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TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Budget Committee

REVERSE THE CURSE

Skyrocketing Health Care Costs and America's Fiscal Future

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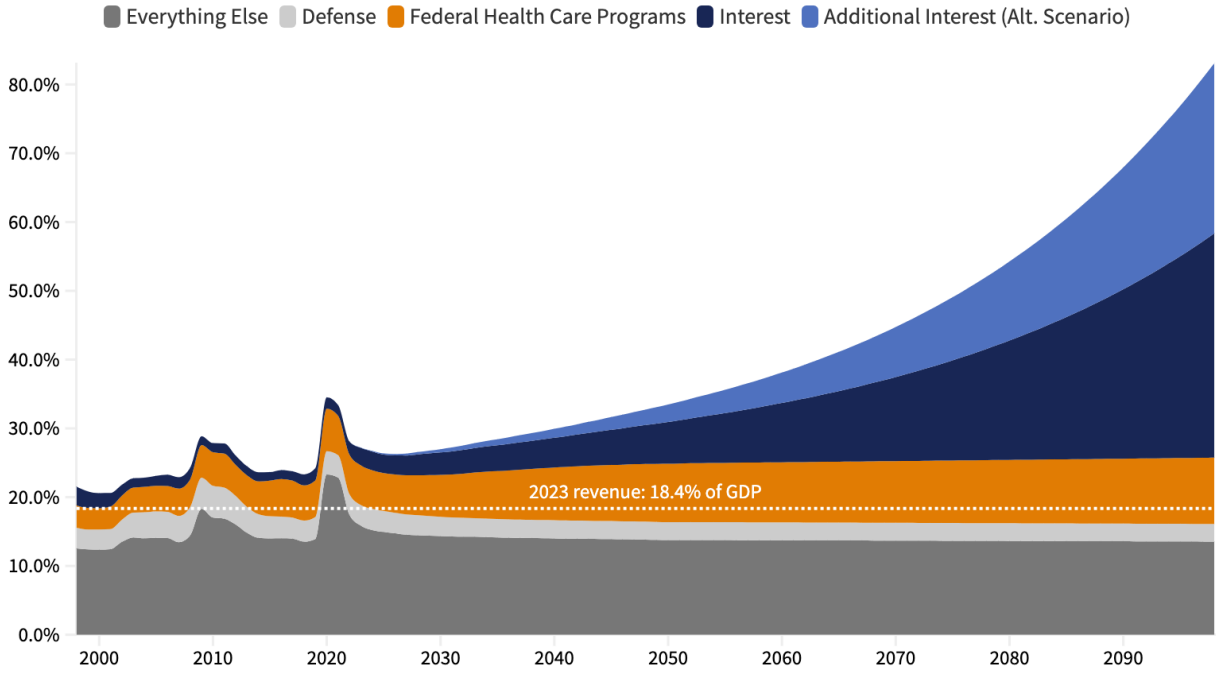
INTRODUCTION

As members of the House Budget Committee are well aware, the biggest drivers of growth in federal spending—and, therefore, the deficit and debt—are health care and interest. The only realistic way to reduce the deficit and debt—absent defaulting on the debt—is to reduce the growth in federal health care spending.

Figure 1. Health Care, Interest Drive Federal Spending Growth



Sources: Congressional Budget Office, A. Roy estimates (post-2053)
Note: CBO baseline assumes 4% interest rate in 2053, vs. 5.8% in alternative scenario

