COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of Joel C. White
President, Council for Affordable Health Coverage (CAHC)
to the House Budget Committee

"Rising Health Care Costs and the Federal Budget"

January 21, 2026

Introduction

Chairman Arrington, Ranking Member Boyle, and Members of the Committee, thank you for the opportunity to testify on how skyrocketing health costs are affecting America's fiscal future and affordability for consumers and patients. My name is Joel White, and I am President of the Council for Affordable Health Coverage, a broad alliance supporting pro-market, pro-consumer, and pro-innovation policies to expand access to affordable health coverage.

Prior to my current role, I served as Staff Director for the Ways and Means Health Subcommittee, where I worked on major health policy initiatives including the creation of the Medicare Part D program and Health Savings Accounts. Over twelve years as staff in the House of Representatives, I worked on four budget reconciliation bills, all of which addressed federal health programs, and I have published research in peer-reviewed journals examining health care costs and reform options.

My testimony makes three key points.

1. Health care costs are too high and rising too fast for typical Americans to afford their coverage and care.

2. Recently enacted laws have worsened market conditions, increased costs, and caused many to lose their coverage, sending them into government run health programs where their costs are greater, or access to care is worse.

3. Congress should use the budget reconciliation process to correct these problems and make health coverage affordable again.

Across the country, families are frustrated with a health care system that costs more each year while delivering less in return, as rising health expenses consume a growing share of household budgets. Over decades, Congress has layered reform upon reform, embedding incentives in law that distort health care markets – micromanaging payment systems, restricting plan options, and expanding taxpayer-funded subsidies. The result is more government, higher premiums, and out-of-pocket costs, along with unsustainable growth in federal health spending.

These policies increasingly place large institutions – health insurers and big health systems – at the center, rather than patients. Whether impacting public programs like Medicare and Medicaid, or the employer provided commercial insurance, they have fueled medical inflation instead of containing it. Worse, these laws created incentives for employers to drop coverage, pushing more people into government-run programs where costs are often higher, and access to care is often worse, but taxpayer subsidies are much more. We pay more and patients get less.

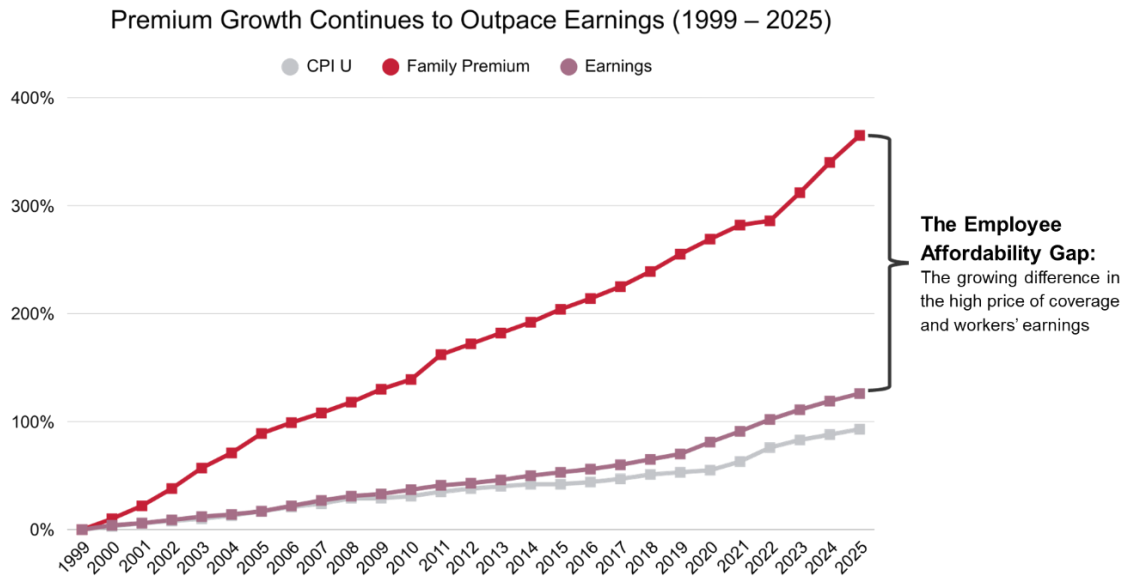
President Trump's *Great Healthcare Plan*[1] and the Republican Study Committee Budget[2] recognize the need to rebalance the health care system away from entrenched interests and toward patients. Congress should build on these frameworks by:

1. Strengthening Commercial Markets, especially for small businesses
2. Reforming the Affordable Care Act and the Inflation Reduction Act; and
3. Enacting policies that lower the cost of health care services and prescription drugs.

Each solution differs by market and the laws governing them, but advancing pro-market, pro-consumer, and pro-innovation reforms that strengthen competition will restore affordability to all Americans and ensure the viability of public programs.

Background – the Core Problem

Today, our health care system is seriously off track, and the central problem is affordability. Health care costs continue to grow faster than wages and inflation, placing increasing pressure on families, employers, and taxpayers. If current trends continue, we project that the typical American family could spend nearly 40 percent of household income on health insurance premiums by 2032.[3]



The trend will continue into 2026, as SHRM found that organizations are projecting a 10 percent hike in health care costs in 2026. According to Mercer, health benefit costs for 2026 may be the

[1] The Great Healthcare Plan – The White House
[2] Making the American Dream Affordable Again: RSC Officially Unveils Reconciliation 2.0 Framework | Republican Study Committee
[3] CAHC calculations based on BLS wage data, KFF survey data

biggest in 15 years, mostly due to consolidated markets, higher prices, and increased utilization.[4]

Why Spending Increases

Over the last 16 years – especially after the ACA (2010) and so-called Inflation Reduction Act (IRA - 2022) – federal policy increased mandates on health plans, restricted consumer choice, and increased regulatory requirements, complexity, and compliance costs. Both laws layered extensive new regulatory and administrative requirements onto insurers, hospitals, and clinicians, which encouraged consolidation and market power over competition based on price and quality. For example:

- The ACA established guaranteed issue and renewal, essential health benefit standards, medical loss ratio compliance, risk adjustment, reinsurance, and extensive federal and state reporting requirements, while simultaneously expanding quality reporting, value-based purchasing, and electronic health record documentation mandates across Medicare and Medicaid.

- Insurers must maintain complex actuarial, utilization management, and compliance infrastructures to meet ACA market rules and parity enforcement, and providers must comply with multiple, overlapping billing, coverage, and reporting standards across ACA marketplaces, Medicare, Medicaid, and employer plans.

- The Inflation Reduction Act added further regulatory obligations, including drug price controls, inflation rebate calculations, benefit redesign, and new reporting and compliance requirements for Medicare Part D and Part B, which require insurers, pharmacy benefit managers, manufacturers, and CMS contractors to develop new data systems, auditing processes, and regulatory interfaces. The primary driver of reduced competition, however, is the increased risk on Medicare plans for high-cost drugs (60 percent of costs above the $2,100 attachment point).

