Testimony Submitted to

the Senate Finance Committee:

"Lower Health Care Costs for Americans:

Understanding the Benefits of the Inflation Reduction Act"

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Thank you, Chairman Wyden and Ranking Member Crapo for calling this hearing and giving me the opportunity to testify.

The August 2022 reconciliation bill (a.k.a. the "Inflation Reduction Act," or IRA) made significant changes to health care law, and it sought to address several legitimate flaws within American health care. Unfortunately, to do so the law embraced superficial fixes.

This has resulted in an expensive Affordable Care Act (ACA) sugar high, induced a likely illegal taxpayer bailout of Medicare Part D plans, and will undermine the quality and value of health care in the long run.

My testimony will cover what I see as the underlying issues, discuss why the approaches adopted in the IRA fail to address them, and propose alternatives that would enhance the quality, value, and sustainability of the American health care system.

1. The IRA's enhanced premium tax credit is an expensive attempt to paper over underlying problems with the ACA and is plagued by fraud.

The shortcomings of the ACA are apparent: The individual market reforms of ACA have come up short — not only in the eyes of its critics but also in comparison to the projections previously touted by its own proponents. In a report for Paragon Health Institute, health actuaries Daniel Cruz and Greg Fann illustrated how, as of 2021, the ACA's individual market reforms produced around half the number of enrollees as expected at a much higher cost than the authors of the law intended.[1] As shown in the table below, at that time the ACA had produced very little net new enrollment in

[1] Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, https://paragoninstitute.org/private-health/shortcomings-of-the-aca-exchanges/.

private health insurance at substantial cost to the federal taxpayer per new enrollee.[2]

Coverage Cost of the ACA, Projected versus Reality (2021)

	CBO Projection	Actual
Individual Market Enrollment Growth (millions)	20	3
Private Insurance Enrollment Growth (millions)	13	2
Exchange Subsidies (billions)	$137	$60
Subsidy Cost / New Net Individual Market Enrollee	$6,850	$20,739
Subsidy Cost / New Net Private Insurance Enrollee	$10,538	$36,798

SOURCE: Enrollment Growth measures the change between 2009 and 2021 for enrollment in the individual market and the private health insurance market. Author's calculation based on research described in this paper and CBO projections shown in "Effects of the Affordable Care Act on Health Insurance Coverage", May 2013 Baseline (https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf).

The American Rescue Plan Act (ARPA) and IRA increased taxpayer subsidies to insurance companies: The authors of the ARPA implicitly acknowledged the underperformance of the ACA and decided to include a substantial, two-year increase to the size and scope of the premium tax credit (PTC) for the purchase of qualified health insurance.[3] The IRA doubled down on this policy while hiding the true cost — temporarily extending the policy for three years.[4] If this change is made permanent, the Congressional Budget Office (CBO) projects that it would increase ACA spending by $415 billion over 10 years.[5]

Increasing the amount of taxpayer money being sent to insurance companies is a straightforward, simple, and expensive approach to increase enrollment in the ACA. However, this approach neither decreases actual premiums — it simply increases the share of premiums the taxpayer pays — nor does it address a major underlying problem of plan quality. Simply put, the quality of ACA plans has been too low relative to the cost. Potential enrollees do not perceive enough value to justify devoting their own resources to purchase these plans, so usually they will sign up only if the coverage is heavily subsidized by the government.

The value of ACA plans is low and has gotten worse over time: A new paper by Cruz and Fann assessed the change in value of ACA plans. Looking at three key metrics —

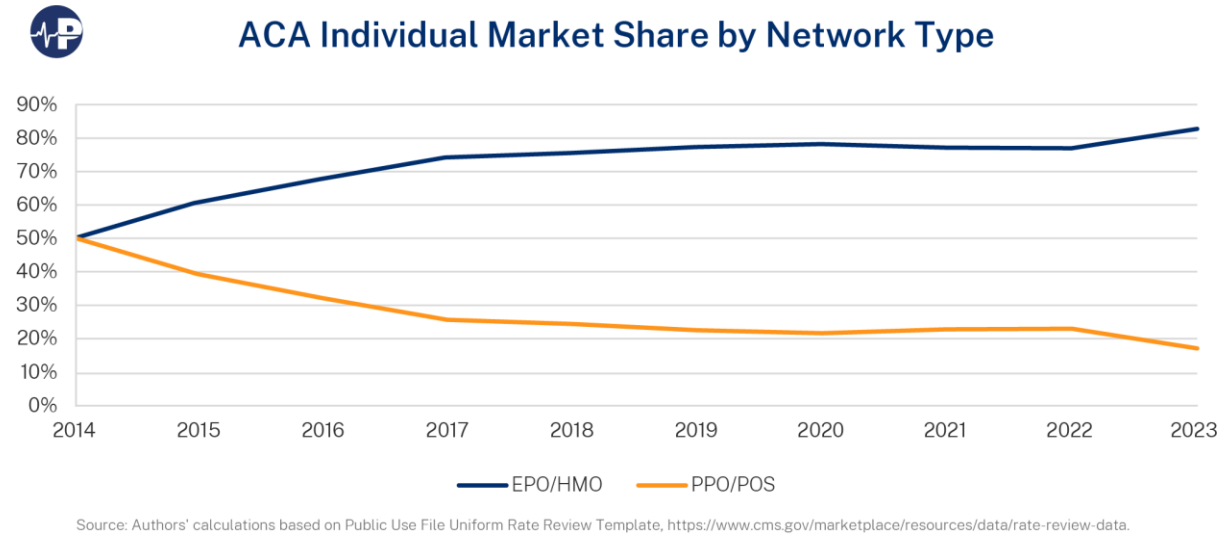
[2] As of 2021, almost all increases in coverage were achieved through the expansion of public coverage in the Medicaid program.

