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 THE ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

"LOWERING HEALTH CARE COSTS FOR ALL AMERICANS: AN EXAMINATION OF HEALTH INSURANCE AFFORDABILITY "

January 22, 2026

Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to submit a statement on the record on behalf of the Partnership for Employer-Sponsored Coverage (P4ESC) for the hearing entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability." We appreciate the Subcommittee's focus on affordability and welcome the opportunity to contribute an employer-driven perspective on the core drivers that continue to push health care costs higher for workers, families, and taxpayers alike.

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

For more than eighty years, employer-sponsored coverage has been the backbone of our nation's health system. Employers are the primary purchasers of coverage, the principal financiers of health benefits, and fiduciaries responsible for ensuring the plans operate in the best interests of workers and families. Each year, businesses of all sizes contribute vast financial, administrative, and other resources to employees and their families through the employer-sponsored system and have a vested interest in health care quality, value, and system viability.

Moreover, employer-sponsored group coverage holds a distinct advantage over coverage sold in the individual market. Workplace-based coverage groups together employees without regard to their health status, producing larger, more stable risk pools with predictable enrollment and lower premium volatility over time. Employer contributions, controlled entry and exit from the plan, 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—outcomes that benefit employees, employers, and taxpayers alike.

However, the success of employer-sponsored coverage depends on a market in which insurers operate with transparency, accountability, and incentives aligned with affordability, value and patient care. As health care costs continue to rise, employers are increasingly concerned that market dysfunctions—including opaque data practices, hidden fees, consolidation, and misaligned incentives—are undermining their ability to manage costs and fulfill their fiduciary obligations. These challenges threaten not only employer-sponsored coverage, but also the broader goal of lowering health care costs for all Americans.

Address the Rising Cost of Health Care

Health care costs are simply out of control. In 2024, the United States spent $5.3 trillion on health care, equivalent to about 18 percent of gross domestic product – up from $4.5 trillion and 17.3 percent of GDP in 2022.[1] Employers routinely face hospital prices that exceed more than two-and-one-half times what Medicare pays,[2] with little evidence that these higher prices reflect commensurate improvements in quality or outcomes. For decades, employers of all sizes have raised concerns about medical cost growth that far outpaces population growth and aging, [3] and small business owners have consistently cited health care costs as one of their most significant operating challenges.[4] Greater congressional and regulatory oversight of escalating health care costs and persistent market failures is long overdue.

According to the Centers for Medicare and Medicaid Services (CMS), health care spending is highly concentrated. Hospital care, physician services, and prescription drugs alone account for **more than 60 percent of total national health expenditures**, while no other spending category

[1]Centers for Medicare & Medicaid Services. *National Health Expenditure Data: NHE Fact Sheet.* CMS, updated 24 June 2025, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.
[2] Whaley, Christopher M., et al. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative.* RAND Corporation, RR-A1144-2-v2, Dec. 10, 2024, https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.
[3] The Peter G. Peterson Foundation. "*Why Are Americans Paying More for Healthcare?*" *Peter G. Peterson Foundation*, 12 Aug. 2025, https://www.pgpf.org/article/why-are-americans-paying-more-for-healthcare/.
[4] National Federation of Independent Business. *About NFIB.* NFIB, https://www.nfib.com/about-nfib/. Accessed 20 Jan. 2026.

exceeds five percent.[5] This concentration underscores that affordability challenges are being driven primarily by a limited number of sectors, rather than by diffuse or unavoidable cost pressures across the system.