- Policy changes like Accountable Care Organizations and Medical Loss Ratio requirements reward large systems. 340B reduces input costs for favored entities versus their competitors, creating unlevel playing fields.

These layered regulatory and compliance requirements create strong incentives to use economies of scale, as larger insurers, hospital systems, and vertically integrated organizations can spread fixed administrative and reporting costs across a broader revenue base. Smaller plans, physician practices, and community hospitals face proportionally higher compliance costs, encouraging consolidation as a rational response to regulatory complexity rather than improved efficiency or quality. To remain profitable amid compliance and payment pressure,

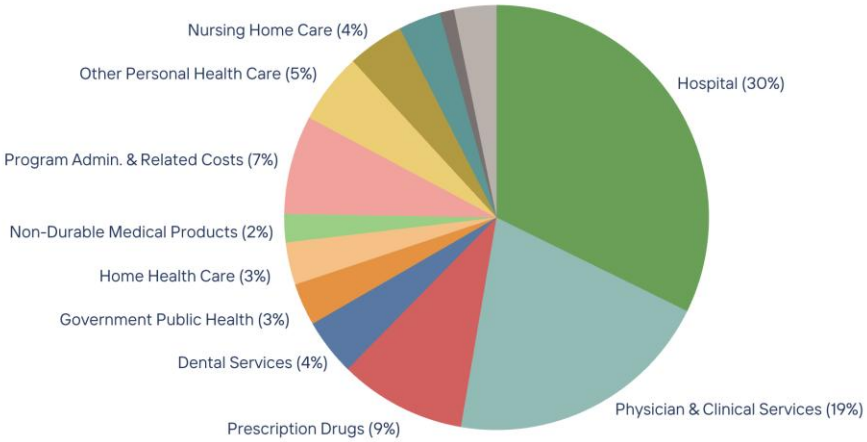
[4] Employers are bracing for the highest health benefit cost increase in 15 years, a projected 6.5% increase in 2026, according to Mercer

insurers, hospitals, and physicians have pursued scale through consolidation strategies that have increased market power.

As regulatory complexity encourages consolidation, increased market power allows dominant insurers and health systems to raise prices and reimbursement rates without corresponding improvements in quality or outcomes. A substantial body of empirical research shows that hospital and insurer consolidation is consistently associated with higher prices for commercial coverage and higher spending in public programs, while measures of quality, patient outcomes, and efficiency generally remain flat or improve only marginally.[5,6,7,8,9] In concentrated markets, competitive pressures that normally discipline prices and reward quality are weakened, reducing incentives for innovation and cost control and leaving employers, patients, and taxpayers to absorb higher costs without demonstrable gains in care value.

Finally, Congress enacted benefit mandates that lower out of pocket costs and reduces price sensitivity, which increases utilization. Higher prices and increased utilization drive higher spending. In the end, the results are bloated market actors and mega-companies providing less choice and higher prices for those purchasing health care – employers, patients, and taxpayers.

Rising Medical Costs: Since 2013, the primary driver of rising premiums has been the steady growth of spending on hospital and physician services. CMS data show that hospitals and clinical providers account for half of all national health spending and a substantial majority of what insurers pay out in medical claims.



[5] Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare and the Health Care Delivery System. Multiple years; see chapters on provider consolidation and market power.
[6] Gaynor, M., Ho, K., & Town, R. "The Industrial Organization of Health Care Markets." Journal of Economic Literature 2015.
[7] Gaynor, M., et al. "What We Know About Competition and Prices in Health Care Markets." 2006.
[8] U.S. Government Accountability Office (GAO). "Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation". GAO-25-107450, 2025.
[9] Cooper, Z., Craig, S., Gaynor, M., & Van Reenen, J. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." Quarterly Journal of Economics 2019.

- Hospital spending has surged since 2013, reaching $1.7 trillion in 2024 with double-digit growth driven by consolidation, high prices, and increased service intensity.

- Physician spending reached $1.1 trillion in 2024, reflecting the continued shift of care into higher-cost, hospital-owned settings. [10]

- Prescription drugs remain a relatively small cost driver—less than 10 percent of total health spending—and are projected to stay at that level over the next decade. Importantly, drugs help people get and stay healthy and may preclude the need to physician intervention or hospital stays. Finally, prescription drugs typically go generic over time, the few areas of health care with a built-in, cost reduction feature.[11]

Absent reforms from Congress, premiums will continue to rise because the dominant cost pressures come from hospitals, outpatient departments, and physician services.

Utilization: Right now, the main driver of spending growth is greater volume (number of physician visits or hospitalizations) and intensity of care (high versus low-cost drugs, inpatient, or outpatient setting, etc.), not prices. CMS estimates this at 4.7 percent of the 7.2 percent increase.

Prices: Number of visits times the price generally equals the cost. In 2024, prices largely mirrored economy-wide inflation (2.5 percent), and prices for retail drugs (net of rebates) increased slower than inflation. Importantly, the Affordable Care Act systemically built higher prices into markets through policies like the MLR, 340B expansion, and regulatory complexity that will likely rebound in 2026 and into the future as prices regain their primary place as the driver of health costs.

- By 2010, 80% of hospital metro areas were already highly concentrated.[12]

- Today, 97 percent of inpatient hospital markets are highly uncompetitive.[13]

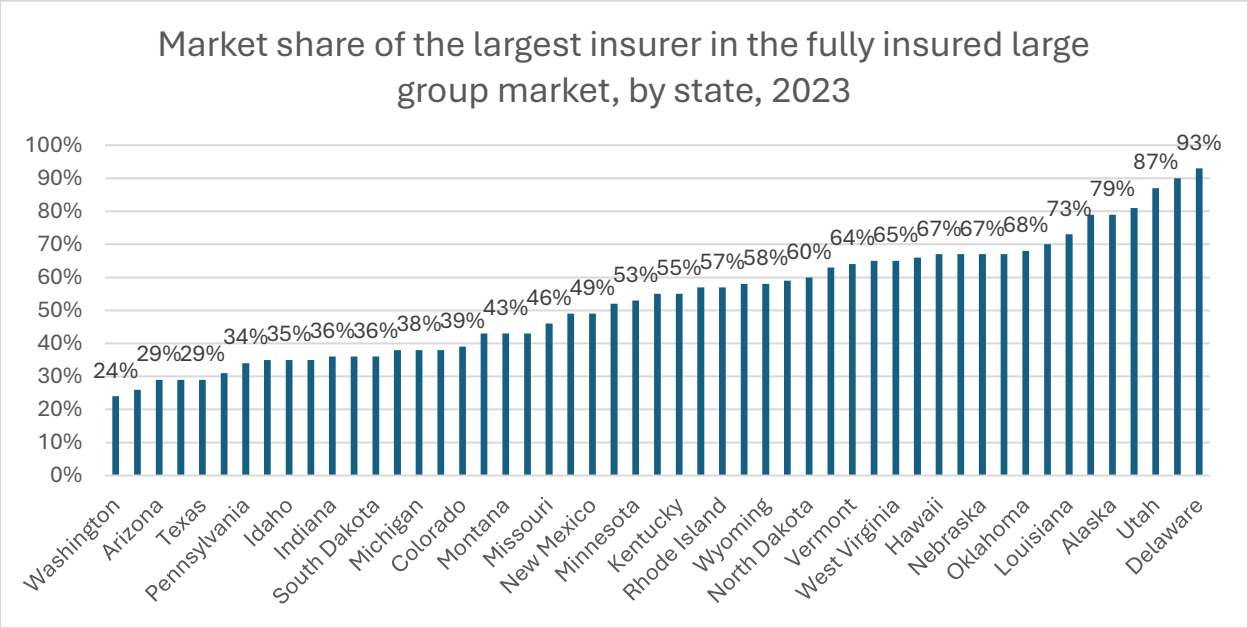
- Moreover, between 2013 and 2021, the percentage of physician practices that were hospital-owned rose from 15 to 53 percent, and the percentage of physicians employed by a hospital rose from 27 to 52 percent.

