FIGHTING OBAMACARE SUBSIDY FRAUD: IS THE ADMINISTRATIVE PROCEDURE ACT WORKING AS INTENDED?

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

JOINT WITH THE

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

OF THE

COMMITTEE ON THE JUDICIARY

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

WEDNESDAY, DECEMBER 10, 2025

Serial No. 119–42

Printed for the use of the Committee on the Judiciary

Available via: *http://judiciary.house.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

62–276 WASHINGTON : 2026

COMMITTEE ON THE JUDICIARY

JIM JORDAN, Ohio, *Chair*

DARRELL ISSA, California
ANDY BIGGS, Arizona
TOM MCCLINTOCK, California
THOMAS P. TIFFANY, Wisconsin
THOMAS MASSIE, Kentucky
CHIP ROY, Texas
SCOTT FITZGERALD, Wisconsin
BEN CLINE, Virginia
LANCE GOODEN, Texas
JEFFERSON VAN DREW, New Jersey
TROY E. NEHLS, Texas
BARRY MOORE, Alabama
KEVIN KILEY, California
HARRIET M. HAGEMAN, Wyoming
LAUREL M. LEE, Florida
WESLEY HUNT, Texas
RUSSELL FRY, South Carolina
GLENN GROTHMAN, Wisconsin
BRAD KNOTT, North Carolina
MARK HARRIS, North Carolina
ROBERT F. ONDER, JR., Missouri
DEREK SCHMIDT, Kansas
BRANDON GILL, Texas
MICHAEL BAUMGARTNER, Washington

JAMIE RASKIN, Maryland, *Ranking Member*
JERROLD NADLER, New York
ZOE LOFGREN, California
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
ERIC SWALWELL, California
TED LIEU, California
PRAMILA JAYAPAL, Washington
J. LUIS CORREA, California
MARY GAY SCANLON, Pennsylvania
JOE NEGUSE, Colorado
LUCY MCBATH, Georgia
DEBORAH K. ROSS, North Carolina
BECCA BALINT, Vermont
JESÚS G. "CHUY" GARCÍA, Illinois
SYDNEY KAMLAGER-DOVE, California
JARED MOSKOWITZ, Florida
DANIEL S. GOLDMAN, New York
JASMINE CROCKETT, Texas

SUBCOMMITTEE ON OVERSIGHT

JEFFERSON VAN DREW, New Jersey, *Chair*

BARRY MOORE, Alabama
ROBERT F. ONDER, JR., Missouri
DEREK SCHMIDT, Kansas
BRANDON GILL, Texas

JASMINE CROCKETT, Texas, *Ranking Member*
JARED MOSKOWITZ, Florida
HENRY C. "HANK" JOHNSON, JR., Georgia

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

SCOTT FITZGERALD, Wisconsin, *Chair*

DARRELL ISSA, California
BEN CLINE, Virginia
LANCE GOODEN, Texas
HARRIET HAGEMAN, Wyoming
MARK HARRIS, North Carolina
DEREK SCHMIDT, Kansas
MICHAEL BAUMGARTNER, Washington

JERROLD NADLER, New York, *Ranking Member*
J. LUIS CORREA, California
BECCA BALINT, Vermont
JESÚS G. "CHUY" GARCÍA, Illinois
ZOE LOFGREN, California
HENRY C. "HANK" JOHNSON, JR., Georgia

CHRISTOPHER HIXON, *Majority Staff Director*
ARTHUR EWENCZYK, *Minority Staff Director*

C O N T E N T S

WEDNESDAY, DECEMBER 10, 2025

OPENING STATEMENTS

	Page
The Honorable Jefferson Van Drew, Chair of the Subcommittee on Oversight from the State of New Jersey	1
The Honorable Jasmine Crockett, Ranking Member of the Subcommittee on Oversight from the State of Texas	4
The Honorable Scott Fitzgerald, Wisconsin, Chair of the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust	6
The Honorable Jamie Raskin, Ranking Member of the Committee on the Judiciary from the State of Maryland	7
The Honorable Jim Jordan, Chair of the Committee on the Judiciary from the State of Ohio	10

WITNESSES

Seto J. Bagdoyan, Director of Audit Services, Forensic Audits & Investigative Service, Government Accountability Office	
Oral Testimony	12
Prepared Testimony	14
Dr. Brian C. Blase, President, Paragon Institute of Health	
Oral Testimony	50
Prepared Testimony	52
Dr. Ge Bai, Professor of Accounting, Johns Hopkins Carey Business School	
Oral Testimony	72
Prepared Testimony	74
Zack Cooper, Associate Professor of Public Health and Economics, Yale University	
Oral Testimony	85
Prepared Testimony	87

LETTERS, STATEMENTS, ETC. SUBMITTED FOR THE HEARING

All materials submitted for the record by the Subcommittee on Oversight and the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust are listed below	114

Materials submitted by the Honorable Jefferson Van Drew, Chair of the Subcommittee on Oversight from the State of New Jersey, for the record
- A report entitled, "Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist," Dec. 3, 2025, *U.S. Government Accountability Office*
- A press release entitled, "President of Insurance Brokerage Firm and CEO of Marketing Company Convicted in $233M Affordable Care Act Enrollment Fraud Scheme," Nov. 17, 2025, *Office of Public Affairs, The Department of Justice*

An article entitled, "The Great Obamacare Enrollment Fraud," Jun. 2024, *Paragon Health Institute*, submitted by the Honorable Barry Moore, a Member of the Subcommittee on Oversight from the State of Alabama, for the record

Page

Materials submitted by the Honorable J. Luis Correa, a Member of the Committee on the Judiciary from the State of California, for the record
An article entitled, “Health Savings Accounts, Backed by GOP, Cover Fancy Saunas but Not Insurance Premiums,” Dec. 5, 2025, *KFF Health News*
An article entitled, “Why health savings accounts aren’t the fix Republicans hope for,” Nov. 25, 2025, *The Washington Post*
An article entitled, “Trump wants more health savings accounts. A catch: they can’t pay insurance premiums,” Dec. 5, 2025, *Fortune*
An article entitled, “Fraud in Marketplace Enrollment and Eligibility: Five Things to Know,” Jun 30, 2025, *Kaiser Foundation*
A fact sheet entitled, “Tell Congress: Don’t make health insurance less affordable for 28,000 working Californians and their families in CA–46,” *Keep Americans Covered*
An article entitled, “The expiration of the ACA’s enhanced premium tax credits will devastate the small business community,” 2025, *Small Business Majority*
Materials submitted by the Honorable Jamie Raskin, Ranking Member of the Committee on the Judiciary from the State of Maryland, for the record
An article enitled, “Setting the Record Straight: Separating Fact from Fiction on Health Insurance Marketplace Fraud,” Aug. 28, 2025, *American Hospital Association*
An article entitled, “$27,000 a Year for Health Insurance. How Can We Afford That?” Dec. 10, 2025, *The New York Times*
An article entitled, “Health Savings Accounts: Robin Hood in Reverse,” Apr. 15, 2024, *Georgetown University*

FIGHTING OBAMACARE SUBSIDY FRAUD: IS THE ADMINISTRATIVE PROCEDURE ACT WORKING AS INTENDED?

Wednesday, December 10, 2025

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON OVERSIGHT

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

COMMITTEE ON THE JUDICIARY
Washington, DC

The Subcommittees met, pursuant to notice, at 3:44 p.m., in Room 2141, Rayburn House Office Building, the Hon. Jefferson Van Drew [Chair of the Subcommittee] presiding.

Present: Representatives Van Drew, Fitzgerald, Moore, Issa, Onder, Harris, Crockett, Correa, Moskowitz, Johnson, Balint, and Garcia.

Mr. VAN DREW. The Subcommittee will come to order. Without objection, the chair is authorized to declare a recess at any time.

We welcome everyone to today's hearing. Thank you so much for being here. I know it's been a little unsettling, a little crazy in New Jersey vernacular, but it is what it is, and we do appreciate your time and your presence.

I now recognize Dr. Onder to lead us in the pledge of allegiance. Then, I ask you to remain standing for a moment of silence.

ALL. I pledge allegiance to the flag of the United States of America, and to the Republic for which it stands, one Nation, under God, indivisible, with liberty and justice for all.

Mr. VAN DREW. I will now recognize myself for an opening statement.

Today this Committee examines a serious question that effects millions of average, everyday Americans every single day. As the Affordable Care Act as written and as implemented allowed waste, fraud and abuse to flourish, while real American families are left to struggle under a system that was supposed to protect them. This is about real people, real families in every district and every State in this great country.

Good families who work hard, play by the rules and yet are still getting crushed by a system that was supposed to help and protect them. It's not fair. It's wrong. Frankly, it is disgusting.

The people have done nothing wrong. The politicians have let them down. That is the real reason we're here. We're not here—and I almost feel like saying this, I hope I don't have to stay it over and over again, we are not here to debate what a new healthcare plan may look like. That is under another Committee's jurisdiction.

We are not here to entertain scare tactics about stripping healthcare away. I really do believe no Republican wants to do that. Let me say up front to my colleagues on the other side, no one should pretend otherwise today. Today we are here to study it and look deep into and understand, particularly what my good friend the Chair of the Committee of the whole brought forward when he asked for a GAO investigation into this, the Government Accountability Office, totally nonpartisan.

We shouldn't distract, we shouldn't dodge, and we shouldn't run from what this nonpartisan GAO investigation uncovered. Everytime someone tries to change the subject, it sends a message to the American people that defending the current corrupt ACA matters more than defending the families being hurt by it.

The worst thing that we could do is pretend this system is working simply because people rely on it. We shouldn't pretend. Yes, people rely on it, but it's not good. People rely on it because they have no other choice very often. We're here to examine the failures of the system that exists right now and right here.

Right now, the nonpartisan Government Accountability Office has revealed the ugly truth. They tested the ACA and the ACA failed. The GAO created fake applicants, get this, they created fake applicants using fictitious identity, missing documents and questionable personal information.

The system approved them all anyway. These imaginary enrollees received tens of thousands of taxpayer dollars month after month, even though they didn't exist. No verified identity, no proof of citizenship and no income documentation. Nothing, nothing at all.

Think about this, this was not a partisan Republican stunt. This was a nonpartisan Government Accountability Office, tens of thousands of your hard-earned tax dollars went sent to identities invented out of thin air.

The fraud doesn't just waste tax dollars, it drives premiums higher for good, honest Americans. This is a program that paid out roughly $124 billion last year. That's a big number. If even a small fraction of that is tied to fraud or improper use, that is a huge number. We're talking about a real national crisis.

Let me be clear and I want to be clear on this too, I'm not calling for the—me, personally, I am not calling for this entire system to be torn town overnight. That is not the question for us today. What we cannot do is make these subsidies permanent forever, because the system is also damaging American livelihoods and weakening their healthcare system.

The real question is how we replace it, how we replace it and when we replace it in a responsible way that makes it safe for good Americans. Even with all the problems we have, we have to make it safe. We have to treat our American people properly.

The American people are the victims of this corrupt structure; they deserve a bridge to hold them up while we build something much better. If a short-term extension—let me be blunt—is necessary, we should be clear about two things of the short-term extension: First, it is only to ensure families do not lose their healthcare in the immediate term.

Second, the system is not sustainable and cannot serve as a long-term or permanent solution.

Those two things we know. We have to take care of the here and now. We have to take care of them. We've got to do something short-term with it, but long-term we've got to do much, much better. Keeping it on autopilot with no reforms or accountability is purely negligent.

When you look at the facts of this report, the depth of negligence becomes undeniable. The nonpartisan Government Accountability Office also found, and boy get all of this, there was no proper verification of income, eligibility, or accuracy in the payments. You couldn't make this stuff up.

The GAO found Social Security numbers used to enroll multiple people into one account and they were all one family. They even found Social Security numbers that belonged to dead people—you can't make it up—that were being used.

Think about it, we are letting criminals use dead Americans identities to scam living Americans out of their healthcare benefits. If a system cannot tell the dead from the living, then for sure it's failing and yet insurance companies get paid, whether the patient is real or fake, while the family who actually needs care is left fighting denials, delays, and rising premiums. That's the real world. This is a moral failure.

Meanwhile, the Government Accountability Office found that hundreds of thousands of Americans are being switched into plans without their knowledge. Imagine a slick con man calling a vulnerable family and tricking them into it a plan they don't want, they don't need and actually hurts them. We have that. We have agents and we have them doing that as we speak. That is sad.

It's horrible and it's cruel what these brokers and agents—not all of them, but these fake ones are doing. The truth is it isn't just random. The ACA structure has allowed an industry with dishonest brokers to profit from exploiting people's confusion and switching people into plans they never wanted and never asked for.

Despite that fact, CMS received hundreds of thousands of complaints last year from people enrolled or moved without their very consent. The GAO also noticed that CMS has not updated its fraud risk assessment since 2018. It's simply unacceptable.

Today we will hear from experts, thank you for being here. You studied how fraud spread through the marketplace. We will hear how insurers profited, while families struggled and were hurt. It has been great for insurance companies. Man, they have been making money hand over fist.

We will assess whether the Administrative Procedure Act is even being applied in a way that prevents meaningful action against the waste, the fraud, and the abuse that have plagued this system.

Our goal is straightforward here today. We must protect those who depend on coverage today. I get it. We must also hold accountable to those who exploited them and exploited the system.

We must build a path forward that delivers affordable, accessible and accountable care for our American people, because the healthcare system cannot function when the rule of law is just optional, just optional for agencies, but somehow it's mandatory for patients.

With that being said, I now recognize the Ranking Member, Ms. Crockett.

Ms. CROCKETT. Thank you very much, Mr. Chair. I must tell you that as you spoke, my little pen got to going, as well as a couple of other people up here, because you said something to the effect of slick con man, calling and tricking people. I thought that was profound, because it seems like that's how we got into this mess, a slick con man has tried to convince people that healthcare should not be available to everyone.

That's why right now there are millions of Americans that have no understanding of what will happen, they don't know if they are going to lose their health insurance or not. Frankly, after the big ugly bill was passed, we know that there's going to be a minimum of 17 million people that will lose their coverage. Let's talk about these subsidies because that's what we're here to talk about today.

In a matter of days Americans across the country will either begin paying thousands of dollars more per month for health insurance or losing their coverage entirely. In fact, more than 350,000 people, all whom live in districts represented by Republicans on this Committee, will lose their coverage entirely.

The 25,000 of Chair Jordan's constituents will lose coverage, 30,000 of Chair Van Drew's constituents will lose coverage, 20,000 of Chair Fitzgerald's constituents will lose coverage. They have the opportunity right now to sign the House Democrats discharge petition to force a vote to extend the Affordable Care Act tax subsidies for three years.

I appreciate that the Chair said that he doesn't feel like it should be permanent. I appreciate that it sounds like the Chair also did not have a fix. What the Chair did not say is whether or not he would sign the discharge petition, which is only asking for an extension. Considering the fact that the last time I checked the House, the Senate, and the White House are run by Republicans, hopefully within the next three years they could actually find a plan. Nevertheless, I invite my colleagues on the other side of the aisle to do right, not by my constituents, but by their own.

Instead, they've called this performative hearing to try to district the American people from what is about to hit them—the fact they have sold out their constituents because Donald Trump and their billionaire donors told them to do so.

Their fake concern for fraud, waste, abuse, and their talking points on lowering the cost of living, well it's all B.S., every single bit of it. They gave these billionaires permanent tax cuts, and they are sacrificing the average American to pay for it. They canceled grants that schools were using to improve student outcomes.

They stole resources that farmers in rural communities to expand local food systems. They took resources from preschool and early childhood education programs. They dismantled programs that helped tackle homelessness and assist seniors. They eliminated medical research grants that have helped thousands of people battling cancer and Alzheimers.

They have done all of that but won't even help their constituents see a doctor, buy food, pay rent, or pay for childcare. They are OK with corporate socialism, but if you're a teacher, a police officer, a student, or a sanitation worker, if you are living paycheck to paycheck, if you can't afford childcare, if you can't pay your rent, if you can't feed your children, if you can't afford to pay for college, and if you're struggling with medical debt, well you're SOL in Trump's America.

Congressional Republicans don't believe they have the responsibility to look out for their constituents; they have been a reckless rubber stamp for Donald Trump who doesn't even believe that there's an affordability crisis. In fact, he thinks affordability is quote, "a hoax." While their constituents were lining up by the hundreds at food banks across the country, the President was literally mocking working class Americans at his Great Gatsby themed Halloween party.

These people have shown us what they prioritize, and it isn't stopping fraud, waste, or abuse. In fact, President Trump has pardoned criminals who have stolen more than a billion dollars from Americans. The only thing they care about is making the rich richer at the expense of their own constituents.

That's been Donald Trump's focus and congressional Republicans have gone along with it. This hearing is nothing more than another Republican attempt to dismantle the Affordable Care Act. It's performative to distract your attention away from the fact that they don't have a healthcare plan. Just concepts of one.

I do want to make sure that I cover one other thing that the Chair spoke about. He specifically said that he's concerned about the fraud. He's not giving us numbers, but I can give you some numbers. If we're concerned about how much money it may be costing us because systems are not perfect, we have no perfect systems, we have always had some level of fraud in anything that we have because there's no such thing as perfection walking on this Earth.

What I can tell you is that I seriously doubt—whatever level of fraud it is that the Chair is speaking of, I seriously doubt that it amounts to the over $200 million that the President is trying to line his pockets with of taxpayer dollars because he feels like he's been aggrieved. I can probably tell you that the $40 billion that he sent to Argentina, I'm sure that $40 billion is probably an amount that also is a lot larger than the alleged fraud that has taken place.

If we are going to talk about being fiscally responsible, if we're going to talk about how we can keep people insured and how we can make sure that people are actually going to live to see another day. If it's really about the concern of fraud, then maybe rein in the person that is wasting money or deciding that taxpayers should just line his pockets to the tune of $200 million.

With that, I will yield.

Mr. VAN DREW. I thank the Ranking Member. Just to remind everybody, this hearing has is a great number of things we could debate. Love it, I love to do it. Maybe we will have some colloquies and debates in the future. We really want to focus on the problems with the ACA as it exists now. I will get you some numbers as well.

With that being said, I will recognize the Chair of the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust. Boy, you have got a long name for your Committee. Mr. Fitzgerald, for an opening statement.

Mr. FITZGERALD. Thank you Chairman Van Drew. Thank you to our witnesses for being here today.

Let me set the record straight, ObamaCare is a complete failure. We are a decade and a half into the so-called Patient Protection Affordable Care Act, a bill that was promised to the American people as a solution to lower healthcare spending. Patients have not been protected and healthcare has certainly not become more affordable.

Since ObamaCare was fully implemented in 2014, healthcare premiums have risen 129 percent, over three times the rate of inflation during the same period. Additionally, premium subsidies have risen right along with the premiums.

In 2014, subsidies cost the taxpayers $20 billion. In 2025, that number ballooned to $130 billion and $110 billion increase in 11 years. If patients and taxpayers have not benefited from ObamaCare, who has? Well, unfortunately, it is the large insurance companies.

Since ObamaCare was signed into law, the weighted average of health insurers stock prices are up over 1,000 percent, far exceeding the S&P 500 during it that period. Even a smaller time period since the creation of enhanced premium tax credits in 2021, the Joint Economic Committee pointed out that both the Biden COVID premium subsidies do more to improve the financial outcomes of large health insurers than to reduce healthcare costs for Americans.

The reality is Democrats created a boondoggle that has funneled billions of tax-payer dollars directly from the U.S. Treasury to large health insurance companies, while at the same time added hundreds of billions to our national debt, delivered few results for the American people, and drove premium and premium subsidy costs far beyond inflation.

The Democrats demand that we keep injecting hundreds of billions of dollars into the very system they told us would make healthcare more affordable. Despite clear evidence, they are throwing more money at their failed system that is producing harmful results for Americans.

Wisconsin commonsense will tell you that trying the same action over and over again while expecting a different result is insane. Aside from the insanity of Democrats position on extending ObamaCare premium subsidies, let's talk about the subsidy program integrity or the complete lack thereof. The enhanced subsidies have given rise to rampant fraud, as we'll hear from Mr. Bagdoyan, the GAO found significant instances of fraud in the premium tax credit program.

The system allows insurance companies to effectively get away with stealing from the Treasury. The brokers are paid by insurance companies for each enrollment and are therefore incentivized to enroll as many people as possible. Whenever a person is enrolled or switches their plan, the health insurance company receives a subsidy, and the broker receives a kickback from the health insurance company. The GAO found that in 2023 there were over 7,000 instances of an already deceased person enrolling in a subsidized health insurance plan.

The GAO has also found in 2023 there were over 19,000 instances of a dead person's Social Security number being used to enroll a living person in a subsidized health insurance. In total, for just one year the GAO found $21 billion in unreconciled subsidies. That number only includes citizens using Social Security numbers. It doesn't include noncitizens who received subsidized care.

Independent research by the Paragon Health Institute estimates as many as 6.4 million enrollees miss represented their income to qualify for the full subsidized ObamaCare premiums. Paragon estimates the cost to taxpayers from this improper enrollment will exceed $27 billion in 2025 alone. This is not incidental. It is systematic risk to a program that has been ripe for abuse from day one. I'm sure our witnesses will elaborate further on that point.

Thankfully, Republicans have taken action to combat this ObamaCare fraud. In H.R. 1, Republicans ensured only U.S. citizens could receive premium tax credits. We also removed the cap on repayments to the Federal Government for excessive subsidies and added stricter eligibility verifications to ensure people do not receive generous subsidies before their eligibility is determined.

In June of this year the Trump Administration, the Department of Health and Human Services issued a rule meant to combat waste, fraud, and abuse in ObamaCare subsidies. The rule would have gone into effect on August 25, 2025, but a Biden-appointed Federal judge issued a stay that prevented most the fraud protection measures in the rule from going into effect.

The judge's opinion was legally and factually ridiculous. The Trump Administration rule would have required individuals enrolled in fully subsidized plans to confirm their eligibility or pay $5, a $5 fee. This judge decided that this easily avoidable fee constituted an illegal premium.

The judge also criticized Paragon data analysis and said the CBO study cited we're too old. We now know that the CBO's analysis is up to date, consistent across the history of ObamaCare and consistent with Paragon's analysis.

In closing, let me just say that Republicans are committed to real reforms that would lower premiums and give patients more choice over their healthcare. Some of our witnesses are prepared to discuss solutions that could do just that.

The ObamaCare as a whole, it's broken. After 15 years, it's broken. Despite generous taxpayer subsidies, it has not made healthcare more affordable, it has not shown evidence of a program that has any integrity and it has only further enriched large health insurance companies. It is truly the un-Affordable Care Act. Now is the time to wheel our healthcare system back into the operating room and perform surgery. Not continue putting billions of dollars and useless Band-Aids on a failed system.

Thank you, Chair. I yield back.

Mr. ONDER. [Presiding.] I now recognize the Ranking Member of the Full Committee, Representative Raskin.

Mr. RASKIN. Thank you very much, Mr. Chair and thank you to all the witnesses for joining us today.

In three weeks, the ACA's tax credits expire. We've got a simple choice in Congress, we can give millions of American families more affordable health insurance by extending the ACA tax credits or we can force on them drastic premium increases, that's the choice. Any other rhetorical exercise today is a diversion and a distraction.

My colleagues want us to change the subject. They want to talk about the problem of fraud, the perennial problem of fraud. There are lots of things we can say about that and maybe we can make some progress on it, but that's a completely different issue.

Fifteen years can ago, the ACA passed and this historic achievement gave millions of Americans who had been priced out of healthcare access actual access to health insurance into it lifesaving medical care. With the enhanced premium tax credits passed by Democrats, coverage became more affordable for tens of millions of people who did not have access to healthcare, but now President Trump and our colleagues want to turn the hands of the clock back, they want to make health insurance more expensive for the American people.

They want to allow tax credits for health insurance to expire. They have a solution to the affordability crisis in America which they call a con job and a Democrat hoax for which hundreds of millions of Americans live with every day. Their solution is to increase health insurance premiums for 22 million Americans by 75 percent on average.

For many Americans their monthly premium payments are doubling or tripling. A 60-year-old in my district who makes $82,000 a year will see their premium increase jump from $581–$1,552, a stunning 167 percent increase. A person making the same salary in our distinguished Chair Jordan's district will see a 248 percent jump in insurance rates with a monthly premium increasing from $581–$2,022.

Thanks to the Kaiser Family Foundation for breaking these down according to congressional districts so Members of Congress can understand what's about to happen to our own people.

Well, our people are looking at working with no health insurance, sending their kids to school with no health insurance, trying to avoid getting the measles under the leadership of Secretary Kennedy at HHS with no health insurance. Our colleagues just say, let them pack the emergency rooms, let them take two conspiracy theories and call me in the morning.

We talk about healthcare for Americans and they change the subject to talk about fraud. That's an old trick. When we talk about Social Security, they talk about fraud. When we talk about Medicare, they talk about fraud. When we talk about Medicaid, they talk about fraud.

All because they oppose these programs for the people, not the fraudulent parts created by criminals who we need to chase down and prosecute, but rather the fairness parts created by Congress for the American people. Now, we talk about extending health insurance and they want to talk about fraud.

Well, why does President Trump have any standing to lecture anyone about fraud? Think about that for a second. He was criminally convicted by a unanimous juries of his peers on 34 different felony counts of falsifying business records to conceal illegal payments he made. He was found guilty of defrauding the State of New York by lying about real estate values and he owes hundreds of millions of dollars in ill-gotten gains to the people of New York. Now, he wants to distract us from their sweeping attack on the healthcare rights the of the people by claiming to be enemies of fraud. What a joke.

The President just used his pardon power to commute the sentence and forgive the fines of a guy, a fellow criminal convict who defrauded the government of $1 billion by exploiting nursing homes and other senior care healthcare facilities. One of the biggest frauds ever committed in the history of the United States he pardoned more than a dozen criminals who stole hundreds of millions of dollars from Medicare and Medicaid for the American people. He pardoned criminals who abused elderly patients and subjected them to unnecessary treatment that were described by the prosecutors in those cases as horrific and barbarian.

If anyone wants to challenge me on any of these facts, I will read to you from the cases. I will give you the documentation. You might prefer not to look at who Donald Trump is pardoning but that does not mean it's not happening.

Not only did he free unrepentant incorrigible fraudsters over the last 11 months, but he also relieved them of their fines and the restitution that they owed to pay their victims. A total right now of more than $1.3 billion and running. Before Trump, all the Presidents had made the people actually payoff their fines and their restitution, but not this President.

A few weeks ago, he pardoned the former president of Honduras, Oscar Hernandez who brought in, check this out, 400 tons which translates to 800,000 pounds of cocaine, billions of individual doses of cocaine into our country to quote, as the President of Honduras said, "to shove up the noses of the gringos," as he so sweetly put it. In our alleged American first President pardoned this sick, fascist, anti-gringo, drug dealer while his war secretary was blowing alleged drug boats and killing 84 people with no declaration of war by Congress and no due process, all allegedly in the name of stopping drugs. What a joke.

The President pardoned Ross Ulbricht, the mastermind behind the dark web platform Silk Road that was used by drug dealers to sell $214 million worth of narcotics. That guy was sentenced to life in prison with no chance of parole. Yet, after Trump pardoned him on day one of his administration, this guy is now back at work, a completely unrepentant criminal and a threat to public safety.

We are being lectured by newly minted antifraud fighters, who utter not a word about any of these pardons of drug traffickers and organized criminals, but people who said nothing when President Trump illegally sat 17 inspectors general in our government, the very people who were tasked with rooting out fraud, abuse and corruption in our government.

In 2024, they saved $71 billion alone. They have been sacked and either not replaced or replaced with a bunch of political hacks. Ten million Americans have already lost their health insurance because of this obscene ugly bill. A new CMS rule will rip care from 1.8 million Americans. Their plan to kill the ACA tax credit would mean another four million American families will no longer have health insurance.

Fraud is a criminally wrong and a serious threat to the well-being of our people. No one is doing more to stop it than the Democrats who built these programs that the fraudsters are going to jail for ripping off for being pardoned by the convicted fraudster President.

Every dollar stolen is a threat to the infrastructure of our safety net. Yes HHS, the Centers for Medicare and Medicaid Services DOJ must do a lot more to fight it. We must all fight, not pardon and exonerate the criminals and fraudsters who steal from the American people.

The way to fight fraud is with targeted antifraud measures not to destroy the public programs that actually serve the American people. They want to get rid of healthcare that we want to protect, and we want to get rid of the fraudsters that they want to pardon done. Choose your side.

I yield back to you, Mr. Chair.

Mr. VAN DREW. [Presiding.] I thank the Ranking Member.

I would like to submit with unanimous consent an article to go into the record. The article is titled, "Patient Protection and Affordable Care Act Preliminary Results," and it just details the Ranking Member asked for numbers, 19,000 in instances of a dead person's Social Security number being used, 160,000 applications in plan year 2024 that had unauthorized changes though brokers, 66,000 Social Security numbers in 2024 that were used for over 365 days illegally. I could go on and on with the numbers of course, but I'd like to submit that.

I'd also like to say again, I want to remind everybody that this hearing is about the Affordable Care Act. If you think it's perfect, if you think there's no fraud, if you think that the Government Accountability Office is lying, then you should say so. I hope that everyone on the other side of the aisle has read this report from one end to the other. It is a nonpartisan report. It's not a Republican report.

With that, I recognize the Chair of the Full Committee, Mr. Jordan.

Chair JORDAN. Thank you, Mr. Chair.

If you like your plan, you can keep your plan. If you like your doctor, you can keep your doctor and premiums will go down. That's what the Democrats told us when they started this thing. They were zero for three. Now, they are telling us oh, the cliff that they created, which is going to happen in 21 days, if we don't extend the subsidies, the whole world is going to end. Subsidies increase costs, choice in competition lower costs. Subsidies drive up premiums, choice in competition lower premiums. No, no, no, they just want to keep doing the same thing.

Now, I understand there is a cliff coming and we should address that, but we should address it in the contact of actually doing something that brings down premiums for all Americans. I think they said 12 million, 22 million, different numbers. Well, there are 340 million and some people in this country that got to deal with healthcare. We would like the premiums to come down for families across the Nation.

Then they said I think the Ranking Member of the Subcommittee, the Senator from Texas said, "there's always some level of fraud." I think the Ranking Member of the Full Committee is talking about perennial fraud, as if it's OK.

Have they read the report? A $21 billion in unreconciled subsidies were paid to insurance companies in one year, 7,000 times dead people enrolled, that's a miracle, holy cow. The 19,000 instances of a dead person's Social Security number being used to enroll someone who's alive. That's crazy too. One time a Social Security number was used to enroll in 125 policies, different policies in one year, that's phenomenal. That's just perennial. That's just your run of the mill, garden variety fraud I guess, according to the Democrats.

We didn't think that's the case. We would like to have healthcare where there is choice in competition, where you don't have this kind of fraud, and you don't have these endless subsidies going on forever so that premiums actually come down for American families. I look forward to hearing from our witnesses to talk about those things that will make a difference for the families we all get the privilege of representing. I yield back.

Mr. ONDER. [Presiding.] Without objection, all other opening statements will be included in the record.

We will now introduce today's witnesses.

