed, those benefits would—those direct-to-consumer benefits would go away, but also would be the savings to the Medicare program and would have a problematic impact on the solvency of Medicare and the trust fund.

Ms. HAYES. Thank you. We are seeing that even with these negotiations, these companies are still putting up record profits. House Democrats are looking to expand the drug pricing negotiation program to private healthcare markets, like those covered under ERISA.

Could you explain how applying the prices secured through the Medicare drug price negotiation program will reduce costs for millions of Americans with private health insurers?

Mr. WRIGHT. To the extent that the Medicare, and the government is using its purchasing power to negotiate discounts, it makes sense that those discounts should be applied to the broader public, whether through including in the commercial market that would help bring down the premiums that payers pay, whether employers, union trusts, or individuals who pay out of pocket for premiums.

Ms. HAYES. Well, will this also have a benefit on the employer?

Mr. WRIGHT. As I said that it would be since the employer is often the one that is paying the main premium often with a shared cost by the worker, it would have a benefit for both, the employer and also the worker, whether the share of premium, or as the ability to have those wage increases in other ways.

Ms. HAYES. Both the employer and the employees would benefit from negotiated drug prices, and lowering the cost of prescription drugs. Thank you so much for being here.

Mr. WRIGHT. Thank you.

Ms. HAYES. The Inflation Reduction Act dramatically lowers costs by requiring drug companies to provide rebates when they raise list prices faster than inflation limits—then inflation. Limits total out of pocket costs through Medicare Part D at $2,000.00 annually, and caps insulin costs at $35.00 per month, but it is imperative that we pass legislation that would expand the drug price negotiation program, and the inflation rebate savings to ensure that individuals with private health coverage also benefit.

Can you just speak in my last 40 seconds, about how we are talking a lot about Medicare Part D, and people who participate in

these programs would benefit. How would this expand to everyone that would benefit from this type of work?

Mr. WRIGHT. I think the more we can do to expand these benefits broader than the Medicare program, that would be a direct benefit to consumers. At the pharmacy, this is one of those monthly costs people feel every time they go to the pharmacy, but also even for folks who do not use prescriptions because it is the premiums everybody pays.

Ms. HAYES. Thank you. As we are talking about rising inflation, and the cost of living, the amount that families are paying should be considered as we are thinking about these things, and this is something that will definitely help. Thank you so much, I yield back.

Chairman GOOD. Thank you. We will now recognize Mr. Burlison from Missouri for 5 minutes.

Mr. BURLISON. Thank you, Mr. Chairman. Dr. Fronstin, in your written testimony you said that small employers have been responsible for the decline in the number of employers that are offering health benefits. What has happened to cause that to occur?

What steps can we take so that small employers are wanting to offer those health benefits?

Mr. FRONSTIN. Yes. Keep in mind that small employers were never as likely to offer health benefits as large employers, and there is clearly an affordability issue there.

Mr. BURLISON. It is just a complexity—part of being a small business, right?

Mr. FRONSTIN. I think the complexity part comes in because a small business, you do not have as many people that you could allocate these responsibilities to. You can certainly hire a broker to help you navigate the health insurance part of it, but that is just one more piece when you are potentially starting a business.

I think the challenge with small businesses is that we have done surveys that are dated, right, about 20 years ago, where we asked small businesses that did not offer coverage why, and whether they thought it had a negative impact on their business.

For the most part they did not. If you cannot convince them, and the NFIB was asked a similar question like that recently. If you cannot convince these businesses that not offering it has a negative impact, I think it is going to be very tough to convince them to offer, even if premiums were more affordable, they are just not focused on it.

Mr. BURLISON. I had a whole list of questions, and I am going to kind of go a little—I am going to wax philosophically here if that is okay. I am reflecting on the fact that in American at one point employers created pensions, right? They managed those pensions, and over time, decades, they became unsustainable, they became a liability. There was a lot of uncertainty with those, that sometimes you would have people that would lose out because their employer might go belly up and now their pension is gone.

The result was this institution created a tax incentive for individuals, or created a mechanism so that employers can offer IRAs, can offer 401K's, that put the money in the hands of the individual. Let me choose where their investments are going, let them choose that.

Could something like that be done with health insurance, where the Federal Government is giving the same tax benefits, but encouraging the employer to provide a benefit that the employee then takes, and takes control of?

Mr. FRONSTIN. You could do that now by existing rules with individual coverage health reimbursement arrangements. Employers can give workers money, a tax-free basis, let them go buy insurance on their own. It is not a very popular benefit. I think at most there are different estimates, on how many people are in such an arrangement. They are all small, right, maybe——

Mr. BURLISON. It is not—I have not heard of it, so it is very under-utilized?

Mr. FRONSTIN. Maybe a million people are in such an arrangement, but I do not think we know exactly. I have seen numbers of 200,000, maybe 400,000, you add in independents, you could double that number, so that is like where the million estimate comes from.

We have asked large employers about it. Some of them we have asked about it to see if this is something they would be interested in, did not even know about it. I think the NFIB survey asked about it as well, and it was a lack of familiarity there. I do not remember the specific numbers.

Mr. BURLISON. Um-hmm. Being a former State legislator, I saw firsthand how a lot of employers were happy to move to an ERISA plan to escape all of the State regulations. The health and the mandates on what they have to provide care for, and I can only imagine how difficult that would be to go if you were occupying or had employees in multiple states.

What—let me ask this, what else can we do, for example, to ramp up that individual program for small business owners. I know that we have got the association opportunities as well. Is there anything else that you can see?

Mr. FRONSTIN. I am not—I do not know to what degree—small business. You have got two kinds of small businesses, both those that offer coverage, those that do not. I do not know that those that offer coverage are going to go in that direction, if they are already committed to offering coverage.

While you have seen some erosion, it has not been very large erosion. I think this would be more appealing to employers, small employers that did not offer coverage as a way just to give their employees some tax-free benefit.

Mr. BURLISON. Has—Ms. Schuman, have these associated plans, these plans that where you are grouping people based on association, have they experienced any savings?

Ms. SCHUMAN. Well, you know our member companies are primarily large, multi-State employers that provide comprehensive healthcare coverage to their employees, so it is just not as——

Mr. BURLISON. This may be a question Ms. Wade can answer.

Ms. SCHUMAN. Yes. I think.

Chairman GOOD. The gentleman's time has expired.

Mr. BURLISON. She can answer.

Chairman GOOD. We would like her to submit that written for the record. Thank you, I apologize. I now recognize Ms. Wild from Pennsylvania for 5 minutes.

Ms. WILD. Thank you. Mr. Wright, I have a particular interest and concern about the role of private equity in health care, and I do see in your written testimony that you mention the role of private equity in health care, and I want your opinion on a couple of things in a minute, but just for the benefit of people who might not understand what private equity is, and tell me if I am incorrect about anything that I say.

Basically, this is private investors who contribute capital, but they leverage their investment with a whole lot of debt, and in the case of health care, they may use and likely do use physical assets, whether it is hospitals, buildings, or whatever, as collateral for that debt.

Then they have to pay off the debt, which to my mind means they probably have to generate a whole lot of revenue in order to keep up with payment of that debt. Have I stated it correctly so far?

Mr. WRIGHT. Yes.

Ms. WILD. Okay. Thank you. I have read that private equity has invested nearly a trillion dollars in the health care system in the United States since 2006. That means private equity collectively, and would it be a fair statement that when a consumer, a patient goes to a health care provider, goes to a hospital, that the chances are they do not know much about the ownership structure of the hospital, or the health care place?

Mr. WRIGHT. That is a fair statement.

Ms. WILD. Okay. It is not like there is a big plaque on the side that says owned by private equity investors, so and so, and so and so. Okay. There has been a number of studies, including one by Harvard Medical School about the fact that private equity actually results in higher prices to consumers, that more profitable services are often performed, but do not match either the need for them, or the benefit that they would convey, surprise medical bills.

Then, one study, the Harvard one in particular, found significantly worse outcomes for patients, particularly Medicare patients in private equity locations. My question to you after all that is, what can Congress do to manage this problematic role of private equity in our health care system?

Mr. WRIGHT. Thank you for the question. I think there is a number of things that Congress can do. It is an issue of concern. We have seen a lot of money come in from private equity. It has certain incentives that are not necessarily aligned with community health and more for short-term profit, even in some cases, stripping the assets of institutions to get the most value, or at least short-term value from them. I think there needs to be some transparency in this regard, just to even know when these transactions are happening.

It has been actually surprising how quickly these ownership relationships have changed, even in the last five, 10 years, whether it is to medical groups, or in certain parts of our health system, and so having greater transparency of ownership, particularly with private equity would be important, and also oversight over the actual transactions themselves, whether by the FTC, the DOJ.

I know states are introducing laws to have oversight by State Attorney Generals, multiple states had bills this year. I believe one

is on the California Governor's desk, and I think it is a concern because the growing body of literature is that private equity is associated with higher costs—the growth and ownership of private equity is associated with higher costs, and in fact, a lower quality, and even closures, depending on the business model.

Ms. WILD. My understanding is that so far at least, it is a relatively small percentage of health care systems in the United States that are owned by private equity, but would it be fair to say that struggling hospitals, for instance, in smaller communities might be more susceptible to a private equity buyout or takeover?

Mr. WRIGHT. I think that is certainly true, and it is becoming a big percentage in certain pockets of our system where those investors are seeing the opportunity to extract more dollars out of our health system.

