COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of Joel C. White
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to the Health, Education, Labor, and Pensions Committee

"Making Health Care Affordable Again: Healing a Broken System."

December 3, 2025

Making Health Care Affordable Again: Healing a Broken System

Chairman Cassidy, Ranking Member Sanders, and Members of the Committee, thank you for the opportunity to testify today. My name is Joel White, and I am the President of the Council for Affordable Health Coverage, a broad alliance focused on lowering health costs so all Americans can access affordable coverage.

In my testimony, I make the following key points:

1. **Health Care Affordability is Getting Worse, Not Better.** This is primarily the result of unrelenting medical inflation, uncompetitive health markets, and the Affordable Care Act.

2. **Consumers Lack Freedom and Power.** The ACA limits plan choices and subsidizes companies, not people, which restricts choice and competition leading to higher costs.

3. **Small Businesses Are Getting Crushed.** ACA's regulations and costs caused small businesses to drop coverage, sending 12 million employees into more expensive coverage.

4. **Lower Cost Plans Are Readily Available.** Solutions that empower consumers and small businesses will lower costs and improve affordability.

Introduction

In 2009, President Obama said "The cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America." He was right in 2009. His answer – the Affordable Care Act – was wrong. The law is an overreach that empowered big companies and big medicine at the expense of consumers and taxpayers.

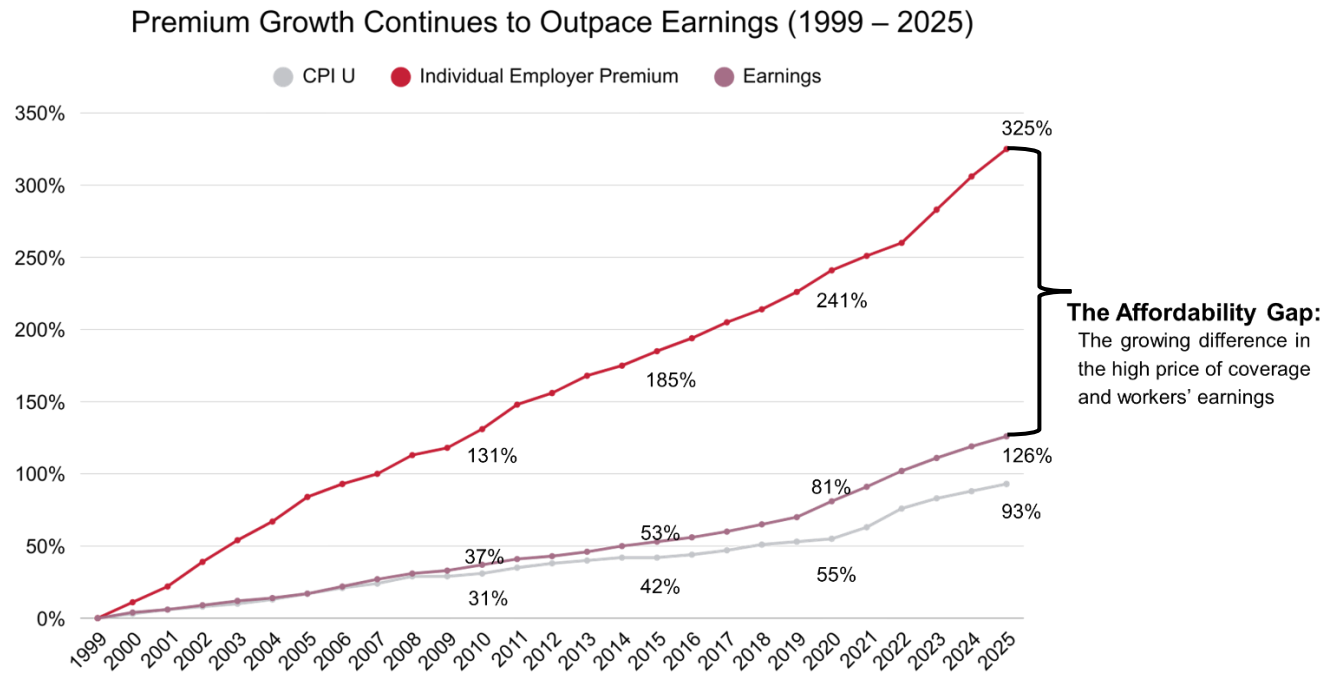
It took choice away from consumers and forced them to buy more expensive plans. It also caused a great migration of at least 12 million small business employees from better, lower cost coverage into more expensive, and more restrictive plans. Premiums in the individual market increased twice as fast as in employer markets, and were well above inflation, while out-of-pocket costs more than doubled. Next year, consumers face a 26 percent average increase in premiums, mostly due to the law's structure and rising medical costs. More subsidies will not fix underlying cost pressures.