Mr. Seto Bagdoyan is a Director of audit services in the Government Accountability Office, Forensic Audits and Investigative Service Division. In FAIS he leads audits of major Federal programs focusing on program integrity and risk management issues.

Dr. Brian Blase is the Founder and President of Paragon Health Institute, a nonprofit organization that works to improve public and private health. He previously served as Special Assistant to the President for economic policy on the White House's National Economic Council.

Dr. Ge Bai. Dr. Bay is a Professor of Accounting at the Johns Hopkins Carey Business School, and Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Her research focuses on healthcare accounting, finance, and policy.

Professor Zack Cooper. Mr. Cooper is an Associate Professor of Public Health and an Associate Professor of Economics at Yale University. His research focuses on healthcare spending and competition in the hospital and insurance markets.

We will begin by swearing you in. Would you please rise and raise your right hand?

Do you swear or affirm under penalty of perjury that the testimony you are about to give is true and correct to the best of your knowledge, information and belief so help you God.

Mr. VAN DREW. Let the record reflect the witnesses have answered in the affirmative. Please know that your written testimony will be entered into the record in its entirety. Accordingly, we ask you to summarize your testimony in five minutes.

Mr. Bagdoyan, you may begin.

STATEMENT OF SETO BAGDOYAN

Mr. BAGDOYAN. Thank you, Mr. Chair, Chair Fitzgerald, Chair Jordan, Ranking Member Crockett, and Ranking Member Raskin, I'm pleased to highlight today initial results of selected aspects from our ongoing review of the ACA APTC program, a program's complex structure, high levels of participation spending and generally weak controls underlie its inherent risks for fraud. This regard APTC spending totaled $124 billion in 2024, making it highly attractive to fraudsters.

To be clear, our review focuses on identifying indicators of potential fraud. This is very important to understand today, in ACA rather than determining the extent of fraud or evaluating its policy or viability aspects. Overall, our current bottom line is threefold, initial results are consistent with those from similar work over 11 years ago.

Risk conditions haven't improved over that time, in fact risks persist and could be significant. The program faces two principle risks, integrity risk from ineligible and eligible applicants perpetrating enrollment or subsidy fraud and consumer harm risk from brokers and agents taking unauthorized actions, jeopardizing health coverage.

More specifically, three principled points were worth noting. First, CM's approach to addressing ACA's fraud risk is short on fundamentals. For example, its capacity to manage risk is weak, including a generally lenient posture regarding controls, obsolete and incomplete fraud risk assessments, the latest dates from 2018 and no comprehensive strategy to proactively counter risk.

Capacity hasn't kept up with significant program changes, including growth and enrollees and spending, frequent shifts in enrollment controls and the expanding role of brokers and agents in facilitating enrollment.

Second, covert testing of enrollment controls indicates that weakness is from similar testing over 11 years ago persist. The 18 of 20 of our ghost applicants using fake information and documents secured ongoing coverage and subsidies totaling $10,000 a month, while many application-related discrepancies remain unresolved.

Third, extensive data analyses flagged multiple indicators of potential fraud. For example, the overuse of SSNs. Multiple policies attached to a single number. The 66,000 instances occurred in 2024, with over 194,000 policies attached to those. That is twice two the 2023 level.

The most overused SSN from 2023 has 127 full year and part year policies attached with annualized subsidies totaling $5,767. Matches with SSAs full death file, deceased individuals associated with active policies of 58,000 matches in 2023, and partial results show 26,000 subsidies, carry subsidies totaling $94 million.

No initial evidence of reconciliation of subsidies, Social Security gaps between pertinent enrollment and tax data suggests that APTCs totaling $21 billion in 2023 were potentially not reconciled as required. This represents 32 percent of all APTCs where applicants included in SSNs and about 23 percent of total APTC spending in 2023.

Also, a potentially unauthorized broker agent activity or as we call it volleying, this involves changes to brokers and agents of record or insurance plans or new coverage initiated, all without consumer knowledge or consent. There were 160,000 instances in 2024, that is five times the 2023 level.

Unauthorized changes jeopardize coverage and could result in consumer harm. For example, curtailed access to providers or medications.

In closing, initial results show ACA's risks persist, undermining program integrity and jeopardizing consumers. However, CMS has not acted decisively and timely to counter them. CMS must acknowledge risks exist and are immediately to take them seriously and bolster its capacity to address them.

This concludes my opening remarks. Thank you.

[The prepared statement of Mr. Bagdoyan follows:]

United States Government Accountability Office

GAO

Testimony Before the Subcommittees on the Administrative State, Regulatory Reform, and Antitrust and Oversight, Committee on the Judiciary, House of Representatives

For Release on Delivery
Expected at 2:00 p.m. ET
Wednesday, December 10, 2025

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Preliminary Results of Ongoing Work Suggest Fraud Risks in the Advance Premium Tax Credit Persist

Statement of Seto J. Bagdoyan, Director of Audits, Forensic Audits and Investigative Service

GAO-26-108811

GAO Highlights

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Preliminary Results of Ongoing Work Suggest Fraud Risks in the Advance Premium Tax Credit Persist

GAO-26-108811 December 10, 2025

A testimony before the Subcommittees on the Administrative State, Regulatory Reform, and Antitrust and Oversight, Committee on the Judiciary, House of Representatives

For more information, contact: Seto J. Bagdoyan at BagdoyanS@gao.gov.

What GAO Found

Preliminary results from GAO's ongoing covert testing suggest fraud risks in the advance premium tax credit (APTC) persist. The federal Marketplace approved coverage for nearly all of GAO's fictitious applicants in plan years 2024 and 2025, generally consistent with similar GAO testing in 2014 through 2016. GAO's covert testing is illustrative and cannot be generalized to the enrollee population.

- **Plan year 2024.** The federal Marketplace approved subsidized coverage for all four of GAO's fictitious applicants submitted in October 2024. In total, the Centers for Medicare & Medicaid Services (CMS) paid about $2,350 per month in APTC in November and December for these fictitious enrollees. For some, the federal Marketplace requested documentation to support Social Security numbers (SSN), citizenship, and reported income. GAO did not provide documentation yet received coverage.
- **Plan year 2025.** Of 20 fictitious applicants, 18 remain actively covered as of September 2025. APTC for these 18 enrollees totals over $10,000 per month. GAO continues to monitor the enrollments as part of its ongoing work.

More broadly, GAO's preliminary analyses identified vulnerabilities related to potential SSN misuse and likely unauthorized enrollment changes in federal Marketplace data for plan years 2023 and 2024. Such issues can contribute to APTC that is not reconciled through enrollees' tax filings to determine the amount of premium tax credit for which enrollees were ultimately eligible. GAO's preliminary analysis of data from tax year 2023 could not identify evidence of reconciliation for over $21 billion in APTC for enrollees who provided SSNs to the federal Marketplace for plan year 2023. Unreconciled APTC may not necessarily represent overpayments, as enrollees who did not reconcile may have been eligible for the subsidy. However, it may include overpayments for enrollees who were not eligible for APTC.

GAO's preliminary analyses identified over 29,000 SSNs in plan year 2023 and nearly 68,000 SSNs in plan year 2024 used to receive more than one year's worth of insurance coverage with APTC in a single plan year. CMS officials explained that the federal Marketplace does not prohibit multiple enrollments per SSN to help ensure that the actual SSN-holder can enroll in insurance coverage in cases of identity theft or data entry errors.

GAO's preliminary analyses also identified at least 30,000 applications in plan year 2023 and at least 160,000 applications in plan year 2024 that had likely unauthorized changes by agents or brokers. This can result in consumer harm, including loss of access to medications. In July 2024, CMS implemented a new control to prevent such changes, which GAO is reviewing in its ongoing work.

GAO preliminarily identified weaknesses in CMS's APTC fraud risk management as compared to leading practices. Specifically, CMS has not updated its fraud risk assessment since 2018 despite changes in the program and its controls. Further, CMS's 2018 assessment may not fully align with leading practices, like identifying inherent fraud risks. Finally, CMS did not use its 2018 assessment to develop an antifraud strategy. Together, these weaknesses appear to hinder CMS's ability to effectively and proactively manage fraud risks in APTC.

Why GAO Did This Study

The Patient Protection and Affordable Care Act provides premium tax credits to help eligible individuals pay for health insurance. The federal government can pay this credit directly to health insurance issuers as APTC. CMS estimated that it paid nearly $124 billion in APTC for about 19.5 million enrollees in plan year 2024. Consumers can enroll in insurance through the federal Marketplace independently or with assistance from an agent or broker.

Recent indictments highlight concerns about agent and broker practices in the federal Marketplace. Further, CMS reported that it received roughly 275,000 complaints in 2024 that consumers were enrolled or had insurance plans changed in the federal Marketplace without their consent.

This testimony discusses preliminary results of ongoing GAO work related to (1) covert testing and (2) data analyses of enrollment controls in the federal Marketplace, as well as (3) CMS's APTC fraud risk assessment and antifraud strategy.

To perform this work, GAO created 20 fictitious identities and submitted applications for health care coverage in the federal Marketplace for plan years 2024 and 2025. The results, while illustrative, cannot be generalized to the full enrollment population. Additionally, GAO analyzed federal Marketplace enrollment data for plan years 2023 and 2024 and compared these data to federal death data and tax data. Finally, GAO assessed documentation related to CMS's fraud risk management activities against relevant leading practices.

What GAO Recommends

GAO's work is ongoing, and it will consider recommendations as part of future products, as appropriate.

Chairmen Fitzgerald and Van Drew, Ranking Members Nadler and Crockett, and Members of the Subcommittees:

I am pleased to appear before you today to discuss preliminary results from selected aspects of our ongoing work related to fraud risk management in the advance premium tax credit (APTC). We recently issued a report summarizing preliminary results from this ongoing work.[1] As a result, the information I present today is subject to that ongoing work and subsequent review and revision.

The Patient Protection and Affordable Care Act (PPACA) provides premium tax credits to those who purchase private health insurance plans and meet certain income and other requirements.[2] Individuals may have the federal government pay this credit to their health insurance issuers in advance on their behalf, known as APTC, which lowers their monthly premium payments.

Millions of consumers have purchased health insurance plans through the marketplaces established under PPACA. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for maintaining the federal Marketplace and overseeing state-based marketplaces. Under PPACA, states may elect to operate their own state-based marketplace or to use the federal Marketplace. These marketplaces determine eligibility for APTC, based in part on income, and allow individuals to compare and choose among insurance plans offered by participating private health care coverage issuers. CMS estimated it paid nearly $124 billion in APTC for about 19.5 million enrollees for plan year 2024.[3]

Consumers can enroll in health insurance coverage through a marketplace independently or with assistance, such as from an insurance agent or broker. As discussed later in this statement, agents and brokers can help a consumer apply for coverage, including for related financial assistance, and enroll in a plan. Assistance from an agent or broker is of no cost to a consumer. Rather, agents and brokers are allowed to receive

[1]GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist*, GAO-26-108742 (Washington, D.C.: Dec. 3, 2025).

[2]26 U.S.C. § 36B and 42 U.S.C. § 18082.

[3]Plan year generally aligns with calendar year.

compensation directly from health insurance issuers in accordance with agreements with those issuers and any applicable state requirements.

Indictments from December 2024 and February 2025 highlight concerns about agent and broker practices in the federal Marketplace. Specifically, the indictments allege that bad actors enrolled consumers in insurance through the federal Marketplace by falsifying information on their applications. Additionally, according to CMS, the agency received approximately 275,000 complaints between January and August 2024 that consumers were enrolled in a plan or had their plan changed without their consent. Such practices can result in wasteful federal spending on APTC for enrollees who are not eligible. Further, such practices can result in harm and unexpected costs for consumers. These can include loss of access to medical providers and medications, higher copayments and deductibles, or repayment of APTC if income or other eligibility was misrepresented.

We previously reported that APTC is at risk of fraud.[4] For example, in September 2016, we found that federal and state marketplaces approved coverage for our fictitious applicants.[5] Nearly all of these fictitious applicants remained covered after we sent fictitious documents or no documents to resolve issues with our applications. Further, in July 2017, we found that CMS did not design processes to verify eligibility for APTC, including preventing duplicate coverage.[6]

[4]See, for example, GAO, *Patient Protection and Affordable Care Act: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year*, GAO-16-784 (Washington, D.C.: Sept. 12, 2016); *Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015*, GAO-16-792 (Washington, D.C.: Sept 9, 2016); and *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29 (Washington, D.C.: Feb. 23, 2016). Appendix I provides the status of GAO's prior recommendations related to fraud risk management in the federal Marketplace. A list of related GAO products is included at the end of this statement.

[5]GAO-16-784.

[6]GAO, *Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit*, GAO-17-467 (Washington, D.C.: July 13, 2017).

My statement today is based on a recent report we issued that summarizes preliminary results and analyses from ongoing work related to fraud risk management in APTC.[7] Specifically, this statement addresses preliminary results from our:

1. covert testing of federal Marketplace enrollment controls for plan years 2024 and 2025,
2. analyses of federal Marketplace enrollment data for plan years 2023 and 2024, and
3. evaluation of CMS's fraud risk assessment and antifraud strategy for APTC.

To perform covert testing of federal Marketplace enrollment controls, we created 20 fictitious identities and submitted applications for individual health care coverage in the federal Marketplace. We submitted applications for four of these fictitious identities in October 2024 for coverage through December 2024, which was the remainder of that plan year. We pursued coverage for plan year 2025 for all 20 fictitious identities, including the four identities for which we already submitted applications. Our covert testing for plan year 2025 is ongoing, since the plan year is not yet complete. As a result, we will describe additional details of the 2025 applications in a future report.

Our covert testing included applications submitted independently through HealthCare.gov, which is the federal Marketplace's website, and applications submitted with assistance from an insurance agent or broker. For all our applicant scenarios, we sought to act as an ordinary consumer would in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

For applications for plan year 2024, our covert tests included fictitious applicants who provided invalid (i.e., never issued) Social Security numbers (SSN). Additionally, we stated income at a level eligible to obtain APTC.[8] As appropriate, we used publicly available information to construct our applications for coverage and subsidies. We also used publicly available hardware, software, and materials to produce counterfeit documents that we submitted, if appropriate for our testing,

[7]GAO-26-108742.

[8]As discussed later in this statement, eligibility for APTC generally requires household income of at least 100 percent or more of the federal poverty level.

when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation. The results of our covert testing, while illustrative of potential enrollment control weaknesses, cannot be generalized to the overall enrollment population.

To examine federal Marketplace enrollment for plan years 2023 and 2024, we obtained and analyzed federal Marketplace enrollment and payment data, including APTC information, from CMS. We also matched enrollee SSNs in the data to two additional data sources: (1) Social Security Administration's (SSA) full death file, a database containing records of death that have been reported to SSA, as of November 2024 and (2) April 2025 data from the Internal Revenue Service (IRS) on APTC reconciliation from tax forms filed for tax year 2023.[9] We assessed the reliability of all data sets by performing electronic tests to determine the completeness and accuracy of key fields. We also reviewed agency documentation and interviewed knowledgeable agency officials about the reliability of the data. Overall, we found that the data were reliable for our purposes.

To examine CMS's fraud risk assessment and antifraud strategy for APTC, we reviewed documentation of CMS's policies and fraud risk management activities related to APTC. This included CMS's 2018 fraud risk assessment for APTC. Additionally, we interviewed agency officials about CMS's fraud risk management activities in this program. We reviewed relevant reports from GAO and HHS's Office of the Inspector General. We evaluated information from relevant documentation and interviews of agency officials against relevant leading practices in GAO's *A Framework for Managing Fraud Risks in Federal Programs* (Fraud Risk Framework).[10]

To support all three objectives, we interviewed CMS officials and representatives from seven stakeholder organizations that represent

[9]SSA does not guarantee the accuracy of the information in the full death file. SSA has historically collected death information about SSN-holders, so it does not pay Social Security benefits to deceased individuals and to establish benefits for survivors. SSA receives death reports from a variety of sources, including states, family members, funeral directors, post offices, financial institutions, and other federal agencies. We refer to SSA's complete file of death records as "the full death file." A subset of the full death file that may not include death data received by the states, which SSA calls "the Death Master File," is available to the public.

[10]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015).

agents and brokers, state insurance regulators, researchers, and one of the entities that CMS approved to host a non-marketplace website where consumers can apply for and enroll in a plan offered through the federal Marketplace.

The ongoing work upon which this statement is based is being conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our preliminary findings and conclusions based on our audit objectives. Additionally, our related investigative work is being conducted in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

APTC Eligibility and Enrollment Processes

APTC Eligibility

To qualify for a premium tax credit, individuals must be enrolled in a qualified health plan offered through a marketplace and meet certain criteria. These tax credits can be paid in advance through APTC.[11] See figure 1 for the APTC eligibility requirements.

Figure 1: Eligibility Requirements for the Advance Premium Tax Credit

In order to be eligible for the advance premium tax credit (APTC), an individual must:

1 Be eligible to enroll in a qualified health plan[a]

- Be a U.S. citizen or national or otherwise lawfully present
- Reside in the marketplace area
- Not be incarcerated[b]

2 Be eligible for the APTC

- Not be eligible for minimum essential coverage through an employer or government-sponsored program
- Meet household income requirements

3 Reconcile APTC

- Annually reconcile household APTC amount on tax return[c]

Source: GAO analysis of APTC eligibility requirements. | GAO-26-108811

[a]To apply and qualify for the APTC, an individual must first be enrolled in a qualified health plan offered through the individual's respective marketplace. The eligibility requirements shown above only

[11]Alternatively, individuals can choose to get all the benefit of the credit when they file their tax return for the year. See 26 U.S.C. § 36B(f) and 45 C.F.R. § 155.310(d)(2)(i).

reflect those that pertain to an individual applying during the open enrollment period, as there may be additional requirements during special enrollment periods.

[b]An incarcerated individual who is awaiting disposition of charges is eligible for a qualified health plan.

[c]Tax return reconciliation is completed for the household of the individual receiving advance payments toward insurance premiums.

The amount of the premium tax credit varies based on household income and the cost of a benchmark plan.[12] The credit limits what the consumer would pay for that plan to be no more than a certain percentage of their household income. The American Rescue Plan Act of 2021 made temporary changes to premium tax credits by expanding eligibility to higher-income individuals and increasing premium tax credits for lower-income individuals for tax years 2021 and 2022.[13] For example, the law increased the premium tax credit amounts for eligible individuals and families, resulting in access to plans with no premium contributions for those earning 100 to 150 percent of the federal poverty level. It also expanded eligibility for premium tax credits to include certain individuals and families with incomes at or above 400 percent of the federal poverty level. Public Law 117-169—commonly known as the Inflation Reduction Act of 2022—extended these provisions through the end of tax year 2025.[14] See table 1.

[12]The cost of a benchmark plan varies based on factors including age and location. Although premium tax credits, including APTC, are calculated based on the premium of a benchmark plan, consumers do not need to be enrolled in a benchmark plan to use these tax credits.

[13]American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182.

[14]An Act To provide for reconciliation pursuant to title II of S. Con. Res. 14, Pub. L. No. 117-169, § 12001, 136 Stat. 1818, 1905 (2022).

Table 1: Maximum Percentage of Household Income Paid for Premiums of the Benchmark Plan, by Federal Poverty Level, 2020 and 2025

Percent of federal poverty level	Maximum percentage of annual household income paid for premiums of the benchmark plan, 2020	Temporary maximum percentage of annual household income paid for premiums of the benchmark plan, 2025[a]
At least 100 up to 150[b]	2.07 – 4.14	0.0
At least 150 up to 200	4.14 – 6.52	0.0 – 2.0
At least 200 up to 250	6.52 – 8.33	2.0 – 4.0
At least 250 up to 300	8.33 – 9.83	4.0 – 6.0
At least 300 up to 400	9.83	6.0 – 8.5
At least 400 and higher	100	8.5

Source: GAO analysis Department of Health and Human Services data. | GAO-26-108811

Note: The cost of a benchmark plan varies based on factors including the consumer's age and location.

[a]These percentages are temporary. The temporary percentages were established in 2021 and extended through 2025. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 and An Act To provide for reconciliation pursuant to title II of S. Con. Res. 14, Pub. L. No. 117-169, § 12001, 136 Stat. 1818, 1905 (2022).

[b]Premium tax credits are generally only available to households with incomes at or above 100 percent of the federal poverty level. Lawfully present immigrants with incomes less than 100 percent of the federal poverty level may receive premium tax credits if they are ineligible for Medicaid based on immigration status. Public Law No. 119-21—commonly known as the One Big Beautiful Bill Act—repealed this eligibility applicable to tax years beginning after December 31, 2025. An Act To provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, title VII, § 71302, 139 Stat. 72, 322 (2025).

In 2013, CMS developed the Data Services Hub (Hub) to help verify applicant eligibility in an automated manner. To do so, the Hub matches applicant information, such as SSN and estimated income, against trusted data sources. These sources include records from SSA and IRS. In the federal Marketplace, the system generates an inconsistency when data matching processes are not able to verify applicant information against the Hub's trusted sources. When an inconsistency is generated, applicants are instructed to provide documentation to support information on their applications that cannot be verified by the Hub's data matching.

Marketplaces and Enrollment Pathways

States, along with the District of Columbia, may elect to rely on the federal Marketplace or operate their own health insurance marketplace. Table 2 describes the types of health insurance marketplaces.

Table 2: Types of Health Insurance Marketplaces

Platform	Description	States using each platform in plan year 2025
Federal Marketplace	The Centers for Medicare & Medicaid Services (CMS) operates the federal Marketplace's website, HealthCare.gov. Consumers in states that operate on the federal Marketplace apply for and enroll in coverage through HealthCare.gov. Consumers can also apply and enroll in coverage through federally approved non-marketplace websites.	28
State-based Marketplace	With approval from CMS, states can choose to operate marketplaces with their own eligibility and enrollment platforms. Consumers in these states apply for and enroll in coverage through marketplace websites established and maintained by the states. Consumers can also apply for and enroll in coverage through state-approved non-marketplace websites.	20
State-based Marketplace on the Federal Platform	States can choose to operate their own marketplace to perform certain core functions and rely on the federal platform to perform eligibility and enrollment functions.	3

Source: GAO analysis of CMS information. | GAO-26-108811

Note: This table includes the 50 states and the District of Columbia.

The federal Marketplace offers multiple pathways to enroll in health insurance coverage and receive APTC. Consumers in states that use the federal Marketplace may enroll in coverage through the pathway known as HealthCare.gov or an enhanced direct enrollment (EDE) pathway, among others. Table 3 describes examples of enrollment pathways in the federal Marketplace.

Table 3: Examples of Enrollment Pathways in the Federal Marketplace

Pathway	Description
Marketplace	The consumer may apply for and enroll in health insurance coverage through the federal Marketplace website, HealthCare.gov.
Direct enrollment	The consumer may use a Centers for Medicare & Medicaid Services (CMS) approved, non-marketplace website to apply for and enroll in health insurance coverage. However, the consumer is directed to HealthCare.gov to complete the eligibility application before enrolling in health coverage. CMS announced plans to end this pathway starting November 1, 2025.
Enhanced direct enrollment	The consumer may use a CMS-approved, non-marketplace website to apply for and enroll in health insurance coverage without being redirected to HealthCare.gov.

Source: GAO analysis of CMS information. | GAO-26-108811

Note: Additional pathways may include applications submitted via paper or telephone.

Role of Agents and Brokers

Consumers seeking to obtain health insurance through the federal Marketplace may receive assistance from agents and brokers who help them apply for coverage, including related financial assistance, and enroll in a health plan.[15] In return, agents and brokers receive payment (commissions or salaries) from the issuers of the health plans. Agents and brokers must be licensed in the state in which they sell plans and registered with CMS to sell plans through the federal Marketplace.[16] According to CMS, most enrollments in the federal Marketplace are assisted by an agent or broker through the EDE and direct enrollment pathways.

CMS is responsible for oversight of agents and brokers in the federal Marketplace and ensuring that they comply with federal rules. Agents and brokers are required to, among other things, obtain and document consumers' consent before assisting them with applying for and enrolling in coverage through the federal Marketplace.[17] For example, consumer consent is required before the agent or broker can:

- collect or use any personally identifiable information, such as name, date of birth, and SSN;
- help a consumer apply for coverage or financial assistance by completing an eligibility application on their behalf; and
- actively enroll a consumer in a plan offered through the federal Marketplace.

After a consumer has applied or is enrolled, the agent or broker can also update a consumer's eligibility application or plan selection on their behalf, if the initial consent authorized the agent or broker to do so, or if they obtained subsequent consent for any new actions. Agents and brokers are required to make documentation of consumer consent available to CMS upon request in response to monitoring, audit, and enforcement actions.

Fraud Risk Management

The objective of fraud risk management is to ensure program integrity by continuously and strategically mitigating both the likelihood and effects of fraud, while also facilitating a program's mission. The Fraud Risk

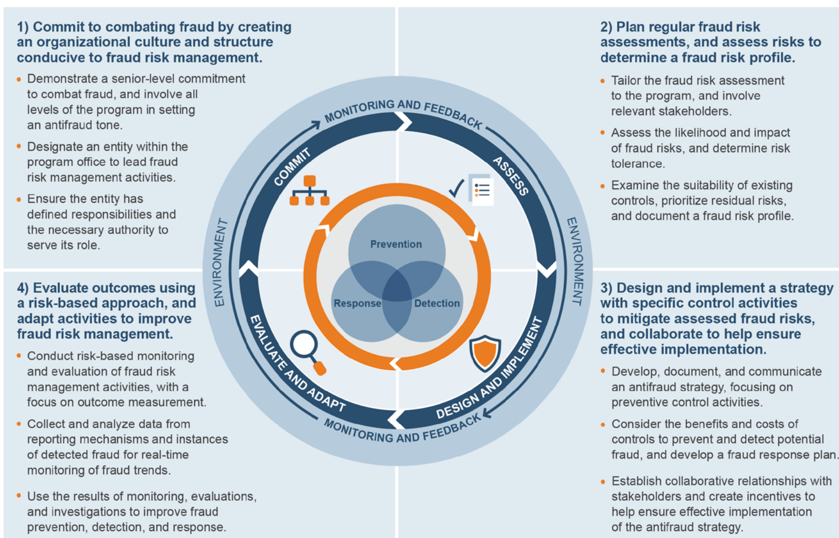
[15] According to HealthCare.gov, agents may work for a single health insurance company, whereas brokers may represent several companies.

[16] To sell plans in the federal Marketplace, agents and brokers must also verify their identity, complete required training, and have signed agreements in place with CMS.

[17] 45 C.F.R. § 155.220(j)(2).

Framework provides a comprehensive set of leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based manner. As depicted in figure 2, the framework organizes the leading practices within four components: (1) Commit, (2) Assess, (3) Design and Implement, and (4) Evaluate and Adapt.

Figure 2: Overview of the Fraud Risk Framework



Source: GAO (information and icons). | GAO-26-108811

In June 2016, the Fraud Reduction and Data Analytics Act of 2015 (FRDAA) required the Office of Management and Budget (OMB) to establish guidelines for federal agencies to create controls to identify and assess fraud risks to design and implement antifraud control activities. The act further required OMB to incorporate the leading practices from the Fraud Risk Framework in the guidelines.[18] The Payment Integrity Information Act of 2019 repealed FRDAA but maintained the requirement for OMB to provide guidelines to agencies in implementing the Fraud Risk Framework.[19]

In its 2016 Circular No. A-123 guidelines, OMB directed agencies to adhere to the Fraud Risk Framework's leading practices.[20] In October 2022, OMB issued a Controller Alert reminding agencies that they must establish financial and administrative controls to identify and assess fraud risks.[21] In addition, the alert reminded agencies that they should adhere to the leading practices in the Fraud Risk Framework as part of their efforts to effectively design, implement, and operate an internal control system that addresses fraud risks.

The Federal Marketplace Approved Subsidized Coverage for Nearly All of Our Fictitious Applicants in Plan Years 2024 and 2025, Suggesting Weaknesses Persist

Our covert testing of enrollment controls in the federal Marketplace suggests weaknesses have persisted since our tests in plan years 2015 through 2016. All four of our fictitious applications received subsidized coverage through the federal Marketplace in late 2024. Additionally, although our work is ongoing, as of September 2025 18 of our 20 fictitious applications for plan year 2025 were receiving subsidized coverage. We will continue to monitor the status of these applications during plan year 2025.

[18]Pub. L. No. 114-86, 130 Stat. 546 (2016).

[19]Pub. L. No. 116-17, § 2(a), Stat. 113, 131 – 132 (2020), codified at 31 U.S.C. § 3357. The act requires these guidelines to remain in effect, subject to modification by OMB as necessary and in consultation with GAO.

[20]Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, OMB Circular No. A-123 (Washington, D.C.: July 15, 2016).

[21]Office of Management and Budget, *Establishing Financial and Administrative Controls to Identify and Assess Fraud Risk*, CA-23-03 (Washington, D.C.: Oct. 17, 2022).

All Four of Our Fictitious Applicants Received Subsidized Coverage in Late 2024

To test enrollment controls, we developed and submitted four fictitious applications to obtain insurance coverage with APTC through the federal Marketplace. We applied for coverage for these four applicants in October 2024. We submitted the applications outside of the open enrollment period, using a special enrollment period for low-income applicants.[22] In two cases, we applied for coverage directly through HealthCare.gov. In the other two cases, we applied via telephone with assistance from an insurance broker.[23] The brokers that assisted us used EDE systems to submit our applications.

The federal Marketplace approved fully subsidized insurance coverage for all four of our fictitious applicants for November through December 2024. The combined total amount of APTC paid to insurance companies for all four fictitious enrollees was about $2,350 per month. While our fictitious enrollees are not generalizable to the universe of enrollees, they suggest weaknesses in enrollment controls—such as identity proofing and income verification—in the federal Marketplace through both HealthCare.gov and EDE systems.[24] Table 4 summarizes the results of our covert testing of enrollment controls for plan year 2024.

[22]To demonstrate eligibility for a low-income special enrollment period, consumers were allowed to self-attest that their income was less than 150 percent of the federal poverty level. Documentation of eligibility for this special enrollment period was not required prior to enrolling. According to agency officials, this special enrollment period is no longer available as of August 25, 2025.

[23]In one case, we called an insurance broker from a list on HealthCare.gov. In the other case, we were connected to an insurance broker after clicking on a potentially misleading advertisement offering a monthly cash subsidy (rather than subsidized insurance coverage). The broker said that he was not familiar with the online advertisement and explained that the money would pay for health insurance premiums rather than a cash subsidy.

[24]According to agency officials, CMS is taking steps to address weaknesses in enrollment controls. For example, CMS issued a rule in June 2025 intended to strengthen controls related to income verification and use of special enrollment periods, among other things. However, as of December 2025, a federal district court has issued an order partially suspending the effective date of the rule pending a final decision in ongoing litigation.

