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Joint Hearing on "Lowering the Cost of Health Care: Technology's Role in Driving Affordability"

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Chairmen Burlison and Grothman, Ranking Members Frost and Krishnamoorthi, and Members of the Subcommittees:

Good morning, and thank you for inviting me to testify. My name is Chris Jacobs, and I am the Founder of Juniper Research Group, a policy and research consulting firm based in Washington. Much of my firm's work focuses on health policy, a field in which I have worked for over two decades, including more than six years on Capitol Hill.

I also appear before you as a long-time—though not necessarily by choice—unsubsidized customer of D.C. Health Link, the insurance Exchange in the nation's capital. As you may know, lax security practices meant that D.C. Health Link suffered a "significant data breach" in March 2023.[1] Shortly after the breach, which exposed my Social Security number and other personal data on the "dark web," I was subject to several identity fraud attempts, which necessitated replacement of my business' bank accounts, a permanent freeze on my Social Security number, and related administrative burdens on me and my small business.[2]

[1] Letter from Speaker Kevin McCarthy and Rep. Hakeem Jeffries to D.C. Health Link Executive Director Mila Kofman, March 8, 2023, https://x.com/MarkBednar/status/1633800558539669504?s=20.

[2] Ironically, to the best of my knowledge, neither Ms. Kofman, nor D.C. Mayor Muriel Bowser, nor members of the D.C. Council personally suffered ill effects from the data breach—because, so far as I am aware, none of them purchase coverage from the D.C. insurance Exchange. See Chris Jacobs, "Obamacare Exchange's Data Breach Exposed Not Only My Private Info But the Hypocrisy of D.C. Officials," *The Federalist* March 13, 2023, https://thefederalist.com/2023/03/13/obamacare-exchanges-data-breach-exposed-not-only-my-private-info-but-the-hypocrisy-of-d-c-officials/.

I will focus my remarks today on how the 2010 health care law has contributed to an increase not just in health insurance premiums, but in overall health care costs. Given this dynamic, Congress should not extend the enhanced COVID-era subsidies scheduled to expire at the end of this month, which would use additional taxpayer funds to mask flaws in a law that has made care less affordable. Instead, Congress should pursue alternative policies that will enhance insurance portability, realign incentives, and promote price and quality transparency.

The Unaffordable Care Act

Calling the law that Congress passed, and President Obama signed, in March 2010 the "Affordable Care Act" represents more than a semantic error, because Obamacare has proven anything but affordable—for patients or taxpayers. The law singularly failed to achieve candidate Obama's 2008 promise that his signature legislation would "bring down premiums by $2,500 for the typical family."[3] Due in part to the newly required benefits contained in the law, premiums on the individual health insurance market more than doubled during the first four years after the law fully went into effect.[4] In the years since, premiums for individual health insurance have continued to rise at a faster pace than those for employer-provided health coverage.[5]

To mask this growing lack of affordability as premiums rose ever higher, a Democratic-controlled Congress enacted two rounds of temporary increases in the premium subsidies, in March 2021 and August 2022.[6] With those COVID-era increases set to expire at the end of the month, some have called for a temporary or permanent extension of the enhanced subsidy regime. Any extension would be unwise, for reasons that go well beyond the estimated $350 billion cost (plus interest) of an extension, at a time when the federal government faces over $38 trillion in debt.[7]

As the Congressional Budget Office (CBO) recently noted, the Exchanges face a serious problem with the enrollment of ineligible individuals. CBO recently released an analysis estimating that 2.3 million enrollees "improperly claimed [subsidies] via

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[3] Quoted in Kevin Sack, "Health Plan from Obama Spurs Debate," *The New York Times* July 23, 2008, https://www.nytimes.com/2008/07/23/us/23health.html.

[4] Department of Health and Human Services Office of Planning and Evaluation, "ASPE Data Point: Individual Market Premium Changes: 2013-2017," May 23, 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

[5] Cited in Brian Blase, Testimony before Senate Homeland Security Permanent Subcommittee on Investigations in hearing on "Assessing the Damage Done by Obamacare," November 6, 2025, https://www.hsgac.senate.gov/wp-content/uploads/Blase-Testimony-2.pdf, Figure 7, p. 6.

[6] Section 9661 of the American Rescue Plan Act, P.L. 117-2; Section 12001 of the Inflation Reduction Act, P.L. 117-169.