Ms. WILD. Can you elaborate on that? What do you mean?

Mr. WRIGHT. Whether it is on ambulances, whether it is in certain specialties, whether it is in certain areas.

Ms. WILD. Okay.

Mr. WRIGHT. Like if you look at overall, it is a relatively small percentage, but in certain markets or certain areas that is a problem.

Ms. WILD. Got it. You were not talking about geographic areas, you were talking about areas of medicine or services provided. One of the things I read was that the higher risk, more specialized areas of medicine are more susceptible to private equity takeovers.

Mr. WRIGHT. That is right.

Ms. WILD. Is that fair to say. Thank you. I think it is a huge problem. I hope that we can address it in the coming years in Congress, and I think that it is a problem that is going to continue to grow unless we reign it in. Thank you for your information.

Mr. WRIGHT. Thank you.

Ms. WILD. I yield back.

Chairman GOOD. Thank you. I recognize now Mr. Bean from Florida for 5 minutes.

Mr. BEAN. Thank you very much, Mr. Chairman. Good morning to you, and good morning HELP Committee. What an honor to be here, and to our distinguished panelists, it is great to see you. Since the COVID pandemic the rise of telehealth has taken American by storm, and it is a popular option for many, many Americans, and there is a convenience factor, it is all kind of things.

Now, we are seeing that it is not as affordable as you would think. You would think with innovation and with the efficiency of telehealth it would be a much less expensive option, one of which, one of the problems is different fees that providers and facilities are putting on telehealth visits to make it just not as affordable as it could be.

Ms. Schuman, you have mentioned it in your testimony. I want you to talk about it. Is it a problem? I am considering, this is just between you and I, I am considering doing a bill to limit fees, and add-ons, which sometimes Americans are confused, and I would be confused if you get a bill from a doctor, but then get a bill from a hospital, then you will get a bill from somebody else facilitating it.

Is it a problem? What do you think? Is there a need to fix? What say you, Ms. Schuman?

Ms. SCHUMAN. I say that it is a problem, and that it needs a fix. Allowing hospitals to charge a facility fee for telehealth appointment is a prime example of a payment distortion that is increasing healthcare costs for employers and patients. If these services are delivered via telehealth, but the facility is a phantom, but the fee is very real.

We strongly support legislation that would protect group health plans from having to pay facility fees for telehealth services. It just does not make sense to pay a facility fee, a hospital facility fee when the facility involved is basically an internet connection, and voters see through this too.

By an overwhelming margin of 82 percent to 9 percent, 8 to 1, voters believe that patients should not be charged a hospital facility fee.

Mr. BEAN. Ms. Schuman, it sounds like that if you were a member, and I presume that you would vote yes. Is that correct?

Ms. SCHUMAN. That is correct.

Mr. BEAN. Yes. Fantastic. You think it is worthwhile to do this bill?

Ms. SCHUMAN. Absolutely.

Mr. BEAN. Fantastic. All right. I am very close to launching this bill. Ms. Wade, NFIB is the forefront, it is the freedom loving businesses that want to get government out of the way, and just provide a service, make money, and be the backbone of small business. I did a roundtable in—I partnered over the break with the Clay County, if they are listening, thank you the city of Orange Park gave us their facilities.

It was town hall. We partnered with the Clay County Chamber of Commerce. They invited just a handful, a variety of businesses, and I sat there and listened to obstacle after obstacle of challenge, inflation, taxes, hiring practices, regulation, and we talked a little bit about healthcare, and many of these small businesses are just—they are challenged by the immense costs of offering health plans.

What say you, Ms. Wade, and NFIB? What do we need to do to make healthcare more affordable in America? That is a big question, and welcome to the world we live in. It is such a little tight window, but is there some 50,000-foot view of what we need to do to get healthcare more affordable in America?

Ms. WADE. Sure. Not surprisingly, our studies find similar to what you heard in the roundtable, that 41 percent say it is a critical issue in operating their business, the cost of health insurance, and their ability to afford it themselves as the owner, but also in offering it to their employees, or potentially offering it to their employees if they do not offer it already.

Transparency, better design choices, more plans available to small business owners will help in having stabilized and lower costs for them to offer benefit, association health plans, expanding those opportunities.

Mr. BEAN. It sounds like you are saying if I could summarize it, choice and competition, that is what the American consumer and small businesses want. How devastating, if we went to a one size

fits all, single-payer system, how devastating would that be to Americans and small businesses?

Ms. WADE. Small business owners would be less able to compete for talent in retaining current employees, and attracting applicants for those positions, if not given the choice to offer the benefit.

Mr. BEAN. You nailed it. Devastating is what you are saying. It would be devastating to have single-payer, that would eliminate single plans, health plans, and wreak havoc across America. Thank you so much. Mr. Chairman, I yield back.

Chairman GOOD. Thank you. I now recognize Mr. Scott from Virginia for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman. Mr. Wright, we have heard a lot about association health plans. It has always seemed to me that if you got a group of lower-cost healthier people, and make an association out of it, the association might save a little bit, but everybody left behind ends up paying more.

Is there any evidence that eroding consumer protections promoting association health plans actually lowers health care prices in general, rather than shifts them to somebody else?

Mr. WRIGHT. I think a lot of the savings comes from the fact that they do not have to abide by certain consumer protections, and patient protections, which is a detriment obviously to the workers or employees, and also this issue of a risk shift, where if you are skimming off the healthiest populations, then you are shifting those costs onto the broader market for small businesses, and having an impact of increased premiums there.

We would—I also just want to make sure that with regard to association health plans, that there is strong financial oversight because you do not want to have a situation of financial fraud or issues where because of lack of due diligence, you know, people are left high and dry without health care because the money went someplace else.

Mr. SCOTT. You are talking about solvency of these plans?

Mr. WRIGHT. Yes.

Mr. SCOTT. What happens when they go broke?

Mr. WRIGHT. Well, then that is a huge obstruction both to the health care for the workers, but also for the employer, issues of liability, issues of great concern. It is not good for anybody.

Mr. SCOTT. What kind of—you talked about consumer protections before, you mentioned a protection if you have a pre-existing condition, what other kinds of consumer protections would you lose if you get into an association plan?

Mr. WRIGHT. Some of the consumer protections are just whether certain basic benefits are covered, whether preventative care, whether, you know, prescription drugs, equipment and services, et cetera.

Mr. SCOTT. The American Rescue Plan Act and Inflation Reduction Act improved tax credits, Mr. Wright, and particularly for those earning over 400 percent of poverty, where there is a cliff, and you have got no benefits. Now you get benefits, you just pay a percentage of your income. At some point on the income scale, you will meet the sticker price.

You would not be entitled to anything, but how have the premium tax credits helped both low-and middle-income individuals?

Mr. WRIGHT. They have been a lifesaver and a lifeline for millions of Americans. Over 5 million more Americans are covered, in part due to the enhanced tax credits that have been put in place in the last several years. People have gotten reduced costs at a time when people are screaming about affordability and have been screaming about health care affordability for decades.

This is a direct form of assistance that says you do not have to pay more than a certain percentage of your income for coverage, and you are right, those folks just over 400 percent, for those under they will have the guarantee that they did not have to pay 8 and ‡ percent of the income on coverage, but just those over, especially if they were older, would be paying 20–30 percent of their income on coverage, having a huge impact on their ability to make ends meet for other needs.

It is incredibly important that those tax credits get extended because they run out next year, and that needs to be done sooner, rather than later in order for them to take effect in 2026.

Mr. Scott, Now, for small businesses where the owner may be just over the threshold, association plans start to look like a nice alternative. How does the elimination of the cliff affect the attractiveness of association health plans?

Mr. WRIGHT. In fact, the—if I had a chance to respond to the Representative here, I think the ACA Marketplace is an especially, with these enhanced tax credits, provide a real benefit for small business. A lot of the people in these Marketplaces are solo entrepreneurs, real eState agents, contractors, and people who are starting family businesses who are in the exchanges and marketplaces right now and getting this benefit.

If these tax credits are not extended, that would be a premium spike of literally hundreds of dollars, and in many cases thousands of dollars to their bill. It would also have the impact of meaning that some of those 5 million people that got coverage, would lose coverage, and then have an impact on premiums overall in the overall marketplace.

Mr. SCOTT. Now, if you are in an association plan, you are not getting a tax credit, right?

Mr. WRIGHT. No.

Mr. SCOTT. The association plan would be competing with an ACA plan with a tax credit?

Mr. WRIGHT. That is right.

Mr. SCOTT. That makes it virtually impossible for association plans to compete.

Mr. WRIGHT. I think that at this moment the ACA marketplace is a much better deal for people up and down the income spectrum.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman GOOD. Thank you. I will now recognize the Ranking Member DeSaulnier, for 5 minutes.

Mr. DESAULNIER. Thank you, Mr. Chairman. Last spring the New York Times published the results of an investigation to MultiPlan, a private equity-backed data analytics company that works with many employer-sponsored health plans, and their third-party administrators, or TPAs.

The investigation found that when MultiPlan lowered reimbursements to providers, consumers would be on the hook for exorbitant

balance bills that employers were liable for huge fees. In many cases, the fees paid to MultiPlan and the TPAs were more than reimbursements being paid to health care providers.