[3] American Rescue Plan Act of 2021, Pub. L. No. 117-2, §9661.

[4] Inflation Reduction Act of 2022, Pub. L. No. 117-169, §12001.

[5] Phillip L. Swagel, Director, CBO, letter to Hon. Jodey Arrington, Chair, House Budget Committee, and Hon. Jason Smith, Chair, House Ways and Means Committee, June 24, 2024, https://www.cbo.gov/system/files/2024-06/60437-Arrington-Smith-Letter.pdf.

the broadness of networks, the associated cost-sharing of plans (copays and deductibles), and the premiums — the study shows that all have steadily become *worse* over time.[6] The figure below provides a clear illustration of this dynamic on network type, as 85 percent of enrollees were in narrower network plans as of 2023. These finding were reinforced by another recent paper by KFF that found that in one major metropolitan area the median enrollee in an ACA plan had in-network access to only 13 percent of area physicians.[7]



Source: Authors' calculations based on Public Use File Uniform Rate Review Template, https://www.cms.gov/marketplace/resources/data/rate-review-data.

Post-ARPA, new enrollment has been driven by people that, under the enhanced tax credit, now pay $0 in premium for a standard plan. Nearly half of 2024 enrollees nationally — and well over half in several states — report income that puts them into this category.[8] Most people in this income category already had access to heavily subsidized plans previous to the IRA. For example, someone at the poverty line in 2019 would have had to contribute less than $30 for a plan that cost $500 per month, yet many still did not see the value in enrolling in such a plan.

Instead of trying to increase the underlying value, the IRA just gives away these same plans completely paid for by the taxpayer. When the government pays plans instead of people, insurers have less incentive to design plans that potential enrollees find valuable. Government regulators attempt to mandate quality, but the

[6] Daniel Cruz and Greg Fann, "It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade," Paragon Health Institute, September 2024, https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/.

[7] Matthew Rae et al., "How Narrow or Broad Are ACA Marketplace Physician Networks?," KFF, August 26, 2024, https://www.kff.org/private-insurance/report/how-narrow-or-broad-are-aca-marketplace-physician-networks/.

[8] Brian Blase, Theo Merkel, and Drew Gonshorowski, "In 2024, Over Half of Federal Exchange Enrollees Claimed Income Below 150% of the Federal Poverty Level," Paragon Health Institute, https://paragoninstitute.org/paragon-pic/in-2024-over-half-of-exchange-enrollees-have-income-below-150-of-the-federal-poverty-level/.

result is that, over time, the private ACA market has looked more and more like Medicaid managed care.

Enhanced subsidies crowd out employer sponsored insurance (ESI): CBO has projected that if made permanent, over half of any increase in coverage gains in the individual market would be a result of decrease of 3.5 million in those who receive insurance through their employer.[9] This will likely particularly impact small businesses. Starting in 2022, KFF reported a distinct drop in the percentage of small businesses with under 10 workers offering health insurance to their employees, hitting a new 25-year low.[10] Similarly, the recently released U.S. Census report on health insurance reported no statistically significant change from 2022 to 2023 in the total number of Americans with health insurance yet a decline of 1.6 million in those who received coverage through their employer.[11]

Enhanced subsidies and administrative actions have jeopardized program integrity: The substantial expansion of fully subsidized plans; embedded rewards for misestimating income; financial incentives for insurers, brokers, and lead generators;[12] and a relaxation of eligibility verification by the Biden administration have all helped increase enrollment in the ACA.

But only through tolerance of substantial fraud.

For fully subsidized plans, the government has effectively removed the single most effective safeguard against enrollment fraud: the enrollee who keeps a far more watchful eye over his or her own money than the federal government does ours. For example, if someone is fraudulently enrolled in a plan by an unscrupulous broker seeking a commission,[13] no longer will the receipt of a bill or the lack of premium payment spur an investigation into the improper sign up.

The ACA also creates a financial incentive to misstate income or, when in doubt, estimate income at just north of 100 percent of the federal poverty line (FPL). In 2024, the average subsidy for the average 40-year-old at 100 percent FPL is $5,723. A person who makes four times that amount is eligible for a subsidy of only $790, but the most that the federal government will reclaim from an overpayment at that income is $1,575. This person thus has a $3,358 incentive to underestimate his or

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[9] Swagel, letter to Hon. Jodey Arrington, Chair, House Budget Committee, and Hon. Jason Smith, Chair, House Ways and Means Committee.