[7] Congressional Budget Office, Letter to Sen. Chuck Schumer, *et al.* regarding selected health coverage policies, September 18, 2025, https://www.cbo.gov/system/files/2025-09/61734-Health.pdf; Department of the Treasury, "Debt to the Penny," https://fiscaldata.treasury.gov/datasets/debt-to-the-penny/debt-to-the-penny.

intentional overstatement of income" this year.[8] Using CBO's most recent baseline estimate of an average per-enrollee subsidy of $6,056 in 2025, these 2.3 million improper enrollees cost taxpayers $13.9 billion in 2025 alone.[9] Other outside groups have shown much higher levels of fraud, with one estimate finding $27.1 billion in potentially fraudulent subsidy payments just this year.[10]

A Government Accountability Office (GAO) report released just last week provided specific examples confirming the Exchange-related subsidy fraud that CBO and other outside groups have quantified.[11] Among GAO's findings:

- All of its four fictitious applicants in 2024 received subsidized health coverage, and 18 of 20 fictitious applicants in 2025 continued to do so as of September.[12]
- As of April 2025, enrollees receiving over $21 billion in subsidies—or approximately 32 percent of the subsidies paid on behalf of enrollees who submitted a Social Security number to the federal Exchange in 2023, the most recent year for which data are available—failed to reconcile the subsidies (which are paid in advance of tax filings) they received in 2023 with their actual income by filing a 2023 tax return (normally due April 15, 2024).[13]
- Over 29,000 Social Security numbers in 2023, and over 66,000 Social Security numbers in 2024, reported more than 365 days of subsidized insurance coverage, indicating potential fraud. In one instance, a single Social Security number was linked to over 26,000 days (more than 71 years) of subsidized insurance coverage "across over 125 insurance policies" in 2023.[14]
- In 2023, a total of 58,000 Social Security numbers received subsidies yet also matched Social Security Administration death data. These instances included over 7,000 numbers "where the reported date of death occurred prior to enrollment" in the Exchange, and over 19,000 numbers where "matches had different names and dates of birth" between the Exchange database and the Social Security Administration database—a potential sign of "synthetic identity fraud."[15]
- At least 30,000 applications in 2023, and at least 160,000 applications in 2024, "had likely unauthorized changes" made by agents or brokers who engaged in "potential

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[8] Congressional Budget Office, Letter to Rep. Jodey Arrington, *et al*. regarding clarifications of Marketplace coverage and eligibility, August 25, 2025, https://www.cbo.gov/system/files/2025-08/61506-marketplace.pdf, p. 7.
[9] Author's calculations using Congressional Budget Office, "Health Insurance and Its Federal Subsidies," June 2024 baseline, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.
[10] Brian Blase, *et al*., "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/wp-content/uploads/2025/06/The-Greater-Obamacare-Enrollment-Fraud_RELEASE_V4.pdf. While I have previously done work for Paragon, I had no involvement in this particular report, and am submitting today's testimony solely on my own behalf.
[11] Government Accountability Office, "Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist," Report GAO-26-108742, December 3, 2025, https://www.gao.gov/assets/gao-26-108742.pdf.
[12] Ibid., pp. 9-12.
[13] Ibid., pp. 12-13.
[14] Ibid., p. 13.
[15] Ibid., pp. 13-14.

> misconduct…seeking to maximize commissions" they would receive for enrolling people in Exchange coverage. GAO cited one actual example (anonymized in the report) whereby a single individual had their coverage changed 15 separate times by 10 different brokers in a single 8-day span in late 2023.[16]

These myriad program integrity problems stem from a subsidy regime that allows low-income enrollees to qualify for zero-dollar "benchmark" premium coverage. Moreover, taxpayer dollars continue to fund insurance plans covering abortion and transgender procedures that many Americans find morally objectionable.[17] For these reasons and more, Congress should allow the temporary COVID-era enhanced subsidies to expire.

Poor Coverage for the Sickest Patients

While perpetually rising premiums and fraud associated with Exchange enrollment have received attention during recent debate on the enhanced subsidies, policy-makers should also remember the many other ways that Obamacare has harmed the health care system. For one, the law has failed sick and vulnerable patients—beginning with the many households who ***lost*** their coverage because of the law. Candidate Obama's 2008 campaign promise that "If you like your plan, you can keep it"—a promise that the measure he signed into law did not and could not keep—won an ignominious award as *Politifact*'s "Lie of the Year" for 2013.[18] At least 4.7 million Americans received cancellation notices that year, as insurers ripped up old policies before Obamacare's major provisions took effect in January 2014.[19]

