Testimony of Anthony Wright
Executive Director
Families USA

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

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

September 10, 2024

Families USA
1225 New York Avenue, NW
Suite 800
Washington, DC 20005

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

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

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

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

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

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

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

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

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

The U.S. Health System in Crisis

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

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

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

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

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

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

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

Building on the Foundation of ERISA

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

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

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

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

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

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

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

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

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

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

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

Improving Health Care Affordability for Working Families

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

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

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

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

Lower Prescription Drug Costs for People in the Private Insurance Market

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

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

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

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

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

Address Underlying Causes of High and Rising Health Care Costs

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

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

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

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

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

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

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

<u>Extend Enhanced Premium Tax Credits for People Who Purchase their Insurance in Marketplaces</u>

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

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

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

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

---

[1] Gary Claxton and Matthew Rae, "What are the recent trends in employer-based health coverage," Peterson-KFF Health System Tracker, December 22, 2023, https://www.healthsystemtracker.org/chart-collection/trends-in-employer-based-health-coverage/#:~:text=dataDownload%20PNG-,In%20March%202023%2C%2060.4%25%20of%20the%20non%2Delderly%2C,someone%20outside%20of%20their%20household.

[2] Joseph Adams, Allison Bans, Nancy Campbell, et al, "Cheers to 50 Years of ERISA: A Major Milestone in Employee Protection," JD Supra, September 4, 2024, https://www.jdsupra.com/legalnews/cheers-to-50-years-of-erisa-a-major-1052592/

[3] "ERISA," U.S. Department of Labor, https://www.dol.gov/general/topic/health-plans/erisa.

[4] Karen Pollitz, Matthew Rae, Cynthia Cox, et al, "Key Issues Related to COBRA Subsidies," KFF, May 28, 2020, https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/.

[5] West Health, and GALLUP, "West Health-Gallup 2022 Healthcare in America Report," West Health, December 14, 2021, West Health-Gallup 2022 Healthcare in America Report - westhealth.org.

[6] Sara R. Collins, Shreya Roy, and Relebohile Masitha, "Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer: Findings from the Commonwealth Fund 2023 Health Care Affordability Survey," The Commonwealth Fund, October 26, 2023, https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-forit-costs-debt-americanssicker-poorer-2023-affordability-survey.

[7] Megan Brenan, "Record High in U.S. Put Off Medical Care Due to Cost in 2022," Gallup, January 17, 2023, https://news. gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx; See also, NORC at the University of Chicago and West Health, "Americans' Views on Healthcare Costs, Coverage and Policy," March 2018, https://www.norc.org/content/dam/ norcorg/pdfs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf.

[8] Noam N. Levey, "100 Million People in America Are Saddled With Health Care Debt," KFF Health News, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medicaldebt/.

[9] "Employer Health Benefits: 2023 Annual Survey," KFF, https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.

[10] Daniel R. Arnold and Christopher M. Whaley, "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages," Rand Corporation, July 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html; See also, Billie Jean Miller and Steve Nyce, "The Big Paycheck Squeeze: The Impacts of Rising Healthcare Costs," WTW, July 27, 2023, https://www.wtwco.com/en-us/insights/2023/07/the-big-paycheck-squeeze-the-impacts-of-rising- healthcare-costs; "Prescription Drug Spending in the U.S. Health Care System: An Actuarial Perspective," American Academy of Actuaries, March 2018, https://www.actuary.org/content/prescription-drug-spending-us-health-caresystem; Benjamin N. Rome, Alexander C. Egilman, and Aaron S. Kesselheim, "Trends in Prescription Drug Launch Prices, 2008- 2021," JAMA 327, no. 21 (2022): 2145–2147, https://jamanetwork.com/journals/jama/article-abstract/2792986.

[11] Drew DeSilver, "For Most U.S. Workers, Real Wages Have Barely Budged in Decades," Pew Research Center, August 7, 2018, https://www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-fordecade.; See also, Gary Claxton, Matthew Rae, Anthony Damico, et al, "Health Benefits in 2022: Premiums Remain Steady, Many Employers Report Limited Provider Networks for Behavioral Health," Health Affairs, October 27, 2022. https://www.healthaffairs.org/stoken/tollfree/2022_11_CLAXTON/full

[12] "2023 Employer Health Benefits Survey," KFF, October 18, 2023, https://www.kff.org/report-section/ehbs2023-summary-of-findings/.

[13] Kurt Hager, Ezekiel Emanuel, and Dariush Mozaffarian, "Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families, "JAMA Network Open 7, no. 1 (2024), https://doi.org/10.1001/ jamanetworkopen.2023.51644.

[14] Aaron Plotke, Sophia Tripoli, Nicholas Chang. “The Weight of High Hospital Prices Is Keeping American Workers Underwater,” Families USA, March 4, 2024, https://familiesusa.org/resources/the-weight-of-high-hospital-prices-is-keeping-american-workers-underwater/.

