Defining Our Health Care Problem, and Principles We Should Follow to Solve it

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Chairman Johnson, Ranking Member Blumenthal, and Members of the Committee, thank you for hosting this important hearing. I am Tarren Bragdon, the founder and CEO of the Foundation for Government Accountability. FGA has worked for many years on preserving resources for the truly needy, cracking down on welfare fraud, and giving Americans more options for affordable health care.

When Democrats enacted ObamaCare, they promised to expand access to health care and make health coverage more affordable. Today, affordable coverage is far out of reach for most Americans—and instead, millions of able-bodied adults have been added to the ever-growing welfare rolls.

Medicaid was originally created for the truly needy—poor children, the elderly, pregnant women, and individuals with disabilities.[1] But ObamaCare's expansion of Medicaid to a new class of able-bodied adults fundamentally changed that reality.[2] Today, there are 34 million able-bodied adults on Medicaid—more than any other group.[3] Federal taxpayers now spend more on Medicaid for able-bodied adults than on services for children, the elderly, or individuals with disabilities.[4]

In the first decade of ObamaCare's Medicaid expansion, the program cost taxpayers more than $1 trillion, roughly twice as much as promised.[5] Every dollar spent on these able-bodied adults is a dollar unavailable for the truly needy.

Meanwhile, more than 700,000 individuals with intellectual, developmental, or physical disabilities are stuck on Medicaid waiting lists for critical home and community-based services, while ObamaCare's able-bodied adults are always at the front of the line.[6]

Ultimately, ObamaCare has broken the American health care system with sky-high premiums, massive fraud, unfair financing schemes, and even a failure to protect those with pre-existing conditions.

Expansion has enabled widespread fraud

Welfare waste, fraud, and abuse run rampant. We need only look at the headlines from the past few weeks.

In Minnesota, billions of dollars of taxpayer money were stolen from child nutrition and Medicaid programs in one of the largest welfare fraud scams in American history.[7-9] Some of this money ultimately landed in the hands of terrorist organizations like Al-Shabaab in Somalia.[10]

Last month, the Department of Justice secured a conviction of one insurance broker in a $233 million ObamaCare fraud scheme.[11] That broker had submitted false and fraudulent applications for ineligible ObamaCare enrollees to boost enrollment and their commissions.[12]

And just last week, the Government Accountability Office (GAO) revealed that it had been conducting a sting operation on fraudulent ObamaCare exchange enrollment.[13] In 2024, GAO created fake identities and attempted to enroll in fully subsidized ObamaCare plans.[14] Not a single fake applicant was denied and 90 percent were still receiving benefits in September 2025.[15] In some cases, the ObamaCare exchange didn't ask for proof of identity, income, citizenship, or a Social Security number.[16] In the few cases in which proof was requested, the ObamaCare exchange approved enrollment even when GAO provided only fabricated documents or no documentation at all.[17]

The GAO audit also revealed that $21 billion of ObamaCare subsidies could not be reconciled with tax return information.[18] Auditors also identified nearly 66,000 Social Security numbers being used multiple times for ObamaCare subsidies, including one number that had been used for more than 125 different insurance policies.[19] Another 58,000 Social Security numbers used to obtain ObamaCare subsidies belonged to individuals who were deceased, often before ever being enrolled in the program.[20]

A review by the U.S. Department of Health and Human Services (HHS) earlier this year uncovered that 60 percent of tax filers receiving ObamaCare subsidies had misreported their income and were given higher subsidies than allowed.[21] HHS identified millions more enrollees reporting income to qualify for ObamaCare subsidies than even exist.[22]

This type of exchange-driven fraud adversely affects Medicaid, as all states accept referrals from the exchange to enroll individuals into Medicaid.[23] Many states even accept those referrals without doing any additional verification.[24] If federal and state exchanges are making incorrect eligibility determinations, then that is clearly translating into inaccurate referrals made to state Medicaid agencies.

It should surprise no one that more than one in every five dollars spent on Medicaid is improper—and approximately 80 percent of these improper payments are due to eligibility errors.[25-26] All told, federal taxpayers are on track to spend more than $2 trillion over the next decade on improper Medicaid payments alone.[27]

States are enrolling individuals on the program who are ineligible to begin with and keeping others on the program long after they have become ineligible.[28] State and federal audits have uncovered millions of enrollees who were enrolled in multiple states at the same time, enrolled multiple times in the same state, enrolled for decades after their deaths, enrolled using stolen or fraudulent Social Security numbers, still enrolled years after having moved out of state, and more.[29] Medicaid expansion helped supercharge and expand this fraud to never-before-seen levels.

