The Honorable Bob Good, Chairman
The Honorable Mark DeSaulnier, Ranking Member
Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions
United States House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

Re: Statement of Scott Behrens, JD, of Lockton Companies before the Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions on "ERISA's 50th Anniversary: the Path to Higher Quality, Lower Cost Health Care."

Chair Good, Ranking Member DeSaulnier, and members of the Committee,

Thank you for the opportunity to testify today. I look forward to the discussion and the opportunity to continue the conversation in the future.

Introduction

In line with our commitment to advancing the interests of our clients and promoting the stability and effectiveness of employer-sponsored insurance (ESI), Lockton offers several actionable recommendations for Congress to consider. Lockton supports the Lower Costs, More Transparency Act, which aligns with many of our recommendations, but we think strengthening the language in that legislation will have an even greater positive impact.

These include protecting ERISA preemption, enhancing clarity surrounding ERISA fiduciary standards, strengthening enforcement mechanisms to ensure access to and use of plan-related data, fostering collaboration between stakeholders to address rising prescription drug costs, streamlining administrative burdens for plan sponsors, and promoting initiatives that support innovation and flexibility in benefit design and administration. I will delve into these topics further throughout the course of this testimony, but first, an introduction to Lockton and myself.

Lockton is the world's largest privately held, independent insurance brokerage firm

At Lockton we help our employer clients understand their risks, evaluate insurance solutions to help meet their business and workforce wellbeing goals, and ensure those solutions are meeting their needs. Relevant to today's conversation, Lockton works with nearly 5,000 health plan sponsors across all industries, geographies, and sizes. Our typical plan sponsor client will have between 300 and 5,000 workers.

Our role as a broker gives us a unique vantage point to objectively observe the entire healthcare landscape. It also provides us a seat at the table as our clients make decisions about how best to provide quality and affordable healthcare coverage to their workers and families.

Lockton is not in the business of offering proprietary solutions to clients; rather, we pride ourselves on providing objective information to help plan sponsors evaluate all their options. Among other services, our expert actuaries, data analysts, pharmacists, and lawyers assist health plan sponsors with:

- Health plan consulting
- Benchmarking
- Benefit plan design
- Pharmacy consulting
- Data analytics
- Health risk solutions
- Compliance consulting
- Actuarial solutions
- Due diligence

Additionally, Lockton sponsors a self-insured health plan with about 12,000 participants.

About me

I became familiar with ERISA in 2006 while in law school and working for a boutique plaintiff's firm in Des Moines, Iowa. I was part of a team that initiated a lawsuit against a retirement plan administrator, arguing they breached fiduciary duties when marketing certain proprietary investments to plan participants eligible to rollover their account balances. I fell in love with ERISA and began practicing employee benefits and executive compensation law in Kansas City, Missouri, in 2008 with the AmLaw 100 law firm Husch Blackwell law firm. I joined Lockton's ERISA Compliance Consulting team ten years ago. I continue to educate plan sponsors about their ERISA obligations and work with policymakers to and other stakeholders to ensure our clients have a voice in ERISA-related policy decisions. My work at Lockton has allowed me the opportunity to host an award-winning podcast – ERISA Is a Friend of Mine. I still enjoy my work with clients, and I appreciate the opportunity to testify before the Committee.[1]

In addition to my work as an ERISA attorney, I have experience with the healthcare industry through my role as Board Chair for Hope Family Care Center, a federally qualified health center look-a-like in Kansas City, Missouri.

Employer sponsored insurance is the bedrock of the American health insurance system

More Americans are covered by a health insurance program through their employers or unions than all other sources of coverage combined (e.g., Medicare, Medicaid, individual/ACA coverage).[2]

According to polling conducted in January 2023, more than three-quarters (77%) of insured adults who receive ESI view it positively (28% view it as "excellent" and 49% view it as "good"). In the same poll, a bipartisan majority (69%) of insured adults prefer to strengthen the existing system so more people have ESI and fewer buy it themselves or get it from a government program.[3]

ESI is successful, in part because the interests of plan sponsors are aligned with participants and beneficiaries.

