Testimony Submitted to the United States House Judiciary Committee
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
"Examining Healthcare Markets: Fraud and Competition"
September 14, 2026
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Chairman Jordan, Chairman Fitzgerald, and Members of the Subcommittee:

Thank you for the opportunity to testify at today's hearing on fraud and competition in health care. I am Brian Blase, 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, where I coordinated the development and execution of health policy. Before that, I worked for the Senate Republican Policy Committee and the House Committee on Oversight and Government Reform.

The subject of this hearing gets to the heart of why American health care is so expensive. Fraud, weak competition, and high prices are often discussed as separate problems. In reality, they frequently share a common cause: government policies that distort normal market incentives. Federal subsidies can become so large and poorly designed that insurers, brokers, states, and providers are rewarded for maximizing government payments rather than delivering value. Regulations can protect incumbent hospitals from competition, restrict new supply, and encourage consolidation. Government payment rules can pay more for the same service simply because of who owns the facility or where the service is delivered.

My testimony makes four principal points. First, improper and phantom enrollment in the Affordable Care Act (ACA) exchanges and Medicaid expansion has reached an enormous scale, reflecting both inadequate verification and excessive federal subsidies. Second, the greatest affordability threat in American health care is the extraordinary growth of hospital prices. Third, government policy has protected hospitals from competition, subsidized inefficient hospital systems, and rewarded consolidation and overhead rather than productivity. Fourth, Congress and the Trump administration have begun to address these problems through the One Big Beautiful Bill (OBBB) and administrative actions on program integrity, Medicaid financing, price transparency, site neutrality, and other market reforms. Those reforms should be defended, fully implemented, and extended.

I. Fraud, Improper Enrollment, and the Failure of Program Integrity

A. Paragon's Work Has Documented a Systemic Enrollment-Integrity Problem

Paragon has spent the past several years examining program integrity in the ACA's two principal coverage expansions: subsidized exchange plans and Medicaid expansion. Our work began with an unusual and increasingly obvious pattern in the exchanges: enrollment among people claiming incomes low enough to qualify for the largest subsidies was far exceeding the

number of people whom Census data suggested could plausibly qualify.[1] We subsequently examined zero-claim enrollment,[2] automatic re-enrollment, broker incentives, federal eligibility controls,[3] Medicaid expansion eligibility, and the federal-state financing rules that determine who bears the cost of mistakes.[4]

Improper enrollment is not a marginal administrative problem. It is a predictable consequence of program designs that reward enrollment, send most federal dollars to third parties, and weaken incentives to verify whether people are actually eligible. Significant problems include misclassification, duplicative coverage, unauthorized enrollment, or people who remain enrolled despite no longer qualifying. The common feature is that federal taxpayers continue paying even when eligibility is wrong.[5]

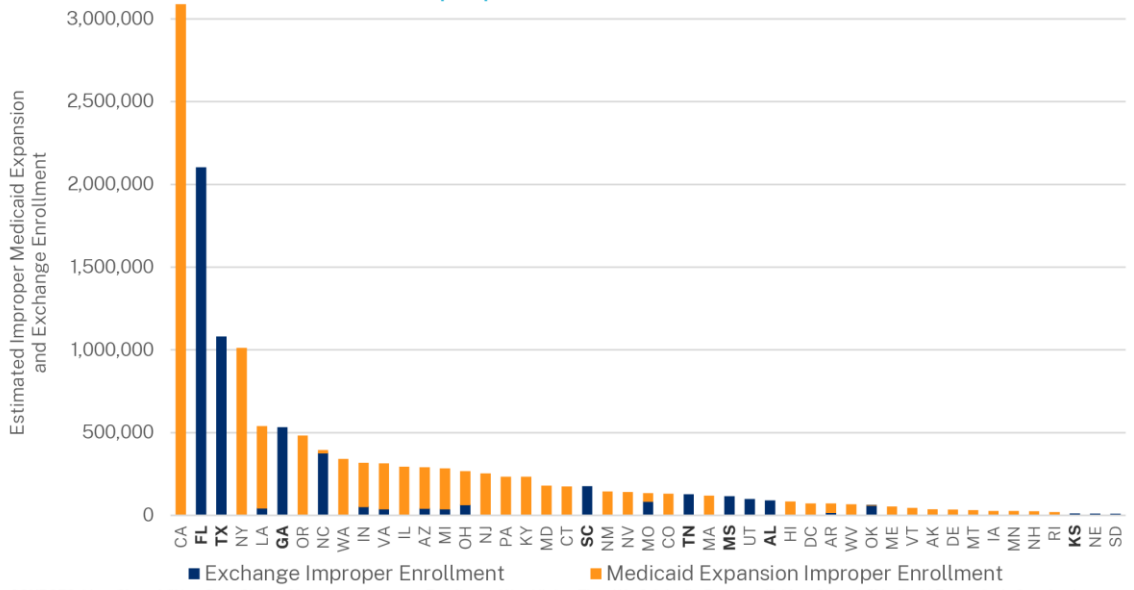
B. The Latest Estimate: 14.3 Million Improper ACA Enrollments and $65 Billion

Paragon's most recent work combines our estimates of improper enrollment for the ACA exchanges and Medicaid expansion. As Figure 1 shows, we estimate that 14.3 million people enrolled in these programs in 2024 were improperly enrolled—about 34 percent of enrollment in the two ACA coverage expansions. We estimate the associated federal cost at approximately $65 billion in 2024, roughly 24 percent of combined federal spending on exchange subsidies and Medicaid expansion (see Figure 2).[6]

[1] Brian Blase and Drew Gonshorowski, "The Great Obamacare Enrollment Fraud," Paragon Health Institute, June 2024, https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.
[2] 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/.
[3] Niklas Kleinworth, Liam Sigaud, and John R. Graham, "Ghostbusting ACA Fraud: Millions Who Don't Use Their Health Insurance Expose Abuse in the Program," Paragon Health Institute, October 1, 2025, https://paragoninstitute.org/private-health/ghostbusting-aca-fraud-millions-who-dont-use-their-health-insurance-expose-abuse-in-the-program/.
[4] Brian Blase and Niklas Kleinworth, "Addressing Medicaid Money Laundering: The Lack of Integrity with Medicaid Financing and the Need for Reform," Paragon Health Institute, March 2025, https://paragoninstitute.org/medicaid/addressing-medicaid-money-laundering-the-lack-of-integrity-with-medicaid-financing-and-the-need-for-reform/; Brian Blase, Gabrielle Minarik, Niklas Kleinworth, Mark Howell, and Liam Sigaud, "The Persistent Obamacare Enrollment Fraud," Paragon Health Institute, June 2026, https://paragoninstitute.org/private-health/the-persistent-obamacare-enrollment-fraud/; Liam Sigaud, "Medicaid Expansion's Growing Improper Enrollment Crisis: Nearly Half of Expansion Enrollees Likely Do Not Meet Eligibility Requirements," Paragon Health Institute, August 3, 2026, https://paragoninstitute.org/medicaid/medicaid-expansions-growing-improper-enrollment-crisis-nearly-half-of-expansion-enrollees-likely-do-not-meet-eligibility-requirements/.
[5] Brian Blase, "Testimony of Brian Blase before the Joint Economic Committee—'Protecting Patients and Taxpayers: Combating Healthcare Fraud and Leakage to Strengthen Program Integrity,'" Paragon Health Institute, June 24, 2026, https://paragoninstitute.org/private-health/protecting-patients-and-taxpayers-combating-healthcare-fraud-and-leakage-to-strengthen-program-integrity/.
[6] Mark Howell, Liam Sigaud, and Brian Blase, "Obamacare Enrollment Abuse Update: $65 Billion Cost in 2024," Paragon Health Institute, August 26, 2026, https://paragoninstitute.org/paragon-prognosis/obamacare-enrollment-abuse-update-65-billion-cost-in-2024/.