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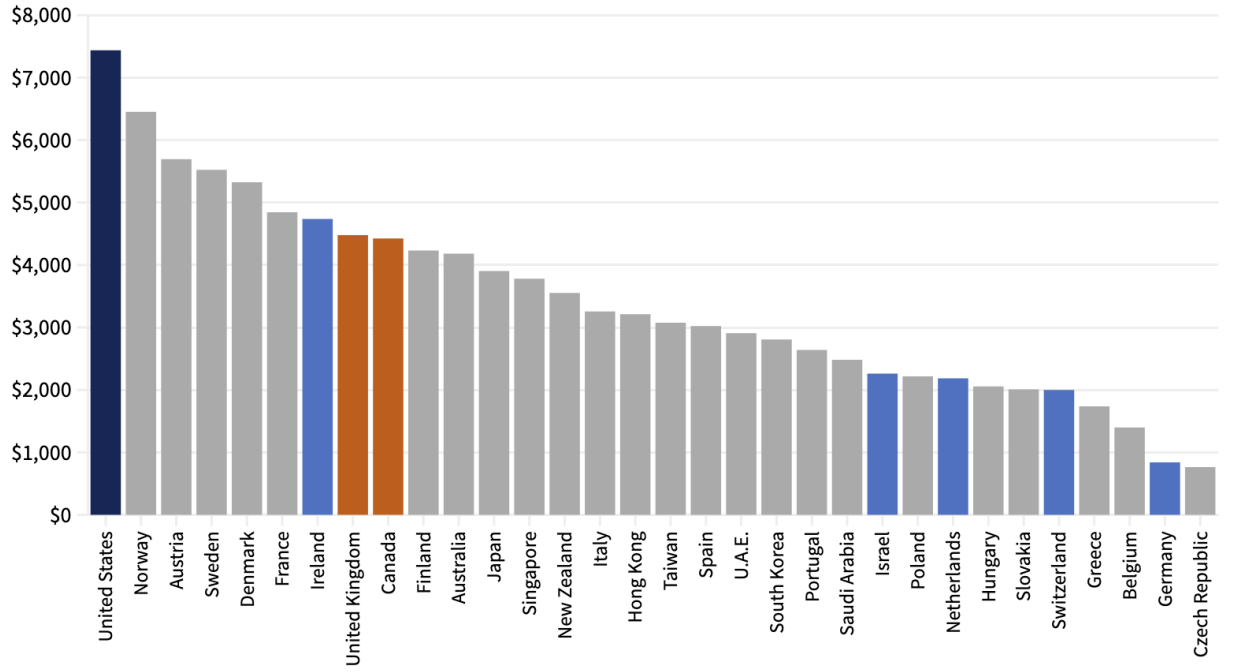
Reducing growth in health care spending is the only viable path out of fiscal failure. Discretionary spending is falling as a share of gross domestic product, but federal health care spending–Medicare, Medicaid, the Affordable Care Act, et al.–are growing. *(Source: CBO; FREOPP projections of future decades)*

In addition, one of the most widely discussed features of the U.S. economy is that that American health care is significantly costlier than that of other industrialized countries, without generally better health outcomes. But what is far less well understood is that the U.S. *subsidizes* health care at a far higher level than other industrialized nations do.

Indeed, in 2022, the most recent year for which we have comparable data across countries, government subsidies of U.S. health care—including Medicare, Medicaid, the Affordable

Care Act, and the exclusion from taxation of employer-sponsored coverage—reached $7,438 per capita, on a purchasing power parity-adjusted basis, compared to a median of $3,144 in the 32 nations with the highest gross domestic product per capita and a population over 5 million.

Figure 2. Government Health Subsidies per Capita, 2022 (PPP-adjusted)



Source: FREOPP World Index of Healthcare Innovation
Graphic: Avik Roy

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The U.S. subsidizes health care far more than any other country in the world. Because U.S. health care is so much more expensive than elsewhere, and because the U.S. heavily subsidizes health insurance for high earners and the wealthy, the U.S. spends far more per capita subsidizing health care than other nations with universal coverage. *(Source: FREOPP World Index of Healthcare Innovation)*

Each year, the Foundation for Research on Equal Opportunity (FREOPP) evaluates the health care systems of these 32 nations, in a survey called the World Index of Healthcare Innovation (WIHI).[1] In the 2024 survey, the U.S. ranked 7th overall: first in Science &

[1] G. Girvan and A. Roy, World Index of Healthcare Innovation. The Foundation for Research on Equal Opportunity. 2024 Dec 21: https://wihi.freopp.org; accessed January 19, 2026.

Technology but dead last in Fiscal Sustainability. On more detailed measures, the U.S. ranked 22nd on disease prevention and last on affordability of health coverage.[2]

Many theories have been offered as to why American health care is so expensive. Almost all of them are wrong.

Some argue, for example, that the U.S. has a "free-market" health care system, and that this is why American health care is so expensive. But nearly half of U.S. health care spending is government spending.[2] Furthermore, there are a number of countries whose health care systems are more free-market-oriented than America's, such as Switzerland and Ireland, who enjoy both lower costs and better outcomes relative to the United States. In the WIHI survey, Switzerland and Ireland rank 6th and 1st, respectively, on disease prevention.[3,4]

Others argue that fee-for-service health care is the primary culprit, because, it is said, charging patients on a fee-for-service basis incentivizes doctors and hospitals to prescribe more services in order to capture more revenue. But many other advanced nations use fee-for-service payments and spend far less on health care than the U.S., including Canada, Japan, France, and Germany.[5] Indeed, several widely-cited studies show that the volume of health care utilization in the U.S. is *lower* than that of other industrialized countries, but that unit prices of health care in the U.S. are far higher.[6,7] For similar reasons, malpractice litigation and "defensive medicine"—the practice of prescribing additional tests to avoid lawsuits—contribute modestly to higher U.S. health spending.

The single biggest driver of high U.S. health care costs—the original sin of U.S. health care–turns out to be the decision in the mid-20th century to exclude the value of employer-sponsored health insurance from all taxation.[8] The problem is not that Americans experience third-party payment for health care services through insurance. That happens all around the world. The problem is that Americans experience third-party payment of *insurance*—that is to say, third-party payment of third-party payment of health care: effectively, *ninth-party health care*.