Unfortunately, much of this improper spending is fraud by design: welfare policies intentionally designed by bureaucrats to maximize enrollment at all costs, especially as it relates to Medicaid expansion.[30] And every dollar squandered to this waste, fraud, and abuse is a dollar stolen from the truly needy.

Expansion financing schemes are patently unfair

These unprecedented levels of fraud are built upon a broken Medicaid financing system. For every dollar states spend on an able-bodied adult in the ObamaCare expansion, federal taxpayers will match $9—a 90 percent match rate.[31] But for a dollar spent on the truly needy—such as children with developmental disabilities—federal taxpayers will match only about $1.30.[32]

Put another way, this 90 percent match perversely means that, in tough times, states will only save 10 cents for every $1 benefit cut from an able-bodied adult's benefits, but they can save 43 cents for every $1 in benefit cuts to the elderly or disabled.[33]

Medicaid expansion fundamentally broke the traditional federal-state share relationship. But equally concerning are the abusive money laundering schemes—hiding behind phrases like "provider taxes," "state-directed payments," and "intergovernmental transfers"—that have been used to finance the ever-growing Medicaid expansion rolls.[34] Provider taxes enable states to draw down federal funds with little or no skin in the game, while state-directed payments jack up Medicaid reimbursement rates to sky-high levels—reaching as high as commercial insurance rates under the Biden administration.[35] Thankfully, the One, Big, Beautiful Bill takes steps to finally rein in these abusive practices.

ObamaCare has harmed—not helped—those with pre-existing conditions

ObamaCare was also promised to be a silver bullet for individuals with pre-existing conditions. Not only has it failed to adequately protect them from skyrocketing health care costs, but it has also actively put them in harm's way.

Premiums in the individual market have more than tripled since 2013, with the average premium for a 40-year-old on HealthCare.gov now totaling more than $7,700 per year.[36-37-38-39-40] These skyrocketing premiums have priced many individuals who receive no government subsidies—including those with pre-existing conditions—out of the market entirely.

Deductibles have also skyrocketed over the last decade, growing by nearly 70 percent since 2014.[41] The average deductible for benchmark ObamaCare plans now exceeds $6,000 per person, while the average out-of-pocket maximum has increased to more than $9,000.[42-45] Rising deductibles put significantly more pressure on individuals with pre-existing conditions, as they typically have higher medical costs.

Some insurers have also used plan designs to discourage those with certain pre-existing conditions from enrolling in their plans. In some cases, this involves using the drug formulary to exclude certain prescriptions or imposing the highest cost-sharing amounts for all prescription drugs to treat certain conditions, even low-cost generics.[46-53]

In other cases, it involves excluding certain providers. For example, most ObamaCare exchange plans exclude all National Cancer Institute–designated cancer centers from their provider networks.[54] More than 80 percent of ObamaCare enrollees are enrolled in health maintenance

organizations (HMOs) or exclusive provider organizations (EPOs), which typically have narrow networks and no out-of-network coverage.[55] Many of these narrow-network plans are run by Medicaid managed care companies that have entered the ObamaCare exchange market.[56]

More than a quarter of all practicing physicians are excluded from every single ObamaCare plan on the market.[57] In some areas—even large metropolitan ones—as many as 60 percent of physicians in the area are excluded from all plans.[58] One plan in Chicago, for example, excludes 97 percent of local physicians, while even the broadest-network plan in the area still excludes 78 percent of local physicians.[59] Insurers use these narrow networks to steer the most costly and complicated enrollees—such of those with pre-existing conditions—away from their plans and toward other insurers.