Figure 1: Distribution of Improper Enrollment in ACA Expansion and Exchanges, 2024

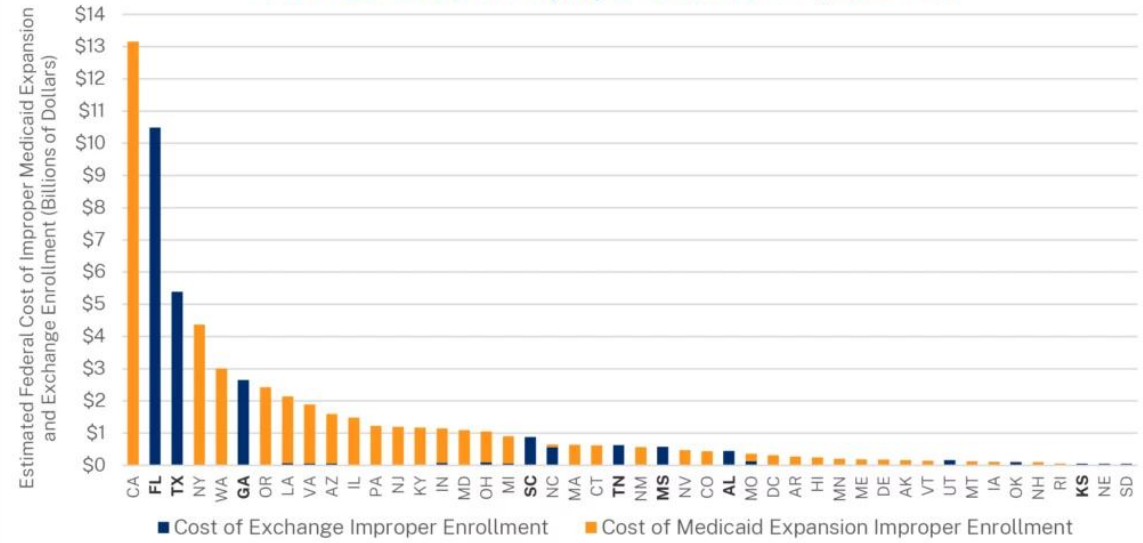
Total improper enrollment = 14.3 million



SOURCES: Liam Sigaud, "New Data Shows Obamacare Improper Enrollment Was Higher Than We Originally Estimated"; Liam Sigaud, "Medicaid Expansion's Growing Improper Enrollment Crisis," Paragon Health Institute, Table 1.
NOTES: States that have not expanded Medicaid are bolded. Medicaid expansion estimates assume a 70 percent take-up rate among eligible adults and use average monthly expansion enrollment from August through December 2024. Exchange estimates use 2024 open-enrollment sign-ups. ACA exchange estimates are unavailable for Minnesota, New York, and Oregon, which operate Basic Health Programs, and for the District of Columbia because of insufficient data. Idaho, North Dakota, Wisconsin, and Wyoming are omitted because neither analysis detected improper enrollment in the categories measured.

Figure 2: Distribution of Federal Costs from Improper Enrollment in ACA Expansion and Exchanges, 2024

Total federal cost of improper enrollment = $65 billion



SOURCES: Liam Sigaud, "New Data Shows Obamacare Improper Enrollment Was Higher Than We Originally Estimated"; Blase et al., *The Persistent Obamacare Enrollment Fraud*, Paragon Health Institute, Table 1; Liam Sigaud, *Medicaid Expansion's Growing Improper Enrollment Crisis*, Paragon Health Institute, Table 1; Author's calculations.
NOTES: States that have not expanded Medicaid are bolded. Federal costs represent the estimated savings if all improper enrollment were eliminated. The estimate accounts for people removed from improper Medicaid expansion coverage who would legitimately qualify for subsidized ACA exchange coverage, including the resulting federal exchange subsidies. Unlike the estimate in Sigaud's Medicaid Expansion's Growing Improper Enrollment Crisis, this figure does not assume that some people removed from improper Medicaid expansion coverage would subsequently enroll improperly in subsidized exchange coverage. West Virginia is excluded because eliminating its estimated improper Medicaid expansion enrollment would slightly increase federal spending, given the state's unusually expensive exchange plans. Idaho, North Dakota, Wisconsin, and Wyoming are omitted because neither analysis detected improper enrollment in the categories measured.

Improper enrollment encompasses multiple categories: people whose income or other circumstances made them ineligible; people incorrectly classified into the Medicaid expansion group even though they qualified through a traditional Medicaid pathway; duplicative enrollment; and other enrollment that should not have generated the federal payment that occurred. Many improper enrollees are also phantom enrollees—people who are unaware they have coverage or, in some fraud schemes, do not actually exist.

C. Zero-Premium Exchange Coverage Created Powerful Incentives for Abuse

The exchange problem became especially severe after Congress temporarily increased ACA premium subsidies to address the pandemic. From 2021 through 2025, enhanced ACA subsidies made the coverage fully subsidized for applicants who claimed low income. This led to a surge of enrollment, much of it improper, and massive growth in subsidy spending.

The widespread availability of fully subsidized plans created strong incentives for insurers and brokers to have applicants submit applications that would qualify them for fully subsidized plans. Insurers strongly prefer enrollees whose premiums are fully paid by taxpayers because those enrollees are unlikely to terminate coverage over cost concerns. In those circumstances, they do not need to actually provide enrollees with any value in the plan to maintain enrollment. Brokers also receive a monthly commission for every month an enrollee is enrolled. Individual brokers operating in high-volume enrollment operations earned upwards of $6,000 a day in commissions, with one customer service agent admitting that half of all enrollees had no idea they were enrolled in coverage.[7]

More sophisticated enrollment schemes have exploited weaknesses in Enhanced Direct Enrollment platforms, identity and income verification, and broker credentialing rules to facilitate improper enrollment at scale. These vulnerabilities can allow bad actors to access or create applications with limited identifying information, obscure which broker or entity is responsible for a submission, and enroll or reenroll consumers without their knowledge. Thus, an unscrupulous intermediary can profit by enrolling or retaining someone who pays nothing and may not even know the coverage exists. The insurer receives the federal subsidy, the broker receives a commission, and the taxpayer bears the cost. This is an obvious recipe for abuse. Paragon's methodology for estimating improper enrollment compares the number of people reporting incomes between 100 and 150 percent of the federal poverty level—the income range receiving the largest subsidies—with Census Bureau estimates of the number of people who could plausibly qualify. In 2024, we estimated 5.1 million improper exchange enrollees and approximately $22.3 billion in improper federal spending.[8] In 2025, our estimate rose to roughly 6.5 million improper enrollees.[9] In 2026, even after expiration of the pandemic-era subsidy boosts, we estimate 6.2 million improper sign-ups, or roughly 27 percent of all exchange sign-ups, with as much as $25 billion in improper subsidy payments.[10] Based on the expiration of the enhanced subsidies combined with some initial program integrity efforts, it

[7] Zeke Faux and Zachary R. Mider, "How Celebrity Deepfakes Supercharged Florida Health-Care Hustle," Bloomberg Businessweek, June 5, 2025, https://www.bloomberg.com/features/2025-deepfake-ads-fueled-florida-health-insurance-scheme/.
[8] Blase and Gonshorowski, "The Great Obamacare Enrollment Fraud."
[9] Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/.
[10] Blase et al., "The Persistent Obamacare Enrollment Fraud."

does appear that a million or two of these improper enrollees likely did not effectuate coverage in 2026.[11]

D. Phantom Enrollment and Zero Claims Corroborate the Problem

From 2021 through 2024, the number of exchange enrollees who did not use their plan for a single medical service tripled, reaching nearly 12 million people. Thirty-five percent of all exchange enrollees and 40 percent of fully subsidized enrollees had zero claims in 2024.[12] Federal taxpayers likely sent more than $35 billion to insurers for people who did not use their plan a single time.[13]

Zero claims do not by themselves prove improper enrollment. Healthy people can legitimately go an entire year without using health care. But the scale, the rapid increase, and the concentration among people whose premiums are entirely or almost entirely paid by taxpayers are warning signs. The same is true of plan selection. Moving to 2026, millions of low-income enrollees have selected bronze plans with very high deductibles even when they qualify for much more generous cost-sharing-reduction silver plans at little additional premium. That is often an economically irrational choice for a legitimate low-income consumer who expects to use coverage. It makes more sense if the objective of the enrollment transaction is simply to keep a person in any zero-premium plan.[14]

E. Federal Investigations Show How Weak Controls Can Be Exploited

Government investigations, criminal cases, and reports further corroborate the scale of improper enrollment. The Government Accountability Office (GAO) has demonstrated serious weaknesses in exchange eligibility controls through undercover testing, including successful subsidized enrollment of fictitious applicants. In its most recent undercover investigation, GAO submitted 24 applications using fictitious identities and obtained subsidized coverage for 23 of them.[15] The Department of Justice has obtained major convictions involving schemes that generated more than $100 million in improper ACA subsidy payments.[16] These investigations demonstrate that a system built around large advance payments and weak front-end verification can be exploited at substantial taxpayer expense.