[10] KFF Employer Health Benefits Survey, 2018-2023, Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017, October 18, 2023, https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.

[11] Katherine Kaiser-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2023," United States Census Bureau, September 2024, https://www2.census.gov/library/publications/2024/demo/p60-284.pdf

[12] Joseph Walker, "Americans Clicked Ads to Get Free Cash. Their Health Insurance Changed Instead." Wall Street Journal, September 13, 2024, https://www.wsj.com/health/healthcare/social-media-ads-health-insurance-scams-37d1ecfa?mod=hp_lead_pos5.

[13] Julie Appleby, "ACA Plans Are Being Switched Without Enrollees' OK," KFF Health News, April 2, 2024, https://kffhealthnews.org/news/article/aca-obamacare-plans-switched-without-enrollee-permission-investigation/.

her income. As shown in the table below, repayment of erroneous subsidies is similarly capped for anyone under 400 percent FPL.

Annual Repayment Limit of Excess Premium Tax Credit Payments, 2024

Houshold Income (Expressed as a Percentage of the Federal Poverty Level)	Applicable Dollar Limits for an Unmarried Individual[a]
< 200%	$375
200% to < 300%	$950
300% to < 400%	$1,575

Source: IRS, Revenue Procedure 2023-34, at http://www.irs.gov/pub/irs-drop/rp-23-34.pdf.
Notes: The applicable dollar limit for all other tax filers is twice the limit for unmarried individuals. Adapted from CRS, https://crsreports.congress.gov/product/pdf/R/R44425.
a. Does not include surviving spouses or heads of housholds

In non-expansion states, anyone under 100 percent FPL is not eligible for the PTC or Medicaid expansion and thus has an even stronger incentive to overestimate his or her income in order to qualify for subsidies. Paragon found that in 2024, nine states using the federal exchange (HealthCare.gov) reported more people enrolled with incomes between 100 percent and 150 percent FPL than the U.S. Census's American Community Survey projected eligible adults living in those states.[14] In one state, the number of enrollees exceeded potential enrollees by a factor of four.

Chasing higher ACA enrollment, the Biden administration has also enabled fraud by relaxing program safeguards. For instance, the Biden administration created a year-round special open-enrollment period for potential enrollees between 100 percent and 150 percent FPL. Eligibility criteria to qualify for this and most other special enrollment periods no longer require verification.[15] Similarly, enrollees are no longer required to pay past due premiums before enrolling,[16] can simply attest to income levels if tax return data is not available, and cannot be determined ineligible for failing to reconcile their tax returns unless they are delinquent for two consecutive

[14] Brian Blase and Drew Gonshorowski, "The Great Obamacare Enrollment Fraud," Paragon Health Institute, June 2024, https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.

[15] Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412-53506 (Sept. 27, 2021), https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver.

[16] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 27208-27393 (May 6, 2022), https://www.federalregister.gov/documents/2022/05/06/2022-09438/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.

years.[17] Even the most modest safeguards, such as two-factor authentication for plan changes on HealthCare.gov, have been avoided for fear of depressing enrollment.[18]

My Paragon colleagues have estimated that as many as 5 million current enrollees — for whom taxpayers will spend $15-26 billion in subsidies just this year — could be under-or over-estimating their income to obtain higher assistance than the law permits.[19]

2. The IRA prescription drug provisions have already required a multi-billion-dollar taxpayer bailout.

Perhaps even more highly touted than the increase in ACA subsidies were the IRA's price controls on prescription drugs. Here the law is heavy-handed, empowering the Centers for Medicare and Medicaid Services (CMS) to effectively dictate the level of payment for certain prescription drugs if manufacturers do not willingly agree to the level suggested by the government.

Price controls produce unintended consequences: Price controls have a long record in Medicare, which has administratively set the level of payment for hospitals since 1983, physicians since 1992, post-acute care since 1997, and outpatient care since 2000. From this process, as well as experience in other countries and failed attempts at price controls in other industries, we know that price controls have enormous consequences in determining how resources are allocated, how care is delivered, and where future innovation flows by determining which good or service is preferred over alternatives. Price controls are designed around and have an inherent bias toward how care is delivered today and the incumbents that do so, creating formidable special interests and providing powerful mechanisms by which to prevent change.

Unfortunately, lawmakers have often embraced price controls because their immediate impact is much easier to quantify than the long-term effect. For instance, CBO provided a point estimate on savings for the IRA price controls, and the Biden administration can now point to specific drugs that will be impacted. However, while everyone agrees that there will be some reduction in future innovation and the bias of the price-control mechanisms against the types of medications Medicare seniors can pick up at the pharmacy counter, it is harder to illustrate the impact of a future disease that does not get cured or a chronic disease that would have become incrementally less burdensome.

