



ADDRESSING THE 2026 AFFORDABILITY CLIFF AND THE COSTS OF HEALTH CARE COMPLEXITY

**Statement of
Jason Levitis*
Senior Fellow, Urban Institute**

**before the
Senate Finance Committee,
United States Senate**

THE RISING COST OF HEALTH CARE: CONSIDERING MEANINGFUL SOLUTIONS FOR ALL AMERICANS

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* The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

Chairman Crapo, Ranking Member Wyden, and distinguished members of the Committee, thank you for the opportunity to testify about the cost of health care.

My name is Jason Levitis. I am a senior fellow at the Urban Institute, a nonprofit organization that conducts research to inform policy debates and improve people's lives. I am also a nonresident senior fellow at the Solomon Center for Health Law and Policy at Yale Law School. The views expressed here are my own and do not represent the Urban Institute or Yale Law School, their trustees, or their funders. I conduct research primarily on the intersections of health care and tax law and policy, as well as more broadly on the Affordable Care Act (ACA) and health insurance Marketplaces. I also provide extensive technical assistance to state health care officials. Before this work, I served at the US Treasury Department for eight years. I spent most of that time in the Office of Tax Policy, working on the tax system generally and then also leading the Department's ACA implementation work. This included drafting tax regulations, forms, and publications regarding the premium tax credit (PTC), the employer shared responsibility provision, the ACA's coverage reporting provisions, and various tax-preferred health spending arrangements like health savings accounts (HSAs), health flexible spending arrangements (FSAs), and health reimbursement arrangements (HRAs).

I greatly appreciate the opportunity to discuss health care affordability, which is a crucial issue for every American, and especially for this Committee.

Much of my focus these days is on how to simplify the health care system to reduce costs for American consumers, employers, and taxpayers. The system has grown too complicated and segmented, with multiple duplicative tax benefits, public programs, and regulatory regimes, each with a cathedral of complex rules. Chairman Crapo has been a leading voice for decades about the importance of tax simplification—for fairness, clarity, and reducing taxpayer burdens.¹ I submit that the complexity of the health care system has similar costs. The Congressional Research Service recently cataloged 24 *distinct tax-preferred health spending arrangements*, each with a different combination of qualifying expenses, contribution caps, eligibility rules, reimbursement processes, and other parameters.² This complexity is a bonanza for benefits consultants, tax lawyers, and financial intermediaries, but it creates confusion and compliance burdens for individual taxpayers, businesses, health care providers, and federal and state governments. As Michael Cannon of the Cato Institute recently highlighted, every new legal rule creates incentives for economic actors to skew their behavior to receive the most beneficial tax

¹ Senator Mike Crapo Press Office, "In Light of Supreme Court Refusal to End Double and Triple Taxation of Businesses, Crapo and Schumer Unveil Legislation to Provide Relief," June 28, 2007, <https://www.crapo.senate.gov/media/newsreleases/in-light-of-supreme-court-refusal-to-end-double-and-triple-taxation-of-businesses-crapo-and-schumer-unveil-legislation-to-provide-relief>; Senator Mike Crapo Press Office, "Americans Deserve A Fair and Competitive Tax Code," February 28, 2011, <https://www.crapo.senate.gov/media/columns/americans-deserve-a-fair-and-competitive-tax-code>; and Senator Mike Crapo Press Office, "Joint Delegation Column: Goodbye to Old Federal Tax System," April 23, 2018, https://www.crapo.senate.gov/media/columns/joint-delegation-column_goodbye-to-old-federal-tax-system.

² Jason Levitis, Claire O'Brien, and Rachael Totz, "The Pointless Proliferation of Tax-Preferred Health Spending Arrangements, Part 1: The Landscape," *Health Affairs Forefront*, May 1, 2025, <https://doi.org/10.1377/forefront.20250429.286011>; and Jason Levitis, Claire O'Brien, and Rachael Totz, "The Pointless Proliferation of Tax-Preferred Health Spending Arrangements, Part 2: Ideas for Reform," *Health Affairs Forefront*, May 2, 2025, <https://doi.org/10.1377/forefront.20250501.88221>.

treatment, burdening our economy overall.³ All these costs flow through to taxpayers in the form of higher health insurance premiums and federal subsidies. So, as we think about how to reduce health care costs, I'd love to partner with this committee on ways to simplify the health care system and the tax rules that play such a large role.

That said, my main focus today is something narrower and more immediate. Millions of Americans are about to see—indeed are already seeing—tremendous increases in health insurance premiums for 2026: people like Mr. Armitage sitting next to me here. That's because the enhanced PTCs—first enacted in the American Rescue Plan and then extended in the Inflation Reduction Act—are expiring at the end of 2025. I hope to make three points about these imminent premium increases:

- First, and I know you've heard this before, the premium increases will cause great harm to taxpayers, increasing their out-of-pocket costs, leaving millions uninsured, and disproportionately harming small businesses, entrepreneurs starting new companies, older people, and people in rural areas.
- Second, while the premium increases don't technically take effect until the end of the year, their harms are already being felt and will increase quickly. Given this reality, a clean extension of the enhanced PTCs appears to be the only way to quickly stem the damage.
- Finally, while the status quo is far from perfect, the ideas being discussed to alter the enhanced PTCs, or replace them with some sort of account, suffer from substantial flaws that would increase premiums, reduce coverage, and hurt people with pre-existing conditions.

Background

For years before the ACA passed, leaders across the ideological spectrum declared the growth of health care spending to be a crisis. Health expenditures as a share of GDP increased from 8.9 percent in 1980 to 13.3 percent in 2000 to 17.2 percent in 2009.⁴ Health insurance premiums were skyrocketing.⁵ Related to this was a narrower issue: people who didn't qualify for employer coverage, Medicare, or Medicaid generally had no affordable source of adequate coverage, especially if they had a pre-existing condition. Plans could discriminate and limit coverage in a whole range of ways. If you had a pre-existing condition, were a woman, or had certain jobs, they could increase your premiums, deny coverage for pre-existing conditions or maternity care, or deny you coverage altogether. If you enrolled and got sick during the year, they could cap your benefits, cancel your plan, or refuse to renew it. To add insult to injury, this "medical underwriting" required costly investigations of applicants' medical histories, which drove up premiums even for the healthy people who could enroll. Finally, people forced to rely on the individual market generally received no help paying for health insurance from the federal government,

³ Michael F. Cannon, "Don't Hate the Player, Hate the Income Tax for Wrecking Health Care," Cato Institute, July 18, 2025, <https://www.cato.org/blog/dont-hate-player-hate-income-tax-wrecking-health-care>.

