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"Direct Contracting: A Prescription for Lower Health Care Costs"

Testimony before the Subcommittee on Health, Employment, Labor, and Pensions

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Introduction and About ERIC

Chairman Allen, Ranking Member DeSaulnier, and members of the Subcommittee, thank you for the opportunity to testify today on direct contracting and its impact on America's largest employers and their employees. I'm James Gelfand, President and CEO of The ERISA Industry Committee (ERIC), the only national association that advocates exclusively for large employers on health, retirement, and compensation policies at the federal, state, and local levels. ERIC member companies are leaders in every sector of the economy, with employees in every state, and we represent them in their capacity as sponsors of employee benefit plans for their workforce.

Each of you and your constituents likely engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, visit a bank or hotel, fly on an airplane, watch TV, benefit from our national defense, go shopping, receive or send a package, visit a restaurant, or enjoy a soft drink.

Our member companies offer comprehensive health benefits to employees, their families, and often retirees. On average, large employers pay around 80 percent of health care costs on behalf of their beneficiaries. There are over 154 million people who receive coverage through employer-sponsored insurance and over 100 million of those receive coverage through ERISA self-insured plans.[1] All of this taken together means that the vast majority of Americans receive their health care coverage through employers, who shoulder exponential costs associated with the coverage they provide.

And these costs are not projected to abate – premium costs for employer-sponsored plans are now growing at a rate of six to seven percent each year.[2] For ERIC's member companies, some of whom provide coverage to over a million beneficiaries across the country, this translates into very real dollars – dollars that are not attributable to any revenue potential, but rather merely a loss on their books, which could have been otherwise realized as increases in wages and other employee benefits.

[1] KFF's analysis of data from the 2023 American Community Survey included in KFF's 2025 Employer Health Benefits Survey published October 22, 2025. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2025 Sep 15]. [Time frame: 2023].
[2] Based on data comparison from Claxton, G., Rae, M., Damico, A., Winger, A., & Wager, E. (2025). Health benefits in 2025: Family premiums rise 6 percent, large employers increase coverage of GLP-1s for weight loss. Health Affairs, 44(11). https://doi.org/10.1377/hlthaff.2025.01106

ERIC member companies provide health benefits to attract and retain employees, to compete for human capital, and to improve employees' health and provide peace of mind. They roll up their sleeves and invest in their employees and communities across the country, improving access to health care. Our members are innovators who drive affordability and quality, through efforts such as the use of digital health, onsite clinics, direct contracting and direct primary care arrangements for their workers. They develop value-driven and coordinated care programs, implement employee wellness programs, provide transparency tools, and a myriad of other innovations that improve quality and value to help mitigate health care costs.

Employer direct contracting generally falls into three use cases. First, an employer may contract directly with a health system in a market where the plan can generate a significant volume of care, allowing the parties to align around better access, quality, and affordability for a concentrated employee population. Second, an employer may contract with specialized and accomplished providers or health systems—often referred to as centers of excellence—for services where demonstrated expertise, outcomes, and patient support can make a meaningful difference for employees and their families. Third, an employer may contract for capitated costs and population health management, including through Direct Primary Care (DPC) and Accountable Care Organization (ACO) arrangements, to strengthen primary care, coordinate services, manage chronic conditions, and create incentives for providers to keep people healthy rather than simply paying for each individual service delivered.

We appreciate being able to share some of our member companies' experiences with direct contracting and how it is lowering costs for employers while providing affordable access to health care providers and their services.

ERIC Members' Experience

Member Company 1

"Preferred Partnerships"

In 2015, one of our member company's began offering employees and their families in certain regions of the U.S. access to health care coverage through a direct contract arrangement Accountable Care Organization (ACO) model the company calls "Preferred Partnerships." The direct contracts between the company and large integrated health systems were structured around the triple aim of improving quality, enhancing the member experience, and lowering costs. Improving and supporting primary care became the central pillar of their Preferred Partnerships, where success is measured through improved clinical and member satisfaction outcomes as well as shared savings with company partners.

Direct contracting has allowed the company to shape the model of care in the primary care setting in ways that benefit patients. For example, in some Preferred Partnerships they have been able to ensure that access to behavioral health specialists is integrated in the model, as such integration of behavioral and physical health services can lead to better outcomes. Primary care doctors in these programs can have access to on-demand psychiatrist consultations as needed, and the behavioral health specialist in the practice can help facilitate soft transfers for patients needing a higher level of behavioral health care.

