

The Rising Cost of Health Care:
Considering Meaningful Solutions for all Americans

Testimony by:
Douglas Holtz-Eakin, President
American Action Forum*

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Chairman Crapo, Ranking Member Wyden and members of the committee, thank you for the privilege of appearing today. In what follows, I wish to make to make three main points:

- The Affordable Care Act was, and remains, a flawed policy that affects health insurance, the labor market, and economic growth;
- In the immediate term, there are limited options to rework the premium tax credits, although these improvements would be a welcome change; and
- Over the longer term, broad reforms will be needed to achieve the goals of higher-value care and affordable insurance.

Let me discuss each in turn.

Problems With the Affordable Care Act

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) has been a problematic policy program since its inception. Even at the time it was debated, the primary policy challenge facing the United States was the unsustainable growth of federal debt – the source of which was, and remains, spending commitments that rise above any reasonable metric of taxation for the indefinite future.

The fiscal future outlined at the time of the ACA's enactment was a direct impediment to job creation and growth. The best way to eliminate deficits is to keep taxes low and reduce public-employee costs and transfer payments. But the ACA moved in precisely the wrong direction. It contained trillions of dollars of new transfer spending, combined with hundreds of billions of dollars in new taxes. It was the wrong economic policy at a pivotal moment.

Employer Mandate and Tax Impacts on Jobs and Growth

A goal of U.S. economic policy should be to maximize the pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. It will generate the resources needed to meet our obligation to provide a standard of living for the next generation that exceeds the one this generation inherited.

Yet key provisions of the ACA – mandate costs, administrative burdens, and new taxes – remain inconsistent with strong, pro-growth policies. Among the key aspects of the ACA is its mandate to cover employees with health insurance. Larger employers, those with more than 50 workers, are faced with employer shared responsibility provisions – so-called “pay or play” – which, beginning in 2014, required them to pay a penalty if any of their full-time workers receive subsidies for coverage through the ACA exchange. The penalty for 2025 is equal to the lesser of \$4,350 for each full-time worker receiving a premium credit, or \$2,900 for each full-time worker, excluding the first 30 full-time workers. The fees are

calculated on a monthly basis. Firms with fewer than 50 employees are exempt from the “play or pay” penalties if they do not offer coverage and their workers receive a subsidy to purchase insurance on the exchange.

As employers sought to avoid penalties, the plans they offered became more generous and more expensive. From the perspective of economic performance, the best-case scenario was that the firm was already offering adequate insurance coverage, with no employee receiving subsidies and triggering penalties, and thus costs were unaffected. In every other instance, renegotiating health insurance coverage created competition with hiring and growth for the scarce resources of those firms.

Tax Increases

The ACA, as passed, was projected to raise more than \$700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions. Many of these taxes have not survived to the present, however – evidence of their poor design and interference with the economy.

There are two Medicare taxes in the ACA. Section 9015 increased the Medicare hospital insurance (HI) tax by 0.9-percentage points on wages in excess of \$200,000 (\$250,000 for couples filing jointly, \$125,000 for married individuals filing separately). The tax also applies to self-employed earnings.

Sec. 1402 of the Health Care and Education Reconciliation Act of 2010 (HCERA) – the follow-on law that made technical corrections to the ACA (among other things) – imposed a 3.8-percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is \$250,000 for joint returns, \$125,000 for married filing separately, or \$200,000 for any other case.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars financed the expansion of the new insurance subsidy entitlement program – the premium tax credits. The second is that these taxes fell predominately on business income and distorted the decisions of these pass-thru entities.

A final tax impact of the ACA is that the impact of the professed refundable credits may have even more perverse growth consequences. As noted in [Brill and Holtz-Eakin](#), the phase-outs in insurance subsidies contribute to high effective marginal tax rates. The effect is to raise to as high as 41 percent the effective marginal tax rate on some lower-income U.S. workers. As evidenced by the discussion that we are having today, there was little to no intention of letting these end. Of the 24.3 million Americans that selected an ACA plan in 2015, 22.4 million qualify for premium tax credits. Thus, the impending effective tax rate

has made it necessary to reform them to avoid a tax increase on those purchasing ACA plans.

ACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of the ACA could not be more different. The law has raised – and continues to raise – national health care spending. The rising bill for national health care spending has, in turn produced sustained upward pressures on health insurance premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. In short, all insurers – *for profit* and *non-profit* alike – will seek to restructure as necessary in an attempt to ensure profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. There are, however, sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is to customers – i.e., families and small businesses. First, if an aggregate fee on the industry were recognized as any sort of tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts and underestimate net budget costs.

The second implication is that the remainder of such a tax is passed on to consumers. If market conditions make it impossible for insurers to absorb the economic burden of any tax (explicit or implicit), they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back cash wage increases and taxable compensation. The health insurance fee will likely quickly and almost completely be incorporated, resulting in higher insurance premiums.

ACA and Employer-sponsored Insurance

The basic design of the ACA is an impediment to employer coverage. At the time of passage, about 163 million workers and their families received health insurance coverage from their employers. As of 2023, that number was estimated to be 178 million covered lives. Proponents of the ACA insisted that one of its key tenets was to build on the system of

employer-sponsored insurance (ESI) coverage. The ACA failed to achieve this purported aim; instead, it continued to provide market-distorting support to marketplace plans.

In the ACA's first 10 years, roughly one-half its \$900 billion in spending was devoted to subsidies for individuals who did not receive health insurance from their employers. These subsidies were remarkably generous, even for those with relatively high incomes. For example, in 2014 a family earning about \$59,000 a year would receive a premium subsidy of about \$7,200; a family making \$71,000 would receive about \$5,200; and even a family earning about \$95,000 would receive a subsidy of almost \$3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies grew substantially: a family earning about \$64,000 would receive a subsidy of over \$10,000; a family earning \$77,000 would receive a subsidy of \$7,800; and a family earning \$102,000 would receive a subsidy of almost \$5,000.

The total federal spending on these subsidies has risen drastically. In 2014, the gross cost of these subsidies was \$18 billion. In 2025, these costs are estimated to reach \$138 billion. If these subsidies continue to be provided at the same rate, modeling estimates that next year's subsidies could total over \$150 billion.

An obvious question is how employers have reacted to the continued presence of an alternative, highly subsidized source of insurance for their workers. Although the number covered through ESI has trended upwards since 2014, the ongoing reorientation of the labor market (through trade disruptions, artificial intelligence, etc.) may result in employers determining that they are better off reducing costs by dropping coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the \$2,900 penalty (per employee) imposed by the ACA on employers whose employees move to subsidized exchange coverage. Consider a policy with the average premium (\$9,325) in 2025. The average covered worker contributes 16 percent of the premium and the employer bears the other 84 percent or \$7,833. A simple comparison of \$7,833 in savings versus a \$2,900 penalty would seemingly suggest large-scale incentives to drop insurance.

The economics of the compensation decision are more nuanced than this simple calculation, however. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee “happy” – appropriately compensated and insured – *and* save money.

As Table 1 outlines, the answer at the time was frequently “yes” – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the federal poverty level (FPL) or \$31,521 in 2014. I projected that this worker will be in the 15 percent federal tax bracket, which means that \$100 of wages (which yields \$85) is needed to offset the loss of \$85 of

employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth \$15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of \$11,941 is the equivalent of a wage increase of \$14,048 to the worker.

Did the economics of ACA ever suggest that employers could drop their insurance offer? Yes. The employee would receive \$14,176 in subsidies – *more than the value of the lost health insurance*. On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – \$11,941 less the penalty. Obviously, there is room for the employer to improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminate employer-sponsored insurance.