⁴ Matthew McGough, Emma Wager, Aubrey Winger, Nirmita Panchal, and Lynne Cotter, "How Has U.S. Spending on Healthcare Changed over Time?," *Peterson-KFF Health System Tracker*, December 20, 2024. <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/>.

⁵ Jonathan Gruber, *Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act*, *The Commonwealth Fund* 11 (1750: June 2014).

while virtually every other American did through Medicare, Medicaid, or, for those with employer coverage, the tax exclusion.

The result was not pretty. In 2009, there were 45 million uninsured people.⁶ People faced financial hardship, inability to access needed health care, added sickness, and loss of income. Unpaid bills meant both crippling debt for consumers and financial burdens on health care providers. The problem was especially acute for self-employed people, who could not access the group insurance market. As a result, many people chose not to start companies or look for new roles because they needed the protections and tax benefits provided through employer-sponsored insurance.

The ACA took steps to address the broader crisis, and evidence shows it has had some effect,⁷ though more needs to be done. But on the narrow problem of the dysfunctional individual market, the ACA took two key steps:

First, it prohibited health insurance companies from some of the worst and most discriminatory practices that made the system unworkable for people with pre-existing conditions: coverage exclusions on pre-existing conditions, higher premiums or outright coverage denials for sick people, annual and lifetime limits, and cancelling policies when people get sick. This also had the nice side effect of reducing administrative costs, since investigating people's medical history is so expensive.

Second, it created the PTC to help make individual coverage affordable. In part, this was only fair, since the federal government helps pay for pretty much every other kind of health coverage. But it was also crucial for getting young, healthy people to enroll, which helped restrain premiums and the program's costs.

The PTC used a premium support model where consumers have a fixed amount to spend. This gives consumers an incentive to pick a cheaper plan to minimize their share, and insurers an incentive to compete on price. The new Marketplace helped consumers compare plans and shop around for the plan that was the best fit for them.

In other words, the PTC was designed to make individual health premiums affordable in three ways: by directly helping people pay their premiums, by ensuring that healthy people enroll to improve the risk pool, and by facilitating natural price competition among health insurers.

I will not say that everything has gone perfectly. Deductibles are still too high for many enrollees. And while many of the worst insurer abuses are gone, they continue to look for ways to deny coverage through prior authorization and other utilization management techniques.

But generally, the approach has worked. Between 2020 and 2025, Marketplace benchmark premiums grew by an average annual rate of just 2 percent⁸—slower than employer-sponsored

⁶ KFF, "Health Insurance Coverage of the Total Population," accessed November 17, 2025, <https://www.kff.org/state-health-policy-data/state-indicator/total-population/>.

⁷ McGough et al., "How Has U.S. Spending on Healthcare Changed over Time?."

⁸ KFF, "Marketplace Average Monthly Benchmark Premiums," accessed November 16, 2025, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/>.

insurance⁹ and inflation,¹⁰ both of which grew at around 5 percent annually. Individual market premiums are now comparable with those for group coverage, or even a bit lower.¹¹ The uninsured rate has trended downward, reaching a historical low of 8 percent in 2024.¹² Insurer competition is strong, with at least three insurers competing in markets serving 97 percent of enrollees in 2025.¹³ Public support for the ACA has doubled, from 33 percent in late 2013 to 64 percent today.¹⁴ More generally, while overall health care prices are still too high, the growth of health spending as a share of GDP finally slowed its relentless growth. After growing from 13.3 percent in 2000 to 17.2 percent in 2009, it has flattened out since then, sitting at 17.6 percent in 2023.¹⁵ More remains to be done, but the growth of spending has slowed since the ACA became law.¹⁶

That brings us to the current debate. Part of the recent success of the ACA is due to a change made in 2021. Until then, while the Marketplace was functioning and the uninsured rate falling, it was also widely recognized that the PTC didn't go far enough to make coverage affordable, for two reasons: it provided too little help for the lowest-income working families; and it left out everyone over 400 percent of the federal poverty level (FPL), or about \$63,000 for a single person in 2026, even though no such caps apply to the employer coverage exclusion.

In 2021, Congress passed legislation to address both issues, increasing the PTC for everyone who received it and extending it for the first time to somewhat higher incomes, while still having it phase out to zero as income goes up (figure 1).

⁹ KFF, "Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2025," October 22, 2025, <https://www.kff.org/health-costs/premiums-worker-contributions-among-workers-covered-by-employer-sponsored-coverage/>.

¹⁰ US Inflation Calculator, "Current US Inflation Rates: 2000-2025," accessed November 16, 2025, <https://www.usinflationcalculator.com/inflation/current-inflation-rates/>.

¹¹ Lynne Cotter, Matthew Rae, Matthew McGough, Shameek Rakshit, and Cynthia Cox, "How ACA Marketplace Costs Compare to Employer-Sponsored Health Insurance," KFF-Peterson Health System Tracker, November 3, 2025, <https://www.healthsystemtracker.org/brief/how-aca-marketplace-costs-compare-to-employer-sponsored-health-insurance/>.

¹² Lisa N. Bunch and Halelujha Ketema, *Health Insurance Coverage in the United States: 2024, Current Population Reports P60-288* (Washington, DC: US Census Bureau, 2025), <https://www.census.gov/library/publications/2025/demo/p60-288.html>.

¹³ Center for Consumer Information & Insurance Oversight (CCIIO), *Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.Gov Marketplaces*, (Baltimore: CMS, 2024).

