



STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE U.S. HOUSE OF REPRESENTATIVES  
HOUSE COMMITTEE ON THE BUDGET

“REVERSING THE CURSE: SKYROCKETING HEALTH CARE COSTS AND AMERICA’S  
FISCAL FUTURE”

January 21, 2026

Chairman Arrington, Ranking Member Boyle, and Members of the full committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled “*Reversing the Curse: Skyrocketing Health Care Costs and America’s Fiscal Future.*” We appreciate the committee’s attention to the impacts of rising health care costs on employers and their workforce and look forward to working with you to find solutions that will make quality health care more affordable and accessible.

ERIC is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

ERIC member companies offer comprehensive health coverage for employees, their families, and retirees through self-insured plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). They do so to attract and retain employees, to be competitive for human capital, to improve health and productivity, and to provide peace of mind. Large employers, like ERIC member companies, roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and a myriad of other innovations that improve quality, reduce costs, and drive value for working families.

Rising health care costs in the United States are placing significant financial strain on both employers and their employees. Surveys and industry analyses show that employers are bracing for substantial cost increases this plan year, ranging from six to nine percent.<sup>1</sup>

---

<sup>1</sup> [Mercer](#), Employers are bracing for the highest health benefit cost increase in 15 years, a projected 6.5% increase in 2026, September 4, 2025,

Additionally, premiums for family coverage have reached an average of \$27,000 per year, up roughly six percent in 2025, forcing many companies to consider shifting more expenses to employees through higher cost-sharing, deductibles, or premium payroll contributions.<sup>2</sup> This will be profoundly impactful for many of the more than 160 million Americans who get their health insurance through an employer.

ERIC's large self-insured employers already shoulder the bulk of health care costs for their employees, covering roughly 75 to 80 percent of health care costs. Without addressing market consolidation and anticompetitive tactics within the health care system, employers and working families will suffer from the consequences of high prices, ranging from delayed care to increased chronic conditions, limited care choices, and costly hospitalizations.

The U.S. House of Representatives has been here before, trying to address unsustainable health care spending and rising costs for employers, employees, patients, and taxpayers. The House Education and Workforce Committee held a bipartisan hearing focused on employer-sponsored health insurance affordability last year.<sup>3</sup> House Republicans have also explored policy solutions with the Healthy Future Task Force.<sup>4</sup> With the House Energy and Commerce Committee's health subcommittee and the Ways and Means full committee holding hearings with CEOs from five large health insurers to answer questions regarding the affordability of health care, particularly the drivers of rising health care costs, Congress now has the opportunity to advance policies that would benefit employees' and patients' pocketbooks. Some of these policies are led or cosponsored by Chairman Arrington, including:

- *Healthy Competition for Better Care Act* (H.R. 3120), which improves fairness in contracting by prohibiting certain abusive contracting strategies used by hospitals and insurance carriers.
- *Eliminating Thickets to Increase Competition Act (ETHIC) Act* (H.R. 3269), which is aimed at streamlining patent litigation for brand-name drugs by limiting companies to asserting one patent per "thicket," preventing multiple lawsuits against the same generic or biosimilar competitor, and safeguarding genuine innovation—all to accelerate market entry of lower-cost alternatives and reduce prescription drug costs for patients.

We urge Congress to consider these bills and address the other matters below to improve patients' health care affordability.

---

<sup>2</sup> [KFF](#), 2025 Employer Health Benefits Survey, October 22, 2025.

<sup>3</sup> A Healthy Workforce: Expanding Access and Affordability in Employer-Sponsored Health Care (April 1, 2025), <https://www.congress.gov/event/119th-congress/house-event/LC74775/text>.

<sup>4</sup> [Healthy Future Task Force Affordability Subcommittee RFI](#). February 4, 2022

## **I. Medical Transparency and Accountability Reforms**

ERIC member companies believe transparency is integral to reduce health care costs and improve quality of care. Health care costs for employers continue to rise at an unsustainable rate. To help mitigate these costs, Congress should significantly strengthen transparency in the health care system, thus giving rise to better care for patients, more competition, greater value, and improved quality and safety.

We strongly urge Congress to codify the Transparency in Coverage final rule and enact the bipartisan, bicameral health care package that was agreed upon in December 2024, but failed to make it onto the final continuing resolution. Additionally, we implore the committee to push for inclusion of Title IV of the *Lower Costs, More Transparency Act*, which provides desperately needed clarifications and enhancements to the *Consolidated Appropriations Act* (CAA), as well as implementing new data sharing and transparency requirements to improve the affordability of employer-sponsored health benefits.

The more accurate, complete, accessible, and up-to-date the data is when shared with employer-sponsored health plans, the more plan sponsors may do to ensure not only their own compliance with current law and regulations, but also to improve affordability and quality for the millions of workers enrolled in these plans. If Congress wants employers to be active purchasers who innovate improvements and advocate on behalf of employees throughout the plan year, then employers need information about costs throughout the plan year – not just in an end-of-the-year summary.