Employers have also long been concerned about consolidation across the health care sector and its impact on prices, competition, and transparency. **P4ESC commends the Subcommittee for advancing provisions in the *Consolidated Appropriations Act, 2026* (CAA) that strengthen transparency and enhance congressional oversight of dishonest billing practices among hospitals and physician practices. We support policies in the CAA that expand price transparency across all stakeholders, including pharmacy benefit managers (PBMs), health plans, and hospitals. P4ESC also supports uniform application of site neutral payment policies and honest billing requirements to deter location-based gaming of coverage.**

Address Misaligned Incentives Which Drive Consolidation

As employers work to manage rising health care costs, they are increasingly concerned that large insurer incentives are not aligned with affordability or value. One such concern is the structure of the medical loss ratio (MLR), which is often described as a consumer protection but can, in practice, reward higher overall spending rather than cost containment. Because MLR is calculated as a percentage of premium revenue, insurers can increase absolute revenue as premiums rise, so long as they remain above the statutory threshold. This dynamic weakens incentives to aggressively negotiate prices, reduce unit costs, or challenge provider consolidation—particularly in markets where employer choice among insurers is limited. Actuarial and policy analyses have long noted that MLR requirements do not directly incentivize efficiency and may, in some circumstances, reinforce cost growth rather than constrain it.[6]

These incentive concerns are compounded by consolidation in the health insurance market. Numerous studies have shown that health insurance markets remain highly concentrated across much of the country, limiting employer leverage and reducing competitive pressure on premiums and service quality.[7] In many regions, employers, particularly small and mid-sized businesses,

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[5] Centers for Medicare & Medicaid Services. *National Health Expenditures 2024 Highlights.* CMS, 2025, https://www.cms.gov/files/document/highlights.pdf.
[6] Rigney, Grant. "*Gaming the Medical Loss Ratio: How Health Insurers Turn Consumer Protections into Corporate Windfalls*." *Free Market Health Care Forum* OppBlog, 16 Dec. 2025, https://freopp.org/oppblog/gaming-the-medical-loss-ratio-how-health-insurers-turn-consumer-protections-into-corporate-windfalls/.
[7] United States Government Accountability Office. *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation.* GAO-25-107450, Government Accountability Office, 22 Sept. 2025, https://www.gao.gov/products/gao-25-107450

have access to only one or two viable carrier options.[8] As insurers grow larger and more vertically integrated, employers increasingly encounter standardized, take-it-or-leave-it contract terms and diminished responsiveness to requests for transparency, flexibility, or innovation. Federal analyses have repeatedly found that market concentration weakens competition and can contribute to higher prices, a concern that is particularly acute in employer-sponsored coverage, where switching costs are high and plan stability matters for workers and families.[9]

Employers are also deeply concerned about persistent barriers to accessing timely, usable data necessary to manage health benefits effectively. Although employers are the primary purchasers and fiduciaries of employer-sponsored plans, insurers frequently restrict access to claims, pricing, and utilization data or provide it in formats that are delayed, incomplete, or difficult to analyze. Without meaningful data access, employers cannot effectively monitor plan performance, evaluate network value, identify wasteful spending, or fulfill their fiduciary responsibilities under the *Employee Retirement Income Security Act* (ERISA). Federal guidance has emphasized the importance of plan sponsor oversight of service providers,[10] yet persistent gaps in data access continue to limit accountability and prevent the market from functioning as intended.[11]

The rapid vertical integration of insurers with pharmacy benefit managers, specialty pharmacies, and other health care intermediaries further complicates these challenges. While integration is often justified as a means of improving coordination, it has also introduced conflicts of interest and opaque financial arrangements that make it difficult for employers to understand where health care dollars are actually going. The Federal Trade Commission,[12] academic researchers,[13] and other government entities[14] have shown how practices like spread pricing, rebate retention

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[8] American Medical Association. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets.* American Medical Association, 2024, https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.

[9] United States Government Accountability Office, *Health Care Consolidation*, GAO-25-107450.

[10] United States Department of Labor, Employee Benefits Security Administration. *Understanding Your Fiduciary Responsibilities Under a Group Health Plan.* U.S. Department of Labor, 2025, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.

[11] United States, House of Representatives, Committee on Education and the Workforce. *House Report 118-260: Health Data Access, Transparency, and Affordability Act of 2023.* 118th Cong., 1st Sess., 1 Nov. 2023, https://www.congress.gov/committee-report/118th-congress/house-report/260.

[12] Federal Trade Commission. *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs.* Interim Staff Report, June 2024. https://www.ftc.gov/reports/pharmacy-benefit-managers-powerful-middlemen-inflating-drug-costs.