To me, this is a clear example of the inefficiencies, and unethical behavior plaguing our health care system. Mr. Wright, can you comment on MultiPlan and its inefficiencies for consumers?

Mr. WRIGHT. Yes. Thank you for the question. I think we are deeply concerned about the potential price fixing, and anti-competitive behavior. I wish I could say I was shocked, but this is the kind of scheme that we have seen in the health care system with corporations trying to take a profit often to shift costs onto consumers.

We are particularly concerned about the issue of a proprietary algorithm that is not public, that is making these decisions, and the issue of the shifting of costs onto consumers through balance billing. We do support the call for investigations by you, and others in the House and in the Senate, to look into this and deal with this appropriately.

Mr. DESAULNIER. Ms. Schuman, much like PBA's, the inefficiencies of the system.

Ms. SCHUMAN. Okay. Well, thank you so much, and I think this just brings the light to need, the need to bring more light to healthcare system, and the need for transparency, to shine a light on these kind of payment distortions and practices that are driving higher costs for employers, and also for working families.

Again, the important work that the Committee has already done to advance those transparency requirements in the Lower Costs, More Transparency Act.

Mr. DESAULNIER. Thank you. The last hearing we had on ERISA we heard testimony about claim denials. Many of us have experienced at least one instance of a denied claim. We all know that claim denials can impose serious health and financial hardships. During our last hearing, the Democratic witness recounted the tragic death of Kyree, 27-year-old flight attendant who was denied prior authorization for a heart transplant, over criterion that never existed in the plan's documents.

The denial would eventually be reversed, but the decision came almost a month after Kyree's death. Despite stories like Kyree's, we do not even collect adequate data to help us understand the extent of the problem. The Affordable Care Act required the Department of Labor to issue regulations to require group health plan reporting on claim denials, and in 2016, the Department proposed to do just that.

Unfortunately, the Trump administration ignored the ACA requirement and pulled the proposal in 2017. Mr. Wright, at least anecdotally, I am hearing the problem is getting worse from providers that claims that they regularly put in to providers, are being denied, denied, denied, and either they, or their clients give up. Do you have any comments about claim denials, and the possible effect of companies like MultiPlan?

Mr. WRIGHT. Thank you for the question. Claim denials is a big issue for both patients and providers who are trying to provide care to their patients, and you do not want a plan or an employer to be judged during an execution, you want independent review.

You want the ability to appeal if your claim—if your care was denied, that was medically necessary. Right now, the relief under ERISA is very limited, and so I think we need to look into this, and right now we basically even just need the transparency to even know why the claim denials are happening, because right now we do not even have that.

We need to be able to know that the timeliness of these claims, how many claims are filed, what is the rate of denial, and for what reasons. Then I do think we need to have a greater look at what kind of relief can be provided under ERISA.

Mr. DESAULNIER. Ms. Schuman, claim denials?

Ms. SCHUMAN. Yes. Well certainly I could not agree more about the need to have more transparency again for these claim denials. I will say that there is an important service that appropriate medical management, and prior authorization plays without a doubt. Again, I think the need for greater transparency to understand where those distortions are.

Mr. DESAULNIER. Thank you. I yield back.

Chairman GOOD. Thank you. I will now recognize myself for 5 minutes. Dr. Fronstin, President Biden and VP Harris have tried to expand even further, government's role in healthcare, including as we saw in the video, a Medicare for All, and lowering the age to qualify for Medicare.

As government control of healthcare expands, like when Democrats increase subsidies for Obamacare plans, what happens to employer-sponsored health insurance?

Mr. FRONSTIN. Yes. We have talked to large employers about expanded subsidies, and for the most part, it does not affect what they do. They are concerned about recruitment and retention. They recognize that their employees value health benefits more than any other benefit, something I remind my retirement colleagues of all the time at EBRI.

Small employers—we have not polled them on how subsidies might affect their behavior, but I would point out to the degree offer rates have eroded in a small group market, that was happening before the ACA passed, so I think its premiums are driving that more so, and the ones that continue to offer coverage are doing so, I think because of business reasons.

They are concerned about recruitment and retention, and even with enhanced subsidies, they are still going to be concerned about recruitment and retention.

Chairman GOOD. No question about it. A CBO report estimates 3 and a half million people would leave employment-based coverage if Democrats are successful in permanently expanding eligibility for enhanced Obamacare subsidies. Why do you think government wants to move more people—why do you think government wants to move more people from a quality private healthcare plan, to a more expensive one, fully paid for by the taxpayer? Why would the government want to do that?

Mr. FRONSTIN. They are different markets, and they serve different purposes. The employment-based market is, you know, those are groups that are formed for reasons other than the provision of health insurance. They are considered a natural group, and the non-group market, it is different, right?

It is people that cannot get coverage through their job, maybe they are in between jobs, subsidies are much higher in that market. I think they are temporary because of people moving in and out. I do not know that one—certainly one system has an advantage over the other, but there are purposes that they both serve.

Chairman GOOD. Ms. Wade, more small businesses would like to offer health insurance to their employees, but many cannot afford it due to the cost of paying for the benefits, the reporting requirements, the bureaucratic burden of offering employer sponsored plans, but how can Congress make it easier for more small businesses to manage this bureaucracy that comes with operating a healthcare plan?

Ms. WADE. First of all, businesses—16 percent are in the self-insured markets, so protecting ERISA, and allowing them to still have the flexibility and affordability of offering those sorts of plans to their employees is hugely important.

Expanding the marketplace for the fully insured market and offering association health plans. Those sorts of tools that they can use to better access affordable plans that they can offer their employees. They are competing with larger businesses for talent that are better able to afford these benefits, and the labor market is still quite difficult for them, and a challenge in recruiting and retaining talent at their business.

Because health insurance is the primary benefit that they are offering, or would like to offer, having that marketplace be affordable and flexible for them is important.

Chairman GOOD. I am glad you mentioned it. I introduced, and this Committee passed, the Self-Insurance Protection Act, which prevents Federal regulators from redefining and regulating stop loss insurance, like a traditional health insurance. Many employers, as you know, choose to self-insure, and they purchase the stop loss insurance to protect themselves from the catastrophic claims.

Why would some want to make it more difficult, some on the other side, for businesses to obtain stop loss insurance, unless it's just to prevent them from being able to provide private insurance?

Ms. WADE. Without having that ability for the small business owners in the self-insured marketplace, it would be catastrophic for them in being able to offer the benefit to their employees and mitigating the catastrophic risk that they might incur with high costs associated with it.

Protecting stop loss insurance, making it widely available to small business, is crucial in keeping that marketplace available to them.

Chairman GOOD. Very good. Thank you. All right. We are going to go to Ranking Member DeSaulnier, for his closing remarks.

Mr. DESAULNIER. Thank you, Mr. Chairman. Thank you to all the witnesses. I appreciate you being here. First, a comment just on this idea that universal health care versus a complete free market. I think what the Congress has tried to do over the years is balance, is to create an avenue for the private sector and employers.

As a former employer, who provided healthcare for my employees, and some of the struggles we had when employees actually needed to use that, and how confused they were about their copays. I can remember instances where employees were crying because

they could not afford their copays, and never understood the documentation.

This balance between the private sector and creating employer/employee good relationship, and NFIB, I was once a member when I was a small business owner, having that balance of a good responsible employer to good, valued employees, healthcare benefits are really important.

Healthcare benefits that are easy for the employer, and the employee to understand, and require value, good quality of care. Too much of this hearing has been about costs, costs, cost. Cost is only important if you get value in exchange for the cost. This idea, Mr. Chairman, with all due respect, that it is one way or the other, just is not the American model.

It is a balance, and I grant you there are some people who would like to switch that balance on both sides. Preemption is important when it is a national issue, but there are states issues. There was another interesting debate today, take the other side of states' rights, I guess in this instance, which I do not regularly do, but maybe from California, as a Member of Congress, I have become more of a states' right person than I was before, Mr. Wright, because I knew you when we both worked in Sacramento.

This balance is important. I do not think it is a choice of either/or. Then last, on universal health care. We already have a universal health care system in this country, it is just really bad. If you call 911, the ambulance will show up. If you go to the emergency room, you will get care. It is called indigent care, and basic adult care. It is required under law.

It is just that it does not pay. The idea that somehow this free market is the heaven on earth that we could get, just is not reality. If we had an efficient delivery system of health care system that had a high quality of care, both in the employer/employee market, and also Medicare and Medicaid, people would live longer lives in this country.

We would have a lower GDP ratio for health care, and we would have a better system. Maybe not perfect, but certainly better than it is right now. ERISA was enacted with a goal of protecting workers and their families. Given the dramatic changes since 1974 when ERISA was enacted, it is clearly evident that ERISA must evolve to effectively address new challenges and opportunities that improve the efficiency of our health care system.

House Democrats' primary goal is to support and build our middle class from the bottom up, and the middle out. This involves not only addressing the immediate needs of workers and their families, but also creating an environment where middle class prosperity can thrive, and small businesses are a part of that middle class.

Ensuring that ERISA has strong consumer protections reduces waste, inefficiencies, and excessive costs, and enhances transparency in this critical effort. Congressional Democrats are committed to fighting for working families, and we have made significant strides through recent legislative achievements to do just that, including passing the Affordable Care Act, the American Plan Rescue Act, and fighting the attempts by our Republican colleagues to overturn the Affordable Care Act, multiple attempts, including protections for consumers for pre-existing conditions.