[15] Sam Hughes, Emily Gee, and Nicole Rapfogel, “Health Insurance Costs Are Squeezing Workers and Employers,” Center for American Progress. November 29, 2022, https://www.americanprogress.org/article/health-insurance-costs-are-squeezingworkers-and-employers/.

[16] Ibid; See also, “‘Deductible Relief Day’ Is May 19: On That Date, Health Spending for People in Employer Plans Will Exceed Average Deductibles,” KFF, May 16, 2019, https://www.kff.org/health-costs/pressrelease/deductible-relief-dayis-may19/#:~:text=Average%20enrollee%20spending%20on%20deductibles,of%20higher%20spending%20on%20 deductibles.

[17] “Vast Majority of Large Employers Surveyed Say Broader Government Role Will Be Necessary to Control Health Costs and Provide Coverage, Survey Finds,” KFF, April 29, 2021, https://www.kff.org/health-reform/press-release/vastmajority-of-large-employers-surveyed-say-broadergovernment-role-will-be-necessary-to-control-health-costs-and-providecoverage-survey-finds/.

[18] Sam Hughes, Emily Gee, and Nicole Rapfogel, “Health Insurance Costs Are Squeezing Workers and Employers,” Center for American Progress. November 29, 2022, https://www.americanprogress.org/article/health-insurance-costs-are-squeezingworkers-and-employers/.

[19] Munira Z. Gunja, Evan D. Gumas, Reginald D. Williams II, “U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes,” Commonwealth Fund, Jan. 31, 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.; See also, OECD (2023), “Life expectancy at birth (indicator),” doi: 10.1787/27e0fc9d-en (Accessed on 27 January 2023); Emma Wager, Matthew McGough, Shameek Rakshit, et al., “How does health spending in the U.S. compare to other countries,” Peterson-KFF Health System Tracker, January 23, 2024, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#Health%20expenditures%20per%20capita,%20U.S.%20dollars,%20PPP%20adjusted,%202022; Rabah Kamal, Julie Hudman, and Daniel McDermott, “What Do We Know About Infant Mortality in the U.S. and Comparable Countries?” Peterson-KFF Health System Tracker, October 18, 2019, https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/.

[20] CDC Office of Minority Health, “Racism and Health,” Centers for Disease Control and Prevention, last reviewed September 18, 2023, https://www.cdc.gov/minorityhealth/racism-disparities/index.html.

[21] *In 1990, the United States Supreme Court interpreted ERISA’s language to “exempt self-funded ERISA plans from state laws that ‘regulat[e] insurance.”* For more information, see, “Reforming ERISA to Help States Control Health Care Costs,” Commonwealth Fund, February 9, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2023/feb/reforming-erisa-help-statescontrol-health-care-costs.

[22] Ibid.

[23] “2023 Employer Health Benefits Survey,” KFF, October 18, 2023, https://www.kff.org/report-section/ehbs-2023-section-10-plan-funding/

[24] "ERISA: A Bipartisan Problem for the ACA And The AHCA", Health Affairs Blog, June 2, 2017. DOI: 10.1377/hblog20170602.060391

[25] Ibid.

[26] Congressional Record, https://www.govinfo.gov/content/pkg/CHRG-105shrg50024/html/CHRG-105shrg50024.htm

[27] “Questions and Answers on the No Surprises Act and State Laws,” U.S. Department of Health and Human Services, U.S. Department of Labor, U.S. Department of the Treasury, Revised August 2023, https://www.cms.gov/files/document/nsa-state-laws-q-and-a.pdf.

[28] *ERISA plans must cover some newborn and maternity care, preventive services, and certain cancer services, and their coverage of mental health and substance use treatment must be at parity with other services.* 29 U.S. Code §1185, §1185a.

[29] Karen Pollitz, Kaye Pestaina, Alex Montero, et al, “KFF Survey on Consumer Experiences with Health Insurance,” June 15, 2023, https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/.

[30] Ibid.

[31] “Health Benefits Advisor,” U.S. Department of Labor, https://webapps.dol.gov/elaws/ebsa/health/

[32] Information from Diane Spicer, Community Health Advocates, Community Service Society of New York, September 6, 2024.

[33] *In 2020, 14.4% of groups with less than 50 employees were in self-insured plans:* “Medical Expenditure Panel Survey,” AHRQ, https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/tiib2b1.htm,; *Thirty percent of employees in those plans also had stop-loss coverage:* “Medical Expenditure Panel Survey,” AHRQ, https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/tiib2b1b.pdf.

[34] Mark Hall and Michael McCue, “Experiences Under the ACA Suggest Association Health Plans Could Harm the Small-Group Market,” Commonwealth Fund, 2018, https://www.commonwealthfund.org/blog/2018/experiences-under-aca-suggest-association-health-planscould-harm-small-group-insurance.

[35] “Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It’s Difficult to Afford Their Medicines, Including Larger Shares Among Those With Health Issues, With Low Incomes and Nearing Medicare Age,” KFF, n.d., https://www.kff.org/ health-

costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicinesincluding-larger-shares-with-low-incomes/.