The remaining rows of Table 1 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless (\$4,936) and the firm's cash-flow benefit from dropping coverage (\$9,941) has narrowed, but the bottom-line decision in the final column is the same. Indeed, the incentives are quite powerful, up to 250 percent of FPL, or \$59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.

At the time of passage, there was legitimate concern over the loss of ESI. There were 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans worked and about 60 percent of those received employer-sponsored insurance. That math suggested that there were about 43 million workers for whom it made sense to drop insurance.

As fate would have it, the failure of healthcare.gov and the botched rollout of the ACA put a stigma on switching to the ACA and reduced the projected immediate dropping of insurance. The incentives reflected in the table have remained embedded in the ACA, and since its inception have been a headwind to the growth of ESI.

This is a real issue, as ESI not only provides health insurance, it also promotes work. As a general matter, policies should support work and the ACA is in contradiction to this objective.

Table 1 Health Care Reform and Employer-sponsored Insurance in 2014 (Employer Health Plan = \$11,941)							
Percent of Federal Poverty Level	Income ¹	Tax Bracket ²	Wage Equivalent of Employer Health	Federal Subsidies ⁴	Required Pay Raise ⁵	Employer Free Cash Flow ⁶	Employer Drop Decision ⁷
133%	\$31,521	15%	\$14,048	\$14,176	(\$128)	\$9,941	Drop

150%	\$35,550	15%	\$14,048	\$13,385	\$663	\$9,941	Drop
200%	\$47,400	25%	\$15,921	\$10,985	\$4,936	\$9,941	Drop
250%	\$59,250	25%	\$15,921	\$7,530	\$8,391	\$9,941	Drop
300%	\$71,100	25%	\$15,921	\$5,187	\$10,734	\$9,941	Keep
400%	\$94,800	28%	\$16,585	\$2,935	\$13,650	\$9,941	Keep
1. Income calculated based on 2009 FPL for a family of four of \$22,050 (HHS), indexed to CPI projections (CBO) 2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO) 3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 (\$11,941), and divided by (1-Tax Rate) 4. Estimated federal insurance subsidy 5. Wage equivalent minus subsidies 6. Value of insurance plan minus \$2,000 penalty 7. Drop if required pay raise is greater than free cash flow							

Potential Reforms to the ACA Premium Tax Credits

In the near term, options are quite limited. Given that policy design, premium decisions, and policy selection are already underway, there is little that Congress can do for plan year 2026. The first possibility is simply to send funds to each ACA beneficiary to offset an appropriate part of the cost of premiums and cost-sharing. This has a number of drawbacks, with the obvious being that there is no way to ensure taxpayer funds are used for health purposes. Much like the stimulus checks sent throughout the pandemic, the sharp increase in money supply could result in a surge of inflation through consumers' increased spending power.

A second possibility is to provide the additional subsidy in the form of cost-sharing reductions (CSRs) in the ACA. This has precedent, but has the drawback that it cannot be provided to those ACA purchasers that elected zero-dollar premium Silver plans, since there is no cost to share.

A third possibility is to deliver the subsidy as a contribution to the Health Savings Accounts (HSAs) of those beneficiaries that have HSA-eligible policies. Since not all policies are eligible for HSAs, this is very narrowly targeted and would not help the majority of ACA policyholders.

Of course, the possibilities are not mutually exclusive and could be combined to achieve the desired level and mix of subsidies.

In plan year 2027 and beyond, reforms can both target subsidies and affect the purchase decisions of beneficiaries and pricing by insurers. Broadly, the subsidies may be channeled through CSRs, HSAs, Flexible Spending Accounts (FSAs), and enhanced medical deductions to achieve financial relief and policy objectives. (See Addendum 1 for a brief summary of health-related, tax-preferred accounts.)

Comprehensive Reforms in the Long term

Over the longer term, it is imperative that federal health policy supports higher-value care – better outcomes at reasonable cost – and affordable insurance.

