STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE U.S. HOUSE OF REPRESENTATIVES
UNITED STATES HOUSE COMMITTEE ON WAYS & MEANS

"FULL COMMITTEE HEARING WITH HEALTH SYSTEM CEOS"

April 28, 2026

Chairman Smith, Ranking Member Neal, and members of the Committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing with health system CEOs. We appreciate the Committee's attention to the impacts of rising health care costs on patients and large employers and look forward to working with you to 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, improve health and productivity, and 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.

ERIC member companies provide health benefits not only to attract and retain employees, but also to support employee well-being and provide financial security. Across the country, our members invest in their employees and communities by improving access to care and driving innovation in health benefits. These efforts include a broad array of approaches, including expanding the use of digital health tools, establishing onsite clinics, and implementing direct primary care arrangements. Employers also develop value-based and coordinated care programs, offer employee wellness initiatives, and deploy transparency tools and other innovations designed to improve quality and value while helping to mitigate rising health care costs

However, rising health care costs continue to place significant financial strain on both employers and their employees. Large, self-insured employers typically cover roughly 75 to 80 percent of overall expenses. Surveys and industry analyses show that employers are bracing for substantial cost increases this plan year, with projected increases ranging from six to nine percent.[1]

[1] Mercer, Employers are bracing for the highest health benefit cost increase in 15 years, a projected 6.5% increase in 2026, September 4, 2025.

At the same time, premiums for family coverage now average approximately $27,000 per year, reflecting roughly a six percent increase in 2025.[2] Unless Congress takes affirmative action to address market consolidation and anticompetitive practices within the health care system, employers and working families will continue to face the consequences of these costs.

The cost associated with payments to providers is one of the largest drivers of health spending costs for employers, with prices charged by hospitals to private plans continuing to rise rapidly. Several reputable research findings show that employers and private insurers pay, on average, 224 percent of Medicare rates for hospital services, with some hospitals charging more than 300 percent.[3] Additionally, research published in Health Affairs consistently shows that price variation—not utilization—is the primary driver of spending growth in the commercial market.[4]

Likewise, ERIC issued a policy brief, *Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices*, which examined the primary drivers of hospital pricing in employer-sponsored insurance markets.[5] The brief focused on research conducted by Charm Economics as evidence that hospital prices are not primarily driven by cost shifting from underpayments in federal programs. Instead, market dynamics, particularly provider consolidation, employer bargaining power, and regional pricing patterns play a much larger role in determining the rates employers ultimately pay. These findings underscore a central problem: hospital pricing in the commercial market is currently not disciplined by competition or tied to underlying costs.

Provider Consolidation and Unfair Pricing Practices

Hospital pricing remains a primary driver of rising health care costs for employers and workers. As large health systems acquire hospitals and physician practices, they eliminate competition and increase the prices charged to patients and purchasers of care.

Over the past several decades, hospital systems have significantly expanded their market power through acquisitions and consolidation. By 2017, approximately 90 percent of health care markets were considered "highly concentrated."[6] Studies have repeatedly found that hospital mergers lead to price increases, with no consistent evidence of quality improvement.[7] Dominant health systems frequently use their market power to block lower-priced competitors and demand higher reimbursement rates from employers and insurers negotiating on their behalf.

Provider consolidation continues to accelerate, including the widespread acquisition of physician practices by hospital systems. This consolidation enables providers to command higher prices and exert increased pressure in contract negotiations.

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[2] KFF, 2025 Employer Health Benefits Survey, October 22, 2025.
[3] Whaley, C. M., Briscombe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. RAND Corporation.
[4] "The Role Of Prices In Excess US Health Spending." Health Affairs, 9 June 2022.
[5] Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices. ERIC, May 2025
[6] Johnson, Noah, et al. "Is Hospital Market Concentration Related to Medical Debt?" Urban Wire, Urban Institute, 16 Oct. 2024
[7] Gale AH. Bigger but not better: hospital mergers increase costs and do not improve quality. Mo Med. 2015 Jan-Feb;112(1):4-5. PMID: 25812261; PMCID: PMC6170097

ERIC member companies experience these pressures firsthand through wide variations in payment rates for identical services depending solely on the site of care.

Allowing such market failures to persist unchecked threatens the affordability of employer-sponsored coverage. Action is needed to preserve competitive markets in health care and prevent costs from continuing to rise for employers and working families. The committee can take several important steps to discourage consolidation and unfair pricing practices, including expanding site-neutral payment policies, strengthening transparency reforms, and promoting fairness in contracting practices.