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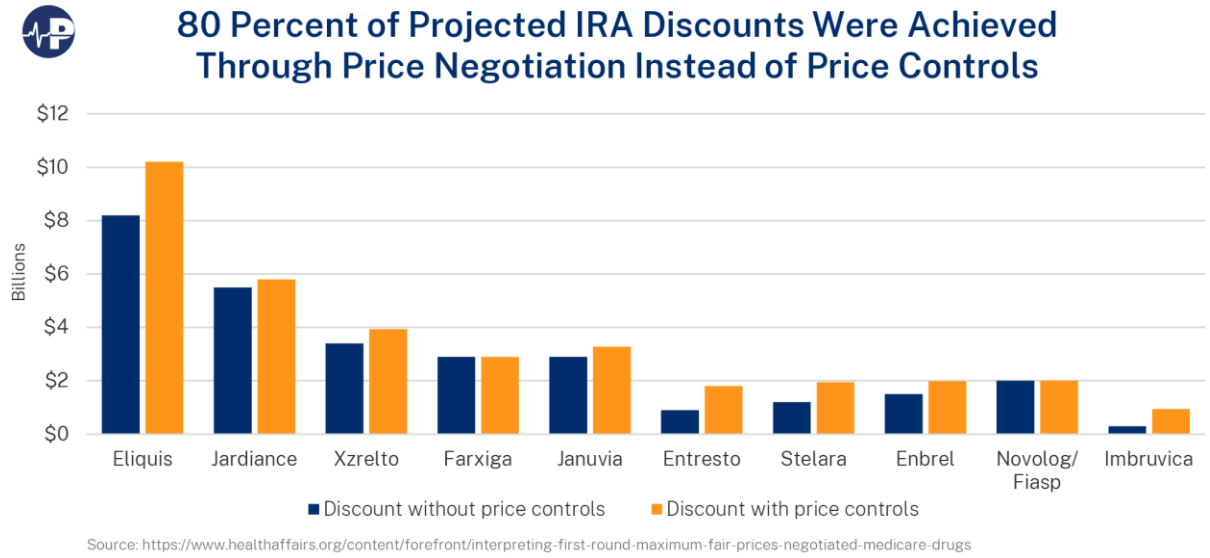
[17] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 25740-25923 (Apr. 27, 2023), https://www.federalregister.gov/documents/2023/04/27/2023-08368/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024.

[18] Brian Blase and Gabrielle Kalisz, "Unpacking the Great Obamacare Enrollment Fraud," Paragon Health Institute, August 2024, https://paragoninstitute.org/private-health/unpacking-the-great-obamacare-enrollment-fraud/.

[19] Blase and Gonshorowski, "The Great Obamacare Enrollment Fraud."

The new IRA bailout: So far, the IRA drug provisions provide a perfect illustration of unintended consequences. According to estimates, as shown in the figure below, 80 percent of the discounts announced last month by the government price setters had already been achieved by private plans negotiating without price controls.[20] This likely overstates the impact, given that these estimates are for the level of savings that would have occurred in 2023, but the new prices do not kick in until 2026, when the privately negotiated discounts would have certainly been larger.



But before *any* potential savings kick in, they are *already being spent* by the administration to bail out another flawed provision of the law.

Medicare Part D did not originally include a cap on catastrophic out-of-pocket expenditures for beneficiaries. However, by 2020, the Trump administration[21] and Republicans and Democrats in both houses of Congress[22] generally agreed that this was a worthy reform. Disagreements over tangential policies and electoral politics prevented agreement that year, but it was clear that this general concept was ripe for bipartisan collaboration.

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[20] Inmaculada Hernandez et al., "Interpreting the First Round of Maximum Fair Prices Negotiated by Medicare for Drugs," Health Affairs Forefront, September 3, 2024, https://www.healthaffairs.org/content/forefront/interpreting-first-round-maximum-fair-prices-negotiated-medicare-drugs.

[21] Joe Grogan, "White House Principles for Reducing Drug Costs," Wall Street Journal, March 10, 2020, https://www.wsj.com/articles/white-house-principles-for-reducing-drug-costs-11583850048.

[22] An out-of-pocket cap on catastrophic retail pharmaceutical spending in Medicare Part D was a common feature of the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), the Prescription Drug Pricing Reduction Act, and the Senate (S. 3129) and House (H.R. 19) versions of the Lower Costs, More Cures Act.

The IRA rewrote this previously bipartisan idea in a way that guaranteed a large increase in premiums.[23] Despite dedicating $40 billion in the law just to keep premiums artificially low from 2024 to 2031,[24] standalone Part D premiums still increased by 21 percent[25] for 2024 and were set for an even larger spike for 2025.

