COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

**Testimony of Joel C. White**

**President, Council for Affordable Health Coverage**

to the Permanent Subcommittee on Investigations

Committee on Homeland Security and Governmental Affairs

Hearing on Defining Our Healthcare Problem,

and Principles We Should Follow to Solve it

December 10, 2025

Chairman Johson, Ranking Member Blumenthal, and Members of the Subcommittee, thank you for the opportunity to testify today. My name is Joel White, and I lead the Council for Affordable Health Coverage (CAHC), a broad, nonpartisan alliance dedicated to lowering the cost of health care so that every American has access to affordable coverage.

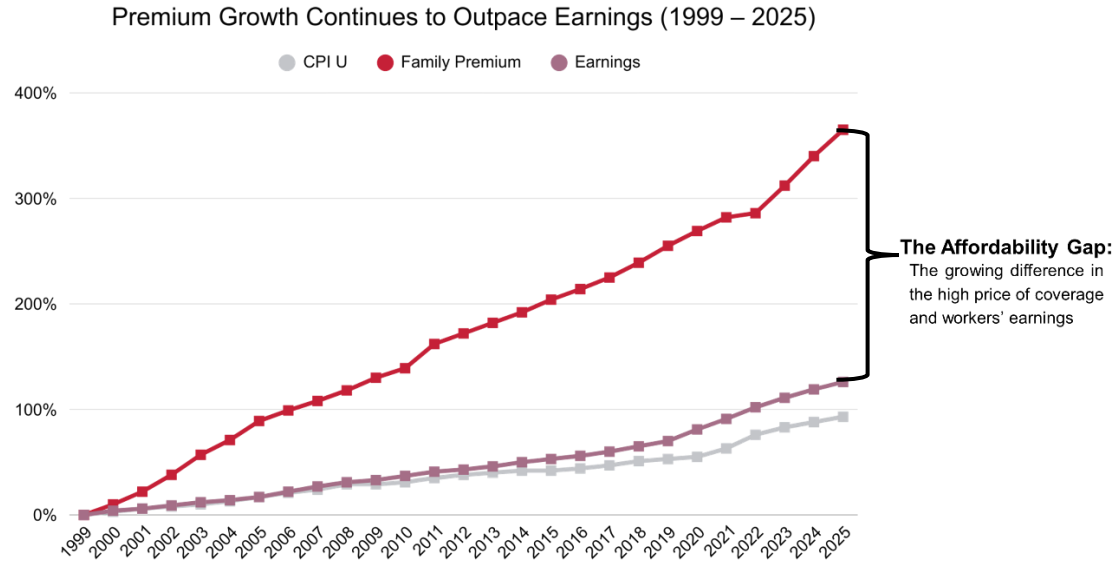
This Subcommittee's investigative mandate is essential, because the problems we face in our health care system today are not simply the result of medical inflation. They are the result of policy choices that reshaped insurance markets, distorted competition, encouraged consolidation, and misaligned incentives in ways that have pushed costs far beyond the reach of families, small businesses, and taxpayers.

While perhaps well intentioned, the ACA was built on a premise that Washington could design the right kind of insurance, encourage people to buy it with rich subsidies, and hope that rising costs embedded in the system would somehow stabilize. They have not. Instead, the law muted price signals, eliminated lower-cost plan options, and created an environment in which insurers became bigger and more profitable as government spending increased - regardless of what happened to consumer costs or access. The result is a system structurally tilted toward large insurers and large health systems that is extraordinarily expensive and heavily dependent on subsidies that enrich companies while increasingly unresponsive to the needs of consumers.

For most Americans, the ACA market is too expensive to enter without subsidies. And for taxpayers, the ACA market is becoming too expensive to sustain without structural reform.

**The Affordability Crisis**

Our health care system is seriously off track, and the number one problem is affordability. 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 by 2032.