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[11] Peter Nelson, Anup Malani, Jack Colleran, Eden Volkov, and Casey B. Mulligan, "ACA Exchange Enrollment in 2026," Office of the Assistant Secretary for Planning and Evaluation, June 26, 2026, https://aspe.hhs.gov/reports/aca-exchange-enrollment-2026.

[12] 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/.

[13] Brian Blase and Trevor Carlsen, "Biden's COVID Credits Are an ObamaCare Expansion That Congress Should Allow to Expire," Foundation for Government Accountability, September 3, 2025, https://thefga.org/wp-content/uploads/2025/09/Bidens-COVID-Credits-are-an-ObamaCare-Expansion-that-Congress-Should-Allow-to-Expire-paper-9-3-25.pdf.

[14] Blase et al., "The Persistent Obamacare Enrollment Fraud." The zero-claim figures (the tripling to nearly 12 million enrollees and the associated subsidy cost) are detailed in Blase, "The Rise of Phantom Obamacare Enrollees."

[15] 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-26-108742, December 3, 2025, https://www.gao.gov/products/gao-26-108742.

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

Government data on multiple sources of coverage also confirm that millions of people have duplicative coverage. In 2024, the Congressional Budget Office estimated that the number of individuals with multiple sources of coverage had risen sharply, from 18 million in 2021 to 29 million in 2023.[1718] That jump is best explained by how Congress expanded subsidies and reduced verification requirements during the pandemic, which made it easier for individuals to stay enrolled after they gained other coverage.

F. Recent Enrollment Declines Are Driven by Exchanges Dropping Improper Enrollees

In 2025, several policy changes occurred that have reduced enrollment. Congress passed and the agency implemented some additional program integrity measures. COVID-era subsidies that Congress passed during the pandemic expired. As a result, the number of exchange enrollees has declined.

Data on the coverage losses indicate the majority of the decline reflects some amount of improper enrollment being resolved. Declines are concentrated in states where improper and zero-claim enrollment was most prevalent.[19]

A report by the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS) concluded that the entire *net* decline in enrollment resulted from the removal of improper and phantom enrollees.[20] The evidence shows that, rather than millions of Americans losing legitimate coverage, the geographic concentration of those declines is consistent with the removal of improper enrollment.

G. Medicaid Expansion Has Its Own Large Improper-Enrollment Problem

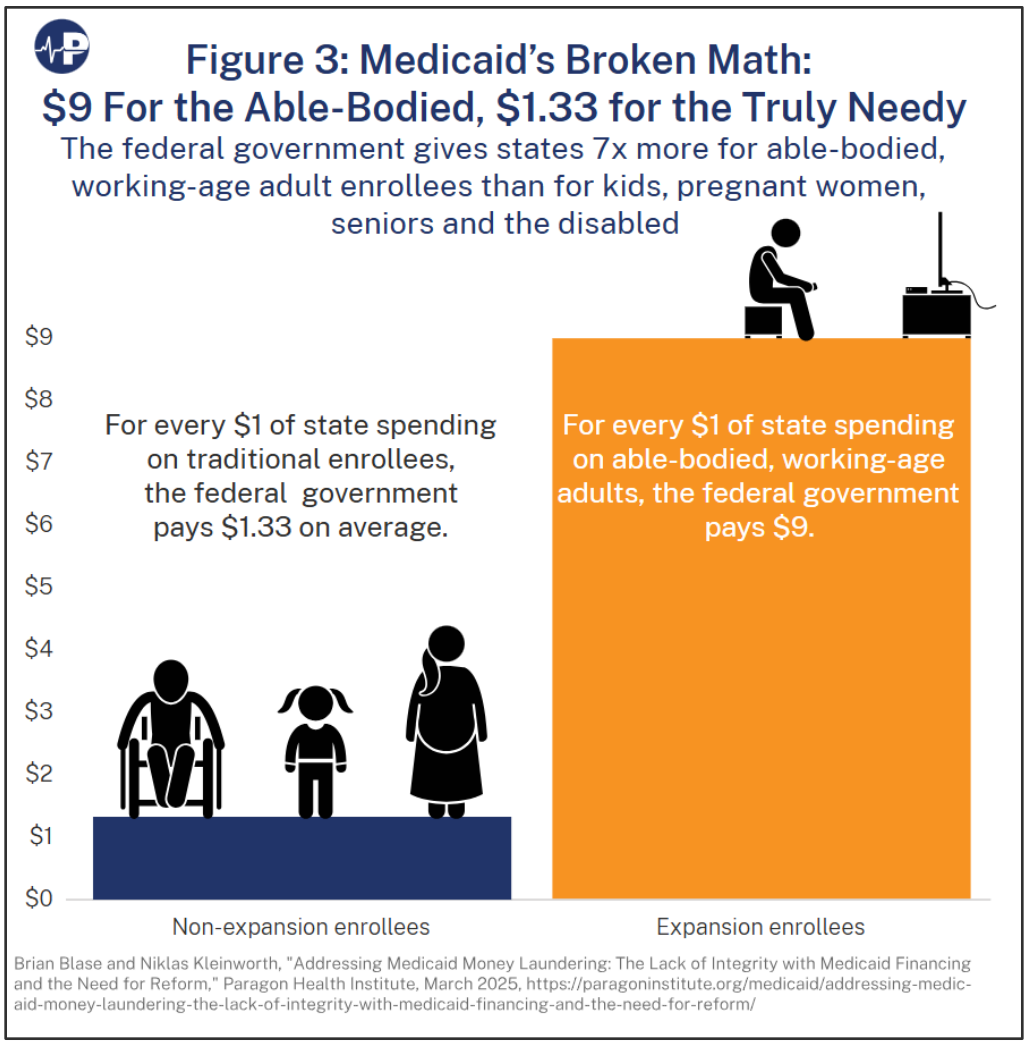
Improper enrollment is not limited to the exchanges. My colleague Liam Sigaud estimates that 9.2 million expansion enrollees — 46 percent of expansion enrollment — were likely ineligible in 2024, with an estimated net federal cost of $32.9 billion.[21]

The Medicaid problem is driven by an especially perverse financing incentive. For traditional Medicaid populations — such as low-income children, pregnant women, seniors, and people with disabilities — the federal government generally contributes between one and three federal dollars for each state dollar. For ACA expansion adults, Washington contributes nine dollars for each state dollar. Thus, for a state dollar devoted to an expansion enrollee, the federal government contributes roughly seven times as much as it does, on average, for a traditional enrollee (see Figure 3).

That differential gives states a strong incentive both to keep expansion enrollment high and to classify people into the expansion category whenever possible. If a state makes a one-dollar

[17] Jessica Hale et al., "Health Insurance Coverage Projections for the US Population and Sources of Coverage, by Age, 2024–34," Health Affairs 43 (2024): 1042, 1044–45, https://doi.org/10.1377/hlthaff.2024.00460.
[18] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032," tbl. 1, June 2022, https://www.cbo.gov/system/files/2022-06/51298-2022-06-healthinsurance.pdf.
[19] Brian Blase and Mark Howell, "Improper and Phantom Enrollment Predict Exchange Attrition," Paragon Health Institute, July 14, 2026, https://paragoninstitute.org/paragon-prognosis/improper-and-phantom-enrollment-predict-exchange-attrition/.
[20] Nelson et al., "ACA Exchange Enrollment in 2026."
[21] Sigaud, "Medicaid Expansion's Growing Improper Enrollment Crisis."

eligibility mistake for an expansion enrollee, the federal government bears at least 90 cents of the cost. If a person who could qualify through a traditional Medicaid category is instead classified as an expansion enrollee, the state can shift substantial cost to Washington. Improper enrollment must therefore be understood not merely as an enforcement issue but more as an incentive problem.[22]



H. Official Medicaid Improper-Payment Rates Understate Eligibility Errors

The official Medicaid improper-payment statistics also understate the problem because comprehensive eligibility reviews were omitted from most recent audit cycles. In work I coauthored with Rachel Greszler, we found that during the two audit cycles over the past decade that included comprehensive eligibility reviews, the Medicaid improper payment rate exceeded 25 percent. Applying those rates to federal Medicaid spending suggests that actual

[22] Brian Blase, "Testimony of Brian Blase before the Senate Committee on the Budget — 'Medicaid: The Reality,'" Paragon Health Institute, August 4, 2026, https://paragoninstitute.org/private-health/testimony-of-brian-blase-before-the-senate-committee-on-the-budget-medicaid-the-reality/; Sigaud, "Medicaid Expansion's Growing Improper Enrollment Crisis."

improper payments over the decade may have approached $1.1 trillion—roughly twice the official amount reported by the Centers for Medicare and Medicaid Services (CMS) over that period.[23]

A program cannot credibly claim a low eligibility-error rate when the audit process is not consistently checking eligibility. Congress should insist on comprehensive eligibility reviews and transparent reporting of the categories and causes of improper payments.[24]
The extent of improper enrollment is not inevitable. Rather it reflects policy choices that the federal government and states have made to reduce program integrity measures and flood federal programs with money. As discussed below, government policy is the same root cause for high costs, particularly at hospitals.