The Biden administration has responded with a "demonstration" project that will simply pay standalone Part D plans at least another $5 billion next year alone to keep premiums lower.[26]

To do so, the administration is flouting Section 402 of the Social Security Amendments of 1967. This provision gives the Secretary of Health and Human Services broad authority to engage in "experiments and demonstrations" to test whether changes in payment will increase the "efficiency and economy" of Medicare without jeopardizing quality.[27] In 2012, the Government Accountability Office (GAO) opined that this authority clearly did not extend to any programs not designed to actually test the effectiveness of a payment change and recommended the cancellation of another legally dubious "demonstration."[28] Similarly, the "Medicare Part D Premium Stabilization Demonstration," which simply pays standalone Part D plans more to keep premiums lower, has no credible research goals and is just an expensive abuse of vague statutory language to bail out the flawed IRA.

3. The poor design of the IRA insulin cap was a gift to incumbent insulin manufacturers.

Finally, one of the most perplexing IRA changes is the insulin provision, which, far from holding drug companies accountable, replaces one set of copay caps with another that is far more favorable to insulin manufacturers.[29] Manufacturers generally support copay caps because they restrict the ability of payers to steer patients to more affordable alternatives and hide the cost of the medication from the

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[23] Casey B. Mulligan and Tomas J. Philipson, "The Inflation Reduction Act Comes for Medicare," Wall Street Journal, November 21, 2022, https://www.wsj.com/articles/the-inflation-reduction-act-comes-for-medicare-ira-elderly-voters-payments-benefits-cuts-revenue-losses-subsidies-11669060307.

[24] Phillip L. Swagel, Director, CBO, letter to Hon. Jason Smith, Ranking Member, House Budget Committee, August 4, 2022, https://www.cbo.gov/system/files/2022-08/58355-Prescription-Drug.pdf.

[25] Juliette Cubanski and Anthony Damico, "Medicare Part D in 2024: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing," KFF, November 8, 2023, https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing.

[26] Jackson Hammond, "Bailing Out Bad Policy," Paragon Health Institute, August 5, 2024, https://paragoninstitute.org/paragon-prognosis/bailing-out-bad-policy/; Chelsea Cirruzzo and Ben Leonard, "Biden's Billion-Dollar Medicare Bet," Politico, August 12, 2024, https://www.politico.com/newsletters/politico-pulse/2024/08/12/bidens-billion-dollar-medicare-bet-00173574.

[27] Social Security Amendments of 1967, Pub. L. No. 90–248, https://www.ssa.gov/OP_Home/comp2/F090-248.html.

[28] Medicare Advantage: Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns: Testimony Before the Committee on Oversight and Government Reform, House of Representatives, 112th Cong. (2012) (statement of James Cosgrove, Director, Health Care, GAO, and Edda Emmanuelli-Perez, Managing Associate General Counsel, GAO, https://www.gao.gov/assets/gao-12-964t.pdf.

[29] Annalisa Merelli, "The Insulin Copay Cap Was a Bad Idea Anyway," Yahoo, August 9, 2022, https://www.yahoo.com/tech/insulin-copay-cap-bad-idea-131100022.html.

end user, increasing the leverage the manufacturer has over the payer while negotiating the level of reimbursement.

Absent caps, insulin copays were already declining: Since 2018, insulin copays have not just been growing more slowly — they have actually been declining. Over 70 percent of Medicare prescriptions for insulin already had copayments under $35 by 2021.[30] In recent years, insulin users have benefited from more competition than ever before. In 2020, the Trump administration created a new pathway for the approval of biosimilar insulins to improve competition in this space.[31] Since that time, multiple new biosimilars have been approved, with seven additional ones in the development pipeline as of 2024.[32]

The Trump administration had already offered a copay cap designed to extract larger discounts from insulin manufacturers: The Trump administration built on this progress by giving all Medicare beneficiaries the option of a plan with a $35 insulin copay cap through a Centers for Medicare and Medicaid Innovation demonstration project. However, a key distinction is that the program forced manufacturers who participated and benefit from the copay cap to provide larger discounts on insulin. The official evaluation by the RAND Corporation stated, "Although we found no evidence of cost shifts to plans or CMS, our findings suggest that drug manufacturers increased their contributions by paying more in total manufacturer rebate and gap discount dollars."[33]

The IRA copay cap transferred cost from manufacturers to beneficiaries and taxpayers: The IRA replaced this program with a mandatory copay cap. Instead of requiring insulin manufacturers to pay for this change, the cost has been shifted to all beneficiaries and taxpayers. According to KFF, "CBO estimates additional federal spending of $5.1 billion ($4.8 billion for Medicare Part D and $0.3 billion for Medicare Part B) over 10 years (2022-2031) associated with the insulin cost-sharing limits" in the IRA.[34]

The Biden administration also repealed a more targeted program to provide the uninsured with low-cost insulin: Amid efforts to impose the new costly copay cap for a population that largely already had access to affordable insulin, the Biden administration repealed a Trump administration program to provide more targeted

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[30] IQVIA Institute, "The Use of Medicines in the U.S. 2022," April 21, 2022, https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2022.

[31] Food and Drug Administration, "Insulin Gains New Pathway to Increased Competition," press release, March 23, 2020, https://www.fda.gov/news-events/press-announcements/insulin-gains-new-pathway-increased-competition.