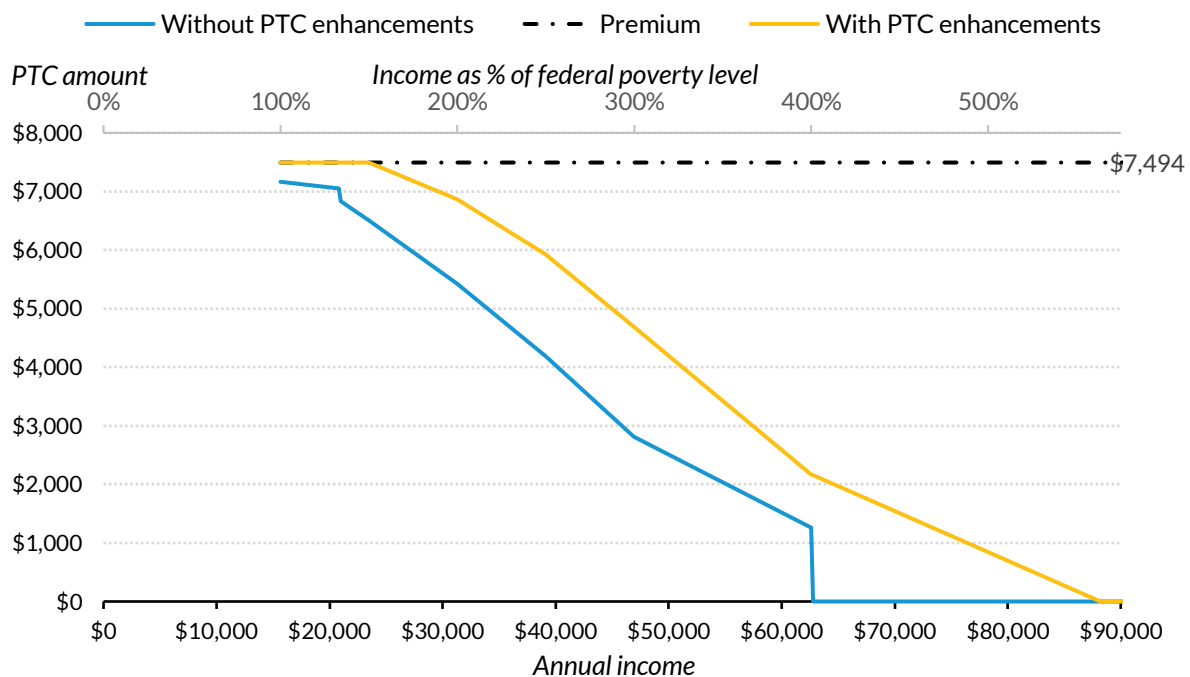
¹⁴ Ashley Kirzinger, Isabelle Valdes, Alex Montero, Alex Montero, and Mollyann Brodie, "5 Charts About Public Opinion on the Affordable Care Act," KFF, October 3, 2025, <https://www.kff.org/affordable-care-act/5-charts-about-public-opinion-on-the-affordable-care-act/>.

¹⁵ McGough et al., "How Has U.S. Spending on Healthcare Changed over Time?."

¹⁶ McGough et al., "How Has U.S. Spending on Healthcare Changed over Time?."

FIGURE 1

PTC Amount with and without Enhancements in Place for a 40-Year-Old in an Average-Premium Benchmark Plan, 2026



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Source: Authors' calculations using "Rev. Proc. 2024-35," IRS, 2024; "Rev. Proc. 2025-25," IRS, 2025; "Federal Poverty Level," Healthcare.gov, accessed November 16, 2025, <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/>; and premiums from "Calculator: ACA Enhanced Premium Tax Credit," KFF, November 16, 2024, <https://www.kff.org/interactive/calculator-aca-enhanced-premium-tax-credit/>.

Notes: PTC = premium tax credit. Income is for an individual tax-filer.

With these changes in effect, the ACA finally achieved its promise of making good health insurance—and the economic security that comes with it—affordable for virtually every American.

Congress extended the enhancements in the Inflation Reduction Act in 2022, but only through the end of 2025. The enhancements are now set to expire in little more than a month, and Congress must decide whether to extend them or let them lapse.

Imminent Reductions in the PTC Would Greatly Reduce Health Care Affordability and Coverage, with Harms Concentrated on Small Businesses, the Near-Elderly, and in Rural Areas

There is broad agreement that the upcoming PTC reductions will increase taxpayers' health insurance premiums and reduce coverage.

The Congressional Budget Office (CBO) estimates the reductions will mean 3.8 million fewer people with health insurance by 2036.¹⁷ My colleagues at the Urban Institute, who run a similar model, estimate a coverage loss of 4.8 million people in 2026. The number of PTC recipients would fall by 7.3 million people, out of the 19 million that receive it today, with reductions as large as 50 percent in some states. All income and age groups would see substantial coverage losses.¹⁸

The reason for these coverage losses is simple—people will face higher premiums to purchase coverage. Premiums will be higher for two key reasons. First, everyone who currently receives the PTC will either be eligible for less or completely ineligible. KFF estimates that average net premiums will more than double.¹⁹ Premium increases will affect every income level: my Urban colleagues found that, among those with subsidized Marketplace coverage, net premiums will be over four times as large for people with incomes below 250 percent of FPL (\$39,125 about for an individual), more than double for people with incomes from 250 to 400 percent of FPL (\$39,125 to \$62,600 for an individual), and nearly double for people with incomes above 400 percent of FPL (\$62,600 for an individual).²⁰

Second, when the net price of coverage increases, relatively healthy people will be most likely to go without coverage, since they expect to use fewer health care services (though, of course, they too could end up with health care costs that would bankrupt them without insurance).²¹ This hurts the risk pool, which increases premiums for people paying for coverage on their own or using an individual coverage health reimbursement arrangement and increases the average cost of the PTC. KFF estimates that gross premiums are increasing by 26 percent in 2026—this after growing by just 2 percent per year between 2020 and 2025 (figure 2).²² This huge increase reflects both the expected PTC reductions and other recent changes to deter healthy people from enrolling, including provisions of the One Big Beautiful Bill Act, the recent Marketplace Integrity and Affordability rule, and announced cuts to outreach and navigator funding, as well as developments like tariffs that increase the underlying cost of health care.²³ The precise portion attributable to expiration of the PTC enhancements is unclear. But it's

¹⁷ Phillip Swagel, “Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance,” CBO, September 18, 2025.