II. Hospital Prices Are the Number One Threat to American Health Care Affordability

A. The Health Cost Crisis Is Concentrated in Hospitals

The most important affordability problem in American health care is the price of hospital services. Hospitals account for about one-third of national health expenditures, and Americans spent more than $1.6 trillion on hospital care in 2024.[25] The hospital sector is therefore both the largest component of health spending and the sector where price growth has been most extreme.

Paragon's April 2026 study, *The Hospital Cost Crisis: How Government Policies Drive Consolidation, Undermine Competition, and Fuel Soaring Prices*, authored by John R. Graham, documents just how unusual this price growth has been.[26] From January 2000 through December 2025, hospital-service prices increased 281 percent. Overall inflation increased 93 percent and average hourly wages increased 131 percent. Hospital prices therefore rose more than three times as fast as overall inflation and more than twice as fast as wages. Medical-care services overall increased 147 percent, which means the health care affordability problem is disproportionately concentrated in hospitals rather than uniformly spread across the health sector (see Figure 4).

High and rising hospital prices are the number one threat to American health care affordability. If policymakers want to make health care more affordable for workers, employers, taxpayers, and patients, they should begin with the sector that consumes the most money and has experienced the most extraordinary price growth.

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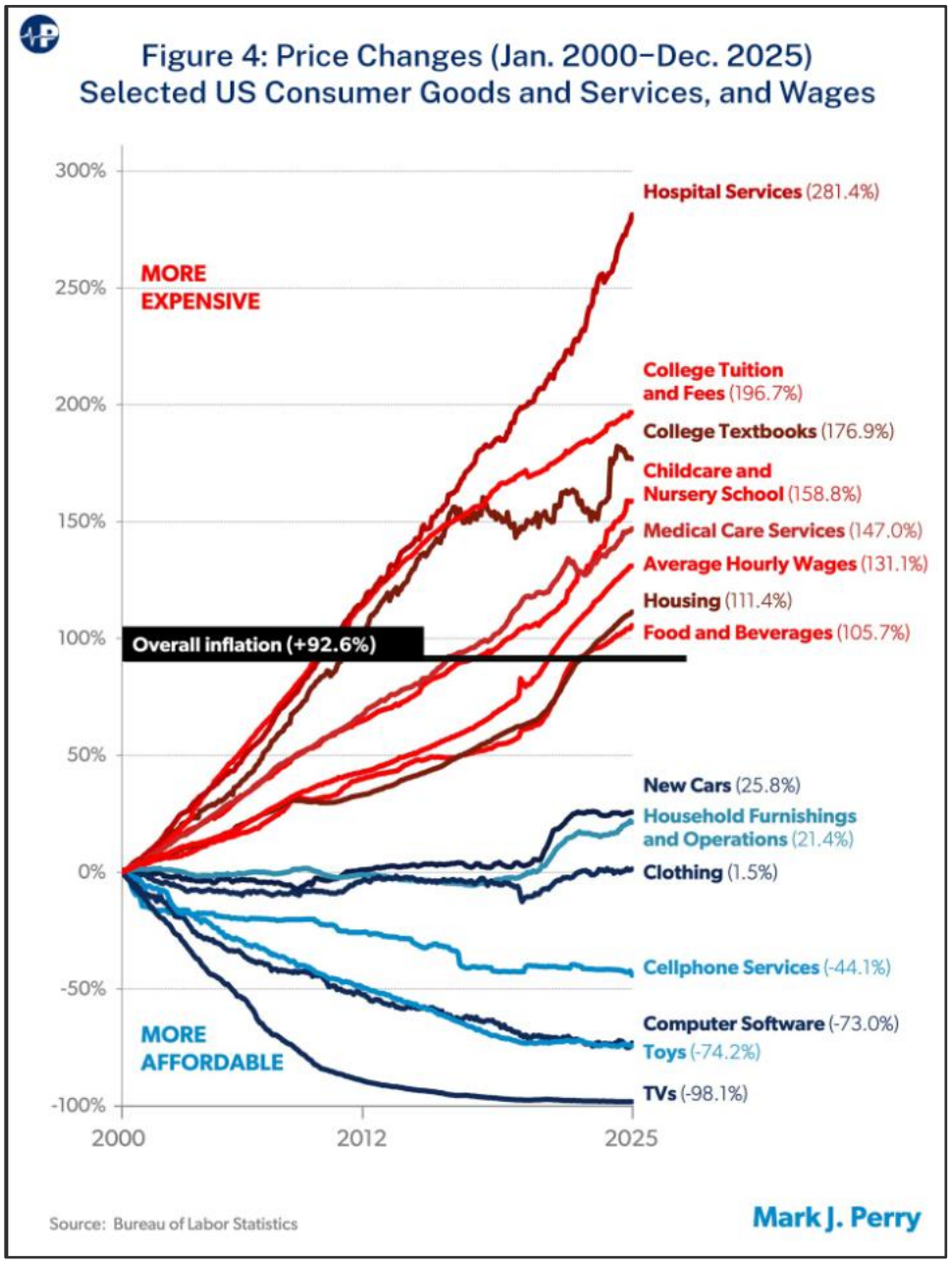
[23] Brian Blase and Rachel Greszler, "Medicaid's True Improper Payments Double Those Reported by CMS," Paragon Health Institute and Economic Policy Innovation Center, March 3, 2025, https://paragoninstitute.org/medicaid/medicaids-true-improper-payments-likely-double-those-reported-by-cms/.
[24] Chris Medrano and Brian Blase, "Medicaid Waste, Fraud, and Abuse: Why CMS's Improper Payment Rate Can't Be Trusted," Paragon Health Institute, April 27, 2026, https://paragoninstitute.org/medicaid/medicaid-waste-fraud-and-abuse-why-cms-improper-payment-rate-cant-be-trusted/.
[25] Brian Blase, "The Hospital Cost Crisis," *Paragon Health Institute*, April 22, 2026, https://paragoninstitute.org/newsletter/the-hospital-cost-crisis/.
[26] John R. Graham, "The Hospital Cost Crisis: How Government Policies Drive Consolidation, Undermine Competition, and Fuel Soaring Prices," Paragon Health Institute, April 22, 2026, https://paragoninstitute.org/private-health/the-hospital-cost-crisis-how-government-policies-drive-consolidation-undermine-competition-and-fuel-soaring-prices/.



B. Hospital Prices Have Risen Even as Technology Should Have Reduced Costs

The trend is especially troubling because technology has reduced the need for expensive inpatient care. Hospital admissions per 1,000 people fell from 120 in 2000 to 99 in 2024, while many procedures migrated to physician offices and ambulatory surgical centers. Advances in anesthesia, imaging, minimally invasive procedures, and other technologies should allow more care to be delivered safely in lower-cost settings.[27]

[27] Graham, "The Hospital Cost Crisis."

In most industries, technological progress and declining demand for a high-cost setting would put downward pressure on prices. Hospitals have experienced the opposite. Prices have soared. That is a strong indication that ordinary competitive forces are not functioning properly. Incentives matter in health care decisions as they do everywhere in the economy. Public policy has insulated incumbent hospitals from competition and subsidized their cost structures.

C. Government Policy Has Accelerated the Transformation of Hospitals into Giant Health Systems

The modern hospital sector is increasingly dominated by regional or multistate health systems that own hospitals, physician practices, outpatient departments, imaging centers, infusion sites, and other facilities. The change has been rapid. In 2012, only 26 percent of physicians were employed by hospitals. By 2024, more than 55 percent were hospital employees.[28] That transformation matters because the ownership of a physician practice can change what Medicare and private plans pay even when the physician, patient, and service are unchanged.