Table 4: Results of GAO's Covert Testing of Enrollment Controls in the Federal Marketplace in Late 2024

Case	Route	Identify proofing	Documentation supporting eligibility: Requested by Marketplace	Submitted by GAO	Accepted by Marketplace	Enrolled and APTC Paid
1	HealthCare.gov	Completed with fictitious documentation	Income	None	N/A	Yes
			Citizenship	None	N/A	
2	HealthCare.gov	Completed with fictitious documentation	None	N/A	N/A	Yes
3	Broker from HealthCare.gov	Not requested[a]	Social Security number (SSN)	None	N/A	Yes
			Income	None	N/A	
			Citizenship	Fictitious[b]	Yes[b]	
4	Broker from Advertisement	Not requested[a]	SSN	None	N/A	Yes
			Income	None	Yes[c]	
			Citizenship	None	N/A	

Legend: APTC = Advance premium tax credit; N/A = Not applicable.

Source: GAO. | GAO-26-108811

[a]In these cases, our fictitious applicants worked with agents or brokers and the Marketplace Call Center to submit applications with invalid SSNs. However, we were not prompted to provide documentation to verify our applicant's identity in either case.

[b]We submitted fictitious documentation to support citizenship for this applicant's 2025 enrollment in December 2024. The Marketplace notified us that it verified our applicant's citizenship using the documentation, which also applied to the applicant's 2024 enrollment.

[c]The Marketplace notified us that it had verified the applicant's estimated income based on documentation we submitted. However, we did not submit documentation to support the applicant's income.

The results of our covert testing for plan year 2024 are generally consistent with results of similar testing we conducted for plan years 2014 through 2016.[25]

Identity Proofing

The federal Marketplace requires applicants to verify their identity before enrolling in insurance coverage. For both of our 2024 applications through HealthCare.gov, our fictitious applicants initially failed the online identity proofing step, as expected.[26] However, we were later cleared by the federal Marketplace to submit our applications after we submitted fictitious identification documents.

[25]See GAO-16-784, GAO-16-792, and GAO-16-29.

[26]We expected our fictitious applicants to fail initial identity proofing because the system used by HealthCare.gov asks the consumer questions based on their credit report. Our fictitious applicants do not have credit reports from which the system can derive questions.

Similarly, per CMS guidelines, EDE entities must require that agents and brokers who assist consumers complete identity proofing for the consumer.[27] For our two broker-assisted applications—which used EDE systems—we were not requested to submit documentation to verify our applicants' identity before enrolling. However, the systems used by the brokers assisting our applicants flagged our applicants' SSNs as unverified. In October 2024, CMS began requiring verifiable SSNs on applications submitted by agents and brokers through EDE systems.[28] In both cases, the brokers assisting our applicants called the Marketplace Call Center to address the issue. During the calls, our fictitious applicants authorized their brokers to discuss the applications with the Marketplace Call Center without the applicants present on the call. Both brokers worked with the Marketplace Call Center—without the applicants—to successfully submit the applications with invalid SSNs.

Data Matching Inconsistencies

As described earlier, the federal Marketplace uses the Hub to help verify applicant eligibility—such as citizenship and estimated income—in an automated manner against trusted data sources. The federal Marketplace generates an inconsistency when data matching processes are not able to verify applicant information against the Hub's trusted sources. Applicants are instructed to provide documentation to support information on their applications that cannot be verified by the Hub's data matching.

However, the federal Marketplace did not always generate data matching inconsistencies across our four fictitious applicants. Specifically,

- in one case, the Marketplace did not request documentation to corroborate the applicant's citizenship status or estimated income.
- in a different case, the Marketplace did not request documentation to support the applicant's SSN.
- in the remaining two cases, the Marketplace requested documentation to support each applicant's SSN, citizenship status, and estimated income, as expected.

We either were not requested to provide the federal Marketplace with documentation or generally did not provide what was requested, yet our four fictitious applicants received subsidized coverage for November and

[27]CMS guidelines offer flexibility in how EDE entities may complete identity proofing for a consumer.

[28]CMS also began requiring verifiable SSNs on applications submitted by agents and brokers through direct enrollment pathways.

December 2024.[29] Because we applied for coverage late in the year, the due dates for the requested documentation to support our applicants' eligibility all fell after the end of the plan year. In one case, we received a notice from the federal Marketplace that it confirmed the applicant's estimated income based on documentation we submitted. However, we did not submit documentation to confirm the applicant's income. Such weaknesses in appropriately generating and resolving data matching inconsistencies may allow ineligible applicants to receive subsidized insurance coverage.

Eighteen of Our 20 Fictitious Applicants Continued to Receive Subsidized Coverage for Plan Year 2025

To further test enrollment controls, we developed 20 fictitious applications to obtain insurance coverage with APTC through the federal Marketplace for plan year 2025.[30] Although our work is ongoing, the federal Marketplace initially approved coverage for 19 of our 20 fictitious applicants for plan year 2025. We did not pursue one application when the broker we were working with stopped responding to us. Additionally, the Marketplace subsequently cancelled coverage for one fictitious enrollee for which we did not provide the requested documentation to support citizenship status. As a result, as of September 2025, coverage for 18 fictitious enrollees remained active. The results of our covert testing for plan year 2025 are generally consistent with results of similar testing we conducted for plan years 2014 through 2016.[31]

The combined APTC paid to insurance companies for these 18 enrollees totals over $10,000 per month. While these fictitious enrollees are not generalizable to the universe of enrollees, they can suggest weaknesses in enrollment controls. We will continue to respond to any future documentation requests from the federal Marketplace and monitor related developments in these enrollments as part of our ongoing work.

[29] In one instance, we submitted fictitious documentation to support citizenship for an applicant's 2025 application. The Marketplace verified the applicant's citizenship and applied the results to both the 2024 and 2025 enrollments.

[30] This includes applications for the four fictitious applicants we initially enrolled in plan year 2024.

[31] See GAO-16-784, GAO-16-792, and GAO-16-29.

Preliminary Results Identify Vulnerabilities Related to Potential SSN Misuse and Unauthorized Enrollment Changes

Preliminary Data-Analytics Results Identify Potential SSN Misuse in Plan Years 2023 and 2024

Consumers who choose to have the credit paid through the APTC must reconcile the amount of APTC paid to issuers on their behalf with the premium tax credit they were ultimately eligible for based on actual family sizes and incomes reported when those consumers file their federal income tax returns. During this reconciliation process, the consumer may receive an additional tax credit or may be responsible for repaying the excess APTC amount paid to an issuer. Federal law may limit the amount of excess APTC that consumers must repay.[32]

SSNs—which should serve as unique identifiers for enrollees that have them—are important for reconciling APTC on individual federal income taxes.[33] We compared enrollment data in the federal Marketplace for plan year 2023 to APTC reconciliation data for tax year 2023.[34] Based on our preliminary analysis, we could not identify evidence of reconciliation in IRS tax data, as of April 2025, for over $21 billion in APTC for enrollees that provided an SSN through the federal Marketplace in plan year 2023.[35] This represents approximately 32 percent of APTC paid on behalf

[32] Public Law No. 119-21—commonly known as the One Big Beautiful Bill Act—repealed these statutory repayment limits, applicable to tax years beginning after December 31, 2025. An Act To provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, title VII, § 71305, 139 Stat. 72, 324 (2025).

[33] Certain noncitizens may be eligible for marketplace coverage without an SSN. These individuals may file taxes and reconcile APTC with an individual taxpayer identification number (ITIN).

[34] Tax year 2023 was the most recent available data when we began our work July 2024.

[35] For our analysis, we determined that APTC had no evidence of reconciliation if none of the SSNs associated with the federal Marketplace application matched an SSN in the reconciliation tax data. We limited our analysis to federal Marketplace enrollees that provided SSNs because CMS enrollment data do not contain ITINs for consumers who do not have SSNs. Further, we did not examine the accuracy of the tax filings for consumers who did reconcile APTC.

of enrollees that provided an SSN to the federal Marketplace for that plan year.

Unreconciled APTC does not necessarily represent overpayments, as enrollees who did not reconcile through tax filing may have been eligible for APTC. However, it may include overpayments for enrollees who were ultimately not eligible for APTC.[36] There are various reasons why consumers might not reconcile APTC, including households that do not file tax returns as required and misuse of SSNs in Marketplace applications.[37] Our preliminary analyses of federal Marketplace enrollment data identified issues with potential misuse of SSNs, including multiple uses of SSNs and those that match death data.

Overused SSNs

One issue that can hinder reconciliation of APTC through tax filing is use of an SSN that does not belong to the enrollee. Our preliminary analysis of federal Marketplace data identified over 29,000 SSNs (0.21 percent of SSNs that received APTC) with more than 365 days of insurance coverage with APTC in plan year 2023. For example, the most frequently used SSN in plan year 2023 was used to receive subsidized insurance coverage for over 26,000 days (over 71 years of coverage) across over 125 insurance policies. Further, our preliminary analysis identified nearly 66,000 SSNs (0.37 percent of SSNs that received APTC) with more than 366 days of insurance coverage with APTC in plan year 2024.[38] This overuse can occur because of identity theft and synthetic identity fraud, as well as data entry errors.[39] Given complexities around identifying the true SSN-holder, we are further examining these cases and other instances of apparently overlapping coverage as part of our ongoing work.

[36] For example, APTC paid on behalf of fictitious enrollees will not be reconciled as these enrollees will not file federal income taxes.

[37] An individual under 65 with income below $14,600 or a married couple under 65 filing jointly with income below $29,200 generally are not required to file a tax return. However, an APTC recipient is required to file a tax return even if the individual is not otherwise required to do so.

[38] We obtained plan year 2023 enrollment data from CMS in October 2024 and plan year 2024 enrollment data in May 2025.

[39] Traditional identity theft uses a real person's identity to commit fraud. Synthetic identity fraud involves creating a fictional identity by combining real and fake personal information. See GAO, *Social Security Administration: Actions Needed to Help Ensure Success of Electronic Verification Service*, GAO-24-106770 (Washington, D.C.: Sept. 10, 2024).

According to CMS officials, the federal Marketplace does not prohibit new enrollments that use an SSN that is already enrolled. They further explained this is done to help ensure that the actual SSN-holder can enroll in insurance coverage in cases of identity theft or data entry errors. These officials told us that the federal Marketplace uses a logic model that analyzes various elements of personally identifiable information to distinguish individual applicants and enrollees. They added that they apply this model on a monthly basis to deduplicate enrollments. Further, applications with SSNs already enrolled should be addressed through CMS's existing data matching inconsistency processes, where applicants provide documentation to support application information that could not be originally verified.

For example, enrollees with these overused SSNs should be identified through CMS's existing data matching inconsistency processes and required to submit documentation to substantiate their SSNs. This is because multiple identities with different personally identifiable information will not match SSA records for the same SSN. However, our analyses and identification of enrollments with these overused SSNs suggests that the data matching inconsistency processes may not always function as expected. We are reviewing the federal Marketplace's data matching inconsistency processes, including overused SSNs, as part of our ongoing work.

Death Data Matches

Another issue that can hinder reconciliation of APTC is use of an SSN that is reported as associated with a deceased individual in SSA death data. Such cases can include benefits for deceased individuals and fictitious or synthetic identities. Our preliminary analysis of plan year 2023 data identified over 58,000 SSNs that received APTC and matched SSA death data (about 0.42 percent of SSNs that received APTC that year).[40]

Because of complexities in determining APTC paid after the reported date of death, we focused our review of death data matches on two scenarios for this statement, which account for about 26,000 of the 58,000 SSNs we

[40]We limited our analysis of death data matches for this statement to plan year 2023 because it was the most recent, complete plan year as of November 2024, when we obtained death data from the Social Security Administration. We are analyzing death data matches for plan year 2024 enrollments as part of our ongoing work.

identified as matching the death data.[41] Based on our preliminary analyses, we found that CMS paid over $94 million in APTC for households with at least one match across these two scenarios for plan year 2023.[42]

- First, we identified over 7,000 SSNs where the reported date of death occurred prior to enrollment in the Marketplace for plan year 2023.[43] In these cases, Marketplace data matched SSA death data on (1) SSN and (2) first name, last name, or birth month and year.
- Second, we identified over 19,000 SSNs that matched death data only on SSN. In these cases, matches had different names and dates of birth across Marketplace enrollment data and SSA's death data. These matches could represent synthetic identity fraud.

Although CMS has processes to review death data during enrollment, the agency does not periodically review death data for all federal Marketplace enrollees. As part of our ongoing work, CMS officials told us that the federal Marketplace checks death status at application through the Hub and twice a year through periodic data matching. However, CMS officials explained that the periodic data matching process only ends coverage for single-member households in which the enrollee is deceased, and it does not end coverage for deceased individuals in households with multiple members. CMS expects households to report member changes, including death, to the Marketplace. We are examining CMS's controls regarding review of death data as part of our ongoing work.

[41]For purposes of this statement, we refer to the end of the month of death listed in the full death file as the reported date of death. It is not possible to determine from data matching alone whether these matches definitively identify individuals receiving coverage with an associated subsidy who were deceased because individuals can be erroneously listed in the full death file.

[42]Because of data limitations, this amount includes a full household's APTC even if only one member's SSN matched SSA's death data. A single policy may include more than one person. The CMS data provided the APTC amounts at the policy level. Eligibility for and amount of APTC for remaining household members depends on a variety of factors that may be affected by the death of a member of the household, such as income and family size. As a result, we could not determine the portion of subsidies associated with each individual on a policy.

[43]We are reviewing the remaining approximately 32,000 instances in which a federal Marketplace enrollee's reported date of death occurred after enrollment in the Marketplace for coverage year 2023 as part of our ongoing work.

Preliminary Data-Analytics Results Identify Likely Unauthorized Enrollment Changes by Agents and Brokers in Plan Years 2023 and 2024, Although CMS Has Taken Some Corrective Steps

The federal Marketplace does not pay commissions to agents or brokers or set their compensation levels. Rather, agents and brokers are allowed to receive compensation directly from qualified health plan issuers in accordance with agreements with those issuers and any applicable state requirements. The federal Marketplace transmits information identifying agents and brokers associated with enrollments to insurance companies to facilitate compensation per these agreements. As a result, agents and brokers have a financial incentive to maximize enrollments and their related compensation. Beyond legitimate enrollments, this may include making unauthorized changes to existing enrollments, enrolling consumers without their knowledge or consent, and creating fictitious enrollments.

For this statement, we focused our analyses on enrollment changes that involve changes in the agent or broker associated with an enrollment (and may include other changes, such as in an insurance plan).[44] Changes in the agent or broker associated with a consumer's enrollment may be directed by the consumer. Other changes may be driven by factors outside of the consumer's control, such as when agents and brokers retire and sell their business to other agents or brokers. For the purposes of this statement, an application with likely unauthorized enrollment changes is one where at least three different agents or brokers—identified based on National Producer Numbers—submitted enrollment actions on the same application for the same coverage start date.[45]

Figure 3 illustrates an actual, though anonymized, example of likely unauthorized enrollment changes for one application we identified through our analyses. This application in the federal Marketplace had coverage in March 2023. Several different brokers submitted likely unauthorized changes to this application to take effect in April 2023, including changes to the enrollee's insurance plan. We cannot determine why brokers made these changes to the enrollee's insurance plan based on the enrollment data. However, we believe that they are likely

[44]More specifically, we limited this analysis to enrollment changes (1) with an associated agent or broker, (2) submitted through enhanced direct enrollment systems, and (3) on applications for which only one household member was noted as the subscriber.

[45]A National Producer Number is a unique identifier assigned to agents and brokers through the National Association of Insurance Commissioners' licensing application process. CMS allows agents and brokers to submit federal Marketplace applications with a National Producer Number that is not their own, although such actions are required to be in compliance with relevant state laws. As a result, applications and related changes may not have been submitted by the agent or broker associated with the enrollment.

unauthorized because it is unlikely that an enrollee would work with more than two different agents and brokers to select different insurance plans, especially with changes on the same day or within the same hour.

Figure 3: Anonymized Example of Application with Likely Unauthorized Enrollment Changes in the Federal Marketplace

Application: 12345

March enrollment		
Broker 1	Plan A	Enrolled in plan A through broker 1

Changes submitted for April enrollment

Broker 2	Plan B	3/22/2023 5:04 PM
Broker 3	Plan A	3/23/2023 5:51 PM
Broker 4	Plan B	3/23/2023 9:48 PM
Broker 1	Plan A	3/29/2023 10:32 PM
Broker 5	Plan C	3/30/2023 3:53 PM
Broker 1	Plan D	3/31/2023 12:57 AM
Broker 6	Plan A	3/31/2023 12:49 PM
Broker 7	Plan B	3/31/2023 6:59 PM
Broker 8	Plan A	3/31/2023 8:10 PM
Broker 9	Plan B	3/31/2023 10:23 PM
Broker 8	Plan A	3/31/2023 11:08 PM
Broker 4	Plan B	3/31/2023 11:34 PM
Broker 3	Plan A	3/31/2023 11:36 PM
Broker 10	Plan C	3/31/2023 11:37 PM

Several different brokers submit changes (likely unauthorized) to this application throughout March to take effect in April, including switches to the enrollee's insurance plan. Each change is overcome by the next, with the last change ultimately going into effect for April.

April enrollment		
Broker 3	Plan B	Enrolled in plan B through broker 3

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-26-108811

Note: We cannot determine why brokers made changes to the enrollee's insurance plan based on the enrollment data.

Based on our preliminary analyses, we identified at least 30,000 applications in plan year 2023 and at least 160,000 applications in plan year 2024 that had likely unauthorized changes.[46] This represents 0.4 percent of relevant applications in plan year 2023 and 1.5 percent of relevant applications in plan year 2024. While only one enrollment change may go into effect for a given month, the volume of these actions indicates potential misconduct by agents and brokers seeking to maximize commissions related to federal Marketplace enrollments.

Stakeholders we interviewed as part of our ongoing work, including those that represent agents, brokers, and insurance regulators, raised concerns that consumers may not have been aware of changes to their enrollment because of a lack of notification about agent and broker activities at the time the unauthorized activity occurred. For example, they said consumers may have learned they were enrolled in a plan when they received a notice from the IRS during tax filing season advising them to reconcile their APTC or when they sought medical care and learned that their plan had been switched.

In July 2024, CMS began blocking changes to enrollments by agents and brokers who were not already associated with the consumer's enrollment. To change the agent or broker associated with an enrollment, CMS required that consumers conduct a three-way call with the Marketplace Call Center and the new agent or broker.[47]

Stakeholders we interviewed questioned the effectiveness of the three-way calls to prevent unauthorized agent and broker activity. For example, they explained that the Marketplace Call Center may take limited steps to verify the identity of the consumer on the three-way call. This may involve asking the consumer for information that may be publicly available, like name and date of birth. According to CMS officials, the Marketplace Call Center validates three pieces of personally identifiable information about the consumer. Additionally, enrollments for new coverage may not trigger the requirement for a three-way call with the Marketplace Call Center. Agents and brokers seeking to maximize enrollments could submit new applications in these cases, thus circumventing the three-way call

[46]Because we limited our analyses to applications that had at least three different agents or brokers submitting enrollment actions for the same coverage start date, we may not capture all instances of unauthorized changes. For example, our analyses would not capture instances of two agents or brokers submitting back-and-forth changes to the same application.

[47]Alternatively, consumers may make the change to their enrollment themselves.

process. We are examining the three-way call process as part of our ongoing work.

In October 2024, CMS issued a press release stating that it had received over 90,000 complaints between January and August 2024 from consumers who had their federal Marketplace insurance plans changed without their consent.[48] CMS further stated that it had resolved nearly all of the complaints and that the number of plan changes associated with an agent or broker decreased by nearly 70 percent. CMS also suspended 850 agents and brokers from the federal Marketplace for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches. However, in May 2025, CMS officials told us that the agency reinstated all these suspended agents and brokers to better fulfill the agency's statutory and regulatory procedures. According to agency officials, CMS continues to monitor agent and broker activity for compliance with Marketplace regulations and the terms and conditions of Marketplace agreements and may take further enforcement action against those individuals.

Preliminary Results Indicate Weaknesses in CMS's Fraud Risk Management for APTC

Preliminary results from our ongoing work indicate weaknesses in CMS's fraud risk management in APTC. Specifically, although CMS assessed APTC's fraud risks in 2018, the agency has not updated its assessment despite changes in the program and its antifraud controls. Further, CMS's 2018 assessment may not fully align with leading practices. Finally, CMS did not use its assessment to develop an antifraud strategy to address the risks it assessed. Together, these weaknesses appear to hinder CMS's ability to effectively and proactively manage fraud risks in APTC.

CMS Assessed Fraud Risks in 2018 but Has Not Updated Its Assessment Despite Program Changes

CMS conducted a fraud risk assessment for APTC in November 2018 in response to a GAO recommendation.[49] However, CMS has not updated its fraud risk assessment for APTC since then despite changes to the program. CMS's 2018 assessment acknowledged that fraud risks in APTC are continually evolving. In addition to evolving fraud risks, program changes affect the likelihood and impact of fraud risks in the

[48]CMS also reported that it received over 183,000 complaints between January and August 2024 from consumers who were enrolled in federal Marketplace coverage without their consent. See CMS, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity" (Baltimore, MD: Oct. 17, 2024), accessed October 23, 2024, https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.

[49]GAO-16-29.

program, as well as the controls the agency uses to mitigate those risks. For example:

- **Program growth.** Estimated APTC has more than doubled since CMS's 2018 fraud risk assessment. Specifically, CMS estimated that APTC totaled over $53 billion in 2018. In 2024, CMS estimated that APTC totaled nearly $124 billion. Additional outlays may increase the likelihood or impact of fraud risks and potentially warrant additional or different antifraud controls.
- **Changes to antifraud controls.** CMS officials told us that the agency paused certain antifraud controls since the 2018 fraud risk assessment. For example, CMS did not act on IRS data for consumers who did not file tax returns and reconcile prior APTC for plan years 2021 through 2024.[50] Conversely, CMS has implemented new antifraud controls—such as requiring verifiable SSNs on applications submitted through EDE systems—since its 2018 fraud risk assessment. Changes to antifraud controls—such as pausing existing controls or adding new controls—may affect the likelihood and impact of fraud risks.

Leading practices in fraud risk management call for planning regular fraud risk assessments that are tailored to programs. For example, leading practices include planning to conduct fraud risk assessments at regular intervals.[51] They also call for assessments when there are changes to the program or operating environment, as assessing fraud risks is an iterative process.

As part of our ongoing work, CMS officials informed us that the agency plans to update its fraud risk assessment for APTC by the end of calendar year 2025. We will continue to monitor CMS's efforts to complete this assessment.

CMS's 2018 Fraud Risk Assessment May Not Have Fully Met Leading Practices

Although our work is ongoing, preliminary results suggest that CMS's 2018 fraud risk assessment for APTC may not fully align with leading practices in GAO's Fraud Risk Framework. Such weaknesses may hinder

[50]According to CMS, the agency did not act on IRS information in part because of the impact of the COVID-19 public health emergency on the processing of federal income tax returns.

[51]As discussed in the Fraud Risk Framework, experts suggest that the frequency of updates to fraud risk assessments can range from 1 to 5 years.

CMS's ability to effectively and proactively manage fraud risks in this program. For example:

- **CMS's fraud risk assessment did not fully identify inherent fraud risks.** CMS did not fully identify inherent fraud risks in APTC in its 2018 assessment. Leading practices state that the first step in conducting an effective fraud risk assessment is identifying the inherent fraud risks affecting the program. This step is critical because it serves as the basis for the entire fraud risk assessment process. CMS identified 27 fraud risks, including risks related to inappropriate enrollment of dependents and misuse of various special enrollment periods.

  However, we found CMS's assessment did not include other significant risks. For example, CMS's 2018 fraud risk assessment did not specifically identify risks related to state-based marketplaces, where states are responsible for making eligibility and enrollment decisions. According to CMS, state-based marketplaces accounted for nearly 25 percent of estimated APTC enrollees in 2018.[52] We have previously found that state-based marketplaces exercise flexibilities in eligibility-verification processes, as allowed by PPACA and CMS regulations.[53] Such a structure and flexibilities present different fraud risks than those in the federal Marketplace that, to be consistent with leading practices, are to be assessed for their likelihood and impact on APTC.

- **CMS's fraud risk assessment did not fully consider the suitability of existing controls.** CMS did not fully consider the suitability of existing antifraud controls in APTC as part of its 2018 fraud risk assessment, as called for by the Fraud Risk Framework. Specifically, we found that CMS's risk ratings did not always align with available information and may overstate the effect of existing controls.

  For example, CMS's 2018 assessment included a fraud risk related to the use of fraudulent documentation to resolve data matching issues. The assessment rated the likelihood of this risk as low, which CMS defined as "not identified or identified but very rare…no reports of risk occurring." However, CMS's assessment also noted that prior GAO

[52]As of February 2025, CMS reported that state-based marketplaces accounted for nearly 28 percent of estimated APTC enrollees.

[53]GAO, *Payment Integrity: Additional Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credits*, GAO-23-105577 (Washington, D.C.: Mar. 9, 2023).

work demonstrated that this risk had occurred and can be exploited. In this regard, in 2016, we found that several of the fictitious applicants we used in covert testing of enrollment controls obtained subsidized health coverage—in many cases using fictitious documents—in plan years 2014, 2015, and 2016.[54]

CMS Did Not Develop a Formal Antifraud Strategy to Address APTC Fraud Risks

CMS did not develop a formal antifraud strategy for APTC based on the fraud risk assessment it conducted in 2018. According to the Fraud Risk Framework, a leading practice is to develop an antifraud strategy that describes the program's approach for addressing the prioritized fraud risks identified during the fraud risk assessment. CMS documented its 2018 fraud risk assessment in a fraud risk profile.[55] This 2018 fraud risk profile contains some elements that would help inform an antifraud strategy. For example, it identifies fraud risks and related antifraud controls.

However, the information in the profile itself does not constitute an antifraud strategy as outlined in the Fraud Risk Framework. Specifically, key elements of an antifraud strategy also include demonstrating links between fraud risk management activities and the highest internal and external residual fraud risks outlined in the fraud risk profile. CMS officials informed us that they will develop an antifraud strategy for APTC once the agency updates its fraud risk assessment for the program.

In summary, preliminary results of our covert testing and data analytics—both of which are ongoing, making the information presented in this statement subject to change—indicate that the fraud risks we previously identified in the federal Marketplace persisted in plan years 2023 through 2025. Furthermore, we identified weaknesses in CMS's fraud risk management activities that appear to hinder the agency's ability to effectively and proactively manage current and future fraud risks in APTC. We are continuing our work on these issues and will report our final results and make recommendations in forthcoming products, as appropriate.

[54]See GAO-16-784, GAO-16-792, and GAO-16-29.

[55]As discussed in the Fraud Risk Framework, effectively assessing fraud risks involves documenting the key findings and conclusions for the assessment process, including the analysis of the types of fraud risks, their perceived likelihood and impact, and the prioritization of risks. This summation is referred to as a program's "fraud risk profile." This profile is an essential piece of developing an overall antifraud strategy.

Chairmen Fitzgerald and Van Drew, Ranking Members Nadler and Crockett, and Members of the Subcommittees, this completes my prepared statement. I look forward to the Subcommittees' questions.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this statement, please contact Seto J. Bagdoyan, Director, Forensic Audits and Investigative Service at BagdoyanS@gao.gov or John E. Dicken, Director, Health Care at DickenJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement are Dave Bruno (Assistant Director), James Healy (Analyst in Charge), Erin Barry, Joshua Hatter, Barbara Lewis, Katie Mack, James Murphy, and Rachel Steiner-Dillon. Other contributors include Gerardine Brennan, Sylvia Diaz Jones, Mark MacPherson, Priyanka Panjwani, and Joseph Rini.

Appendix I: Status of GAO's Prior Recommendations Related to Fraud Risk Management in the Federal Marketplace

Table 5: Status of GAO's Prior Recommendations Related to Fraud Risk Management in the Federal Marketplace

Report	Recommendation Language	Status	Status Narrative
GAO-16-29	The Secretary of Health and Human Services (HHS) should direct the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) to conduct a comprehensive feasibility study on actions that CMS can take to monitor and analyze, both quantitatively and qualitatively, the extent to which data hub queries provide requested or relevant applicant verification information.	Closed - Implemented	In May 2019, HHS provided GAO with a study containing statistical analyses of the data-matching performance of the data services Hub used in the application process for health care coverage established under the Patient Protection and Affordable Care Act (PPACA). This study also included qualitative discussion of the results of the analyses, and actions implemented to improve the data-matching process.
	The Secretary of Health and Human Services should direct the Acting Administrator of CMS to track the value of advance premium tax credit and cost-sharing reduction (CSR) subsidies that are terminated or adjusted for failure to resolve application inconsistencies and use this information to inform assessments of program risk and performance.	Closed – Not Implemented	Tracking CSR subsidies is no longer a relevant recommendation. The Attorney General of the United States provided HHS and the Department of the Treasury with a legal opinion regarding CSR payments made to issuers of Qualified Health Plans. With that opinion, and the absence of any other appropriation that could be used to fund CSR payments, CSR payments to issuers were stopped as of October 2017. In addition, CMS cannot track the advance premium tax credit (APTC) provided to consumers during the inconsistency period unless it is granted access to IRS tax reconciliation data.
	The Secretary of Health and Human Services should direct the Acting Administrator of CMS to, in the case of CSR subsidies that are terminated or adjusted for failure to resolve application inconsistencies, consider and document whether it would be feasible to create a mechanism to recapture those costs, including whether additional statutory authority would be required to do so.	Closed – Not Implemented	Tracking CSR subsidies is no longer a relevant recommendation due to programmatic changes. The Attorney General of the United States provided HHS and the Department of the Treasury with a legal opinion regarding CSR payments made to issuers of Qualified Health Plans. With that opinion, and the absence of any other appropriation that could be used to fund CSR payments, CSR payments to issuers were stopped as of October 2017.

	The Secretary of Health and Human Services should direct the Acting Administrator of CMS to identify and implement procedures to resolve Social Security number (SSN) inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them.	Closed – Implemented	In January 2019, CMS finalized the implementation of functionality to validate and save an SSN to a consumer's application when either an SSN inconsistency was generated as part of the original eligibility determination or an SSN was not entered at the time of application. CMS updated the application user interface to require applicants to input either an SSN or to check a box affirming (under penalty of perjury) that they do not have an SSN in order to proceed through the application without providing it. CMS also implemented a process to obtain a consumer's SSN from acceptable consumer-provided documents. These new functionalities substantially address the recommendation that the agency identify and implement procedures to resolve SSN inconsistencies where the Marketplace is unable to verify SSNs or applicants do not provide them.
	The Secretary of Health and Human Services should direct the Acting Administrator of CMS to reevaluate CMS's use of Prisoner Update Processing System (PUPS) incarceration data and make a determination to either: (a) Use the PUPS data as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage or (b) if no suitable process can be identified to verify incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with information that may indicate incarceration, and forego the inconsistency process.	Closed – Implemented	CMS determined that it is not practical to use the information from the Social Security Administration's PUPS as an indicator of further research to clear incarceration inconsistencies or terminate coverage. When actively processing incarceration inconsistencies based on the information, CMS found there to be a high degree of false positives. Additionally, it does not have a readily available source through which to conduct follow-up investigations. CMS is currently accepting attestation in alignment with the recommendation.