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[2] G. Girvan and A. Roy, United States: #7 in the World Index of Healthcare Innovation. The Foundation for Research on Equal Opportunity. 2024 Dec 21: https://freopp.org/united-states-7-in-the-world-index-of-healthcare-innovation/; accessed January 19, 2026.

[3] G. Girvan and A. Roy, Switzerland: #1 in the World Index of Healthcare Innovation. The Foundation for Research on Equal Opportunity. 2024 Dec 21: https://freopp.org/switzerland-1-in-the-2024-world-index-of-healthcare-innovation/; accessed January 19, 2026.

[4] G. Girvan and A. Roy, Ireland: #2 in the World Index of Healthcare Innovation. The Foundation for Research on Equal Opportunity. 2024 Dec 21: https://freopp.org/ireland-2-in-the-2024-world-index-of-healthcare-innovation/; accessed January 19, 2026.

[5] M. K. Gusmano et al., Getting The Price Right: How Some Countries Control Spending In A Fee-For-Service System. 2020 Nov: *Health Affairs* 39(11): 1867-1874.

[6] G. F. Anderson, U. E. Reinhardt et al., It's The Prices, Stupid: Why The United States Is So Different From Other Countries. 2003 Mar: *Health Affairs* 22(3): 89-105.

[7] G. F. Anderson, P. Hussey, and V. Petrosyan, It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt. 2019 Jan: *Health Affairs* 38(1): 87-95.

[8] A. Roy, How Employer-Sponsored Insurance Drives Up Health Costs. *Forbes*. 2012 May 12: https://www.forbes.com/sites/theapothecary/2012/05/12/how-employer-sponsored-insurance-drives-up-health-costs/; accessed January 19, 2026.

Figure 3. U.S. Health Care Underperforms That of Other Industrialized Nations

The U.S. scores highly on medical advances, but poorly on disease prevention, affordability, and fiscal sustainability. Out of 32 surveyed countries with the highest gross domestic product per capita and a population over 5 million, the U.S. ranked 22nd on disease prevention, 32nd on affordability of health coverage, and 32nd on fiscal sustainability. *(Source: FREOPP World Index of Healthcare Innovation)*

THE ORIGINAL SIN OF U.S. HEALTHCARE: THE ESI TAX EXCLUSION

In 1942, President Franklin Delano Roosevelt signed into law the Stabilization Act of 1942, which required employers to adhere strictly to a federally controlled schedule of salaries and wages for U.S. workers.[9] Congress and the President were concerned that, with young

[9] F. D. Roosevelt, Executive Order 9250—Providing for the Stabilizing of the National Economy. 1942 Oct 3 https://www.presidency.ucsb.edu/documents/executive-order-9250-providing-for-the-stabilizing-the-national-economy; accessed January 19, 2026.

American men off to war, employers would raise wages to compete for increasingly scarce workers, leading to a wage-price spiral and an inflation crisis.[10]

Employers quickly found a workaround. The wage control system did not account for fringe benefits like health insurance. Employers began offering health insurance as a way of competing for those scarce workers. In 1943, the Internal Revenue Service ruled that these benefits were exempt from taxation. As more and more Americans became subject to the federal income tax, employer-sponsored health insurance became more popular. By 1945, 32 million Americans had employer-sponsored coverage—30 percent of the population—compared to 1.3 million in 1940.[11]

The World War II-era loophole limited the value of the health insurance benefit to 5 percent of a worker's salary. But in 1954, within an overhaul of the Internal Revenue Code, Congress excluded the value of employer-sponsored health insurance from *all* taxation, including federal, state, and local income taxes, as well as Medicare and Social Security payroll taxes.

The exclusion from taxation of employer-sponsored insurance (hereafter "the ESI exclusion") effectively forced workers to become dependent upon their employers for health insurance. Imagine a worker in the 22% federal tax bracket, paying a 4% state income tax and 7.65% in FICA, for a total of 33.65%. That worker keeps 66.35 cents after tax for every additional dollar received in wages. But that same dollar, if spent on employer-sponsored health insurance, is worth 100 cents: a 51% premium.