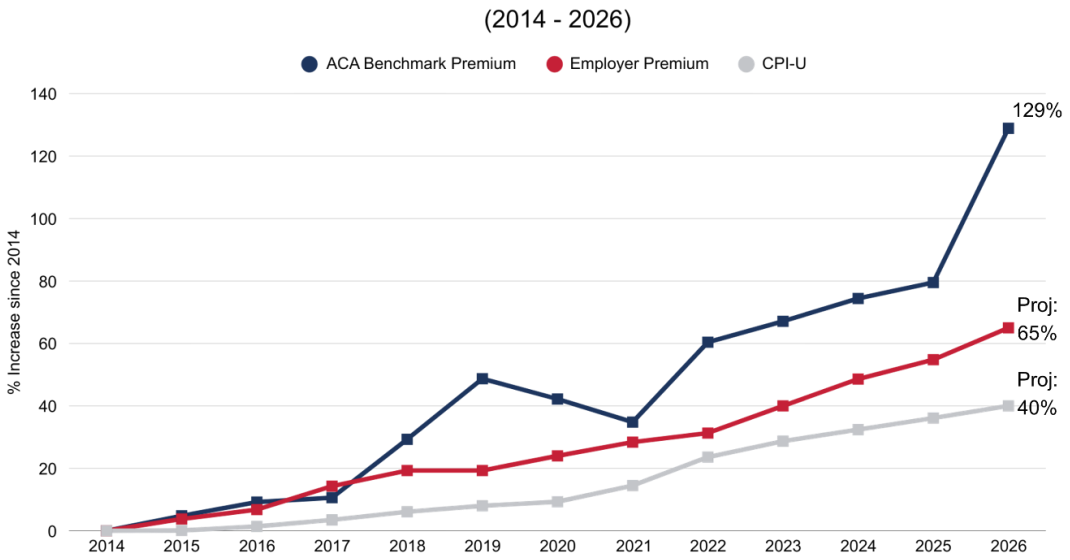

Sources: CPI: CBO; Premium: KFF; Earnings: BLS

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, encourage market power, and push prices higher.

Since 2013, the primary driver of rising premiums has been the steady growth of underlying medical costs, particularly in 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. Since 2013, hospital spending has risen sharply - reaching $1.7 trillion in 2024 with more than 10 percent year-over-year growth - driven by high commercial prices, consolidation, increased service intensity, and rising labor and input costs. Physician and clinical spending have followed a similar pattern, climbing to $1.1 trillion in 2024 as more services shift into hospital-owned or system-affiliated settings where prices are higher.[1] These trends directly feed into premium increases because insurer pricing is a function of expected hospital, outpatient, and physician, and drug claims.

*Premiums*

ACA premiums have more than doubled - rising 129 percent - since the law took effect, far outpacing employer-sponsored coverage and the general rate of inflation. We are now nearing a breaking point: by 2026, the average premium for an ACA family plan is projected to exceed $27,000 - more than the price of a new Toyota Corolla or Chevy Trailblazer.[2]



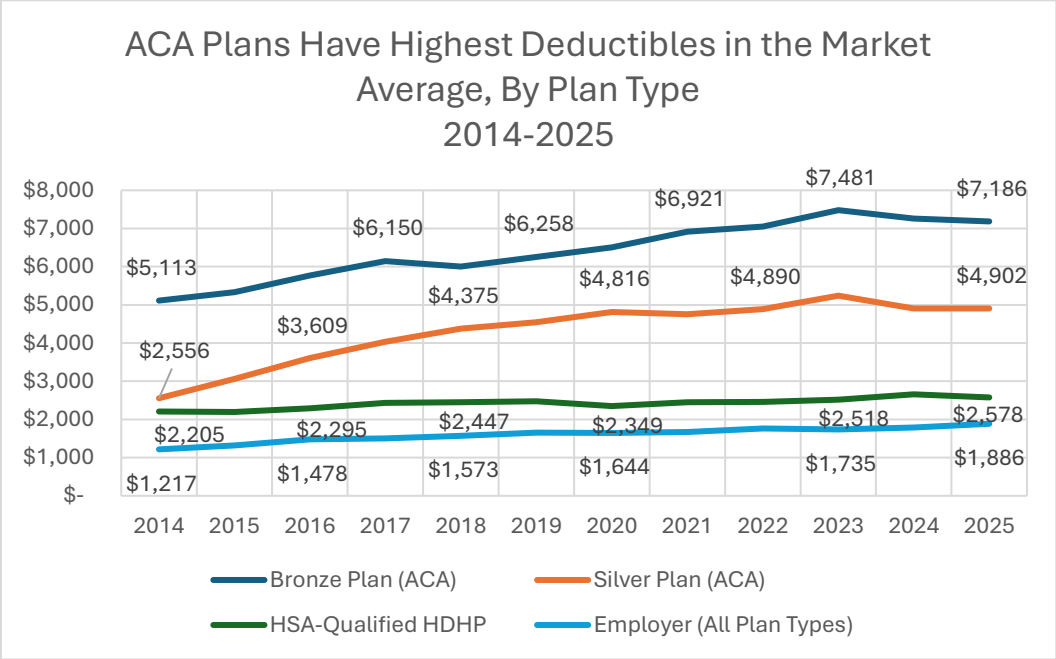

Sources: Benchmark and Employer Premium: Kaiser Family Foundation; CPI: CBO

*Out of Pocket Costs*

Even after paying record-high premiums, families face substantial out-of-pocket costs before most insurance benefits begin. For the Silver plans that cover most ACA enrollees, deductibles have