The Secretary of Health and Human Services should direct the Acting Administrator of CMS to create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to CMS's documents processing contractor.	Closed – Implemented	In 2018 CMS completed integration of the Document Storage and Retrieval System (DSRS) into the Call Center's Desktop system. DSRS provides access to consumer submitted documents. This functionality allows Call Center Representatives to see the type of supporting document that a consumer submitted to the Eligibility Support Worker. By providing this, CMS makes the application process more efficient, strengthens its eligibility determination process, and helps to make sure determinations are completed in a timely manner.
The Secretary of Health and Human Services should direct the Acting Administrator of CMS to conduct a fraud risk assessment, consistent with best practices provided in GAO's framework for managing fraud risks in federal programs, of the potential for fraud in the process of applying for qualified health plans through the federal Marketplace.	Closed – Implemented	In December 2018, CMS officials told GAO they had completed the fraud risk assessment of the Marketplace application process, based on GAO's Fraud Risk Framework. GAO reviewed documentation submitted by the agency and concurred. By conducting a fraud risk assessment, CMS is better equipped to know whether existing control activities are suitably designed and implemented to reduce inherent fraud risk to an acceptable level. The action also helps to lower the risk of improperly providing benefits and to reduce reputational risks to the program that could arise through perceptions that program integrity is not a priority.
The Secretary of Health and Human Services should direct the Acting Administrator of CMS to fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.	Closed – Implemented	CMS prepares an annual Marketplace and Related Programs Cycle Memo to fulfill reporting requirements for internal control. The memo describes all significant eligibility and enrollment policy and process changes, including new internal key controls associated with these changes. In addition, each year CMS publishes its Notice of Benefit and Payment Parameters (i.e., 'Payment Notice') in draft and then in final. This regulation provides a comprehensive description of major proposed Marketplace changes that allows CMS to document prior to implementation and in a public forum, any significant decisions on qualified health plan enrollment and eligibility matters.

GAO-18-169	As part of its efforts to assess and document the feasibility of approaches to identify the deaths of enrollees that may occur during the plan year, the Administrator of CMS should specifically assess and document the feasibility of approaches—including rechecking the full death file—to identify the deaths of individuals prior to automatic reenrollment for subsequent plan years and, if appropriate, design and implement these verification processes.	Closed – Implemented	In December 2018, CMS provided GAO with its assessment of the feasibility of identifying deceased individuals prior to automatic reenrollment into the federally facilitated marketplace. Specifically, CMS determined that it would be feasible to perform a periodic death match. CMS stated that it is outlining plans and expects to complete the process within three years. GAO found that the federally facilitated marketplace checks applicant information against SSA's full death file before enrolling and not after. However, by performing a periodic death match, CMS will meet the intent of GAO's recommendation to prevent automatic reenrollment of deceased individuals.

Source: GAO. | GAO-26-108811

Related GAO Products

Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist. GAO-26-108742. Washington, D.C.: December 3, 2025.

Health Insurance: Enhanced Data Matching Could Help Prevent Duplicate Benefits and Yield Substantial Savings. GAO-25-106976. Washington, D.C.: September 25, 2025.

Payment Integrity: Additional Coordination Is Needed for Assessing Risks in the Improper Payment Estimation Process for Advance Premium Tax Credits. GAO-23-105577. Washington, D.C.: March 9, 2023.

Federal Health-Insurance Marketplace: Analysis of Plan Year 2015 Application, Enrollment, and Eligibility-Verification Process. GAO-18-169. Washington, D.C.: December 21, 2017.

Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit. GAO-17-467. Washington, D.C.: July 13, 2017.

Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period. GAO-17-78. Washington, D.C.: November 17, 2016.

Patient Protection and Affordable Care Act: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year. GAO-16-784. Washington, D.C.: September 12, 2016.

Patient Protection and Affordable Care Act: Final Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015. GAO-16-792. Washington, D.C.: September 9, 2016.

Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk. GAO-16-29. Washington, D.C.: February 23, 2016.

Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015. GAO-16-159T. Washington, D.C.: October 23, 2015.

Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act. GAO-15-702T. Washington, D.C.: July 16, 2015.

Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act. GAO-14-705T. Washington, D.C.: July 23, 2014.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on X, LinkedIn, Instagram, and YouTube.
Subscribe to our Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454

Media Relations

Sarah Kaczmarek, Managing Director, Media@gao.gov

Congressional Relations

A. Nicole Clowers, Managing Director, CongRel@gao.gov

General Inquiries

https://www.gao.gov/about/contact-us

Mr. ONDER. Thank you, Dr. Bagdoyan. Mr. Blaze.

STATEMENT OF DR. BRIAN BLASE

Dr. BLASE. Mr. Chair, Chair Fitzgerald, Chair Jordan, Ranking Members Crockett and Raskin, and the Members of the Committee. Thank you for the opportunity to testify this afternoon.

The failures of the Affordable Care Act are well-known, canceled health plans, soaring premiums and deductibles, lost doctors and narrow networks. The law entrenched in inefficient insurance dominated health sector by sending massive subsidies straight to insurance companies.

A new Joint Economic Committee report found that the main winners of the ACA subsidies are health insurers whose stock prices have soared. My testimony today will focus on one profound and expanding failure, massive fraud and abuse in the exchanges. The GAO's work shows how vulnerable the program is to fraud, with 96 percent of fake applications enrolled in subsidized coverage. Paragon's work shows the staggering cost. Our research grew out of a single conversation.

In May 2024, I testified in Texas, a State Senator asked me about techniques being used to inappropriately enroll people in fully subsidized ACA plans. I responded that there were large incentives for abuse, but that I did not know the scale. On returning, I asked my team to do a simple analysis, compare the number of people enrolled claiming income between 100–150 percent of the poverty level to the number of people who would be eligible for a plan with that income.

Under a COVID-era subsidy boost, the ones set to expire after this year, coverage was made fully subsidized for people who claimed income in that category. Using conservative assumptions, we found five million more people enrolled in that income category than were eligible in 2024. Nearly half of all enrollees claimed income in this narrow band. More than half of them were not eligible.

In 2024, Federal spending on ineligible enrollees likely exceeded $20 billion. We published our findings in a paper entitled, "The Great ObamaCare Enrollment Fraud." Others replicated Paragon's work and they got the same result. Exchange enrollment had surged in large part because eligibility rules were ignored. Improper and phantom enrollment took off.

After ignoring the problem for two years, the Biden Administration's actions to penalize some brokers were too little, too late. As proof of their failure, improper enrollment surged in the last enrollment period on President Biden's watch. After open enrollment in 2025, there were 6.4 million people enrolled in fully subsidized plans and were not no eligible at a cost of $27 billion. Many enrollees were victims, signed up without their knowledge. Some lost plans they liked, and others now face tax penalties.

One customer service agent said that half of people signed up had no idea that they were enrolling in health insurance. A new study from the Competitive Enterprise Institute, shows two times more people enrolled in exchange plans than report being enrolled in those plans. Automatic reenrollment has simply shuffled improper eligibility determinations from one year to the next.

In 2025, 45 percent of all exchange enrollees took no action and were automatically reenrolled. Given widespread and proper enrollment, many enrollees unaware of their coverage we would expect many to never use their plan. The Biden Administration didn't release information on zero claim enrollees. Fortunately, in August, the Trump Administration did. What did we find? A surge in enrollees had who never used their plan, no doctor visit, no prescription, and no lab work.

In 2024, nearly 12 million enrollees did not use their plan a single time, up from fewer from four million in 2021. Overall, 35 percent of all exchange enrollees never used their plan and 40 percent of fully subsidized enrollees did not have a single plan. Zero claim exchange enrollees are more than double what occurs in a normal health insurance market and are double the rates before the COVID-era subsidy expansion. There are unquestionably millions of phantom enrollees in the exchanges. Federal taxpayers sent more than $35 billion to insurers in 2024 for people who never used their plan.

This one Big Beautiful Bill took some important steps to improve exchange program integrity. The best way to reduce the fraud and waste is for the COVID-era subsidy boost to expire as scheduled. That would still leave in place extremely generous subsidies. It would cover the vast majority of premiums and grow more generous over time on autopilot.

Thank you. I look forward to answering your questions.

[The prepared statement of Mr. Blase follows:]

PARAGON HEALTH INSTITUTE

Testimony Submitted to the House Judiciary Committee:
"Fighting Obamacare Subsidy Fraud:
Is the Administrative Procedure Act Working as Intended?"
December 10, 2025
Brian C. Blase, PhD
President, Paragon Health Institute

My name is Brian Blase, and I am the founder and president of Paragon Health Institute. From 2017 through 2019, I served as a special assistant to the president for economic policy at the White House's National Economic Council. From 2011 through 2014, I worked for the House Committee on Oversight and Government Reform under then-Chairman Darrell Issa. I appreciate the opportunity to testify on this important topic. This written testimony was greatly assisted by the work of my colleague, Gabrielle Minarik.

Last month, I testified before the Senate Finance Committee on how government policies drive health insurance and health care costs higher and how we can make health coverage and care more affordable. In today's testimony, I focus on specific problems with the Affordable Care Act (ACA) exchanges that have led to significant improper enrollment and spending and created a climate that invites, and even rewards, fraud. I first outline general problems with the ACA that have driven premiums higher.

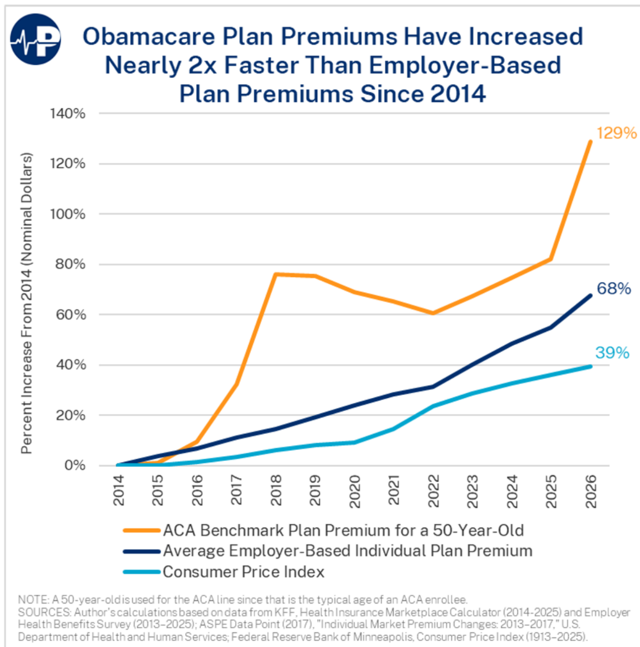
The Affordable Care Act's Escalating Premiums

The ACA promised affordable, high-quality insurance for individuals and lower health care spending for the nation. It failed to deliver. Premiums and deductibles escalated — often for coverage that excludes the best hospitals and doctors. The law entrenched an inefficient, insurance-dominated health sector with massive subsidies flowing straight from the U.S. Treasury to insurance companies — adding hundreds of billions to the debt since its enactment.

Here are the economic realities of the ACA:
- Its regulations increased premiums for the vast majority of people.
- Subsidies were then needed so people could afford the coverage made more expensive by these regulations.
- The underlying regulatory and subsidy structure leads to ever-escalating premiums and prices.
- Higher premiums create pressure for still more subsidies.
- And those additional subsidies only worsen the underlying problems — fueling the very premium and price escalation they are meant to offset.

The ACA's regulations drive higher costs. For example, the ACA's essential health benefit mandates require all plans to cover the same set of services regardless of what consumers want or need for their health. In addition, these rules increase wasteful spending and drive premiums higher.

From 2014 to 2026, individual market premiums are up 129 percent, employer-sponsored insurance premiums are up 68 percent, and general inflation is up 39 percent.[1] This is after individual market premiums increased nearly 50 percent from 2013 to 2014, the first year the ACA's regulatory changes took effect.[2] In 2026, the average deductible for an individual on a bronze plan is $7,476, and the average deductible for an individual on a silver plan is $5,304.[3]



During the annual open enrollment period, applicants estimate their household income for the following year, often with the assistance of brokers or agents. Based on this reported income, the government sends monthly subsidies, dubbed advance premium tax credits, to the insurer offering the plan selected by the applicant. Almost all of the subsidies are direct payments from the Treasury to health insurance companies. In many cases, the insurer receives more money than the enrollee was lawfully entitled to during the year — and the insurer gets to keep the excess payments, with some combination of the federal taxpayer

[1] Mark Howell and Brian Blase, "Obamacare Plan Premiums Have Increased Nearly 2x Faster Than Employer-Based Premiums Since 2014," Paragon Health Institute, https://paragoninstitute.org/paragon-pic/obamacare-plan-premiums-have-increased-nearly-2x-faster-than-employer-based-premiums-since-2014/.
[2] Avik S. A. Roy, Manhattan Institute, "Transcending Obamacare: Achieving Truly Affordable, Patient-Centered, Near-Universal Coverage," testimony before House Committee on Energy and Commerce, Subcommittee on Health, May 11, 2016, https://media4.manhattan-institute.org/sites/default/files/T-AR-0516.pdf.
[3] KFF calculated these figures as simple averages of all unique plans available in each metal tier on a per-individual basis. KFF, "Deductibles in ACA Marketplace Plans, 2014-2026," November 6, 2025, https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/.

taking the loss and the enrollee liable for a portion of the excess payment.

As a temporary pandemic measure, the American Rescue Plan Act increased subsidies for this coverage from 2021 through 2022. It increased taxpayer assistance for exchange plans in two ways. First, it reduced what people with income between 100 and 400 percent of the federal poverty level (FPL) need to pay for a benchmark plan, including making coverage fully subsidized for enrollees claiming income between 100 and 150 percent FPL. Second, it lifted the cap on subsidy eligibility at 400 percent of FPL. The Inflation Reduction Act did not introduce any reforms in the market and continued the expanded subsidies — setting them to expire after 2025.

If Congress wants to make health care more affordable, it must reform the ACA's broken regulatory and subsidy structure itself, not throw more good taxpayer money after bad. In fact, the surest way to avoid meaningful reform would be to extend the pandemic-era subsidy boosts.

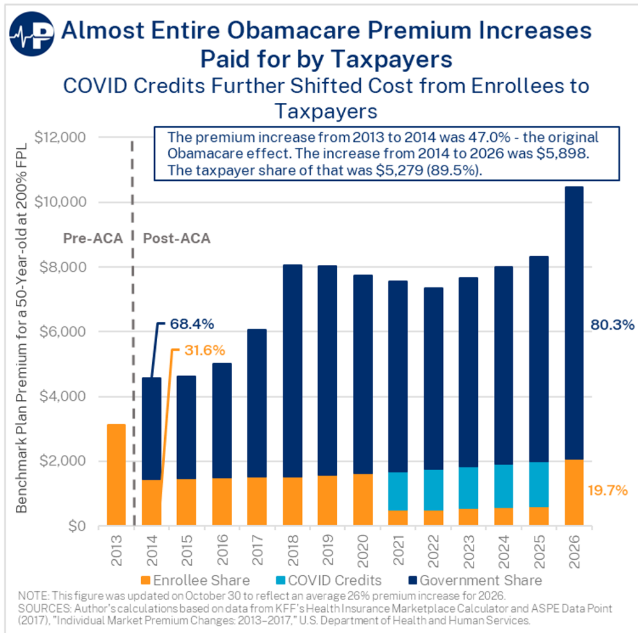
How the ACA's Subsidy Formula Fuels Premium Inflation

The ACA's subsidies are ill-designed and inflationary in critical ways. The enrollee's share of the premium is capped — regardless of the total premium. This structure is inherently different than other federal health programs, such as Medicare Part B and the Federal Employees Health Benefits Program, where enrollees pay a percentage of the premium. The figure below demonstrates the increase in premiums and the split between taxpayer and enrollee from 2014 through 2026 for a 50-year-old enrollee at two times the FPL. (This approximates the average ACA enrollee's age and income.)

The federal taxpayer share of the premium increased gradually from 68 percent of the premium in 2014 to nearly 80 percent in 2020.[4] As a result of the COVID-era subsidy boosts, the federal taxpayer share of the premium reached 93 percent from 2021 through 2025. Next year, when the COVID boosts expire, the federal share will exceed 80 percent. Because enrollees pay only a small slice of the premium, insurers face virtually no price discipline — giving them incentives to inflate costs rather than improve value.

[4] Mark Howell, "Almost Entire Obamacare Premium Increases Paid for By Taxpayers," Paragon Health Institute, n.d., https://paragoninstitute.org/paragon-pic/almost-entire-obamacare-premium-increases-paid-for-by-taxpayers/.

PARAGON
HEALTH INSTITUTE



The ACA subsidy structure does not just fail to control costs — it actively rewards insurers for raising them. A recent analysis by the Joint Economic Committee shows that consumers capture only 34 percent of the benefit, with roughly two-thirds captured by insurers through higher premiums and inflated benchmark prices.[5] This occurs because subsidies automatically increase as premiums rise, insulating insurers from competition and enabling them to absorb most of the subsidies rather than pass savings on to enrollees.

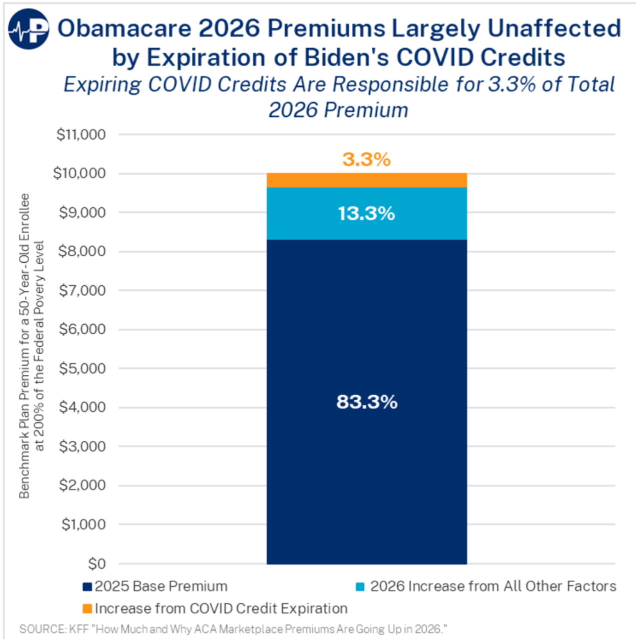
ACA premiums will rise next year because of underlying flaws with the program and growing cost pressures. Only a small portion of the increase is from the expiring COVID subsidy boosts. As the next figure shows only 3.3 percent of the 2026 premium is from the expiration of the COVID subsidy boosts.[6]

---

[5] Liam Sigaud, "New JEC Report: Insurers and Brokers Receive More Benefit from ACA Subsidies Than Enrollees," Paragon Health Institute, November 2025, https://paragoninstitute.org/paragon-prognosis/new-jec-report-insurers-and-brokers-receive-more-benefit-from-aca-subsidies-than-enrollees.

[6] Gabrielle Kalisz, "Obamacare 2026 Premiums Largely Unaffected by Expiration of Biden's COVID Credits," Paragon Health Institute, n.d., https://paragoninstitute.org/paragon-pic/obamacare-2026-premiums-largely-unaffected-by-expiration-of-bidens-covid-credits/.

PARAGON
HEALTH INSTITUTE



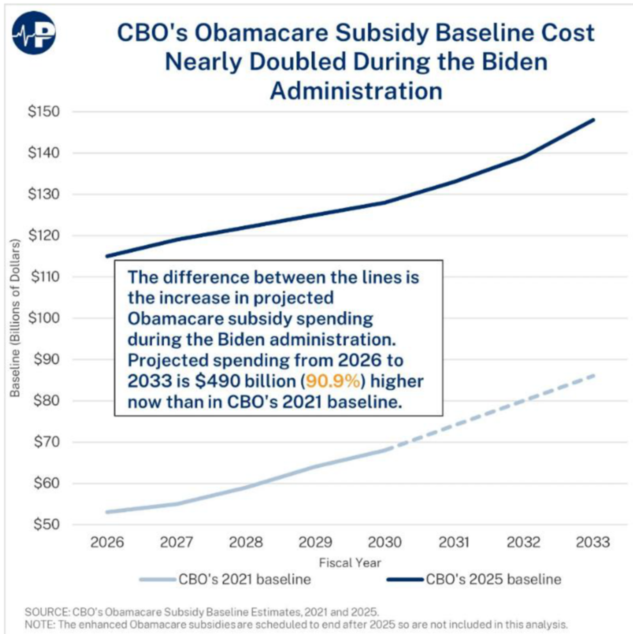
How COVID-era Subsidy Boosts and Lax Oversight Produced Widespread Fraud

The enhanced subsidies transformed the exchanges into an environment where misstatements and unauthorized enrollments became highly profitable. Pandemic-era policies that suspended tax-filing and reconciliation requirements weakened the few guardrails that previously existed and opened the door to large-scale improper enrollment.

CBO's most recent ACA subsidy baseline projection is 91 percent above its 2021 projection over the 2026–2033 period.[7] Continuing the COVID credits would result in deficits about $40 billion a year higher over the next decade.

[7] The reason we show spending on the ACA subsidies only through 2033 is that CBO projects that spending on the subsidies will drop in 2034 because of repayment of excess Basic Health Plan subsidies that New York state has accumulated.

PARAGON
HEALTH INSTITUTE



Many of those improperly enrolled do not even know about their coverage, as they are victims of fraud schemes designed to pocket commissions and subsidies. This is evidenced by the rising percentage of people who do not use their coverage at all, the rising number of government enforcement actions, and news stories and investigations.

Improper Enrollment Pressures Exacerbated by the COVID Subsidy Boosts

Improper enrollment is not a marginal issue — it is now one of the defining characteristics of the ACA exchanges, driven by a perverse subsidy design, weak documentation rules, and financial incentives that reward misrepresentation. From 2015 to 2020, exchange enrollment averaged about 10–11 million people[8] — about 60 percent below what the Congressional Budget Office (CBO) projected in May 2013 in its last analysis before the ACA's provisions took effect.[9] The sharp enrollment increase after 2021 did not reflect improved value; it reflected a surge of government subsidies, widespread income misrepresentation, relaxed verification rules, and aggressive third-party enrollment tactics that prioritized volume over accuracy.

---

[8] The average number of enrollees over the course of the year accounts for (1) the fact that some people who choose coverage during open enrollment fail to pay any premium and (2) net attrition in enrollment over the course of the year.
[9] CBO, "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013, https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf.

COVID Subsidy Boosts Created Financial Incentives for Misreporting and Manipulation

COVID-era subsidy boosts resulted in fully subsidized coverage for people claiming income within a category — 100 to 150 percent of FPL. This policy change created large financial incentives for applicants — and those allegedly acting on their behalf — to misstate income and enroll in this income category. In a June 2025 paper that I coauthored, we found the amount of improper enrollment grew substantially between 2024 and 2025 for those claiming income between 100 and 150 percent of FPL.[10] The number of ineligible enrollees rose from an estimated 5.0 million to 6.4 million from 2024 to 2025. In total, 29 states had more sign-ups in this income category than the number of eligible individuals in the population, based on our conservative methodology for determining improper enrollment.[11] In 15 states, there are more than twice as many enrollees in fully subsidized plans than are eligible. The estimated cost to taxpayers from this improper enrollment will likely exceed $27 billion in 2025 alone. Under more expansive assumptions, the number of ineligible enrollees in 2025 could reach as high as 7.1 million. The sheer scale of these discrepancies makes clear that improper enrollment is not incidental but systemic to the program.

Fraud, Misrepresentation, and Unauthorized Enrollment Are Widespread

Fraudsters took advantage of these relaxed eligibility checks. Many enrollees were signed up without their knowledge or consent. A recent *Bloomberg* investigation highlighted how large-scale deception rings take advantage of these perverse incentives, with some enrollees being coached on how to fill out their applications to take advantage of the fully subsidized coverage and some brokers and agents just enrolling people without their consent. Tactics include misleading "cash benefit" ads, aggressive lead-generation funnels, and brokers submitting applications without consent.[12] One former customer service worker at a large brokerage firm said, "Half the time they didn't even know they were signing up for insurance."[13]

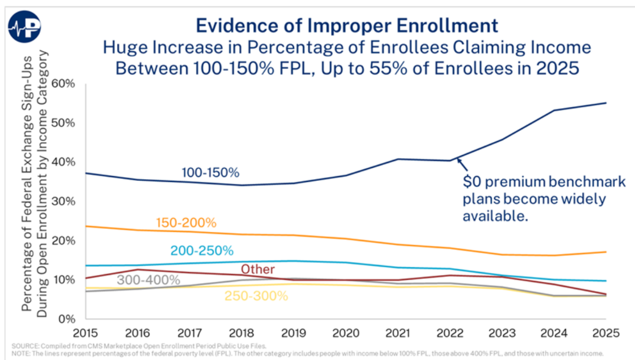
Lead generation companies used deceptive digital advertising to target lower-income Americans — promising "$0 coverage." Some ads featured deepfake impersonations of Taylor Swift, Joe Rogan, Andrew Tate, Dr. Phil, and Steve Harvey on TikTok, claiming, "They're giving out $6,400 to anyone who makes the call." Once consumers click, they are prompted to enter a name, date of birth, state, and phone number — more than enough for a web broker to create or access an application. This information is then sold to brokerages and call centers. One call center made enough money to sponsor a NASCAR team, and former employees told Bloomberg that "almost all the callers were looking for cash cards, not insurance." As one former agent put it: "You have to throw away a little bit of your morality." This deceptive ad ecosystem exists because enrolling a fully subsidized consumer — even fraudulently — guarantees commissions for brokers and monthly federal payments for insurers, with essentially no downside risk for either.

[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/private-health/the-greater-obamacare-enrollment-fraud/.
[11] These states include Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, and West Virginia.
[12] Zeke Faux and Zachary R. Mider, "Chasing Big Money with the Health-Care Hustlers of South Florida," *Bloomberg*, June 5, 2025, bloomberg.com/features/2025-deepfake-ads-fueled-florida-health-insurance-scheme/.
[13] Faux and Mider, "Chasing Big Money."

PARAGON
HEALTH INSTITUTE

The Centers for Medicare and Medicaid Services (CMS) received more than 200,000 complaints about unauthorized plan switches in 2024 alone.[14] In 2025, the Department of Justice brought charges against insurance executives accused of defrauding taxpayers out of more than $160 million.[15] In addition, a Florida-based brokerage executive pled guilty to a separate $133 million scheme that targeted homeless and mentally ill individuals to improperly enroll them in subsidized ACA plans.[16]

Four figures demonstrate the large scale of improper enrollment. The first figure shows the shift in overall enrollment to the lowest income category in the states that use HealthCare.gov. The first open enrollment period with fully subsidized plans was 2022.



By 2025, a stunning 55 percent of people who signed up for coverage during open enrollment reported that their income was between 100 and 150 percent of FPL.[17] This figure shows only the federal exchange sign-ups, because not all states with state-based exchanges reported sign-ups by income grouping prior to 2022. We estimate that 62 percent of individuals reporting income between 100 and 150 percent of FPL in HealthCare.gov states are not actually eligible, meaning that for every two eligible enrollees, there are more than three ineligible enrollees in this category. Improper enrollment is further illustrated by the unprecedented surge in people who never use their coverage.

---

[14] Joseph Walker, "Americans Clicked Ads to Get Free Cash," *Wall Street Journal*, September 13, 2024, https://www.wsj.com/health/healthcare/social-media-ads-health-insurance-scams-37d1ecfa; and Turner et al. v. Enhance Health, LLC et al., no. 0:24-cv-60591 (S.D. FL), https://litigationtracker.law.georgetown.edu/litigation/conswallo-turner-et-al-v-enhance-health-llc-et-al/.

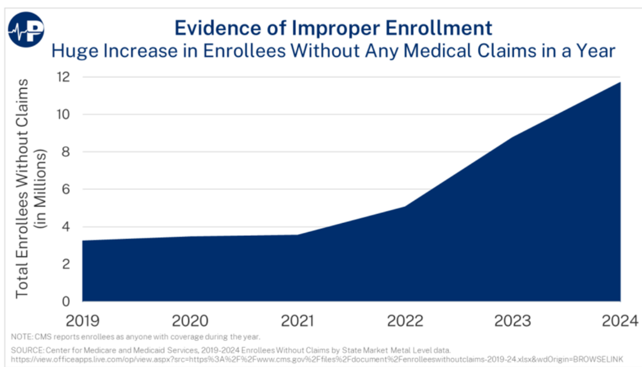
[15] Department of Justice, "President of Insurance Brokerage Firm and CEO of Marketing Company Charged in $161M Affordable Care Act Enrollment Fraud Scheme," press release, February 19, 2025, https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care.

[16] Department of Justice, "Executive Vice President of Insurance Brokerage Pleads Guilty in $133M Affordable Care Act Fraud Scheme," press release, April 18, 2025, https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.

[17] Brian Blase, Niklas Kleinworth, Chris Medrano, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/.

Zero-Claim and Phantom Enrollment Has Exploded

The next figure shows the explosive growth in zero-claim enrollees. From 2021 to 2024, the number of ACA exchange enrollees who did not use their plans for a single service tripled, reaching almost 12 million people.[18] The zero-claim enrollment data include anyone enrolled during the year. Overall, 35 percent of enrollees did not use their plans a single time. A staggering 40 percent of fully subsidized enrollees used no medical services in 2024. These percentages are up from 19 and 20 percent, respectively, in 2021. Many of these zero-claim enrollees are "phantoms" — people who are unaware of their enrollment in the program or have duplicate coverage. Federal taxpayers sent more than $35 billion to insurers for people who did not use their plans a single time. In contrast, only 15 percent of people with private health insurance typically do not use their plans at all.[19] When 40 percent of fully subsidized enrollees use no services — not even free preventive care — the most plausible explanation is that a large share were improperly enrolled, enrolled without consent, or enrolled solely for the purpose of generating subsidies.



These patterns persist despite aggressive insurer marketing that emphasizes free preventive care. If millions of people with $0 premiums are not accessing even free and commonly recommended services, the most plausible explanation is that a significant share were either enrolled improperly, enrolled without their knowledge, or enrolled but never intended to use coverage. These findings are consistent with new data from the Centers for Medicare & Medicaid Services, which identified 1.6 million people simultaneously enrolled in both Medicaid and ACA exchange plans.[20]

Meanwhile, yet another data study (see figure: "Obamacare enrollment: CMS vs CPS"), this

---

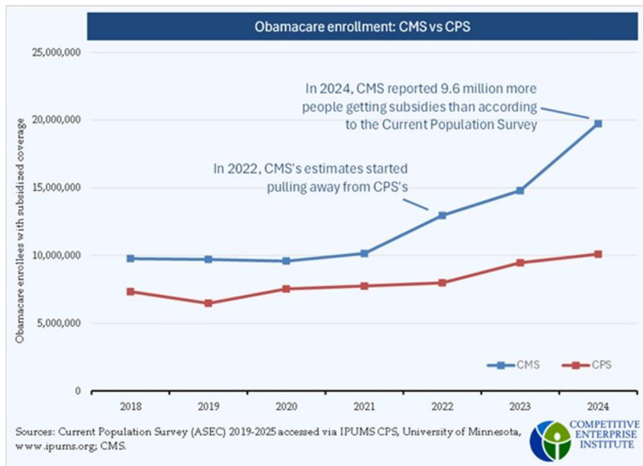
[18] Brian Blase, "The Rise of Phantom Obamacare Enrollees: Biden COVID Credits Drive Massive Increase in Individual Market Enrollees With No Medical Claims," Paragon Health Institute, August 13, 2025, https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/.