Over time, this 51% premium for compensation spent on health insurance had several pernicious inflationary effects:

1. ***Cost insensitivity and lack of price transparency***. Because workers' health benefits are taken out of their paycheck pre-tax, they usually have no idea how much they are paying (indirectly) for health insurance. This means that they are unaware that rising health insurance premiums are depressing their wages, and lack the agency to shop for less-costly, higher-value coverage.
2. ***Conflict of interest between employers and workers***. Workers have an incentive to shop for the best value when it comes to their health benefits: a high-quality plan at an affordable price. Employers, on the other hand, are concerned about keeping their workers away from competitors by offering generous benefits, and incentivized to become passive about cost-control measures. Workers, in turn, are more likely to be upset about employer efforts at health care cost control (such as lower negotiated provider and drug prices) because they are not aware that the lack of cost control leads directly to higher premiums and lower wages.
3. ***Disincentives for insurers to control costs***. Insurers' operating margins are relatively constant over time, and regulated at the federal and state levels. If an insurer is

[10] B. Bartlett, The Question of Taxing Employer-Provided Health Insurance. *The New York Times*. 2013 Jul 30: https://archive.nytimes.com/economix.blogs.nytimes.com/2013/07/30/the-question-of-taxing-employer-provided-health-insurance/?_php=true&_type=blogs&_r=0; accessed January 19, 2026.

[11] M. A. Thomasson, The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance. National Bureau of Economic Research. 2000 Feb: https://www.nber.org/system/files/working_papers/w7543/w7543.pdf; accessed January 19, 2026.

effectively required to keep its operating margin at 10%, for example, the best way for the insurer to grow its operating income over time is to collect higher premiums over time. In other words, insurers in the employer market are incentivized to encourage health care inflation, because 10% of a bigger number is more income for them. This incentive is weaker in the non-group (i.e., non-employer) market for health insurance, because workers' price sensitivity rewards lower-cost insurance.

4. ***Health insurance mission creep***. To use an analogy, we do not use auto insurance to pay for routine items like gasoline or oil changes. But because the tax code heavily rewards spending on health insurance over other forms of personal spending, we now think of health insurance as a vehicle for any and all kinds of health care products and services, even if those services or products do not comprise what we normally think of as insurable events. As more and more products and services are covered by health insurance, those additional items also participate in rapid health care inflation.

It has become common for health care commentators to talk about "eliminating the middlemen" from health care. There is no costlier middleman than employers.

The high cost of U.S. health care also worsens American health outcomes. There is considerable literature indicating that the high cost of health care leads patients to avoid routine care and to use prescription drugs less frequently than medically recommended. Also, rising health care costs for employers lead to lower rates of employment, increasing deaths of despair from suicides and overdoses.[12]

THE SWISS MODEL: UNIVERSAL, INDIVIDUALLY PURCHASED INSURANCE

As noted above, there are numerous alternatives to single-payer health care for achieving lower costs and better outcomes. The FREOPP World Index of Healthcare Innovation ranks 32 high-income countries along dozens of measures of quality, choice, science & technology, and fiscal sustainability.

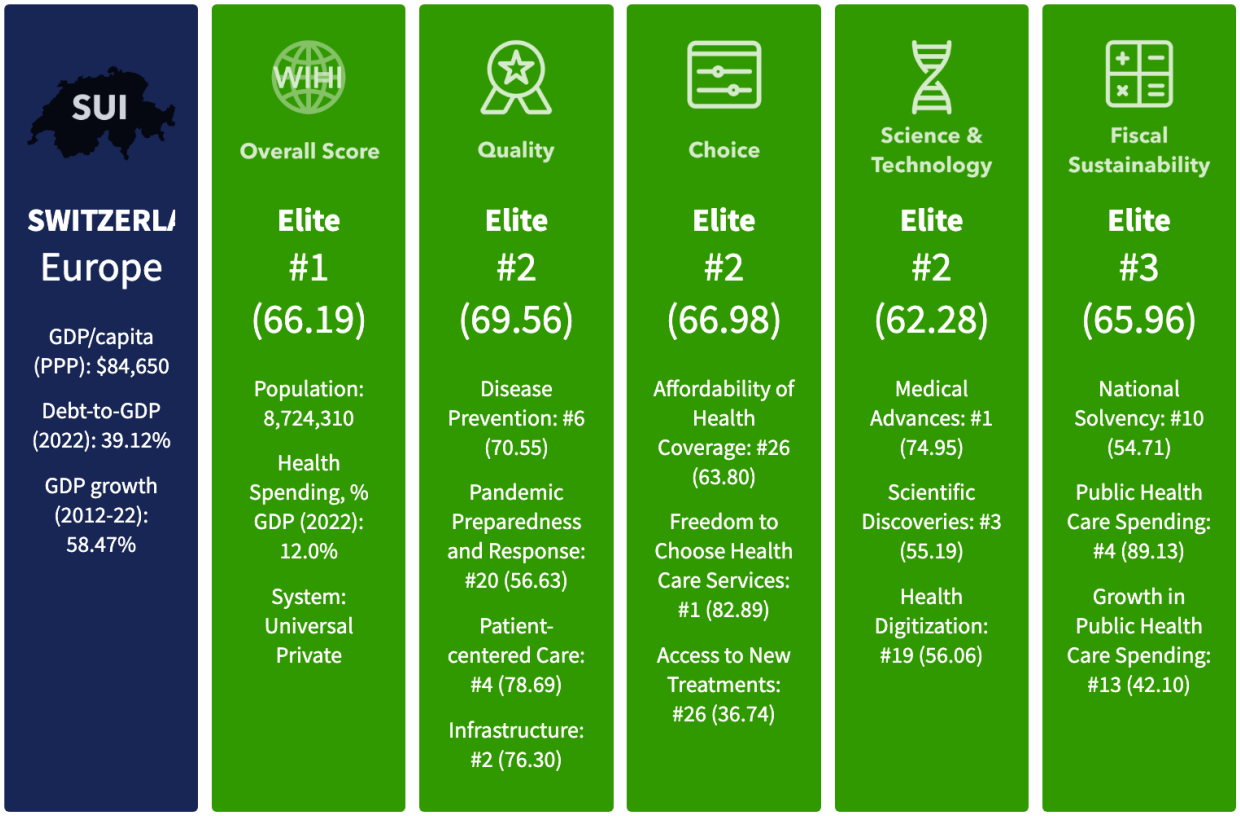
In each year of the survey, Switzerland has ranked first overall. In 2024, Switzerland ranked 2nd in Quality, 2nd in Choice, 2nd in Science & Technology, and 3rd in Fiscal Sustainability.[3] Notably, Switzerland does not have single-payer health care, but rather a system of universal, individually-purchased health insurance, similar in important ways to Medicare Advantage (the market for private insurers who deliver the Medicare benefit to seniors) and the Affordable Care Act's insurance marketplaces (a.k.a. Obamacare). As befitting a nation famous for precision engineering, Switzerland's individual insurance marketplace produces results that are superior to the Affordable Care Act's.