And premiums are only the start. Even after paying record-high premiums, families face substantial out-of-pocket costs before most insurance benefits begin. When care is finally covered, patients often encounter friction and delay through aggressive utilization controls—such as prior authorization requirements, narrow provider networks, and restrictive drug formularies. The result is a system in which consumers and taxpayers finance extraordinarily high premiums, significant cost-sharing, and reduced access, all while reinforcing local health provider and insurance monopolies and oligopolies at their expense.

The law poured gasoline on the health cost fire, while burdens on families and businesses have never been greater. Our current health system is clearly unsustainable and is the primary driver of deficits and national debt. If Congress wants a more affordable health marketplace that works for consumers, not against them, it must undertake health reform, by strengthening what works, empowering consumers, not companies, and reducing medial inflation.

How the System is Broken

Our health care system is seriously off track, and the number one problem is affordability. Put simply, health costs are too high and rising too fast. Because health costs are rising faster than wages, we project the typical American family will spend 40 percent of their income on health insurance premiums alone by 2032. It's no surprise that voters consistently rank affordability as their top health-care concern.



Sources: CPI: CBO; Premium: KFF; Earnings: BLS

Health care costs continue to rise for many reasons, but the central problem is that we no longer operate in anything resembling a free market. Instead, we have a web of overlapping government programs and regulations that distort competition and push prices higher. In the ACA, these rules limit consumer choice, subsidize increasingly narrow and expensive coverage, and reinforce uncompetitive markets. As insurers, hospitals, and physician groups consolidate, market power grows, costs increase, and families lose access to competing plans, independent physicians, and lower-cost alternatives.

Over several decades, Congress has layered on reform after reform—micromanaging payment systems, restricting the kinds of plans people can buy, and expanding generous taxpayer-funded subsidies. Although well-intentioned, these interventions have fueled medical inflation rather than contained it. We are now nearing a breaking point: by 2026, the average premium for an ACA family plan or an employer-sponsored plan is projected to exceed $27,000—more than the price of a new Toyota Corolla or Chevy Trailblazer.[1]

[1] 2024 Employer Health Benefits Survey | KFF

The Affordable Care Act is the most visible example of how policy interacts with market concentration, but it is only part of a broader pattern. For decades, federal and state decisions have layered mandates, restrictions, and subsidies onto an already strained system, producing the dysfunction felt today across all health-care markets.

Perverse Incentives: Spending More, Getting Less (than Employer Coverage)

The ACA made health plans more expensive and raised premiums, then subsidized insurance companies to lower premiums. The ACA's structure encourages higher premiums, and rewards scale and size. This has increased inflation, limited consumer options, and restricted competition.

When the ACA was enacted, CBO estimated the law would reduce deficits by $130 billion, and spend $788 billion extending coverage to 31 million people.[2] CBO's latest estimate is that ACA coverage costs will total $1.3 trillion over 10 years, while insuring about 20 million annually.[3] Taxpayer subsidies per enrollee have climbed 56 percent in constant dollars since 2014—from $3,890 to $6,072 in 2025. The law itself is structurally driving cost inflation due to multiple incentives created by the subsidies, which also raise serious fairness issues:

1. Fairness: Most news reports highlight older, higher income individuals paying significantly more in premiums if EPTCs expire. It is important to note, there is no cap on income levels for enhanced subsidies. Families with incomes up to $500,000 could qualify for ACA subsidies. Enhanced subsidies also have no asset test, meaning wealth is not a factor in receiving subsidies, just income. This means lower income, working Americans pay taxes to subsidize higher income, wealthy individuals.

2. Limited Choice: A primary concern with the ACA's structure is it limits competition by restricting consumer choices. The ACA only allows consumers to use subsidies on qualified health plans – the most expensive in the market due to government regulations – on government run exchanges. Even if a consumer wanted another product such as a term plan or an off-exchange policy the state's insurance commissioner had approved, they could not use a subsidy to purchase that plan. For example, the average premium for a term plan is three times less than the benchmark premium in 2025.[4] Restricting access to government approved plans thus increases costs to both consumers and taxpayers, and disregards consumer preferences.

3. Limited Incentives: Because premium subsidies reduce payments to a percent of an enrollee's income, there is little incentive to shop for and buy a plan based on price. It will not matter to a consumer if a standard plan is $100 per month or $10,000 per month if the cost to the consumer is $20 per month for both.

