A Sleeping Giant of Health Care Affordability — Self-Insured Employers

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More than half of Americans — approximately 178 million people — have employer-sponsored health insurance, the coverage sector where health care prices have risen the fastest. More than 60% of this population is covered by self-insured (or "self-funded") plans: the employers or unions themselves, not insurance companies, pay the medical bills of their workers and workers' dependents. Increasingly, health care expenses among these workers and families are driving the nation's reckoning over the cost of living and the policy shift toward affordability.

Medical and pharmaceutical spending has increasingly crowded out core business activities and suppressed wage growth, particularly for low-income workers and people from underserved racial and ethnic groups.[1] Starbucks pays more for health care than it does for coffee beans. Car manufacturers spend more on health care than on steel. Between 1999 and 2023, employer-sponsored health insurance costs grew by more than 300% — three times as much as workers' earnings.[2] With these costs driven by consolidation of health care providers (which leads to higher negotiated prices), increasing utilization (including service and billing intensity), and expensive drugs, employers have struggled to respond.

Employers have long shifted these costs onto workers in the form of higher premiums, higher cost sharing, or slower wage growth.[3] As a result, increases in worker contributions to employer-sponsored insurance have outpaced even the growth in total costs of coverage.[2] In 2025, family premiums averaged nearly $27,000 (6% more than in 2024), with deductibles of more than $3,300 for preferred provider organization plans and $5,000 for high-deductible plans.

As painful as it is to pass costs onto employees, this strategy remains the path of least resistance for employers. It maintains the status quo of relationships between the insurers that employers hire to manage their self-funded plans (third-party administrators) and in-network hospitals and physicians. It also maintains the status quo with most workers, who can tolerate incrementally higher out-of-pocket costs and can't necessarily detect slower wage growth (without knowing what wages could have been).

Yet this strategy sidesteps the root causes of spending growth. It has not slowed delivery-system consolidation, touched high drug prices, or stemmed low-value services. For employers, combating these underlying forces is more challenging than passing costs onto employees. With multiple barriers limiting their ability to respond, employers in general have not adequately addressed health care affordability.

A key barrier is a collective-action problem. Most employers are businesses in a single industry, relatively siloed from other employers and historically with little incentive to collaborate, even in the same locality. Within industries, businesses are competitors that may benefit when peers are weakened by escalating health care costs. Antitrust concerns further discourage collaboration. Yet employers in the same community, whose workers use the same provider organizations, have reason to work together on health care affordability.

A second set of barriers is time and expertise. Most employers have limited bandwidth to engage with third-party administrators, health systems, or policymakers regarding prices and payment models. Most lack the in-house resources to push back against provider consolidation.

Third, employers may not have enough plan members receiving care in any health system to warrant advocating for payment reforms or procompetitive policies. Value-based payment arrangements can also be complex for human resources divisions to manage. For example, earning shared savings next year requires generating savings this year from money that was already budgeted for medical bills.

Fourth, many intermediaries, even those hired by employers, may be more focused on their own margins than on mitigating health care spending or low-value care for their employer clients. Recent lawsuits have alleged that pharmacy benefit managers direct members to higher-cost drugs, and third-party administrators bury administrative costs in claims, refer to their own subsidiaries despite higher prices, or charge high "shared savings" fees for out-of-network claims that are readjudicated at lower prices, even if that leaves workers subject to balance billing.[4]

Broader constraints also persist. Despite wanting a healthier workforce, employers face shortages in primary care for their workers. Despite wishing to nudge workers to high-value providers, employers face the same difficulties as insurers in evaluating the appropriateness of services. These struggles, ultimately of lower priority than core business activities, are often delegated to third-party administrators, who don't bear the risk of paying medical bills and so have weaker incentives to go to bat for their employer clients.

These barriers are not insurmountable. If employers leveraged their collective power to actively manage their health benefits, their efforts could boost their businesses and raise their workers' take-home pay, while increasing the appropriateness of care received. Without such efforts, the unaffordability of health benefits may push more companies to further reduce coverage generosity, forgo offering insurance altogether, or pursue cheaper alternatives that shift more risk onto employees, such as individual coverage health reimbursement arrangements (ICHRAs).

Several strategies can help. First, employers can develop in-house expertise on health care spending, starting with taking control of their health care data. Self-insured employers are legally empowered to obtain the claims data for services their workers received, even if insurers contend that patient privacy or the proprietary nature of their negotiated prices prohibit it. Deidentified data protect privacy, and federal regulations support price transparency. Claims data can help clarify the value employers are getting for their health care dollar. Some employers hire analysts to make sense of claims and inform human resources leaders; some even hire clinical pharmacists to help manage growing pharmaceutical claims.