[1] National Health Expenditure Projections 2024-2033 Forecast Summary
[2] 2024 Employer Health Benefits Survey | KFF

nearly doubled, now approaching $5,000 - almost twice the HSA average and three times the typical employer plan.[3]




*Access to Care*

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.

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.[4] 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 report completing an average of 39 prior authorizations per week, with doctors and staff spending 13 hours weekly on these tasks. [5]

Networks have narrowed sharply. While only 18 percent of workers in employer-sponsored plans are in restrictive HMOs or EPOs, a striking 83 percent of ACA marketplace enrollees are in those narrow-network designs.[6] Exchange networks routinely include only one-third to one-half of local providers, and families with ACA coverage frequently encounter narrower hospital access and more restricted formularies. As a result, more people in exchange plans face significant barriers to care, and delay or skip care more frequently than those in employer plans.

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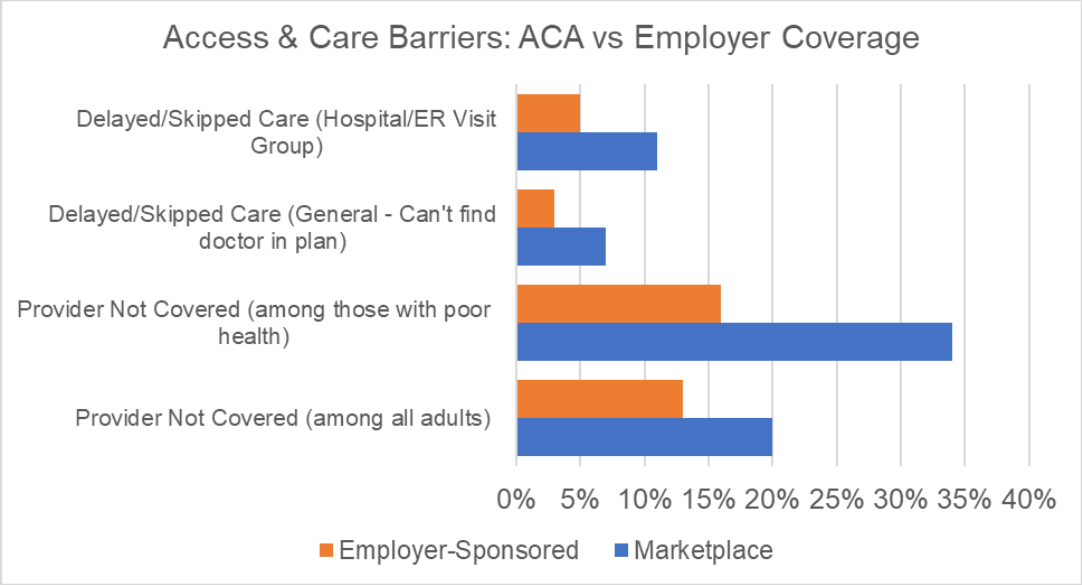
[3] Source: Kaiser Family Foundation various market surveys

[4] KFF Survey of Consumer Experiences with Health Insurance | KFF

[5] Fixing prior auth: Nearly 40 prior authorizations a week is way too many | American Medical Association

[6] ACA Individual Market Share by Network Type




The combination of remarkably high deductibles, insurance friction, and highly restrictive networks means many ACA enrollees face significant financial and access barriers. The problem is not simply that families pay too much - it is that they are paying more for less.