Additionally, the very nature of a limited open enrollment period delays coverage for pre-existing conditions and boxes in consumers who may develop a condition to only enrolling during a limited window, since developing a serious health condition is not a qualifier for a special enrollment period. This stands in contrast to the pre-ObamaCare environment, particularly in certain states that engaged in innovative health care policies. For example, Wisconsin previously utilized a Health Insurance Risk-Sharing Plan (HIRSP)—essentially a high-risk pool—that allowed individuals to obtain affordable coverage immediately, with a short waiting period for pre-existing conditions.[60]

Lastly, Democrats' obsession with increasing ObamaCare enrollment at any cost has also drastically reduced options for those who develop medical conditions. Short-term plans, for example, are effective options for individuals to acquire health coverage at a lower price point, largely because they are not subject to all of the red tape associated with ObamaCare.[61] In fact, switching from the average benchmark ObamaCare plan to a short-term plan would save the average 40-year-old roughly 59 percent in premiums, or nearly $4,600 per year.[62-65]

For decades, these plans were available for up to a year, with the Trump administration authorizing individuals to buy short-term policies that could be renewed for up to three years without additional underwriting.[66] This allowed individuals who developed a medical condition after purchasing the plan to extend their existing policies without new underwriting.[67]

But in 2024, the Biden administration unilaterally and unlawfully slashed individuals' ability to purchase short-term plans by reducing the duration to just four months in total.[68-70] The Biden administration justified the rule to increase ObamaCare enrollment, despite widespread opposition to the change.[71]

These new restrictions not only prohibit individuals from buying more affordable options for a timeline that suits their needs, but it actively harms individuals who develop new medical conditions after enrolling in short-term plans. Under the Biden administration's policy, individuals in these plans would need to have their deductibles completely reset and undergo medical underwriting every three to four months.[72-73] If they developed a serious medical condition during that much shorter period, their premiums would increase drastically, or they could be denied coverage altogether.[74] Because losing access to a short-term plan is not a qualifying event for special

enrollment in the ObamaCare exchange, those individuals could lose their health coverage entirely with no recourse whatsoever.

Consider a person who purchased an affordable short-term plan and then developed serious cancer. Under Trump-era rules, that individual could keep their existing coverage for a year, with the option to renew for up to three years and would have plenty of time to transition to other coverage options if they chose to do so. But under the Biden regulations, that individual would lose their coverage a few months later and would be prevented from enrolling in a new plan until the open enrollment window arrived months later.

The Biden-era policy is cruel and unfair. It actively punishes Americans seeking more affordable options, including those who develop serious conditions. But it was justified as part of the "expand ObamaCare at whatever cost" mentality.

State innovation has offered better pathways to affordability

There are effective examples from the states of how to really protect individuals with pre-existing conditions and lower premiums for everyone.

In 2011, then-Governor Paul LePage opted to reform Maine's individual market through a series of bipartisan reforms. Specifically, Maine:

- Expanded age rating flexibility and
- Created a reinsurance program to help cover the cost of expensive claims for those with pre-existing conditions.[75]

The reforms worked tremendously. Within the first year, individual market premiums for the state's largest insurer declined by 70 percent, while membership grew by 13 percent in the first 18 months, especially among younger and healthier applicants.[76]

Most importantly, Maine still required insurers to enroll individuals *year-round* (not just a January 1 open enrollment like under ObamaCare) and required the same plan options and same premiums to everyone. Maine made no changes to any benefit mandates as part of these reforms.[77]

Rather than broad reinsurance like ObamaCare, Maine used target reinsurance for eight specific pre-existing conditions driving claim costs: chronic obstructive pulmonary disease, endometrial cancer, metastatic cancer, prostate cancer, congestive heart failure, renal failure, rheumatoid arthritis, and HIV.[78]

This reinsurance was funded by a $4 per month assessment on private health insurance policies in the state.[79] The reinsurance reimbursed insurers for 90 percent of individuals' claims between $7,500 and $32,500 per year and 100 percent of claims more than $32,500, removing most of the costly risk of insurers taking those with pre-existing conditions while producing dramatically lower premiums and the same plan options for everyone, including those with pre-existing conditions.[80]

In the years that followed, even as ObamaCare increased premiums nationwide, Maine's individual market remained relatively stable. For example, from 2013 to 2017, Maine had one of the most modest changes in premiums in the nation among the states operating on the federal exchange, with 35 out of 39 federal exchange states seeing greater premium increases than Maine.[81]

ObamaCare is a failure

By every standard, ObamaCare has been a disaster. It has opened the floodgates to fraud, pushed able-bodied adults to the front of the line, enabled the worst financing schemes that have robbed taxpayers blind, and has left those with pre-existing conditions behind. It is long past time we recognize the detrimentally harmful effects this law has had on taxpayers and the truly needy alike.

Thank you for the opportunity to discuss this critical issue and I look forward to answering any questions you may have.

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