¹⁸ Matthew Buettgens, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin, “4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire,” (Washington, DC: Urban Institute, 2025), <https://www.urban.org/research/publication/48-million-people-will-lose-coverage-2026-if-enhanced-premium-tax-credits>.

¹⁹ Justin Lo, Larry Levitt, Jared Ortaliza, and Cynthia Cox, “ACA Marketplace Premium Payments Would More than Double on Average Next Year If Enhanced Premium Tax Credits Expire,” KFF, September 30, 2025, <https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/>.

²⁰ Buettgens et al., “4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire.”

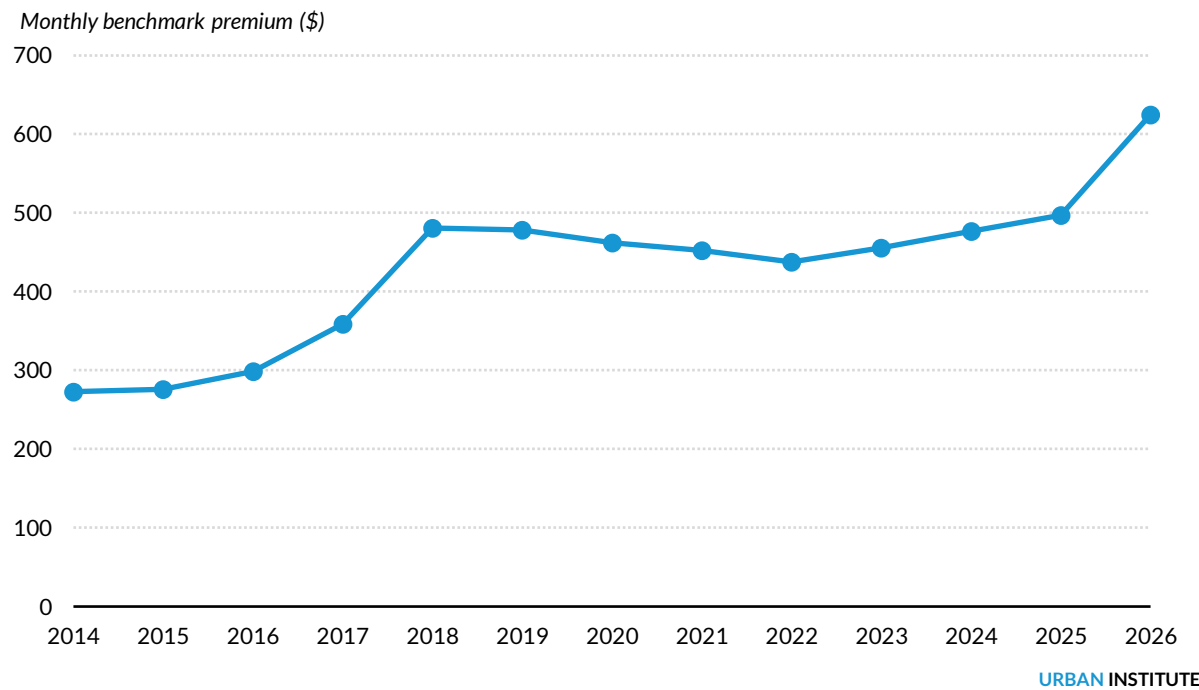
²¹ Jared Ortaliza, Matthew McGough, Kaitlyn Vu, et al. “How Much and Why ACA Marketplace Premiums Are Going up in 2026.” KFF-Peterson Health System Tracker, August 6, 2025, <https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/>.

²² Cynthia Cox, “ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay,” KFF, October 28, 2025, <https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/>; and KFF, “Marketplace Average Monthly Benchmark Premiums.”

²³ Ortaliza et al., “How Much and Why ACA Marketplace Premiums Are Going up in 2026.”

clear this combination of factors has upended a market that had been working to keep premiums in check.

FIGURE 2
Average Gross Monthly Benchmark Premium for a 40-Year-Old, 2014–26



Source: “Marketplace Average Monthly Benchmark Premiums,” KFF, November 16, 2024, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/>.

The reductions would also be especially harmful to certain groups of taxpayers. Because insurers generally charge higher gross premiums based on age, there are particularly large effects on older people (figure 1).²⁴ Half of enrollees who will lose PTC eligibility are over 50—people like Mr. Armitage.²⁵ For the same reason, people in high-premium areas of the country will be hit hard. This is disproportionately concentrated in rural areas, likely because they experience greater provider

²⁴ Jessica Banthin, Laura Skopec, and Michael Simpson, “Enhanced PTCs Help Older Adults and Those in High-Premium States Afford Coverage,” (Washington, DC: Urban Institute, 2024), <https://www.urban.org/research/publication/enhanced-ptcs-help-older-adults-and-those-high-premium-states-afford-coverage>.

²⁵ Justin Lo and Cynthia Cox. “Who Might Lose Eligibility for Affordable Care Act Marketplace Subsidies If Enhanced Tax Credits Are Not Extended?” KFF, March 3, 2025. <https://www.kff.org/affordable-care-act/who-might-lose-eligibility-for-affordable-care-act-marketplace-subsidies-if-enhanced-tax-credits-are-not-extended/>.

concentration and less provider competition.²⁶ The nation's highest premiums are in Alaska, Vermont, West Virginia, and Wyoming.²⁷

Small businesses are also disproportionately affected. Treasury Department data shows that 3.3 million self-employed workers and small business owners ages 21 to 64 enrolled in Marketplace coverage in 2022, including 285,000 with incomes above 400 percent of FPL (\$62,600 for an individual).²⁸ This represents 28 percent of total Marketplace enrollment for consumers ages 21 to 64 and 18 percent of all self-employed workers and small business owners; by comparison, the Marketplace covered just 6 percent of the rest of the population. This share is even higher in some states: in Florida, North Carolina, and Wyoming, at least a quarter of self-employed workers and small business owners enrolled in the Marketplace. With Marketplace enrollment growth since 2022, the Center on Budget and Policy Priorities estimates that the number of self-employed workers and small business owners enrolled in the Marketplace has increased from 3.3 million to 5 million, and the uninsured rate among them has hit a record low.²⁹

The reductions would also hit hard among the lowest-income PTC recipients. With the enhancements in place, enrollees earning up to 150 percent of FPL (about \$23,500 for an individual) generally don't have a premium contribution for a benchmark silver plan. After the reductions, someone earning \$23,000 would have to pay a premium of about \$1,000 per year (figure 3). That's a lot of money for someone trying to pay for housing, food, and everything else on such a small amount. An added challenge is that many lower-income people don't have a bank account to set up recurring payments. A Brookings analysis found that nearly 1 million people would drop Marketplace coverage if their premiums increased from \$0 to \$1.³⁰ These low-income individuals are also least likely to have other affordable coverage options, meaning most will end up uninsured.