[32] Brian Biehn, "U.S. Biosimilar Landscape," Cencora, https://www.amerisourcebergen.com/-/media/assets/cencora-biosimilars-usmarketlandscape-sep24.pdf.

[33] Erin Audrey Taylor et al., "Evaluation of the Part D Senior Savings Model," RAND Corporation, May 2023, https://www.cms.gov/priorities/innovation/data-and-reports/2024/pdss-second-eval-rpt.

[34] Juliette Cubanski, Tricia Neuman, and Meredith Freed, "Explaining the Prescription Drug Provisions in the Inflation Reduction Act," KFF, January 24, 2023, https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/#bullet04.

assistance to low-income and uninsured Americans. In 2020, the Trump administration unveiled a program that required all federally qualified health centers to provide insulin to beneficiaries under 350 percent FPL, regardless of insurance status, at their acquisition cost plus a minimal administration fee. Given that these health centers have access to insulin through the 340B program, in which it is often priced at well under $1 per vial,[35] this would have been far more substantial relief than $35 per prescription to a population with more obvious need.

The Biden administration immediately paused this program upon entering office and repealed it on October 21, 2021, citing an unspecified administrative burden that health centers would have incurred to simply pass through the savings they already receive to low-income insulin users.[36]

4. There are sound alternatives to actually lower the cost of care and improve quality for Americans.

On the ACA: The enhanced PTC should be allowed to expire. Instead of paying insurers more to hide the flaws of the ACA, Congress should reform the underlying statute to improve value for enrollees and taxpayers.

a. **Improve risk adjustment:** As thoroughly detailed in the Paragon report "It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade," the current risk adjustment program overcompensates insurance companies for enrollees under 200 percent FPL by close to 30 percent.[37] This has caused insurers to design plans targeted to this demographic while aggressively underpricing them, "consequently overpricing other plans, rendering them unattractive." Because of the zero-sum nature of risk adjustment in the ACA, improving its accuracy should be a non-controversial, low-cost fix that would improve the quality of plan offerings.

b. **Appropriate cost-sharing reduction (CSR) payments and give eligible enrollees the option to receive directly:** The CSR program was included in the ACA to reduce cost-sharing for individuals under 250 percent FPL, but the original law never included an actual authorization of appropriations. The legal odyssey that followed has produced a suboptimal scenario where insurers build the anticipated costs of CSR payments into premiums for the benchmark plans used to calculate the PTC. The actual mechanics of this process vary state to state, but it highly distorts premium amounts by metal tier so that the price of plans is often

[35] Eli Lilly and Company, "How Lilly Is Helping Discounts Reach People with Diabetes in 340B," July 26, 2021, https://www.lilly.com/news/stories/lilly-helps-discounts-reach-people-with-diabetes-in-340B.

[36] Implementation of Executive Order on Access to Affordable Life-Saving Medications; Rescission of Regulation, 86 Fed. Reg. 54390-54396 (Oct. 1, 2021), https://www.federalregister.gov/documents/2021/10/01/2021-21457/implementation-of-executive-order-on-access-to-affordable-life-saving-medications-rescission-of.

[37] Cruz and Fann, "It's Not Just the Prices."

no longer reflective of the underlying actuarial value and raises the cost of silver plans to a cost-prohibitive level for people who do not qualify for subsidies.

Congress should rationalize the ACA market by appropriating CSR payments, with appropriate accompanying pro-life protections. In 2018, CBO estimated that this would save taxpayers $29 billion over 10 years, a number that has likely grown over time.[38] In addition, Congress should allow eligible enrollees the option to own these payments directly in a tax-advantaged account that rolls over unused balances for future years — as opposed to the current design of simply passing funds through to insurance companies to subsidize higher-actuarial-value plans.[39]

c. **Encourage individual coverage health reimbursement arrangements (ICHRA):** More and more employers, especially small and medium sized businesses, are looking for a stable option to provide employee health benefits with accompanying choice in plans. An ICHRA allows an employer to set a defined amount it will contribute to an employee for health coverage, retain the tax advantages of ESI, and let the employee use those funds to purchase a plan of his or her choosing in the individual market.

   Unfortunately, the low quality of current plan offerings in the individual market has made many employers reluctant to choose ICHRAs as the vehicle to provide health insurance benefits. Because the amount of the employer contribution is tied to the value of the lowest-cost silver plan for the purpose of meeting the employer mandate in the ACA, the inflation in silver plan premiums as a result of Congress's failure to appropriate CSRs is another clear deterrent.