4. An Unlimited Draw: Subsidies are paid by taxpayers directly to insurance companies, not consumers. The subsidies to insurers are not capped (as a percentage of national costs, or any other measure), meaning premium increases raise subsidies dollar for dollar. They are structured as corporate welfare where big insurance companies set premiums

[2] How Has CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Coverage Provisions Changed Over Time? | Congressional Budget Office
[3] The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance | Congressional Budget Office
[4] What is the average cost of short-term health insurance?

within actuarial standards and are then paid a percentage of their premium based on the rate they set.

5. Medical Loss Ratio: The law links higher profits to higher premiums. The MLR was designed to ensure that a certain percentage of premium dollars are spent on medical care, not administrative costs or profits. In reality, it has led to two outcomes: incentives to increase premiums to earn profit within the MLR, and incentives to buy providers (doctors, clinics, hospitals, PBMs) to shift revenue from the plan to the provider side, where profits are captured by the parent plan, but do not count against MLR obligations. In July 2025, this Committee heard testimony from Wendell Potter who highlighted these problems and noted the seven largest insurers collectively made $71.3 billion in profits and paid $146 million in CEO compensation as premiums and out-of-pocket costs increased. I believe in the free market, but MLR encourages game playing to avoid regulations at the expense of consumers.

6. Subsidy Capture: Because subsidies increase as premiums rise, and are paid directly to insurance companies, there is every incentive to drive up premiums in concentrated markets, such as the ACA. The Joint Economic Committee recently found just one third of subsidy payments directly benefit consumers.

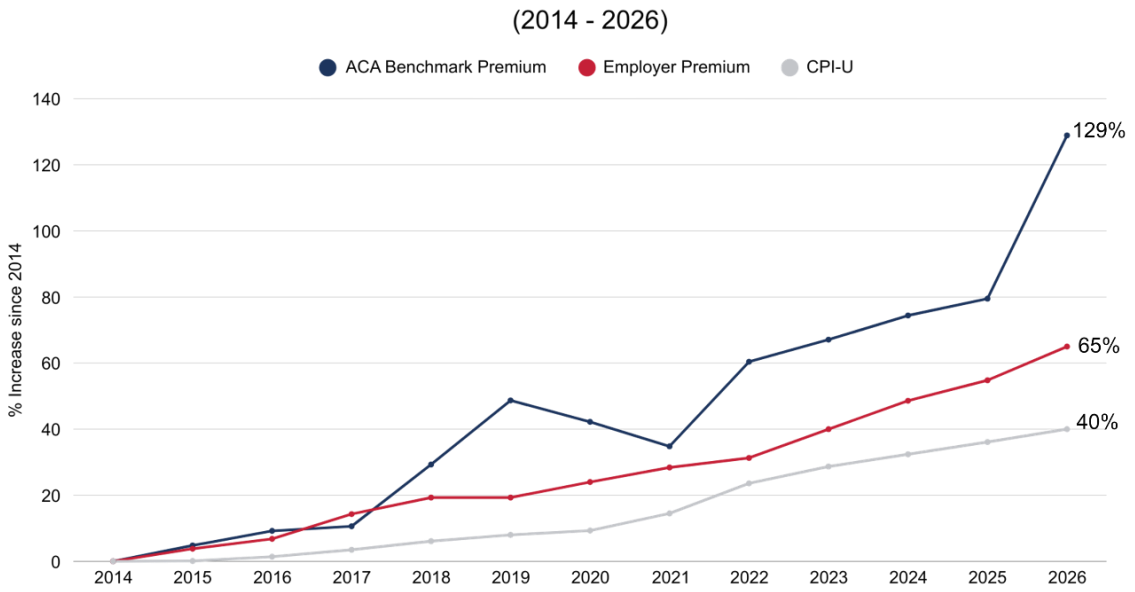
7. Fraud: EPTCs lower to zero dollars premiums for those with incomes below 150% of poverty, which many have shown has increased inappropriate or fraudulent enrollments. The number of people who never used their health plan for any services (including “free” preventive benefits) was stable at 3.2 to 3.5 million until EPTCs became available. Now, CMS estimates show up to 35 percent of enrollees never had a claim. Paragon Health Institute reports that up to 6 million individuals may have been enrolled without their knowledge. Taxpayer subsidies flow to insurers even when an enrollee has zero interaction with their health plan.

If all this money were purchasing excellent coverage that offered wide access to doctors and frictionless insurance, policymakers could make a reasonable argument high consumer, and taxpayer costs are worth the outcome. The results we see in ACA markets reflect the opposite: high premiums, with extremely high out-of-pocket costs, and limited access to doctors and drugs. In addition, ACA plans are inferior to most other products on the market.

In every market, there are health plans that are less expensive than ACA products. If consumers were empowered to use subsidies for alternative plans and shop for coverage, competition would drive down costs and access to care would improve.