Principles for Comprehensive Health Care Reforms.

In my experience, health policy is too often divorced from the principles that broadly guide economic policy making. This is a mistake.

Principle 1: The delivery of health care is an economic activity; health care policy should be good economic policy. It should be built on a small, contained government; light touch regulation; low and efficient taxation; and stable, predictable policies.

Principle 2: High prices are a supply problem and cannot be solved by more government subsidies to demand. As it relates to the topic of this hearing, the enhanced ACA subsidies are a classic case of making a high-price problem worse by subsidizing demand.

Principle 3: Reforms should focus on outputs – quality outcomes and high-value – and permit the health sector to flexibly pursue these goals. The basic ingredients will be capitated payments (a preset payment per patient) and a rigorous quality metric. Failure to hit the metric should mean loss of the payment.

Fixing Federal Insurance Subsidies. (This section draws on my contribution to the [Grand Bargain](#) project.) Taxpayers subsidize nearly every health insurance policy in the United States. For example, Medicare, Medicaid, and the ACA receive direct subsidies and ESI is exempt from taxation. (See the [Congressional Budget Office](#).) Excessive subsidies incentivize the overuse of health care. The level and distribution of subsidies across types of insurance and households is an arbitrary accident of history, leading to unfairness and inefficiency. A goal for reform would be to rationalize subsidies to make the insurance system more efficient and less unfair.

Employer-sponsored insurance is subsidized by non-taxation of this form of employee compensation. The subsidy is open-ended and regressive, getting larger with the employee's income tax rate. ACA individual-market policies – the subject of this hearing – are subsidized in a progressive fashion. These subsidies compete with ESI subsidies for many of the same individuals in an inefficient and unfair manner. Medicaid is a sharply progressive subsidy but varies across states and is available only to those of very limited means.

The existence of this array of subsidies supports the notion that Americans have decided that health insurance should be subsidized. To the extent possible, the existing system of subsidies should be reformed to deliver the same federal subsidy to a family of a certain size and income, regardless of the source of their insurance. For example, the ESI subsidy could be changed from an exclusion to a tax credit, and the credit amounts set to reflect the same schedule as in the ACA individual markets. Similarly, one could choose a level (e.g.,

133 percent of the federal poverty level) below which insurance is entirely subsidized – whether it be Medicaid or any other source.

A side benefit of this process is that it would generate a debate that would force a consensus decision on the “right” level of subsidy from an overall budget perspective and health policy objective. For example, at present the standard, non-enhanced ACA subsidies phase out at 400 percent of the federal poverty level. Matching this policy in the employer setting immediately raises the question of how large the subsidy should be and how broad the population of recipients is.

Providing Incentives for High-Value Care. The most pressing policy problem facing the federal government is the unsustainable fiscal trajectory. Medicare is a central feature of this outlook, and delivers low-value care in the process. A goal of reform is to place an overall budget constraint on Medicare, improve incentives to control costs, and provide a subsidy to Medicare coverage consistent with the discussion above. When combined with appropriate quality metrics, the outcome will be higher-value Medicare practices. Since Medicare practice patterns contribute significantly to the patterns of care delivery in the United States, this will contribute to a more efficient delivery system overall.

The starting point is to put Medicare on a budget. The current system was never designed to be financially self-sufficient, with Parts B, C, and D having an open-ended draw on the Treasury. This is bad budgeting (or non-budgeting); it also creates bad health policy incentives. Only when there are finite resources will stakeholders have a common interest in providing a quality outcome with the resources available. The central concept is a risk-adjusted, capitated subsidy for care. Under this strategy, each senior will receive a fixed subsidy, which will be larger for those who have greater health and/or financial needs.

Medicare Advantage (MA) is the best vehicle for the transition, as more than 50 percent of beneficiaries are now in MA and the evidence is that future retirees will prefer it as well. It is geographically diverse, with care tailored to meet the local population’s health characteristics. There is significant health plan competition in most areas, so plans that do not provide high quality care can be permitted to – and should – fail.