   However, combined with the steps outlined above to improve plan quality, the infusion of additional enrollees into the individual market through the adoption of ICHRAs would have a self-reinforcing impact on plan quality. Instead of designing plans primarily to target low-income enrollees who do not pay their own premiums, insurers would likely offer more options that resemble the current ESI market. Congress could make this an even more appealing option for employers by allowing them to give their employees a choice of a traditional employer plan or an ICHRA.

d. **Fix the inflationary nature of the PTC:** The amount of the federal subsidy for health coverage under the ACA is tied to the value of the benchmark plan (second-lowest-cost silver plan) in a region, and the premium contribution for an eligible individual (if anything) is capped as a percentage of income. Therefore, any subsidy-eligible enrollee (which is the vast majority) is largely shielded from

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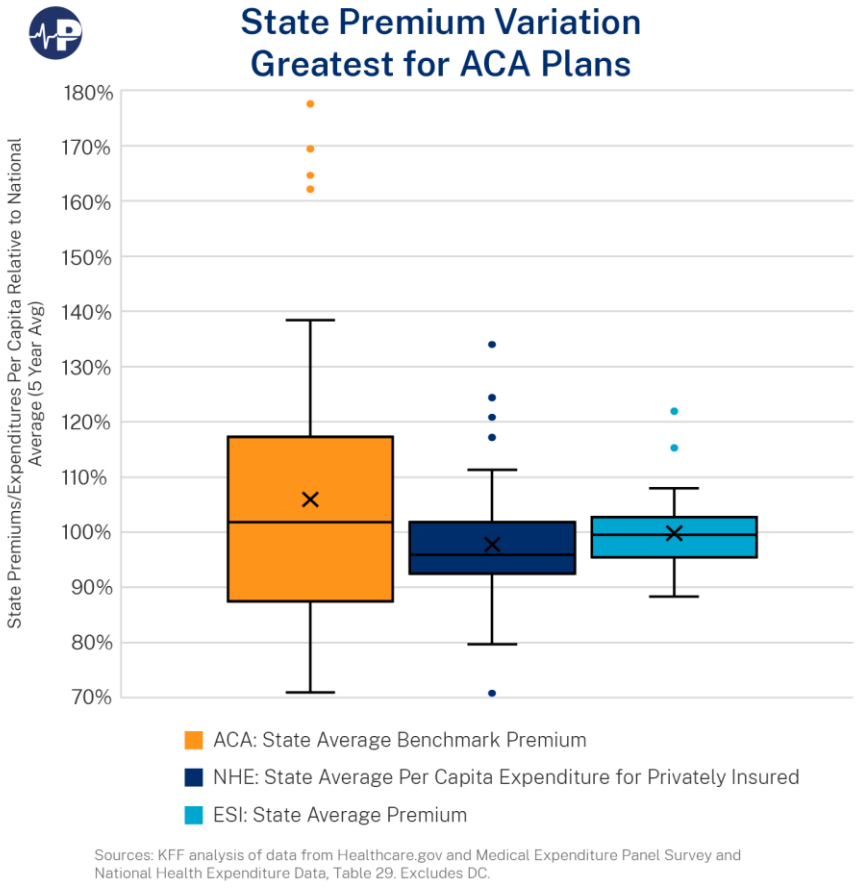
[38] Keith Hall, Director, CBO, letter to Hon. Lamar Alexander, Chair, Senate Health, Education, Labor and Pensions Committee, March 19, 2018, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53664-costsharingreduction.pdf.

[39] Brian Blase et al., "The HSA Option: Allowing Low-Income Americans to Use a Portion of Their ACA Subsidy as a Health Savings Account Contribution," Paragon Health Institute, November 2022, https://paragoninstitute.org/private-health/the-hsa-option/.

the impact of higher premiums, and the higher the premium, the higher federal subsidies the insurer receives. In regions with robust competition among multiple different insurers, this is a lesser problem. However, in the many areas with little competition, the design is highly inflationary. Furthermore, it has allowed states and the executive branch to impose additional requirements on plans that increase the cost of the ACA without additional congressional action.

The result has been higher costs and substantial variation of premiums that does not correlate to the underlying cost of care in a region or the health of the population.[40] The figure below shows the much higher variation in state averages for benchmark premiums in the ACA relative to national health expenditures for those with private insurance and premiums in the employer market. For example, even in New England states with similarly high private per enrollee spending, the 2024 benchmark premium in Massachusetts was 88 percent of the national average and 139 percent in Connecticut.



[40] John Holahan, Erik Wengle, and Claire O'Brien, "Changes in Marketplace Premiums and Insurer Participation, 2022-2023," Urban Institute and Robert Wood Johnson Foundation, April 2023, https://www.urban.org/sites/default/files/2023-03/Changes%20in%20Marketplace%20Premiums%20and%20Insurer%20Participation%2C%202022-2023.pdf.

To mitigate the impact of this poor design, Congress should cap the benchmark used to calculate the PTC at 125 percent of the national average.[41] As explained in the Paragon report "Follow the Money: How Tax Policy Shapes Health Care,"[42] this would allow sufficient variation for regional differences in health expenditures while limiting the ability of any insurer or state to excessively increase the amount of federal subsidies.