The Inflation Reduction Act, these historic pieces of legislation, all of them, have increased coverage, protected consumers from nefarious practices, and lowered costs for millions of working families and seniors. Notably, the Inflation Reduction Act capped out—of-pocket drug costs at $2,000.00 a year for Medicare.

Capped insulin cost at $35.00 a month for seniors and secured significant price reductions through drug price negotiations. The negotiations alone will save an estimated 1 and one-half billion dollars for nearly 9 million seniors. We must remain vigilant against proposals like those in the Republican's 2025 that seek to roll back these critical reforms and eliminate the protections in the Affordable Care Act.

Our work is far from finished. We must continue to build on these successes, and focus on creating a fair, more efficient system, that benefits all workers, families, and businesses. Thank you, and I yield back.

Chairman GOOD. Thank you. I now recognize myself for a closing statement. It was interesting to hear the minority members reaction to the video we saw today, with the unedited words of Vice President Harris, without commentary, presented by none other than CNN and the Washington Post. I guess this is because she has been trying to express different positions over the past few weeks, than she has expressed over her entire career prior to that time.

As noted last week by none other than Bernie Sanders, whose Medicare for All bill she cosponsored. Democrats seem to know that Americans do not support their actual positions, whether it is open borders, non-citizens voting, electric vehicle mandates, appliance prohibitions, anti-police policies, pro-criminal policies, higher taxes, more spending, and controlled by government, and yes, government mandated, government provided healthcare.

This is a policy discussion, and the video revealed the Vice President's policy statements, relative to the topic at hand. The American healthcare system is far from perfect, but most Americans prefer their private health insurance offered by their employer. Naturally, Democrats do not want Americans to know that they want to eliminate that.

On behalf of the 153 million Americans whose healthcare benefits rely on ERISA, I think we have learned a lot today. Government, especially the Biden Harris administration, continues to burden employer sponsored health insurance through over regulation. Meanwhile, they prop up the expensive Obamacare plans, and daydream about single payer Medicare for All.

Government should actually though decrease intervention in healthcare markets, not increase it. Americans want flexible, innovative healthcare, not one size fits all. Employers have a strong incentive to keep healthcare costs low, to help their own bottom line, and they have an incentive to offer good benefits to keep their workers.

Democrats never seem to understand that. For 50 years, ERISA has provided the guardrails to protect individuals, while allowing employers to develop robust benefit plans. We can amend ERISA while protecting it, because in doing so we defend private insurance and shield Americans from devolving into a single-payer system.

We thank the witnesses today for your time and testimony, and without objection, there being no further business, this Subcommittee stands adjourned.

[Whereupon, at 12:10 p.m., the Subcommittee was adjourned.]


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# Health Insurance Issuers in Violation of State Copay Accumulator Adjustor Laws

## *Issuers in 10 States Have Copay Accumulator Adjustment Policies; Insurance Commissioners Must Enforce the Laws*

**Washington, DC**—The AIDS Institute, a national, nonpartisan, nonprofit organization, released a new analysis today showing that health insurance plans in 10 states include copay accumulator adjustment policies (CAAPs) despite laws prohibiting the practice. The findings highlight the need for state insurance commissioners to ensure that insurers are following state laws that protect patient access to prescription drugs.

People living with HIV, viral hepatitis and other serious and complex chronic conditions rely on copayment assistance to afford the specialty medications they need to maintain their health. State legislators stepped in when it became apparent that insurers and pharmacy benefit managers (PBMs) were collecting the financial assistance intended for patients, but not counting it to the patient's out-of-pocket costs.

In 2024, 18 states and Puerto Rico have laws in effect requiring insurers and PBMs to count payments made by or on behalf of an enrollee toward the enrollee's annual out-of-pocket limit. The AIDS Institute reviewed health insurance policies for plans offered through the state and federal marketplaces to determine how insurers were implementing the laws. The results reveal that 21 insurers in 10 of those states continue to have copay accumulator adjustment policies in plan documents:

- In GA, IL, LA, NM, NC, OK, TN, TX, VA, and WA, at least 1 insurer has CAAPs
- In TX, six out of fifteen insurers (40%) include CAAPs in their plans
- In GA, three out of eight insurers (38%) include CAAPs in their plans

- In NM, NC, TN, and WA, two insurers include CAAPs in their plans
- In IL, LA, OK, and VA one insurer includes CAAPs in their plans

The number of states that have enacted laws restricting use of CAAPs has continued to grow since West Virginia passed the first law of its kind in 2019. To-date, 21 states, DC, and PR have passed laws that protect patient access (but laws in CO, DC, OR, and VT were not yet in effect in 2024).

"We were surprised to find so many insurers still applying CAAPs, especially in states that have had laws in effect since 2019," stated Stephanie Hengst, Manager for Policy & Research at The AIDS Institute.

Rachel Klein said that The AIDS Institute is working with state departments of insurance to make them aware of the insurers and PBMs that are out of compliance with state laws and regulation. "It is imperative that insurance regulators take action; people are struggling to afford their life-saving medications, and are continuing to be taken advantage of by for-profit insurance companies and PBMs."

The full analysis can be found here: https://www.theaidsinstitute.org/copays/tai-2024-caap-report

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*The AIDS Institute is a national non-partisan, nonprofit organization that promotes action for social change through public policy, research, advocacy and education.*

*For more information and to become involved, visit www.TheAIDSInstitute.org or write to us at Info@theaidsinstitute.org, and follow The AIDS Institute on Twitter @AIDSAdvocacy and Facebook at www.facebook.com/The-AIDS-Institute*


**STATEMENT FOR THE RECORD**

BY THE

**THE NATIONAL ASSOCIATION OF PROFESSIONAL EMPLOYER ORGANIZATIONS**

BEFORE THE

**THE UNITED STATES HOUSE OF REPRESENTATIVES**

**COMMITTEE ON EDUCATION & THE WORKFORCE**

**SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS**

HEARING ON

**ERISA AT 50:**
**THE VALUE OF EMPLOYER-SPONSORED HEALTH BENEFITS**

**SEPTEMBER 10, 2024**

We are pleased to submit this statement for the record on behalf of the National Association of Professional Employer Organization (NAPEO) at the Subcommittee on Health, Employment, Labor and Pensions hearing, "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits."

NAPEO is the Voice of the PEO Industry™. NAPEO's 219 PEO members provide payroll, benefits, workers' comp, regulatory compliance assistance and other HR services to hundreds of thousands of small and mid-size businesses. Our members account for more than 90 percent of the industry's $358 billion in revenue. An additional 216 companies that provide services to PEOs are associate members of NAPEO.

ERISA provides the legal framework for PEOs to provide employee benefits services to small businesses and their employees. Under ERISA, PEOs act as the employer sponsor of group health and retirement plans for the benefit of the employees of their small and mid-sized business clients. PEOs assume the role of employer by co-employing their clients' employees.

Co-employment is a contractual agreement between a company and a PEO that allocates and divides employer responsibilities. The contract is often called a client service agreement (CSA). In a co-employment agreement, a PEO client's employees (also called worksite employees) are employed by two separate entities, the client company and the PEO.

The client company is the employer who has a direct relationship with the employee and is responsible for all business decisions, operations, day-to-day supervision of employees, job assignments, employee reviews and assessments, and determining the employee's salary and benefits offerings.

The PEO provides services related to employment such as: payroll processing, payroll tax administration, employee benefits, HR services, workers' comp coverage and claims management, compliance assistance and HR technology platforms.

This arrangement allows small businesses to gain access to Fortune 500-level employee benefits such as: health insurance, dental and vision care, life insurance, retirement saving plans, job counseling, adoption assistance, educational benefits and more. These are benefits they might not typically receive as employees of a small business.

PEO-sponsored health plans provide coverage through high-quality group insurance policies that are ACA-compliant, underwritten by licensed carriers and approved by the applicable state insurance regulator. The dynamics of the marketplace for PEO services are such that PEOs must distinguish themselves by providing the best level of comprehensive benefits possible at an affordable value. As a result, the ACA's (and other) requirements and protections apply to PEO-sponsored plans.

PEO clients also receive ubiquitous access to ERISA retirement benefits. Through regulatory and legislative recognition of PEO-sponsored retirement plans, PEOs can offer low to no-cost access to robust 401(k) retirement plans. Additional changes enacted by Congress through the SECURE and SECURE 2.0 Acts have made it easier for PEOs to expand retirement offerings to their small business client employees.

PEOs recognize the important role that ERISA plays in establishing consistent and administrable rules for employers and the coverage provided under employer-sponsored health plans. ERISA is crucial for giving employers (including PEOs) the assurance that they can offer stable and enduring benefit programs to their worksite employees enrolled in their plans.

In particular, the principle behind ERISA's broad preemption rules is critical, as most PEOs operate in multiple states and want to be able to offer benefits to employees without having to worry about navigating a patchwork of inconsistent state laws.

In recent years, NAPEO has seen states become increasingly aggressive in seeking to regulate employer-sponsored benefits, including those traditionally seen as covered by ERISA and its preemptive effect. This includes certain retirement plans as well as medical plans. Often, these state laws seek to indirectly regulate ERISA plans through the plan's service providers. Additionally, NAPEO is aware of efforts by various stakeholder groups to limit ERISA's preemptive effect through federal legislation. It is imperative that Congress stand with employers in protecting ERISA, including its long-standing preemption provision.