Plan sponsors have strong incentives to invest in quality coverage that participants and beneficiaries find valuable. According to a study by Avalere Health, employer-sponsored health insurance will have provided

[1] I want to thank three key mentors who have cultivated my understanding of and love for Lockton, Professor James Albert, Husch Blackwell partner Craig Kovarik, and my podcast co-host Ed Fensholt.
[2] *U.S. Census Bureau, Health Insurance Coverage in the United States: 2022 (September 2023),* Table 1. 65.6 percent of Americans (179 million) participate in employment-based health coverage.
[3] Alliance to Fight for Health Care & Morning Consult, *Coverage and Reforming the System* (February 21, 2023), pp. 4 and 11.

an estimated 47% return on investment to employers with 100 or more employees in 2022, rising to a 52% return in 2026. This includes $275.6 billion from improved productivity in 2022 and $346.6 billion in 2026.[4]

This is one of the reasons plan sponsors invest heavily in healthcare coverage for workers and their families. According to the annual Kaiser Family Foundation Employer Health Benefits Survey, plan sponsors pay 83% of the premium for single coverage and 71% of the premium for family coverage.[5] Moreover, 65% of people who have ESI participate in a self-funded plan, which means the plan sponsor is directly paying healthcare claims out of their general assets.[6] Premium costs are a reflection of plan costs, which reflect a mixture of administrative costs and underlying healthcare costs. Accordingly, ensuring quality and cost-efficient care helps keep premiums low for everyone.

Not only do plan sponsors and workers benefit from ESI, but it is also an outstanding investment for the federal government. According to an American Benefits Council analysis, for each dollar the government invests in encouraging ESI by not taxing workers on their healthcare, plan sponsors produce $3.73 in benefits for covered workers and their families.

ERISA is essential to the success of ESI because it establishes a clear and consistent set of rules that allow plan sponsors the ability to innovate and respond to the needs of their workers and their families. This framework includes participation standards, fiduciary requirements, rules for processing claims and appeals, reporting and disclosure requirements, benefit mandates, privacy and security, and more.

The "crowning achievement" of ERISA is its preemption provision

One of the driving forces behind the adoption of ERISA was the need to promote uniform and equitable benefits for workers of multistate employers. To facilitate this goal, ERISA Section 514 "supersede(s) any and all State laws insofar as they may now or hereafter relate to an employee benefit plan . . . ."[7] The law's architects emphasized the importance of this strong preemption provision, highlighting in legislative history that preemption is the "crowning achievement" of ERISA.[8]

At a high level, ERISA's preemption provision works differently depending on whether the plan at issue is insured or self-funded. ERISA permits states to adopt rules governing insurance, which can be applied to insured group health plans in addition to ERISA. ERISA's preemption provision does not allow those insurance laws, or other state laws that relate to employee benefit plans, to apply to self-funded plans. This is not to say self-funded plans are unregulated—self-funded plans are still subject to many important laws including ERISA, HIPAA, HITECH, GINA, COBRA, the ACA, the tax code, and others.

ERISA's preemption provision provides for nationally uniform and central administration, flexibility in plan benefit design, and the ability of plan sponsors to treat employees consistently regardless of where they live or work. As important as this was in 1974, it is even more important today as technology has led to a boom in remote work.

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[4] Avalere Health, *Return on Investment for Offering Employer-Sponsored Insurance* (June 28, 2022).
[5] KFF, *Employer Health Benefit Survey 2023 Annual Survey*. Figure 6.1.
[6] KFF, *Employer Health Benefit Survey 2023 Annual Survey*. Figure 10.2. The bulk of self-funded plan sponsors will buy stop loss to reimburse them for costs that exceed a certain threshold.
[7] 29 USC § 1144(a).
[8] See, comments of Rep. Dent and Sen. Williams; 120 Cong. Rec. 29,197, 933.

Preemption has led to greater flexibility and more innovation. Look no further than how self-funded plan sponsors were able to respond to the COVID-19 pandemic and related stay-at-home orders. Self-funded employers didn't need to wait on state regulators to quickly modify their plan designs to incorporate telehealth, expand coverage for testing and treatment, and provide additional avenues for mental and behavioral healthcare.[9]

Any attempts to weaken ERISA preemption will have a profoundly negative impact on ESI, especially for those individuals covered by self-funded plans. State-by-state regulation increases complexity, adds unnecessary administrative burdens, opens the door to lawsuits and other compliance risks, and ultimately drives up costs.

It might be tempting to assume multistate companies can dedicate resources to manage the complexities of state-by-state regulation, but that misses several important points. Regardless of employer size, increasing the financial burdens, compliance risks, and administrative complexities will change the incentives for employers to offer healthcare coverage, which could result in less access to quality and affordable care. Additionally, many multistate employers are small- or medium-sized businesses with limited resources. Further, because premium costs reflect plan costs, workers and their families will face a greater financial burden when overall plan costs rise.