²⁶ John Holahan, Erik Wengle, and Claire O'Brien, "ARPA's Enhanced Premium Subsidies Provide Particularly Large Benefits to Residents of Rural Areas," (Washington, DC: Urban Institute, 2022), <https://www.urban.org/research/publication/arpas-enhanced-premium-subsidies-provide-particularly-large-benefits-residents>.

²⁷ KFF, "Marketplace Average Monthly Benchmark Premiums."

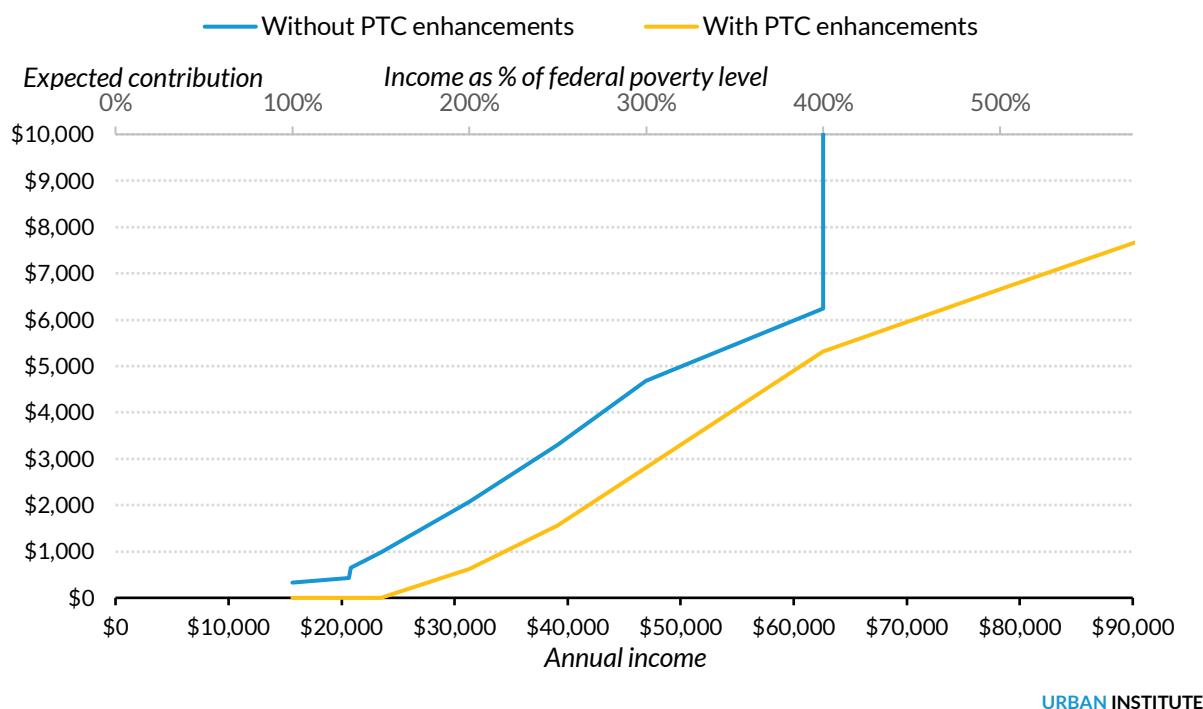
²⁸ USDT (US Department of the Treasury, Office of Tax Analysis), "Affordable Care Act Marketplace Coverage for the Self-Employed and Small Business Owners," (Washington, DC: USDT, 2024).

²⁹ Gideon Lukens, "5 Million Small Business Owners and Self-Employed Workers Likely Enrolled in ACA Marketplace in 2025," Center on Budget and Policy Priorities, June 12, 2025, <https://www.cbpp.org/research/health/5-million-small-business-owners-and-self-employed-workers-likely-enrolled-in-aca>.

³⁰ Matthew Fiedler, "How Would Eliminating \$0 Marketplace Premiums Affect Insurance Coverage?," (Washington, DC: Brookings, 2025), <https://www.brookings.edu/articles/how-would-eliminating-0-marketplace-premiums-affect-insurance-coverage/>.

FIGURE 3

Expected Contribution with PTC to Purchase Individual Benchmark Coverage, with and without the PTC Enhancements, 2026



Source: Authors' calculations using "Rev. Proc. 2024-35," IRS, 2024, "Rev. Proc. 2025-25," IRS, 2025; and "Federal Poverty Level," Healthcare.gov, accessed November 16, 2025, <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/>.
 Notes: PTC = premium tax credit. Income is for an individual tax filer.

It's also important to put this in the context of the other expected coverage losses. CBO estimates that the recent reconciliation bill will cut coverage by 10 million people.³¹ Combined with the PTC reductions, that means about 14 million people will lose coverage in the coming years.³² Urban estimates that this means a reduction in provider revenue of \$1.1 trillion between 2025 and 2034.³³ This could be devastating to the health care sector, causing a wave of hospital closures beyond those already underway.

Given all these harms, it is unsurprising that there's broad support to avoid these reductions across the political divide: Three-quarters of Americans support an extension, including half of Republicans

³¹ Phillip Swagel, "Re: Distributional Effects of Public Law 119-21," CBO, August 11, 2025.

³² Swagel, "Re: The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance."