[19] KFF, "Key Facts about the Uninsured Population," December 18, 2024, https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/.

[20] Centers for Medicare and Medicaid Services, "CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/ACA Exchange Plans," press release, July 17, 2025, https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.

PARAGON
HEALTH INSTITUTE

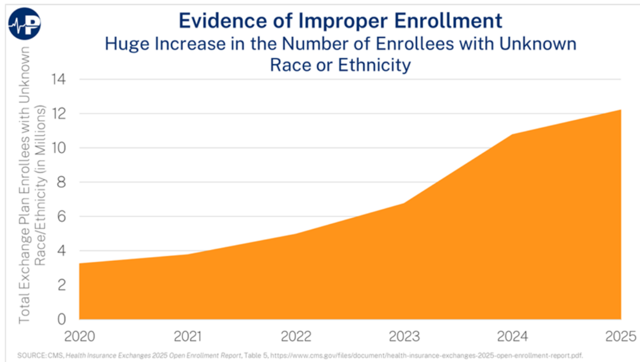
one from Jeremy Nighohossian of the Competitive Enterprise Institute, is also suggestive of a surge of phantom enrollment in the ACA exchanges. According to Nighohossian's review of federal data, twice as many people were enrolled in exchange plans in 2024 as reported having coverage, a much larger gap than in the years prior to the COVID credits.[21]



The collapse of demographic reporting further signals large-scale improper or unauthorized enrollment. In 2024 and 2025, the exchanges lacked race or ethnicity data for more than half of enrollees — a dramatic shift from 2021.[22] This is yet another indication that many enrollees were likely signed up by agents or brokers who did not really know the applicant — obtaining only the minimum amount of information to get them enrolled in fully subsidized plans.

[21] Jeremy Nighohossian, "Obamacare's Subsidy Cliff: How Many Enrollees Are Actually Affected?," Competitive Enterprise Institute, November 7, 2025, https://cei.org/blog/obamacares-subsidy-cliff-how-many-enrollees-are-actually-affected.
[22] Brian Blase, Niklas Kleinworth, Chris Medrano, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud.

PARAGON HEALTH INSTITUTE



The Congressional Budget Office has confirmed that large amounts of improper enrollment permeate the exchanges. According to CBO, there are 2.3 million ineligible enrollees in the 100 to 150 percent FPL category in the 10 non-Medicaid expansion states who have overestimated their income to unlawfully qualify for a subsidy.[23] CBO did not assess the other 40 states that adopted Medicaid expansion and did not assess the problem of people in the non-expansion states who underestimated their income to qualify for fully subsidized plans. Thus, CBO's estimates are in-line with Paragon's estimates of improper exchange enrollment.

Turning the Exchanges into a Wild West Where Fraud and Abuse Flourish

Bad policy and negligent oversight reward those who misstate income, and allow third parties to enroll individuals without consent, provide year-round access to fully subsidized plans without documentation, automatically renew improper or fraudulent enrollments, and compensate brokers in ways that create powerful incentives to exploit enrollees rather than assist them. And taxpayers are footing the bill — tens of billions of dollars for coverage that provides no value and undermines the integrity of the ACA. Moreover, enrollment fraud harms more than just taxpayers. When individuals are fraudulently enrolled despite having employer coverage or income above eligibility thresholds, they become legally responsible for repaying subsidies — often thousands of dollars — despite never having chosen the coverage. Many do not learn they were enrolled until the IRS rejects their tax return for missing Form 1095-A. Because CMS suspended enforcement of reconciliation rules between 2021 and 2024, millions of individuals continued receiving subsidies without filing taxes — creating enormous potential liabilities for innocent Americans who never chose these plans.

Here are the stories from just a few of the recent victims:

Mary Zhelyazkova of Miami, Florida,[24] while struggling with addiction and homelessness, needed Suboxone to manage opioid withdrawal. She was receiving it for free through the

---

[23] "Clarifications of Marketplace Coverage and Eligibility Under Public Law 119-21 (H.R. 1) and the 2025 Marketplace Integrity and Affordability Rule," Congressional Budget Office, August 25, 2025, https://d1dth6e84htgma.cloudfront.net/08_25_2025_Letter_CBO_Response_to_07_29_2025_ACA_Letter_5b33c15fef.pdf.
[24] Daniel Change, "Fraudsters Are Duping Homeless People Into Signing Up for ACA Plans They Can't Afford," KFF, June 2023, Fraudsters Are Duping Homeless People Into Signing Up for ACA Plans They Can't Afford - KFF Health News.

Ryan White program — until an unscrupulous broker offered her $5 to sign up for a "free" ACA plan. What she did not know: the broker used fake information to get her enrolled in a plan she did not qualify for. That plan disqualified her from the Ryan White program, charged her copays she could not afford, and left her without access to medication. She went into withdrawal. She suffered. And the unscrupulous broker walked away with a commission.

Ashley Zukoski, an ultrasound technologist in Charlotte, North Carolina,[25] had employer coverage but now faces a tax bill for an ACA plan she said she never signed up for. Ashley now faces a $700 tax penalty instead of a $4,100 refund as a result of being enrolled in a fully subsidized ACA plan without her knowledge or consent.

Michael Debriae of North Carolina[26] was enrolled in an ACA plan without his consent two months after cancelling previous ACA coverage due to receiving employer coverage. Debriae now must pay back the $2,445 in premium tax credits paid to the insurer from less than four months of coverage.

Lorie and Randy Delaney of Ohio[27] had their ACA plan repeatedly changed without their knowledge and faced thousands of dollars in additional prescription costs. They realized something was wrong when Randy's insulin prescription cost $1,096 — far more than expected. Lorie contacted the exchange and learned their plan had been changed from Medical Mutual to United Healthcare by an insurance broker in Texas, whom they had never interacted with.

All of these elements — zero-premium plans, lax documentation, and EDE vulnerabilities — combined to produce a marketplace with almost no functional guardrails. As a result of expanded subsidies and lax Biden administration oversight, the exchanges became a "wild west" atmosphere, as described by one broker.[28] The evidence is clear: Following the law has been optional.

Unscrupulous brokers and fraudulent entities make commissions they never would have earned, and insurers acquire additional customers whose premiums are largely — and often entirely — paid by the government. Moreover, these enrollees receive premium and out-of-pocket cost subsidies for which they are not eligible, and they often do not need to be fully paid back if their actual income turns out to be different than the income that they claim.[29] This is a preventable, policy-driven scandal — one that knowingly prioritized increasing enrollment numbers over basic program integrity.

During the Biden administration and potentially still true today, CMS has permitted deceptive

---

[25] Julie Appleby, "When Rogue Brokers Switch a Person's ACA Health Insurance, Tax Surprises Can Follow," National Public Radio, April 15, 2024, Tax headaches snare people when rogue health insurance agents switch ACA plans : Shots - Health News : NPR.

[26] Julie Appleby, "ACA Plans Are Being Switched Without Enrollees' OK," KFF Health News, April 2, 2024, https://kffhealthnews.org/news/article/aca-obamacare-plans-switched-without-enrollee-permission-investigation/.

[27] WHIO Staff and John Bedell, "I-TEAM: Multimillion-dollar scheme leaves families with ACA coverage with changed or no insurance," WHIO-TV, November 22, 2024, https://www.whio.com/news/local/i-team-multimillion-dollar-scheme-leaves-families-with-aca-coverage-with-changed-or-no-insurance/OO5I46QNNZBQBHZXTK272RHDCU/.

[28] "The reality is this stuff works. ACA is definitely the wild west right now. As you will find out in five years there will be more agents involved in it and what will probably happen is the red tape will be pulled up. This opportunity will not last forever" (Insurance Sales Success, "The ACA No Call Money Printer System for Insurance Agents," YouTube video, 32:32 mark, March 14, 2023, https://www.youtube.com/watch?v=92S7axeghsY)

[29] An enrollee with income below the federal poverty level does not need to pay back any of the subsidy, which was advanced to the health insurance company on behalf of the enrollee.

PARAGON HEALTH INSTITUTE

marketing practices, a marked contrast to its oversight of the marketing for Medicare Advantage plans. CMS's failure led to large conglomerate practices of third-party Enhanced Direct Enrollment (EDE) firms. Enhanced direct enrollment platforms — a feature of the federal exchange (HealthCare.gov) but not state-based exchanges, enables brokers and agents, including web brokers, to more easily enroll people in coverage through integration with HealthCare.gov.

To date, CMS enforcement action has been limited to individual brokers, despite sophisticated fraud and large-scale improper enrollment primarily originating from EDE firms. EDE platforms exploited the COVID-era subsidy boosts plus weak income verification rules to manipulate eligibility and enroll ineligible people into coverage.

EDE platforms allow brokers and agents to access or create applications with only a name, date of birth, and state — far less information than is needed to actually verify identity or eligibility. Until April 2024, any agent or broker could view a consumer's full Social Security number on HealthCare.gov, enabling rogue agents and EDEs to harvest identity information, reuse it, or reenroll people without their knowledge.[30] While the full SSN is no longer supposed to be visible, an enrollee's last four digits can still be accessed.

Additionally, EDE platforms exploit regulations and standards surrounding National Producer Number (NPN) overrides, allowing one broker to submit applications under another broker's ID. This eliminates any clear line of accountability and creates a structure where fraudulent agencies can enroll thousands of people using a single NPN.

For example, one of the most egregious examples occurred in September 2024 when CMS suspended Speridian Health, an EDE entity that processed more than one million exchange applications.[31] CMS cited credible evidence that Speridian altered exchange applications, enrolled people without their consent, and routed large volumes of enrollment traffic through overseas IP addresses in Hong Kong, India, Japan, Pakistan, Ireland, and Sweden. These weaknesses explain how large-scale unauthorized changes and fraudulent enrollments occurred without consumer consent.

The Biden administration created a year-round special enrollment period (SEP) for those claiming income between 100 percent and 150 percent FPL, creating more opportunities for unscrupulous brokers to perpetrate fraud. Fortunately, the Working Families Tax Cut Act shut down this SEP to better safeguard against fraudulent activity.

One particularly galling problem involved the intersection of zero-premium plans with the year-round Native American Special Enrollment Period.[32] In 2025, Blue Cross Blue Shield (BCBS) of Oklahoma uncovered a "body brokering" scheme in which vulnerable Native Americans and homeless individuals were recruited, coached to misstate income, enrolled in zero-premium exchange plans, and transported to out-of-state treatment centers that billed

[30] Julie Appleby, "After Public Push, CMS Curbs Health Insurance Agents' Access to Consumer SSNs," KFF, April 9, 2024, After Public Push, CMS Curbs Health Insurance Agents' Access to Consumer SSNs - KFF Health News.
[31] Centers for Medicare & Medicaid Services, "Suspensions of Web-Broker and Enhanced Direct Enrollment Entity Activities and Notice of Compliance Audit," U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, September 2, 2024, CMS-Suspension-Letter-090224.pdf.
[32] "Attachment Two: American Indian and Alaska Native Liaison Committee," June 10, 2025, Attachment Two - 6/17/25 AIAN Liaison Cmte Conf Call - Fraudulent ACA Recruitment Survey Results.

insurers for tens of millions in fraudulent claims.[33,34] BCBS Wyoming similarly reported a "significant health care fraud scheme" involving over 1,500 potentially fraudulent enrollments — fewer than 40 of which were legitimate.[35] These cases show how SEPs combined with zero-dollar premiums are taking advantage of some of the most vulnerable communities in the country.

Insurance companies have full discretion to terminate contracts and rescind commissions with brokers who engage in misconduct or submit questionable applications. But in practice, they rarely do. The monthly payments insurers receive from the U.S. Treasury for each enrolled individual — regardless of the enrollee's eligibility — create strong financial incentives to look the other way. As long as the subsidies keep flowing, there is little appetite to disrupt arrangements that drive volume, even when that volume is built on fraudulent or unethical practices.

Under current law, health insurance agents and brokers are prohibited from charging consumers directly for their services, meaning their income is dependent on commission payments from insurance carriers. This structure places ethical, independent brokers at a disadvantage when carriers refuse to police fraud within their networks. As unscrupulous brokers exploit the system to generate high-volume enrollments — often through questionable or outright fraudulent means — they continue receiving commissions. Meanwhile, legitimate brokers lose out on business, face reduced opportunities, and watch resources flow to bad actors who game the system with impunity.

The wild west atmosphere within the exchanges rewarded bad actors and punished good ones. Insurers, focused on maximizing enrollment, face little downside risk from continuing to contract with brokers who manipulate or falsify applications while shutting out ethical or independent brokers who play by the rules. The result is a program where fraud is tolerated, integrity is discouraged, and responsible intermediaries are pushed out — further entrenching abuse in the ACA.

Department of Justice Actions Against the Fraud

Federal prosecutors have now begun to intervene, underscoring how pervasive and profitable ACA exchange fraud has become. On November 17, 2025, the DOJ convicted a president of an insurance brokerage firm and a CEO of an insurance marketing company of orchestrating a massive exchange enrollment fraud scheme that sought over $233 million in fraudulent ACA plan subsidies for which the federal government paid at least $180 million. This case marks one of the first federal crackdowns on unscrupulous brokers and business models exploiting gaping vulnerabilities with the ACA exchanges to manufacture and submit fraudulent enrollments to rake in millions in commissions. "The defendants exploited a health care safety net designed for working families to carry out a $233 million scheme to defraud

[33] Haley Parsley, "Hundreds of Oklahomans Lured to California for Drug Treatment Through Insurance Scheme, Lawsuit Says," The Oklahoman, August 25, 2025, https://www.oklahoman.com/story/news/2025/08/25/blue-cross-blue-shield-oklahoma-sues-california-drug-treatment-facilities/85820137007/.
[34] Blue Cross and Blue Shield of Oklahoma, Complaint Against Asana Recovery, Inc. et al., U.S. District Court for the Central District of California, April 10, 2025, https://www.documentcloud.org/documents/26053678-govuscourtscacd96545110/
[35] Blue Cross Blue Shield of Wyoming, "Fraudulent Out-of-State Substance Abuse and Mental Health Treatment Centers Are Targeting and Exploiting Wyoming's Native American Population," Fraud Alert Brief to the Wyoming Select Committee on Tribal Relations, May 22, 2025, STR-2025052210-01BCBSWYFraudAlert_WYSelectCommitteeTribalRelations.pdf

taxpayers," said Acting Assistant Attorney General Matthew R. Galeotti of the Justice Department's Criminal Division. According to the DOJ:

> [Defendants] targeted vulnerable, low-income individuals experiencing homelessness, unemployment, and mental health and substance abuse disorders, and, through 'street marketers' working on their behalf, sometimes offered bribes to induce those individuals to enroll in subsidized ACA plans.

In April 2025, DOJ announced that a Florida insurance brokerage executive, Dafud Iza, pled guilty to a scheme to "fraudulently enroll ineligible individuals into ACA plans that offered tax credits to eligible enrollees."[36] According to DOJ, "Iza and his accomplices deceptively marketed subsidized ACA plans to ineligible consumers and falsely inflated consumers' incomes to obtain the federal subsidies." They even targeted vulnerable individuals, such as "low-income individuals experiencing homelessness, unemployment, and mental health and substance abuse disorders."[37]

GAO Confirms Large-Scale Vulnerabilities in Exchanges: 96 Percent of Fake Applications Approved

A new undercover investigation by the Government Accountability Office (GAO) reveals just how fundamentally broken and vulnerable the ACA exchanges remain.[38] GAO submitted 24 fictitious applications using fake identities, fake documents, and invalid Social Security numbers. The exchanges approved 23 out of 24 — an astonishing 96% approval rate. And as GAO notes, these findings are "generally consistent" with its investigations from nearly a decade ago. In other words, nothing has improved. The system is still wide open.

The failures did not stop with initial enrollment. Eighteen of the GAO's fake enrollees were still receiving subsidized coverage months later, meaning insurers continued to collect premium tax credits for people who do not exist. These phantom enrollees mirror what we are seeing across the country: a system that rewards volume, ignores verification, and has almost no mechanisms to detect or remove ineligible or nonexistent enrollees.[39]

GAO also uncovered egregious identity-verification failures. More than 66,000 Social Security numbers showed over 366 days of coverage in 2024, including one SSN used to generate more than 26,000 days of subsidized coverage across 125 different policies. Another 58,000 SSNs belonged to deceased individuals, with thousands showing enrollment beginning after the date of death. These are not minor errors — they reflect a program architecture that cannot reliably distinguish a real applicant from a synthetic identity or a dead person.

---

[36] Department of Justice, "Executive Vice President of Insurance Brokerage Pleads Guilty in $133M Affordable Care Act Fraud Scheme," press release, April 18, 2025, https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.
[37] Ibid.
[38] U.S. Government Accountability Office, "Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist," December 3, 2025.
[39] Brian Blase, "The Rise of Phantom Obamacare Enrollees: Biden COVID Credits Drive Massive Increase in Individual Market Enrollees With No Medical Claims," Paragon Health Institute, August 13, 2025, https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/.

In addition, the IRS has no record of tax reconciliation for over $21 billion in premium tax credits for 2023 enrollees with SSNs. For years, CMS simply stopped enforcing the statutory requirement that recipients file taxes and reconcile subsidies. When the federal government abandons the most basic eligibility safeguard in the program, the inevitable result is the explosion of improper enrollment and fraudulent submissions we are witnessing today.

The ACA exchanges have become a high-risk environment for fraud, abuse, and improper payments. They routinely approve fake people, retain them on the books, pay insurers for them, and lack the oversight tools necessary to ensure program integrity. These latest GAO findings confirm what independent analyses and real-world cases have shown: the exchange system is structurally incapable of preventing large-scale fraud and continues to hemorrhage taxpayer funds as a result.

Important Exchange Integrity Reforms in the One Big Beautiful Bill

The OBBB includes several important program-integrity reforms that would meaningfully strengthen eligibility rules and prevent some of the abuses now documented in GAO investigations, DOJ prosecutions, and independent research. While each of these provisions is needed, it is critical to recognize that they address symptoms of the larger problem. The primary driver of fraud is the wide availability of zero-premium plans, which eliminates any financial stake for enrollees and creates irresistible opportunities for brokers and intermediaries to enroll people without their knowledge or consent. As long as millions of enrollees face a $0 premium, the exchanges will remain highly susceptible to fraud — no matter how strong the administrative guardrails. Ensuring that everyone pays at least some premium is the single most important step Congress can take to restore integrity to the exchanges.

Starting in 2028, Section 71303 restores a fundamental program-integrity tool: verification before enrollment. Requiring consumers to affirm their coverage annually and requiring exchanges to verify eligibility up front will reduce improper and fraudulent enrollment.

Starting in 2026, Section 71304 eliminates the year-round special enrollment period for people claiming incomes between 100 percent and 150 percent of the federal poverty level — a provision never authorized in the original ACA and repeatedly exploited by unscrupulous brokers. CMS reported that this SEP generated tens of thousands of complaints about improper enrollments and unauthorized plan switches in just the first three months of 2024. Ending this SEP will improve the risk pool and sharply reduce opportunities for fraud.

Starting in 2026, Section 71305 removes the ACA's caps on repayment of excess subsidies for people who underestimate their income — or brokers acting on their behalf — to claim excessive subsidies, eliminating a powerful incentive to misstate income. Under current law, many enrollees who underreport income face only modest repayment obligations — even if they received thousands of dollars in excess subsidies.

These statutory reforms are essential, and they provide far more durable protections than administrative actions alone. The Trump administration issued a smart program-integrity regulation addressing many of these problems, but much of it has been stayed by a single judge. That experience demonstrates a central limitation of relying on regulation alone: a single judge can block key safeguards for years.

Ultimately, however, even the strongest statutory oversight cannot overcome the structural incentive created by zero-premium plans. When individuals can be enrolled in coverage without paying anything, they have little reason to monitor their accounts, verify eligibility, or report fraud — and brokers have every reason to enroll as many people as possible, regardless of eligibility. Requiring every enrollee to contribute something to the cost of coverage would dramatically reduce fraudulent enrollments and align incentives across consumers, brokers, insurers, and taxpayers. The most effective path is for the COVID-era subsidy boosts to expire after this year and for Congress to require a minimum premium payment from every enrollee, regardless of plan. Without this change, fraud will remain embedded in the program's financial architecture.

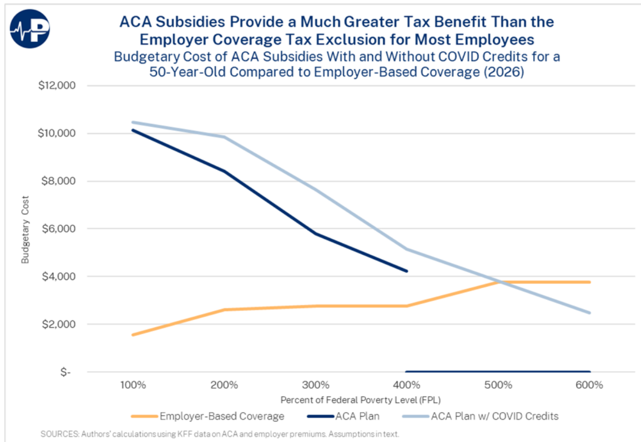
Other Problems with the ACA: Harming Workers with Employer-Based Coverage, Employers Dropping Coverage, Incentivizing Early Retirement, Punishing Upward Mobility

Beyond fueling fraud and phantom enrollment, the ACA's subsidy design — especially with the COVID-era subsidy boosts — harms work, productivity, and people who obtain coverage through a job. CBO has concluded that the enhanced subsidies in the Inflation Reduction Act increase deficits, reduce labor supply, and lower long-run economic output by diminishing the financial returns to work.[40] When government will heavily subsidize coverage for those who earn less or retire early, people respond: some work fewer hours, some leave the labor force altogether. Lifting the original income cap so that subsidies extend well above four times the poverty line has even encouraged early retirement. It has produced situations such as a retired couple in their mid-50s with $136,000 in pension income from government service receiving roughly $15,000 in ACA subsidies — federal dollars that both reward non-work and crowd out resources that could be better targeted.[41]

At the same time, the ACA penalizes people who earn their health benefits at work and pressures small employers to drop coverage.[42] The tax exclusion for employer-sponsored insurance reduces income and payroll taxes on premiums, but for low- and middle-income households the value of that tax break is dwarfed by what they can receive through ACA subsidies — especially with the COVID add-ons (see figure: "ACA Subsidies Provide Much Greater Tax Benefit"). For a typical young family at twice the poverty line, the original ACA subsidy is already more than three times as large as the tax benefit for job-based coverage; with the Biden COVID subsidy boosts, the gap grows even larger, turning that advantage into a five-figure government penalty for receiving coverage at work.[43]

[40] CBO, "Economic Analysis of Budget Reconciliation Legislation," August 4, 2022, https://www.cbo.gov/publication/58357.
[41] Greg Iacurci, "ACA Enhanced Subsidy Lapse Could Hit Early Retirees Hardest Amid Shutdown Fight," *CNBC*, October 17, 2025, https://www.cnbc.com/2025/10/17/aca-enhanced-subsidy-lapse-government-shutdown.html.
[42] Brian Blase and John R. Graham, "Problems with ACA Subsidies Compounded by COVID Credits: Unfair to Americans with Employer-Based Insurance, Punish Work, and Incentivize Employers to Drop Coverage," Paragon Health Institute, November 6, 2025, https://paragoninstitute.org/private-health/problems-with-aca-subsidies-compounded-by-covid-credits-unfair-to-americans-with-employer-based-insurance-punish-work-and-incentivize-employers-to-drop-coverage/.
[43] Ibid.

PARAGON HEALTH INSTITUTE



Take a young family with 35-year-old parents and two children, ages 7 and 10 years. If the family's income is $64,300 (200 percent of the federal poverty level), it will receive an original ACA subsidy of $19,059. The tax break for an employer-based health plan for the family would be only $5,904 (in a state with no income tax). The difference is a $13,155 net government benefit for not receiving coverage at work. However, if Congress extends the Biden COVID subsidy boosts, the family's subsidy would be $22,017, and the net government penalty for receiving coverage at work would increase to $16,113.[44]

CBO projects that over 4 million people would replace employer or unsubsidized individual coverage with subsidized exchange plans if the COVID credits are made permanent.[45] And the share of small employers offering health plans has already fallen by about one-third since 2010, shifting millions into a more expensive federal program.[46]

[44] Ibid.
[45] CBO, "The Effects of Permanently Extending the Expansion of the Premium Tax Credit and the Costs of That Credit for Deferred Action for Childhood Arrivals Recipients," June 24, 2024, https://www.cbo.gov/publication/60437.
CBO reports a 600,000 enrollment decline in unsubsidized ACA enrollment and a 3.5 million decrease in enrollment in employment-based coverage.
[46] Brian Blase and John R. Graham, "Problems with ACA Subsidies Compounded by COVID Credits: Unfair to Americans with Employer-Based Insurance, Punish Work, and Incentivize Employers to Drop Coverage,"

Employer-Based Coverage at Small Firms Has Significantly Declined with the ACA and COVID Credits

Percentage of Firms Offering Health Coverage, by Firm Size

Year	3-9 Employees	10-24 Employees	25-49 Employees
2010	59%	76%	92%
2020	48%	59%	70%
2025	N/A	51%	64%

SOURCE: KFF, Employer Health Benefits Survey (2020, 2025).

From a federal budget standpoint, this is deeply problematic: employer coverage costs taxpayers roughly one-third as much per enrollee as Medicaid, CHIP, or exchange subsidies.[47] The ACA also led state and local governments to drop retiree health coverage and push early retirees under age 65 into the exchanges, offloading their own obligations onto federal taxpayers—an offloading that will accelerate if the COVID credits are extended.[48]

Enrollee Share of the Premium Will be Low Next Year When COVID Subsidy Boosts Expire

Even as premiums continue to rise because of the program's underlying flaws, more than 93 percent of enrollees will still be insulated from most of the cost, with the vast majority paying modest monthly amounts while federal taxpayers shoulder roughly 80 percent of the premiums and even higher shares for lower-income enrollees. The table below shows the weekly premiums that enrollees would pay for the lowest-cost silver plans available to them.[49] In 2025, 45 percent of exchange enrollees claimed income between 100 and 150 percent of FPL. Those enrollees would pay between $4 and $14 a week for silver plans next year. Another 20 percent of enrollees are between 150 and 200 percent of FPL and would need to pay up to $32 per week. Another 10 percent of enrollees are between 200 and 250 percent of FPL and would have to pay up to $52 a week for coverage.

[47] CBO, "Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections," June, 2024, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

[48] Allysia Finley, "The ObamaCare Blue-City Bailout: Federal Taxpayers Pay as Municipalities Save Billions by Dumping Their Retirees onto the Government Exchanges," *Wall Street Journal*, November 2, 2025, https://www.wsj.com/opinion/the-obamacare-blue-city-bailout-e7d72bee.

[49] Brian Blase and Trevor Carlsen, "Biden's COVID Credits Are an ObamaCare Expansion That Congress Should Allow To Expire," Foundation for Government Accountability and Paragon Health Institute, September 3, 2025, https://thefga.org/research/bidens-covid-credits-are-obamacare-expansion-congress-should-allow-expire/.

PARAGON
HEALTH INSTITUTE

Taxpayers will pay most of enrollees' premiums after Biden's COVID credits expire

Average per-person weekly premium for the cheapest silver-tier plan after accounting for subsidies

	Weekly premium paid by average enrollee	Share of premiums paid by taxpayers
100 percent FPL	$3.45/week	98%
150 percent FPL	$14.12/week	92%
200 percent FPL	$32.00/week	81%
250 percent FPL	$52.43/week	68%

Source: Authors' calculations 4

In high-cost areas, the expanded subsidies deliver very large benefits to affluent households: in one Arizona market, a family of five can receive subsidies well into the six-figure income range and does not lose eligibility until income is around $614,000.[50]

Insurers Are Big Beneficiaries of the ACA and the Enhanced Subsidies

These enormous ACA subsidies, made even larger by the COVID subsidy boosts, flow straight to insurers. In 2024, more than 83 percent of exchange premium revenue came from the U.S. Treasury.[51] Insurers' business models now revolve around maximizing federal subsidies rather than designing plans that consumers value, and profits surged during the pandemic subsidy expansion not because coverage improved but because federal payments exploded.

Policies to Lower ACA Premiums and Expand Patient Control

In my testimony before the Senate Finance Committee, I discussed nine affordability ideas to address problems with the ACA — either reforms to the program or broader reforms focused on expanding choices for people harmed by the ACA or reforms to enhance competition in the market.[52] I list the reforms here but for a discussion, please see my testimony before the Finance Committee.

- Appropriate the ACA's cost-sharing reduction subsidies to address silver loading
- Enact the Health Savings Account (HSA) option to empower patients, not insurers[53]

---

[50] KFF's health insurance subsidy calculator. The zip code was 86301 and the information is for two 60-year-old adults and children ages 20, 18, and 16.

[51] Niklas Kleinworth and Brian Blase, "Insurer Revenues from ACA Premiums Were 87% Taxpayer-Funded in 2024: Ten Percentage Points Higher Than Pre-COVID Credits," Paragon Health Institute, n.d., https://paragoninstitute.org/paragon-pic/insurer-revenues-from-aca-premiums-were-87-percent-taxpayer-funded-in-2024-ten-percentage-points-higher-than-pre-covid-credits/.

[52] Brian Blase, "Testimony of Brian Blase before the Senate Finance Committee: 'The Rising Cost of Health Care: Considering Meaningful Solutions for All Americans'" Paragon Health Institute, November 19, 2025, https://paragoninstitute.org/private-health/testimony-of-brian-blase-before-the-senate-finance-committee-the-rising-cost-of-health-care-considering-meaningful-solutions-for-all-americans/.

[53] Brian Blase, Dean F. Clancy, Andrew Lautz, and Roy Ramthun, "The HSA Option: Allowing Low-Income Americans to Use a Portion of Their ACA Subsidy as a Health Savings Account Contribution" Paragon Health Institute, November 2022, https://paragoninstitute.org/private-health/the-hsa-option/.

Mr. VAN DREW. [Presiding.] Thank you very much and now we will move on to Dr. Bai.

STATEMENT OF DR. GE BAI

Dr. BAI. Chair, Ranking Members, and the Members of the Subcommittees, thank you for the honor of testifying. My views do not represent Johns Hopkins or its affiliates.

First, in a study soon to be published in *JAMA Health Forum*, my colleagues and I found that from 2014–2023, a 10-year period, ObamaCare premium subsidies grew from under $20 billion–$83 billion. This year it is going to be $130 billion.

Second, for subsidized plans the taxpayers' share rose from 29 percent—74 percent.

Third, unsubsidized plans lost appeal. Their marketshare shrank about a quarter. Taxpayers spent hundreds of billions of dollars on ObamaCare subsidies, but did the money go to the right place? GAO, DOJ, Paragon institute, and others have found the answer is no.

What they found is actually only a tip of the iceberg. Fraud is like cockroach infestation. Once we see one, there are more.

Subsidy fraud happened because government agencies have little incentive to care when they spends taxpayer money. The insurers and the brokers have no incentive to stop it. As we discuss subsidy, we should always remember the root of the problem is the unaffordable, low-value ObamaCare itself. It was originally sold to American people as affordable.