Premiums

Since enactment, ACA premiums more than doubled (129 percent) versus a 70 percent increase for employer plans and a 40 percent inflation increase. This points to structural problems between ACA and employer plans, where employers have less regulations, more flexibility in plan choices and more incentives to keep costs low.

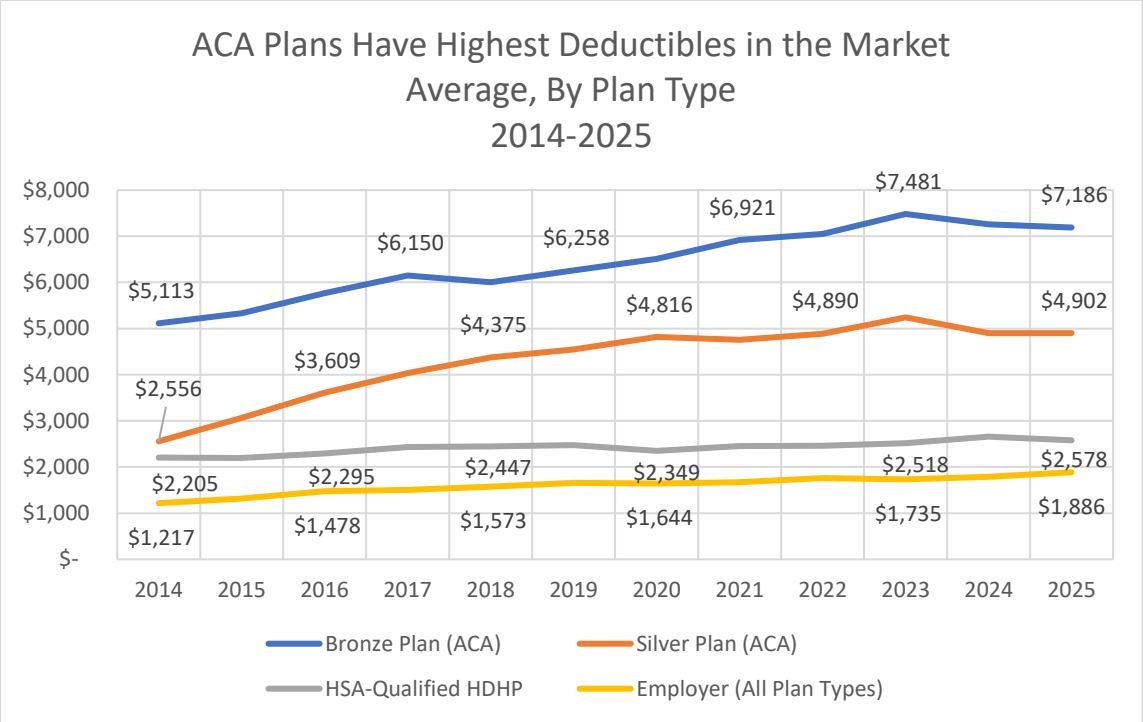


Sources: Benchmark and Employer Premium: Kaiser Family Foundation; CPI: CBO

Deductibles and OOP Costs

Since the ACA's enactment, deductibles – the costs patients pay before insurance benefits begin - have nearly doubled, leaving ACA enrollees with much higher out-of-pocket burdens compared to other plans. Deductibles for ACA's Silver plans have doubled since enactment and now total almost $5,000 annually. This is almost twice as much as the HSA average and three times more than the typical employer plan. Because many families have $1,000 or less in savings[5], high deductibles on ACA's exchanges create real barriers to routine or necessary urgent care.

[5] Nearly 7 in 10 Americans have less than $1,000 in Savings | First United Bank



Source: Kaiser Family Foundation various market surveys

As a result of the One Big Beautiful Bill, Bronze and Catastrophic plans are now deemed HSA qualified.[6] As consumers buy a lower premium plan, they have more resources to fund out-of-pocket costs and doctors or drugs that may not be covered by their plan. CMS estimates 1.6 million people will have expanded access to HSA-eligible plans in 2026.[7]