[13] Commonwealth Fund. *What Pharmacy Benefit Managers Do and How They Contribute to Drug Spending.* 17 Mar. 2025, https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending.

[14] United States Government Accountability Office. *Pharmacy Benefit Managers: Use of Spread Pricing and Related Practices.* GAO-24-105476, April 2024. https://www.gao.gov/products/gao-24-105476.

and associated fees, and steering towards vertically consolidated entities can drive up costs for employers and patients while making it harder to see where the health care dollars are going. These practices erode trust, reduce competition, and impair employers' ability to act in the best interests of plan participants.

Taken together, these dynamics—misaligned insurer incentives, consolidation, data opacity, and vertical integration—have allowed inefficient spending to persist even as premiums and out-of-pocket costs continue to rise. Employers are routinely told that premium increases are driven by "medical trend," yet they are given little visibility into how insurers are actively working to lower prices, improve value, or challenge cost growth within the system. **P4ESC encourages the Subcommittee to continue to support policies that will increase employers' access to their own data, like strengthening the *Consolidated Appropriations Act, 2021* "no gag clause" requirement that mandates insurers provide plan sponsors access to their own claims data. P4ESC additionally urges the Subcommittee to support policies that will provide transparency to the hidden fees that are often levied on plan sponsors without their knowledge, driving up the overall cost of coverage.** Without greater transparency and accountability, cost pressures are increasingly shifted onto workers and families through higher premiums, higher deductibles, and constrained wage growth. Addressing these issues is essential to preserving the affordability and sustainability of employer-sponsored coverage and to ensuring that the private insurance market works as intended for those who depend on it.

Uphold the tax treatment of employer-sponsored coverage

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

The exponential growth in our nation's employment-based health coverage system can be traced back to a cap on wages initiated during World War II to help stifle inflation. Employers began offering fringe benefits – such as health insurance – to offset the limit on wages and attract employees. This approach has supported coverage for more than 80 years. The direct benefits and federal spending offsets of employer-provided coverage result in an annual net social impact of $1.5 trillion, driven by increased labor participation, business formation, increased health coverage, and reduced federal health subsidies.[15] Each dollar of federal expenditure – the tax

[15] Mulligan, Casey B. *The Value of Employer-Sponsored Health Insurance.* National Bureau of Economic Research Working Paper No. 28590, March 2021, https://www.nber.org/papers/w28590.

revenue foregone for employer-provided coverage – yields approximately $5.34 in benefits for covered employees and their families.[16]

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

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

Preserve ERISA Preemption

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

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

Unfortunately, states and local governments are increasingly passing laws that challenge ERISA's preemption framework. For example, Seattle's "pay-or-play" ordinance effectively dictates employer health care spending levels and layering on new disclosure mandates that

[16] Joint Committee on Taxation's Estimates of Federal Tax Expenditures For Fiscal Years 2019-2023; The Bureau of Economic Analysis' National Income and Product Accounts (Table 6.11)

undermine national uniformity. Unfortunately, the courts have allowed this city ordinance to stand adding to the increasing patchwork of state and local laws.

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

Conclusion

P4ESC commends the Subcommittee for making significant progress towards addressing many of these issues this Congress through enacting the first major reforms to high-deductible health plans and health savings accounts (HSAs) in more than 20 years. The passage of the ***Primary Care Enhancement Act*** increases affordability for patients by allowing them to participate in a direct contracting arrangement and use their HSA to pay for their direct primary care arrangement. Additionally, HSA reforms that are now law include permanent first dollar coverage for telehealth services and greater access to HSAs in marketplace coverage. We encourage Congress and the administration to prioritize additional HSA reforms.

P4ESC is the leading defender of employer-based coverage. We respectfully ask that lawmakers consider return on investment for employer-sponsored coverage as they consider health care legislation, and that lawmakers work to strengthen employer-sponsored health care by championing policy to increase affordability for patients. Employers have a significant stake in developing and implementing health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout the 119th Congress. If you or your staff would like to meet with members of P4ESC, please contact P4ESC's Executive Director, Taylor Hittle.[17]

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