We encourage the Committee to continue ERISA's significant role in fostering valuable employer-sponsored benefits. We hope that it will explore ways that ERISA can continue to foster an environment in which employers can pursue innovative benefit designs that enrich their employees' lives, without imposing unnecessary government regulations that hamstring employers' ability to provide benefits to employees in the most efficient and effective ways available.

September 10, 2024

The Honorable Bob Good
Chairman
House Committee on Education and the Workforce
Subcommittee on Health, Employment,
Labor and Pensions

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

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

On behalf of Associated Builders and Contractors, a national construction industry trade association with 67 chapters representing more than 23,000 members, I appreciate the opportunity to comment on today's hearing, "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." Providing quality health care benefits is a top priority for ABC and its member companies. ABC advocates for policies that would ensure employer-sponsored coverage is strengthened and remains a viable, affordable option for millions of hardworking Americans and their families.

The Employee Retirement Income Security Act was enacted to encourage employee health benefit plans and promote uniformity in those plans across state lines. ERISA applies to all employer-sponsored plans, whether self-insured and fully insured, and is critical in allowing multistate employers to develop plans with uniform design and administration of benefits.

ERISA preempts application of state laws that relate to these employer-sponsored plans, but in recent years there has been an increase in state laws attempting to regulate ERISA plans. ABC, as a member of the Partnership for Employer-Sponsored Coverage, encourages Congress to ensure that ERISA preemption remains strong so ABC member companies can continue to offer their employees quality health care plans, regardless of the state in which they reside.

In addition, ABC urges the subcommittee to consider principles and priorities that are important for ensuring employment-based health coverage thrives, including:

- Addressing medical costs and challenges to help keep coverage affordable
- Upholding the current tax treatment of employer-sponsored coverage
- Providing employers with compliance relief from burdensome regulations governing health coverage
- Promoting innovations and diversity of plan designs and offerings for employees

Employer-sponsored coverage should continue to be the foundation of our nation's health coverage system. ABC appreciates the subcommittee's efforts to emphasize the importance of employer-sponsored health benefits and will continue to promote the benefits of ERISA uniformity to the health and well-being of Americans.

Sincerely,

Kristen Swearingen
Vice President, Legislative & Political Affairs

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**Statement for Hearing on**
**"ERISA'S 50th Anniversary: Value of Employer Sponsored Benefits"**

**House Committee on Education and Workforce**
**Subcommittee on Health, Employment, Labor, and Pensions**

**September 10, 2024**

As the bipartisan Employee Retirement Income Security Act (ERISA) turns 50, AHIP appreciates the Committee's continued support of employer provided health coverage. AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for millions of Americans. Collectively, our member plans provide access to health care for over 205 million people covered by employer-sponsored insurance, the individual insurance market, and public programs such as Medicare and Medicaid.

Employer-provided coverage (EPC) is the leading source of affordable, comprehensive, and high-quality health coverage in the U.S. Approximately 180 million Americans count on health care coverage provided by an employer, including more than 150 million people whose plans are regulated under ERISA. The ERISA framework provides indispensable stability and security to consumers, providers, unions, employers, and the overall health care system.

AHIP greatly appreciates the Committee's recognition of EPC as the "core of America's health care system" highlighting the innovative, market-driven approach to providing health benefits that creates both health and financial security for so many Americans. We also agree that many health care costs are increasingly becoming unaffordable and unsustainable, largely driven by prices set by drug manufacturers and hospital systems. AHIP is committed to advancing bipartisan solutions at the federal and state levels to make health coverage more affordable. Preserving ERISA preemption is essential to those solutions and to expanding health coverage. A uniform national minimum benefit standard under ERISA is an essential foundation for health plans, employers, and labor unions to work together to make health care coverage more affordable and to increase quality and access to care.

ERISA was designed to incentivize employers to voluntarily offer robust coverage to employees across the country – and it has worked. Beyond the sheer scope, ERISA has resulted in employers and plan administrators providing coverage people value. Respondents to a 2024 AHIP survey reported a growing majority of consumers (75%) with EPC are satisfied with their current coverage and an overwhelming majority (74%) prefer to get their coverage through their employer rather

than through the federal or state government. The growing majority (71%) believe the quality of their plan is "high."

AHIP recently conducted a nationwide survey of Americans enrolled in health coverage through an employer to understand consumers' perceptions, priorities, and expectations toward their current coverage as well as benefits, employers, and public policy impacting their coverage. Key findings from the survey showed that Americans enrolled in EPC find value in their coverage, have comprehensive benefits and access to care through telehealth, feel more financially stable, and believe the federal government should protect access to EPC.

**Americans Value and Are Satisfied with Their EPC**
An overwhelming majority of consumers with EPC are satisfied with their current coverage and prefer to get their coverage through their employer rather than through the federal or state government. Most consumers also report that the health insurance their job provides was impactful in their decision to accept a job and even more consumers found it impactful in their decision to stay at their current job. Competition among employers to attract and retain quality talent fuels EPC that is comprehensive – often including robust coverage that goes beyond what is required by federal mandates for prescription drugs, behavioral health care, emergency services, laboratory services, preventive care, and maternity care.

**EPC Offers Comprehensive Benefits and Access to Virtual Care**
ERISA's framework enables plan sponsors to keep administrative costs low by adhering to a uniform, national standard for regulation instead of attempting to provide health plans that meet the different, and at times conflicting, requirements of each state. This framework allows employers to create flexible plans with robust coverage without the added cost of compliance with a patchwork of differing, conflicting and costly state regulations. Consumers are not only satisfied with their coverage, but the overwhelming majority also believe that the quality of their plan is "high." This satisfaction is driven by the comprehensive coverage, affordability and choice of providers. The most important benefits delivered through EPC's comprehensive coverage include emergency care, prescription drugs, and preventive care. Coverage for mental health care is also highly valued, especially for dependents, with a majority of consumers believing that EPC is effectively meeting their children's mental health needs. Most consumers consider it important for EPC to cover expanded access to care through telehealth services, with many likely to consider the option of being seen by a doctor or treated via telehealth.

**EPC Provides Financial Security to Employees**
ERISA plan sponsors owe a fiduciary duty to those covered by the health plan. Therefore, the employer or plan sponsor must run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses. Fiduciaries must act prudently and follow the terms of plan documents to the extent that the plan terms are consistent with ERISA.

The fiduciary duty of the plan sponsor translates into financial security for consumers. A growing majority of consumers with EPC report that what they currently pay for their coverage overall is reasonable. Once informed that the average company pays between 70-80% of the cost of coverage, a vast majority have a favorable impression of companies who provide their employees with health insurance benefits. In addition, most consumers find EPC gives them financial peace of mind because EPC covers preventive services and provides access to quality providers.

**Federal Government Should Protect Access to EPC**
Proposals have been floated to disrupt the current federal tax treatment of EPC and tax employee health benefits. The American decisively oppose taxing employee health benefits. Surveys show that a large majority of consumers oppose taxing employee health benefits and an even greater majority would be less likely to vote for a candidate who supports taxing them.

In addition to maintaining the current federal tax treatment of EPC, it is also crucial that lawmakers preserve ERISA's federal preemption status. EPC is a model for other forms of health insurance coverage, due in large part to its regulatory structure under ERISA, including its preemption provisions. In recent years, some state legislatures and legal challenges have threatened federal ERISA preemption. Preserving broad ERISA preemption is essential for EPC to remain viable in an economy in which employers operate in many states and workers and their families are increasingly remote and mobile. Disrupting ERISA preemption would inevitably lead to higher costs and disruptive changes in coverage for workers and their dependents across the country.

We encourage Congress to focus on protecting and strengthening EPC to ensure health coverage remains affordable for millions of hardworking Americans. Whenever possible, Congress should publicly and officially articulate the breadth of ERISA preemption, including the applicability of existing law to direct or indirect regulation of group health plans or the administration of group health benefits.

Given ERISA is essential to the U.S. health care system, we need to preserve federal preemption, which ensures a framework in which EPC can offer high-quality, flexible and valuable benefits to employees. For fifty years, the law has included a broad and robust express preemption provision to protect against inconsistent and conflicting state laws and ensure uniform, equitable benefits to all employees of self-insured group health plans, regardless of where they live or work. Preserving ERISA protections for consumers for decades to come will prevent disparities and disruptions in coverage and benefits that would otherwise disadvantage employees and create serious and costly challenges for employers to continue to offer quality affordable coverage.

We appreciate the Committee's interest in these issues and commitment to protecting and improving EPC by recognizing ERISA's milestone 50th anniversary. We look forward to working

with Members to ensure the American people can continue to count on employer-provided coverage for their health and financial security.

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**

**"ERISA'S 50TH ANNIVERSARY: THE VALUE OF EMPLOYER-SPONSORED HEALTH BENEFITS"**

**September 10, 2024**

Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, Business Group on Health appreciates the opportunity to submit a statement for the record on behalf of our members regarding the subcommittee's September 10, 2024, hearing: "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." We applaud the subcommittee for its continued recognition of the Employee Retirement Income Security Act (ERISA)'s importance – particularly that of its preemption provisions – as the foundation of American health coverage for nearly 165 million Americans with employment-based plans.[1]

In August of 1974 – just one month prior to the enactment of ERISA – Business Group on Health was established by a group of forward-thinking employers, and quickly became a major force in ensuring that employers were fostering leading edge thinking about health and well-being. Fifty years later, Business Group on Health has grown to represent a vibrant community of more than 450 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 –

[1] Kaiser Family Foundation. Employer-Sponsored Health Insurance 101. 28 May 2024.