[36] Ashley Kirzinger et al., "Public Opinion on Prescription Drugs and Their Prices," KFF, August 21, 2023, https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

[37] Kirzinger et al., "Public Opinion."

[38] Hayden Bosworth et al., "Medication Adherence: A Call for Action," American Heart Journal 162, no. 3 (September 2011): 412–424, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3947508/.

[39] Fred Kleinsinger, "The Unmet Challenge of Medication Nonadherence," Permanente Journal 22 (2018): 18–33, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6045499/.

[40] "Prescription Drug Spending in the U.S. Health Care System: An Actuarial Perspective," American Academy of Actuaries, March 2018, https://www.actuary.org/content/prescription-drug-spending-us-health-caresystem.

[41] Rome, Egilman, and Kesselheim, "Prescription Drug Launch Prices."

[42] "Rising Health Care Costs Mean Lower Wages," T.H. Chan School of Public Health, Harvard University, n.d., https://www.hsph.harvard.edu/news/hsph-in-the-news/baicker-health-care-costs-wages/#:~:text=%E2%80%9CWhen%20health%20care%20costs%20go,according%20to%20the%20Census%20Bureau.

[43] "2023 Medicare Costs," CMS Product No. 11579, Medicare.gov, U.S. Centers for Medicare & Medicaid Services, November 2022, https://www.medicare.gov/Pubs/pdf/11579-medicare-costs.pdf.

[44] "Cost Sharing," Medicaid.gov, U.S. Centers for Medicare & Medicaid Services, n.d., https://www.medicaid.gov/ medicaid/cost-sharing/index.html.

[45] Kim Keck, "Six Ways We're Lowering Drug Prices," Blue Cross Blue Shield of America, March 3, 2022, https://www. bcbs.com/the-health-of-america/articles/six-ways-were-lowering-drug-prices#:~:text=In%20the%20United%20States%20today,cost%20can%20be%20much%20higher.

[46] H.R. 5376 – Inflation Reduction Act of 2022, https://www.congress.gov/bill/117th-congress/house-bill/5376.

[47] Sara Hansard, "Employer Benefit Seen From New Medicare Drug Price Law," Bloomberg Law, September 28, 2022, https://news.bloomberglaw.com/health-law-and-business/employer-benefit-seen-from-new-medicare-drug-price-law.

[48] Robert A. Berenson, Jaime S. King, Katherine L. Gudiksen, et al., "Addressing Health Care Market Consolidation and High Prices," The Urban Institute, January 2020, https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.; See also, Leavitt Partners, "Assessing Current and Expected Growth of Alternative Payment Models: A Look at the Bold New Goals for Downside Risk," Leavitt Partners, November 18, 2019, https://leavittpartners.com/assessing-current-and-expected-growth-of-alternative-payment-models-a-look-at-thebold-new-goals-for-downside-risk/.; See also, Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy," MedPAC, March 2023. https://www.medpac.gov/wpcontent/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

[49] Danielle Scheurer, "Lack of Transparency Plagues U.S. Health Care System," The Hospitalist, May 1, 2013, https://www.the-hospitalist.org/hospitalist/article/125866/health-policy/lack-transparency-plagues-us-health-caresystem.

[50] Robert A. Berenson, Jaime S. King, and Katherine L. Gudiksen, et al., "Addressing Health Care Market Consolidation and High Prices," The Urban Institute, January 2020, https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.; See also, Jaime S. King, "Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers: Testimony before the House Committee on Energy and Commerce and Subcommittee on Oversight and Investigations," U.S. House of Representatives, July 17, 2018, https://docs.house.gov/meetings/IF/IF02/20180717/108550/HHRG-115-IF02-Wstate-KingJ-20180717.pdf.

[51] Ibid.

[52] Ibid.

[53] Ibid.

[54] Hannah T. Neprash, Michael E. Chernew, and Andrew L. Hicks, et al. "Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices." JAMA Internal Medicine, 2015;175(12):1932-1939, December 2015, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591.

[55] Ibid.; See also, David I. Auerbach and Arthur L. Kellerman, "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family," Health Affairs 30, no. 9, September 2011, https://www.rand.org/pubs/external_publications/EP201100172.html

[56] Health Savers Initiative, "Equalizing Medicare Payments Regardless of Site-of-Care," Committee for a Responsible Federal Budget, February 23, 2021, https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

[57] Eric Zimmerman, and Emily Jane Cook, "CMS extends site-neutral payments to all off-campus hospital outpatient clinic services, but declines to limit service line expansion (for now)," McDermott Will & Emery, November 12, 2018, https://www.mwe.com/insights/cms-extends-site-neutral-payments/

[58] "Advance premium tax credit (APTC)," HealthCare.gov, U.S. Centers for Medicare & Medicaid Services, accessed May 6, 2024 https://www.healthcare.gov/glossary/advanced-premium-tax-credit/#:~:text=A%20tax%20credit%20you%20can,(or%20%E2%80%9Cpremium%E2%80%9D). *The minimum income limits are slightly higher in Alaska and Hawaii due to those states' poverty guidelines*