Hospital mergers increase commercial prices 5–20% on average, sometimes greater than 30%, with no significant improvements in mortality, patient experience, or readmission rates on

[10] National Health Expenditure Projections 2024-2033 Forecast Summary
[11] Ibid
[12] Bates White Economic Consulting, Market Concentration of Hospitals, June 2011: Microsoft PowerPoint - Market concentration of hospitals (June 2011).pptx
[13] One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022 | KFF

average.[14,15] "Site-of-service" billing adds $75–$100 per outpatient visit when a physician office becomes hospital-owned.[16] Facility fees for (non-facility) physician office visits needlessly increase costs for patients.

Insurance Markets: Insurers have vertically integrated their offerings, owning PBMs, pharmacies, and even physicians and clinics. Today, commercial, ACA and Medicare plan markets are highly concentrated and uncompetitive (see charet below).[17] Even before the ACA, one or two carriers dominated most state individual markets. While ACA marketplace participation has increased since 2020, many county-level markets remain highly concentrated, with two insurers holding more than 70 percent of enrollment.



Similar trends are happening in Part D and Medicare Advantage. While enrollment and plan offerings have expanded, local insurance markets remain highly concentrated. In 2024, 97 percent of counties were highly or very highly concentrated, and roughly 93 percent of beneficiaries were enrolled in those markets. The appearance of choice has not produced meaningful competition at the local level.[18]

Disempowered consumers are a central feature of today's health care system. Most consumers lack usable information on prices and quality and have limited resources to actively choose plans or care. Federal subsidies flow primarily to large insurers and health systems rather than directly to consumers, while federal law tightly prescribes which plans may be offered. Benefit mandates increase plan costs, and subsidy rules often steer consumers toward the most expensive benchmark plans, even when lower-cost options are available.

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[14] Mergers When Prices Are Negotiated: Evidence from the Hospital Industry - American Economic Association

[15] Impact of Hospital Consolidation on Outcomes, Quality, and Access - Penn LDI

[16] MedPAC September 4, 2025 Presentation: Tab-E-Context-Sept-2025-SEC.pdf

[17] Recent trends in commercial health insurance market concentration - Peterson-KFF Health System Tracker

[18] Most Medicare Advantage Markets are Dominated by One or Two Insurers | KFF

Demographic challenges: Part of the challenge of current programs is they are tilted to the elderly. As America ages, costs will increase such that within 30 years, spending for Social Security, Medicare, and Medicaid for people age 65 or older will make up more than 50 percent of all noninterest spending.

Sick Care: The U.S. health care system is largely designed to treat illness after it occurs rather than prevent disease before it begins. A small share of patients accounts for a disproportionate share of spending – roughly one percent of individuals drives a large share of total health care costs – reflecting the high burden of chronic disease. The Make America Healthy Again movement underscores a growing recognition that improving affordability and outcomes requires a greater emphasis on prevention and wellness, including addressing root causes of chronic illness such as nutrition, physical activity, social connection, and environmental factors.

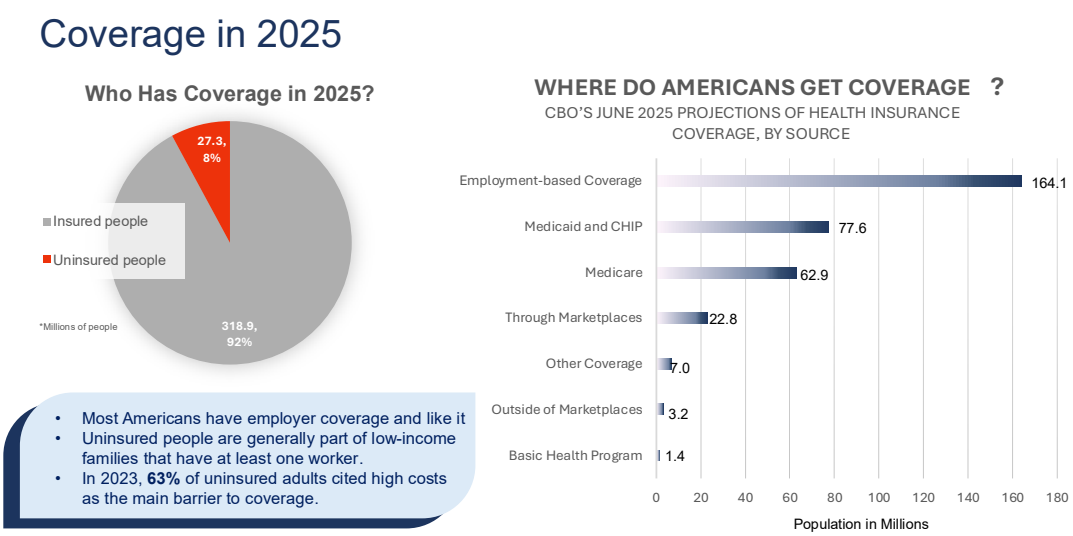
Solutions: Strengthen Private Coverage – Addressing the Affordability Gap

Congress should make the following reforms to restore better coverage at lower costs to taxpayers and workers:

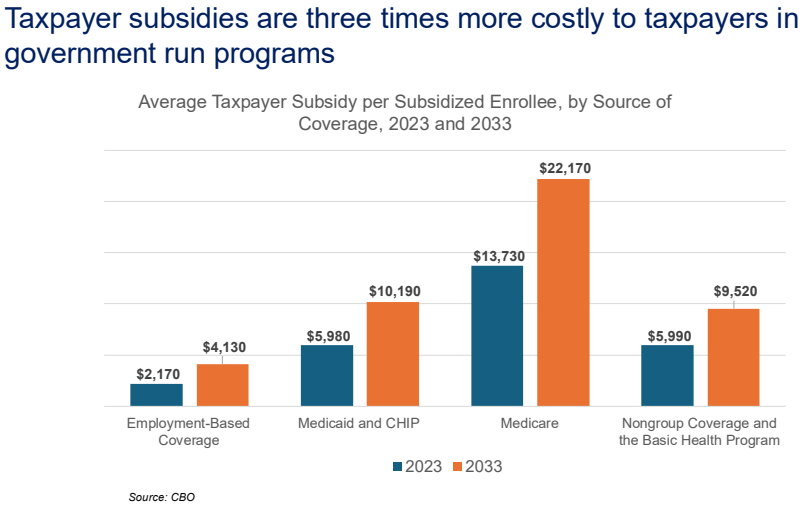
- Expand HSAs to Patients in All Plans
- Codify and Expand ICHRAs with a tax incentive
- Restore the Small Business Tax Credit
- Enact the Healthy Competition for Better Care Act
- Expand Wellness Incentives
- Create Gig Worker HSAs
- Repeal Biden Administration ACA “Family Glitch” Rule