I know one such individual, the father of a friend and colleague. He and his wife lost their coverage in the fall of 2013, and when he was subsequently diagnosed with colon cancer, the consequences proved devastating:

> We turned to a Christian [health care] sharing ministry after Obamacare canceled our Blue Cross Blue Shield plan because it was the only affordable option we had. And we prayed we'd make it to 65 without getting sick. Unfortunately, that didn't happen. When we realized that I needed to get treatment at M.D. Anderson [Cancer Center] because of the tricky location of the tumor, the cost of entry was prohibitive because our sharing ministry plan was considered 'self-pay' by the hospital. That's

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[16] Ibid., pp. 14-16.
[17] Center for Renewing America, "Primer: Obamacare Subsidies and Abortion Coverage," September 15, 2025, https://americarenewing.com/issues/primer-obamacare-subsidies-and-abortion-coverage/; Center for Renewing America, "Obamacare Subsidies and Transgender Procedures," September 30, 2025, https://americarenewing.com/issues/obamacare-subsidies-and-transgender-procedures/.
[18] Angie Drobnic Holan, "Lie of the Year: 'If You Like Your Health Care Plan, You Can Keep It,'" *PolitiFact* December 12, 2013, https://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/.
[19] Associated Press, "Policy Notifications and Current Status, by State," December 26, 2013, https://finance.yahoo.com/news/policy-notifications-current-status-state-204701399.html.

> when my son started up a GoFundMe to get me in the door to get the care I needed.[20]
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> God worked a miracle in that operating room. I'm cancer-free and back to a normal life. But the stress of the financial burden, which would've been greatly diminished if we had still had our previous plan, was overwhelming in the face of the diagnosis. That was pain inflicted on our family because of decisions made by politicians and bureaucrats in a distant city. That's not how things are supposed to be.[21]

My friend's father was not alone in his distress. In fact, many of the best-known hospitals, like the M.D. Anderson Cancer Center and the Mayo Clinic, take few if any Obamacare Exchange plans, placing the sickest patients with the most complicated cases in danger of poor health outcomes.[22]

These problems occur not despite provisions in Obamacare that purportedly "ended discrimination against patients with pre-existing conditions," but ***because of them***. With insurers forced to charge healthy and sick patients the same premium, they have strong incentives to narrow provider networks and limit benefits to avoid attracting sick patients. For instance, shortly after the law's main provisions took effect, a group of HIV patients filed a complaint against several Florida health insurers for failing to cover HIV drugs. The insurers placed all HIV/AIDS drugs, including generics, in the highest-cost tier, to discourage HIV-positive patients from applying for coverage—another example of how Obamacare's perverse incentives have harmed those the law intended to help.[23]

Raising Health Care Costs

Obamacare has not only proved unaffordable in raising health insurance premiums for those purchasing coverage on insurance Exchanges, but in raising health care costs overall. Even prominent Democrats have—very subtly—admitted as much.

In November 2023, Sen. Elizabeth Warren (D-MA) co-authored a letter to the Department of Health and Human Services Inspector General.[24] Citing an article in *The Wall Street Journal*, she said she was

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[20] https://www.gofundme.com/coachwhite.
[21] Jim White, personal communication, May 8, 2019.
[22] John Goodman, "Obamacare Can Be Worse Than Medicaid," *The Wall Street Journal* June 27, 2018, https://www.wsj.com/articles/obamacare-can-be-worse-than-medicaid-1530052891; John Goodman and Beverly Gossage, "Obamacare Turns Out to Be Affordable Only for the Healthy," *The Wall Street Journal* September 12, 2023, https://www.wsj.com/opinion/obamacare-turns-out-to-be-affordable-only-for-the-healthy-hospital-medical-costs-da3e831d.
[23] Michelle Andrews, "Complaint Says Insurance Plans Discriminate Against HIV Patients," NPR July 8, 2014, https://www.npr.org/sections/health-shots/2014/07/08/329591574/complaint-says-insurance-plans-discriminate-against-hiv-patients.
[24] Sens. Elizabeth Warren and Mike Braun, Letter to Department of Health and Human Services Inspector General Christi Grimm, November 21, 2023, https://www.warren.senate.gov/imo/media/doc/2023.11.21%20Letter%20to%20HHS%20OIG%20regarding%20MLR%20evasion.pdf.

