AMERICAN BENEFITS COUNCIL

TESTIMONY OF

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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."

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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

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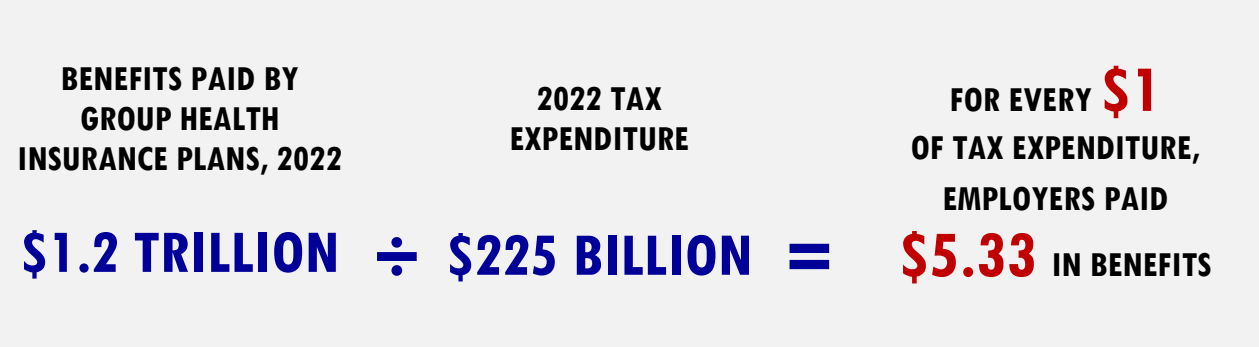
[2] The Winston Group, *Alliance to Fight for Health Care National Survey* (September 2024)

[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.