³³ Frederic Blavin and Michael Simpson, "State-Level Estimates of Health Care Spending and Uncompensated Care Changes under the Reconciliation Bill and Expiration of Enhanced Subsidies," (Washington, DC: Urban Institute, 2025), <https://www.urban.org/research/publication/state-level-estimates-health-care-spending-and-uncompensated-care-changes>.

and three-quarters of independents.³⁴ There is also bipartisan support in Congress, including within this Committee.³⁵ The National Association of Insurance Commissioners (NAIC), which represents the insurance regulators in all 50 states, has repeatedly called for speedy extension.³⁶ Although some may be suspicious of insurers' motivations,³⁷ patient groups,³⁸ state Marketplaces,³⁹ and providers⁴⁰ are all broadly supportive as well.

Harms from PTC Reductions Are Already Being Felt and Will Increase Quickly; A Clean Extension of the Enhancements is Likely the Only Way to Quickly Stem the Damage in 2026

So, the question is what to do about it. The coming harms have long been clear.⁴¹ The NAIC first wrote to Congress about it in July 2024.⁴² State Marketplaces have written several letters on this issue, starting in March of this year.⁴³

Yet no action has been taken, even as Congress enacted a huge tax package that permanently extended numerous other tax provisions set to expire after 2025.

There is now talk of holding a vote by December 12.⁴⁴

In recent months, we've seen a raft of ideas advanced. Some call for replacing the enhancements—or ACA subsidies more generally—with some sort of health spending account or similar vehicle. Others call for extending the enhancements, but with changes or limitations.

³⁴ Audrey Kearney, Alex Montero, Mardet Mulugeta, Ashley Kirzinger, and Liz Hamel, "KFF Health Tracking Poll: Public Weighs in on Health Care Debate and Government Shutdown," KFF, November 6, 2025, <https://www.kff.org/public-opinion/kff-health-tracking-poll-public-weighs-in-on-health-care-debate-and-government-shutdown/>.

³⁵ Paige Masten, "Is Tillis the Only NC Republican Who Sees the Pain Expiring ACA Subsidies Will Bring?," *The Charlotte Observer*, November 10, 2025, <https://www.charlotteobserver.com/opinion/article312826785.html>.

³⁶ "State Insurance Regulators Urge Extension of Enhanced Premium Tax Credits to Protect Millions of Consumers," NAIC, September 5, 2025, <https://content.naic.org/article/state-insurance-regulators-urge-extension-enhanced-premium-tax-credits-protect-millions-consumers>.

³⁷ "Don't Let Health Care Tax Credits Expire: What's at Stake for Millions," AHIP, July 24, 2025, <https://www.ahip.org/news/articles/dont-let-health-care-tax-credits-expire-whats-at-stake-for-millions>.

³⁸ Kevin L. Hagen, "Letter of Support for Bipartisan Premium Tax Credit Extension," PAN Foundation, September 22, 2025.

³⁹ "State-Based Marketplace (SBM) Directors Support Continued Tax Credit Enhancements, State Marketplace Network, September 23, 2024, <https://statemarketplacenetwork.org/state-based-marketplace-sbm-directors-support-continued-tax-credit-enhancements/>.

⁴⁰ American Medical Association, "Letter of Support for Premium Tax Credit Extension - Physician Organizations," September 15, 2025.

⁴¹ Jason Levitis, Sabrina Corlette, and Claire O'Brien, "Damage from Inaction on ACA Tax Credits Has Begun and Will Grow with Further Delays," *Health Affairs Forefront*, October 8, 2025, <https://doi.org/10.1377/forefront.20251007.680448>.

⁴² Levitis, Corlette, and O'Brien, "Damage from Inaction on ACA Tax Credits Has Begun and Will Grow with Further Delays."

⁴³ State Marketplace Network, "Letter on Premium Tax Credits," March 14, 2025.

⁴⁴ Caitlyn Kim, "Government Shutdown Ends after House Passes Spending Package, Trump Signs It," *CPR News*, November 12, 2025, <https://www.cpr.org/2025/11/12/government-shutdown-ends/>.

It is certainly worth considering options. American families face too much complexity and excessive out-of-pocket costs.

Unfortunately, the calendar has left little time to successfully implement broader structural changes to PTC going into 2026. That's because the damage from the reductions discussed above has already begun and will grow with each additional day the extension is delayed.⁴⁵

This may be unintuitive. Some have argued there's still plenty of time to negotiate another solution. This may stem from experience with other tax provisions, where expiring tax cuts are sometimes extended after they have technically ended but before tax returns are due for the year. But this timing does not work for the PTC. That's because people are deciding right now whether to purchase coverage for next year. If they do not enroll, they are ineligible for the PTC—even if the enhancements are later extended. The deadline to enroll for January 1 coverage is December 15—less than four weeks from today and less than three days from the proposed vote. Already, millions of enrollees have received notices informing them that their premiums are skyrocketing, or they have learned it by going into the Marketplace to shop. More are learning it every day. And, per the consensus described above, many of those learning of higher premiums—especially young and healthy people—will drop coverage, choose not to enroll, and/or cancel their automatic re-enrollment.

Others, especially those with pre-existing conditions, will have made painful choices to re-enroll with the much-higher premiums. To do this, they'll have cashed out their retirement funds or forgone their dream to start a small business, go to school, or buy a house.

All will have dealt with the stress and fear of this affordability shock, of worrying they cannot afford coverage or their much-needed knee replacement or cancer treatment.

With open enrollment now in full swing, all these harms are growing every day.

This is not to say it is “too late” to help people by extending the enhancements. If the tax credits are restored, this will be big news, and some people will come back and enroll. But many others won't hear, or won't have time to come back in. Or they'll have lost trust in the system. In its score of the American Rescue Plan—which passed in March 2021 and made the enhancements effective for 2021 and 2022—CBO projected that the bill would increase Marketplace coverage in 2022 by 1.7 million, but would increase coverage in 2021 to “a much more limited extent... because the enhanced subsidy structure would take effect midway through the plan year.”⁴⁶ In short, many of these coverage losses won't be reversed.

So, what's the fastest way to stop this pain from spreading further and start reversing it? The answer is clear: a clean extension of the existing enhancements.

This is in part because none of the ideas discussed to replace or alter the enhancements are fully baked. As discussed in detail below, some are not workable as described, many are vague and lack

⁴⁵ Levitis, Corlette, and O'Brien, “Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays.”

