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Before the House Committee on Oversight and Government Reform,
Joint hearing of the Subcommittees on Economic Growth, Energy Policy, and Regulatory Affairs and Health Care and Financial Services

"***Lowering the Cost of Healthcare: Technology's Role in Driving Affordability***."

December 10, 2025

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Chairs Comer, Grothman, and Burlison, and Ranking Members Garcia, Krishnamoorthi, and Frost, thank you for holding this hearing and for the opportunity to discuss the urgent need to lower the cost of health care in America. Families from your districts and all across the country urgently need solutions for the affordability crisis they face when trying to obtain lifesaving and sustaining care.

It is an honor to be with you this morning. My name is Sophia Tripoli, and I am the senior director of health policy at Families USA, the long-time national, non-partisan voice for health care consumers. For almost 45 years, Families USA has been working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all.

This hearing could not be held at a more critical time. Despite having had several opportunities to act this year on meaningful affordability solutions, the 119th Congress has failed to provide Americans with desperately needed relief from crushing health care costs. In fact, it has done just the opposite by passing H.R. 1, which cut $1 trillion from our health care system and compounded this crisis by limiting access to affordable care while failing to do anything to lower the cost of health care.

This is unacceptable. Congress must take immediate steps to support families whose health and financial security are in jeopardy and to address the root causes of our nation's skyrocketing health care costs.

While it is important that Congress confront this crisis from a variety of angles, including by exploring the role technology can play in driving affordability, **the first step is to come together right now to extend – in their current form and without harmful changes – enhanced premium tax credits for the nearly 22 million Americans who rely on them to purchase comprehensive health coverage from the federal or state health insurance Marketplaces**.[1] Open enrollment began on November 1, and now millions of Americans are logging in to re-enroll in coverage only to see their health insurance premiums skyrocketing for next year — more than doubling on average,[2] with people paying not just hundreds but thousands of dollars more. Many will not be able to afford to buy a plan at all: if Congress fails to act, roughly 4 million people are likely to lose coverage next year altogether.[3]

Congress' delay in extending these tax credits has only further exacerbated a health care cost crisis that has been brewing for decades. Members of Congress from every state and district have a role to play in discussing and advancing commonsense legislation that would remedy some of the most obvious health system failings that drive unaffordable care, and the American people are eager to see action. **A new poll from Families USA and Hart Research Associates shows that lowering health care costs is the top priority for Americans across demographics, even surpassing concerns related to housing, jobs, crime, and immigration.** Over 9 in 10 voters think it is important that Congress and the President act to lower health care costs to reduce stress on family budgets, bring down the cost of living, and to make health care more affordable and accessible to millions of families around the country.[4]

To address this crisis, policymakers must pursue policy solutions that provide direct and immediate relief from crushing health care costs to individuals, families, and small business owners AND enact policies that get at the root causes of high and irrational prices in the first place – namely unchecked health care consolidation and the widespread pricing abuses that stem from corporate health systems as a result.

A Health System in Crisis: High and Rising Costs, Including Skyrocketing Premiums

Across the country, Americans are sounding the alarm: the cost of health care is too high, the system too complex, and relief is desperately needed. In 2025, nearly half of all Americans struggle to afford the health care that they and their families need due to the high cost.[5] More than a quarter of all Americans skip or delay needed health care due to cost and over 100 million people in the U.S. have medical debt totaling over $200 billion nationally, leading many to make significant sacrifices such as cutting back on necessities like food or taking on credit card debt that they can never pay back.[6] High health care prices also come directly out of worker's paychecks in the form of higher premiums and out-of-pocket health care costs, which have resulted in nearly $1 trillion dollars in lost workers' wages since 2012.[7]

Decades of data clearly shows that **prices for hospital services and prescription drugs continue to be the leading drivers of high and rising health insurance premiums** for both people who get coverage through their employers and people who purchase insurance in the Affordable Care Act (ACA) Marketplaces. The majority of 2026 rate filings directly connect higher insurance rates to these high and rising costs.[8] To make matters worse, this year, insurers also raised premiums to account for the looming expiration of enhanced premium tax credits, which will force millions of people to drop their coverage and lead to a smaller and sicker insured population, thus significantly destabilizing insurance risk pools.