Site-Neutral Payments

Provider consolidation has contributed to problematic billing practices. Hospitals increasingly reclassify physician offices they own as hospital facilities to charge higher rates for the same goods and services, and "facility fees" despite services not taking place on an actual hospital campus. Congress took an important, but very narrow, first step towards addressing this issue in *the Consolidated Appropriations Act of 2026* (CAA 26) by requiring the use of a unique National Patient Identifier (NPI) for off-campus hospital outpatient departments when billing Medicare. However, broader site-neutral reforms are needed, and Congress should build upon this momentum to fully address the distortions created by differential payment structures. Site-neutral payment reform will help curb unnecessary spending and restore fairness in health care pricing.

Strong Transparency Reforms

ERIC member companies believe that transparency is essential to reducing health care costs and improving quality of care. Too many hospitals still fail to meaningfully comply with Department of Health and Human Services (HHS) regulations requiring the public disclosure of standard charges, including negotiated rates. ERIC applauds the House's work last Congress on the *Lower Costs, More Transparency Act* (LCMT, H.R. 5378). The legislation would have codified the requirement that hospitals publicly post negotiated prices for health care items and services in a machine-readable format and would have strengthened compliance and enforcement. Access to timely and accurate information allows employers to design better benefits and manage costs more effectively on behalf of their employees.

ERIC encourages the Committee to build upon the principles of the LCMT and pass the *Patients Deserve Price Tags Act* (H.R. 5582), which provides clear statutory authority requiring hospitals and others to disclose key pricing information. Specifically, hospitals would be required to publish their standard charges, including negotiated rates with insurers, cash-pay discounts, and billing codes, and disclose the costs of services that can be scheduled in advance. The enhanced disclosure requirements under this bill will lead to a better understanding of the costs associated with care for employers and their workers, empowering them to require competitive prices for high-quality care.

Fairness in Contracting

Provider market power is increasingly reflected in unfair contracting practices that raise costs while limiting competition and choice. The Committee should advance the bipartisan *Healthy Competition for Better Care Act* (H.R. 6248), led by Ways and Means Committee member and Budget Committee Chairman Jodey Arrington (R-TX).

This legislation would improve fairness in contracting by allowing employers and insurers to provide incentives for enrollees to choose high-quality, lower-cost providers, and prevent the use of anti-competitive contract requirements imposed by hospitals and health systems on health benefit plans. These reforms would enable health benefit plan sponsors to design provider networks that maximize value for patients and exclude sites of care with inflated prices or poor quality—creating truly value-driven benefits for plan beneficiaries.

The No Surprises Act Independent Dispute Resolution Process is Adding to Costs

The *No Surprises Act* (NSA) was intended to protect patients from surprise medical bills and reduce health care costs by encouraging network agreements between providers and carriers. However, emerging Centers for Medicare and Medicaid Services (CMS) data, academic research, and real-world experience show that the Independent Dispute Resolution (IDR) process, originally designed as a last resort to solve surprise billing disputes, has become a significant driver of medical cost inflation, administrative inefficiency, and payment manipulation. The system is being exploited by provider organizations who have turned the arbitration mechanism into a routine profit-extraction strategy. The result is a system that increases health care costs and undermines our health care system.

Every dollar added through inflated arbitration awards, wasteful administrative fees, or inappropriate claims, ultimately flows back into premiums and out-of-pocket costs. Insurers faced with mounting arbitration losses adjust premiums to maintain solvency. Employers, from small businesses to Fortune 100 companies, face increased financial pressure that limits wage growth and restricts benefit enhancements.

Changes to the IDR process must be made to restore the integrity of the NSA and mitigate the impact of the process' failings on the ever-rising costs of health care. Without changes, the NSA will continue to be undermined by a system that rewards excessive pricing, encourages profiteering, and burdens the very people it was designed to protect. The IDR process must be restored to its original purpose: a fair, limited, and transparent tool.

Conclusion

ERIC remains committed to working with the Committee and Congress to advance policies that improve health care access, affordability, quality, transparency, and patient safety. We believe the policy recommendations outlined above can help address key drivers of rising costs while strengthening the employer-sponsored health system that serves over 160 million American workers and their families. We look forward to continuing to work with the Committee to develop and enact meaningful reforms.