The pace of this consolidation accelerated after the ACA, whose payment and regulatory framework favored larger integrated systems and encouraged hospitals to acquire independent physician practices.[29] A substantial body of economic research finds that such consolidation raises prices without commensurate improvements in quality, with mergers between nearby competing hospitals often producing price increases exceeding 20 percent in concentrated markets.[30]

Government policy has contributed directly to this consolidation. Site-of-service payment differentials, the 340B program, federal referral rules with employment exceptions, and the ACA restriction on new physician-owned hospitals each reward acquisition or shield incumbents from competition — and each is addressed in the sections that follow.

Policymakers should distinguish genuine efficiencies from consolidation driven by government-created payment advantages. Vertical integration can sometimes improve coordination. Horizontal combinations can sometimes create efficiencies. But when the government pays more after an acquisition simply because the ownership label has changed, consolidation is a rational response to a distorted payment system. The first policy response should be to remove the distortion.[31]

[28] Physicians Advocacy Institute and Avalere Health, "PAI-Avalere Study on Physician Employment and Practice Ownership Trends, 2019–2023," April 2024, https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023.
[29] Graham, "The Hospital Cost Crisis."
[30] Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Quarterly Journal of Economics 134, no. 1 (2019): 51–107; Martin Gaynor, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," Journal of Economic Literature 53, no. 2 (2015): 235–284.
[31] Graham, "The Hospital Cost Crisis."

D. Government Restricts Competition Through Certificate-of-Need Laws and Limits on Physician-Owned Hospitals

Certificate-of-need laws require government permission before providers can open facilities, add beds, or offer certain services. Incumbent hospital systems can use the regulatory process to challenge potential entrants. The predictable result is less supply, less competition, and weaker pressure to reduce prices.[32] If policymakers are concerned about concentration, they should not maintain laws whose very purpose is to limit entry.

Federal law compounds the problem by restricting physician-owned hospitals. The ACA restricted Medicare payment to new physician-owned hospitals. Yet physician-owned hospitals can be important competitors, particularly for scheduled services where physicians can organize specialized and efficient care. Research suggests these hospitals can deliver comparable or better care at lower cost compared to traditional hospital systems.[33] It is difficult to reconcile concern about hospital consolidation with a federal policy that prevents physicians from creating competing hospitals.

E. Medicare Payment Policy Rewards Hospital Ownership and Vertical Consolidation

Medicare also pays substantially more when the same outpatient service is delivered in a hospital outpatient department rather than an independent physician office. That differential is effectively a subsidy for hospital ownership. A hospital can acquire a physician practice, change the billing status, and collect a higher payment for care that may be clinically identical. Commercial insurers frequently follow Medicare's payment architecture, magnifying the distortion. Government policy therefore contributes directly to vertical integration and then policymakers express concern about the resulting consolidation.

The consequences are predictable. Hospitals have strong incentives to buy physician practices and ambulatory facilities. Independent physicians face an uneven playing field. Patients pay more in cost sharing. Taxpayers pay more.

Site-neutral payment reform is essential. Medicare should pay the same amount for the same service regardless of whether it is delivered in a hospital-owned outpatient department or an independent physician office, with appropriate adjustments where genuine differences in patient acuity or resource needs justify them. Site neutrality would reduce incentives for hospital acquisitions, strengthen independent medical practice, and lower costs for seniors and taxpayers.[34]

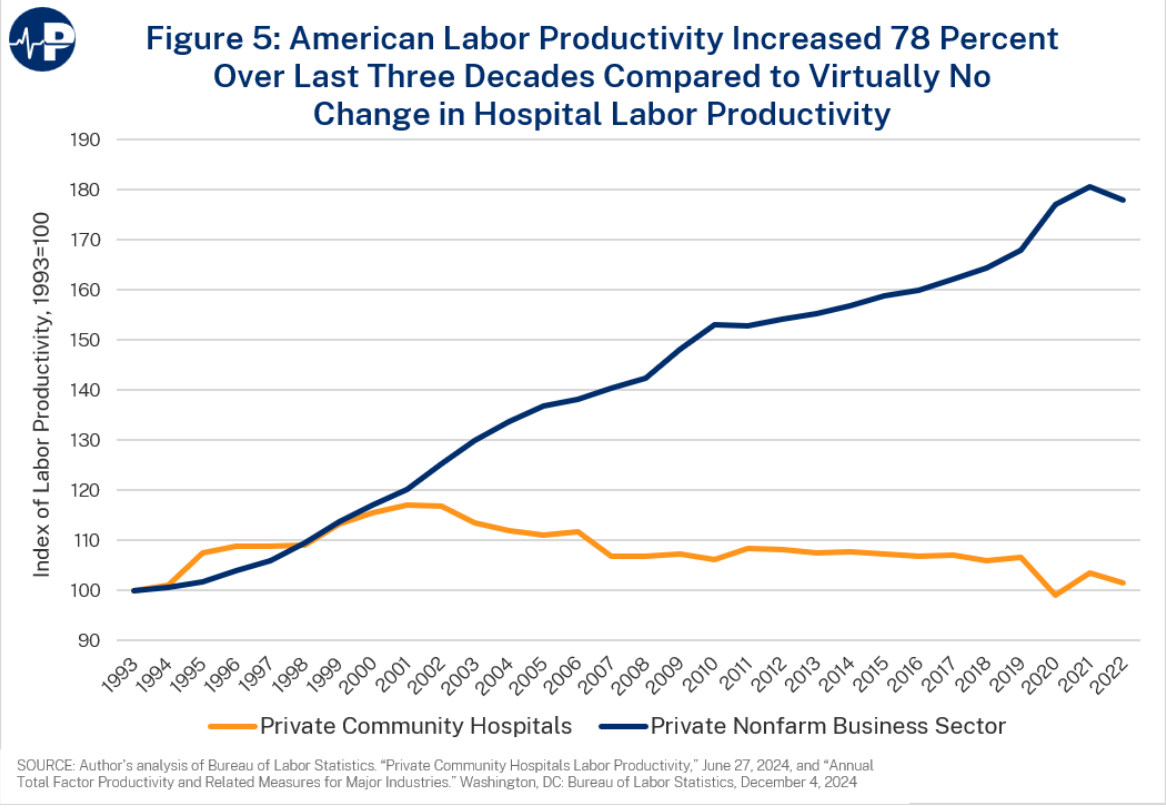
[32] Cicero Institute, "Ranking Certificate of Need Laws in All 50 States," December 2024, https://ciceroinstitute.org/research/ranking-certificate-of-need-laws-in-all-50-states/.
[33] Katherine Hall, "Let Affordable Hospitals Compete: Lift Restrictions on Physician-Owned Hospitals," Paragon Health Institute, May 2026, https://paragoninstitute.org/paragon-prognosis/let-affordable-hospitals-compete-lift-restrictions-on-physician-owned-hospitals/.
[34] Graham, "The Hospital Cost Crisis."

F. Government Subsidizes Inefficient Hospitals Instead of Rewarding Productivity

The hospital sector also illustrates a broader problem with government payment: reimbursement frequently rewards costs, which reduces incentives for efficiency. Hospitals receive extensive direct and indirect subsidies through Medicare and Medicaid payment systems, supplemental payments, graduate medical education, 340B, tax preferences, and other programs. Many of these subsidies are poorly targeted and are not conditioned on measurable improvements in efficiency, quality, or affordability.

Medicare's hospital payment systems incorporate overhead and capital costs into reimbursement. Hospitals can allocate overhead across inpatient and outpatient services, and payment formulas can carry those costs forward. A hospital that maintains an expensive administrative structure may therefore be able to recover part of that cost through government reimbursement rather than facing consequences for excessive costs.

The hospital sector has experienced remarkably weak productivity growth. Bureau of Labor Statistics measures indicate that long-term labor productivity in private community hospitals increased by only about 0.2 percent per year from 1993 through 2021, with productivity declining over long periods after 2001. In a sector transformed by information technology, better diagnostics, less invasive procedures, and a major shift away from inpatient care, that lack of productivity improvement should concern policymakers.[35]



[35] Graham, "The Hospital Cost Crisis."

G. Hospital Overhead Has Grown Instead of Direct Resources for Patient Care

One of the most striking findings in Paragon's hospital work is the growth of spending not directly associated with patient care. Hospitals often argue that these overhead costs are necessary for information technology, compliance, billing, and quality improvement. Some overhead is obviously necessary. The relevant question is whether rising overhead produces measurable gains in productivity, quality, or lower unit costs. In competitive industries, investments in technology and administration ultimately have to generate efficiencies. If overhead continues rising while productivity stagnates and prices soar, government should not automatically reimburse or subsidize that cost structure.