The median monthly premium for a benchmark ACA Silver plan in 2026 is $625, compared to $586 (CHF 465.30) in Switzerland. The median deductible for an ACA Silver plan in 2026 is

[12] Z. Brot-Goldberg, Z. Cooper, et al., Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers. National Bureau of Economic Research. 2024 Dec: https://www.nber.org/system/files/working_papers/w32613/w32613.pdf; accessed January 19, 2026.

$5,300, compared to around $375 (CHF 300).[13,14,15] Compared to single-payer systems, Swiss consumers enjoy broad freedom of choice in both insurers and doctors, and access to the latest medical technologies, many of which originate from Swiss-based companies.

Figure 4. The Swiss Health Care System: A Model for U.S. Reform



Switzerland achieves the best combination of quality, choice, innovation, and fiscal sustainability. Switzerland is the perennial leader of the FREOPP World Index of Healthcare Innovation, combining universal, private-sector, individually-purchased health insurance with affordable prices, strong health outcomes, and fiscal sustainability. *(Source: FREOPP World Index of Healthcare Innovation)*

[13] Kaiser Family Foundation. Average Monthly Marketplace Premiums by Metal Tier. https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; accessed January 19, 2026.
[14] Kaiser Family Foundation. Deductibles in ACA Marketplace Plans, 2014-2026. 2025 Nov 6: https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/; accessed January 19, 2026.
[15] Swissinfo.ch. Swiss health premiums to rise by 4.4% on average. 2025 Sep 24: https://www.swissinfo.ch/eng/various/health-premiums-to-rise-by-4-4-on-average/90056839; accessed January 19, 2026.

Why are Swiss plans more affordable, with better outcomes, than ACA plans? The biggest reason is that 80 years of U.S. health care inflation driven by the ESI exclusion have led to significantly higher unit prices in the U.S. relative to Switzerland. Since we cannot rewind history, it is not so easy to simply wipe out the longstanding policy impact of the ESI exclusion.

Figure 5. American vs. Swiss Private Health Insurance

	Individually-Purchased Insurance	Employer-Sponsored (excl. FEHBP)	Federal Employees Health Benefits	Medicare Advantage	Switzerland
2019 Enrollment	13 million	151 million	8 million	22 million	9 million
Annual Premium (Unsubsidized)	$5,724	$7,103	$9,572	$8,150	$5,014
Average Public Subsidy	**$2,123**	**$2,379**	**$6,892**	**$6,042**	**$596**
Annual Premium (Net of Subsidy)	$3,601	$4,723	$2,680	$2,108	$4,417
Standard Deductible	$4,375	$1,620	$500	$1,549	$300
Out-of-Pocket Cap	$7,374	$3,988	$2,500	$5,187	$1,000
Underlying Cost	D	F	F	C+	B+
Fiscal Sustainability	A	C	C	D	A-
Consumer-Driven Incentives	B+	D	B-	B	A+
Freedom of Choice	C	D	A+	A+	A+
Access to Doctors	A-	A	A+	A	A
Access to Innovation	A	A	A	A+	A
Overall Grade	**B**	**C-**	**B-**	**B+**	**A**

Switzerland proves the value of a highly functioning individual health insurance market. Switzerland's system of universal, individually purchased health insurance achieves better outcomes and lower costs than U.S. coverage. *(Source: The Foundation for Research on Equal Opportunity)*

Critically, Swiss premium subsidies work similarly to the ACA's, under which subsidies gradually phase out as one goes up the income scale. In contrast, the ESI exclusion becomes more valuable for high earners, because they occupy higher tax brackets. Because Switzerland subsidizes fewer people, and because (as a result) Switzerland has lower health care prices, Swiss subsides in 2022 were $1,411 per capita, 66% lower than the U.S. level.