**How ACA Design Muted Market Incentives and Drove Costs Higher**

The core of the problem is not the intentions of the ACA, but its architecture. The law imposes a rigid set of federally designed insurance products - complete with essential health benefits, actuarial values, guaranteed issue of policies, community-rating rules, and narrow age bands. It then dictates that premium subsidies may only be used for these products. In every market today, there are plans less expensive than ACA policies, but government rules prohibit consumers from using subsidies on these plans, including HSA-based alternatives, state-approved off-exchange options, direct primary care, or term products - despite term plan premiums being roughly one-third of the cost of benchmark ACA coverage.[7]

Consumer Demand: This structure means that consumer demand is no longer shaped by price or preference, but by federal mandate. It also meant that insurers no longer compete across a wide range of plan designs, but within a narrow regulatory box where differentiation is limited and where price competition is irrelevant for subsidized consumers who make up 92 percent of enrollees in 2025.[8] For a subsidized enrollee, a $100 monthly premium and a $1,000 premium can both cost the same $20 out-of-pocket. When price signals disappear, cost discipline disappears as well.

Risk Pools: The ACA also dismantled state high-risk pools and forced all risk into a single, combined pool. That structure raised premiums for everyone in the standard market. Temporary federal reinsurance masked these effects at first, but once those programs expired, the full cost of the highest-risk patients was reflected directly in premiums - which is why, in 2017 and 2018, we saw some of the steepest premium spikes in the history of the individual market. States that later reintroduced risk stabilization through Section 1332 waivers demonstrated what might have been

[7] What is the average cost of short-term health insurance?
[8] How much and why ACA Marketplace premiums are going up in 2026 - Peterson-KFF Health System Tracker

possible: when high-cost claims are managed efficiently, statewide premiums fall sharply (See Appendix A).

Medical Loss Ratio: The MLR was supposed to ensure that consumers received value for their premium dollars by requiring insurers to spend most revenue on medical care rather than overhead or profit. The ACA requires insurers in the individual and small-group markets to spend at least 80 percent of premiums on medical claims and quality improvement, while large employer plans are required to spend at least 85 percent.

Over the past decade, large insurers have used integration strategies to use the MLR to their advantage by buying physician groups, pharmacies, and pharmacy benefit managers (PBMs).

- UnitedHealth Group illustrates this point. The company now owns 90,000 physicians (about 10 percent of all U.S. doctors) and pays its own clinicians 17 percent more than outside providers, and 61 percent more in markets where it dominates.[9] As a result, UnitedHealth's internal revenue streams have surged to $136 billion in 2025, or about 42 percent of its total revenue.[10] Over time, these inter-subsidiary payments have more than doubled—from about 15 percent of total company revenue in 2008 to one fourth today.[11] This means UnitedHealthcare plans are increasingly paying Optum-owned physician groups, PBMs, claims-processing systems, and revenue-cycle vendors, creating a loop in which premium dollars are routed through internal transactions that escape MLR limits. The other big insurance companies have similar relationships with service providers, typically doctors.

- Likewise, four of the five largest PBMs are owned by insurers, and the top three PBMs process 80 percent of the country's 6.6 billion pharmacy prescriptions. Once insurers own the providers and PBMs to whom they pay claims, they can count internal transfers as medical spending while shifting profits to subsidiaries that sit outside MLR limits. For PBMs, these are typically wholly owned or affiliated pharmacies.[12]

Instead of disciplining prices, the MLR encourages integration strategies that drive revenue higher through increased costs on both the insurer side and the provider side. This dynamic penalizes efficiency and protects large corporate structures while undermining competition in both the individual and small-group markets. What was intended as a consumer protection has become a tool that rewards market power, encourages higher premiums, and inflates medical spending.

Because plans are tightly standardized, most of the competitive margin is administrative scale, brand, and network leverage, which favors larger carriers, and encourages consolidation and exits.

[9] UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers | Health Affairs
[10] UNH 2025.9.30 10-Q
[11] UnitedHealth's self-dealing is accelerating
[12] Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies

**ACA Limits Competition and Rewards Market Consolidation**

In the individual market, the GAO shows that the median number of insurers per state fell from 21 in 2014 to just 10 in 2022—a collapse of more than half the participating companies in less than a decade.[13] In 2023, three companies controlled 32 percent of the market nationwide. In my home state of Connecticut, two insurers control 99 percent of the market.[14]

During this same period, benchmark premiums nearly doubled, rising from about $4,100 in 2014 to a projected $7,500 in 2026. This is exactly what happens when markets consolidate: consumers face fewer choices, prices rise, and insurers acquire more leverage over both patients and providers. Subsidies have masked the impact for some enrollees, but they have not solved the underlying cost problem, nor have they restored competition. In fact, the structure of ACA subsidies rewards higher premiums by increasing federal payments dollar-for-dollar, creating incentives to raise, not restrain costs.