Underlying concerns of accelerating costs from the subsidy structure led even the authors of the ACA to create a mechanism that capped the overall cost of PTC and CSR payments at a percentage of GDP. This is a blunt tool that, if triggered, would impact all plans regardless of efficiency. A cap on benchmarks at a percentage of the national average is a far more nuanced approach to mitigate legitimate concerns that the PTC design is inflating health insurance costs in certain regions.

e. **Improve income verification and increase recapture of erroneous subsidies:** Lax program integrity standards undermine the ability to ensure taxpayer resources are reaching the neediest among us and undermine support for public programs. The high risk of improper payment for benefits made based on estimates of income not only is intuitive but was also well established through experience prior to the ACA.[43] Congress should ensure that the ACA is benefiting those intended by ensuring that eligibility standards are taken seriously and reduce the current financial incentive for under-or overestimating income by enrollees or third parties.

On prescription drug pricing: Instead of using a temporary, legally dubious, and expensive band-aid, Congress should revisit the IRA redesign of Medicare Part D. Separately, drug pricing reforms should focus on areas with the most explosive spending growth.

a. **Improve the Medicare Part D redesign:** The Medicare Part D Premium Stabilization Demonstration is not a credible demonstration and offers no long-term solution for the underlying cause of increasing premiums. Congress should cancel years two and three of the demonstration and revisit the Part D redesign to more closely hew to the bipartisan framework considered in 2020.

b. **Prevent abuse of demonstration programs:** In both 2012 and 2024, Section 402 demonstration authority has been used in legally dubious ways to increase payments to insurance companies at the expense of billions of taxpayer dollars with no congressional oversight. Traditionally, Section 402 demonstrations have

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[41] Over the past 10 years, no state has had average ESI premiums higher than 125 percent of the national average. In 2022 (the most recent year for which there was data), no state had average ESI premiums higher than 114 percent of the national average.

[42] Theo Merkel and Brian Blase, "Follow the Money: How Tax Policy Shapes Health Care," Paragon Health Institute, May 2024, https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/.

[43] GAO, Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance, August 2007, https://www.gao.gov/assets/gao-07-1110.pdf.

been minor in scale and budget neutral, but given these repeated aberrations, Congress should make the budget neutrality requirement statutory.

c. **Replace flawed price controls with improving value for most costly prescription drugs:** Medicare Part D spending has grown at 2.6 percent per beneficiary annually over the past decade, while Medicare Part B prescription drug spending per beneficiary has grown at 9.2 percent annually over the same time period.[44] As I note in my recent report for the Manhattan Institute, "How to Deliver Lower Prices for Seniors," this explosive growth is concentrated in a small subset of Part B prescription drugs with little or no competition.[45]

   When pursuing prescription drug pricing reforms, Congress should be wary of upending parts of the Medicare program that have successfully moderated spending growth over time and focus on aspects of the program that are not functioning as well. Average sales price (ASP) is the current method for determining payment for therapeutics in Medicare Part B. Because ASP effectively uses the average of discounts achieved by private payers in the commercial (non-Medicare) market, its success at discerning value is predicated on robust competition in the commercial market. If a novel therapeutic has no competitors and the majority of revenue is anticipated to come from Medicare patients, manufacturers have little incentive to offer discounts in the commercial market, because they know it will negatively impact a more important source of revenue. For this subset of prescription drugs, Medicare is effectively a price taker of whatever the manufacturer determines is appropriate.

   Congress should reform the ASP payment methodology for this expensive subset of drugs. In "How to Deliver Lower Prices for Seniors," I suggest empowering private Medicare Advantage plans (instead of commercial plans that have no Medicare patients) to negotiate discounts for novel therapeutics, which would then be used to set payment in traditional Medicare as well.

On insulin copayments: Congress should revisit the IRA copay cap in a way that is more favorable to Medicare beneficiaries and taxpayers while reviving the Health Resources and Services Administration program to provide targeted relief for low-income insulin users.

a. **Revive insulin copay cap based on previous demonstration program:** The Trump administration gave all insulin-dependent seniors with Medicare prescription drug coverage the option of a plan with a $35 copay cap on insulin. Insulin manufacturers contributed to the cost of the program by providing larger discounts on their products. The IRA disbanded this program and replaced it with

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[44] Nguyen X. Nguyen et al., "Medicare Part B Drugs: Trends in Spending and Utilization, 2008-2021," U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, June 9, 2023, https://aspe.hhs.gov/reports/medicare-part-b-drugs-spending-utilization.

[45] Theo Merkel, "How to Deliver Lower Prices for Seniors: A Market-Based Reform for Expensive Drugs with Limited Competition," Manhattan Institute, June 18, 2024, https://manhattan.institute/article/how-to-deliver-lower-prices-for-seniors.

a copay cap paid for through higher premiums for beneficiaries and higher subsidies from taxpayers. Congress should suspend the misguided IRA copay cap and replace it with a more balanced policy based on the Trump-era cap.

b. **Reinstate program to deliver low-cost insulin for the uninsured:** The vast majority of insured patients already have access to insulin at under $35 per prescription. The Trump administration created a targeted program that provided extremely low-cost insulin to the uninsured and low-income insured at no additional cost to the taxpayer. Congress should reverse the inexplicable decision by the Biden administration to shutter this program.

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