⁴⁶ CBO, “Reconciliation Recommendations of the House Committee on Ways and Means,” 2021, <https://www.cbo.gov/publication/57005>.

sufficient detail to assess their ramifications, most would harm people with pre-existing conditions, virtually all would lead to coverage losses in their current form, and every one would be controversial. Even for the world's greatest deliberative body, hammering out the details of an agreement and building the coalition to pass it through both chambers, all in just a few weeks, is a heavy lift. This is exactly the type of complex work that the Finance Committee is well-suited to, considering the views of state governments, key stakeholders, consumers, and others. But such work takes time.

Even if a proposal could be finalized and passed through Congress very quickly, it would take months or years to implement. When the enhancements first passed in March of 2021, many Marketplaces took months to modify their systems. The good news is that the Marketplaces have built the enhancements into their current systems, and they've been preparing for months for the possibility of an extension.⁴⁷ My understanding is that many Marketplaces could update their systems for a clean extension within a few weeks. They have a head start on the notices, call center scripts, navigator trainings, and other materials.

But implementing something different would likely take months or years longer. Many changes would require notice-and-comment rulemaking from the Treasury Department and/or the Centers for Medicare & Medicaid Services. Changes to state law or insurance regulation could then be needed. Once these new rules were in place, Marketplaces would need new IT builds, new contracts, new testing, new training, and new educational materials for consumers. Changing the PTC architecture could take months. Building a whole new benefit—such as funneling federal funds into an HSA or another type of account—could easily take years, likely requiring the involvement of fiscal intermediaries. Such changes would also be costly for Marketplaces, taxing budgets that are already strained by lower enrollment, and potentially requiring higher user fees, further increasing premiums.

I was working on the ACA at the Treasury Department in those painful months in late 2013 and 2014 when the Marketplaces, having been rushed into service, initially failed to function. That lesson should be heeded today: building a new policy takes time and, if rushed, risks operational failure.

Prominent Ideas for Modifying the Enhancements or Replacing Them with Some Sort of Account Would Raise Premiums, Reduce Coverage, and Hurt People with Pre-Existing Conditions

Again, the health care system is far from perfect, and I agree it is worth exploring a range of reform options to control costs, make coverage more affordable, and improve the consumer experience. Unfortunately, reform options being discussed in recent weeks suffer from serious flaws: some are grounded in clear falsehoods, many are not workable at all, and virtually all would increase premiums, reduce coverage, and/or harm people with pre-existing conditions.

⁴⁷ Robert King, "Congress' Obamacare Subsidy Vote Could Set off State Scramble," *POLITICO*, November 16, 2025, <https://www.politico.com/news/2025/11/16/states-prep-for-daunting-task-of-implementing-a-health-subsidy-extension-if-it-comes-00653131>.

Two categories of alternative proposals are generally being discussed: modifying the current parameters of the enhancements or the underlying PTC, or replacing the enhancements (or other current subsidies) with some sort of account.

Proposals to Modify the Enhancements' or PTC's Parameters

The PTC is one of the most complicated tax provisions individuals must contend with. Simplifying it to improve and clarify the consumer experience and improve efficiency is a worthwhile goal.

However, reforming the PTC will require a clear understanding of how it works. Unfortunately, several proposals for changing the enhancements and the PTC itself are grounded in falsehoods. For example, undocumented immigrants have never been eligible for PTCs or even to enroll through the Marketplace.⁴⁸ The ACA already follows Hyde Amendment rules in prohibiting federal spending—including PTC spending—on abortion coverage.⁴⁹

Some have claimed that the enhanced PTC has no income cap and is “available to everyone... even millionaires.”⁵⁰ But as seen in figure 1 above, the enhanced PTC is income-limited—it just phases out gradually rather than dropping off suddenly like the reduced PTC.

Another inaccurate claim is that providing zero-premium coverage has led to millions of people receiving PTC fraudulently, and therefore, that people close to poverty need to be charged more, on top of the deductibles and copays they already owe.⁵¹ There is fraud in every public program, and it must never be tolerated.⁵² But the claims of widespread PTC fraud are not credible. Indeed, a federal court recently struck down CMS regulations to restrict Marketplace coverage, which the agency attempted to justify using the estimates based on the same methodology, finding that the analysis was of “questionable validity and limited relevance,” and that CMS hadn’t even tried to defend it.⁵³ That said, there is clear evidence that, in 2024, rogue brokers improperly enrolled or switched the enrollment of a few hundred thousand people without their permission. CMS responded with several measures to crack down on this fraud, including unwinding the enrollments to ensure these consumers were held

⁴⁸ “Can Immigrants Get Help Paying Premiums and/or Cost-Sharing for Health Insurance in the Marketplaces?” KFF, September 29, 2025, <https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/immigrants/can-immigrants-get-help-paying-premiums-and-or-cost-sharing-for-health-insurance-in-the-marketplaces/>.

⁴⁹ Laurie Sobel, Alina Salganicoff, and Rolonda Donelson, “Deja Vu: The Future of Abortion Coverage in ACA Marketplace Plans,” KFF, September 26, 2025, <https://www.kff.org/womens-health-policy/deja-vu-the-future-of-abortion-coverage-in-aca-marketplace-plans/>.

⁵⁰ Dean Clancy, “The Pandemic Is over—Let Biden’s Health Insurance Handouts Expire,” *The Hill*, September 18, 2025, <https://thehill.com/opinion/healthcare/5509018-biden-tax-credits-expire/>.

⁵¹ Niklas Kleinworth, Liam Sigurd, 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/>; and “Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability: A Rule by the Health and Human Services Department,” *Federal Register*, June 25, 2025, <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>.

⁵² U.S. Government Accountability Office, “Fraud & Improper Payments,” March 11, 2025, <https://www.gao.gov/fraud-improper-payments>.

⁵³ *City of Columbus et al. v. Kennedy et al.*, Order on Motion for Preliminary Injunction, August 22, 2025.

harmless, tightening controls on data sharing and plan switching, and suspending 850 brokers implicated in the abuses.⁵⁴ More could be done by the administration and Congress to crack down on these rogue brokers, including by increasing penalties, expanding enforcement powers, and increasing cooperation with state insurance regulators. But neither Congress nor CMS has pursued these measures, and indeed CMS reinstated many brokers earlier this year.⁵⁵ Regardless, it's troubling to reason that broker fraud requires taking coverage from or undermining affordability for consumers—who in fact are the victims here.