### *Gag Clauses*

Section 201 of the *Consolidated Appropriations Act of 2020* (CAA), which aims to increase transparency by removing “[gag clauses](#)” on price and quality information, still needs clarity so that providers, health plans, and plan sponsors can fully benefit and the legislation can achieve Congress’ intent. While Section 201 allows enrollees, plan sponsors, or referring providers to see cost and quality data, it also extends to contracts between providers and group health plans. Currently, some plans and providers prevent plan sponsors from accessing de-identified claims data that could be shared under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements with third parties for plan administration and quality improvement purposes. Employers need their own health claims data to satisfy their ERISA fiduciary duties to keep health plan costs low and act in the best interest of plan participants. If plan sponsors cannot access their plan’s health claims data, they cannot satisfy their ERISA fiduciary duties.

Congress needs to strengthen the “Gag Clause Prohibition” by imposing penalties on owners of the provider network that refuse to share complete and accurate health claims data with the plan administrator, especially in cases when a plan sponsor cannot rightfully “attest” that there are no restrictive “gag clauses” in their health plan’s agreement. Congress must also allow plan sponsors to share their health claims data with service providers hired by the sponsor to assist in the administration of the health plan. This means that the “Gag Clause Prohibition” requirements must be extended to non-disclosure agreements and to agreements in which the health plan may not be the contracting party, including agreements between the medical providers and the insurance carrier.

## **II. Pharmacy Benefit Manager Transparency Reforms**

The vertical integration of health insurance companies and pharmacy benefit management (PBM) companies affiliated with specialty and mail-order pharmacies adds to the complex health care system and increased premiums for employees. When insurers, PBMs, and pharmacies operate under the same corporate umbrella, incentives can become misaligned. These vertically integrated entities can steer patients toward higher-priced drugs, preferred pharmacies, or in-house specialty pharmacies that maximize corporate profit rather than clinical appropriateness or affordability. For employees and patients, this often results in reduced access to pharmacies, narrow formularies that do not prioritize the lowest net cost products, increased out-of-pocket costs, and delays in care. For employers, certain PBM activities weaken competition and undermine their ability to effectively manage benefit spending, leading to higher premiums and benefit costs without improved outcomes.

Today, three PBMs process nearly 80 percent of prescription drug claims in the U.S., giving them immense market power. This consolidation has created a skewed marketplace that again drives up drug costs, limits patient choice, and makes it difficult for employers to negotiate contract terms for medications. Patients living with chronic and acute conditions face delays, denials, and unaffordable prices for life-saving medications, even with most employers paying 80 percent or more of employees' health care and prescription drug costs.

Employers, patients, and consumers are united in calling for meaningful reform that prioritizes transparency, accountability, and patient access. Specifically, we urge Congress to take up the PBM policies included in the December 2024 health care package, agreed to by both Chambers, and intended to be included in the year-end continuing resolution. These policies were on the cusp of becoming law last December, and it is time for Congress to finish what it started and enact these measures at the first opportunity.

The health policies contained in the December 2024 package take an important first step at providing transparency and reforms both in the employer-sponsored insurance market and in federal and state programs, including:

- Full transparency of PBM practices, including business arrangements, financial incentives, and formulary design.
- Banning spread pricing, which allows PBMs to profit from the difference between what they charge for insurers and reimburse pharmacies, in the Medicaid program.
- 100% pass-through of rebates, discounts, fees, and other payments from drug manufacturers to plan sponsors and patients.
- De-linking PBM compensation from drug prices in the Medicare program.

These policies have broad bipartisan support and reflect the needs of both employers and patients. Additionally, ERIC encourages Congress to advance the *PBM Fair Act* (H.R. 6837), which holds PBMs accountable for their actions while performing functions on behalf of a group health plan. Employers, workers, and families should be able to rely on those who provide services to employer-sponsored group health plans, such as pharmacy benefit managers, to adhere to the same fiduciary duties employers are held to. That means working to save money for patients, and doing what is right for the plan's beneficiaries.

Every day without action is a day in which Americans are forced to make impossible choices—between their health and their financial stability. These changes are imperative to ensure a free market operates as intended, without steering plans and patients toward higher-priced medications and making health care unaffordable. We firmly believe that congressional action is necessary to correct the dysfunction present in the marketplace.

### **Conclusion**

Thank you for this opportunity to share our views. ERIC is committed to helping forge solutions that result in improved health care affordability, transparency, access, quality, and safety for all Americans. We are confident that our policy recommendations can provide meaningful changes to the health care system. We look forward to working with the committee to further help in policy development, and to enact legislation into law to drive real affordability for patients.