For example, imagine a manufacturer with 200 workers in Virginia, another 50 workers in North Carolina, a remote marketing professional in California, an accountant in Connecticut and regional sales associates in Georgia, Missouri, Colorado, and Washington. Without ERISA preemption, this manufacturer could be forced to comply with ERISA and eight different states' regulations. Further, it's possible that a worker in Virginia doing the same job as a worker in North Carolina could receive wildly different benefit packages because the states require or forbid certain benefits and benefit plan design.

This example is not an abstract consideration. The state of Oklahoma, like several other states, adopted aggressive rules applicable to PBMs that have a significant impact on employer plan design. While the 10th Circuit has ruled many provisions of Oklahoma's PBM laws are preempted by ERISA, plan sponsors were still required to comply with the law while the case worked its way through the courts. One Lockton client with more than 25,000 plan participants and beneficiaries has seen their drug costs increase by 25% as a direct result of the Oklahoma law. Sadly, many other states have adopted similar legislation that is not subject to the 10th Circuit's decision, which is leading to increased costs across all regions. Even worse, states have been empowered, in part by inaccurate statements by the Departments of Labor and Justice to propose even more far-reaching laws that would further wreak havoc on multistate employer plan sponsors.

We believe ERISA preemption is effective, as evidenced by the 10th Circuit decision. However, Congress should reign in the Departments of Labor and Justice and demand they uphold traditional notions of ERISA preemption.

Plan sponsors would benefit from more clarity surrounding ERISA's fiduciary standards

ERISA's fiduciary duties are generally accepted as the highest known to the law.[10] ERISA fiduciaries must act solely in the best interest of plan participants and beneficiaries. In general, there are two types of fiduciaries:

[9] See, American Benefits Council, *Silver Linings Pandemic Playbook* (July 23, 2021)

[10] *Donovan v. Bierwirth*, 680 F.2d 263, 3 EBC 1417, n.8 (2d Cir. 1982). See also *Chao v. Hall Holding Co., Inc.*, 285 F.3d 415, 27 EBC 2153 (6th Cir. 2002) ("Clearly, the duties charged to an ERISA fiduciary are 'the

named fiduciaries and functional fiduciaries. Each plan must name a fiduciary, generally the plan sponsor. A party is a functional fiduciary if it exercises discretion with respect to plan administration or plan assets.

One fundamental fiduciary duty is the requirement to monitor service providers. Further, a plan fiduciary may only use plan assets on behalf of a plan, and a plan service provider may only receive *reasonable* compensation, for *necessary* services rendered by the service provider to the plan.

Unfortunately, it has become increasingly difficult for named fiduciaries to determine what constitutes reasonable and necessary compensation and when they have met their duty to monitor. At the same time, numerous recently enacted standards hold plan sponsors accountable for things they have little or no control over.

The complexity of healthcare and health plan coverage demand that plan sponsors rely on service providers for many plan functions. Named fiduciaries often have little insight and influence over who their service providers contract with and the terms of those contracts. This makes it difficult for to determine whether expenses the plan pays are reasonable and necessary. This is particularly concerning considering vertical integration where it is possible, for example, for a single entity to control network determinations, charges, and reimbursement rates.

Increased transparency in healthcare can provide fiduciaries with greater insight to better monitor service providers and ensure plan assets are used appropriately. To that end, we are supportive of efforts to standardize and expand the transparency requirements for hospitals, providers, PBMs, TPAs, and other service providers.

In addition, we encourage the Committee to consider the importance of timing. Fiduciaries must have access to information in a timely fashion to give them leverage in negotiations with service providers. Requiring disclosures only after the plan or contract year can be helpful, but it does not provide as much negotiating leverage as disclosures before contracts are entered and throughout the plan year. For example, a typical pharmacy plan audit can easily cost $100,000 or more and requires significant amounts of labor. Requiring regular data transfers instead of after-the-fact audit rights will save plan sponsors from incurring these additional administrative costs just to confirm PBMs are complying with their contractual duties.