In addition to the direct impact on families and individuals, the impact of high health care costs on state economies is undeniable. In 2021, over 10% of state and local expenditures went to health and hospitals, making it the third highest spending category for states.[9] As a result of rising health care costs, state and local government spending on health and hospitals increased by 266% in inflation-adjusted dollars from 1977 ($103 billion) to 2021 ($377 billion).[10]

The Dual Role of Technology in Both Driving and Lowering Health Care Costs

Without question, technology plays a key role in determining health care affordability. But as this Committee explores the role of technology in addressing the affordability crisis it must also acknowledge that even the best new technology cannot replace the need for people all across America to have affordable, high-quality and comprehensive health insurance. People who don't have insurance are in no position to reap the benefits of health care technology. Nor does the adoption of this technology do anything to address the root causes of health high prices stemming from industry abuses and poorly designed payment incentives that drive unaffordable care in the first place.

In fact, the story of technology and health care affordability is a nuanced one. New technology often drives health care costs up, particularly in a payment system in which fee-for-services economics incentivize providers to order extensive use of expensive diagnostic devices and advanced imaging that contributes to high costs for the health system and individual patients alike.[11]

At the same time, technological advances to streamline electronic health records have led to more cost-efficient and coordinated care.[12] Improvements in telemedicine and remote patient monitoring have increased access to early intervention and made chronic disease management easier for people in rural and urban areas alike.[13] And wearable health devices and health apps have the potential to support better prevention and improved overall health for those who are able to afford and benefit from them.[14] These kinds of technologies can serve as critical tools to help

drive improvement in health care delivery, patient experience and even prevent unnecessary and inefficient care from needing to be delivered in expensive settings like emergency rooms.

The rise of artificial intelligence (AI) and its varied applications across the health system underscores both the promise and pitfalls of technology in relation to health care affordability. As health systems explore how best to leverage AI to automate cumbersome administrative processes and improve operational efficiencies, they are also discovering ways to utilize AI to delay and deny care more rapidly and easily. For example, it has been widely reported that Medicare Advantage (MA) insurers use AI tools to aggressively deny care that have led to inappropriate denials of post-acute care.[15] In fact, a federal class action lawsuit filed in Minnesota against UnitedHealthcare asserts that their AI tool had a 90 percent error rate, leading to thousands of elderly and disabled Medicare beneficiaries being denied medically necessary care.[16]

As this Committee explores how best to maximize the benefits of technology in lowering the cost of care it must hold it in tension with the importance of guardrails that prevent new technologies like AI from doing just the opposite — limiting access to patient care and leading to worse health outcomes and more ineffective and costly care down the line.

Congress Must Act Now to Pass a Clean Extension of Health Care Tax Credits

Without a doubt, the most pressing priority for Congress right now is to extend the expiring enhanced premium tax credits to ensure millions of people can continue to afford their health insurance. Despite Congress having several opportunities over the last year to extend these premium supports, no fix for families has moved forward. Now, in the midst of open enrollment, millions of families find themselves either being forced to try to secure health insurance with premiums that are double or triple their current amount or going without ANY health care coverage purely due to the cost.

The scale of this problem is significant: 22 million American workers who don't get coverage on-the-job or through Medicaid or Medicare qualify for premium tax credits for a plan through healthcare.gov or a state marketplace. That means their current household income is at least $15,060 for an individual or $31,200 for a family of four, and they do not have other options for affordable health coverage.[17] These tax credits are a lifeline for workers and their families, including those with serious and chronic health conditions like diabetes, heart disease, and cancer who need access to regular care to stay healthy and keep working when they don't get insurance through their job.[18]

The numbers are compelling, but so too are the stories of the real people who rely on premium tax credits for their health and financial wellbeing. The enhanced premium tax credits have been lifechanging for people like Amy from New Castle, Colorado who runs a small print publishing business with her husband that garners a household annual income of about $40,000. While her husband is covered by Medicare, Amy relies on the marketplace for the health insurance she needs to manage her chronic health condition. Utilizing enhanced premium tax credits, her monthly premiums dropped from a staggering $923 to just $1.57 each month. Only with these credits can Amy get the coverage she needs to stay healthy, keep their small business open, and contribute to the local economy.[19]