This is an important distinction in the affordability debate. Policymakers frequently hear that hospitals need more money because their costs are rising. But rising costs can reflect inefficiency as well as need. A payment system that responds to rising hospital overhead with higher reimbursement can create a self-reinforcing cycle: overhead rises, reported costs rise, government payments rise, and the pressure to become more efficient weakens. Public policy should instead reward hospitals that deliver excellent care with leaner cost structures.[36]

H. The Claim That Hospitals Must Charge Private Plans More Because Government Underpays Is Misleading

Hospitals frequently justify high commercial prices through the theory of cost shifting: Medicare and Medicaid allegedly pay too little, forcing hospitals to charge employers and private insurers more. A large body of academic work shows that this explanation is wrong. More than half of hospitals make money on Medicare under a marginal-profit measure, and at least one-third make money on Medicaid. Medicare marginal profit has remained positive in recent years.

More fundamentally, prices in competitive markets are not determined by adding up a seller's costs and allocating them across buyers. Commercial hospital prices are high primarily where hospitals possess bargaining leverage. Consolidation and restrictions on competition increase that leverage.

Rather than increase subsidies to high-cost systems, policymakers should expose hospitals to stronger competition, eliminate policies that reward consolidation, and target public support to genuine access needs.[37]

I. Medicaid Financing Schemes Have Become Large Hospital Subsidies

Medicaid financing provides another example of government policy subsidizing hospital systems while weakening affordability. States increasingly use provider taxes and intergovernmental transfers to draw down additional federal funds without any commensurate increase in state expenditures.[38] States have increasingly used the federal funds raised

[36] Graham, "The Hospital Cost Crisis."
[37] Graham, "The Hospital Cost Crisis."
[38] Blase and Kleinworth, "Addressing Medicaid Money Laundering."

through these financing schemes to deliver large corporate welfare to hospitals through state-directed payments (SDPs). SDPs are payments that states order insurers to make to health care providers — mostly hospitals — and they grew from approximately $43 billion in 2021 to $144 billion in 2025. HHS economists projected that annual spending could have reached $316 billion within a decade absent the reform in the OBBB.[39]

The Biden administration's 2024 managed-care rule clarified that certain SDPs could reach average commercial rates. HHS found that among states using the average-commercial-rate benchmark, base Medicaid payments averaged 96 percent of Medicare rates but reached 186 percent of Medicare after state-directed payments were included. CMS approved some arrangements reaching 350 percent of Medicare.

Linking Medicaid payments to commercial prices created an especially damaging incentive. If a hospital negotiates a higher price from employers and private insurers, the state can use that higher commercial rate to justify a larger Medicaid payment and draw down additional federal matching funds. A policy intended to finance Medicaid can therefore put upward pressure on the prices paid by workers and employers outside Medicaid.[40]

J. High Commercial Prices Reflect Market Power, Not a Mechanical Cost Shift

The gap between commercial and Medicare hospital prices is enormous. A 2024 RAND analysis found that employers and private insurers paid, on average, 254 percent of Medicare rates for the same inpatient and outpatient hospital services at the same facilities in 2022.[41] That gap is one of the principal reasons that hospital costs are such a burden for employers and workers. Higher hospital prices ultimately show up in higher premiums, lower wages, higher cost sharing, and higher taxes.

Hospitals often argue that these high commercial prices are necessary because Medicare and Medicaid underpay. But the evidence does not support a simple cost-shift story. If Medicare were simply increased, hospitals with market power would have no reason to voluntarily reduce the prices they charge private plans. Suppliers generally charge what each market segment will bear. The discipline on commercial prices comes from competition, not from increasing government reimbursement.

Indeed, the relationship can run in the opposite direction from the industry narrative. Commercial prices often move with Medicare prices, and some Medicaid payment arrangements now explicitly use commercial prices as a benchmark. When a state permits Medicaid payments to rise with average commercial rates, hospitals can gain twice from higher commercial prices: they collect more from employers and private plans and can use those

[39] Brian Blase, "The Massive Win of OBBB's Medicaid Financing Reforms: HHS Economists Find Lower Health Care Prices on Top of Sizeable Taxpayer Savings," Paragon Health Institute, August 18, 2026, https://paragoninstitute.org/paragon-prognosis/the-massive-win-of-obbbs-medicaid-financing-reforms-hhs-economists-find-lower-health-care-prices-on-top-of-sizeable-taxpayer-savings/.
[40] Blase, "The Massive Win of OBBB's Medicaid Financing Reforms."
[41] Christopher M. Whaley et al., "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative," RAND, December 10, 2024, https://www.rand.org/pubs/research_reports/RRA1144-3.html.

higher rates to justify larger Medicaid payments financed substantially by federal taxpayers. That is an especially perverse incentive.

K. Hospitals Are Not Broadly Financially Distressed

A second recurring argument is that broad hospital subsidies and high commercial prices are necessary because hospitals as a sector are financially fragile. The data do not support that generalization. In 2024, hospital operating profits averaged 6.4 percent and total margins averaged 6.5 percent.[42] Hospitals also received billions of dollars in investment income, and many systems maintain substantial cash reserves and investment portfolios. There are certainly individual hospitals, particularly some rural and true safety-net institutions, that face genuine financial challenges. Public policy should address those needs directly rather than using them to justify open-ended subsidies for an entire sector that disproportionately flow to larger, often wealthier, systems.

A subsidy justified by the needs of a rural hospital should not become a windfall for a wealthy metropolitan health system. A payment intended to support uncompensated care should be tied to actual charity care and bad debt. Tax-exempt status should carry measurable obligations. Graduate medical education funding should support the education of residents rather than function as another opaque revenue stream for hospitals. Government assistance should be targeted to need and performance, not distributed through overlapping formulas that reward size, political influence, or historical spending.

The current system too often does the opposite. Hospitals benefit from Medicare and Medicaid payments, graduate medical education, disproportionate-share payments, uncompensated-care payments, provider-tax arrangements, state-directed payments, 340B discounts, tax exemptions, and other subsidies. These programs developed at different times for different purposes and are rarely evaluated together. Congress should understand the total federal support flowing to each system and whether that support is producing access, quality, charity care, or greater efficiency.[43]

L. Efficient Hospitals Demonstrate That High Costs Are Not Inevitable

Some hospitals provide high-quality care, serve substantial Medicare and Medicaid populations, control labor and administrative costs, and provide meaningful charity care. Their performance demonstrates that high subsidies and ever-rising costs are not prerequisites for good patient outcomes.

That evidence should change how policymakers evaluate hospital requests for higher payments. The relevant question should not be whether a hospital can document that its costs increased. The question should be whether those costs are necessary to deliver high-quality care efficiently. If comparable hospitals can deliver excellent care with lower overhead, lower labor costs, and better productivity, federal policy should not automatically compensate the less efficient hospital for maintaining a more expensive structure.

[42] Graham, "The Hospital Cost Crisis."
[43] Graham, "The Hospital Cost Crisis."

Federal payment policy should reward hospitals that become more productive rather than compensate inefficient systems for higher costs. Technological improvements have lowered costs throughout the economy. Health care should be no different.

III. Government Policies Inflate Demand While Restricting Supply

A. Third-Party Payment Weakens Consumer Price Discipline

The hospital problem sits within a broader financing system that separates consumers from prices. Government programs directly finance a large share of health expenditures, and federal tax policy heavily subsidizes employer-sponsored insurance. Most Americans therefore consume health care with someone else paying most of the bill. Only a very small share of hospital revenue comes directly from patients.

Insurance is essential for protecting people against large and unpredictable medical expenses. But when nearly every service is financed through third parties, providers face weaker pressure to compete on price. Consumers have less reason and less ability to compare prices, and employers often have limited tools to steer workers toward high-value care.[44]

B. ACA Subsidy Design Rewards Higher Premiums

The ACA illustrates the demand-side problem. Its regulations increased the underlying cost of coverage — particularly individual market coverage — and its subsidies then insulated many enrollees from those higher premiums. The subsidy formula caps what eligible enrollees pay for a benchmark plan, leaving taxpayers to absorb much of any premium increase. During the pandemic-era subsidy expansion, the federal taxpayer share of premiums reached nearly 85 percent.