The small-group market shows a parallel, and in some respects more troubling, deterioration. Fully insured small-group enrollment fell from 17.3 million in 2013 to roughly 11 million today, even as the median number of participating insurers per state dropped from 13 to 5. Small businesses now face some of the highest premiums and the fewest insurance options in the entire system. Average small-firm family premiums climbed from $14,400 in 2013 to more than $21,000 in 2023, while offer rates have fallen to around 50 percent, pushing 12 million workers into more expensive and more restrictive individual-market plans.

| Year | Individual Enrollment (M) | Median # Individual Issuers | Annual Benchmark Premium (SLCSP) | Small-Group Enrollment (M) | Median # Small-Group Issuers | Small-Firm Premium – Single | Small-Firm Premium – Family | Small-Firm Offer Rate |
|---|---|---|---|---|---|---|---|---|
| **2014** | 15.6 | **21** | $4,128 | 16.4 | 10 | $5,589 | $14,976 | 54% |
| **2015** | 17.4 | **20** | $4,368 | 15.6 | 9 | $5,785 | $15,575 | 54% |
| **2016** | 17.2 | **15** | $4,632 | 14.9 | 7 | $5,987 | $16,198 | 53% |
| **2017** | 17.6 | **10** | $5,664 | 14.3 | 6 | $6,197 | $16,846 | 53% |
| **2018** | 14.0 | **9** | $5,940 | 13.8 | 5 | $6,414 | $17,520 | 52% |
| **2019** | 13.8 | **8** | $6,036 | 13.2 | 6 | $6,790 | $18,251 | 51% |
| **2020** | 14.0 | **7** | $5,544 | 12.6 | 5 | $7,028 | $18,981 | 51% |
| **2021** | 15.3 | **7** | $5,424 | 12.1 | 6 | $7,274 | $19,740 | 50% |
| **2022** | 16.4 | **10** | $5,256 | 11.6 | 6 | $7,529 | $20,530 | 50% |
| **2023** | 18.9 | **10*** | $5,472 | 11.0 | 6 | $7,974 | $21,351 | 49% |
| **2024*** | 20.6 | **10*** | $5,724 | 10.6 | 6 | $8,373 | $22,419 | 49% |
| **2025*** | 22.0 | **10*** | $5,964 | 10.2 | 6 | $8,875 | $23,764 | 48% |
| **2026*** | 23.0 | **10*** | $7,500 | 9.8 | 6 | $9,452 | $25,309 | 48% |

**2024 through 2026 is carried forward from the 2022 GAO estimate.* Sources: GAO, KFF, MEPS; 40YO SLCSP

[13] GAO-25-107194, Accessible Version, Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022

[14] Market Share and Enrollment of Largest Three Insurers - Individual Market | KFF State Health Facts

Together, the data show two ACA-regulated markets moving in the same direction: shrinking competition where 76 percent of county-level markets are very highly concentrated.[15]

**How the ACA Benefited Insurers—and Why That Matters to This Subcommittee**

The most important point for this Subcommittee's oversight mission is that the ACA benefited insurers immensely and aligned their financial success with higher government spending and fewer consumer options.

In the ACA marketplace the government:

- Defines the product – ACA plans.
- Mandates expensive coverage and restricts lower cost alternatives.
- Only allows subsidies for expensive ACA plans.
- Sends subsidies directly to insurers, not consumers.
- Increases subsidies when premiums rise.
- Caps administrative margins in ways that incentivize insurers to supersize.