Second, employers can bargain collectively across industries and localities. The Purchaser Business Group on Health, a coalition of nearly 40 employers that self-insure 21 million people, shares best practices for designing self-insured plans and negotiating prices. The National Alliance of Healthcare Purchaser Coalitions similarly brings together employers, labor unions, and public purchasers. Analytics and digital tools are now available for these purposes.

Third, employers can not only choose the providers they contract with, but also work with their third-party administrators to pay more for high-value services and less for low-value services. This effort could entail adjusting the valuation of services in a self-funded plan's fee schedule to make high-value services higher priced and low-value services lower priced. Alternatively, if workers disproportionately face mental health conditions, for instance, self-funded plans could pay higher prices for mental health services, encouraging more clinicians to join their networks, and offset these costs by paying lower prices for other types of services. Such use of the price lever provides an alternative to restricting utilization by means of narrow-network plans or claims denials, while still helping to reduce low-value spending.

Fourth, self-insured employers can demand contracts with third-party administrators and pharmacy benefit managers that prohibit arbitrage strategies, such as spread pricing and steering to companies that charge higher prices. Protections against these practices both save money and shield employers from lawsuits alleging failure of fiduciary responsibility under ERISA (the Employee Retirement Income Security Act).[4]

Finally, some employers, including in North Carolina and New York, have contributed to federal antitrust action against high, nontransparent health care prices. In rare cases, employers have excluded high-priced health systems from their plans' networks. Others have pursued advocacy for such bills as the bipartisan Patients Deserve Price Tags Act in the U.S. Senate, which aims to strengthen employer access to their plan members' claims data and price transparency.

These strategies may both empower employers and stave off less desirable federal policies. For example, employer contributions to workers' health benefits have long been tax-deductible. The federal government forgoes hundreds of billions of dollars per year owing to this tax benefit — one of its largest domestic expenditures.[5] Policymakers are reconsidering this exclusion because it is expensive, regressive (it benefits higher-income people more than lower-income people), and may exacerbate overuse when coverage is overly generous. The Affordable Care Act aimed to tax high-cost employer-sponsored plans. Although this provision was later repealed, the Republican Study Committee has again proposed taxing these health plans.

With provider consolidation continuing largely unabated, high-price drugs coming to market, utilization and billing intensity on the rise, persistent arbitrage opportunities for intermediaries, new tariffs that raise business

expenses, and potential federal actions on the tax exclusion, the urgency for employers to take charge of their health benefits and purchasing is growing. Employers have much to gain from being a proactive rather than a sleeping giant of health care affordability: their workers will benefit from more affordable care, which ultimately supports wage growth and eases the overall cost of living.

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Unpacking the Ordinary

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There are certain inevitabilities in life. One is that a medical student within range of a hospital will never lack for career advice. It's a "canon event." Strangers in elevators, residents on call, attendings between cases — each has a theory about the "right" specialty. Much of what they have to say, I learned, is less about the student than the adviser: a mirror held up to the adviser's own choices, regrets, and roads not taken.

The advice, I quickly realized, could be sorted into three piles: the Ugly, the Bad, and the Good.

The Ugly arrived with a paternalistic air, often minutes after the adviser met me and without any knowledge of who I was. An attending once pulled me aside after a case, for example, and advised me not to have children during residency. Would I be willing to miss weddings and funerals? The questions were brisk and theoretical, as if my life were a variable to be controlled, a call schedule to be managed.

The Bad was ambient — a specialty declared to be a mistake by the resident who had chosen it, a field that a senior physician would never choose again, accompanied by advice to marry rich. Their certainty was as constant as weather, and no matter the forecast, there was always something wrong — the sun too bright, the ground too hard, water too wet. It sounded more like venting than mentorship.

But then there was the Good. It was quieter, and it asked something of me: find the specialty whose ordinary work you can love, because most of medicine is ordinary. Find your people — the ones whose company steadies you on the worst days. Choose a place where time sometimes disappears into flow. Above all, keep a foothold in wonder. I didn't understand what that meant until later, years after I'd selected my specialty.

It was a Friday night on call, the kind that begins in fluorescent light and a stack of smudged notes. A new patient had been admitted for a possible kidney transplantation. She sat at the edge of the bed, shoulders rigid, knees keeping time with a private metronome. Her eyes moved from the clock to the door to me, then back to the clock.

We walked through the risks and logistics, the choreography that precedes a transplantation. I explained the possibility particular to donation after circulatory death — that there was roughly a one-in-three chance the donor would not progress in time. She nodded, the way people nod when they've been there before. When the forms were signed and the consent witnessed, she exhaled and said, almost to herself, "I don't know what to do with myself till then."

That was when I noticed the suitcase: a small black roller bag parked by the couch, its handle locked upright as if it were already halfway out the door.

"Anything fun in there?" I asked, trying to ease the tension. I pictured my own carry-on from some past weekend, stuffed with pajamas and paperbacks and too many snacks.