Access to Care

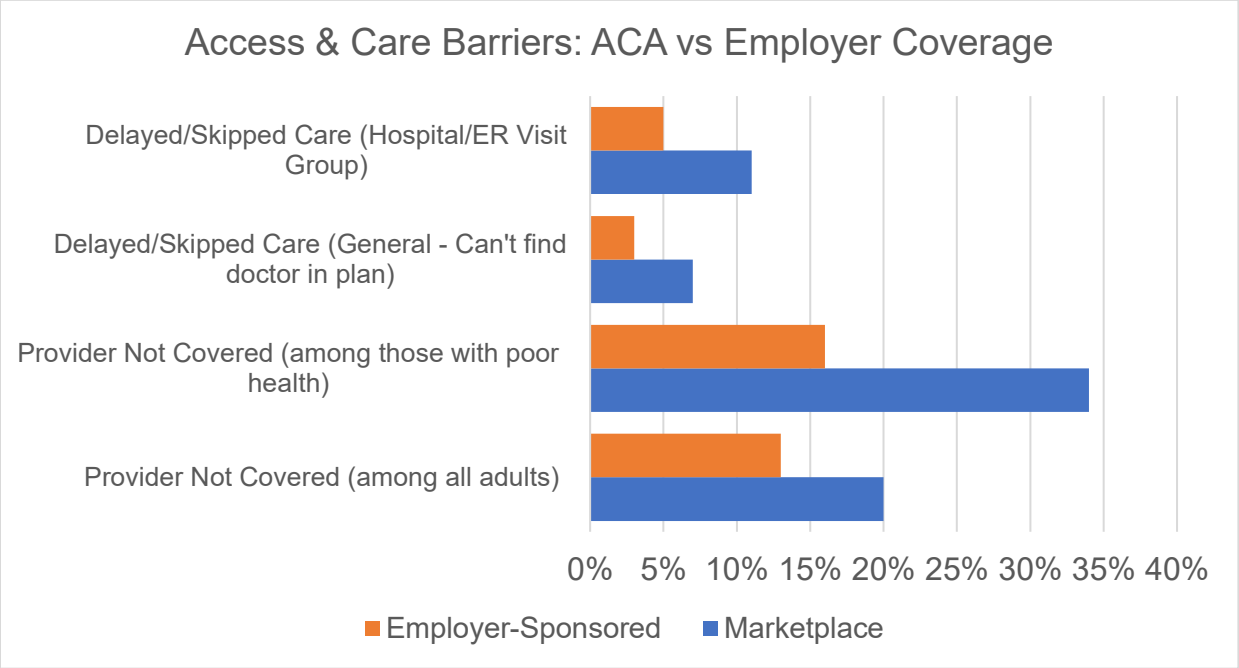
Premiums are meant to purchase meaningful coverage—hospital care, physician services, prescription drugs, and other essential benefits—but the type and quality of coverage varies sharply across markets. On the ACA exchanges, 83 percent of enrollees are in restrictive HMOs or EPOs, compared with just 18 percent of workers in employer-sponsored plans.[8] Network breadth differs as well: a 2020 study found large-group employer plans included 57% of local primary care providers, 68% of cardiologists, and 60% of hospitals, while exchange plans in the same areas covered only 36% of primary care providers, 46% of cardiologists, and 51% of hospitals.[9]

At the same time, consumers are facing more friction when using their benefits. KFF reports that 58 percent of insured Americans experienced a problem with their insurer in the past year—from denied claims to network and prior-authorization issues.[10] Those in poorer health face even more problems because they interact with insurers more often. Prior authorizations are especially burdensome: nearly half of insured adults faced one in the past year, and physicians

[6] Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access – The White House
[7] Plan Year 2026 Marketplace Plans and Prices Fact Sheet | CMS
[8] ACA Individual Market Share by Network Type
[9] How Narrow or Broad Are ACA Marketplace Physician Networks? | KFF
[10] KFF Survey of Consumer Experiences with Health Insurance | KFF

report completing an average of 39 prior authorizations per week, with doctors and staff spending 13 hours weekly on these tasks. [11]

The combination of remarkably high deductibles and narrow, insurance friction, and highly restrictive networks means many ACA enrollees face significant financial and access barriers. As a result, large numbers of patients report delaying or forgoing needed care.



Enrollment and Private Coverage

Under the Affordable Care Act, employers have faced steadily rising costs and shrinking coverage options. The ACA applied the full set of individual-market regulations to small-group plans—even though small employers sponsor and purchase coverage very differently than individual consumers. These rules narrowed the types of plans small businesses can offer, reduced flexibility, and compressed pricing in ways that pushed many insurers out of the small-group market.

As these pressures intensified, the ACA's publicly subsidized markets expanded dramatically, crowding out the private small-group market. Today, roughly 24 million people are enrolled in the ACA exchanges and another 21 million receive coverage through Medicaid. About half of exchange enrollees—12 million people—are small-business workers, many of whom lost more affordable or more robust employer coverage after the ACA's implementation.[12]

[11] Fixing prior auth: Nearly 40 prior authorizations a week is way too many | American Medical Association
[12] About Half of Adults with ACA Marketplace Coverage are Small Business Owners, Employees, or Self-Employed | KFF

Taken together, the data show a market in distress: shrinking small-group enrollment, rising premiums, falling offer rates, and declining insurer participation—all evidence of a system that is no longer working for small employers or their employees.