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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 health equity, furthering population health, and keeping people well.

At its founding, the Business Group recognized and acted on the urgency of the moment as landmark health care and pension legislation, ERISA, was signed into law by President Gerald Ford on September 2, 1974, allowing employers in the U.S. to offer comprehensive and consistent benefit plans.

The American economy has transformed significantly in the half-century since ERISA was enacted; health care prices have soared, there are many more multi-state employers, and the competitive pressures of the global marketplace have intensified. Despite these changes, ERISA's framework remains indispensable. Millions of Americans continue to rely on, and value, employer-sponsored health coverage underpinned by ERISA's consistent and reliable statutory and regulatory structure for employer plan sponsors.

**ERISA Preemption**

Arguably the most vital provision included in ERISA is the concept of preemption – 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.)[2]

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 90 percent of employers surveyed by Business Group on Health in our 2025 Employer Health Care Strategy Survey report that ERISA preemption is very important (71%) or important (19%) to their organization, with a majority ranking protecting and affirming ERISA preemption as the highest priority for Congress and the administration with respect to ERISA health and welfare plans.**[3] 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

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

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 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,[4] 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.

Maintaining ERISA as the primary legal framework for employer-sponsored benefit plans supports efficient plan administration and allows plan sponsors to deliver comprehensive, nationally consistent resources for employee benefits. ERISA allows a multistate employer to offer a uniform program across different jurisdictions, freeing businesses from navigating a complex patchwork of regulations that would otherwise increase costs and administrative burdens.

**Fiduciary Responsibility under ERISA**

Employers also have a fiduciary responsibility under ERISA to act with diligence and prudence, administering the plan in the best interest of participants and beneficiaries. Business Group on Health supports additional and meaningful transparency and clarifications about when pharmacy benefit manager (PBM) services intersect with

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

fiduciary standards. (See: Business Group's Position Statement on Drug Pricing.)[5] Business Group on Health's 2025 Employer Health Care Strategy Survey revealed that 97 percent of employers seek greater transparency in their vendor partnerships.[6]

However, not all parties involved in a plan's ecosystem need be or should be fiduciaries. Employer plan sponsors and the individuals acting as the named fiduciaries of the plan(s) should continue to be empowered to determine when a partner or service provider will serve as a delegated or co-fiduciary. According to the Business Group's 2025 Employer Health Care Strategy Survey, seven out of ten employers believe that control of whether a vendor partner serves as a fiduciary should remain with the employer as plan sponsor.[7]

ERISA already provides a mechanism to review arrangements through an operational analysis of decision-making and control. Overly broad, one-size-fits-all fiduciary amendments may raise concerns of control, discretion, and plan interpretation, misalignment between the plan and its service provider(s), increased confusion and litigation risk, wasted resources and unnecessarily higher costs that have negative impacts on employers, employees, and their families.

Employer plan fiduciaries understand and are committed to diligent decision-making and execution in accordance with ERISA's long-standing fiduciary principles. The real-life terms and practices underpinning fiduciary decision-making have and will continue to appropriately evolve over time with innovation, industry adaptation, and credible, reliable plan adoption in the myriad of disciplines incumbent in the modern provision of health coverage, including but not limited to medical, technological, data-generation/handling, transparency, privacy, and payment and reimbursement arrangements.

The past 50 years have provided countless innovations, changes, and challenges – ERISA's existing fiduciary provisions for employer plans have and will continue to guide appropriate decision-making based largely on the then-current assessment of what is/was reasonable and prudent for fiduciaries at that time. Additional Congressional action risks disrupting the ever-present evolution, triggering disputes and litigation, driving waste and higher costs, and stifling innovation and improvements with calcified statutory requirements. We do not believe additional legislation is required to further clarify or expand these duties as they pertain to employer plan sponsors and their named fiduciaries.

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[5] Business Group on Health. Position Statement on Prescription Drug Pricing and Pharmaceutical Supply Chain Position Statement.
[6] Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024.
[7] Ibid.

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 ERISA health and welfare plans, plan sponsors, and other stakeholders.

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

"**ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits**"

September 10, 2024

Chairman Good, Ranking Member DeSaulnier, and Members of the Subcommittee, thank you for the opportunity to submit a statement on behalf of the Partnership for Employer-Sponsored Coverage (P4ESC) for the hearing entitled "*ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits.*" We appreciate the continued bipartisan support for ERISA – the vital core of employer-sponsored health benefits. We look forward to working with you to help continue to support employer-sponsored health benefits: the single largest source of health coverage in our country.

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

Employer-sponsored coverage – the single largest source of coverage in our country – covers 180 million Americans[1]. Yet, this coverage is under constant threat. The three biggest threats facing employer-sponsored coverage are the rising cost of health care, threats to ERISA

[1] U.S. Census Bureau, September 2023. https://bit.ly/4aLy762.

uniformity, and threats to the federal income tax exclusion for employer-provided coverage. P4ESC is ever ready to defend employer sponsored coverage.

**ERISA**

The federal **ERISA law (*Employee Retirement Income Security Act of 1974*)** plays an essential role for employers and employees by enabling uniform pension and welfare benefits (health coverage) and administration across state lines. These common benefits through ERISA have made possible the innovation that has driven employer-based coverage. ERISA should be celebrated and strengthened in this, its 50th anniversary year.

ERISA's biggest strength is the ability to maintain common benefit plans across state lines. If that was no longer the case, then it might be hard to continue the extent of employer-sponsored coverage.

ERISA is the backbone of employer-sponsored coverage. It makes possible uniform plans across state boundaries. It encourages innovation in plan design to help attract and retain employees. Without ERISA, employers would face a bewildering maze of state regulation no matter how many or how few employees they might have in a given state. Absent ERISA, employers could not maintain common, equitable benefits. It could also complicate compliance with the Affordable Care Act's employer mandate, among other federal laws.

Many employers have multistate operations with employees scattered around the country. About one in five workers teleworked[2] or worked at home for pay in August 2023. These locations might well be in a different state than other workers. In a world without ERISA, employers then would be forced to seek state-regulated coverage on a state-by-state basis.

Employers – robbed of ERISA uniformity – would be forced to manage the disparate plans across the states they operate in. Common benefit plans would be a distant memory as they struggle to provide equitable coverage across state lines.

P4ESC rejects this vision for health coverage. We will fight against federal carveout efforts and state litigation supporting provider efforts to make an end-run around ERISA preemption.

States have long had an ambivalent relationship with ERISA. Despite their retained ability to regulate health insurance, states have sought access to ERISA-covered employee populations for state reform schemes. The politics of benefit mandates – exacerbated by the rapid pace of state

[2] Bureau of Labor Statistics, U.S. Department of Labor, *The Economics Daily*. https://www.bls.gov/opub/ted/2023/one-out-of-five-workers-teleworked-in-august-2023.htm.

legislatures – has resulted in a widely varying array of benefit mandates. Advocates for health providers have found the states to be fertile ground for their self-protection efforts.

Without ERISA, employees would lose nationwide uniformity and face state-by-state regulation and benefit mandates. Their ability to innovate to attract and retain employees would be strangled by thickets of varying state benefit mandates. Employers would also lose much or most of their ability to resist cost increases.

We encourage you to join us in supporting ERISA's 50th birthday. We respectfully remind this Subcommittee of its jurisdiction over ERISA and your consequent responsibility to safeguard the coverage supported by ERISA. Again, we would respectfully remind all Members of Congress that they should stand up for ERISA, too.

***Advantages of Employer-Sponsored Coverage***

Employer-sponsored 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 employer 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. This natural pooling of employees is a more affordable and effective approach than pools in which less healthy individuals have a greater incentive to join than do healthier ones.

Employers have led the way in benefit design and innovation for decades and will continue to do so for many decades to come. There is no one-size-fits-all employer health plan, nor should there be.

***Conclusion***

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage appreciates the opportunity to provide these comments to members of the Subcommittee. P4ESC represents employers across the spectrum of the employer system – from the smallest family-owned business to the largest corporations. Employers have a significant stake in developing and implementing health care policies. We look forward to working with you and your colleagues in a bipartisan manner in the remaining days of the 118th Congress and in future Congresses. If you or your staff would like to meet to discuss any of the issues raised in our statement, please ask your staff to contact P4ESC's Executive Director Neil Trautwein at neil@trautweinstrategies.com.

COMMITTEE ON
EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100



October 8, 2024

Paul Fronstin
Director, Health Benefits Research
Employee Benefit Research Institute
901 D St., SW, Suite 802
Washington, DC 20024

Dear Dr. Fronstin:

Enclosed are additional questions submitted by a Committee Member following the September 10, 2024, Subcommittee on Health, Employment, Labor, and Pensions hearing on "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." Please provide written responses no later than October 29, 2024, for inclusion in the hearing record. Responses should be sent to Alexander Knorr (Alexander.Knorr@mail.house.gov) of the Committee staff, who can be contacted at (202) 225-7101.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

**Questions for the Record for Paul Fronstin**
**Subcommittee on Health, Employment, Labor, and Pensions Hearing**
**"ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**
**September 10, 2024**
**10:15 a.m.**

**Rep. Rick Allen (R-GA)**

1. People with chronic conditions rely on their employer-sponsored health coverage and prescription drug coverage to manage their condition. Long and frustrating fights to get their medications approved through the PBM step therapy process often result in missed days of work and a worsening of their condition. The lack of transparency of PBM practices makes it difficult for employers to assess whether the administration of drug benefits aligns with their employees' best interests and well-being. Many people I represent in the Georgia 12th district experience these same frustrations, which is why I am a proud cosponsor of the *Safe Step Act*, which would ensure employer health plans, including their contracted PBMs, offer an expedient and medically reasonable step therapy exceptions process.

    a. How would legislation such as the *Safe Step Act* help people with chronic conditions who are covered by an ERISA plan?
    b. What can be done to help employers navigate the complex benefit structures, pharmacy networks, and formularies that are obscured by PBM incentives?