Although it is often masked in today’s health care debate by discussions around Obamacare, employer provided coverage is by far the largest source of health insurance for Americans, exceeding coverage through ACA’s marketplaces, Medicare, and Medicaid combined. For example, just 7 percent of Americans get coverage through ACA marketplaces, but more than 181 million get coverage through work.[19]

[19] Health Insurance Coverage in the United States: 2024



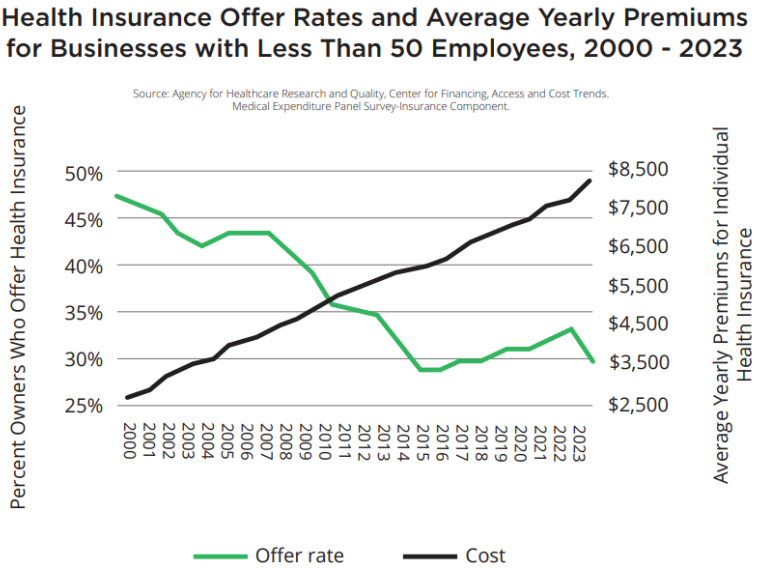
Most large firms offer coverage to their employees. Congress created ERISA to give employers regulatory flexibility to provide high quality, lower cost benefits to their workers. For example, employer deductibles are half as expensive than the most popular ACA plan. The employer tax exclusion creates powerful financial incentives to provide benefits, but at much lower "cost" to taxpayers than government subsidies. The table below shows the "cost" of allowing employers to keep and use their tax-free money compared to government subsidies.



Keeping consumers in private plans is thus better for the country's long term fiscal health, and better for patients and consumers.

And while small business accounts for more than 60 percent of new jobs, the smaller the company, the less likely they are to offer health insurance. A full 97 percent of firms with more than 200 employees provide coverage for their workers. But for those companies with less than

50 employees, the offer rate is just 31 percent, which represents a significant decline since the enactment of Obamacare.[20]



More than half (55%) of small business leaders cite high costs of health insurance as a barrier to offering health coverage. And 98 percent fear they will not be able to afford their coverage within five years. Small businesses are also challenged to find relevant health care benefit packages. According to a survey from the Small Business Entrepreneurship Council, only 1 in 5 (17%) small business leaders strongly agree that the employer health care solutions available to them have kept up with changing market conditions.

Over the past 16 years, Congress has enacted several laws that make it more difficult for employers to offer coverage, and that create incentives for people to leave employer coverage and join government programs. For example:

- Biden rules on the “Family Glitch” – 1 million
- American Rescue Plan – 100,000 loss
- Inflation Reduction Act – 2.8 million loss
- Permanent extension of EPTCs – 3.7 million loss
- Three-year extension of EPTCs – 2.1 million loss
- Lowering Medicare Age to 60 – 3.2 million loss
- Public Option – 6 people lose coverage for every 10 who sign up
- Single Payer – 180 million

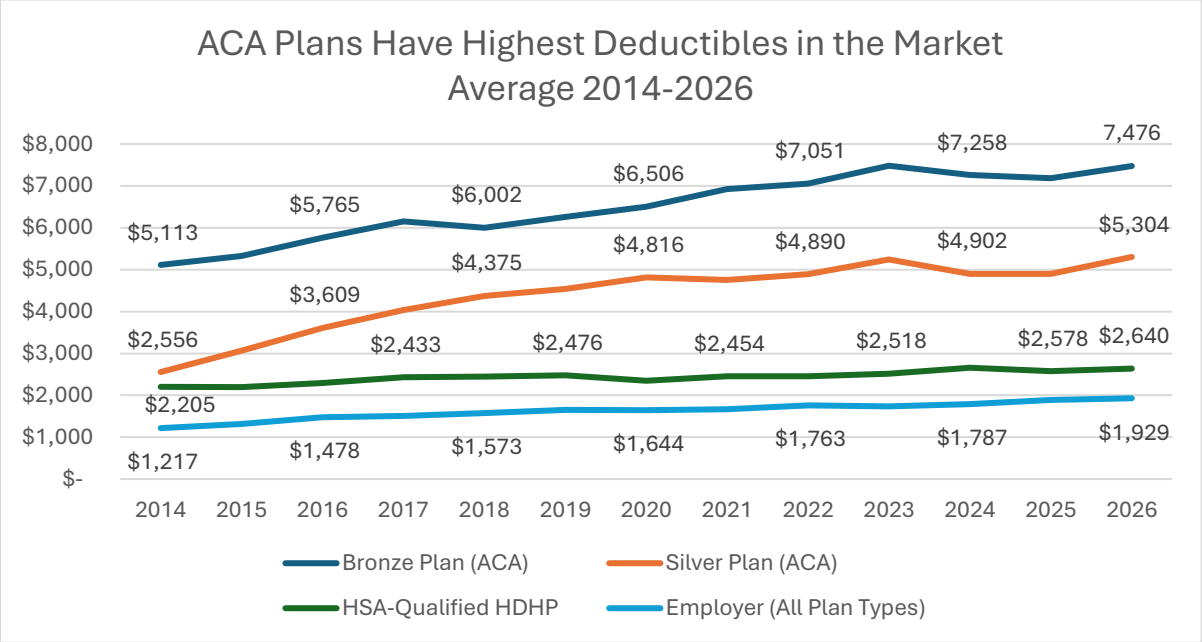
Chief among these is the Affordable Care Act, where employers have faced steadily rising costs and shrinking coverage options. The ACA applied the full set of individual-market regulations to small-group plans—even though small employers sponsor and purchase coverage very differently than individual consumers. These rules narrowed the types of plans small businesses

[20] Health-Care-Coverage-Policy-Paper-07.pdf and CAHC calculations based on MEPS data.