Or take Claire, a 43-year-old small business owner in Lafayette, Louisiana, who has been self-employed for her entire career. Diagnosed with breast cancer at 27, she relies on the Affordable Care Act's premium tax credits to afford the ongoing care she needs to stay healthy. Living with a preexisting condition that requires comprehensive care, she could never be well-served by the kind

of short-term "junk plans" often misleadingly marketed as ideal for young adults. Thanks to the enhanced premium tax credits, she is able to secure the comprehensive insurance she needs through the health care marketplace. She now pays about $117 per month for her plan after tax credits — compared to the $570 that she would pay without them — allowing her to maintain her coverage for frequent screenings and biannual oncology visits. "My appointments are really important to not only my physical health but my mental health," she said. Losing those credits, losing access to her trusted physicians, or being forced into a cheaper plan with higher out-of-pocket costs worries her deeply. "Not being able to afford to go to the doctor is a reason that a lot of people don't go," she shared.[20]

Amy and Claire need Congress to take immediate action, and they are not alone: **Roughly three-quarters of Americans polled from across the country — and across party lines — want Congress to act to extend the enhanced credits.**[21]

And since Congress failed to act to extend the health care tax credits before Marketplace Open Enrollment began, it is critical to both cleanly extend the tax credits without delay AND to ensure people who have already decided they cannot afford to keep their coverage have the opportunity and assistance to come back and re-enroll. We recommend that Congress also:

- **Extend the current open enrollment period or authorize a Special Enrollment Period (SEP) to allow time for the new rates to be adjusted and for enrollees to shop for a plan that best meets their needs.** This year, the uncertainty over tax credits is already making it challenging to attract consumers to the marketplace and to determine which plan will best serve them. Given that Open Enrollment has already begun, consumers must be notified as quickly as possible with up-to-date information to ensure their families are covered by January 1st with the right plan. Since Marketplace insurers maintain up-to-date contact information and send trusted communications to enrollees about their health coverage, they should also be required to notify consumers about changes to the enhanced premium tax credits that will impact a consumer's enrollment decision.
- **Restore $90 million in funding for Affordable Care Act (ACA) Navigators to help ease confusion among enrollees.** Earlier this year, CMS announced a $90 million reduction in funding for the ACA Navigator program, which provides outreach and free assistance to people shopping on the federal marketplace for health coverage.[22] We anticipate that there will be significant confusion among consumers about their options since decisions about enhanced premium tax credits were still pending when the Open Enrollment Period began. ACA Navigators are well-positioned to clear up questions regarding enrollment this year and can help ensure that consumers are informed about their options for coverage.

Working Families Need Real Coverage and Affordability Solutions – Not Misdirected Alternatives

As families grapple with the rising cost of health care, rising unemployment, and continued high costs of living, Congress must focus on serious solutions that actually meet peoples' needs and not on exacerbating the effects of a health care system that separates those who can afford higher quality coverage from those who cannot afford coverage at all. For instance, any suggestion that people losing tax credits can instead be made whole through a one-time cash handout or coupon, or through bigger uptake of Health Savings Accounts (HSAs), Flexible Savings Accounts (FSAs), or Health Reimbursement Accounts (HRAs), utterly fails to meet this moment and would strand millions of people without any meaningful access to care.

Tax-advantaged spending accounts (HSAs, FSAs, and HRAs) take various forms. FSAs and HRAs are available to people with employer-sponsored coverage, and HSAs are available to people with high-deductible health plans. They generally permit people to draw down pre-tax funds to pay certain health care costs, like deductibles, copayments, and over-the-counter medications. They might work as an incentive for insured Americans who can afford to save money to cover future out-of-pocket health expenses, but they do nothing to guarantee affordable coverage for people who need to buy their own health insurance and pay monthly premiums. For instance, in the marketplace, the lowest cost plans that can be paired with HSAs are "bronze" and "catastrophic." Bronze plans typically have deductibles of $7,476 for an individual in 2026, plus additional cost sharing for services.[23] Catastrophic plans have deductibles of $10,600 for an individual or $21,200 for a family.[24] Without this amount *fully* funded, a family would be left vulnerable in the case of major illness. So while additional tax flexibility or designated health funds can be helpful in offsetting some portion of health care costs, this is not sustainable for people in need of ongoing care and wholly insufficient for families living paycheck to paycheck.[25]