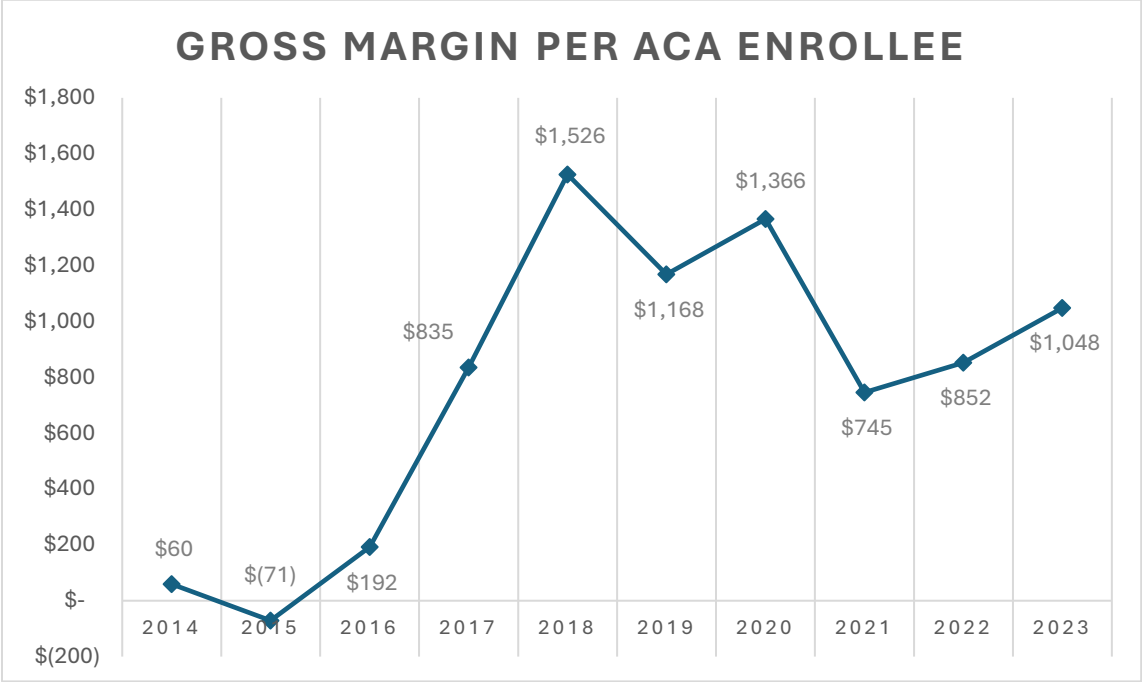
This is a market where insurers are most financially successful when premiums are high, enrollment is growing, subsidies are large, and lower-cost competitors are restricted or eliminated. In such a system, the alignment of incentives is upward - toward growth in gross spending, not reduction in underlying costs. This is how the ACA is designed.

It is not criticism of insurers to acknowledge their rational response to the incentives Congress set. But it is a criticism of the structure. Because when insurers can increase profits as government spending increases, and when they face little competitive pressure to lower premiums or expand benefits, the result is predictable: a system in which costs rise for everyone, while insurers earn more through taxpayers. This dynamic is visible in the financial data.

*Gross Margins*

Gross margins show the percentage of revenue left over after subtracting the gross cost of producing or delivering a product or service. It is an indicator of profitability because it shows how much money is made before operating expenses. In ACA markets, gross margin per ACA enrollee rose significantly in the 2017-2023 period after insurers significantly increased premiums.

[15] Market concentration in the ACA individual marketplaces | Health Affairs Scholar | Oxford Academic




Sources: KFF and Mark Farrah Associates[16]