> Concerned by a recent report suggesting that large insurance companies—including Cigna, CVS Aetna, and UnitedHealth—are hiking drug prices at their vertically integrated specialty pharmacies to evade the Medical Loss Ratio (MLR), a statutory requirement for health insurers to spend at least 80 or 85 percent of health care premium dollars on medical claims.[25]

Both the letter and the *Journal* article outlined how big insurers that own pharmaceutical benefit managers (PBMs) are charging patients far more—in some cases thousands of dollars more—for generic drugs than Cost Plus, an independent pharmacy founded by Mark Cuban.[26] The companies overcharge patients for generic drugs as part of a deliberate strategy that shifts profits to their pharmacy business and away from their insurance business, to circumvent the MLR's profit caps on their insurance rates.

Sen. Warren's letter claimed that "insurance companies are exploiting loopholes in the law by buying up entities that are eligible for medical claims payments, including pharmacies, so that they can get a cut from both sides of the transaction," citing UnitedHealth's 2011 creation of Optum, an entity that now includes both a PBM and a group of over 70,000 physicians.[27] However, she did not mention the specific law that created the MLR requirement—Obamacare.

What Sen. Warren now calls a "loophole" that Democrats created as part of Obamacare has increased costs in myriad ways, both directly—via higher costs for generic drugs, as the *Journal* expose revealed—and indirectly, by encouraging greater consolidation within the health care sector. One progressive blog post cited in Sen. Warren's letter admitted as much, with a title discussing "How Obamacare Created Big Medicine."[28]

As this post noted, the MLR provisions ***discourage*** rather than encourage insurers from containing costs, because the MLR's cap on profits as a percentage of premium means that insurers can generate additional profit only by allowing premiums to rise.[29] More broadly, it correctly notes that "since the passage of Obamacare, the firms who control our health care system have become far bigger, and much more powerful."[30]

Consider for instance just this list of consummated and proposed health care acquisitions in a November 2023 story that broke the news of Cigna's proposed merger with Humana:

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[25] Ibid.
[26] Joseph Walker, "Generic Drugs Should Be Cheap, But Insurers Are Charging Thousands of Dollars for Them," *The Wall Street Journal* September 11, 2023, https://www.wsj.com/health/healthcare/generic-drugs-should-be-cheap-but-insurers-are-charging-thousands-of-dollars-for-them-ef13d055.
[27] Sens. Warren and Braun, Letter to Christi Grimm.
[28] Matt Stoller, "How Obamacare Created Big Medicine," April 4, 2023, https://www.thebignewsletter.com/p/how-obamacare-created-big-medicine.
[29] Ibid.
[30] Ibid.

- "Humana also owns a major home-health business and a growing array of primary care clinics that could bolster Cigna's growing Evernorth health services arm."
- "Cigna and Humana previously explored merging in 2015, but Humana instead struck a deal with another rival, Aetna, that was blocked by a judge on antitrust grounds, leaving Aetna to be scooped up by CVS in 2018."
- "Another deal that would have combined Cigna with Anthem, now known as Elevance Health, also died after an adverse antitrust ruling."
- Cigna's "$54 billion acquisition of Express Scripts Holding in 2018 made it one of the biggest players in pharmacy benefits, and it has been building up its Evernorth unit, which includes an array of non-insurance businesses."
- "Humana has said its home health unit and expanding primary care footprint support its Medicare patients."[31]

If the list above did not demonstrate the problems associated with a heavily consolidated health insurance sector, the chaos sparked by the spring 2024 hack of Change Health Care—a UnitedHealth affiliate that processes 15 billion health care claims per year—brought home its impact.[32] Sadly, by creating acute cash flow problems that particularly impacted small physician practices, the hack itself may have encouraged some of these practices to close, exacerbating the consolidation trend.[33]

The merger trend within health care has not remained confined to insurers. Hospitals, seeing insurers combine and grow, spent the years after Obamacare's passage buying up each other—and physician practices—to gain more leverage over the insurers staring across the table from them in contract negotiations. A 2018 analysis in *The Wall Street Journal* concluded that the number of hospital mergers more than doubled in the years after Obamacare, from 42 in 2009 (the year before enactment) to 92 in 2012, and remained above pre-Obamacare levels thereafter.[34] As a result, the percentage of hospitals that are part of a larger system has risen from more than half (56%) in 2010 (the year of Obamacare's enactment) to two-thirds (67%) in 2022.[35] Likewise, the percentage of physicians employed by hospitals went from only about one in four (25.8%) in 2012 to

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[31] Lauren Thomas, Anna Wilde Mathews, and Laura Cooper, "Cigna, Humana in Talks for Blockbuster Merger," *The Wall Street Journal* November 29, 2023, https://www.wsj.com/business/deals/cigna-humana-in-talks-for-blockbuster-merger-c5c7f1b0.