Other reforms have also been discussed to reduce PTC amounts, narrow eligibility, or make it harder to enroll.⁵⁶ These proposals share a common theme: making coverage less affordable for those who need it, resulting in coverage losses. Because people with pre-existing conditions are generally willing to pay more or jump through more hoops for the same coverage, any of these options would increase premiums in the Marketplace.

Ideas for Replacing the Enhancements with an HSA or Other Type of Account

It is difficult to analyze the ideas for replacing the enhancements—or the PTC generally—with some form of health spending account, as their effects would depend heavily on the details of the proposal, none of which are currently available. But to the extent we understand what they would do, they appear to be unworkable, or at least to drive premiums higher, hurt people with pre-existing conditions, and do nothing to restore coverage for people like my co-witness, Mr. Armitage.

As an initial matter, it's worth noting that we should be skeptical of efforts to create additional tax-preferred health spending arrangements without first streamlining the ones we have. As noted earlier, we have now accumulated 24 separate varieties—a proliferation that only a third-party administrator or benefit consultant could love. All these options would add more middlemen to a system already rife with middlemen. As discussed earlier, all the options would require complex policy development and then months or years of implementation.

But setting that aside, let's consider the potential options. They seem to fall into three buckets:

1. Some or all the money could be put in an account that can be used to pay for health services, even if the consumer lacks health insurance, sort of like an FSA.
2. Some or all the money could be put into an account that pays for health services but can only be used with insurance, like an HSA.

⁵⁴ "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," CMS, October 17, 2024, <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>.

⁵⁵ Kaye Pestaina, Rayna Wallace, Michelle Long, Meghan Salaga, and Emma Lee, "Fraud in Marketplace Enrollment and Eligibility: Five Things to Know," KFF, June 30, 2025, <https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/>.

⁵⁶ Benjamin Guggenheim, "Four GOP Ideas for an Obamacare Subsidies Compromise," *POLITICO*, October 13, 2025, <https://subscriber.politicopro.com/article/2025/10/republicans-democrats-shutdown-obamacare-subsidies-00606480>; and Meredith Lee Hill, "Obamacare 'Auto-Enrollees' Are Key Target as Republicans Formulate Tax-Credit Extension Plan," *POLITICO*, October 23, 2025, <https://www.politico.com/live-updates/2025/10/23/congress/brett-guthrie-obamacare-auto-enrollees-00620622>.

3. Some or all the money could be put into an account that could be used to pay for health insurance, or directly for health care services—sort of like an old-fashioned HRA.

Some of these possibilities were addressed by my co-witness, Douglas Holtz-Eakin, in a recent post.⁵⁷

The first option, he notes, would simply deny people health insurance, leaving them to self-insure with a few thousand dollars to spend:

“[T]he money could be put in a FSA to cover the direct purchase of medical care. That solves the BIG, BAD Insurance Companies problem by essentially forcing everyone to self-insure and leaving them exposed to financial ruin from an expensive episode of acute care.”

This same logic seems to apply to the second option, but it’s even worse, because consumers could use the accounts only if they had health insurance, and they would be denied the subsidies they need to buy it. This would apparently leave them without either insurance or the use of the account.

The third option, he writes, would lead to an adverse selection death spiral that would likely destroy the market, at least if applied to PTC spending:

“Let’s...imagine that all the subsidies being sent to insurers to cover ACA policyholders is, instead, sent in cash to the policyholders. Those policyholders with the greatest health needs will likely combine the government check with their own premium contribution and buy the same insurance. But some policyholders will not, especially if their health is good and they weren’t paying anything out of pocket to begin with.

Enrollment would drop, but especially so among the healthy. This is classic adverse selection; the remaining pool will be sicker and the premiums would have to rise. This would tend to drive out the remaining relatively healthy and the spiral would continue. At some point in the process, insurers would leave the ACA market. Eventually there would be some sort of residual high-risk pool serviced at high cost by a few insurers.

So, giving people cash will not work.”

A more limited version of this option—converting only the funding for the enhancements into an account—would have results that are less catastrophic, but still quite bad. Again, sicker people would use the funds to buy insurance, while healthy people would use the funds to self-insure, resulting in classic adverse selection and higher premiums. This would increase costs to the federal government and anyone seeking to purchase on their own. Any of those newly uninsured people would be at risk of incurring thousands of dollars in out-of-pocket costs if they have even modest health care needs in 2026.

Based on this speculative journey, none of these options seems attractive. Any diversion of the enhanced PTC into a tax-advantaged savings account still results in over 20 million Americans’ premiums more than doubling on average, and nearly 4 million people losing coverage. If funds in a tax-

⁵⁷ Douglas Holtz-Eakin, “TrumpCare,” American Action Forum, *The Daily Dish*, November 12, 2025, <https://www.americanactionforum.org/daily-dish/trumpcare/>.

advantaged account could be used on premiums, all the proposal will have accomplished is adding administrative hurdles for working people. Nor do any of these options address the underlying concern about rising health care costs for consumers, employers, and the government.

To be fair, none of these options has been explained in any detail. As we approach the challenges of making coverage more affordable, it is important to keep an open mind and consider a wide range of options. But one thing is clear—none of these options is viable as a fix for 2026.

Conclusion

Making health care affordable for all Americans has been an abiding policy goal of the modern era. Americans need health insurance to shield them from financial ruin, but insurance is complex and comes with incentives to deny needed care. We have finally seen some slowing of the growth of health care spending and health insurance premiums, yet prices remain too high. Public programs and tax benefits can help people pay for health care, but their complexity adds costs and siphons off funds to consultants and middlemen. The ACA has prohibited some of the worst insurance company practices, but much more remains to be done. The Senate Finance Committee is well-suited to undertake a rigorous process to identify bipartisan reforms for the future that address costs and complexity. But these efforts will take months or years and thus cannot address the immediate crisis: Marketplace enrollees seeing their premiums more than double in 2026 because of enhanced PTCs expiring. For Mr. Armitage and millions more like him, the only help that can come in time is to extend the enhanced PTCs in their current form.