In any event, it is important for the lawmakers, regulators, and courts to understand the limits of transparency. While transparency provides insights into plan costs, responsible fiduciaries might still not have the leverage with service providers to reduce costs or increase quality. Even where service provider costs can be controlled, those costs pale in comparison to the amount a plan pays for the underlying cost of care. In addition to looking more closely at the underlying cost of care, it would be helpful for lawmakers to consider ways to limit anti-competitive provisions in contracts between service providers (e.g., TPAs and carriers) and healthcare providers and facilities—e.g., most-favored nations, all-or-nothing, gag clauses, anti-tearing, and anti-steering.[11]

While some have called for service providers to be deemed fiduciaries by statute, we caution there could be significant unintended consequences including enhanced litigation, decreased flexibility and control for

highest known to the law.'"); *Howard v. Shay*, 100 F.3d 1484, 20 EBC. 2097 (9th Cir. 1998) (ERISA's duties are "highest known to the law").

[11] See, HR 2861.

plan sponsors, increased costs, and an emphasis on cost instead of value. Congress will want to carefully consider the ramifications of expanding the pool of named or statutory fiduciaries.

Regardless of fiduciary status, third parties often have the information and technical expertise responsible plan fiduciaries are held accountable for by Congress and regulators. For example, in our experience the vast majority of employers are actively trying to find ways to provide top-tier behavioral health benefits, but other parties like TPAs and network administrators ultimately determine contract terms with providers, and providers get to decide whether to participate in a given network or demand cash payment only. We believe it is important for Congress and regulators to seek ways to ensure that the right parties are held accountable under the law.

Holding plan sponsors responsible for standards they do not control is unfair and makes it much more difficult for policy goals to be achieved. Whether an ERISA fiduciary has met its obligations has traditionally been a question of procedural prudence instead of being outcome determinative. Congress and regulators can help plan sponsors by providing clear guidance on the appropriate processes to follow to meet various obligations, while also not punishing plan sponsors when the outcome is less than ideal if the plan sponsor is not in control of the outcome.

Finally, we believe plan sponsors would benefit from clarifying the 408(b)(2) compensation disclosure to ensure that TPAs and PBMs and others like drug purchasing coalitions report to the plan sponsor their direct and indirect compensation.

Restrictions on what data plan sponsors can access and how they can use it makes it more difficult for them to monitor service providers and ensure the best interest of plan participants and beneficiaries

Plan sponsors use data to manage costs, ensure quality, and measure the effectiveness of service providers. Typically, plan sponsors rely on third parties like brokers and consultants to receive and analyze plan data.

For example, Lockton uses both objective data (e.g., claims data) and subjective data (e.g., surveys) on behalf of plan sponsors to help them achieve their overall population health strategy. The process starts with understanding the plan sponsor's goals and stratifying the risk within the population. Stratifying the risk is an important step as the tactics used to maintain the apparently healthy/low risk population are different than those needed for the "at risk" population.[12]

We use data to determine the prevalence and severity of risk and determine what is driving the risk.[13] From there, we can help plan sponsors develop population health strategies that are responsive to the needs of the plan's participants and beneficiaries and align with the plan sponsor's goals.

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[12] Population health management tactics are often lumped together under a bucket of "wellness." It is important to understand that traditional wellness programs are more aligned with helping keep the already healthy population healthy. For example, health screenings, participation in healthy eating webinars, and incentives for exercising. Our data suggest those who have developed chronic conditions benefit more from tactics that are typically outside of the traditional wellness program.

[13] Generally, the healthy/low risk population typically accounts for 70%-75% of the population and each low-risk member typically incurs $1,200 annually in claims cost (about 15% of total client spend). Conversely, the at-risk population accounts for about 25% of the population but about 85% of spend!

Examples of how data is used include:

- We have several government entity clients who, based on their demographics and claims data, have invested more heavily on traditional wellness and prevention. In these cases, the tactics deployed along with low turnover have resulted in the low-risk population staying low risk for a longer period compared to our overall book of business. As a result, these organizations have incurred lower annual increases in cost compared to peers who have less robust strategy and tactics.

- We have clients with higher turnover and/or elevated risk profiles who have deployed a strategy that forgoes traditional wellness to focus more of their resources on their "at risk" population. In these instances, the "at risk" population is provided very specific, high-quality and timely resources (e.g., access to centers of excellence, pertinent information, second opinion services, therapies, and navigation resources) in a more cost-effective manner. It can also lead to direct contracting with high-quality providers. The result has been more timely, higher-quality care, more favorable clinical outcomes and near-term and long-term cost reduction (for both the employer and participant).