1. Enrollment in the fully insured small-group market has fallen sharply. Regulators at the NAIC and GAO report that fully insured small-group enrollment dropped from roughly 17 million covered lives in 2013 to about 11 million in 2023, with additional declines expected.[13,14] This loss reflects affordability pressures, ACA's regulatory costs, and the migration of many small employers to level-funded or individual-market alternatives.

2. Premiums for those who remain in the small-group market have risen substantially. National MEPS-IC data[15] show that average small-firm family premiums increased from roughly $14,400 in 2013 to more than $21,000 in 2023, with projections reaching the mid-$20,000s by 2026. Small-firm workers consistently pay a larger share of premiums and face higher deductibles than employees in large firms.[16]

3. Fewer small businesses even offer coverage. MEPS and the Commonwealth Fund[17] show that by 2023 only about 49 percent of workers in small firms were at establishments offering health insurance. NFIB finds that among the very smallest businesses, with fewer than 10 employees, only about one-third offer health benefits at all. These declining offer rates compound affordability problems and shift workers into the individual market, where they face deductibles that are 2.5 times more expensive and limited access to doctors and drugs, or into being uninsured.

4. Competition in the small-group market has deteriorated. According to GAO, the median number of small-group issuers per state fell from 13 in 2013 to just 5 by 2020, holding near 6 through 2022.[18] In many states, three or fewer carriers control more than 80 percent of enrollment. High concentration and fewer market participants mean less competition, fewer choices, and weaker pressure on premiums.

Key Small-Group Market Indicators (2013–2026)
(Enrollment = fully insured small-group covered lives; premiums = average total annual premium at small firms; offer rate = % of workers in small firms whose establishment offers health insurance; issuers = median number of small-group insurers per state)

Year	Small-group enrollment (millions)	Single premium	Family premium	Offer rate	Median # of issuers
2013	17.3	$5,400	$14,400	55%	12
2014	16.4	5,589	14,976	54%	10
2015	15.6	5,785	15,575	54%	9
2016	14.9	5,987	16,198	53%	7
2017	14.3	6,197	16,846	53%	6

[13] GAO-25-107194, Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022
[14] Individual and Small Group Health Insurance Segment Profitability as Reported by Mark Farrah Associates | Business Insurance - Magazine
[15] Medical Expenditure Panel Survey (MEPS) Insurance Component Data Tools - Catalog
[16] 2025 Employer Health Benefits Survey | KFF
[17] Appendix Tables — Trends in Employer Health Insurance Costs, 2014–2023: Coverage Is More Expensive for Workers in Small Businesses
[18] Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022 | U.S. GAO

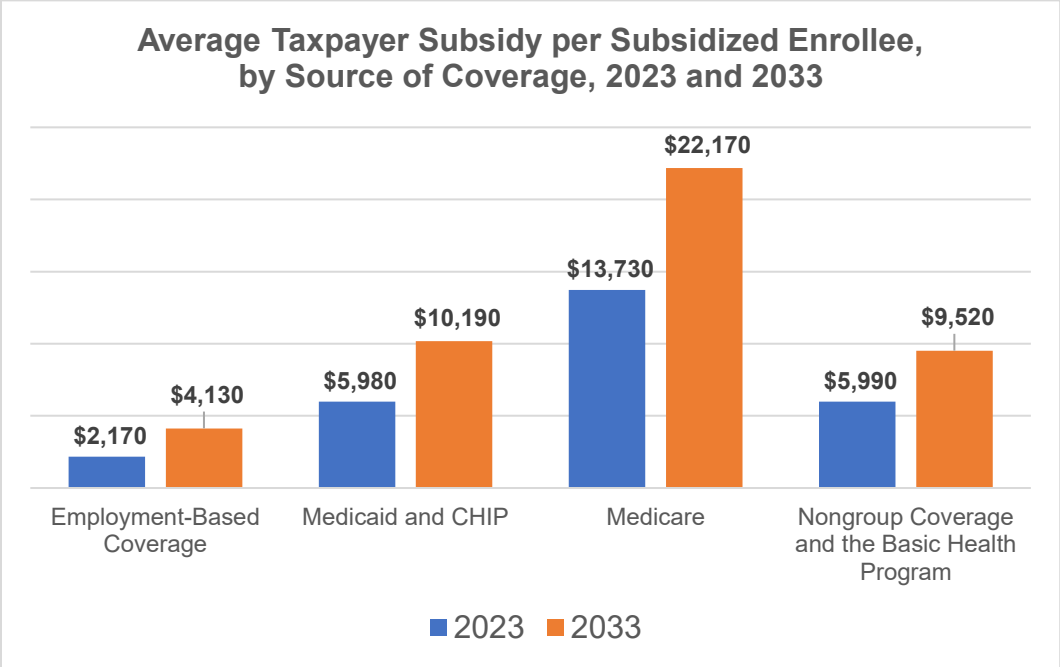
2018	13.8	6,414	17,520	52%	5
2019	13.2	6,790	18,251	51%	6
2020	12.6	7,028	18,981	51%	5
2021	12.1	7,274	19,740	50%	6
2022	11.6	7,529	20,530	50%	6
2023	11.0	7,974	21,351	49%	6
2024*	10.6	8,373	22,419	49%	6
2025*	10.2	8,875	23,764	48%	6
2026*	9.8	9,452	25,309	48%	6