[32] Chris Jacobs, "Nationwide Ransomware Attack Exposes the Problem with Health Care Monopolies," *The Federalist* April 2, 2024, https://thefederalist.com/2024/04/02/nationwide-ransomware-attack-exposes-the-problem-with-health-care-monopolies/.

[33] Emily Olsen, "Small, Financially Struggling Providers at Risk from Change Cyberattack: Moody's," *Health Care Dive* March 11, 2024, https://www.healthcaredive.com/news/change-healthcare-cyberattack-provider-financial-impact-moodys/709875/.

[34] Anna Wilde Mathews, "Behind Your Rising Health Care Bills: Secret Hospital Deals That Squelch Competition," *The Wall Street Journal* September 18, 2018, https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963.

[35] Jamie Godwin, Zachary Levinson, and Tricia Neuman, "One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022," KFF, October 1, 2024, https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas-in-2022/.

more than half (55.1%) by 2024, with a further 22.5% employed by corporate entities (including insurers).[36]

Unsurprisingly, less competition in health care markets has resulted in anti-competitive tactics that raise health costs and premiums for consumers. The *Journal* noted that some hospital contracts "prevent patients from seeing a hospital's prices by allowing a hospital operator to block the information from online shopping tools that insurers offer."[37] Other provisions include "must-carry" clauses, which prevent employers like Wal-Mart from excluding the lowest quality performers from their networks.[38] These provisions not only lead to higher costs for businesses and workers, but may also leave patients receiving sub-standard care.

Hospitals have joined forces not just to gain market clout, but because provisions of Obamacare encouraged them to do so, raising underlying health care costs in the process. For instance, the law expanded the 340B drug program, under which certain covered entities receiving federal grants can purchase pharmaceuticals at a discount, which they later re-sell to generate revenue for their organization. Obamacare broadened the definition of 340B covered entities to include children's hospitals, critical access hospitals, rural referral centers, and sole community hospitals, while expanding the discounted pharmaceuticals offered to include inpatient drugs.[39]

Coupled with a regulatory change in the month that Obamacare passed allowing covered entities to utilize an unlimited number of contract pharmacies to obtain 340B discounts, the number of covered entity sites more than doubled, from 20,183 in 2013 to 55,339 in 2023.[40] Over that same time period, the number of hospital and associated sites rose more than fourfold, from 7,806 to 33,532.[41] According to a recent CBO analysis, spending on drugs purchased through the 340B program rose from $6.6 billion in 2010 to $43.9 billion in 2021—an average growth rate of 19 percent per year.[42] The budget office believes that approximately two-thirds of this growth came due to the result of 1) "the integration of hospitals and off-site clinics," i.e., industry consolidation, 2) the "expanded facility participation" permitted by Obamacare, and 3) the Obama Administration's

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[36] Avalere Health, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023," Report for Physicians Advocacy Institute, April 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf.
[37] Mathews, "Behind Your Rising Health Care Bills."
[38] Ibid.
[39] Section 7101 of the Patient Protection and Affordable Care Act, P.L. 111-148.
[40] Health Resources and Services Administration, "Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services," *Federal Register* March 5, 2010, https://www.govinfo.gov/content/pkg/FR-2010-03-05/pdf/2010-4755.pdf, pp. 10272-79; Government Accountability Office, "340B Drug Discount Program: Agency Oversight Has Improved, but Actions Needed to Address Weaknesses," Testimony before Senate Health, Education, Labor, and Pensions Committee, Report GAO-26-108784, https://www.gao.gov/assets/gao-26-108784.pdf, Figure 2, p. 5.
[41] GAO, "340B Drug Discount Program," Figure 2, p. 5.
[42] Congressional Budget Office, "Growth in the 340B Drug Pricing Program," September 9, 2025, https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf, Figure 1, p. 2.

regulatory change in the month of Obamacare's enactment that permitted covered entities to contract with unlimited off-site pharmacies.[43]

That same CBO analysis also concluded that the 340B program expanded by Obamacare "encourages behaviors that tend to increase federal spending."[44] Among the behaviors the budget office highlighted:

- "An incentive to prescribe more drugs and to shift prescriptions to drugs" on which they can generate the greatest amount of profits from the 340B program;
- A lowering of rebates that manufacturers provide to Medicare Part D, Medicare Advantage, and commercial insurance plans, leading to higher spending on these forms of coverage;
- The use of 340B profits "to offer new types of services," particularly those that could require prescribing drugs, potentially leading to higher spending; and
- An increase in consolidation within the health care sector, because the 340B program "incentivize[s] the integration of hospitals and off-site clinics," giving providers greater market clout against insurers in ways that result in higher prices for care.[45]

Other independent analyses confirm CBO's conclusions. A recently published study used regression analysis to find that the 340B program—which Obamacare greatly expanded—accounted for a 1.8% increase in Exchange benchmark premiums, and $2.2 billion in additional federal subsidy spending, in 2024.[46]

While I don't agree with all of the policy solutions proffered by the author of "How Obamacare Created Big Medicine," I agree with much of its diagnosis regarding the problems plaguing the health care system. Letters like that sent by Sen. Warren demonstrate that both the progressive left and conservative right agree that Obamacare exacerbated the problem of unaccountable oligopolies raising health care costs.

Impact of Enhanced Subsidies' Expiration

Unlike Sen. Warren, however, I do not believe Congress should throw good taxpayer money after bad by extending the enhanced Obamacare subsidies, and continuing to prop up a system that has failed the American people. With GAO finding that the Centers for Medicare and Medicaid Services (CMS) has not updated its fraud risk assessment in seven years—despite subsidy payments more than doubling from 2018 to 2024—and that CMS' 2018 fraud assessment contained several material omissions, taxpayers should not have more of their hard-earned money put at risk for continued fraud.[47]

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[43] Ibid., p. 3.
[44] Ibid., p. 3.
[45] Ibid., pp. 22-23.
[46] Neal Masia, *et al*., "The Association of the 340B Program with Affordable Care Act Premiums: A Longitudinal Analysis from 2018 to 2022," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* September 2025, https://journals.sagepub.com/doi/pdf/10.1177/00469580251370317.
[47] GAO, "Patient Protection and Affordable Care Act," pp. 17-20.

Moreover, Obamacare's insurance subsidy structure "shields buyers from premium increases but ensures that when premiums rise, taxpayers pay more," giving insurers *carte blanche* to raise premiums, particularly in areas with little competition.[48] A recent Joint Economic Committee paper analyzed data from an earlier study to conclude that in 2017, consumers received the benefit of only 34 cents of every marginal dollar in Obamacare subsidy spending, because 1) insurers used the subsidies to raise premiums, allowing them to receive 38 cents of every subsidy dollar in benefits to their bottom line and 2) higher premiums discouraged enrollment, making 28 cents of every subsidy dollar a deadweight loss.[49]

While Congress should allow the temporary COVID-era subsidy regime to expire at the end of the month, it is worth headlines about their expiration in context:

- Claims that "premiums will double" conflate *total premiums* with *the portion of premium that enrollees pay out-of-pocket*.[50] According to health insurers' own rate filings, the expiration of the enhanced subsidies will have only a modest impact on total premium increases for 2026—and total premiums will by no means double.[51]
- Expiration of the enhanced subsidies means the average percentage of premium paid by federal subsidies will decline from approximately 88% to 78%.[52] To repeat: ***If the enhanced subsidies expire, the federal government will still pay an average of approximately 80% of enrollees' premiums***.[53]
- Under the enhanced subsidy regime, nearly half of Exchange enrollees qualify for "free" benchmark coverage based on their income.[54] A Brookings Institution study concluded that approximately 8 million (34%) Exchange enrollees are currently

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[48] Tony LoSasso and Kosali Simon, "The Real Fix for Obamacare," *The Wall Street Journal* November 17, 2025, https://www.wsj.com/opinion/the-real-fix-for-obamacare-8f340a08.

[49] Joint Economic Committee, "Long Overdue: Enhanced Premium Tax Credits Should Expire," November 6, 2025, https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/issue-briefs/Enhanced%20Premium%20Tax%20Credits%20Should%20Expire.pdf; Maria Polyakova and Stephen P. Ryan, "Subsidy Targeting with Market Power," National Bureau of Economic Research Working Paper 26367, August 2021, https://www.nber.org/system/files/working_papers/w26367/w26367.pdf.

[50] Chris Jacobs, "Obamacare Premiums Are Doubling? Don't Believe It," *The Wall Street Journal* October 20, 2025, https://www.wsj.com/opinion/obamacare-premiums-are-doubling-dont-believe-it-6a7316d7.