When insurers know that higher benchmark premiums largely translate into higher federal subsidies rather than higher consumer payments, normal price discipline is weakened. From 2014 to 2026, individual-market premiums increased far faster than general inflation — and twice as fast as employer plan premiums. Government can make insurance appear cheaper to the subsidized enrollee while making the underlying health care system more expensive.[45]

C. The No Surprises Act Arbitration Process Is Undermining Competition

Congress was right to protect patients from surprise medical bills. But a new Paragon research paper shows that the federal arbitration system created by the No Surprises Act has produced unintended and increasingly costly consequences.[46] In 2025, providers initiated 2.56 million

[44] 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/.
[45] Blase, "The Rising Cost of Health Care."
[46] Jackson Hammond and Katherine Hall, "Fixing the No Surprises Act: Scaling Back and Reforming the Federal Arbitration System," Paragon Health Institute, forthcoming 2026.

disputes—115 times the federal government's original projection. Providers prevailed in 86 percent of disputed services, and the median arbitration award was nearly four times the qualifying payment amount, essentially an adjusted median in-network rate, and roughly 5.5 times the Medicare rate.

These outcomes have transformed arbitration from a backstop for unusual out-of-network disputes into an alternative payment system. Providers can remain outside an insurer's network and pursue generous arbitration awards, or use the prospect of those awards to demand higher rates to join the network. Either response puts upward pressure on health care prices and premiums. Estimates indicate that the IDR process generated $22.4 billion in costs through 2025, with costs accelerating rapidly. The system has also attracted sophisticated organizations, including private-equity-backed provider groups and third-party dispute filers; four organizations accounted for about half of all provider-initiated disputes determined in 2025.

Congress should preserve strong protections against surprise bills while restoring incentives for providers and insurers to negotiate market prices. For elective services, where patients can make choices in advance, Congress should eliminate federal arbitration and require meaningful advance disclosure of out-of-network participation and prices. For emergency care, where patients cannot shop, surprise billing protections should remain, but Congress should substantially reform the dispute process and limit excessive awards.

D. Price Transparency Is Necessary for Competition

A functioning market also requires usable information about price and quality. Health care institutions have historically hidden both. Patients often cannot obtain a reliable price before care, and employers may not know the prices their plans have negotiated on their behalf. That opacity protects high-cost providers and makes it difficult for innovative benefit designs to reward value.

The hospital and insurer transparency rules initiated during the first Trump administration began to expose negotiated prices that had long been treated as proprietary secrets. The current administration's renewed emphasis on enforcement and data usability is important as meaningful competition is impossible when buyers cannot see prices.[47] But the most important thing Congress can do to further price transparency is to empower patients, not insurers. That means expanding access to health savings accounts (HSAs) and individual coverage health reimbursement arrangements (ICHRAs).[48] If patients have power over their health care financing, the market will respond by catering to their preferences.

[47] Katherine Hall and Gabrielle Kalisz, "Shining a Light Where It Hurts: How Trump's Transparency Orders Are Dispelling Health Care Darkness," Paragon Health Institute, May 27, 2026, https://paragoninstitute.org/paragon-prognosis/shining-a-light-where-it-hurts-how-trumps-transparency-orders-are-dispelling-health-care-darkness/.
[48] Brian Blase, "Nine Reform Ideas to Improve the ACA Status Quo," Paragon Health Institute, November 25, 2025, https://paragoninstitute.org/newsletter/nine-reform-ideas-to-improve-the-aca-status-quo/.

IV. The OBBB and Trump Administration Are Correctly Reorienting Federal Policy

A. The OBBB Reforms Address Incentives, Not Merely Symptoms

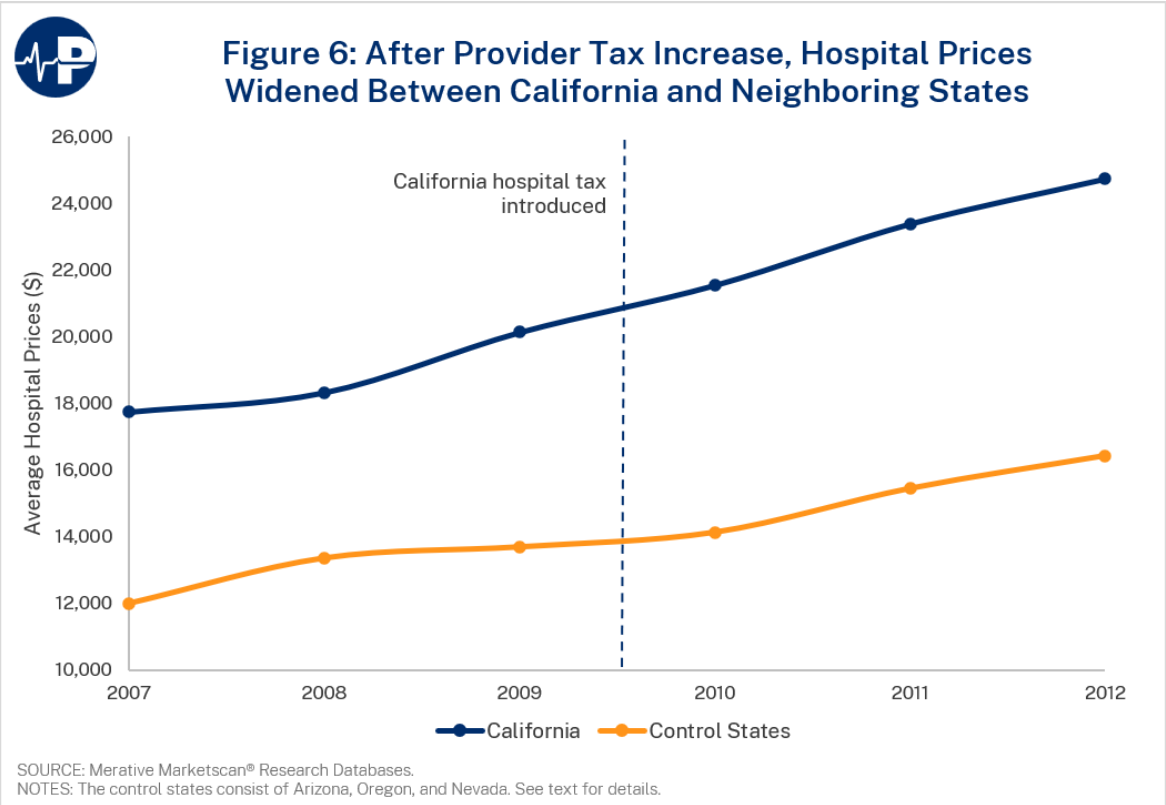
The One Big Beautiful Bill (OBBB) contains some of the most consequential federal health reforms in decades because it addresses the incentives that produced excessive spending, improper enrollment, and hospital subsidies. The OBBB tightened eligibility and verification rules, strengthened accountability for ACA subsidies, addressed duplicate and improper Medicaid enrollment, established community-engagement requirements for certain able-bodied expansion adults, and reformed Medicaid financing arrangements that allowed states and providers to maximize federal matching payments and corporate welfare in the program.[49]

B. Medicaid Financing Reform Protects Taxpayers and Can Lower Commercial Prices

The OBBB appropriately reforms both sides of the Medicaid financing scheme. It limits states' ability to create or expand provider taxes and gradually lowers the provider-tax safe-harbor threshold in expansion states from 6 percent to 3.5 percent. It also limits major categories of SDPs, generally to Medicare rates in expansion states and 110 percent of Medicare rates in non-expansion states, with transition rules for existing arrangements.[50]

These reforms are particularly important for hospital affordability. Provider taxes are not free money. Research by Paragon's Liam Sigaud and Eric Sun found that a California hospital provider tax was associated with approximately a 4 percent increase in commercial hospital prices. Economic estimates suggest that a substantial portion of provider taxes is passed through to private payers. The nominal tax on hospitals can therefore become a tax on workers and employers while simultaneously generating additional federal Medicaid matching funds for hospitals (see Figure 6).[51]

[49] Blase, "Medicaid: The Reality."
[50] Blase, "The Massive Win of OBBB's Medicaid Financing Reforms."
[51] Liam Sigaud and Eric Sun, "The Hidden Cost of Medicaid Provider Taxes: Higher Prices in the Commercial Market," Paragon Health Institute, June 24, 2026, https://paragoninstitute.org/medicaid/the-hidden-cost-of-medicaid-provider-taxes-higher-prices-in-the-commercial-market/.