It is not too late for the U.S. to start a voluntary, gradual migration away from employer-sponsored insurance and into individually purchased coverage. Such a migration can take place without capping or restricting the ESI exclusion. The most important reform Congress

should consider is transitioning the ESI tax break from one centered around *employers*—the middlemen—to one centered around *workers*.

In 2019, President Trump finalized a rule allowing employers to fund tax-advantaged individual coverage health reimbursement arrangements (ICHRAs). ICHRAs give employers and workers an alternative to traditional employer-sponsored group health insurance. Instead of employers purchasing coverage for all their eligible workers, irrespective of what workers may actually want, employers deposit a pre-tax amount into an ICHRA and let the worker choose the insurance of his or her choice in the non-group market.

Congress should codify the ICHRA rule to give it the force of statutory law. Furthermore, Congress should strengthen ICHRAs by requiring that for newly incorporated businesses to benefit from the ESI exclusion, they must do so using ICHRAs rather than by purchasing group coverage that diminishes worker choice.

Finally, for ICHRAs to become a truly superior option to employer-sponsored coverage, we must repair the ACA's biggest design flaws, because the quality of ICHRA-based coverage depends on the quality of the coverage allowed by the ACA's regulations and economic distortions. In addition, we can learn from the Swiss health care system to lower costs and improve outcomes for all Americans.[16]

REPAIRING THE ACA'S BIGGEST FLAWS

While ACA insurance premiums are lower than those for employer-sponsored insurance, their prices are rapidly rising, due to a structure of regulations and subsidies that discourage younger and healthier individuals from enrolling.

1. ***Overcharging the young***. The ACA made health insurance less affordable for Americans in their 30s and late 20s by preventing insurers from charging young people a lower premium. Specifically, the ACA forbids insurers from giving young people more than a 67 percent discount relative to what insurers charge their oldest customers. As a result, young people drop out of the market, making health insurance costlier for everyone, including those in their 60s. A simple measure increasing the allowable discount to 80 percent — a 5-to-1 "age band" — could largely fix this problem. More young people would enroll, improving the quality of the risk pool and thereby reducing premiums for the young and old alike. Congress could also age-adjust the ACA subsidy formula to make absolutely sure that premiums for older enrollees stayed the same.[17]
2. ***Overcharging the healthy***. A related flaw in the ACA is that it requires insurers to overcharge healthy people in order to (theoretically) undercharge those with

[16] A. Roy, Bringing Private Health Insurance Into the 21st Century. The Foundation for Research on Equal Opportunity. https://freopp.org/whitepapers/bringing-private-health-insurance-into-the-21st-century/; accessed January 19, 2026.
[17] A. Roy, The Fair Care Act of 2020: Market-Based Universal Coverage. The Foundation for Research on Equal Opportunity. https://freopp.org/whitepapers/the-fair-care-act-of-2020-market-based-universal-coverage/; accessed January 19, 2026.

preexisting conditions. Again, this encourages healthy people to drop out of the market, raising premiums for everyone who remains. A bipartisan reform package could fix this by creating a $10 billion-per-year reinsurance fund that would directly subsidize premiums for the sick and the chronically ill, while leaving protections for those with preexisting conditions unchanged.[18] The reinsurance program could deploy innovative value-based strategies to address chronic metabolic and cardiovascular diseases like diabetes and coronary artery disease.

3. ***Lack of appropriations for cost-sharing reduction subsidies***. A drafting error in the ACA has resulted in increased Silver premiums—commonly called *Silver loading*—because insurers are required to offer low-deductible plans to low-income enrollees, but are not currently compensated by the federal government for the extra cost for doing so. A Congressional appropriation for these cost-sharing reduction subsidies would enable insurers to reduce premiums for Silver plans.[19] In 2018, the Congressional Budget Office estimated that appropriating CSRs would reduce the deficit by $29 billion over ten years, because reducing ACA premiums would also reduce the cost of subsidizing ACA premiums.[20]
4. ***Facilitate employer funding of individually purchased insurance***. The ACA requires employers with more than 50 full-time workers to sponsor traditional employer coverage. But workers would benefit from a repeal of this mandate, and a codification of rules enabling employers to fund Individual Coverage Health Reimbursement Arrangements, or ICHRAs.[21]
5. ***Arbitrary churn between Medicaid and individual coverage***. The authors of the ACA believed that Medicaid-based coverage would be a less costly way for low-income able-bodied uninsured adults to gain health insurance. But in fact, ACA-based coverage is now less costly than the Medicaid expansion. In addition, under the ACA, low-income adults with volatile incomes end up churning between Medicaid-based coverage and ACA marketplace-based coverage, with different premiums and provider networks. We estimate that migrating able-bodied adults on the ACA Medicaid expansion into the exchanges would save $159 billion over a decade.[22]
6. ***Program integrity issues***. A recent investigation by the U.S. Government Accountability Office found that "the federal Marketplace approved coverage for nearly all of GAO's fictitious applicants in plan years 2024 and 2025, generally