There will have to be extensive improvement in measuring the quality of MA plans. Plans should be rated on the quality of beneficiary outcomes and not what services are provided or the location of delivery. This can be a flexible vehicle for delivering increasing elder care as well as acute health care.

At the same time, fee-for-service traditional Medicare should be relegated to history. It is widely recognized as having incentivized excessive medical consumption, contains no attempt to verify the quality of care, and suffers from a lack of coordinated care delivery.

I look forward to your questions.

Addendum 1

GLOSSARY OF SELECT TAX-ADVANTAGED HEALTH ACCOUNT TERMS

Cost-Sharing Reductions (CSRs)

Cost-sharing reductions are extra subsidies that lower out-of-pocket costs (like deductibles, copayments, and coinsurance) for certain people who buy health insurance through the Affordable Care Act (ACA) marketplaces.

- Only available on Silver-level marketplace plans.
- Eligibility is based on income, generally for lower- to moderate-income enrollees.
- Instead of lowering monthly premiums, CSRs make it cheaper to use care—such as doctor visits, prescriptions, and hospital services.

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) is a tax-advantaged savings account used to pay for qualified medical expenses.

- A person must be enrolled in a High-Deductible Health Plan (HDHP) to contribute.
- Contributions are tax-deductible, growth is tax-free, and withdrawals for qualified medical expenses are tax-free (a “triple tax advantage”).
- Funds roll over from year to year – unused money is not lost at the end of the year.
- After a certain age, HSA funds can be used more flexibly, similar to retirement funds, subject to specific tax rules.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account (FSA) is an employer-based account that lets a person set aside pre-tax money to pay for eligible out-of-pocket health care expenses.

- Contributions reduce a person’s taxable income.
- Commonly used for copayments, deductibles, prescriptions, and other eligible health expenses.
- Most FSAs are “use it or lose it” within the plan year, though some plans allow a small carryover or a brief grace period.
- FSAs are generally tied to a specific employer and usually cannot be taken with an individual if they leave the job.
- Unlike HSAs, an individual typically does not need a high-deductible health plan to participate.

Enhanced Medical Deductions

“Enhanced medical deductions” is a general term that describes policy changes making it easier or more generous for taxpayers to deduct medical expenses on their income taxes.

- May involve lowering the threshold at which medical expenses become deductible (for example, allowing deductions above a smaller percentage of adjusted gross income).
- Can expand the list of expenses that qualify as deductible medical costs.
- Often refers to temporary or targeted expansions, such as for older adults, people with disabilities, or during a public health emergency.

- Overall, these policies increase the likelihood that taxpayers can reduce their tax burden based on health care spending.

Health Reimbursement Accounts (HRAs)

A Health Reimbursement Account or Arrangement (HRA) is an employer-funded benefit that reimburses employees for certain medical expenses on a tax-free basis.

- Only the employer contributes; employees do not fund the account themselves.
- Employers may define which expenses are eligible for reimbursement within IRS rules (for example, deductibles, copayments, or premiums in some designs).
- Reimbursements are generally tax-free to the employee.
- Whether unused funds roll over from year to year depends on the employer's specific plan design.
- HRAs are often paired with a group health plan but can also be structured to reimburse individual coverage under specific federal rules.

Medicare Medical Savings Accounts (MSAs)

A Medicare Medical Savings Account (MSA) is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account funded by Medicare.

- The plan includes a high deductible that must be met before most covered services are paid by the plan.
- Each year, Medicare deposits a set amount of money into a special MSA account in the beneficiary's name.
- Funds can be used tax-free for qualified medical expenses, including those incurred before meeting the deductible.
- Beneficiaries generally cannot contribute their own money to a Medicare MSA; only Medicare makes deposits.
- These plans are relatively niche and have limited availability; a person must enroll in a Medicare MSA plan to have an associated account.