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.[21]

The table below shows that had those 12 million people stayed in their small business plan, their out-of-pocket costs would be $3,000 less per year.



Small businesses got all of the mandates that increased costs, but none of the benefits of premium reduction subsidies. Congress created a tax credit for small businesses to offset these costs, but the credit was structured so poorly, just 7,000 firms (out of 30 million) took the tax incentive in 2016, the last year data from the IRS is available. As Congress increased their costs and limited their choices, the authors of the ACA created powerful incentives for small businesses to drop coverage.

In addition, small firms do not have large pools of employees to spread risk across broad populations or to reduce the administrative costs associated with offering coverage. One sick person at a small business can blow a hole in profits and potentially sink the enterprise.

[21] About Half of Adults with ACA Marketplace Coverage are Small Business Owners, Employees, or Self-Employed | KFF

Congress should make the following reforms to restore better coverage at lower costs to taxpayers and workers:

- Expand HSAs to All Employer Plans: Delink HSAs from minimum deductible requirement to expand to all commercial insured. Since their creation in 2003, about 67 million Americans now use their Health Savings Accounts to better afford care. The average employer deductible is now greater than the minimum HSA deductible requirement, but employers cannot link an HSA to their plan because maximum out of pocket restrictions and first dollar coverage of some items disqualifies the plan for HSA purposes. To maximize flexibility for workers, Congress should allow HSAs to be paired with major medical insurance plans that meet basic coverage (an actuarial value).

- Codify and Expand ICHRAs With a Tax Incentive: ICHRAs are a powerful new tool for small businesses, but employers are uncertain if they will continue because they are a regulatory construct. Congress should codify ICHRAs to provide that certainty. Under this approach, employers would offer defined, pre-tax contributions to employees who would then use those funds to purchase individual health insurance coverage of their choosing, either on or off the ACA marketplaces. This would increase flexibility for employers. To make individual coverage more affordable, the CHOICE Act would also establish a refundable, age-adjusted tax credit available to individuals and families who do not receive employer-sponsored insurance. The credit would be available regardless of income level and could be used to offset premiums for qualifying individual market plans. Unlike ACA subsidies, the credit was designed as a fixed contribution, providing budget certainty and encouraging price competition among insurers.

- Small Business Tax Credit: The ACA provided tax credits for both the individual market and the small employer market. Unfortunately, the restrictions for the small employer tax credit made it difficult to claim. To qualify only small businesses with 25 full-time equivalent (FTE) employees or less were eligible. In most markets, small group is defined as 50 or fewer employees. The ACA credit was also only available to employers who capped wages at $56,000 per year or less, creating powerful disincentives to grow. The tax credit also only applied for two years, even though employers incur benefit costs annually. Finally, the credit was only offered for Obamacare plans. Employers could often get better deals off exchange even if a state made SHOP coverage available. Congress should offer small employers an incentive for continuing to offer coverage to their employees. The tax credit could be designed to encourage the fully insured small employer market or via an Association Health Plan and should include all plans available in the small employer health insurance market, not just ACA plans. If small businesses were able to offer coverage, consumers would enjoy lower deductibles and more access to care, while taxpayers would pay less than the current ACA subsidy.

- Healthy Competition for Better Care Act (Rep. Arrington / H.R. 6248[22]): Addresses market consolidation by eliminating anti-competitive contract terms in provider and insurance agreements while promoting access to higher-value healthcare providers. While CBO estimates this would save $5 billion, CAHC believes the effect would be far more dynamic.

- Wellness and Prevention: Congress should expand the HSA preventive care safe harbor to include wellness benefits (such as healthy eating, fitness, mental health, etc.) and allow preventive and wellness benefits regardless of any deductible requirements.

- Gig Workers: Approximately 59 million Americans currently participate in the gig economy but are not considered full-time employees and are therefore ineligible for employer health benefits. Many obtain coverage through exchange plans, sometimes with an HSA. If an employer contributes to a gig worker's HSA, it could trigger a reclassification of the gig worker to an employee under labor and tax laws. To avoid this, companies simply do not offer HSA contributions to gig workers. Congress should clarify businesses can contribute to gig workers' HSAs without affecting their contractor status, helping both workers and businesses.[23]

- Repeal Biden Administration ACA "Family Glitch" Rule: The ACA is very clear that individuals with affordable employer coverage are not eligible to receive Obamacare subsidies for ACA plans. The affordability standard in Obamacare specifically applied only to individuals and not to the cost of family coverage overall. In October 2022, the Biden Administration created a new affordability standard for both employees and their dependents, running afoul of the text and Congressional intent of the law, resulting in one million people leaving employer coverage and onto ACA plans.

Reform the Affordable Care Act

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. Congress should:

- Give Subsidies to Consumers
- Let Consumers Choose a Plan That Works Best for Them
- Expand Different Types of Plans
- Make it Easy for States to Set Up Risk Pools
- Deem Silver Plans HSA Eligible
- Fund CSRs and End Silver Loading
- Reform or Repeal the Medical Loss Ratio Rule

[22] H.R.6248 - 119th Congress (2025-2026): Healthy Competition for Better Care Act | Congress.gov | Library of Congress

[23] Reforming HSAs To Expand Gig Workers' Access To Affordable Health Care | Health Affairs

- Enact a Cap on Subsidies

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.[24] CBO's latest estimate is that ACA coverage costs will total $1.3 trillion over 10 years, while insuring about 20 million annually.[25] 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 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.[26] 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.

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.

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

[24] 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
[25] 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
[26] What is the average cost of short-term health insurance?

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.

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 remarkably 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 inflated 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.

Congress should not extend COVID era bonus subsidies. CBO estimates that permanently expanding EPTCs would cause 3.7 million people in the group market, most from small businesses, to lose coverage.[27] 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.

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.

Congress should pursue the following reforms:

- Subsidy Portability: Instead of subsidizing insurance companies, Congress should pursue a different approach to give consumers far more value. Consumers should be

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

allowed to directly receive the subsidy and purchase any plan on the market. If the plan premium is less than the subsidy, Congress should allow consumers to keep most of it in an HSA. This would be more expansive than the Crapo-Cassidy approach that only provided help to people who bought down to a lower tier Bronze plan. It creates powerful market dynamics to lower premiums and compete for consumer business. 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. Dollars could be used for premiums on any medical plan approved for sale in a state market that meets a defined actuarial value level.

- Expand HSAs to Silver Plans: As a result of the One Big Beautiful Bill, Bronze and Catastrophic plans are now deemed HSA qualified.[28] 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.[29] Congress should expand this policy to Silver Plans, whose average deductibles are $2,600 more per year than the HSA average.