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[18] A. Roy, This bipartisan compromise could end the government shutdown. *The Washington Post*. 2025 Oct 1: https://www.washingtonpost.com/opinions/2025/10/01/obamacare-shutdown-bipartisan-solution/; accessed January 19, 2026.

[19] S. Parente, Reinsurance and Cost-Sharing Reductions Estimates. Center for Health and Economy. https://healthandeconomy.org/reinsurance-and-cost-sharing-reductions-estimates/; accessed January 19, 2026.

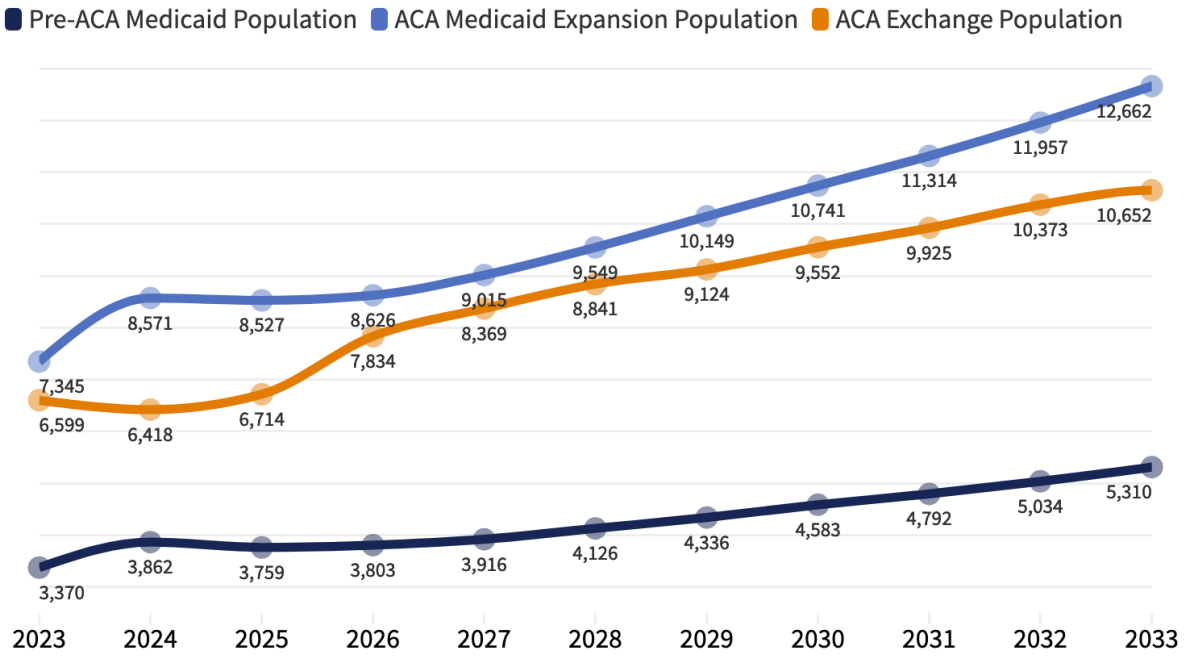
[20] K. Hall, Re: Appropriation of Cost-Sharing Reduction Subsidies. Congressional Budget Office. 2018 Mar 19: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53664-costsharingreduction.pdf; accessed January 19, 2026.

[21] A. Roy. Trump could revolutionize the private health insurance market. *The Washington Post*. 2019 Jun 17: https://www.washingtonpost.com/opinions/trump-could-revolutionize-the-private-health-insurance-market/2019/06/17/bc8ccce4-9124-11e9-aadb-74e6b2b46f6a_story.html; accessed January 19, 2026.

[22] A. Roy, New ways to reduce Medicaid spending while protecting the vulnerable. The Foundation for Research on Equal Opportunity. 2025 May 9: https://freopp.org/oppblog/new-ways-to-reduce-medicaid-spending-while-protecting-the-vulnerable/; accessed January 19, 2026.

consistent with similar GAO testing in plan years 2014 through 2016."[23] Better verification technology can help, as can reforms that benchmark ACA subsidies to prior-year tax returns, as opposed to estimated future income.