President Obama promised premiums would go down by $2,500. At that time, many economists already predicted unaffordability as we are experiencing today.

Soon numerous regulations to ObamaCare damaged both the provider market and the insurance market. Consolidation, stagnation, high prices and high premiums follow. Some people blame private companies, but the private companies are merely responding to the very incentives created by ObamaCare. Others blame FTC for consolidation, but by the time merger acquisition transactions reach FTC, it's already too late. ObamaCare has made the soil so toxic that only large entities can survive. That is why ObamaCare is both a taxpayer fraud and a consumer deception.

The COVID-era enhanced subsidy used the taxpayers to lure higher income consumers LOEs into unaffordable plans that they would not have bought otherwise without addressing any underlying unaffordability. Also, set them up as political pawns for another future premium cliff. This is also consumer deception and taxpayer fraud.

The ObamaCare defrauds taxpayers three times. First, paying for expensive premium subsidies. Second, paying those fraudsters. Third, paying a high price in premiums for their own healthcare caused by ObamaCare. Except for a small number of people who benefited critically and financially from ObamaCare all Americans lose.

Patients are deprived of affordability and excess that a free market could have brought. Physicians, entrepreneurs innovators, and American workers can reach their productivity potential. Our employment, the economy and global leadership suffered.

ObamaCare fraud was created by Congress and can only be fixed by Congress.

First, open the book and let the public help detect and deter subsidy fraud.

Second, most importantly, invigorate healthcare markets, let the patient control their healthcare dollars. Let providers compete and level the playing field. Let the insurers then offer plans that consumers actually want and deregulate and unburden—hundreds and millions of Americans want better health and a lower price, confidence builders want to compete, innovate, and earn returns. Their hands are tied by ObamaCare.

Member of Congress please unleash American dynamism into healthcare and bring true access and affordability to all. Thank you.

[The prepared statement of Ms. Bai follows:]

JOHNS HOPKINS
CAREY BUSINESS SCHOOL

Testimony for the Record
Submitted to the
House Committee on the Judiciary
Subcommittee on Oversight
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
for the Hearing
"Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?"

December 8, 2025

Ge Bai, PhD, CPA
Professor of Accounting, Carey Business School
Professor of Health Policy & Management (Joint), Bloomberg School of Public Health
Johns Hopkins University

Chairmen Van Drew and Massie, Ranking Members Crockett and Correa, and Members of the Subcommittees:

Thank you for devoting your valuable time to focusing on Obamacare subsidy fraud. It is my honor to participate in today's hearing. I am grateful for the opportunity to share my testimony.

I am Ge Bai, a Certified Public Accountant, Professor of Accounting at the Johns Hopkins Carey Business School, and Professor of Health Policy and Management (joint) at the Johns Hopkins Bloomberg School of Public Health. My research focuses on health care accounting, finance, and policy. I am affiliated with the Johns Hopkins Center for Health Services and Outcomes Research, the Hopkins Business of Health Initiative, and the Johns Hopkins Drug Access and Affordability Initiative. From 2022 to 2023, I served as a visiting scholar at the Health Analysis Division of the Congressional Budget Office (CBO). I have published numerous research articles in leading academic journals examining healthcare affordability and incentive structures.

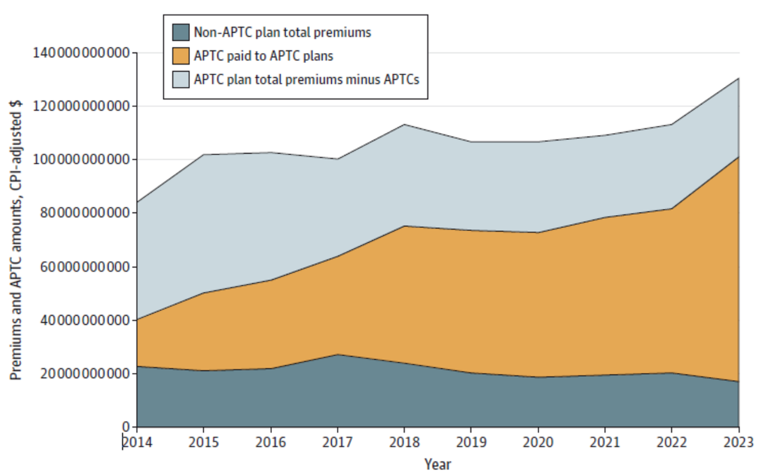
My testimony has three objectives: (1) to describe the growth of the Obamacare subsidy, (2) to explain Obamacare subsidy fraud, and (3) to discuss the effectiveness of various policy solutions, including the Administrative Procedure Act. I aim to provide an objective, evidence-based summary of these issues. The opinions expressed are my own and do not represent the views of Johns Hopkins University or any affiliated entities.

Section I: Obamacare Subsidy Growth

In a forthcoming study in *JAMA Health Forum*, Professor Elizabeth Plummer, Mr. Joshua Brooker, Professor Mark Meiselbach, and I document the explosive growth of Obamacare premium subsidies. Using mandatory Medical Loss Ratio reports from health insurers, our study provides more accurate quantification than previous analyses. As shown below, Obamacare premium subsidies (the orange area) totaled less than $20 billion (in 2024 dollars) in 2014. By 2023, they had grown to $83 billion. For subsidized plans, the taxpayers' share of premium payments jumped from 29% in 2014 to 74% in 2023.[1]

Obamacare premium subsidies were originally available only to Americans with incomes up to 400% of the federal poverty level. In March 2021, at the height of the pandemic, the American Rescue Plan Act temporarily extended premium subsidy eligibility to those with incomes above 400% of the federal poverty level, thereby eliminating any income limit. In August 2022, the Inflation Reduction Act extended those subsidies through December 2025. Our chart below clearly demonstrates the impact of Covid-era enhanced subsidies.

Figure 2. Total Premiums and Advanced Payment Tax Credits (APTCs) for APTC and Non-APTC Plans From 2014 to 2023[a]



[1] In the chart, subsidized plans are labeled at APTC (Advance Premium Tax Credit) plans. Taxpayers' share of premiums is represented by the height of the orange area divided by the combined height of the orange and light grey areas.

As more people became eligible for Covid-era enhanced subsidies, enrollment grew. However, the amount of premiums paid by enrollees themselves (the light grey area) fell from over $40 billion in 2014 to approximately $30 billion in 2023. This occurred because the American Rescue Plan Act lowered the maximum percentage of income that households between 100–400% of federal poverty level were required to pay for Obamacare. As a result of greater subsidy generosity, many plans had $0 or near $0 premiums.[2]

Unsubsidized Obamacare plans have become increasingly unpopular. The size of the unsubsidized market (the dark grey part) shrank by 23% from $23 billion in 2014 to $17 billion in 2023. This represents the actual size of the Obamacare market if no taxpayer subsidies existed.

Section II: Obamacare Subsidy Operational Fraud

Taxpayers have spent hundreds of billions of dollars subsidizing Obamacare premiums, yet substantial evidence indicates widespread fraud. Because these activities diverted taxpayer dollars intended to pay insurers to subsidize eligible Obamacare enrollees' premiums, I categorize them as *operational fraud*. Examples of operational fraud are listed below.

- An undercover investigation by the Government Accountability Office found that 18 of 20 fictitious applications were approved and retained for Obamacare enrollment, with insurers collecting taxpayer subsidies while incurring no medical spending.[3]

- A marketing company CEO and an insurance brokerage executive were convicted in $233 million scheme that targeted vulnerable people with bribes.[4] An executive vice president of insurance brokerage pled guilty to $133 million scheme involving the fraudulent enrollment of ineligible individuals.[5]

- Paragon Health Institute estimated that 6.4 million ineligible enrollees in 2025 (up from 5.0 million in 2024) misrepresented their income to qualify for fully subsidized Obamacare coverage ($0 premium), costing taxpayers over $27 billion in 2025 alone.[6]

- Paragon Health Institute also found that zero-claim enrollees in Obamacare individual markets tripled from 2021 to 2024, reaching nearly 12 million and accounting for 40% of

[2] https://www.kff.org/affordable-care-act/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/
[3] https://www.gao.gov/products/gao-26-108742
[4] https://www.law360.com/articles/2412091/2-execs-found-guilty-in-233m-aca-fraud-scheme
[5] https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud
[6] https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/?utm_source=chatgpt.com

total enrollees. Meanwhile, zero-claim enrollees remained stable in Obamacare small-group markets, suggesting significant fraudulent enrollment in individual markets.[7]

These examples are neither accidental nor exhaustive. They represent only the tip of the iceberg. Operational fraud persists because regulatory oversight is insufficient to ensure program integrity. More importantly, brokers and insurers, compensated per enrollment, have strong incentives to chase enrollment volume while ignoring integrity. For example, insurers rarely terminate fraudulent brokers in order to preserve subsidy payments from taxpayers.[6] Additionally, the subsidy structure—particularly the proliferation of $0-premium plans enabled by Covid-era enhanced subsidies—is easily exploitable. Operational fraud will continue to grow in the fertile environment created by Obamacare's subsidy design and incentive structure.

Section III: Obamacare Structural Fraud

Operational fraud, as discussed in the previous section, diverts taxpayer dollars away from their intended purpose: subsidizing Obamacare premiums. A fundamental weakness of Obamacare is its unaffordability. As I wrote in the *Wall Street Journal*, "premiums have increased by nearly 80% since 2014 and more than doubled since 2011. They are projected to rise another 15% to 20% next year. Despite record taxpayer spending on premium subsidies—exceeding $130 billion annually—enrollees still pay average deductibles of $5,000 and out-of-pocket maximums of $21,000 while 1 in 5 of their medical claims are denied." [8]

The unaffordability of Obamacare—the direct and predictable consequence of Obamacare's own design—created both the need for taxpayer subsidy and the conditions for widespread operational fraud. Subsidies feed the growing and hungry "dragon," and the dragon's underlying unaffordability was intentionally obscured from the American public at the time of Obamacare's passage. I refer to this phenomenon as Obamacare's *structural fraud*.

Simply put, structural fraud—the root cause—has spawned operational fraud, its derivative problem.

<u>Insurance Regulation</u>

Insurance regulations imposed by Obamacare in the name of protecting patients and improving affordability have instead undermined insurance markets. Main examples include:

1. Essential Health Benefits. As Dr. David A. Hyman and I, along with our coauthors, have written in *JAMA Internal Medicine*, *JAMA Health Forum*, and the *Journal of General*

---

[7] https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/?utm_source=chatgpt.com
[8] https://www.wsj.com/opinion/let-the-obamacare-enhanced-premium-subsidies-expire-16ef7e1b

Internal Medicine, insurance exists to protect enrollees against the financial risks of rare, high-cost events.[9,10,11] That is why car insurance does not cover oil changes and property insurance does not cover faucet replacement. Plans that cover routine, low-cost services would require much higher premiums and would hold little appeal to consumers. The same logic applies to health insurance.

When patients use health insurance for routine care, they do not benefit directly from lower prices and are typically limited in their choice of providers. As a result, patients are less mobile and care less about prices than they would in cash transactions, thus reducing downward pricing pressure and inhibiting competition and innovation. Cash prices are often lower than negotiated prices, and medical products and services not covered by insurance have experienced persistent price deflation and improving quality similar to most other commodities.[12,13,14,15,16]

Additionally, insurance generates administrative expenses for processing, adjudicating, and paying each claim, as well as a profit margin for insurers. Coverage also imposes administrative burdens on physicians, reducing the time available for patient care.

Despite these economic realities, Obamacare forced insurance to cover ten Essential Health Benefits, such as mental health services, substance abuse treatment, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness care, and gender affirming care. This rule inflated both service prices and plan premiums, and impeded innovation in care delivery.

2. Medical Loss Ratio. Obamacare requires insurers to spend at least 80% of premium revenues on medical services for individual and small-group plans (85% for large-group plans), a rule known as the Medical Loss Ratio (MLR) requirement. As my coauthors and I recently wrote in *Health Affairs Forefront*, this rule ignored important realities of insurance markets.[17] First, when profit and administrative expenses are capped, insurers are forced to grow profit by increasing medical spending. Second, large insurers, with diverse business units and markets, can better stabilize claim volatility, manage intercompany eliminations, and more easily meet the MLR requirement than small or regional insurers. Third, innovative plans, which require greater strategic investment, and more affordable plans, which cover relatively fewer

[9] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2814226
[10] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2827713
[11] https://link.springer.com/article/10.1007/s11606-025-09541-3
[12] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787285
[13] https://jamanetwork.com/journals/jamasurgery/fullarticle/2817652
[14] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00977
[15] https://www.washingtonpost.com/opinions/2023/04/11/hospital-prices-health-insurance-high-costs/
[16] https://www.hoover.org/research/patient-centered-healthcare
[17] https://www.healthaffairs.org/content/forefront/unintended-consequences-aca-s-medical-loss-ratio-requirement

services, face greater challenges meeting the MLR requirement because of their relatively high administrative costs.

Therefore, the MLR rule, purportedly intended to curb insurers' greed and administrative waste, has driven up medical spending and undermined small, regional, innovative, and affordable plans. These anticompetitive effects have contributed to insurance market consolidation and further premium increases.

3. Community Rating. Prior to Obamacare, medical underwriting was used to determine a person's premiums based on their individual health risks, similar to how car insurance considers a driver's record. Under Obamacare, insurers are required to charge the same premium to all enrollees of the same age and geographic area, a requirement known as community rating. Moreover, it limits premium variation by age to a 3:1 ratio—older enrollees cannot be charged more than three times the premiums of younger enrollees in the same region.

   Community rating undermines incentives for individuals to engage in healthy activities, following the same logic as higher car insurance premiums discouraging reckless driving. More importantly, it discriminates against younger and healthier individuals by effectively taxing them through higher premiums than their risk profile would justify, in order to subsidize older and sicker enrollees. This rule violates fundamental actuarial and economic principles and directly contributed to the premium increases experienced by many Americans,[18] imposing financial burdens and discouraging entrepreneurship.[16] Because this group was deterred by unaffordable premiums from enrolling in Obamacare, the risk pool deteriorated, driving premiums even higher, as observed.

4. No Annual/Life Limit. Obamacare prohibits health plans from capping the total dollar amount they pay for covered services for an enrollee in a year or over the enrollee's lifetime. This requirement exposes insurers to potentially unlimited medical spending, restricts their ability to steer patients to more affordable alternatives, and incentivizes hospitals and drug manufacturers to raise prices, knowing that insurers have to pay anyway. Not surprisingly, very expensive individual claims (e.g., exceeding $1 million) grew rapidly,[19] driving up premiums for both marketplace plans and employer-sponsored plans, which are also subject to this rule.

5. Premium Price Sensitivity. After the Covid-era enhanced subsidies were implemented, all Americans, regardless of income level, are potentially eligible for Obamacare subsidies. This shift of financial responsibility from individual enrollees to taxpayers eliminates enrollees' price sensitivity and interest in seeking more affordable, higher value options—why

[18] https://www.johnhcochrane.com/research-all/after-the-aca-freeing-the-market-for-health-care
[19] https://sunlife.showpad.com/share/G9vemnF3cmEx0h70xC7bo

economize when someone else is footing the bill? As a result, insurers have little incentive to contain premiums for existing plans or design more affordable options. Prospective entrants face a closed market, which stifles innovation and competition and undermine the health and function of the insurance market.

Provider Regulation

Obamacare imposed significant regulatory burdens and skewed the competitive landscape in the provider market, contributing to health system consolidation, the decline of independent physician practices, and ultimately higher prices and insurance premiums. Several examples are listed below:

1. Ban on Physician-Owned Hospitals. Obamacare prohibits the formation of new physician-owned hospitals and limits the expansion of existing ones. Prior research found that physician-owned hospitals enhance physician engagement, provide higher-quality care, and incur lower costs compared with other hospitals.[20] My coauthored research, published in *JAMA Network Open*, shows that both commercial negotiated prices and cash prices in physician-owned hospitals were about one-third lower than their competitors in the same referral region.[21] As my coauthors and I explained in *Health Affairs Forefront*, this restriction is anti-competitive in nature, enabling incumbent hospitals to preserve market power and command high prices while depriving patients of affordable hospital care options.[22]

2. The 340B Drug Pricing Program. This program, created by Congress in 1992, allows eligible nonprofit and government hospitals to purchase outpatient drugs from pharmaceutical companies at steep discounts and sell them at full prices, retaining the difference.[23] Obamacare substantially expanded 340B program eligibility, fueling its subsequent explosive growth.[24] While hospitals benefit substantially from this lucrative "buy-low-sell-high" program, independent physician practices are not eligible. This differential treatment incentivizes hospitals to acquire physician practices in order to capture 340B program profits, contributing to market consolidation and the decline of independent physician practices, and ultimately leading to higher medical spending and insurance premiums.

3. Accountable Care Organizations (ACOs). Obamacare created ACOs and the Medicare Shared Savings Program. Although targeted at Medicare, these programs have reshaped

[20] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-4-Letter-to-Verma-re-2021-OPPS-FINAL.pdf
[21] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806510
[22] https://www.healthaffairs.org/content/forefront/rationalizing-physician-regulation
[23] https://waysandmeans.house.gov/wp-content/uploads/2025/09/2025WM_Bai_FinalFinalFinal.pdf
[24] https://www.cbo.gov/publication/61730

provider markets. To participate effectively, hospitals sought greater control over patient volume through vertical integration (purchasing physician practices) and horizontal consolidation (merging or acquiring hospitals). These consolidations strengthened hospital market power, raised commercial prices, and undermined independent physician practices. As commercial prices increased, Obamacare plan premiums rose.

4. Value-Based Payment Modifier. Obamacare mandated the Value-Based Payment Modifier, which adjusted Medicare physician payments based on reported quality and cost measures. As my coauthors and I noted in *Health Affairs Forefront*,[25] this program substantially increased administrative burdens for physicians—especially small and independent practices—and created incentives for them to integrate into larger health systems with the infrastructure to handle quality reporting. This mechanism contributed to vertical consolidation, higher prices, and elevated premiums for Obamacare and other commercial plans. Importantly, the mandate did not improve quality but fostered a quality industrial complex that profits from expanding quality measures that add friction to care delivery.

Taken together, Obamacare distorted both insurance and provider markets, contributing to consolidation and driving up healthcare prices and insurance premiums. Some analysts have blamed inadequate Federal Trade Commission (FTC) oversight of mergers and acquisitions, while overlooking this fact: by the time numerous transactions reach the FTC, it's already too late—the competitive landscape has already been so poisoned by Obamacare that only big players can survive.

Obamacare has deprived the American people of broad access to high-quality, innovative, and dynamic healthcare markets, saddled businesses, entrepreneurs, and innovators, and threatened our nation's global leadership.[26] It represents a highly inefficient approach to finance care for low-income, high-risk Americans. A dedicated risk pool—backed by state-sponsored reinsurance and direct subsidies to patients—would cost far less and provide far more robust and sustainable protection.[16,27]

Obamacare was promised to the American people as exactly the opposite of what it has become—for example, President Barack Obama promised that it would reduce premiums by $2,500. In essence, American taxpayers are defrauded three times: they pay for rapidly expanding Obamacare subsidies; they suffer from disrupted healthcare markets and shoulder high commercial prices, and they fund operational fraudsters. Congress must recognize this structural fraud.

---

[25] https://www.healthaffairs.org/content/forefront/reforming-medicare-quality-measurement

[26] https://gjia.georgetown.edu/2025/04/07/a-patient-centered-approach-to-improving-the-return-of-investment-in-us-healthcare/

[27] https://direct.mit.edu/itgg/article/14/1-2/90/134017/Improving-Health-Care-Affordability-Access-and

From this perspective, the framing and promotion of the Covid-19 enhanced subsidy without addressing Obamacare's underlying structural fraud also constitutes a form of consumer deception and taxpayer fraud. It lures higher-income Americans into unaffordable plans—by using taxpayer dollars—that they would not otherwise purchase and sets them up as political pawns for a looming premium cliff.

Section IV: Policy Solutions

Operational Fraud: Close Loopholes and Open the Books

To combat operational fraud in Obamacare subsidies, agency oversight should be strengthened. CMS's 2025 Marketplace Integrity and Affordability Rule includes key provisions for this purpose: stricter income and eligibility verification, a $5 monthly premium for auto-reenrolled fully subsidized plans, tighter checks on enrollment periods, disqualification from future subsidies for failure to reconcile tax credits, shortened open enrollment periods, and other measures intended to reduce improper payments.[28]

Although CMS estimated that this rule would effectively address operational fraud and save up to $12 billion in 2026 subsidy payments,[29] a U.S. District Court issued a preliminary injunction partially blocking it in August 2025.[30] The Administrative Procedure Act (APA) was central to the legal challenge, with plaintiffs arguing that the rule was arbitrary and capricious, exceeded ACA statutory authority, and conflicted with the statute's goals. Given the APA's central role in legal debates over Obamacare implementation, only Congress can enact the provisions included in 2025 Marketplace Integrity and Affordability Rule.

Because the techniques used to commit operational fraud are constantly evolving, ongoing and adaptive oversight efforts are essential. As Professor David A. Hyman and I argued in *STAT News*, it would be a mistake for HHS to be the only "cop in town" tasked with detecting and deterring operational fraud.[31] HHS should make de-identified data on Obamacare widely available, allowing researchers, analysts, journalists, and concerned citizens to constantly discern irregularities, uncover fraud, and explore solutions. HHS can and should minimize information barriers on spending and taxpayer subsidies under Obamacare and other taxpayer-funded programs, and leverage the collective efforts of the public to maximize oversight efficiency and effectiveness. They can do a far better job of identifying and deterring fraud and ensuring program integrity, at no cost to taxpayers, than any government agency, regardless of its size or staffing.

---

[28] https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability
[29] https://www.cms.gov/newsroom/press-releases/cms-finalizes-major-rule-lower-individual-health-insurance-premiums-americans?utm_source=chatgpt.com
[30] https://www.courtlistener.com/docket/70684987/city-of-columbus-v-kennedy/
[31] https://www.statnews.com/2025/09/26/health-care-spending-data-de-identified-claims-aca-medicaid/

Structural Fraud: Invigorate Markets

Opening alternative healthcare markets for Americans would mitigate Obamacare's structural fraud. This approach does not impose new regulations that dictate market operations; rather, it would remove existing regulatory barriers that have hindered these markets from emerging organically in the first place. For example, the Biden Administration's restrictions on the eligibility for association health plans and limits on the duration of short-term plans have significantly narrowed patient access to affordable non-Obamacare options. Similarly, constraints on the eligibility and usage of health savings accounts (HSAs) and providers' ability to offer or disclose cash prices prevent many Americans from taking advantage of tax benefits and accessing low-cost cash-pay markets.[10] Eliminating these barriers would foster bottom-up innovation and competition in care delivery and payment models, providing much-needed relief to Americans.

To fundamentally fix the structural fraud of Obamacare, Congress should adopt a four-pronged approach.[16] First, *free patients*. Directly subsidizing Americans in need would unleash market forces to achieve nondiscriminatory, affordable prices and higher quality through competition and innovation. Empowering patients to choose providers and insurance plans would align incentives throughout the system, forcing all players to focus on attracting and retaining patients rather than regulatory compliance. Insurance-based access restrictions, such as prior authorization and network requirements, would largely vanish for routine care, disproportionately benefiting low-income populations.

Second, *free providers*. Health systems did not accidentally become conglomerates, swallowing independent physician practices and driving up prices and premiums—they did exactly what Obamacare and other regulations incentivized. Congress should level the playing field by removing anticompetitive regulations, allowing physician practices and alternative facilities to enter and compete. Free market competition is unforgiving to underperforming providers, leaving little room for price gouging, low quality, shortages, stagnation, or other behaviors contrary to patients' best interests. Market discipline, driven by self-interested consumers, is more powerful and effective than any regulation.

Third, *free insurers*. Obamacare mandates have banned or restricted insurance choices and undermined competition by dictating insurance operations. Vertical and horizontal integration in the insurance market is not a market failure but a survival strategy for insurers capable of complying, scaling, and exerting political influence amid policy failures. Congress should free insurance markets from regulatory strangleholds, allowing competition to drive all players to innovate, improve, and offer insurance products that consumers want.

Fourth, *deregulate and unburden*. Healthcare regulations that restrict behavior typically advantage incumbents, suppress competition, and ultimately harm patients and society. Bad policies persist because regulators and special interest groups benefit from their implementation, maintenance, and the perpetual efforts to "fix" the problems they create. Over time, the expansion of bureaucracy and crony relationships has made healthcare regulations extremely complex. More Band-Aid solutions will only worsen this complexity, threatening the survival of small players, deterring aspiring entrants, and further protecting special interests.[16,26,27] The solution is not more or better regulations, but fewer. Congress must recognize that only the collective wisdom of all market participants—not a small group of experts or bureaucrats—can determine the "right" behaviors that truly benefit patients. Regulatory power must be permanently constrained to allow markets to survive and thrive.

Obamacare fraud is created by Congress and can only be fixed by Congress. The power to transform U.S. healthcare lies with tens of millions of Americans who want control over their healthcare dollars and access to affordable care they choose, along with countless "builders" eager to compete for patients and earn returns. Yet, their hands have been tied by Obamacare.

Release American dynamism in healthcare to benefit all.

Thank you again for giving me the opportunity to participate in this hearing. I would be pleased to answer any questions you may have.

Mr. VAN DREW. Dr. Bai, thank you. Next, we will ask Professor Cooper. Thank you for being here.

STATEMENT OF ZACH COOPER

Mr. COOPER. Thank you. Good afternoon, Chair Jordan, Chair Van Drew, Chair Fitzgerald, Ranking Member Raskin, and the Members of the Committee. My name is Zack Cooper. I am a health economist and Professor at Yale University, where my reach focuses on the understanding the drivers of healthcare spending growth in the United States and how healthcare spending impacts the wider economy.

Today I'm testifying here on my own behalf, not on behalf of Yale University and the views I am going to express are my own. I really appreciate the opportunity to be here.

A decade ago in my health economics class, when I taught my students about the relationship between health insurance, health and mortality, what I told them was health insurance is a fundamentally a financial tool. I was wrong. A decade later, my views have changed because the research has changed. The clearest evidence we have now is that enrolling an American in a Affordable Care Act plan on the exchanges make them less likely to die.

The enhanced ACA subsidies that help approximately 22 million people in this country's purchase plans are set to expire at the end of year. People getting health insurance on the exchanges are farmers, they are ranchers, they are cooks in small restaurants, they are contractors who run their own businesses. If those subsidies end, the premiums people pay are going to skyrocket and approximately four million people are going to lose their coverage. Extending those subsidies matters.

If you focus only on whether the subsidies remain in place, we're having the wrong conversation. The real problem we're facing in this country is the underlying cost of healthcare. The growth in healthcare spending is what makes the subsidies necessary in the first place. It's driving up premiums for employer sponsored health insurance coverage; it is driving up premiums on the exchanges.

Rising healthcare spending is crushing families, it's slowing wage growth, and it is reducing employment for Americans earning less than $100,000 a year who are working outside the healthcare sector. As I've said, healthcare spending is literally crushing the American Dream.

Next year premiums from employer sponsored plans are expected to increase 10 percent, premiums on the exchanges are projected to rise 18 percent. The premiums growth is largely driven by the growth we're seeing at hospital and provider prices. I want you to think of mergers, staffing shortages, and tariffs on medical devices. Then, there is the increasing use of GLP–1s.

As the Congressional Budget Office has said, the exchange plans are seeing a sharper increase in premiums in the employer plans precisely because of the uncertainty over the expiration of the ACA subsidies. Insurers had to factor in the risk that if the subsidies expired, healthier people would be less likely to buy insurance on the exchanges, which could lead to sicker insurance risk pool.

Price growth is the biggest problem we're facing. Over the last two decades, prices in the hospital sector as an example have grown faster than prices in virtually any other sector of the U.S. economy. We've seen huge numbers of hospital mergers, mergers of hospitals and physician practices, mergers of pharmacy benefits managers. This is what the problem is that we're facing. There are practical steps Congress could take to address this.

The first is introducing so-called site neutral billing. Medicare often pays more, sometimes double the identical services when they are delivered in a hospital versus an independent physician's office. This encourages content consolidation, it raises prices, and it drives up premiums.

The second is increasing funding for antitrust enforcement. Increasing enforcement budgets turns out to be cost effective for the Federal Government. It makes a difference.

Finally, we need to begin serious exploration of larger healthcare reforms, they could be implemented over the next decade. During the shutdown, one idea briefly surfaced was a bipartisan commission to study ways to lower healthcare spending in this country. That commission shouldn't be a footnote, its' essential, healthcare costs are crushing your constituents.

Now, a brief word on fraud, as the GAO report makes clear, there is a fraud risk on the exchanges. In 2024, CMS took action to spend 850 agents and brokers from the federally run marketplaces because they had a reasonable suspicion of fraud.

We shouldn't tolerate fraud. We should work tirelessly to stop it. However, my review or my reading of the literature is that fraud is not the primary driver of the growth we're seeing right now in healthcare spending. What's really driving premium growth is growth in healthcare providers' prices.

We as a country have failed to take the necessary steps to make healthcare affordable for people in this Nation. My insurance is good. I'm going to assume that most of the folks in this room have pretty good insurance coverage.

The reason that subsidies are important is because lower- and middle-class, lower- and middle-income Americans shouldn't be left uninsured or stuck paying astronomical premiums because policymakers, healthcare purchasers like employers have failed to make the tough choices that need to be made to rein in healthcare cost in this country.

Subsidies alone aren't a solution. What they do is buy us time. The point is to use the time that they provide to build a system where coverage is affordable because care is affordable. I'm delighted to talk about the steps we could take as a country to make healthcare more affordable.

Thanks for the opportunity to testify, and I look forward to your questions.

[The prepared statement of Mr. Cooper follows:]

Testimony of

Zack Cooper, PhD[1]
Associate Professor of Public Health & Associate Professor of Economics
Yale University

Statement before the House Committee on the Judiciary
Subcommittee on Oversight and
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust

"Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?"

Wednesday, December 10, 2025

[1] I am testifying on my own behalf, not on behalf of Yale University, and the views expressed are my own.

Opening Statement

Good afternoon, Chairman Jordan, Chairman Van Drew, Chairman Fitzgerald, Ranking Members Raskin and Crockett, and Members of the Subcommittees.

My name is Zack Cooper. I am a health economist and a professor at Yale University, where my research focuses on understanding the drivers of health care spending growth in the United States and how health spending impacts the wider economy.

I greatly appreciate the opportunity to testify before the Committee.

A decade ago, in my health economics class, when I taught my students about what the literature suggested about the relationship between health insurance, health, and mortality, I told them that I thought health insurance was a financial tool that did not impact health outcomes.

A decade later, my views have changed.

The clearest evidence we have is that enrolling an American in an Affordable Care Act Marketplace plan makes them less likely to die.[2]

The enhanced ACA subsidies that help approximately 22 million people purchase those plans are set to expire at the end of the year. The people getting health insurance on the exchanges are farmers and ranchers; they're cooks in small restaurants; and they're contractors who run their own businesses.

If those subsidies end, the premiums people pay will skyrocket, and approximately 4 million people will lose coverage.[3] Extending them matters.