*Stock Prices*

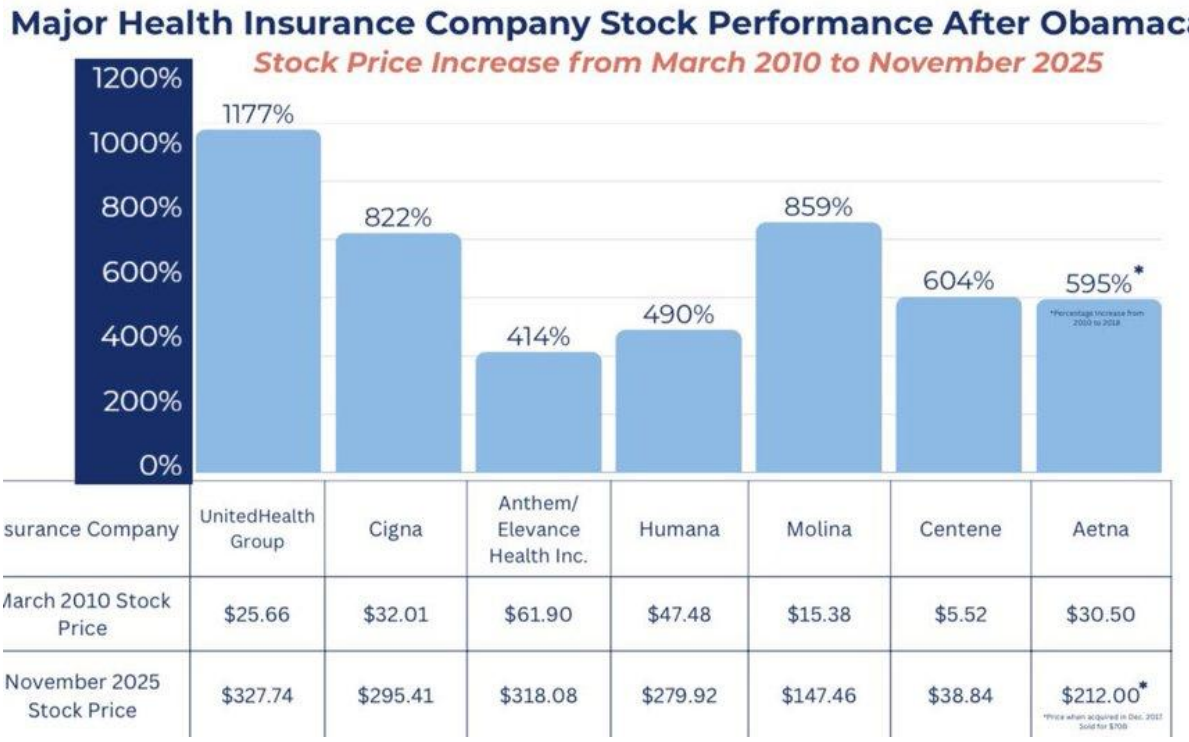
Any discussion of ACA and markets could not avoid the now famous chart on stock prices since the ACA was enacted in 2010 (shown below).[17] The ACA creates a massive transfer of taxpayer dollars to private insurance companies. Subsidies are paid by taxpayers directly to insurance companies, not consumers. CBO estimates taxpayers will spend $143 billion this year, and $1.3 trillion over the next ten years.[18]

Extra subsidies drive demand to buy products consumers would not normally purchase because of their expense. Enrollment drives up gross margin and benefits stock prices.

[16] KFF analysis of Exhibit of Premiums, Enrollment and Utilization data from Mark Farrah Associates Health Coverage Portal TM

[17] Paragon Health Institute on X: "Thank you, @POTUS for sharing our work!!" / X

[18] Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections




As cited in testimony before the HELP Committee[19], the largest insurers earned more than $71 billion in profits in a single recent year, while their CEOs earned nearly $150 million in compensation, even as premiums and out-of-pocket costs for consumers rose.

This Subcommittee has previously taken great interest in examining federal programs where contractors or intermediaries profit from rising government spending. The ACA exchanges, absent reform, represent one of the clearest such cases in health policy.

**Taxpayers on the Hook**

In 2014, taxpayers paid 68 percent of the premium. By 2025, taxpayers spent 93 percent.[20] Next year, CMS estimates, on average tax credits will cover 91% of the lowest cost plan premium in 2026, compared to 85% in the 2020 coverage year, which was the last year not impacted by temporary COVID-19 pandemic policies.[21]

Today, the ACA marketplace is sustained not by consumer demand for its products but by extraordinary levels of taxpayer subsidies. Ninety-three percent of enrollees now receive subsidies, and subsidies per enrollee have increased 56 percent since 2014.[22] Large numbers of enrollees never use their coverage at all; recent CMS estimates show that up to 35 percent of subsidized enrollees have no claims during the year. Combined with widespread reports of enrollment fraud

[19] HELP testimony
[20] Almost Entire Obamacare Premium Increases Paid for By Taxpayers
[21] Plan Year 2026 Marketplace Plans and Prices Fact Sheet | CMS
[22] Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections

affecting as many as 6 million individuals, these patterns raise serious questions about whether taxpayer funds are being efficiently or appropriately spent.[23]

Continuing to pour more money into such a system will not fix the systemic problems driving unaffordable coverage and ever greater spending. What we need is a new path: restore real competition, re-establish flexible risk-pooling, and give subsidies to consumers, not big companies.

**Principles for Reform: Restoring Market Incentives and Consumer Power**

The central lesson of the ACA is simple: when government subsidizes high costs, it locks high costs in place. Real reform must reverse those incentives and put consumers, not insurers or large health systems, in charge. Five principles should guide that effort:

1. **Transparency First.** Consumers cannot shop for value without knowing prices. Congress should require full price and quality transparency for all services and drugs in every market—before care is delivered. If insurers or providers refuse to disclose prices, they should not get paid. Research shows 89 percent of consumers want to shop for care, and up to half would switch providers for a better price. Transparency is the foundation for a functional market.