The company currently is engaged in three Preferred Partnerships and has had as many as five at one time. The Preferred Partnerships are located in various regions across the country where the company has larger concentrations of employees, dependents, and retirees, including in Puget Sound, Washington, southern California, and Charleston, South Carolina. They require provider partners to accept up- and down-side risk and meet financial, meaningful quality, and patient satisfaction metrics. Over the last several years, the company has seen improvement in the health of plan participants who elect one of the Preferred Partnership medical plan options, including significantly better results in depression screenings, improved control of blood pressure and diabetes, and better early detection due to higher rates of cancer screenings. In addition, members like the customer-focus these programs bring to their health care experience and re-enroll at high rates. Approximately 30 percent of the company's eligible plan beneficiaries have enrolled in a Preferred Partnership program.

The company works hand-in-hand with their partners to rein in rising health care costs by developing innovative plan designs and service delivery mechanisms that produce high-quality, coordinated care. The company also believes in incentivizing plan participants to seek care with clear evidence of measurably better outcomes. For example, employees and their families who choose to participate in the Preferred Partnerships benefit from lower paycheck deductions, access to zero-dollar costs for generic medication and primary care services, and higher employer contributions to employees' health savings account (HSA), to name of few.

Direct Primary Care

After seeing the success of their Preferred Partnerships and the benefit of focusing on highly coordinated and integrated primary care, the company searched for a way to bring high-quality, lower-cost preventive care to all plan participants throughout the country. While their U.S. population is concentrated in certain geographies, they are also spread-out across the country. As a result, the company, which employs thousands, looks a lot more like a smaller purchaser in certain health care markets. This is when they began exploring a Direct Primary Care (DPC) model of care to offer their plan beneficiaries.

DPC is an innovative alternative payment model for primary care in which patients, employers, or health plans pay the primary care practice periodic fees directly for unlimited access to primary care and prevention services in a medical clinic. Commonly, DPC fees are paid monthly but they can also be paid annually or semi-annually. One attribute that distinguishes DPC from concierge medicine, is that the DPC fee pays for the actual primary care services. In a concierge practice, the membership or subscription fee pays for access to the practice, and insurance is applied to the services rendered following care delivery.

A defining element of DPC is an enduring and trusting relationship between a patient and their primary care doctor and care team. Coordinated primary care affords the patient more time with the doctor and allows the doctor and team the time to build a trusting relationship with their patients so they can better understand their health needs leading to earlier interventions. Empowering this relationship is the key to achieving superior health outcomes, lower costs, and enhanced patient experience.

Since the inception of DPC in 2004, studies have demonstrated outcomes including high patient satisfaction, reduced costs, and decreased hospital admissions.[3] Others have shown cost reduction potential of up to 20 percent[4] and reduction in inpatient hospital admissions of 37 percent.[5] The DPC model has produced meaningful results in the management of chronic conditions.

In a traditional primary care environment, the employer plan participants can experience average wait times for care of 21 days or more, forcing patients to use urgent care or emergency care or, worse, delaying care. A DPC team-based care model provides same and next-day access to care. This makes it easier for patients to engage through multiple modalities. The volume of virtual visits in the DPC arrangements ranges from 15 to 34 percent, while non-DPC virtual use averages 4 percent.

The company currently offers direct primary care in four locations: Puget Sound, Washington; St. Louis, Missouri; Mesa, Arizona; and San Antonio, Texas. They launched the first DPC arrangement in 2018 near their Mesa, Arizona facility as a pilot for local employees, their families, and early retirees. Preliminary data over a nine-month period indicated a 14 percent reduction in emergency room utilization and an 11 percent reduction in specialist spend. In addition, the use of virtual and digital access by participants was 32 percent higher than for non-participants. The program enjoys a Net Promotor Score (NPS) of 88 versus an average NPS of 58 across the health care industry.[6] NPS scores quantify customer loyalty and satisfaction. A Net Promoter Score is a patients' rating on how likely they would recommend a health care provider or services. That matters because a high score indicates that patients are not only receiving care, but are satisfied enough with that care to recommend it to others.