- Fund Cost Sharing Reduction Subsidies: Spending on CSRs was considered discretionary and was not appropriated by Congress. This was a problem with how the law was originally written. The Obama Administration employed a workaround by using the premium tax credit financing mechanism – in Title 31 of the *U.S. Code*.[30] In a court case, the US District Court in DC agreed the Title 31 mechanism was illegal and enjoined any future funding until Congress provided an appropriation. CSR reimbursements were subsequently terminated in October 2017. For the 2018 plan year, many state regulators allowed insurers to file plans with "silver loading" which allowed insurers to recapture CSR costs on Silver plans only, and in many cases allowed insurers to offer non-loaded silver plans off exchange. The result was a significant increase in Silver plan premiums, which led to higher costs for 2nd least cost Silver plans. Since premium subsidies are based on the second least cost silver plan, this substantially increased taxpayer funded premium subsidies. Funding CSRs and preventing Silver Loading lowers premiums by 11 percent and reduces the deficit by $36 billion.

- Create a High-Risk Pool (Condition-Based Reinsurance): Once the ACA's guaranteed-issue rules took effect in 2014, states lost the ability to distinguish between standard-risk and high-risk applicants. This helped many people with health needs but also

[28] Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access – The White House
[29] Plan Year 2026 Marketplace Plans and Prices Fact Sheet | CMS
[30] 31 USC 1324: Refund of internal revenue collections

contributed to exceedingly high premiums and deductibles for the unsubsidized middle class. Congress anticipated this challenge by creating Section 1332 State Innovation Waivers, allowing states to experiment with approaches that preserve ACA protections while improving market performance. Seventeen states have used this authority to implement reinsurance programs—effectively modern, invisible high-risk pools that sit behind the market and absorb a share of high-cost claims. Reinsurance reimburses insurers when costs exceed a threshold or for designated high-cost conditions. This reduces the average cost of coverage in the entire market. The results have been significant and measurable. In 2023, CMS found that statewide average second lowest-cost silver plan premiums were:

- 4 to 41 percent lower in reinsurance-waiver states than they would have been without the waiver.
- With a weighted average reduction of 15.22 percent across all states operating these programs
- States like Alaska, Maryland, Minnesota, Colorado, Georgia, and Virginia have seen reductions near or above 20 percent.

The takeaway is that 1332 reinsurance programs are delivering year-over-year premium reductions in ACA markets without weakening protections for people with pre-existing conditions. Congress should reform the 1332 waiver process to make it easier for states to set rules in their markets that best meet their consumer needs by directing CMS to establish a high-risk pool template and fast track approval process. Congress should fund a high-risk pool reinsurance fund at $5 billion/annually conditioned on risk pools designed to lower market-wide rates by at least 10 percent.

- Reform MLR: MLR rules were intended to cap profits and administrative costs. They have turned into an excuse to consolidate and vertically integrate. Congress should repeal the MLR entirely or ban intercompany transfers for purposes of avoiding the MLR. As Gei Bai and others have suggested, Congress could direct the Administration to allow MLR relief in markets with robust competition and for small/new entrants, such as a reduction in required thresholds or a time-limited suspension. For households receiving subsidies, MLR rebates should be calculated on the self-pay portion of premiums, or a proportional share of rebates should be allocated to state reinsurance funds to lower future premiums.[31]

- Cap Subsidies to Insurers / National Benchmark Cap: The ACA limits premiums consumers pay to a percentage of income. Premium subsidies to insurers are unlimited based on the difference between what the consumer pays and the premium amount. It is an uncapped liability that encourages premium inflation. The ACA's premium subsidy structure ties subsidies to the benchmark premium without limits on total spending, it shifts premium costs onto taxpayers. Because subsidies protect enrollees from price increases, premium growth creates minimal price sensitivity among consumers, reducing

[31] The Unintended Consequences Of The ACA's Medical Loss Ratio Requirement | Health Affairs

competitive pressure to control costs. Congress should cap premium subsidies at 125 percent of the national average to create insurer cost discipline in high-cost areas.

Reform the Inflation Reduction Act

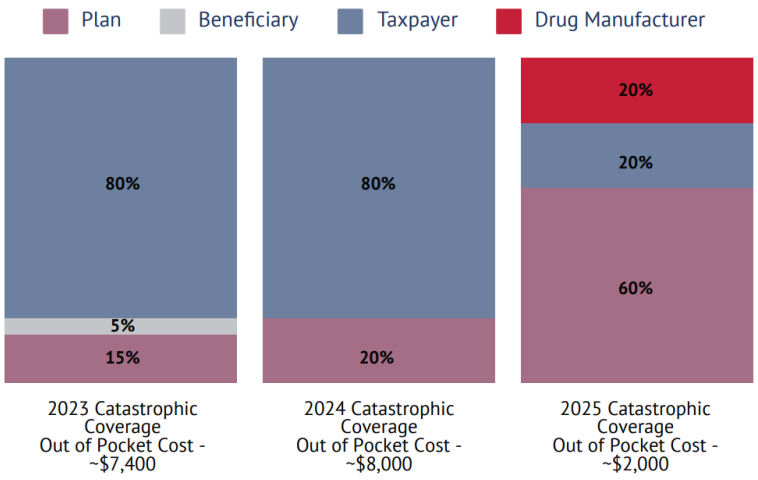
The Medicare Part D market is unstable, and marked by higher premiums, fewer plans, reduced service areas and greater out of pocket costs. Price controls do not ensure patients access lower costs at the pharmacy counter. Congress should:

- Stabilize Part D by Adjusting Catastrophic Risk
- Ensure Medicare Beneficiaries Have Access to the Drugs They Need
- Require Access to Lower Prices Through TrumpRx

Medicare Advantage and Part D were originally enacted as a competitive model that would continuously drive average costs and taxpayer exposure down year over year. Plans would negotiate costs on behalf of enrollees and plans would compete based on premium and access to care. Costs were linked to benchmarks that set taxpayer subsidies to lower cost plans. Inefficient plans would send strong price signals to beneficiaries, and cheaper, more efficient plans would gain market share, continuously reducing benchmarks.

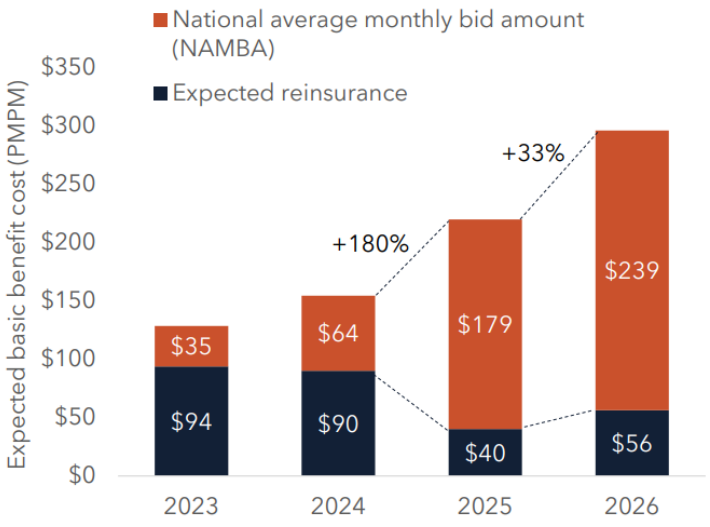
This all worked fairly well until the Inflation Reduction Act, which fundamentally restructured Medicare Part D with the stated goal of lowering out-of-pocket costs for beneficiaries. While some beneficiaries (less than 2 million) have benefited from a new $2,100 annual spending cap, the broader effect of the law has been to increase premiums, reduce plan choice, and destabilize the Part D market for all beneficiaries, with costs increasingly shifted onto consumers and taxpayers.