2. **Empower Consumers, Not Companies.** Subsidies should flow directly to consumers, not insurers. Restoring subsidy portability—and allowing people to use federal assistance to buy any state-approved plan that meets a basic actuarial standard—would force insurers to compete on price and service rather than rely on regulatory protection.

3. **Real Choice in Coverage.** Consumers and small businesses should be able to buy any plan approved for sale in a state. Congress should give states additional flexibility to design their markets, and remove statutory barriers to high risk pools, Association Health Plans, ICHRAs, catastrophic and term policies, direct primary care arrangements, sharing plans, and HSAs. This shifts individuals from renting coverage each year to owning their health-care decisions.

4. **Expand Supply and Lower Medical Costs.** Affordability requires more care options and lower underlying prices. Congress should eliminate incentives that drive medical inflation: unchecked hospital consolidation, site-of-service payment disparities, 340B abuses, anticompetitive contracting, and vertically integrated systems that hide costs and raise prices. Expanding the supply of providers and care settings reduces prices and expands access.

5. **Freedom to Pay Less.** If a patient finds a better price and pays cash – through platforms like TrumpRx or similar tools – those purchases should count toward their insurance out-of-pocket obligations. No one should be penalized for securing a better deal.

[23] New Paragon Report: Obamacare Enrollment Fraud Surged in 2025

Together, these reforms share a common goal: restore power to consumers and small businesses instead of limiting them to government-designed products and subsidizing corporate intermediaries.

**Conclusion**

The ACA is failing because it relies on government-designed plans, subsidies, and regulatory structures that reward size, spending, and consolidation. In this system, rising costs are not discouraged, they are financially rewarded.

The results are now unavoidable: premiums and out-of-pocket costs have doubled, provider networks have narrowed, and taxpayers are financing a subsidy system far larger than anyone predicted. At the same time, the insurers and hospital systems at the core of this model have grown larger, richer, and increasingly dependent on ever-greater federal spending.

For most families, ACA coverage is now unaffordable without subsidies. And for taxpayers, the program is becoming unaffordable without structural reform. Congress can restore competition, expand choice, and lower costs by realigning incentives so insurers and providers succeed only when consumers do.

Thank you for the opportunity to testify. I look forward to your questions.

## APPENDIX A

Section 1332 waivers demonstrate that properly financed, targeted risk pooling dramatically lowers premiums. This table uses CMS's April 2024 Data Brief data on 2023 SLCSP premium reductions relative to a no-waiver scenario.[24]

| *State* | *First Waiver Year* | *Waiver Type* | *2023 Premium Reduction vs. No Waiver* |
|---|---|---|---|
| *Alaska* | 2018 | Condition-based reinsurance | **38.79% lower** |
| *Minnesota* | 2018 | Claims-based reinsurance | **20.38% lower** |
| *Oregon* | 2018 | Claims-based reinsurance | **8.59% lower** |
| *Maine* | 2019 | Hybrid (claims + condition) | **12.46% lower** |
| *Maryland* | 2019 | Claims-based reinsurance | **32.56% lower** |
| *New Jersey* | 2019 | Claims-based reinsurance | **14.60% lower** |
| *Wisconsin* | 2019 | Claims-based reinsurance | **12.50% lower** |
| *Colorado* | 2020 | Claims-based reinsurance | **19.66% lower** |
| *Delaware* | 2020 | Claims-based reinsurance | **15.60% lower** |
| *Montana* | 2020 | Claims-based reinsurance | **8.26% lower** |
| *North Dakota* | 2020 | Claims-based reinsurance | **8.38% lower** |
| *Rhode Island* | 2020 | Claims-based reinsurance | **5.47% lower** |
| *Pennsylvania* | 2021 | Claims-based reinsurance | **4.34% lower** |
| *New Hampshire* | 2021 | Claims-based reinsurance | **13.40% lower** |
| *Georgia* | 2022 | Claims-based reinsurance | **19.20% lower** |
| *Virginia* | 2023 | Claims-based reinsurance | **17.14% lower** |
| *Idaho* | 2023 | Hybrid reinsurance | **12.50% lower** |

[24] CCIIO DATA BRIEF SERIES Data Brief on State Innovation Waivers: Section 1332 Waivers