Figure 6. Per-Enrollee Subsidies in Medicaid vs. ACA, 2023–33



Source: Congressional Budget Office, A. Roy analysis
Graphic: Avik Roy • Note: Medicaid figures are for able-bodied non-elderly adults

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Obamacare exchanges are a bargain vs. Medicaid. Partly because states have sophisticated techniques for inflating Medicaid costs to draw down more federal dollars, enrollees in the Affordable Care Act's Medicaid expansion cost more in subsidies per person than do enrollees in the ACA's private-sector insurance marketplaces. *(Source: FREOPP analysis of CBO data)*

LEARNING FROM THE SWISS MODEL

There are several additional reforms Congress could enact in order to lower costs and improve health outcomes.

[23] 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. 2025 Dec 3: https://www.gao.gov/products/gao-26-108742; accessed January 19, 2026.

1. ***Longer health insurance contracts***. Switzerland gives consumers the option of supplemental insurance contracts that last up to 5 years. The problem with standard one-year enrollment periods is that insurers lack the incentive to invest in long-term prevention, because they are unlikely to reap the rewards of those investments if patients switch insurers later on. Swiss insurers, by contrast, can benefit economically from prevention. Some offer 50% refunds if enrollees meet certain targets for common laboratory measures like blood pressure or hemoglobin A_1c.[24]
2. ***Trade association-based price negotiation***. Switzerland has developed sophisticated mechanisms for combating the pricing power of health care monopolies, such as regional hospital systems and branded pharmaceuticals. Within a given canton (the Swiss equivalent of a U.S. state), insurers are able to jointly negotiate reimbursement rates, alongside the trade associations for hospitals, physicians, pharmaceutical companies, and the like.[25]
3. ***Migrating FEHB participants into the individual market***. Congress could strengthen the individual market for health insurance by migrating enrollees in the Federal Employee Health Benefits Program into the ACA marketplaces. In 2025, the average monthly premium for an FEHB plan was $897 for self-only coverage, compared to $497 for the median ACA Silver plan. We estimate that a full transition could reduce the deficit by over $10 billion per year in reduced subsidies and regained tax revenue.[26] Doing so would also double the size of the individual market, creating economies of scale whereby more insurers would participate and compete with each other, lowering premiums and increasing quality.

CUTTING SPENDING WHILE PROTECTING BENEFITS FOR THE VULNERABLE

A widely held view among policymakers and experts is that the only way to reduce health care spending is to cut benefits for low earners and other vulnerable populations. This is manifestly untrue.

First of all, we heavily subsidize health insurance for the wealthy through Medicare and the ESI exclusion. Greater means-testing of Medicare, and a migration from ESI group insurance to worker-controlled ICHRAs, can save hundreds of billions of dollars over time without affecting the poor.

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[24] A. Roy, Why Switzerland Has the World's Best Health Care System. *Forbes*. 2011 Apr 29: https://www.forbes.com/sites/theapothecary/2011/04/29/why-switzerland-has-the-worlds-best-health-care-system/; accessed January 19, 2026.

[25] A. Roy, High Drug Prices Don't Accelerate Innovation—Lower R&D Costs Do. The Foundation for Research on Equal Opportunity. https://freopp.org/whitepapers/high-drug-prices-dont-accelerate-innovation-lower-rd-costs-do/; accessed January 19, 2026.

[26] A. Roy, The GOP Should Put ObamaCare to Good Use. *The Wall Street Journal*. 2025 Nov 24: https://www.wsj.com/opinion/the-gop-should-put-obamacare-to-good-use-subsidies-exchange-651adb1b; accessed January 19, 2026.

Second, we force tens of millions of able-bodied low earners into the profoundly inefficient Medicaid program, when they could receive higher quality coverage at a lower cost in the individual insurance market.

Third, we make individually purchased insurance needlessly expensive by forcing insurers to discriminate against the young and the healthy, driving them out of the market and raising prices for those who remain.

Fourth, we are too complacent about the power of regional and national health care monopolies to engage in anticompetitive practices that raise prices for consumers, and thereby also raise the cost of subsidizing coverage for those consumers.[27,28]

Fifth—and most importantly—we have denied the vast majority of Americans the agency to choose the health insurance plans that are best for them and their families, instead forcing them to surrender that agency to their employers or the government. If we want to have a patient-centered health care system, the simplest and best way to do so is to put patients in charge of the money that funds their care.

[27] A. Roy, Affordable Hospital Care Through Competition and Price Transparency. https://freopp.org/whitepapers/affordable-hospital-care-through-competition-and-price-transparency/; accessed January 19, 2026.
[28] A. Roy, The Growing Power of Biotech Monopolies Threatens Affordable Care. https://freopp.org/whitepapers/the-growing-power-of-biotech-monopolies-threatens-affordable-care/; accessed January 19, 2026.