The purpose of the CAA's gag clause prohibition was to ensure plan sponsors are able to access and use plan-related data, in accordance with the strong protections of HIPAA. Without data, the programs discussed above cannot work. Unfortunately, our experience is that the prohibition on gag clauses is producing limited benefit for a variety of reasons:

- Even when gag clauses are removed from the plan sponsor contract, TPAs, PBMs, and other third parties continue to limit disclosures arguing the prohibition merely prevents gag clauses and does not mandate any disclosures.

- We still hear arguments that the information is proprietary despite regulatory guidance dismissing that argument.

- TPAs, PBMs, and other third parties may remove gag clauses from contracts with plan sponsors, but they will still demand restrictions on brokers and consultants that are helping plan sponsors understand and act on the data (see below). Few plan sponsors have the technical expertise or resources to directly receive the data. Instead, they direct data to be sent to their broker or consultant that does have the necessary technical expertise. This also shields the plan sponsor from inadvertently receiving or using data contrary to HIPAA.

- TPAs, PBMs, and other third parties distinguish between data access and data use. While data might be made available, the TPAs, PBMs, and other third parties will restrict how the data can be used or disclosed. These restrictions are over and above those imposed by HIPAA and subvert the purpose of the gag clause prohibition allowing restrictions on public disclosure.

- Plan sponsors have little to no insight into the downstream contracts that TPAs, PBMs, and other third parties have with hospitals, providers, and their own service providers. This makes it impossible for plan sponsors to truly know if their ability to access and use data is restricted.

We continue to work with TPAs, PBMs, and other third parties, but the following are some of the clauses we still see in contracts:

- The XXXX Global NDA restricts Lockton's use of the data as follows: Lockton shall not use the Confidential Information to calculate or determine any financial or discount analysis of reimbursement terms or for bundled payment initiatives.
- The XXXX Global NDA restricts Lockton's use of the data as follows: Lockton shall not use the Confidential Information to perform health plan to health plan comparisons, create provider score cards, or calculate XXXX provider discounts or reimbursements or validate and adjust financial information received from other sources. Further, Lockton shall not use the Confidential Information for health advocacy, network advocacy, and/or transparency of healthcare services.
- The XXXX Global NDA restricts Lockton's use of the data as follows: Lockton shall not use Confidential Information for the creation, operation, or contribution to the development of any cost or price transparency tool program that would enable Plan members to obtain comparative cost and pricing information across providers in a service area for episodes of care, treatments and procedures or for any similar program. Further, Lockton shall not include an analysis of XXXX's claim cost data to assess XXXX's discount competitiveness within a market, or pharmacy analytics.

These limitations of the gag clause prohibition must be addressed for the provision to function as intended.

The prohibition on gag clauses can be further strengthened by simplifying the attestation requirement. The current law and informal guidance contain so much ambiguity and confusion that plan sponsors have difficulty completing the process in an accurate manner. The attestation should be based on the plan sponsor's knowledge and best efforts rather than a binary yes or no.

In all events, the Committee should be mindful not to change the protections and flexibilities afforded by HIPAA. HIPAA, as amended by HITECH[14], provides a comprehensive framework for the privacy and security of protected health information. Importantly, HIPAA allows health plan sponsors and their business associates (like Lockton) acting on their behalf to access and use health plan data, including identifiable data, for payment, treatment, and healthcare operations.[15] Among other things, HIPAA regulations specify that "healthcare operations" includes population-based activities relating to improving health or reducing healthcare costs, case management, and coordination of care. This is a crucial tool for plan sponsors to ensure quality and affordability, and it must be preserved.

Plan sponsors continue to struggle with the cost of care, especially drug costs

Prescription drug costs now account for nearly 30% (and sometimes more) of a group health plan's claim expenses. Two percent of a typical plan's population utilizes a specialty medication, accounting for over

[14] Cybersecurity is an increasingly important topic for plan sponsors and all businesses. Lockton Associates work directly with employers and cybersecurity insurance carriers. In general, the cyber risks of health plan sponsors are similar to all entities that hold sensitive information, as are the steps necessary to protect that information. Importantly, because so many health plans cross state lines, we believe it is important that a federal cybersecurity standard be developed that ensures plan sponsors do not need to comply with a patchwork of state cybersecurity and privacy laws. Further, it is important that any federal framework recognize and maintain the safeguards and flexibilities of HIPAA.

[15] 45 CFR §164.506(c)(1).