The primary source of market disruption is the dramatic increase in plan risk imposed by the IRA. Beginning in 2025, Part D plans are responsible for 60 percent of drug spending above the $2,000 out-of-pocket limit, up from just 20 percent prior to the law.



This represents a three-fold increase in insurer liability on a much more generous benefit, shifting risk away from taxpayers and onto plans in a way that predictably drove higher bids. In

2025 alone, this redesign resulted in a 178 percent increase in plan bids for 2025, and another 33 percent increase for 2026.[32]



Note: GLP-1s (Glucagon-Like Peptide-1). The NAMBA is the sum of the capitated direct subsidy plus the base beneficiary premium.
Source: CMS's bid announcements.

[33]

Plans are responding rationally to increased risk by raising premiums and cost sharing, tightening utilization management, expanding coinsurance tiers, and reducing geographic participation. As a result, millions of beneficiaries are expected to lose plan options – particularly in the standalone Part D market – with spillover effects in Medicare Advantage prescription drug plans. The number of standalone Part D plans has fallen to a historic low of 360 plans, representing a 50 percent reduction in choice since the IRA redesign began. In many states, beneficiaries now have access to only one premium-free benchmark plan, and most states offer three or fewer benchmark plans, sharply limiting meaningful choice.

CMS has attempted to blunt these effects through the Part D Premium Stabilization Demonstration, which will spend billions of taxpayer dollars on insurers to suppress premium increases through 2027. However, this approach treats the symptoms rather than the cause. By buying down premiums without addressing excessive plan risk, the demonstration rewards higher bids and shifts additional costs back onto taxpayers. Without structural reform, this risks locking the program into a cycle of higher costs, higher subsidies, and ongoing market instability.

The lesson from the 2026 Part D market is clear: the IRA did not reduce drug costs in a sustainable way. Instead, it reallocated costs, increased insurer risk, and destabilized plan markets. While some beneficiaries may see lower point-of-sale costs, they pay for those benefits through higher premiums, reduced access, and fewer plan choices. Taxpayers, in turn,

[32] MedPAC January 2026 meeting: Tab-K-Part-D-bids-Jan-2026.pdf
[33] MedPAC January 2026 Meeting: Tab-K-Part-D-bids-Jan-2026.pdf

face growing exposure through direct subsidies, reinsurance, and premium buy-downs that were not contemplated when the law was enacted.

- Part D Reform: Congress should restore stability to Part D and make it a truly competitive program again. Redirecting already allocated funds to mitigate risk, rather than subsidizing premiums, ensures a smarter use of taxpayer dollars and avoids perpetuating the underlying instability that prompted the need for a demonstration in the first place. By reducing catastrophic risk more equitably among plans, taxpayers, and manufacturers, reform should limit incentives for dramatic bid and premium increases and support a more competitive, sustainable market. Beneficiaries should have access to lower prices that the President voluntarily negotiated via TrumpRx, and those purchases should count against out-of-pocket obligations (described below).

Medicare Advantage

Medicare Advantage was intended to introduce competition and innovation into the program, but recent market developments underscore growing instability rather than sustainable competition. To rebalance the program, Congress should:

- Reform the Bidding Process
- Revise the STARS Program
- Encourage Supplemental Benefits Be Used for MAHA Activities

For calendar year 2026, insurers reduced plan offerings and service areas nationwide. The total number of non-SNP Medicare Advantage and MA-PD plans declined 10 percent, forcing many beneficiaries to switch plans involuntarily. PPO plans experienced the steepest contraction, particularly among $0 premium products, signaling growing difficulty in sustaining low-cost options under current payment and regulatory structures. Premiums for remaining non-zero premium MA-PD plans increased, while out-of-pocket limits rose significantly.

Beneficiary choice is also narrowing at the local level. Average plan availability declined from 42 plans per county in 2025 to 39 in 2026, with sharper reductions in certain markets. At the same time, benefit generosity is eroding. In 2026, a growing share of plans imposes the maximum Part D deductible, dental and over-the-counter benefits are being reduced or eliminated, and millions of enrollees face higher monthly premiums and out-of-pocket exposure. These changes reflect rational insurer responses to rising costs and regulatory constraints—not improved efficiency.

Policymakers have increasingly responded to these symptoms with regulatory overlays rather than structural reform. CMS's recent focus on medical loss ratio enforcement and vertical integration reflects legitimate concerns, but existing MLR rules often fail to capture transfers within vertically integrated organizations, potentially masking profit extraction while overall Medicare spending continues to rise. Market concentration and payment distortions remain largely unaddressed.

- MA Benchmarks: Congress should reform Medicare Advantage benchmarks to reflect true market pricing rather than administratively derived rates. There are multiple ways to restore market discipline and improve fiscal sustainability. Common approaches include

tightening the link between benchmarks and competitive bids, making quality bonuses budget-neutral, correcting coding and geographic distortions, and reducing reliance on administratively linked fee-for-service spending. Together, these reforms would preserve beneficiary choice and plan participation while slowing spending growth and aligning Medicare Advantage more closely with its original competitive purpose.

- STARS: Medicare Advantage quality bonuses and supplemental benefits are areas where Congress can add accountability. MedPAC has recommended replacing the current quality bonus program because Star Ratings and bonus payments are no longer well aligned with true quality improvement. Congress should tighten Star bonus design to reflect real performance rather than inflated administrative thresholds.

- Supplemental Benefits: Supplemental benefits need clearer guardrails, so they remain targeted, evidence-based, and clinically justified. Currently, movie tickets, bowling balls and greens fees are considered "primarily health related," whereas healthy food is not. As a result, plans must document multiple, expensive physician and hospital visits to qualify a beneficiary for healthy food. Congress should require SSBCI benefits like food support to be 'primarily health related' in practice – limited to medically tailored meals or clinically targeted nutrition interventions tied to chronic conditions, with auditable eligibility and outcomes reporting.

Medicare's fiscal challenges are not inevitable. They are the result of policy choices that favor administrative pricing, consolidation, and open-ended spending. By restoring competition, enforcing budget discipline, and empowering beneficiaries, Congress can strengthen Medicare, improve affordability, and reduce one of the largest drivers of federal deficits and debt.