[51] Jared Ortaliza, *et al*., "How Much and Why ACA Marketplace Premiums Are Going Up in 2026," KFF, August 6, 2026, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/; Cynthia Cox, "ACA Insurers Are Raising Premiums by an Estimated 26%, But Most Enrollees Could See Sharper Increases in What They Pay," KFF, October 28, 2025, https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/.

[52] Jared Ortaliza, *et al*., "Inflation Reduction Act Health Insurance Subsidies: What Is Their Impact and What Would Happen If They Expire?" KFF, July 26, 2024, https://www.kff.org/affordable-care-act/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

[53] Blase, "Assessing the Damage," Figure 1, p. 3.

[54] KFF, "Marketplace Plan Selections by Household Income," 2025 Open Enrollment Period, https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-household-income-2/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

enrolled in such "zero-dollar" insurance plans.[55] Focusing solely on percentage increases gives a highly misleading picture, particularly for this population, because paying any portion of the total premium out-of-pocket—*even one penny*—represents an infinitely large increase in percentage terms.

- In absolute dollar terms, the enhanced subsidies' expiration will have a modest impact. KFF estimates an average annual out-of-pocket increase for Exchange enrollees of $1,016, or $84.67 monthly.[56]
- A separate Urban Institute study found that, for enrollees with incomes below 250% of poverty—who qualify for the richest subsidies, and represent roughly three-quarters of enrollees—increases will average $750 per year, or $62.50 per month.[57]
- Some enrollees with incomes just above four times poverty may face sizable cost increases, as they will lose all subsidy eligibility if the enhanced subsidies expire. However, all households with incomes above four times poverty, including those who qualify for no subsidies at present—like myself—comprise 7% of Exchange enrollees.[58] The Urban Institute estimated the uninsured rate for this cohort would rise by only 5%, because they "are more likely to pick up coverage from an employer" and "are more willing to pay the full premium."[59]

I had previously asked KFF, formerly the Kaiser Family Foundation, for more granular data on the estimated financial impact of the enhanced subsidies' expiration on households; KFF declined to provide the requested information.[60] I think this topic would be ripe for an oversight request from the respective subcommittees to KFF and the Urban Institute, because I believe release of the more granular data would demonstrate that most households would face a relatively modest financial impact.

I would also add that at the end of 2021, Congress allowed provisions creating an enhanced refundable child tax credit, also enacted as part of the American Rescue Plan Act, to expire.[61] While extending the enhanced Exchange subsidies would cost $23.4 billion over one year, and $349.8 billion over a decade, extending the enhanced child tax credit had a

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[55] Matthew Fiedler, "How Would Eliminating $0 Marketplace Premiums Affect Insurance Coverage?" Brookings Institution, October 8, 2025, https://www.brookings.edu/articles/how-would-eliminating-0-marketplace-premiums-affect-insurance-coverage/.

[56] Justin Lo, *et al*., "ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire," KFF, September 30, 2025, https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/. By comparison, the premium increase for my (unsubsidized) bronze plan will total $100.63 per month, or $1,207.56 for all of 2026. Personal communication from D.C. Health Link, November 1, 2025.

[57] KFF, "Marketplace Plan Selections;" Matthew Buettgens, *et al*., "4.8 Million People Will Lose Coverage in 2026 if Enhanced Premium Tax Credits Expire," Urban Institute, September 2025, https://www.urban.org/sites/default/files/2025-09/4.8-Million-People-Will-Lose-Coverage-in-2026-If-Enhanced-Premium-Tax-Credits-Expire.pdf, Figure 1, p. 8.

[58] KFF, "Marketplace Plan Selections."

[59] Buettgens, *et al*., "4.8 Million," p. 10.

[60] Jacobs, "Obamacare Premiums."

[61] Section 9611 of ARPA.

far larger price tag—$185 billion over one year, and nearly $1.6 trillion over ten years, according to CBO.[62]

In other words, just a few short years ago, a Democratic Congress allowed a COVID-era policy ***more than four times as large as the enhanced subsidies*** to expire—with little long-term economic impact, and markedly less attention paid to the expiration by the media, the public, and Congress itself. Given the numerous reports about fraud associated with the enhanced subsidies, I hope that this Republican Congress will follow the example of its Democratic predecessor and allow this temporary COVID-era policy to expire.