2. As of today, 18 states, including my home state of Georgia, have laws in place that ban copay accumulator policies to protect patients from predatory insurance practices that increase out of pocket costs at the counter.

    Unfortunately, insurers are not following the law. In a recent analysis by the AIDS Institute (attached), it was found that 10 of those 18 states have insurers still implementing copay accumulators in their plans.

    In my home state alone, 3 out of 8 insurers include copay accumulators in their plans. These state laws must be enforced, and insurers need to follow the law.

    I support the HELP COPAYS Act, a federal bill which bans copay accumulators. Do you agree that copay accumulators in plans increase a patient's out of pocket expenses by not allowing financial assistance payments to count towards their cost sharing obligation?

# Response to the House Committee on Education and the Workforce on behalf of the Employee Benefit Research Institute

Statement of Paul Fronstin
Director, Health Benefits Research
Employee Benefit Research Institute, Washington, DC

**United States House of Representatives**

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

## ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits

October 22, 2024




901 D Street, SW, Suite 802, Washington, DC 20024 | (202) 659-0670 | info@ebri.org

Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee, I am Paul Fronstin, Director of Health Benefits Research at the Employee Benefit Research Institute (EBRI). Thank you for the opportunity to appear before the Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions on Tuesday, September 10, 2024. I am pleased to submit for the hearing record answers to additional questions received by EBRI on October 8, 2024.

Established in 1978, EBRI is committed exclusively to data dissemination, policy research, and education on financial security and employee benefits. Consistent with our mission, EBRI does not lobby or advocate specific policy recommendations: The mission is to provide objective and reliable research and information. All of EBRI's research is available on the internet at www.ebri.org.

1. **Rep. Rick Allen (R-GA) —** People with chronic conditions rely on their employer-sponsored health coverage and prescription drug coverage to manage their condition. Long and frustrating fights to get their medications approved through the PBM step therapy process often result in missed days of work and a worsening of their condition. The lack of transparency of PBM practices makes it difficult for employers to assess whether the administration of drug benefits aligns with their employees' best interests and well-being. Many people I represent in the Georgia 12th district experience these same frustrations, which is why I am a proud cosponsor of the Safe Step Act, which would ensure employer health plans, including their contracted PBMs, offer an expedient and medically reasonable step therapy exceptions process.

   **1a. How would legislation such as the Safe Step Act help people with chronic conditions who are covered by an ERISA plan?**

**Response from Paul Fronstin**: Unpublished estimates from the Employee Benefit Research Institute (EBRI) indicate that there were about 135 million persons under age 65 covered by ERISA plans in 2024, or about 82 percent of the population with employment-based health coverage. The Safe Step Act aims to improve access to medications, particularly for health plan enrollees relying on step therapy protocols. The Act seeks to reduce barriers to care by streamlining the process for receiving treatment and increasing transparency between health plans and enrollees regarding step therapy requirements. The Act should benefit individuals with chronic conditions, who represent a small segment of enrollees in ERISA plans. However, it is unclear to what degree enrollees in ERISA plans are subject to step therapy requirements. Despite the growing data on step therapy in Medicare Advantage plans, there appears to be only one, less recent, study related to commercial health plans. For example, a recent study found that just over one-half of Medicare Advantage enrollees were in plans that required step therapy for 10 commonly used drugs for rheumatoid arthritis in 2023.[1] In contrast, a 2021 study found that among some of the largest U.S. commercial insurance plans, they applied step therapy in 38.9 percent of drug coverage policies, with the frequency across plans ranging from 20.6 percent to 57.5 percent.[2] Given the different measurements in the commercial health plan study, it is difficult to estimate how much the Act will benefit enrollees in ERISA plans. EBRI has conducted research that shows when financial barriers to health care are changed, medication adherence sometimes improves.[3] However, more research is needed on step therapy and its impact on enrollees in ERISA plans.

**1b. What can be done to help employers navigate the complex benefit structures, pharmacy networks, and formularies that are obscured by PBM incentives?**

**Response from Paul Fronstin**: Not only is navigating PBMs complex, building an employee benefits program is often beyond the expertise of many benefit managers. That is why they often engage the expertise of benefits consultants and ERISA attorneys. They also often consult with other employers. I have found that employers like to learn from what other employers are doing. And employers can often join with other employers in purchasing coalitions to help them not only navigate the complex health care system, but also to provide them with some leverage.

2. **Rep. Rick Allen (R-GA) —** As of today, 18 states, including my home state of Georgia, have laws in place that ban copay accumulator policies to protect patients from predatory insurance practices that increase out of pocket costs at the counter. Unfortunately, insurers are not following the law. In a recent analysis by the AIDS Institute, it was found that 10 of those 18 states have insurers still implementing copay accumulators in their plans. In my home state alone, 3 out of 8 insurers include copay accumulators in their plans. These state laws must be enforced, and insurers need to follow the law. I support the HELP COPAYS Act, a federal bill which bans copay accumulators. **Do you agree that copay accumulators in plans increase a patient's out of pocket expenses by not allowing financial assistance payments to count towards their cost sharing obligation?**

   **Response from Paul Fronstin**: I have studied high-cost claimants and have found that a small portion of the population accounts for a large percentage of health care spending. There is the familiar 80/20 rule, where 20 percent of the population accounts for 80 percent of spending. Relatedly, 10 percent of the population (one-half of the 20 percent) accounts for 70 percent of spending (nearly as much). These are people who are most likely to use copay assistance programs, as they are being treated for chronic conditions, cancer, and rare diseases, which can have not only particularly high medication costs, but also high

non-medication spending. EBRI research has found that at least one-half of these people reach their out-of-pocket maximum.[4] A copay accumulator program, a provision in health plans that prevents manufacturer assistance from counting toward an enrollee's deductible or out-of-pocket maximum, would theoretically reduce patient spending on health care services. Related EBRI research has found that improvements in deductibles do not necessarily translate into lower overall out-of-pocket spending.[5] EBRI has not researched whether enrollees would still reach their out-of-pocket maximum even when they benefit from a copay accumulator program.

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[1] See https://avalere.com/insights/ma-plans-increase-use-of-step-therapy-for-part-b-drugs.

[2] See https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00822.

[3] See https://www.ebri.org/publications/research-publications/issue-briefs/content/the-impact-of-expanding-pre-deductible-coverage-in-hsa-eligible-health-plans-on-medication-adherence.

[4] See Figure 6 in https://www.ebri.org/publications/research-publications/issue-briefs/content/persistency-in-high-cost-health-care-claims-it-s-where-the-spending-is-stupid.

[5] See https://www.ebri.org/publications/research-publications/issue-briefs/content/premium-impact-of-expanding-pre-deductible-coverage-to-chronic-disease-management-medications-in-hsa-eligible-health-plans.

COMMITTEE ON
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October 8, 2024

Ilyse Schuman
Senior Vice President
Health and Paid Leave Policy
American Benefits Council
1501 M Street, NW, Suite 600
Washington, DC 20005

Dear Ms. Schuman:

Enclosed are additional questions submitted by a Committee Member following the September 10, 2024, Subcommittee on Health, Employment, Labor, and Pensions hearing on "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." Please provide written responses no later than October 29, 2024, for inclusion in the hearing record. Responses should be sent to Alexander Knorr (Alexander.Knorr@mail.house.gov) of the Committee staff, who can be contacted at (202) 225-7101.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

**Questions for the Record for Ilyse Schuman**
**Subcommittee on Health, Employment, Labor, and Pensions Hearing**
**"ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**
**September 10, 2024**
**10:15 a.m.**

**Rep. Rick Allen (R-GA)**

1. In recent years, there has been a growing adoption of so-called alternative funding programs, or AFPs, in employer-sponsored plans. Some stakeholders have suggested that AFP vendors divert employees into their programs and push employers to adopt discriminatory benefit designs that single out medicines that treat specific conditions. It's suggested that this type of action could violate ERISA and HIPAA compliance. Rep. McBath and I recently sent a letter urging the Department of Labor (DOL) to investigate the prevalence of AFPs in the employer-sponsored health coverage market and asking the DOL to take action to prevent these predatory practices.

    a. How well do you think employers are aware of potential ERISA compliance risks with AFPs?
    b. Have you provided any education about compliance risk to member companies?

2. There has been a troubling trend under the Biden-Harris administration to add on health insurance regulations issued by the Department of Health and Human Services to employer-sponsored health plans governed by ERISA. For example, the HHS Notice of Benefit and Payment Parameters for 2025 final rule adds additional requirements to ERISA plans. If HHS continues to infringe on employer-sponsored health insurance governed by ERISA, what effects will this have on employer-sponsored insurance?