Member Company 2

Another ERIC member company supports direct contracting arrangements that enable self-funded employer health benefit plans to work directly with physicians, labs, and specialists at mutually agreed-upon rates. Through their direct contracting model, providers are paid in near real time outside the traditional carrier claims process, while plan sponsors receive transaction-level data that gives them clear visibility into where health care dollars are spent.

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[3] Satisfaction with one DPC practice showed an average Net Promoter Score (NPS) – which represents a patients' willingness to recommend the practice to a friend or colleague – of 86 on a -100 to 100 scale. In 2015, the industry's average NPS score for primary care was 2.7 and it dropped to -1.2 in 2019. See 2019 Updates in Primary Care Consumer Preferences, Advisory Board (Sep. 5, 2019), https://www.advisory.com/topics/clinical-services/2019/09/2019-updates-in-primary-care-consumer-preferences

[4] Fritz Busch, Dustin Greskowiak & Erik Huth, *Direct Primary Care: Evaluating a New Model of Delivery and Financing*, Society of Actuaries (May 2020), https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

[5] Iora Health Claims Database 2009 - 2016.

[6] Health systems and providers use the Net Promoter Score as a measurement tool for patient satisfaction that is done internally. The Net Provider Score is then shared with government agencies, third-party aggregators, research reports, or the health care provider or health systems own marketing materials. An example of a public matrix that aggregates self-submitted and publicly stated corporate NPS metrics for health systems, clinics, and payers is CustomerGauge Healthcare Benchmarks.

Today, the company's model serves more than 2,500 self-funded employer health benefit plans, covering 20 million lives and more than $100 billion in health care spending. Employers and patients are benefitting from this model - employees participating in direct contract arrangements had costs that were 40 percent lower with greater use of primary care and fewer emergency room visits and inpatient admissions. And, for example, in Michigan, plans that used the company's direct contracting arrangements saw medical costs that were 29 percent lower, measured by total medical spend per member per year, than the statewide commercial benchmark, which is increasing by 10 percent to 15 percent annually.

The company processes approximately 42,000 claims each day, with more than 99 percent of daily payments clearing without delays or complications. Under these direct contracting arrangements, Tier 1 rates are approximately 130 percent of Medicare, compared with commercial benchmarks that typically range from 200 percent to 300 percent of Medicare. As a result, providers can be paid in near real time, rather than waiting weeks for reimbursement through the traditional carrier claims process.

Centers of Excellence

Another way employers are using value-based plan designs is by reducing the cost-sharing for medical services obtained through "centers of excellence" (COE). These providers are typically health systems that have met the highest standards of achievement for treating a specific disease (e.g., cancer or heart disease) or providing medical services for a particular episode (e.g., hip and knee replacements or spine care). The idea is to encourage employees to select medical providers with high quality ratings and experience for a given procedure or medical condition, by providing a financial incentive to employees who choose to receive care from those providers.

A good example of the use of value-based insurance design is the Employers Centers of Excellence Network (ECEN)[7]. If an employee or family member chooses to receive care at one of the designated centers of excellence, the deductible and coinsurance are waived. The programs has had positive results. Patients have achieved better outcomes with lower rates of preventable complications while those patients who chose another hospital instead of one of the centers of excellence were nine times more likely to be readmitted to the hospital. Employers and their employees have saved millions of dollars by avoiding unnecessary services and 100 percent of participating patients recommend the COE.

Opportunities for Additional Employer Direct Contracting

Many ERIC member companies that are not currently engaged in direct contracting are interested in exploring these arrangements in the future. Our member companies are looking for new ways to improve access, strengthen primary care, increase transparency, and reduce unnecessary health care spending for employees and their families. However, the current environment makes direct contracting complicated to establish and difficult to scale, particularly for employers with a geographically dispersed workforce or limited concentration in any one health care market.

[7]Pacific Business Group on Health. (2019, July). *Employers Centers of Excellence Network (ECEN) Frequently Asked Questions*. https://www.pbgh.org/wp-content/uploads/2021/01/ECEN_Consumer_FAQs__July_2019.pdf

The passage of the Primary Care Enhancement Act (H.R. 1026) is an important first step in a longer process of making these models more workable for employers and employees. By reducing barriers related to DPC and HSA eligibility, Congress has helped create a clearer pathway for employers to consider broader direct contracting strategies. But additional steps will be needed to make these arrangements easier to implement, administer, and expand across markets.