Long-Term Policy Recommendations

More broadly, Congress should keep a few simple principles in mind when considering health policies to move away from the failed Obamacare model:

Portability: However well-intentioned, Obamacare's emphasis on "protecting" people with pre-existing conditions has only incentivized insurers to avoid the sickest patients. By contrast, conservative policy should encourage individuals to buy coverage before they develop a pre-existing condition—that is, portable insurance that individuals can buy, hold, and keep. If more individuals purchased portable coverage that they, and not their employer, owned, Americans would not face the horrific prospect of losing both their job and their health coverage if an illness makes them too sick to continue working.

Rules issued by the first Trump Administration regarding Health Reimbursement Arrangements (HRAs), which allow employers to provide a pre-tax subsidy to their employees to buy a policy that the worker, not the employer, owns and controls, represent a good first step in this direction.[63] Other proposals in this vein include Association Health Plans, short-term limited-duration plans, and catastrophic coverage.

Incentives: Broadly speaking, President Trump's comments about empowering patients over insurance companies point towards the correct approach. While Americans obviously cannot "shop" for health care while in an ambulance suffering a medical emergency, they can and should have the ability to select the form of health coverage, and health care, that would best meet their needs. Just as important: Empowering patients would move away from the current system of Exchange subsidies that sees nearly half of enrollees qualifying for "free" benchmark coverage, and shifts the marginal cost of every additional premium dollar on to taxpayers.[64]

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[62] CBO, Letter to Sens. Schumer, *et al*., Table 1, p. 13; Congressional Budget Office, Letter to Rep. Gary Palmer regarding making selected Build Back Better policies permanent, December 21, 2021, https://www.cbo.gov/system/files/2021-12/57706-BBBA-Palmer-Letter.pdf, Table 1, p. 3.
[63] Departments of the Treasury, Labor, and Health and Human Services, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," *Federal Register* June 20, 2019, https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf, pp. 28888-29027; Chris Jacobs, "Republicans Already Have an Obamacare Alternative," *The Wall Street Journal* November 12, 2025, https://www.wsj.com/opinion/republicans-already-have-an-obamacare-alternative-f1accff2.
[64] KFF, "Marketplace Plan Selections;" LoSasso and Simon, "The Real Fix."

Expanding Health Savings Accounts would help to realign incentives. If Congress removed the existing prohibition on using HSA dollars to fund insurance premiums, such a solution would also enhance portability, and allow employers to fund (via an HSA contribution) a health insurance policy that the worker, and not the employer, chooses and owns.[65] Empowering patients with their own health care dollars could also lead to an expansion of Direct Primary Care arrangements, which in many cases provide quality, personalized care at a lower monthly cost than Obamacare-compliant insurance plans.

Transparency: Realigning incentives to empower patients over insurers is necessary, but not sufficient. Changing incentives will only change outcomes if patients have the price and quality information necessary to make educated decisions about their care options.

For many years, the health care-industrial complex, most notably the hospital industry, has worked overtime to prevent consumers from learning the details behind the care they receive. As noted above, hospitals have utilized their market power to write a lack of transparency into their contracts, blocking their prices from an insurer's online shopping tools, and even forbidding a company like Wal-Mart from excluding low-quality hospitals from its provider networks.[66] More recently, some hospitals used special coding on their websites to block pricing information that federal law requires them to disclose from being available via web search engines like Google.[67]

More robust transparency measures, and more robust enforcement of existing measures, appear necessary to effect meaningful change. As a conservative, I am traditionally loathe to embrace new regulatory requirements. However, the intransigence of many in the health care sector to reveal their prices—a foundational principle in practically every other segment of the economy—may make such a move necessary, and certainly better than the alternative of a fully government-run health care system.

Conclusion

More than 15 years after its passage, and over a decade after its major provisions took effect, it is clearer than ever that Obamacare has failed. Premiums did not fall by $2,500 per family, as candidate Obama promised; in fact, the law has contributed to consolidation within the health care sector that has saddled Americans with ever-higher costs and care of inconsistent quality. We can—and must—do better than our current failed system.

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

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[65] The current statutory prohibition on using HSA dollars to pay for insurance premiums (in most cases) is at 26 U.S.C. 223(b)(2).

[66] Mathews, "Behind Your Rising Health Care Bills."

[67] Tom McGinty, Anna Wilde Mathews, and Melanie Evans, "Hospitals Hide Pricing Data from Search Results," *The Wall Street Journal* March 22, 2021, https://www.wsj.com/health/healthcare/hospitals-hide-pricing-data-from-search-results-11616405402.