*Projections. Sources: GAO "Markets Remain Concentrated," 2022; Commonwealth Fund, "Trends in Employer Health Insurance Costs", 2024; MEPS-IC data and author's calculations.

These trends together demonstrate a market under structural strain. Small employers face some of the highest premiums, the fewest choices, and some of the lowest offer rates in the health insurance system – problems created or caused by federal policies.

Enhanced Subsidies Will Further Drive Small Employers to Drop Private Coverage

CBO estimates that permanently expanding EPTCs would cause 3.7 million people in the group market, most from small businesses, to lose coverage.[19] Mom and pops simply cannot compete with rich taxpayer funded insurance companies. This encourages more people to move from better, employer coverage into ACA's marketplaces or Medicaid where deductibles are more (ACA), access to care is worse (ACA and Medicaid), and taxpayer subsidies are three times more expensive to taxpayers. Subsidizing inferior coverage at much higher cost is not the answer.



Source: CBO, Federal Subsidies for Health Insurance[20]

[19] CBO "Memo to Interested Hill Staff" accessed at Ways and Means Democrat Website November 4, 2025: cbo-aca-coverage-loss-estimates.pdf

[20] Federal Subsidies for Health Insurance: 2023 to 2033 | Congressional Budget Office

Making Health Care Affordable Again

Empower Consumers, not Big Companies

Premium subsidies under the Affordable Care Act are intended to help people afford coverage, yet for most enrollees, the structure of these subsidies provides little real value at the point of care. Most ACA exchange enrollees never meet their deductibles, meaning they pay premiums each month but receive little or no financial protection until they incur very high medical expenses. Today, federal subsidies—hundreds of dollars per month per enrollee—flow directly to large insurers. But for most people who never reach their deductible, these subsidies do not translate into even a single dollar of actual medical care.

At the same time, the financial gains from the current system are not accruing to patients. Insurer stock prices have risen dramatically since the ACA took effect, far outpacing wage growth for American workers. This highlights a fundamental flaw: funneling ever-larger federal subsidies into a consolidated insurance market rewards high costs, rather than encouraging affordability or value. Simply increasing subsidies to large insurers does not solve the health-care affordability crisis. It reinforces incentives to raise premiums, expand deductibles, and increase the underlying prices of care.

1. Subsidy Portability: A different approach would give consumers far more value. Subsidy portability would allow individuals to use the same federal dollars to purchase the coverage or care arrangement that best meets their needs—whether it is first-dollar coverage, direct primary care, a lower-deductible plan, or a combination of services purchased at transparent cash prices. Instead of sending $7,500 a year to an insurer with little return, consumers could use those dollars directly to pay for coverage and real care. Subsidies should be deposited into an HSA the patient owns and controls. Dollars could be used for premiums on any medical plan approved for sale in a state market that meets a defined actuarial value level.

2. Empower More Consumers Through HSAs: Considering Silver plans have deductibles that are three times the HSA minimum and almost twice as high as the HSA average, Congress should build off the reforms included in H.R. 1 by allowing all Silver plans to be deemed HSA eligible. This would open up subsidy portability quickly to an additional 13 million Americans on Silver plans.

3. Speed Up State Waivers: Congress should amend Section 1332 waivers to allow states to quickly implement market rules that facilitate uptake of consumer-controlled accounts.

Subsidy portability would shift power away from insurers and toward patients. By letting individuals control the federal dollars allocated on their behalf, Congress can spur real competition, reduce costs, and ensure that taxpayer subsidies purchase meaningful access to care. This reform would empower consumers and bring transparency, choice, and value back into a system increasingly defined by rising prices and diminishing affordability.

Expand Small Business Coverage

According to the NFIB, 93 percent of small businesses offer group health coverage, which is subject to all individual market mandates, but 98 percent are concerned about whether they will

be able to continue offering coverage in the next few years. The two biggest barriers cited by mom and pops are cost and lack of choices.

Congress should address these barriers to get better coverage for the 12 million exchange enrollees employed by small businesses: 1) provide help to offset plan costs, and 2) expand new options for coverage.