In fact, while many families – regardless of income – are struggling with the high cost of health care, HSAs primarily are a tool to support higher income families rather than the enhanced tax credits which largely support those with lower incomes. According to the IRS, the most likely people to contribute to these types of accounts are those who make over $500,000 per year, while 85 percent of people enrolled in the ACA make less than $50,000 for an individual or $100,000 for a family of four.[26]

Conflating the purpose of these spending accounts with the importance of premium tax credits marks a total failure to recognize why families struggle to afford coverage. It also fails to acknowledge why these tax credits have ensured record enrollment in ACA marketplace insurance in 2025,[27] and some of the lowest rates of people going without insurance in U.S. history.[28]

Committing to an Agenda that Addresses Root Causes of High Health Costs

The extension of enhanced premium tax credits is a desperately needed and essential immediate-term fix for families collapsing under the weight of health care costs. But premium tax credits are not designed to lower skyrocketing health care costs across the system over the long term. That is why this Committee must also work with your colleagues to commit to an agenda that takes on the corporate interests and underlying drivers of high health care costs in the first place.

Importantly, America's health care affordability crisis stems from high, rising, and variable prices across a wide range of health care goods and services, particularly for hospital care and prescription drugs. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in our country as in the United Kingdom and almost twice as expensive as in Germany.[29] The average price of a hospital-based MRI in the United States is $1,475,[30] while that same scan costs $503 in Switzerland and $215 in Australia.[31]

Importantly, health care prices in the U.S. are not only high, but have become irrational:

- In 2020, across all hospital inpatient and outpatient services, employers and private insurers paid on average 224% of what Medicare pays for the same services.[32]:
- Prices at hospitals in concentrated markets are 12% higher than those in markets with four or more rivals without any demonstrated improvement in quality or access to care.[33]
- Prices for the exact same service vary widely, sometimes even within a single hospital system:

- A colonoscopy at a single medical center in Mississippi can range from $782 to $2,144 depending on insurance.[34]
- At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[35]
- Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento, California.[36]
- The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200, depending on the insurance carrier.[37]

This irrational price structure underscores that without action to address the root causes of high and variable prices, new technologies will become subject to the same abusive pricing practices that are rife across the health system today.

What's more, health care is one of the only markets in the U.S. economy in which consumers are blinded to the price of a service until they receive a bill *after* the services are delivered.[38] Consumers and employers, who are the ultimate purchasers of health care, have limited insight into what the prices of health care goods and services are. For the majority of Americans (66%) who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[39] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[40]

These exorbitant, opaque, and unjustifiable prices are largely due to trends in health care industry consolidation across the U.S. that have eliminated healthy competition and allowed monopolistic pricing to flourish.[41] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[42]

The end result is a system with few truly competitive health care markets left: 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets, and 58% of MSAs having highly concentrated insurer markets.[43] Consolidation has been particularly pronounced among hospitals, drug companies, and pharmacy benefit managers and is made worse by the increasingly harmful role of private equity firms in the U.S health care system:

- *Hospitals*, health systems and other providers have rapidly consolidated, via horizontal and vertical integration, into large health care corporations, amassing outsized market power in order to increase prices for hospital care year after year. In fact, over 1,500 hospital mergers have occurred between 1998 and 2017, with an estimated 40% of those mergers taking place from 2010 to 2015.[44] Moreover, between 2013 and 2021, the percentage of physician practices that were hospital-owned rose from 15% to 53%, and the percentage of physicians employed by a hospital rose from 27% to 52%.[45]

- *Drug manufacturers* have increasingly engaged in anti-competitive behavior and transactions to similarly amass significant market power, regularly buying up or paying off their competition in order to game the U.S. patent system and price gouge our nation's families for prescription medications. The vast majority (70%) of drug industry profits now go to only a small number (25) of the top prescription drug companies in the country.[46]