A recent HHS Assistant Secretary for Planning and Evaluation report confirms the broader benefits of the OBBB reforms. ASPE estimates that the provider-tax and related financing reforms could reduce non-Medicaid prices by as much as 3.5 percent in affected markets and generate between $502 billion and $875 billion in benefits for non-Medicaid consumers from 2025 through 2034. Roughly 60 percent of the modeled benefit comes from lower health care prices, with the remainder reflecting additional care consumers can purchase as prices fall.[52]

The status quo shifted costs to federal taxpayers, weakened state incentives to be prudent purchasers, subsidized large hospital systems, and in some cases increased commercial prices. The OBBB reforms therefore save federal taxpayers money while also benefiting workers and families with private coverage.

C. The OBBB's Program-Integrity Reforms Respond to Documented Enrollment Abuse

The law's eligibility reforms are also justified by the evidence of improper enrollment. Requiring more frequent eligibility checks, strengthening duplicate-coverage controls, improving subsidy reconciliation, and ensuring that federal assistance goes to people who meet statutory requirements are basic responsibilities of program administration.

Every dollar spent on an ineligible or phantom enrollee is a dollar unavailable for legitimate beneficiaries or other public priorities. Weak eligibility controls also undermine public

[52] Blase, "The Massive Win of OBBB's Medicaid Financing Reforms."

confidence in safety-net programs. Congress has an obligation to ensure that benefits go to the people the law makes eligible.[53]

D. Trump Administration Implementation on Medicaid Financing Is Important

The Trump administration has taken important steps to implement the OBBB's Medicaid financing reforms. CMS's SDP rule is particularly consequential because the growth of these payments transformed Medicaid managed care into an end run around payment constraints that had long applied in fee-for-service Medicaid.

Strong implementation should ensure that states cannot evade the statutory limits through creative payment classifications, manipulated commercial-rate benchmarks, or financing arrangements that recycle provider money to draw down federal matching funds. Transparency should also improve. Policymakers and taxpayers should be able to identify which hospitals receive SDPs, how large those payments are, and how they compare with Medicare rates.[54]

E. The Administration's Hospital Payment Agenda Moves in the Right Direction

CMS's proposed 2027 outpatient payment rule also moves policy in a more pro-competitive direction. The proposal advances site-neutrality and 340B payment reform while strengthening program integrity. Paying more appropriately for services based on the service delivered rather than hospital ownership reduces incentives for vertical consolidation. Paying 340B hospitals more closely to actual acquisition costs can reduce an artificial financial incentive for hospitals to acquire physician practices and infusion sites.[55]

Full site-neutral payment reform and repeal of the restrictions on physician-owned hospitals require Congress. But the administration should use the authority it has to stop rewarding unnecessary hospital overhead and ownership structures.

F. Price Transparency Should Be Strengthened by Empowering Consumers

The hospital problem sits within a broader financing system that separates consumers from prices. Government programs directly finance a large share of health expenditures, and federal tax policy heavily subsidizes employer-sponsored insurance. Most Americans therefore consume health care with someone else paying most of the bill. Only a very small share of hospital revenue comes directly from patients.

On the demand side, the most important thing lawmakers can do to make health care affordable is empower patients and give them more control over their health care financing. Markets work best when people control their own spending and are sensitive to prices and price changes. Unfortunately, the current health system puts more control of personal health care

[53] Blase, "Medicaid: The Reality."
[54] Blase, "The Massive Win of OBBB's Medicaid Financing Reforms."
[55] Jackson Hammond, "CMS's 2027 OPPS Proposed Rule Advances 340B Payment Reform, Site Neutrality, and Program Integrity," Paragon Health Institute, July 14, 2026, https://paragoninstitute.org/medicare/cmss-2027-opps-proposed-rule-advances-340b-payment-reform-site-neutrality-and-program-integrity/.

decisions in the hands of government bureaucracies, insurers, and employers rather than employees or patients.[56] This system hides prices from patients.

To increase affordability, Congress must give workers and patients greater control over their health care dollars by expanding ICHRAs and HSAs. This would increase price transparency because, if patients have power over their health care financing, the market will respond by catering to their needs rather than the needs of insurance companies.

President Trump's continued focus on health care price transparency is also critical. Transparency rules are most useful when prices are accurate, standardized, accessible, and tied to specific services. Enforcement matters because sophisticated hospital systems and insurers have strong incentives to comply minimally if opacity preserves bargaining leverage. Employers and patients should be able to know what a service costs before it is purchased, compare prices across providers, and design benefits that reward high-value care.[57]

G. The Next Step Is a Broader Pro-Competition Hospital Agenda

Congress should build on these reforms. It should enact broad site-neutral payments, repeal the federal restrictions on physician-owned hospitals, encourage states to repeal certificate-of-need laws, reform 340B so discounts benefit patients rather than subsidize consolidation, and rationalize the numerous direct hospital subsidies so that assistance is targeted to genuine access needs. The strongest pro-competition agenda both enforces the antitrust laws and removes government policies that suppress entry and reward consolidation.[58]

H. Congress Should Adopt a Comprehensive Hospital Competition and Accountability Agenda

The Hospital Cost Crisis lays out a broader reform agenda that Congress and the administration should pursue. The goal should be to reverse policies that inflate hospital costs and prices, target subsidies to genuine needs, and reward efficiency rather than consolidation.

1. Congress should enact broad site-neutral payment reform in Medicare, and CMS should use its existing authority to advance site neutrality where it can. States should consider the same principle in Medicaid.
2. CMS should modernize rate-setting where better market information is available, including the growing body of Medicare Advantage price-transparency data. Administrative prices should not indefinitely embed historical cost structures and inefficiencies.
3. Congress should build on the OBBB's provider-tax and state-directed-payment reforms and prevent states from constructing workarounds that recreate the same financing schemes under new names.

[56] Theo Merkel and Brian Blase, "Follow the Money: How Tax Policy Shapes Health Care," Paragon Health Institute, May 2024, https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/.
[57] Hall and Kalisz, "Shining a Light Where It Hurts."
[58] Graham, "The Hospital Cost Crisis."

4. CMS should improve oversight of hospital supplemental payments, including disproportionate-share payments, so Congress can rationalize overlapping subsidy streams and direct support toward true safety-net institutions.
5. Congress should direct GAO to inventory the full range of federal hospital payments and recommend ways to simplify them and condition support on quality, efficiency, financial transparency, and genuine need.
6. Congress and the administration should reform 340B to ensure that the program benefits vulnerable patients and safety net providers rather than serving as an acquisition and revenue strategy for large health systems.
7. States should repeal certificate-of-need laws, and federal programs should continue to reward states that remove anticompetitive barriers.
8. Congress should repeal the ACA restrictions that effectively prevent new physician-owned hospitals from competing for Medicare patients.
9. Congress and the administration should strengthen oversight of tax-exempt hospitals and ultimately tie tax-exempt status to measurable charity care rather than broadly defined community benefit.
10. Hospital and insurer price-transparency rules should be vigorously enforced.
11. Medicare uncompensated-care payments should be better targeted to actual charity care and non-Medicare bad debt.
12. Graduate medical education funding should be restructured so that federal dollars support residents' education rather than simply supplementing hospital revenue.[59]

Together, these changes would move the hospital sector away from a system organized around maximizing government reimbursement and toward one organized around competing for patients on price, quality, and service.[60]

Conclusion

Fraud, high prices, and consolidation are not isolated defects in American health care. They are often consequences of the same underlying problem: government has created powerful incentives to maximize subsidies, reimbursement, enrollment, and market power while weakening incentives to verify eligibility, control costs, improve productivity, and compete for patients.

Our latest estimates indicate that 14.3 million people were improperly enrolled in the ACA exchanges or Medicaid expansion in 2024, costing the federal government approximately $65 billion. That scale of improper enrollment should cause policymakers to reconsider not only enforcement procedures but the subsidy and matching structures that make improper enrollment lucrative and place so little of the cost on the entities making enrollment decisions.

At the same time, the number one affordability threat is the hospital sector. Hospital prices have risen 281 percent since 2000, far faster than inflation, wages, or other medical services. Government policies have protected incumbent hospitals from competition, paid more when

[59] Graham, "The Hospital Cost Crisis."
[60] Graham, "The Hospital Cost Crisis."

hospitals acquire independent practices, restricted physician-owned competitors, and subsidized hospital overhead and inefficient cost structures. Medicaid financing arrangements have further directed enormous federal subsidies to hospitals and, in some cases, put upward pressure on commercial prices.

The OBBB and the Trump administration have begun to reverse these incentives. The Medicaid financing reforms, program-integrity provisions, price-transparency initiatives, and movement toward site-neutral and more rational outpatient payments are significant steps toward a system that rewards value rather than the ability to maximize government reimbursement. These reforms should be implemented vigorously and extended.

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