1. Small Business Coverage Credit: The law also created a small-business tax credit intended to help with rising costs, but it was so narrowly structured and administratively complex that only about 7,000 businesses nationwide ever used it. In effect, small employers absorbed all the mandates but received none of the assistance policymakers envisioned. The result is a small-group market that is less competitive, more heavily regulated, and increasingly unaffordable for the very businesses that anchor local economies and provide coverage for millions of workers. Senator Rick Scott recently introduced S. 3264, the More Affordable Care Act[21] that includes a small business coverage credit that would help small businesses offer better coverage to their employees.

2. Association Health Plans: Many Americans understand the value of a Sam's Club, BJ's, or Costco membership. It gets them more options and lowers costs by leveraging collective purchasing power. CBO has indicated allowing small businesses to similarly join forces would lower premiums by up to 30 percent and expand coverage to 750,000.[22] Senator Rand Paul has championed legislation (S.1847) in this area, and CAHC urges the Committee to quickly pass it. [23]

3. Self-Insurance Arrangements: The Self Insurance Protection Act (H.R. 2571[24]) would clarify ERISA to ensure small businesses can continue to use these lower cost arrangements.

4. CHOICE Act: Codifying and expanding ICHRAs would provide certainty to small businesses that these arrangements are a viable vehicle to support employee health choices. Congress should pass the CHOICE Act (S. 2875) introduced by Senator Tim Sheehy. [25]

5. Gig Worker HSAs: Finally, many self-employed individuals are businesses that contract with employers in construction, software development, and other gig work. Their biggest concern is health care security. Many buy coverage through an HSA. stability in buying health coverage. Creating new Gig Worker HSAs would allow firms to provide financial support to 17 million contracted employees through new Gig Worker HSAs.[26]

Expand Competition

Long term, coverage will not be affordable until we address the underlying cost of medical care, which drives both premiums and out-of-pocket spending. After the Affordable Care Act, provider

[21] Sen. Rick Scott Introduces Bill to Fix Obamacare and Drive Down Health Care Cost...
[22] How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans
[23] S.1847 - 119th Congress (2025-2026): Association Health Plans Act | Congress.gov | Library of Congress
[24] Text - H.R.2571 - 119th Congress (2025-2026): Self-Insurance Protection Act | Congress.gov | Library of Congress
[25] S.2875 - 119th Congress (2025-2026): CHOICE Act | Congress.gov | Library of Congress
[26] Reforming HSAs To Expand Gig Workers' Access To Affordable Health Care | Health Affairs

markets became the most concentrated in U.S. history. By 2010, 80 percent of hospital metro areas were already highly concentrated[27]; today, 97 percent of inpatient hospital markets are uncompetitive.[28] This consolidation increased hospital prices by 15 to 30 percent, directly raising medical spending. These higher medical costs are the primary driver of premium growth, accounting for about 75 percent of the 26 percent premium increase expected for exchange plans next year.[29]

Multiple ACA-era policies accelerated consolidation, including complex payment reforms, explosive growth in 340B entities, and the medical loss ratio rule, which pushes insurers to acquire PBMs, pharmacies, and physician practices to shift profits into less regulated lines of business.

Congress should advance the Healthy Competition for Better Care Act, introduced by Congressman Jodey Arrington.[30] The bill increases transparency, curbs anti-competitive contracting and steering practices, and allows group health plans and insurers to form value-based arrangements with providers that guide patients to higher-quality, lower-cost care. CBO estimates the bill would reduce premiums and save $4.9 billion over ten years by fostering more competitive health care markets.[31]

Conclusion

Additional subsidies will not fix underlying structural and cost problems in health care. CBO estimates permanent expansion of EPTCs would cost $400 billion and cause 3.7 million Americans to lose better, lower deductible private coverage, mostly from small businesses.[32] Instead of pumping more money into an expensive system, Congress should take steps to empower consumers, small businesses, and lower medical costs so, so coverage is more affordable for all Americans.

[27] Bates White Economic Consulting, Market Concentration of Hospitals, June 2011: Microsoft PowerPoint - Market concentration of hospitals (June 2011).pptx

[28] One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022 | KFF

[29] How much and why ACA Marketplace premiums are going up in 2026 - Peterson-KFF Health System Tracker

[30] Arrington Fights to Lower Health Care Costs, Increase Transparency | U.S. Representative Jodey Arrington

[31] H.R. 3120, Healthy Competition for Better Care Act | Congressional Budget Office

[32] CBO "Memo to Interested Hill Staff" accessed at Ways and Means Democrat Website November 4, 2025: cbo-aca-coverage-loss-estimates.pdf