Lower the Cost of Medical Care

Over the next decade, CMS projects more than $21 trillion in federal health spending, much of it channeled through private insurance companies rather than paid directly to providers. Medicare Advantage, Part D, ACA subsidies, and Medicaid managed care increasingly dominate the flow of federal health dollars. Based on baseline projections, CAHC estimates that taxpayers will send roughly $17 trillion to private insurers over the next ten years, underscoring the significant role insurers now play in shaping costs and coverage.[34]

Program	10-Year Payments to Insurers
Medicare Advantage	$8.316T
Medicare Part D	$1.836T
ACA subsidies	$1.3–$1.5T
Medicaid & CHIP MCOs (federal share)	$3.5–$4.5T
FEHB	$1.0–$1.2T
TRICARE managed care	$0.6–$0.8T
Total	**≈ $16.5–$18.0 trillion**

[34] Calculated by CAHC based on CBO, MACPAC, OMB and Department of Defense budget projections.

- Vertical Integration: When insurers own PBMs, pharmacies, and physician groups, they can steer patients within their own corporate ecosystems, suppress competition, and capture margins at multiple points in the health care supply chain. These arrangements weaken price discipline, limit patient choice, and raise costs for plans, beneficiaries, and taxpayers. Breaking up or placing guardrails on insurer-PBM-pharmacy-physician integration, including banning self-referrals to affiliated pharmacies or providers, would restore competition, improve transparency, and lower drug and medical costs more effectively than stand-alone transparency reforms alone.

Prescription Drugs

In the Prescription drug space, CAHC has cautioned that drug price controls risk reducing access and innovation while shifting costs rather than lowering them. Market-based reforms that promote competition and transparency are more effective at delivering durable savings to patients and taxpayers. Because half of every dollar spent on brand drugs goes to entities that did not make them, Congress should enact reforms that ensure patients realize lower costs through direct purchasing and point of sale discounts.

- PBM Reform: Pharmacy Benefit Managers play a significant role in prescription drug pricing, yet current PBM practices often obscure true costs and weaken competition. Spread pricing, rebate-driven formularies, and limited transparency can incentivize higher list prices and favor drugs with larger rebates rather than lower net costs. Targeted PBM reforms – such as requiring pass-through of rebates and fees, prohibiting spread pricing, and increasing transparency around formulary decisions – would better align PBM incentives with lowering drug costs. By ensuring that negotiated discounts flow directly to plans and patients rather than being retained by intermediaries, PBM reform can reduce premiums, lower out-of-pocket costs, and generate savings for federal programs like Medicare and Medicaid without restricting access to needed medications.

- TrumpRx: TrumpRx is a market-based approach to lowering prescription drug costs by restoring competition, transparency, and consumer choice rather than relying on price controls. Today, discounts and rebates routinely reduce drug prices by 80 to 90 percent off list price, yet those savings are often hidden from patients and excluded from benefit design. TrumpRx recognizes that transparency is critical: patients and plans should be able to see and access the lowest available prices at the point of sale. The proposal would also ensure that cash purchases and prices available through third-party discount platforms are treated as legitimate market prices, not excluded from insurance accounting. Congress should permit Medicare Part D beneficiaries to use pharmacy cash prices and discount programs and require that those amounts count as negotiated prices for purposes of TrOOP and annual out-of-pocket limits. Allowing patients to benefit directly from real-world prices would reduce out-of-pocket costs, increase price

competition, lower premiums, and generate savings for federal programs – without undermining innovation or access.

- 340B Reform: The 340B Drug Pricing Program has strayed far from its original purpose and is now a significant driver of consolidation and higher health care costs. Since 2010, 340B drug purchases have grown more than sixfold, rising from roughly $7 billion to more than $50 billion annually, far outpacing growth in charity care or the uninsured population. While intended to support safety-net providers, the program allows participating hospitals to purchase deeply discounted drugs and bill insurers and Medicare at full market rates, retaining the spread. These incentives have encouraged large nonprofit hospital systems to acquire physician practices and expand outpatient facilities to capture 340B margins, shifting care into higher-cost settings without demonstrable improvements in access for vulnerable patients. Congress should set a threshold level for charitable care to qualify to participate in the 340B program and reduce payments to covered entities by aligning reimbursement to acquisition costs Congress should also strengthen eligibility standards, improve transparency, and ensure discounts flow directly to patients.

Health Services

True affordability requires lowering the cost of health services themselves. The following section focuses on reforms that address rising hospital and physician prices by restoring competition and eliminating payment distortions that drive costs higher.

- Transparency: Price transparency must be enforced, not optional. Providers should be required to disclose prices in advance, and when they fail to do so, patients should not be required to pay undisclosed charges.

- Expand the Supply of Providers: Federal policy constrains the health care workforce and pushes patients into higher-cost settings. Medicare caps on residency slots limit physician supply even as demand rises, while scope-of-practice and payment rules prevent nurses and pharmacists from practicing at the top of their training. At the same time, CMS administrative barriers make it difficult for pharmacists and other non-physician providers to participate in Medicare Advantage networks, further restricting access. These policies ignore the fact that pharmacies are among the lowest-cost sites of care, capable of safely delivering vaccinations, test-and-treat services, medication management, and preventive care. Congress should expand billing flexibility, reform graduate medical education, and expand reimbursement and access to pharmacists.

- Physician Owned Hospitals: Finally, Congress should remove statutory barriers that restrict competition, including the Affordable Care Act's prohibition on Medicare payment to physician-owned and specialty hospitals. Evidence consistently shows these facilities deliver high-quality care at lower cost, yet current law suppresses this competition, reinforcing hospital consolidation and higher prices. Opening these markets would encourage innovation and improve value for both beneficiaries and taxpayers.

- Facility Fees: Facility fees allow hospitals to charge additional fees for outpatient services solely because care is delivered in a hospital-owned or hospital-affiliated setting, even when the service is identical to one provided in a physician's office. These fees raise costs for patients, insurers, and taxpayers without improving quality or access, and they encourage hospitals to acquire physician practices to capture higher reimbursement rather than improve care. Banning facility fees - particularly for routine outpatient and evaluation-and-management services - would level the playing field between hospital-based and community providers, reduce incentives for consolidation, and lower premiums and out-of-pocket costs while generating savings for Medicare and the broader health care system.

Conclusion

America's health care affordability crisis is not inevitable – it is the result of policy choices. For decades, Congress has layered mandates, subsidies, and administrative pricing on top of one another, rewarding consolidation, insulating powerful institutions from competition, and shifting ever-rising costs onto families and taxpayers. The result is a system that costs more, delivers less, and now stands as one of the largest drivers of federal deficits and debt.

The solutions outlined today are not about cutting care or reducing access. They are about restoring competition, aligning incentives, and empowering consumers so markets can function again. By strengthening private coverage, reforming the ACA and Medicare, addressing consolidation, lowering the cost of health services and prescription drugs, and using budget reconciliation to impose fiscal discipline, Congress can bend the health care cost curve while improving access and affordability.

If Congress acts decisively, it can protect Medicare for future generations, lower premiums and out-of-pocket costs for families and employers, and put the federal budget on a more sustainable path. I urge the Committee to seize this opportunity to enact reforms that put patients – not institutions – back at the center of the health care system.