**Questions for the Record for Ilyse Schuman**
**Subcommittee on Health, Employment, Labor, and Pensions Hearing**
**"ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**
**September 10, 2024**
**10:15 a.m.**

**Rep. Rick Allen (R-GA)**

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   a. How well do you think employers are aware of potential ERISA compliance risks with AFPs?
   b. Have you provided any education about compliance risk to member companies?

***Response:*** ***The Council's membership typically relies on traditional PBM and drug payment models, so members have not raised AFPs as an issue that I am aware of, and the Council has not actively addressed AFPs with its members.***

2. There has been a troubling trend under the Biden-Harris administration to add on health insurance regulations issued by the Department of Health and Human Services to employer-sponsored health plans governed by ERISA. For example, the HHS Notice of Benefit and Payment Parameters for 2025 final rule adds additional requirements to ERISA plans. If HHS continues to infringe on employer-sponsored health insurance governed by ERISA, what effects will this have on employer-sponsored

***Response:*** ***We have seen a number of instances where HHS has sought to carry over rules applicable to the individual and small group insurance markets to self-funded plans. Such efforts can significantly alter the cost of coverage for both employers and employees. These types of insurance regulations, when applied to group health plans, can create utilization and cost burdens that some employers may not be able to absorb without increasing the cost for their employees.***

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October 8, 2024

Anthony Wright
Executive Director
Families USA
1225 New York Avenue, NW
Washington, DC 20005

Dear Mr. Wright:

Enclosed are additional questions submitted by a Committee Member following the September 10, 2024, Subcommittee on Health, Employment, Labor, and Pensions hearing on "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits." Please provide written responses no later than October 29, 2024, for inclusion in the hearing record. Responses should be sent to Alexander Knorr (Alexander.Knorr@mail.house.gov) of the Committee staff, who can be contacted at (202) 225-7101.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

**Questions for the Record for Anthony Wright**
**Subcommittee on Health, Employment, Labor, and Pensions Hearing**
**"ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**
**September 10, 2024**
**10:15 a.m.**

**Rep. Robert C. "Bobby" Scott (D-VA)**

1. As important as it is for Congress to enact legislation to reform our health care system, it is just as vital to enforce the consumer protection laws and regulations that we already have on the books. The agency tasked with overseeing ERISA-covered health plans, the Employee Benefits Security Administration, is a small agency with a massive jurisdiction. EBSA currently oversees more than 2.8 million health plans covering more than 130 million Americans. At its current staffing levels, EBSA has only *one* investigator for every 13,900 ERISA-covered plans.

    a. Could you please talk about how an underfunded EBSA hurts workers and their families?
    b. Why is it important for consumers—and also employers—that we make strong investments in EBSA?

**House Education and Workforce Subcommittee on**
**Health, Employment, Labor, and Pensions**

**Hearing on "ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits"**

**September 10, 2024**

**Questions for the Record**
**Anthony Wright**

**Rep. Robert C. "Bobby" Scott (D-VA)**

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**a. Could you please talk about how an underfunded EBSA hurts workers and their families?**

An underfunded Employee Benefits Security Administration (EBSA) does not have capacity to provide sufficient education to workers and their families about rights and protections in health insurance, nor enough staff to enforce laws that are supposed to ensure claims payment, access to health and mental health care, no surprise bills, and a fair system to dispute denials of coverage.

153 million workers and their families rely on EBSA to tell them about their rights to retirement and health benefits and oversee these plans' compliance with the law.[i] With regard to health care benefits, this means explaining issues like how to maintain coverage in the worker's former plan or join a new plan when they leave or lose a job; how to appeal denials of care; rights to mental health and substance use services, newborn care, and other benefits; and rights to plan benefits when an employer (or employer-provided plan) declares bankruptcy. Besides providing educational materials, EBSA enforces laws, investigating complaints and issuing cease and desist orders - for example, when a Multiple Employer Welfare Association is fraudulent or does not have the funds to play claims; and EBSA writes regulations. EBSA's responsibilities have increased as new consumer protection laws have been enacted: for example, EBSA enforces the No Surprises Act for employer-sponsored plans and their enrollees.

Though EBSA must assist a growing population and oversee implementation of new laws, the General Accounting Office reported in 2023 that EBSA's budget had been flat in nominal terms from 2013 to 2021, and its staffing had declined.[ii] As a result, EBSA prioritized its investigations and enforcements to complex cases affecting a large number of participants – and subsequently the number of cases EBSA is able to close has declined.[iii] However, many consumers who are denied care need much more help to understand why their claims are denied and to get their problems

resolved.[iv] *The New York Times* reported that patients with unexpectedly large bills sometimes forego care and complain that appeals are "fruitless" while understaffed regulators rarely intervene – the Department of Labor has one investigator for every 8,800 health plans.[v]

State agencies, attorneys general, and nonprofit organizations that assist consumers with health coverage problems have informed the ERISA Advisory Council of some of the problems they see. For example, with regard to health plan claims and appeals processes, patients and other consumers need more education about their health care rights, including how to file claims and what to do when they are denied services. Explanations of benefits in group plans often do not give people enough information about how to start an appeals process nor that a plan is governed by ERISA and that EBSA is the appropriate enforcement agency. Health plan notices of denial are often deficient; and overall, the claims and appeals process for employer-sponsored health plans needs improvement and oversight. [vi]

The growth of level-funded plans, which evade the Affordable Care Act's pre-existing conditions protections and are increasingly sold to small businesses, poses another challenge for EBSA. Nationally, the percentage of small firms offering level-funded plans increased to 40% in 2023.[vii] In Connecticut, the fully insured small group market declined by 24% in just one year as self-funding and level-funding increased.[viii] Some Connecticut small businesses are in self-funded products that are going bankrupt and have not funded any runout system to protect employees. And in Vermont, an insurer is offering a self-funded product to businesses of five.[ix]

**b. Why is it important for consumers—and also employers—that we make strong investments in EBSA**

Consumers and their employers do not usually have the resources or ability to thoroughly examine benefit arrangements, bargain for protections, or assure that plan administrators meet their fiduciary responsibilities. They depend on the Employee Benefits Security Administration (EBSA) to educate them and intervene when necessary. Strong investments in EBSA will help ensure that the agency can oversee the growing number of health and benefit plans that are regulated and overseen solely at the federal level.

As the delivery of health care evolves, EBSA also plays a key role in spotting emerging trends and providing oversight. It enforces new laws and writes necessary rules. The No Surprises Act, Transparency in Coverage final rules, and Mental Health Parity and Addiction Equity Act are all examples of recent laws and regulations in which EBSA has a key enforcement role. Continued investments will equip the agency to spot and respond to new issues. For instance, the use of artificial intelligence in health benefit determinations,[x] the role of private equity in plans,[xi] and appropriate boundaries for health plans' usage of telemedicine[xii] are among the emerging issues of interest both to Congress and to EBSA.

[i]General Services Administration, "Employee Benefits Security Administration 2023 Action Plan" https://www.performance.gov/agencies/dol/service-providers/dol-ebsa/

[ii] US Government Accountability Office, "Employee Benefits Security Administration: Systematic Process Needed to Better Manage Priorities and Increased Responsibilities," GAO=24-104667, October 24, 2023, https://www.gao.gov/products/gao-24-105667v

[iii] Ibid.

[iv] Testimony of Meiram Bendat, JD, Ph.D, to ERISA Advisory Council, July 9, 2024, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2024-claims-and-appeals-procedures-meiram-written-statement-07-09.pdf; Maya Miller and Ash Ngu,"You Have a Right to Know Why a Health Insurer Denied Your Claim. Some Insurers Still Won't Tell You," ProPublica, November 8, 2023, https://www.propublica.org/article/your-right-to-know-why-health-insurer-denied-claim

[v] Chris Hamby, "Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill." *New York Times*, April 7, 2024, Insurance Companies Reap Hidden Fees as Patients Get Unexpected Bills - The New York Times

[vi] Consumer Assistance Programs' Statement for the Record to the ERISA Advisory Council, October 14, 2024.

[vii] Kaiser Family Foundation. (October 18, 2023). 2023 Employer Health Benefits Survey. https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf. Page 172

[viii] CBIA, " State Sets 2025 Health Insurance Rates," September 8, 2024, https://www.cbia.com/news/issues-policies/2025-health-insurance-rates/

[ix] Statement for the Record to ERISA Advisory Council, op cit.

[x] Michelle Mello et al, "Denial – Artificial Intelligence Tools and Health Insurance Coverage Decisions, JAMA Health Forum, March 7, 2024, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2816204 *JAMA Health Forum*. 2024;5(3):e240622. doi:10.1001/jamahealthforum.2024.0622

[xi] "US Department of Labor Guidance on Private Equity Investments in Defined Contribution Plans," June 3, 2020, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/06-03-2020

[xii] Letter from US Senators Tammy Duckworth, Jeffrey Merkley, et al to Lisa Gomez, Assistant Secretary for Employee Benefits Security Administration, September 25, 2024,https://www.duckworth.senate.gov/imo/media/doc/sen_duckworth_letter_to_dol_for_lactation_service_coverage_1wnohc56j395d.pdf and Congressional Research Service, "Federal Telehealth Flexibilities in Private Health Insurance During COVID-19 Public Health Emergency," February 14, 2023, https://sgp.fas.org/crs/misc/R47424.pdf .



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