But if we focus only on whether the subsidies remain in place, we are having the wrong conversation.

[2] Jacob Goldin, Ithai Z Lurie, Janet McCubbin, Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach, *The Quarterly Journal of Economics*, Volume 136, Issue 1, February 2021, Pages 1–49, https://doi.org/10.1093/qje/qjaa029.

[3] See Phillip Swagel, "Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," CBO, September 18, 2025 and Matthew Buettgens, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin, "4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire," (Washington, DC: Urban Institute, 2025). The Congressional Budget Office (CBO) estimates that 3.8 million will lose their insurance coverage. The Urban Institute, using a similar approach, estimates that eliminating the Premium Tax Credits would lead 4.8 million people to lose coverage.

The real problem we're facing in this country is the underlying cost of health care.

The growth in health spending is what makes the subsidies necessary in the first place. It is driving up premiums for employer-sponsored insurance, and it is driving up premiums on the exchanges.

Rising health care spending is crushing families; it's slowing wage growth; and reducing employment for Americans earning less than $100,000 a year outside the health sector.[4]

Next year, premiums for employer plans are expected to increase by 10%.[5] Premiums on the exchanges are projected to rise 18%.[6] This premium growth is largely being driven by the growth we're seeing in hospital and provider prices—think mergers, staffing shortages, and the impact of tariffs on medical devices—and then there is increasing use of GLP-1s.

As the Congressional Budget Office notes, exchange plans are seeing a sharper increase than employer plans because of the uncertainty over the expiration of the subsidies.[7] Insurers had to factor in the risk that, if the subsidies expired, healthier people would be less likely to buy insurance, which would lead to a sicker insurance risk pool.

Price growth is our core problem. Over the last two decades, prices in the hospital sector, for example, have grown faster than prices in virtually any other sector of the economy.[8] We have seen huge numbers of hospital mergers, mergers of hospitals and physician practices, and mergers of pharmacy benefit managers.[9]

---

[4] Brot-Goldberg, Zarek, Cooper, Zack, Craig, Stuart, Klarnet, Lev, Lurie, Ithai, Miller, Corbin. *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers.* NBER Working Paper No. 32613, June 2024, revised Dec. 2024. National Bureau of Economic Research, 2024. https://doi.org/10.3386/w32613.

[5] Anna Wilde Mathews. "Health Insurance Costs to Rise by Most in Years." *The Wall Street Journal*, 10 Sept. 2025, www.wsj.com/health/healthcare/health-insurance-costs-rise-6cc1b934.

[6] Ortaliza, Jared, et al. "How Much and Why ACA Marketplace Premiums Are Going Up in 2026." *Peterson-KFF Health System Tracker*, 6 Aug. 2025, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/.

[7] Congressional Budget Office. *The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance.* Report No. 61734, 18 Sept. 2025, cbo.gov/system/files/2025-09/61734-Health.pdf.

[8] Mike Cummings. "Lax antitrust enforcement linked to rising hospital prices." *Yale News*, April 24, 2024. https://news.yale.edu/2024/04/24/lax-antitrust-enforcement-linked-rising-hospital-prices. Cooper Z, Craig S, Gaynor M, Harish NJ, Krumholz HM, Van Reenen J. Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007-14. Health Aff (Millwood). 2019 Feb;38(2):184-189. doi: 10.1377/hlthaff.2018.05424.

[9] Brot, Zarek, Zack Cooper, Stuart V. Craig, and Lev Klarnet. 2024. "Is There Too Little Antitrust Enforcement in the US Hospital Sector?"*American Economic Review: Insights* 6 (4): 526–42. Zack Cooper, Stuart V. Craig, Aristotelis Epanomeritakis, Matthew Grennan, Joseph R. Martinez, Fiona Scott Morton,

There are practical steps Congress could take to address this.

The first is introducing so-called site-neutral billing.[10] Medicare often pays more—sometimes double—for the same service when delivered in a hospital versus an independent physician's office. That encourages consolidation and drives up premiums.

A second is increasing funding for antitrust enforcement. Increasing enforcement budgets is cost-effective and makes a difference.[11]

Finally, we should begin serious exploration of larger health care reforms that could be implemented over the next decade. During the shutdown, one idea that briefly surfaced was a bipartisan commission to study ways to lower health care spending. That commission shouldn't be a footnote—it's essential.

Now, a brief word on fraud. As the GAO report makes clear, there is a fraud risk on the exchanges.[12] And in 2024, CMS took action to suspend 850 agents and brokers from the federally run marketplaces because they had reasonable suspicions of fraud. We shouldn't tolerate fraud and should work to stop it.

However, my read of the literature is that fraud is not a primary driver of the growth we're seeing in health care spending. What's really driving the premium growth is growth in providers' prices.

We, as a country, have failed to take the steps necessary to make health care affordable. My insurance coverage is good. I'm going to assume most people in this room have good insurance coverage.

---

and Ashley T. Swanson, "Are Hospital Acquisitions of Physician Practices Anticompetitive?," NBER Working Paper 34039 (2025), https://doi.org/10.3386/w34039.

[10] Cooper, Zack, Elizabeth Jurinka, and Daniel Stern. *Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program*. Tobin Center for Economic Policy, Yale University, 30 Oct. 2023. https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf

[11] Cooper, Zack, and Martin Gaynor. *Addressing Hospital Concentration and Rising Consolidation in the United States*. 1% Steps for Health Care Reform, Feb. 2021, onepercentsteps.com/wp-content/uploads/brief-hc-210208-1700.pdf. Brot, Zarek, Zack Cooper, Stuart V. Craig, and Lev Klarnet. 2024. "Is There Too Little Antitrust Enforcement in the US Hospital Sector?"*American Economic Review: Insights* 6 (4): 526–42.

[12] U.S. Government Accountability Office. *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist.* GAO Report No. GAO-26-108742, 3 Dec. 2025. https://www.gao.gov/assets/gao-26-108742.pdf

The reason I think the subsidies are important is because lower- and middle-income Americans shouldn't be left uninsured or be stuck paying astronomical premiums because policymakers and health care purchasers, like large employers, have failed to make tough choices and rein in health care spending.

Subsidies alone aren't a solution; they buy us time. The point is to use the time they provide to build a system where coverage is affordable because care is affordable.

In what follows, I provide a more detailed summary of the consolidation that has occurred in the US health industry and described how it has impacted domestic health spending.

Overview[13]

In 2024, the United States (US) spent more than $5 trillion— approximately 18% of Gross Domestic Product (GDP) — on health care.[14] To put that number in context, Germany is the fourth largest economy in the world and had a GDP of $4.6 trillion in 2024.[15] As a result, if the US health care system was a country, in dollar terms, it would be the third largest country in the world with an output larger than the entirety of the German economy.

The US relies on private markets to provide health care services and administer health insurance. In part, this reliance on markets is a function of the sheer scale of the US health system. As a result, the health of the US health system is a function of the health of the markets that underpin our health system.

As I'll argue, the provider markets that underpin our health system are becoming increasingly concentrated. This rise in concentration is harmful to the public. Increasing consolidation raises provider prices (thus increasing health spending) and harms access to health care services (by increasing insurance premiums and out of pocket costs). In turn, rising health spending is putting pressure on government programs, lowering tax revenue, and leading to lower wages, job losses, and rising inequality among those with employer-sponsored insurance coverage. In short, efforts to guarantee the long-run sustainability of public insurance programs and rein in the growth of private insurance premiums cannot ignore rising consolidation and the shifting market landscape in the health care sector.

It is near universally accepted by economists that even when employers contribute to their employees' insurance premiums, these premiums and the cost of health care services are almost wholly borne by individuals and families, not by their employers or by insurers.[16] In 2025, annual premiums for family coverage via an employer-sponsored

---

[13] My thanks to Yale PhD student Genna Liu for her excellent research assistance, which aided greatly in the preparation of this testimony.

[14] Keehan, S. P., Madison, A. J., Poisal, J. A., Cuckler, G. A., and others. "National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health To Grow As Share Of GDP." *Health Affairs*, vol. 44, no. 7 (2025): 776–787.

[15] "GDP (current US$) - Germany," *The World Bank*, https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=DE.

[16] Gruber, Jonathan, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, 1994, Vol. 84(3), pp. 622-641; Baicker, Katherine, and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics*, 2006, Vol. 24(3), pp. 609-634 ("Baicker and Chandra, 2006"); Currie, Janet, and Brigitte C. Madrian, "Health, Health Insurance and the Labor Market," in *Handbook of Labor Economics*, 1999, Vol. 3, eds. Orley Ashenfelter and David Card, pp. 3309-3416 ("Currie and Madrian, 1999"); Gaynor, Martin, "Antitrust Applied: Hospital Consolidation Concerns and Solutions," Statement Before the Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights, U.S. Senate, 2021,

insurance plan were $27,000.[17] For context, a new Toyota Corolla costs $22,725.[18] In other words, the average family in the US is buying approximately a new car's worth of insurance each year, even if this purchase is obscured because their employer is purchasing insurance on their behalf.

The rising cost of health care in the US is placing a financial burden on families and the federal government.[19] From 2000 to 2021, insurance premiums in the US rose by 215%.[20] This increase in premiums was driven by an increase in health spending. By contrast, median earnings during this period grew by only 73%.[21] As a result, over the last two decades, the rising cost of health care has meant that families have had less money to spend on everything from food to housing to leisure and that the price of insurance has become out of reach for many.[22] And even with full insurance coverage, 44% of adults in the US in 2018 were worried about affording a medical bill and 19% reported using up all or most of their savings on health care costs.[23]

From 2013 to 2023, insurance premiums increased 61% whereas inflation was 30%. Results from my work suggest that, if health care spending had grown at the rate of inflation, wages in the US would have been approximately 10% higher today.[24]

Historically, most of the discussion of provider consolidation in the US has focused on the impact of, for example, hospital mergers on hospital prices. However, the way the US funds health care for the privately insured — the ubiquity of and tax exclusion given to

---

https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf ("Gaynor Senate Testimony").

[17] "Employer Health Benefits 2021 Annual Survey," *Kaiser Family Foundation*, 2025, https://www.kff.org/report-section/ehbs-2025-summary-of-findings/.

[18] See: "2026 Corolla," *Toyota*, https://www.toyota.com/corolla.

[19] Tax revenues go down when increases in premiums for employer-sponsored coverage lower wages and employment. Likewise, tax revenue goes down when rising health spending increases the tax subsidies required for health insurance plans sold on exchanges.

[20] Family coverage. "Employer Health Benefits 2021 Annual Survey," *Kaiser Family Foundation*, 2021, https://www.kff.org/report-section/ehbs-2021-summary-of-findings/.

[21] Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2021.

[22] Tolbert, Jennifer, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Population," *Henry J Kaiser Family Foundation*, 2022, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[23] Peterson-KFF Health System Tracker, 2020; Montero, Alex, "Americans' Challenges with Health Care Costs," *Henry J Kaiser Family Foundation*, 2022 https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/; "Kaiser Family Foundation / LA Times Survey of Adults with Employer-Sponsored Health Insurance," *Henry J Kaiser Family Foundation*, September 15-October 9, 2018, https://files.kff.org/attachment/Topline-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance.

[24] Brot-Goldberg, Zarek, Cooper, Zack, Craig, Stuart, Klarnet, Lev, Lurie, Ithai, Miller, Corbin. *Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers*. NBER Working Paper No. 32613, June 2024, revised Dec. 2024. National Bureau of Economic Research, 2024. https://doi.org/10.3386/w32613.

employer-sponsored health insurance — means that consolidation that increases health spending is driving decreases in tax revenue, lower wages, job losses, and economic inequality. Theory neatly predicts and empirical evidence highlights that when health spending on those with employer-sponsored coverage goes up, this is paid for by workers in the form of lower wages and job losses.[25] Job losses also impact health. A literature studying the effect of, for example, factory closures highlight that individuals who lose their job have an increased risk of death within a year, often from a suicide, an accident, or a drug overdose.[26] Debt, less tax revenue, lower wages, job losses, and death: these are the consequences of provider consolidation and rising health spending in the US.[27]

Moreover, as recent work highlights, because insurance premiums do not vary markedly across workers, when health spending goes up, employer-sponsored health insurance discourages the hiring of non-college educated workers, since insurance premiums make up a higher share of their costs of employment.[28] Indeed, Finkelstein et al., (2023) note, the scale of the effect of our employer-sponsored health insurance system on wage inequality is similar in magnitude to the measured effects of the outsourcing of jobs, robot adoption, and the decline in real minimum wage.[29]

Most health care services in the US are furnished by private firms. Private providers compete to deliver care to publicly and privately funded patients. Likewise, the majority of the public receives their health insurance from a private insurer via a market where insurers compete against one another. Indeed, even in publicly funded programs, like Medicare and Medicaid, more than half of the coverage is provided by private insurers. We rely on pharmaceutical firms to develop and manufacture drugs; we rely on pharmacy benefits managers (PBMs) to help firms and purchasers build formularies; we rely on

[25] Gruber, Jonathan, and Alan Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy*, 1991, Vol. 5, pp. 111-143; Baicker and Chandra, 2006; Gaynor Senate Testimony, Currie and Madrian, 2000.

[26] Sullivan, Daniel, and Till von Wachter, "Job Displacement and Mortality: An Analysis Using Administrative Data," *Quarterly Journal of Economics*, 2009, Vol. 124(3), pp. 1265-1306; Eliason, Marcus, and Donald Storrie, 2009, "Does Job Loss Shorten Life," *Journal of Human Resources*, Vol. 44(2), pp. 277-302; Venkataramani, Atheendar, et al., 2020, "Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States, *JAMA Internal Medicine*, Vol. 180(2), pp. 254-262.

[27] Cooper, Zack, et al., "Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-based Care in 2007-14," *Health Affairs*, 2019, Vol. 38(2), pp. 184-189; Cooper, Zack, et al., "Variation in Health Spending Growth for the Privately Insured From 2007 to 2014," *Health Affairs*, 2019, Vol. 38(2), pp. 230-236; Kluender, Raymond, et al., "Medical Debt in the US, 2009-2020," *JAMA*, 2021, Vol. 326(3), pp. 250-256; Case, Anne, and Angus Deaton, *Deaths of Despair and the Future of Capitalism*, 2020 ("Case and Deaton, 2020").

[28] Finkelstein, Amy, et al., "The Health Wedge and Labor Market Inequality," *Brookings*, 2023, ("Finkelstein et al., 2023"); Saez, Emmanuel, and Gabriel Zucman, *The Triumph of Injustice*, 2019; Case and Deaton, 2020.

[29] Finkelstein et al., 2023.

private firms to distribute the vast array of medical products we consume across the country.

Ultimately, the health of the US health system is a function of the extent to which the underlying health care markets in the US are competitive. This competition disciplines the pricing of private firms and creates incentives for quality.[30] Markets are not perfect. Markets can fail and all markets, particularly those for health care goods, insurance, and services, require oversight and external support to maintain competition. This oversight and support must include keeping health care markets from becoming overly concentrated, providing the information that supports market participants (e.g., quality and pricing information), and regulating parts of the market where competition will not produce efficient or equitable outcomes.

Markets in the health sector can function efficiently. Evidence clearly illustrates that when hospitals compete, hospitals deliver higher quality care and patients experience reductions in mortality.[31] In competitive markets, the hospitals with higher prices have better outcomes and those higher prices tend to be cost effective.[32] Similarly, higher quality hospitals tend to grow more over time - a signpost of a functioning market.[33] This same logic applies to other sectors of the health system outside of hospitals, like the market for physician services or the market for private insurance.

However, ongoing changes in health care markets over the last two decades should have the warning lights on our dashboard blinking red. The changes occurring in US hospital markets parallel changes occurring in other parts of the US health system.[34] From 2000 to the present, there have been well over 1,000 mergers among the nation's approximately 5,000 hospitals.[35] Partly as a function of this consolidation, at present,

---

[30] Gaynor, Martin, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," *Journal of Economic Literature*, 2015, Vol. 53(2), pp. 235-284 ("Gaynor, Ho, and Town, 2015").

[31] Cooper, Zack, et al., "Does Hospital Competition Save Lives? Evidence from the English Patient Choice Reforms," *Economic Journal*, 2011, Vol. 121, pp. F228-F260 ("Cooper, et al., 2011"); Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper, "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy*, 2013, Vol. 5(4), pp. 134-166 ("Gaynor, Moreno-Serra, and Propper, 2013"); Kessler, Daniel P., and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?" *Quarterly Journal of Economics*, 2000, Vol. 115(2), pp. 577-615 ("Kessler and McClellan, 2000").

[32] Cooper, Zack, et al., "Do Higher-Price Hospitals Deliver Higher-Quality Care?" *NBER Working Paper 29809*, 2022 ("Cooper, et al., 2022").

[33] Chandra, Amitabh, et al., "Health Care Exceptionalism? Performance and Allocation in the US Health Care Sector," *American Economic Review*, 2016, Vol. 106(8), pp. 2110-2144 ("Chandra, et al., 2016").

[34] Fulton, Brent D., "Health Care Market Concentration Trends in The United States: Evidence and Policy Responses," *Health Affairs*, 2017, Vol. 36(9), pp. 1530-1538 ("Fulton, 2017").

[35] Cooper, Zack, and Martin Gaynor, "Addressing Hospital Concentration and Rising Consolidation in the United States," *1% Steps for Health Care Reform*, https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/.

nearly 90% of US metropolitan areas have hospital markets that make them "highly concentrated" according to the 2010 Department of Justice and Federal Trade Commission Horizontal Merger Guidelines.[36] While not all mergers are harmful, evidence clearly shows that hospital mergers of neighboring facilities can raise prices (so too can so-called "cross market mergers" of hospitals in the same state).[37]

Like hospital markets, insurance markets in the US are also generally regarded as highly concentrated.[38] More concentrated health insurance markets have higher premiums, and mergers of insurance companies raise premiums and lower payments to doctors.[39] Physician markets, while less easily observed, are also regarded as highly concentrated. Higher concentration in physician markets is also associated with higher prices, and mergers between physician practices have been found to raise prices.[40]

US health care markets are also evolving in new and distinct ways. There is increasing vertical integration: hospitals are acquiring physician practices, insurers are acquiring physician practices, and insurers are acquiring PBMs. There is a steady increase in private capital flowing into health care markets (ranging from venture capital, to private equity, to publicly traded companies). Finally, there is the growing ubiquity of health care conglomerates: large firms like Aetna CVS Health and UnitedHealth Group that have insurance businesses, own providers, own pharmacy benefits managers, and have huge proprietary data repositories. Collectively, these large acquisitions, mergers, and new deals are appropriately giving the public, and researchers like me, pause, as we seek to understand the effects of these arrangements in the near and long term. As such, I applaud the Committee for hosting this hearing and its efforts to learn more about what

---

[36] Fulton, 2017.
[37] Gowrisankaran, Gautam, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review*, 2015, Vol. 105(1), pp. 172-203 ("Gowrisankaran, Nevo, and Town, 2015"); Cooper, Zack, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics*, 2019, Vol. 134(1), pp. 51-107; Dafny, Leemore, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics*, 2019, Vol. 50(2), pp. 286-325; Lewis, Matthew S., and Kevin E. Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *RAND Journal of Economics*, 2017, Vol. 48(3), pp. 579-610.
[38] "Competition in Health Insurance: A Comprehensive Study of U.S. Markets," *American Medical Association*, 2022, https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.
[39] Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review*, 2012, Vol. 102(2), pp. 1161-1185 ("Dafny, Duggan, and Ramanarayanan, 2012").
[40] Koch, Thomas, and Shawn Ulrick, "Price Effects of a Merger: Evidence From a Physicians' Market," *Economic Inquiry*, 2021, Vol. 59(2), pp. 790-802; Dunn, Abe, and Adam Hale Shapiro, "Do Physicians Possess Market Power?" *Journal of Law and Economics*, 2014, Vol. 57(1), pp. 159-193 ("Dunn and Shapiro, 2014"); Koch, Thomas, Brett Wendling, and Nathan E. Wilson, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries," *Health Services Research*, 2018, Vol. 53(5), pp. 3549-3568 ("Koch, Wendling, and Wilson, 2018").

drives consolidation in health care markets, as well as what might be done to keep the US health care markets functioning efficiently.

In this testimony, I will outline the major changes occurring in US health care provider markets. I will also offer some recommendations on ways to address rising concentration and thwart abuses of market power.

Learning from the Challenges and Changes in Hospital Markets

While studying the functioning of the US hospital industry is vital in its own right, understanding the impact of reductions of competition in the hospital industry in the US over the last three decades can provide important insights into the impact of competition and consolidation in the health sector more broadly. An analysis of the US hospital industry highlights how competition can drive quality and illustrates how some mergers can be harmful to patients and wider communities.

The hospital industry accounts for 5.7% of US GDP and 31.1% of health spending.[41] When discussing provider market power, it is important to distinguish between payments made to providers by the Medicare and Medicaid programs and payments made by commercial insurance plans offered by for-profit and not-for-profit insurers. At a high level, Medicare pays hospitals using regulated payments implemented by the Centers for Medicare and Medicaid Services. By contrast, for the privately insured, hospitals and insurers engage in bilateral negotiations over the prices for care for each insurance plan. The Medicaid program pays hospitals using a combination of negotiated and regulated prices.

During the 2000s, the Bureau of Labor Statistics found that hospital prices grew faster than prices in any other US industry.[42] Ultimately, the prices hospitals negotiate with insurers are markedly higher than the regulated prices they are paid by the Medicare program.[43] Commercial reimbursements have also risen much more quickly than Medicare payment rates. In the late 1990s, commercial payments to hospitals were only approximately 10% higher than Medicare reimbursements; by 2012, hospital payment rates from private insurers were 75% higher than Medicare rates.[44] At present, it is not

---

[41] National Health Expenditure Data, *Centers for Medicare & Medicaid Services*, 2021, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata.

[42] Bureau of Labor Statistics, Consumer Price Index and Producer Price Index data, https://www.bls.gov/data/.

[43] Cooper, Zack, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics*, 2019, Vol. 134(1), pp. 51-107.

[44] Selden, Thomas M., et al., "The Growing Difference between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, 2015, Vol. 34(12), pp. 2147-2150.

uncommon for hospitals to be paid 200% or more of Medicare rates.[45] Here, it is vital to point out that most academic experts do not accept the idea of cost shifting - the concept that hospitals' payments from insurers are going up because of low payments from public payers.[46] Rather, the broad consensus is that the difference in the growth in prices hospitals negotiate with insurers reflects the impact of changes in providers' bargaining leverage and reductions in competition.

Economists are broadly concerned with rising market power across industries.[47] However, a literature dating back to the 1960s generated a conventional wisdom that questioned whether competition could function in the hospital sector and posited that non-profit hospitals would behave differently from for-profit actors and not abuse their market power should they have it. More recently, a growing body of work highlights that competition between hospitals can incentivize quality and generate efficient prices, and that non-profit hospitals often behave similarly to for-profits.[48] A key takeaway from this literature: for markets to function, they must not become too highly concentrated, regardless of the tax status of market participants.

As Chandra et al. (2016) note, "a classic 'signpost of competition' in manufacturing industries is that higher productivity producers are allocated greater market share at a point in time and over time."[49] In other words, better firms grow more quickly. The authors then assess, via analyzing the Medicare program, whether higher quality hospitals have higher market share and grow more quickly. The authors find that, when using measures of both outcomes (e.g., mortality and readmissions) and process (e.g., adherence to guidelines), higher quality hospitals have greater market share and experience more growth in market share over time. They conclude that "health care may have more in common with 'traditional' sectors subject to market forces than often assumed."

In Cooper et al. (2022), my coauthors and I analyze whether higher-priced hospitals deliver higher quality care - a simple test for assessing the extent to which the market for hospital care is functioning.[50] We have two notable findings. First, patient death rates are markedly lower at high-priced hospitals. However, this positive correlation between prices

[45] Chernew, Michael E., Andrew L. Hicks, and Shivani A. Shah. "Wide State-Level Variation in Commercial Health Care Prices Suggests Uneven Impact of Price Regulation," *Health Affairs*, 2020, Vol. 39(5), pp. 791-799.
[46] Frakt, Austin B., "How Much Do Hospitals Cost Shift? A Review of the Evidence," *Milbank Quarterly*, 2011, Vol. 89(1), pp. 90-130; Glied, Sherry, "COVID-19 Overturned the Theory of Medical Cost Shifting by Hospitals," *JAMA Health Forum*, 2021, Vol. 2(6), e212128.
[47] Berry, Steve, Martin Gaynor, and Fiona Scott Morton, "Do Increasing Markups Matter? Lessons from Empirical Industrial Organization," *Journal of Economic Perspectives*, 2019, Vol. 33(3), pp. 44-68.
[48] Handel, Ben, and Kate Ho, "Industrial Organization of Health Care Markets," in *Handbook of Industrial Organization*, 2021, Vol. 5, eds. Kate Ho, Ali Hortaçsu, and Alessandro Lizzeri, pp. 521-614.
[49] Chandra, et al., 2016.
[50] Cooper, et al., 2022.

and quality is only present in hospitals in unconcentrated markets where there is scope for competition (e.g., markets with a Herfindahl Hirschman Index (HHI) of less than 4,000). By contrast, in more concentrated markets, going to a higher-priced hospital raises health spending markedly with no effect on clinical outcomes. Second, we find that high hospital prices in competitive markets appear to be cost-effective given their association with better outcomes.

Several studies find that hospitals facing more competition have better outcomes. Kessler and McClellan (2000) study outcomes for Medicare beneficiaries and observe that patients receiving care from hospitals in the most concentrated (least competitive) markets had mortality rates that are 4.4% higher than patients receiving care at hospitals in less concentrated (more competitive markets)[51]. Likewise, Cooper et al. (2011) and Gaynor, Moreno-Serra, and Propper (2013) study the effect of a set of reforms in the English National Health Service which gave patients a choice of their provider and forced hospitals to compete.[52] This is a setting with regulated price that is quite analogous to the markets hospitals face when offering care to Medicare beneficiaries. Both studies find that hospitals exposed to competition after these reforms lowered their mortality rates.

Consolidation in the Hospital Industry

From 1998 to 2025, as the American Hospital Association notes, there were more than 1,500 hospital mergers among the nation's approximately 5,000 hospitals. As Cooper et al. (2019) note, the vast majority of hospitals in the US have either been directly involved in a merger or have been a neighbor to a merger. While some of the mergers that occurred had little or no impact on competition, many of the mergers that happened were between hospitals that were close competitors. My own calculations suggest that approximately 20% of mergers between 2000 and 2020 could be classified by the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines as "presumed likely to enhance market power."[53]

There is now a large body of academic evidence on the impact of hospital mergers which yields four core conclusions.

- First, mergers of hospitals that are geographically proximate and are close substitutes to one another can lead to meaningful price increases.[54] The literature

[51] Kessler and McClellan, 2000.
[52] Cooper, et al., 2011; Gaynor, Moreno-Serra, and Propper, 2013.
[53] U.S. Department of Justice and Federal Trade Commission, "Horizontal Merger Guidelines," Technical Report 2010.
[54] Town, Robert, and Gregory Vistnes, "Hospital Competition in HMO Networks," *Journal of Health Economics*, 2001, Vol. 20(5), pp. 733-752; Krishnan, Ranjani, "Market Restructuring and Pricing in the

shows that it is not uncommon for hospital mergers to generate price increases of 20% or more and, in some cases, they can generate price increases of more than 50%. Recently, two studies have found that mergers of hospitals that are not geographically proximate but share common customers can raise prices by between 10% and 20%. Of note, both non-profit hospitals and for-profit hospitals have been found to raise prices after mergers that lessen competition.[55]

- Second, the literature suggests that most mergers either have no effect on clinical quality or have led to modest reductions in clinical quality.[56]

- Third, the literature suggests that mergers of nearby competing hospitals tend not to reduce costs and that if there are cost reductions, it generally is not passed on to consumers.[57] By contrast, there is some evidence of 4% to 7% cost savings among mergers involving hospitals that are not competitors (and thus are deals that are less likely to raise prices).[58]

- Fourth, consistent with theory, in addition to impacting product markets (e.g., the market for hospital services), mergers can give merging parties more bargaining power over their workers' wages (e.g., it gives hospitals market power in input

---

Hospital Industry," *Journal of Health Economics,* 2001, Vol. 2, pp. 213-237; Vita, Michael G., and Seth Sacher, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study," *Journal of Industrial Economics*, 2001, Vol. 49(1), pp. 63-84; Gaynor, Martin, and William B. Vogt, "Antitrust and Competition in Health Care Markets," in *Handbook of Health Economics*, Vol. 1, eds. Anthony J. Culyer and Joseph P. Newhouse, pp. 1405-1487; Capps, Cory, David Dranove, and Mark Satterthwaite, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics*, 2003, Vol. 34(4), pp. 737-63; Capps, Cory, and David Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs,* 2004, Vol. 23(2), pp. 17-181; Dafny, Leemore, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law and Economics*, 2009, Vol. 52(3), pp. 523-550; Haas-Wilson, Deborah, and Christopher Garmon, "Hospital Mergers and Competitive Effects: Two Retrospective Analyses," *International Journal of the Economics of Business*, 2011, Vol. 18(1), pp. 17-32; Tenn, Steven, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," *International Journal of the Economics of Business*, 2011, Vol. 18(1), pp. 65-82; Thompson, Aileen, "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," *International Journal of the Economics of Business*, 2011, Vol. 18(1), pp. 91-101; Gowrisankaran, Nevo, and Town, 2015.

[55] Gaynor, Martin, Kate Ho, and Robert J. Town, "The Industrial Organization of Health Care Markets," *Journal of Economic Literature,* 2015, Vol. 53(2), pp. 235-84.

[56] Beaulieu, Nancy D., et al., "Changes in Quality of Care After Hospital Mergers and Acquisitions," *New England Journal of Medicine*, 2020, Vol. 382(1), pp. 51-59; Romano, Patrick, and David Balan, "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare," *International Journal of the Economics of Business*, 2011, Vol. 18(1), pp. 45-64; Capps, Cory, "The Quality Effects of Hospital Mergers," unpublished manuscript, 2005, Bates White LLC; Haas, Susan, Atul Gawande, and Mark E. Reynolds, "The Risks to Patient Safety from Health System Expansions," *JAMA*, 2018, Vol. 319(17), pp. 1765-1766.

[57] Craig, Stuart, Matthew Grennan, and Ashley Swanson, "Mergers and Marginal Costs: New Evidence on Hospital Buyer Power," *RAND Journal of Economics,* 2021, Vol. 52(1), pp. 151-178.