52% of prescription drug spend. With new and dramatically more expensive specialty drugs coming online, that trend will only worsen.[16]

Plan sponsors we work with want to ensure meaningful access to plan participants and beneficiaries, even for the costliest drugs; however, in some cases, specialty prescription drug expenses threaten the very solvency of their health plans.[17]

Congress must understand that added costs get spread to all plan participants in the form of higher premiums. Limiting the tools available to plan sponsors to control costs (e.g., use of specialty pharmacies) and shifting costs to the plan (e.g., requiring the plan to accumulate drug coupons toward the participant's deductible or out-of-pocket maximum) result in higher costs for everyone.

As discussed above, Lockton uses data on behalf of plan sponsors, which includes data on prescription drugs. The high-risk population within a plan consumes the highest percentage and cost of drugs, including specialty drugs. As part of the overall population health strategy, compliance with care plans is often the focus. This includes the proper use of medications, site of care determinations, and ensuring medications, especially costly specialty medications, are acquired in the most cost-effective way possible. Limiting flexibility for plan sponsors makes it more difficult for them to respond to the needs of all plan participants and beneficiaries.

Managing the PBM relationship and contract is also an essential function for plan sponsors, and this too requires data. Given the cost of many new medications, the economics of care plan adherence quickly diminishes if PBM contracts are not aggressively negotiated to include performance guarantees for pricing and utilization management. Without data and robust analytics, plan sponsors are limited in their ability to negotiate and hold PBMs accountable to the terms of their contracts.

Numerous private solutions are being leveraged beyond care management, but there is often limited effectiveness due to the high cost of drugs.

For example, many plan sponsors have attempted to use private reinsurance models to help when a specific spend threshold is exceeded. This threshold is typically set to where only very high-cost patients are covered due to the cost of reinsurance. But the reinsurance companies will often set exclusions in later years to stop covering that cost. We are seeing some reinsurance carriers exclude from coverage any patients who have a disease state that has a potential high-cost gene therapy in the pipeline. The Committee must understand that reinsurance is not a magic bullet willing to take on any risk – if the risk is too unpredictable or too high, reinsurers will not accept it.

In the ACA marketplace, certain states have used Section 1332 waivers to establish reinsurance or risk-pooling programs. This is an approach that could work more broadly for specific drugs, specific conditions, or when claims costs for a participant or beneficiary reach a certain level. We encourage

[16] We are seeing specialty drug spend increase 10%-15% per year.

[17] While many specialty drugs are for oncology or a limited course of treatment (e.g., gene therapies costing $3 million-$4 million), many others are for treating ongoing chronic conditions. For example, in 2023, Veopoz was approved to treat CHAPEL disease for a cost of $1.8 million per year. The average cost for chronic, non-oncology rare disease therapies approved in 2023 was $574,000 per year. While it is unlikely any individual plan will incur a claim for many of these drugs, a single claim could be catastrophic for the plan sponsor.

Congress to consider these models, but caution against imposing additional costs or limiting opportunities for plan sponsors to innovate.

Administrative red tape makes plan administration more costly and burdensome

Plan sponsors are responsible for more than 50 reporting and disclosure obligations. Lockton maintains a document for clients summarizing these obligations, when they are required, who must receive them, and how they must be submitted. This high-level summary takes more than 40 pages. Complying with the requirements demands significant time and resources and adds costs.

The Committee and regulators can help reduce information overload for participants and unnecessary burdens for plan sponsors. This includes allowing health plan sponsors to provide notices electronically, following rules like those applicable to retirement plan sponsors. Regulators should look for ways to simplify and combine required notices. Further, regulators should consider consolidating reporting platforms, so plan sponsors do not need to access so many different platforms to file necessary reports.

Conclusion

I appreciate the opportunity to provide testimony on the value of employer-sponsored healthcare and the critical role of employee benefit brokers in navigating the complex landscape of health insurance. As evidenced by the insights shared today, ERISA has had a wonderful 50 years and has made ESI the cornerstone of the American healthcare system, offering stability, affordability, and quality coverage to millions of workers and their families. To further strengthen this vital system, Lockton urges Congress to heed the recommendations outlined in this testimony. By taking decisive action to address challenges such as fiduciary standards, data access, prescription drug costs, administrative burdens, and innovation, Congress can ensure the continued success of employer-sponsored healthcare for generations to come.

Thank you for the opportunity to testify and I look forward to your questions.

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