Streamlining the process, creating clearer rules, and allowing employers to work together where appropriate could help more companies pursue direct contracting. Group-employer approaches may be especially useful in markets where one employer alone does not have enough covered lives to support a dedicated arrangement or negotiate effectively with providers. At the same time, employers face real challenges, including the complexity of contracting directly with providers, integrating direct contracts with existing plan administration and carrier relationships, ensuring compliance across state and federal requirements, managing data exchange and payment operations, and educating employees about when and how to use these arrangements. Addressing these barriers would make it easier for more employers to test, adopt, and expand direct contracting models that can lower costs and improve care.

Additional Policies to Drive Health Care Affordability - Transparency and Competition

ERIC applauds the Committee for passing the *Health Data Access, Transparency, and Affordability (Health DATA) Act of 2026* (H.R. 9228).[8] H.R. 9228 will strengthen accountability across the health care system and help address many of the health care affordability challenges facing employers and employees alike. Importantly, the bill will allow plan sponsors to access claims data, which is essential to understanding where health care dollars are flowing, supporting enhanced benefit designs that better serve employees, and lowering premiums and overall health care costs. Employers are uniquely positioned to leverage health care data and transparency tools to improve health outcomes, lower costs, and enhance the value of employer-sponsored coverage.

The Committee has a critical opportunity to advance other affordability reforms that would support working families' ability to access employer-sponsored health benefits, including:

- *PBM Fiduciary Accountability, Integrity, and Reform (FAIR) Act* (H.R. 6837): Led by committee member Congressman Ryan Mackenzie (R-PA) and Congressman Jake Auchincloss (D-MA), the bill clarifies that fiduciary standards for ERISA employer health benefit plans apply in full to pharmacy benefit managers (PBMs) when performing services on behalf of the plan. This would hold PBMs accountable to act in the best interest of the plan, doubling down on the reforms passed in *Consolidated Appropriations Act of 2026*.

- *Healthy Competition for Better Care Act* (H.R. 6248): Led by Budget Committee Chairman Jodey Arrington (R-TX) with Education and Workforce Subcommittee on Health, Employment, Labor, and Pensions Chairman Rick Allen (R-GA) as an original cosponsor, this legislation would improve fairness in contracting by allowing for enrollee incentives to choose high-quality and low-cost providers, allowing for insurers and employers to contract with hospitals and providers without requirements to enter into additional contracts with other affiliated providers or hospitals.

[8] Large employer group support letter sent June 24, 2026

This measure will ensure that plan sponsors can build provider networks in a way that maximizes value for patients and excludes those sites of care where prices are inflated – including drug prices, as some hospital systems add unconscionable markups to drugs.

We encourage the Committee to hold a markup on these bills this year and support their enactment.

Furthermore, ERIC supports policies that address unnecessary costs for employers and patients, such as:

- Request For Proposal (RFP) Reform – Net Effective Cost Disclosures

  Congress should consider policy changes to ensure that broker- and consultant-led RFP processes give a fair opportunity to a broad range of entities and are not designed to keep plan sponsors with a small set of vendors with regards to their drug benefit offering. Those RFPs should require bottom-line disclosures from RFP respondents that a plan sponsor can compare, apples-to-apples, to choose the lowest net effective costs for beneficiaries.

- Vertically Integrated GPOs and "Drug Companies"

  Congress should consider clarifying to the U.S. Departments of Health and Human Services and Labor that the language in CAA26 was intended to apply transparency to the entire PBM enterprise, including affiliates. This should include revealing the "spread pricing" between what is paid to the manufacturer and what is retained by the PBM for "white label" drugs, as well as applying the rebate passthrough requirement to the various "fees" collected by the PBM's group purchasing organizations (GPOs) in lieu of rebates.

Conclusion

In closing, large employers share Congress's goal of lowering health care costs and improving patient access. However, these objectives cannot be achieved without confronting roadblocks currently facing direct contracting from being implemented more broadly. Some of the bills and related reforms highlighted here represent critical steps toward restoring competition, aligning incentives, and ensuring that savings flow to the employers and patients who ultimately bear the costs.

ERIC stands ready to work with this Subcommittee to advance pragmatic solutions to drive health care affordability for working families. By promoting transparency, accountability, and market competition, Congress can help ensure that employer-sponsored health coverage remains available, sustainable, and responsive to the needs of American across the country.