[58] Schmitt, Matt, "Do Hospital Mergers Reduce Costs?" *Journal of Health Economics*, 2017, Vol. 52, pp. 74-94.

markets). Here, recent work by Prager and Schmitt found that mergers which resulted in large increases in concentration led to 1.7 percentage points slower wage growth for nurses and pharmacy workers.[59]

While my testimony is focused on the impact of market power among providers, it is worth noting that similar patterns can be observed in insurance markets. There are two peer-reviewed studies that examine the impact of insurance mergers.[60] Both studies found that premiums increased after the mergers in markets where the merging parties had the most overlap before the mergers occurred. One of these studies also found that insurance mergers led to a reduction in the payment rates to providers and, notably, did not find that these savings were passed on to consumers.[61]

Physician Markets

There are approximately a million physicians in the US.[62] The market for physician services has experienced changes over the last two decades that, in many ways, parallel what happened in hospital markets.[63] During this period, physician markets have experienced horizontal mergers (e.g., two physician practices merging), vertical integration (e.g., hospitals or insurers buying physician practices), and an expansion in the share of physician practices owned by private equity (PE) firms. From 2010 to 2016, the increase in concentration in physician markets paralleled the rise in concentration among hospital markets.[64] At present, approximately 40% of US markets are "highly concentrated" for primary care services. Likewise, over the last decade, the share of physicians employed by hospitals roughly doubled and reached nearly 40%.[65]

While both vertical and horizontal integration of physician practices could, in theory, lead to efficiency gains, the empirical evidence thus far suggests both types of transactions have raised the prices physicians negotiate with insurers and increased health spending on Medicare beneficiaries and the privately insured. For example, recently published work by economists at the FTC found that horizontal physician practice mergers led to

[59] Prager, Elena, and Matt Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review*, 2021, Vol. 111(2), pp. 397-427.
[60] Dafny, Duggan, and Ramanarayanan, 2012; Guardado, Jose, David Emmons, and Carol Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra," *Health Management, Policy and Innovation*, 2013, Vol. 1(3), pp. 16-35.
[61] Dafny et al., 2012.
[62] "Professionally Active Physicians," *Kaiser Family Foundation*, January 2023, https://www.kff.org/other/state-indicator/total-active-physicians/.
[63] Fulton, 2017.
[64] Fulton, 2017.
[65] Fulton, 2017.

increases of between 10% and 20% in the prices negotiated with insurers.[66] This finding builds on past work showing that physicians in more concentrated markets have higher prices.[67] Likewise, evidence on the effect of hospital acquisition of physician practices (e.g., vertical integration) has found that these transactions raised prices, on average, by more than 10% and led to marked increases in both public and private health spending.[68] Notably, this literature has not found that the vertical integration of hospitals and physicians has led to improvements in quality and has found that acquired physicians tend to shift their patient referrals to their new acquiring entities.[69] At present, there is little evidence on whether insurer acquisition of physician practices impacts spending. However, we should be vigilant about whether these transactions lessen competition and how they impact risk-adjustment coding, particularly in the Medicare Advantage program.

Addressing Consolidation in the Health Sector

Provider consolidation has adversely impacted the American public, lowered tax revenue, and raised health spending for the publicly and privately insured. There are, however, a number of steps that could be taken to avoid unintentionally incentivizing consolidation, strengthen antitrust enforcement laws and enforcement, promote competition in existing markets, and expand data availability and create a national claims database.

Avoiding Incentivizing Consolidation

Steps could be taken to lessen the incentive for firms to consolidate.

1. Firms might be merging to try to defray high (fixed) administrative costs. Here, for example, duplicative quality reporting requirements across Medicare and private insurers, as well as claims forms that differ across insurers, can raise administrative costs for hospitals. This in turn might encourage mergers. As the Congressional Budget Office reports, in 2020, the Centers for Medicare & Medicaid Services used more than 2,000 quality metrics to oversee providers'

---

[66] Kock, Thomas, and Shawn Ulrick, "Price Effects of a Merger: Evidence from a Physicians' Market," *Economic Inquiry*, 2020, Vol. 59(2), pp. 790-802 ("Kock and Ulrick, 2020").
[67] Dunn and Shapiro, 2014.
[68] Cory Capps, David Dranove, and Chris Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics*, 2018, 59(2), pp. 139-152.
[69] Scott, Kristin W., et al., "Changes in Hospital-Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care," *Annals of Internal Medicine*, 2018, Vol. 168(2), pp. 156-157; Kock and Ulrick, 2020; Short, Marah Noel, and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review*, 2020, Vol. 77(6), pp. 538-548; Chernew, Michael, Zack Cooper, Eugene Larsen-Hallock, and Fiona Scott Morton, "Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans," *Journal of Health Economics*, Vol. 76(1); Lin, Haizhen Lin, et al., "Owning the Agent: Hospital Influence on Physician Behaviors," *NBER Working Paper 28859*, 2021.

performance.[70] Steps should be taken constantly to lower the administrative costs facing hospitals. Here, Harvard University Professor David Cutler has produced a detailed set of thoughtful recommendations for reducing administrative costs for hospitals, including establishing a clearinghouse for bill submission and simplifying prior authorization.[71]

2. At present, the Medicare program often pays more for health care services if they are performed at hospital outpatient departments versus in a physician office. As a result, hospitals and physicians can receive higher payments and share the surplus post acquisition if the hospital buys the physician practice (e.g., they vertically integrate). Academic research and MedPAC have suggested that this lack of site neutral payments encourages vertical integration and raises public and private health spending.[72] While Congress worked to address this in 2015, more could be done to expand site neutral payments to a wider array of outpatient services across hospital outpatient departments.

3. The 340b program provides hospitals with discounted access to infused medications. The program is designed to offset the costs of delivery of these products to certain low-income populations. However, one consequence of the program is that it can allow certain hospitals with a 340b waiver to acquire these products at cheaper prices than certain physician practices. As the Congressional Budget Office and a wide range of outside experts have noted, this can unintentionally incentivize hospitals to vertically integrate with physician practices that give their patients large quantities of infused products.[73] One strategy, proposed by scholars at the Brookings Institution and the American Enterprise

[70] "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," *Congressional Budget Office*, September 2022, https://www.cbo.gov/publication/58541; Cutler, David, "Reducing Administrative Costs in U.S. Health Care," *The Hamilton Project*, March 10, 2020, https://www.hamiltonproject.org/publication/policy-proposal/reducing-administrative-costs-in-u-s-health-care/ ("Cutler 2020").
[71] Cutler 2020.
[72] "Aligning Fee-for-Service Payment Rates Across Ambulatory Settings," in *Report to the Congress: Medicare and the Health Care Delivery System*, *MedPac*, June 2022, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf; Dranove, David, and Chris Ody, "Employed for Higher Pay? How Medicare Payment Rules Affect Hospital Employment of Physicians," *American Economic Journal: Economic Policy*, 2019, Vol. 11(4), pp. 249-71.
[73] Desai, Sunita, and J. Michael McWilliams, "Consequences of the 340B Drug Pricing Program," *New England Journal of Medicine*, 2018, Vol. 378(6), pp. 539-48; "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Service," *Congressional Budget Office*, September 2022, https://www.cbo.gov/publication/58541; Adler, Loren, and Benedic Ippolito, "Procompetitive Health Care Reform Options for a Divided Congress," *Brookings*, 2023, https://www.brookings.edu/essay/procompetitive-health-care-reform-options-for-a-divided-congress/ ("Adler and Ippolito, 2023").

Institute to lower the incentives from the 340b program for providers to integrate, is to lower the scale of the 340b discounts.[74]

Strengthening Antitrust Enforcement Laws and Enforcement

1. There is broad agreement from experts that the antitrust enforcement agencies are significantly underfunded, and funding for the FTC and DOJ antitrust enforcement teams should be increased.[75] Over the last decade, merger filings have increased markedly more quickly than the agencies' enforcement budgets. Limited enforcement budgets make it challenging for the FTC to take the appropriate volume of enforcement actions, which means, in practice, that deals which do lessen competition are not being challenged. Recent legislation, for example, the Competition and Antitrust Law Enforcement Reform Act of 2021, would introduce large increases to the enforcement agencies' budgets.[76]

2. At present, the FTC is not allowed to pursue cases for anticompetitive conduct against not-for-profit firms (FTC Act, Section 45(a)(2), Section 44). Since the majority of hospitals in the US are not-for-profit, this leaves a significant blind spot in enforcement and should be changed. Recent proposed legislation — Stop Anticompetitive Healthcare Act of 2022 — would provide the FTC with enforcement activity over these non-profit hospital actions.[77]

3. At present, the Hart-Scott-Rodino (HSR) Act exempts deals with relatively small merging parties from reporting those transactions to the FTC. Academic evidence suggests that there are virtually no enforcement actions against deals under HSR thresholds because they are not observed by regulators.[78] However, in the health sector, even small mergers in local health care markets can have big local effects. My own calculations in ongoing work with Stuart Craig, Zarek Brot-Goldberg, and

---

[74] Adler and Ippolito, 2023.

[75] Gaynor Senate Testimony; Dafny, Leemore, "How Health Care Consolidation is Contributing to Higher Prices and Spending, and Reforms that Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets," Statement Before the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021, https://www.hbs.edu/ris/Profile%20Files/4.29.2021%20Dafny%20Oral%20Statement%20and%20Written%20Testimony%20Before%20U.S.%20House_47df362c-9f24-4ca3-a9aa-bebf5af8fa7a.pdf ("Dafny House Testimony"); Baer, Bill, et al., "Restoring Competition in the United States," *Washington Center for Equitable Growth*, 2020, https://equitablegrowth.org/research-paper/restoring-competition-in-the-united-states/ ("Baer, et al., 2020").

[76] "S. 225 - Competition and Antitrust Law Enforcement Reform Act of 2021," *Congress.gov*, https://www.congress.gov/bill/117th-congress/senate-bill/225

[77] "H.R.9510 - Stop Anticompetitive Healthcare Act of 2022", *Congress.gov*, https://www.congress.gov/bill/117th-congress/house-bill/9510.

[78] Wollman, Thomas, "Stealth Consolidation: Evidence from An Amendment to the Hart-Scott-Rodino Act," *American Economic Review: Insights*, 2018, Vol. 1(1), pp. 77-94.

Lev Klarnet suggest that more than 30% of hospital mergers are under HSR reporting thresholds and so too are the majority of physician horizontal and vertical acquisitions. Actions should be taken to lower the reporting thresholds, so that the vast majority of physician and hospital mergers are visible to the enforcement agencies.[79]

4. The DOJ and FTC should revise the guidelines for antitrust enforcement in the health sector. These were last issued in 1996 and the market has evolved significantly since then.[80] Revised guidelines that replace the withdrawn 1996 guidance could aid enforcement agencies, courts, and players in the health sector.

Both Harvard's Leemore Dafny and Carnegie Mellon's Martin Gaynor were officials at the FTC and have described additional, detailed steps in their past Congressional testimony that could be taken to strengthen antitrust enforcement laws in the US.[81] One key area where they agree (and I support) is amending the Clayton Act to make it easier for enforcement agencies to challenge anticompetitive mergers. This could include shifting language that currently requires regulators to demonstrate that a merger "substantially" lessens competition to require regulators to demonstrate that a merger "meaningfully" lessens competition. Crucially, this type of shift would allow enforcement agencies to have more tools to address serial acquisitions of small physician practice by larger firms (including hospitals and physician staffing companies), where individual transactions might not warrant individual scrutiny, but the collective series of transactions meaningfully impact a market.

Promoting Competition

1. Certificate of Need (CON) laws are state regulations that, for example, necessitate a regulator's permission for new firms to enter a health care market (e.g., to build a new hospital or outpatient facility), for facilities to purchase new equipment (e.g., MRI scanners), or for facilities to expand (e.g., to add more inpatient or outpatient beds). At present, 35 states and Washington, D.C. operate CON laws, although the scope of laws vary markedly across states.[82] Often, CON laws are a vehicle for incumbent firms to block the entry of rivals. The FTC and DOJ have put out a joint statement highlighting how CON laws tend to restrict competition in the health

---

[79] There are detailed suggestions on ways to achieve this in Baer, et al., 2020.
[80] "Statements of Antitrust Enforcement Policy in Health Care," *U.S. Department of Justice and the Federal Trade Commission*, Aug. 1996, https://www.justice.gov/atr/page/file/1197731/download.
[81] Gaynor Senate Testimony; Dafny House Testimony.
[82] "Certificate of Need Laws," *National Conference of State Legislators*, 2023, https://www.ncsl.org/health/certificate-of-need-state-laws.

sector and that there is little evidence that they lower health spending.[83] The academic evidence supports the agencies' views on CON laws.[84] For example, Cutler, Huckman, and Kolstad (2010) show that the repeal of CON laws in Pennsylvania led to a redistribution of surgeries to higher-quality surgeons.[85] States should continue to either rescind CON laws or structure them in a manner that does not lessen competition. States should also focus on avoiding additional laws that also could unintentionally limit competition, including any willing provider laws, scope of practice laws, and licensing board decisions.

2. Increasingly, hospital/insurer contracts contain so-called 'all or nothing' provisions, 'anti-steering' provisions, and 'anti-tiering' provisions. 'All or nothing' provisions require that insurers include all a health system's sites in their network if they include any one site in their network. 'Anti-tiering' and 'anti-steering' provisions can require that insurers not take steps to increase cost sharing for certain hospitals or actively steer patients away from high-cost facilities. Collectively, these types of provisions can reduce competition and raise prices. States and federal regulators should be mindful of these types of provisions and, where appropriate, strongly discourage their use or seek to take enforcement action against them for limiting competition. Likewise, Congress would be justified in exploring the possibility of banning these types of provisions in hospital/insurer contracts.

---

[83] Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate of Need Laws and South Carolina House Bill 3250, January 11, 2016, https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf.

[84] Gaynor, Ho, and Town, 2015; Mitchell, Matthew, "Do Certificate-of-Need Laws Limit Spending?" *Mercatus Working Paper, George Mason University*, 2016.

[85] Cutler, David, Robert Huckman, and Jonathan Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," *American Economic Journal: Economic Policy*, Vol. 2(1), pp. 51-76.

Mr. VAN DREW. [Presiding.] I thank the gentleman. I am now going to recognize the Ranking Member for his statement.

Ladies and gentlemen, I want to apologize a little bit. We cannot control what happens on the floor. Things took much longer today. We're going to have another voting session.

We are going to attempt to have two people, to be as fair as we can, on either side of the aisle speak, and that's going to wrap the hearing up. Otherwise, we'd have to come back, and everybody has previous commitments.

Please accept my apology in advance to Members on both sides of the aisle and to the witnesses. I am truly sorry about this. I was looking forward to a robust, thorough, full-throated debate on this. I really was. It didn't happen.

The gentleman from Maryland.

Mr. RASKIN. Mr. Chair, thank you very much.

Professor Cooper, let me just pick up with what you just said. You testified that it was actually growth in healthcare prices and insurance prices that is really driving the cost increases, not so much fraud, but then you mentioned that there were 850 insurance agents and brokers who were suspected of fraud, waste, and abuse who had been removed by the Biden Administration.

Then, this is somewhat of a bombshell, tucked in the GAO report—all 850 of those shady insurance agents and brokers accused of fraud were allowed back into the marketplace that they were suspected of defrauding.

Did I hear that right?

Mr. COOPER. That's my understanding, yes.

Mr. RASKIN. Well, I know you don't think fraud is the big deal here, but that can't be a sound practice, can it be, to have the Trump Administration restoring potentially fraudulent brokers and agents to the government, to the program?

Mr. COOPER. If your goal, Congressman Raskin, is to reduce fraud, that's not what I would do.

Mr. RASKIN. Mr. Bagdoyan, let me come to you. You identify in your report potential risks for fraud in the ACA program. Just to be clear, are those kinds of potential risks you identified unique to the ACA program or are those potentially present in all healthcare programs or all government programs?

Mr. BAGDOYAN. That's a great question. Thank you for asking it.

The indicators for identity proofing and eligibility determination, those are the key ones that pretty much run the gamut of any kind of a—

Mr. RASKIN. If I could, and just to followup on that, this also is not something new that's taking place now or was not new in the last administration.

You identified that that potential risk of fraud went back to 2014, right?

Mr. BAGDOYAN. That's when we first started this work, sir, yes.

Mr. RASKIN. OK. It seems to me that really this hearing should be about what is the administration doing to confront this risk of abuse that has been in place for more than a decade.

Can anybody answer what Secretary Robert F. Kennedy, Jr., at HHS and men mutt Oz are actually doing about the potential kinds of fraud that go back to 2014? I don't know.

Dr. Blase, can you answer that?

Dr. BLASE. Thank you for that question, Congressman.

The administration made a final rule on exchange program integrity that included a lot of policies that would reduce the fraud.

One of them was to have a $5 minimum payment to review people's eligibility prior to continuing enrollment to address issues with auto-reenrollment. That rule was stayed by one judge so it wasn't in effect.

The reconciliation bill actually has three important provisions to address some of the fraud. It will require enrollees starting in 2028 to take action prior to being auto-reenrolled. The insurer won't be able to just keep them in the plan. The enrollee will have to do something.

Mr. RASKIN. Yes.

Dr. BLASE. It addresses—the Biden Administration opened up enrollment for anyone claiming income in a certain category at any point in the year. The GAO report showed just how vulnerable the exchanges were. It's called the special enrollment period—significantly opened up the opportunity for fraud.

Mr. RASKIN. Let me just stop you because I'm running out of time here.

The United States District Court in Maryland struck down that rule, stayed enforcement of that rule, as I understand it, right? That was based on the report that you prepared. Is that the *Paragon Report*? Am I getting that right?

Dr. BLASE. No. There were commentators that cited the *Paragon Report*. The judge in his decision said that CMS didn't do an adequate explanation of describing the policy. There was also another judge in a Massachusetts Court that looked at the same issue and threw out the challenge.

Mr. RASKIN. Here's what the Court said, this is not really my field, but it said:

> Defendants are not free to support a rule change with data of questionable validity and limited relevance and then refuse to engage with commenters' reasonable concerns if the data fails to support the conclusion the agency drew from the data.

The Court essentially rejected the underlying methodology and the data that was collected.

Dr. BLASE. Well, the Court didn't look at the *Paragon Report*. The court looked at the commentators that wrote about the *Paragon Report*.

I can tell you, Congressman, CBO has cited that report in their work. CBO has estimated improper enrollment in the exchange, and CBO's estimates are consistent with what *Paragon* predicts.

Mr. RASKIN. OK. Well, thank you for that. I just hope that the administration will take the problem of fraud and abuse seriously and work on it because the tools exist now.

Thank you for your patience, Mr. Chair, and I yield back to you.

Mr. VAN DREW. I thank the Ranking Member. I'm just going to ask a couple of questions quickly, because I want a couple other Members to be able to speak. Really quick to all of you, is the GAO a nonpartisan organization? Mr. Bagdoyan?

Mr. BAGDOYAN. Absolutely.

Mr. VAN DREW. Dr. Blase?

Dr. BLASE. Yes.

Mr. VAN DREW. Nonpartisan.

Dr. BLASE. Yes.

Mr. VAN DREW. It's not a Republican organization.

Dr. Bai? Dr. Bai?

Ms. BAI. Yes.

Mr. VAN DREW. Yes? OK, thank you. Professor Cooper?

Mr. COOPER. Yes.

Mr. VAN DREW. OK, thank you.

Did the GAO—Dr. Blase, I'll ask you this question—say that dead people are receiving benefits?

Dr. BLASE. They did.

Mr. VAN DREW. Did the GAO say that fraudsters, brokers, and agents were misusing the system, getting benefits themselves and moving people into plans they don't want?

Dr. BLASE. Yes. The GAO report showed significant vulnerabilities with the exchange.

Mr. VAN DREW. Did the GAO show, nonpartisan, that money was going to Social Security numbers, not families, to multiple numbers of Social Security numbers from multiple individuals, and they were receiving subsidies and it couldn't be possible?

Dr. BLASE. Yes. Tens of thousands.

Mr. VAN DREW. Tens of thousands.

Dr. BLASE. Yes.

Mr. VAN DREW. OK. That's my first point and the point I wanted to make as well. I think that we have—you say—can you please—

Mr. MOORE. Yes, Mr. Chair. I'd like to submit for unanimous consent. For the record, this article is titled "The Great ObamaCare Enrollment Fraud." This is a *Paragon Health Institute* paper led by our witness Brian Blase.

The paper takes a deep dive into the Affordable Care Act and explains how it is susceptible to fraud, opening the door to insurance brokers to take advantage of the Marketplace.

Mr. VAN DREW. I thank the gentleman. Without objection.

I just want to say briefly and then we're going to move on to some other questions, that's what this hearing is about, and I wish we had more time.

I know people have different visions of what healthcare should be in the United States of America, but we have a system now that's wrought with fraud that doesn't work, that isn't right, that's taking money from good American people and giving it to people who are fraudulent in so many different ways, individuals, insurance companies, brokers, and agents. Man, people are tired of it. We owe them to do better so we—

Mr. RASKIN. Mr. Chair.

Mr. VAN DREW. I'm on my time, please.

Mr. RASKIN. Are you? OK.

Mr. VAN DREW. I am.

Mr. RASKIN. It wasn't working.

Mr. VAN DREW. For that reason, regardless of what you feel, man, I hope—I'm not even going to ask you because I'm not out to embarrass anybody—I hope that every Member on the other side read the entire GAO report.

I didn't know that was all that was in there. It was startling. It was scary. It was of concern. Republicans didn't write the damn thing. It came from a nonpartisan government organization that just does what's right. Sometimes I don't like what they do, but they do what they think is right and tell the truth.

With that, I will yield to Mr. Correa.

Mr. CORREA. Thank you, Mr. Chair.

Mr. Bagdoyan, you talked about fraud, the GAO report. In that GAO report, is there anything there that suggests that the premium tax credit should be eliminated?

Mr. BAGDOYAN. No. That is not part of our work. We're not looking at policy or viability, sir.

Mr. CORREA. OK. I'm going to come back to Professor Cooper.

You talked about subsidies being important to cover with healthcare lower- and middle-class. We're talking about working-class families in this country who when these premiums' tax credits expire they will essentially be uninsured.

That's really the issue here, insurance for working-class families, not about fraud, because there's a lot of fraud in a lot of areas in this government. To go after healthcare for working-class families, that's what we're talking about today.

They're going to expire without a doubt. I want to see each and every one of us up here, what kind of phone calls we're going to get from our constituents when they end up not being able to pay for their healthcare in the richest country in the world with the most advanced medical technology in the world.

Mr. Cooper, let me ask you a question: Senators are talking about healthcare savings plans as opposed to tax credits. How is this going to enable Americans to afford healthcare?

Mr. COOPER. Thank you for the question, Congressman. I don't think they do. I don't think they fundamentally address three core issues.

The first is it still exposes consumers to significant out-of-pocket costs. If you look at the plans people are going to enroll in, they're going to have out-of-pocket maximums for individuals at $10,000, for families around $20,000. We're not going—

Mr. CORREA. Small business owners, entrepreneurs, and their employees, how will this tax credit cancellation help them afford healthcare?

Mr. COOPER. The health savings accounts won't make getting insurance easier. We're going to see premiums for a couple making $85,000 who are 60 years old jump by $20,000. It's not going to help those people.

Mr. CORREA. Let's talk about this red herring, fraud. There is fraud. Are individuals insured getting rich off this fraud? Getting a subsidy for their healthcare, are they using it to finance their vacations, or are we talking about an industry with brokers that are essentially making money?

The 850 that were suspended. How many of those individuals actually spent time in jail or actually were able to cough up those illegally gotten gains? Anybody here tell me? How many of those folks spent a day in jail, gave back ill-earned savings, earnings that they got fraudulently?

We're talking about fraud here today, and nobody, nobody went to jail. How serious really are we about fraud versus insuring individuals? Dead people and Social Security numbers. Did those people benefit from the subsidies, did their relatives benefit from the subsidies, or did the brokers make a buck off the government? Which one is it? Anybody?

Ms. BAI. The insurance company and the brokers. They have every incentive.

Mr. CORREA. Why didn't they go to jail?

Dr. BLASE. There have actually been some people that have gone to jail.

Mr. CORREA. The punishment here is to punish every American that's subsidized today on the Affordable Care Act. They're the ones that are going to be punished because they are going to lose the ability to afford healthcare. That's what we're saying here today.

I'm going to tell my colleagues here, let's see what happens January 1st next year when you start getting the phone calls from your constituents that are uninsured, lose insurance, or those hospitals that are relying on those premiums to stay open, not in the big cities but out in the countryside.

That's what this debate is really about. Fraud? Let's get the DAs, attorneys general to go after these criminals. To go after middle-class hardworking families and take away the possibility of having healthcare and saying it's a broken system? If it's a broken system, I challenge my colleagues, show me something better. We're waiting for your solutions.

Thank you, Mr. Chair, and I yield.

Mr. VAN DREW. Thank you, Mr. Correa.

I'd like to submit with unanimous consent an article into the record. The press release is titled, "President of Insurance Brokerage Firm and CEO of Marketing Company Convicted in $233 Million Affordable Care Act Enrollment Fraud."

The American people are the victim. This is a press release from the Department of Justice. I'd like to submit that. With that being said—

Mr. CORREA. Mr. Chair, I'd also like to submit some articles for the record:

(1) The *Kaiser Healthcare News*, "Health Savings Accounts, backed by GOP, cover fancy saunas, not insurance premiums";

(2) *The Washington Post*, "Why Healthcare Savings Accounts aren't the fix Republicans hope for";

(3) By *Fortune Magazine*, "Trump wants more healthcare savings, yet they can't pay for the insurance premiums";

(4) *Kaiser Foundation*, "Fraud in the Marketplace, Enrollment and Eligibility: Five Things to Know";

(5) *Keep Americans Covered* fact sheet on healthcare; and then finally

(6) *Small Business Majority*, "The expiration of the ACA enhanced tax credits will devaState the small business community."

Mr. VAN DREW. Without objection. I now recognize Mr. Issa from the great State of California.

Mr. ISSA. Thank you. Dr. Blase, is it true that if government subsidizes part of healthcare that it lowers the cost to the individual who pays for healthcare?

Dr. BLASE. Yes.

Mr. ISSA. Is it equally true that it has no side effect on the actual cost of healthcare?

Dr. BLASE. Yes. Well, it raises the taxpayer's cost.

Mr. ISSA. The fact is, if we want to lower the cost of healthcare, we have to attack the cost of healthcare, not the subsidy that ultimately lowers it for some while raising it for others through being taxed.

There was a lot of discussion today about there isn't fraud. In your experience, if we prosecute as many frauds as we can, if we claw back as much dollars as we can, do we make the return on investment and the likelihood of additional fraudsters going down? In other words, is prosecution and clawback a deterrent?

Dr. BLASE. It is. Mr. Issa, I would say here the real problem is the underlying incentives. The underlying incentive—

Mr. ISSA. I'll get to that.

Dr. BLASE. OK.

Mr. ISSA. Then, the next one is an affirmative request to have a benefit, an unreasonable thing to ask for from everyone who receives the benefit, in general?

Dr. BLASE. I do not think that's an unreasonable request, no.

Mr. ISSA. Requiring that if someone wants to renew, they apply for it not only reduces fraud, but it clearly is intended to be a reasonable request that somebody say they want it and they're entitled to it.

Dr. BLASE. Especially if the product is nearly fully or entirely fully subsidized by the government.

Mr. ISSA. I agree. I would like to yield the remainder of my time to Mr. Onder.

Mr. ONDER. Thank you, Representative Issa.

I wanted to read a portion of a letter in my office. I'll abbreviate it in interest of time. This is from a Missouri dairy farmer.

He says,

> We seem to have gotten health insurance confused with actual healthcare. I can say from personal experience that having coverage through the Marketplace does absolutely nothing for me in regard to actually getting healthcare. The plan we've had for the last years has a deductible and copay that is so high I typically go to see doctors as a self-pay patient. This gets me a discount on care, and I will be charged less than half of what it would be to pay the deductible if insurance was billed.

He said,

> Second, the consolidation of health providers has led to skyrocketing costs. This leads to total lack of price transparency.

He goes on.

Basically, this dairy farmer laid out the Republican plan for healthcare, which is to promote competition and transparency and thereby deliver lower prices and better quality.

Dr. Blase, I know you covered this in your testimony, but this is important to reiterate. For the record, the expiring COVID-era subsidies are responsible for what percentage of the 2026 premium?

Dr. BLASE. The expiring subsidies are responsible for a very small percentage, Congressman. About 3 percent are expiring.

Mr. ONDER. About three percent. The remaining 13.3 percent premium increase will still go into effect regardless of whether the COVID-era subsidies—

Dr. BLASE. Yes. Premiums are going up next year because of underlying problems with ObamaCare, not because the enhanced COVID-era subsidies are expiring.

Mr. ONDER. What is the actual cause of that 13.3 percent increase?

Dr. BLASE. There is a lot of structural problems with ObamaCare. The regulatory structure increases cost over time, and the underlying subsidy structure within ObamaCare has increased cost.

I think Professor Cooper is right. There are underlying healthcare costs, but ObamaCare is inherently inflationary, both the regulations in ObamaCare and the subsidy structure in ObamaCare.

If you want to lower healthcare prices and costs within ObamaCare, you need to tackle the basic architectural flaws.

Mr. ONDER. Thank you, Dr. Blase. Here we have this chart, if you can put that back up. We see that rates in ObamaCare went up twice that of the average employer-based plan and three times the rate of inflation.

I yield to the Chair of the Full Committee, Representative Jordan.

Chair JORDAN. I thank the gentleman for yielding.

I was just going to point out, this is something that doesn't happen too often, where the Democrat witness actually agrees with the Republican plan, because Professor Cooper said, quote, "Subsidies aren't a solution, aren't the solution, they should be temporary."

That's where we're at. We want to address the underlying problem. Then, he talked about reform. He talked about site-neutral. We want all those things too. That's the point.

A Democrat, someone, I think the Ranking Member said earlier, "the Republicans don't have a fix." The Democrat fix is to continue the same old thing, which is just what that chart displayed doesn't work, and continue the subsidies forever, not temporary, as their witness said they should be.

We want temporary subsidies to deal with the cliff, but we need the reforms that encourage choice and competition and would actually bring down premium costs.

I wish we had more time. I appreciate the witnesses and the testimony they gave. I appreciate the study from the GAO, which showed just all the fraud that's taking place as well.

I yield back to the Chair. Thank you for having this.

Mr. VAN DREW. Thank you, Chair.

Let me just say I agree with the Chair. It's something I've been saying all along. Temporarily, you have got to do something. Long term, we have to do so much better. That's what this was about, this hearing.

With that being said, it concludes today's hearing. We thank our witnesses for appearing before the Subcommittee today. Feel free before I gavel out. Yes, go ahead.

Mr. RASKIN. This is from the *American Hospital Association*. This is “Setting the Record Straight: Separating Fact From Fiction on Health Insurance Marketplace Fraud”; Professor Cooper’s article in *The New York Times*, “The Health Care Debate We Really Need”; and finally, the *Georgetown Center on Health Insurance Refor*m, “Health Savings Accounts: Robin Hood in Reverse.”

Mr. VAN DREW. I thank the Ranking Member. Without objection.

That concludes today’s hearing. Without objection, all Members will have five legislative days to submit additional written questions for the witnesses or additional materials for the record.

I again want to apologize to you all. I wanted to keep you here until you were exhausted and we had a couple of hours we were stuck on the floor. You did a good job. Thank you.

Again, I apologize to the other side of the aisle. Again, I wish we could have debated even longer.

With that, without objection—and I apologize to our guys. Without objection, this hearing is adjourned.

[Whereupon, at 5:06 p.m., the Subcommittees were adjourned.]

All materials submitted for the record by Members of the Subcommittee on Oversight and Subcommittee on the Administrative State, Regulatory Reform, and Antitrust can be found at: *https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=118732*.