- *Pharmacy benefit managers,* as third-party administrators designed to serve as middlemen between health insurers and drug makers, have increasingly merged with insurers and pharmacies to increase their own market power to negotiate pricing structures that serve their financial interests, often to the detriment of securing more affordable prescription medicines for consumers. This has led to the top three PBMs controlling 80% of the PBM market.[47]

- *Health insurers* are increasingly consolidated. Between 2006 and 2014, the four-firm concentration ratio — the extent of market control held by the four largest firms, Aetna, Anthem Blue Cross Blue Shield, UnitedHealthcare and Cigna — for the sale of private insurance increased from 74% to 83%.[48] This results in monopolistic health care prices that lead to unaffordable health care and poorer quality.[49] There is also growing vertical integration between insurers and health care providers; UnitedHealthcare for instance now employs almost 50,000 physicians as of 2021, and their reported share of medical expenses that flow to employed providers or other related businesses increased nearly 250% between 2016 and 2019.[50]

Widespread consolidation across the health care system has been compounded by the growing role of private equity (PE) firms over the last decade. Once largely uninvolved in the U.S. health care system, PE firms are increasingly purchasing and reselling a variety of health care provider organizations in order to make short term profit, largely to the detriment of the financial wellbeing of those providers and ultimately to health care access and affordability in a community. In 2020, health care became the second largest sector for private equity investment, accounting for 18 percent of all reported deals, up from 12 percent in 2010.[51] Private equity investors spent more than $750 billion on health care acquisitions between 2010 and 2019.[52]

Policymakers should prevent future horizontal, vertical, and cross-market mergers that undermine healthy competition in health care markets and drive unaffordable care by ensuring the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) are fully applying federal antitrust laws to horizontal integration, such as mergers between hospitals and other health systems, pharmacy benefit managers and drug companies; and vertical integration, such as mergers between physician practices and hospitals, health plans and pharmacy benefit managers. Specifically, Congress should improve the infrastructure needed to monitor anti-competitive mergers and contracting practices among health care corporations by increasing FTC and DOJ funding for anti-trust enforcement, and by giving the FTC authority to investigate and rein in anti-competitive practices by non-profit health care entities, including non-profit hospitals. Special attention should be given to PE firms and the smaller transactions that may traditionally fall below existing thresholds of review. Congress should increase the number of health care transactions reported to FTC and DOJ and subject to anti-trust review and enforcement by reducing the *Hart-Scott-Rodino Act* reporting threshold.[53]

In addition, the below list of pro-consumer reforms to the health care system would put money back in people's pockets, have strong bipartisan and bicameral support in Congress, and would make important strides to begin addressing corporate abuses in health care.

These bold actions are overwhelmingly popular with voters across the political spectrum and have proven to be effective at getting at the drivers of rising health care costs:[54]

- Requiring all hospitals to disclose rates they charge in dollars and cents (91% support)
- Allowing Medicare to negotiate lower prices on more drugs (89% support)

- Closing legal loopholes that allow drug companies to raise prices by blocking generics (87% support)
- Prohibiting health systems from charging Medicare more for the same procedure if performed at a hospital facility instead of a doctor's office (84% support)
- Prohibiting Medicare Advantage companies from exaggerating health risks to get paid more (79% support)
- Eliminating legal loopholes that allow health care providers to overcharge (75% support)
- Restricting aggressive billing practices like surprise billing (73% support)
- Reducing unnecessary middlemen between patients and providers, who increase costs (72%)
- Reforming the way doctors and providers are paid, so pay is based on keeping people healthy and quality of care rather than the number of procedures (80% support).

Families Need Workable Solutions Now

The urgency couldn't be clearer. Americans are demanding relief from rising health care costs and this Congress has a responsibility to deliver.

Thank you again for holding this timely and critical hearing. Now, more than ever, families across the country are feeling the negative impacts of our nation's affordability crisis firsthand and are eager for Congress to pass legislation that provides meaningful relief and reaffirms that their elected representatives are doing all they can to deliver on their promises to lower costs and improve health care. The technological innovations being discussed today might be helpful, but only in the context of policy and incentives that drive the health system to be better, not just bigger. The journey to fully transform our health care system so that it truly works for American families is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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