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Before the United States Congress
Joint Economic Committee

"Stop Paying More for Less:
Realigning Healthcare Incentives to Improve Outcomes and Reduce Costs"

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Chairman Schweikert, Ranking Member Hassan, and members of the committee, thank you for inviting me here today. My name is Matthew Fiedler, and I am a health economist and the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Institution.[1]

My testimony examines how policymakers can reduce premiums for private health insurance, including plans obtained from employers and on the individual market. It makes four main points:

- **Substantially reducing health insurance premiums—without shifting costs onto enrollees or excluding high-cost people from coverage—requires reducing either health care prices or utilization.** In 2023, 90% of the dollars spent on private health insurance were ultimately spent on health care, with only 10% consumed by plan administrative costs or profits. Thus, while there are surely opportunities to reduce plan administrative costs and profits, achieving large reductions in insurance premiums (without excluding high-cost people from coverage or shifting costs onto enrollees by raising out-of-pocket costs or narrowing benefits) would require reducing underlying spending on health care, especially hospital care, physician care, and prescription drugs. There are ultimately only two ways to do that: pay lower prices for health care or use less of it.

- **Increasing competition in health care markets could reduce prices, although achieving large reductions would likely require more aggressive steps.** A fundamental challenge is that U.S. health care markets are often not that competitive. In almost half of metro areas, patients have only one or two hospital systems to choose from. Physician markets are also often highly concentrated, in part because around half of physicians are now employed by hospital systems. Steps aimed at improving competition, such as increasing antitrust scrutiny of health care mergers or reducing incentives for hospitals to buy up physician practices by implementing site-neutral payment reforms in Medicare, could reduce the prices that private insurers are able to negotiate with providers.

  While steps like these merit serious consideration, they would likely only modestly reduce concentration. Consistent with this, the Congressional Budget Office has estimated that even a robust package of steps aimed at improving competition would reduce prices by 1 to 3% over the medium run. If policymakers wanted to achieve larger price reductions, that would likely require more aggressive steps, like capping the prices providers can collect or introducing a "public option" that sets prices administratively, as Medicare does, with the goal of driving prices toward the much lower prices that Medicare pays for care.

[1] The views expressed in this testimony are my own and should not be attributed to others affiliated with Brookings.

- **Saving money by reducing utilization may be more challenging.** Insurers have strong incentives to root out overutilization and invest considerable effort in doing so (e.g., by creating prior authorization processes). Indeed, insurers may often be *too aggressive* in this regard, rather than not aggressive enough. While it is clear that substantial overutilization occurs despite insurers' efforts, this may largely reflect obstacles (e.g., challenges in identifying waste) that would be hard for policymakers to address.

  Nevertheless, there are policy options in this area worth exploring. One is encouraging delivery of services that generate downstream cost savings, such as certain preventive care and curative therapies. Insurers may be too stingy with these services since some downstream savings may accrue after an enrollee has switched to a new insurer. In practice, it may be hard to achieve large net savings in this way since relatively few services appear to reduce costs on net after accounting for their upfront costs, but there are exceptions (e.g., some vaccines for children and treatment for Hepatitis C), and there may still be opportunities to improve health at low cost. Another option is continuing efforts to move traditional Medicare away from fee-for-service payment, which may generate "spillover" savings in the private market that insurers could not readily achieve on their own.

- **Efforts to reduce insurance premiums, while valuable, are not a substitute for extending the enhanced premium tax credits.** Congress faces an imminent choice about whether to extend enhancements to the premium tax credit that were first enacted in 2021. Estimates indicate that, if the enhancements expire, Marketplace enrollees will pay around $1,000 more per year, on average, and around 4 million will become uninsured.

  Steps to reduce underlying insurance premiums are not a viable way to prevent these effects on Marketplace enrollees (even if they could be implemented immediately, which is unlikely). Because of how the premium tax credit works, fully protecting enrollees from higher costs would require reducing pre-subsidy premiums to be at least as low as the income-based amounts that Marketplace enrollees pay under the enhanced credits. For the large majority of enrollees, this would require implausibly large premium reductions. (This is not because Marketplace coverage is uniquely expensive. To the contrary, pre-subsidy Marketplace premiums are typically lower than premiums for employer plans.)

  Consider, for example, a 40-year-old with an income at 200% of the federal poverty level ($31,300 per year), an income level that 65% of enrollees were at or below in 2025. With the enhanced credits, this enrollee pays $626 per year for the "benchmark" plan. The average benchmark premium for this enrollee is $7,500 per year, so to fully protect the enrollee from paying more, pre-subsidy premiums would need to fall by 92%. To even partly protect the enrollee, the pre-subsidy premium would need to fall below the $2,067 per year that the enrollee would pay without the enhanced credits, a more than 72% decline.

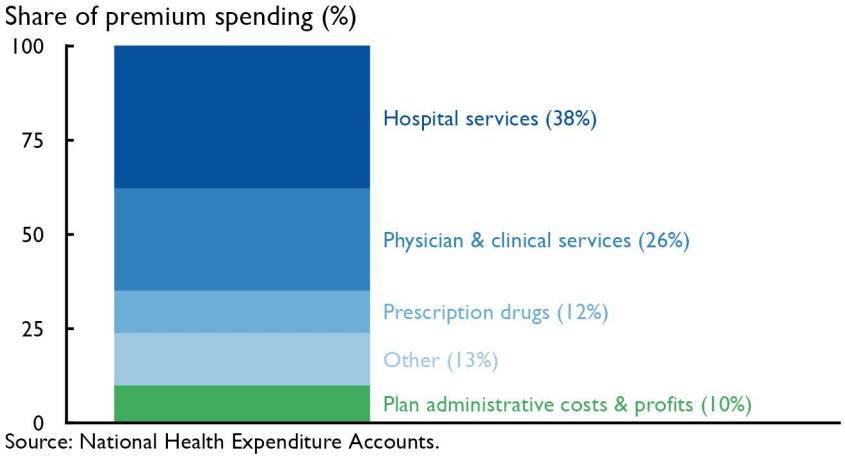
  To be clear, steps to reduce underlying insurance premiums would have other important benefits. They could directly reduce costs for people who get coverage from an employer. They would also reduce the federal cost of subsidizing both Marketplace and employer coverage, savings that policymakers could use to offset the roughly $30 billion annual cost of extending the enhanced credits. But they would not, in themselves, meaningfully address the near-term cost increases that are facing Marketplace enrollees.

The remainder of my testimony examines each of these points in greater detail.

Strategies for Reducing Private Health Insurance Premiums

To understand the options for reducing health insurance premiums, it is useful to first examine where premium dollars go today.[2] Figure 1 uses data from the National Health Expenditure Accounts to break down how the dollars that individuals and employers spent on private health insurance during 2023 (the most recent year for which data are available) were ultimately used.

Figure 1. Uses of Private Insurance Premiums, 2023



Source: National Health Expenditure Accounts.
Note: Estimates include spending on health coverage by employers and individuals, but exclude spending on coverage delivered by private insurers in public programs.

The figure shows that 90% of the dollars spent on private health insurance in 2023 were ultimately spent on health care, with only 10% accounted for by insurer administrative costs and profits. An important takeaway is that, while there are surely opportunities to squeeze insurer profit margins and reduce administrative costs, substantially reducing premiums (at least without excluding high-cost enrollees from coverage or shifting costs onto enrollees by increasing cost-sharing or narrowing benefits) is likely to require reducing underlying health care spending. This includes spending on hospital and physician services, which consume almost two-thirds of premium dollars.

There are two basic ways to reduce spending. The first is reducing the *prices* insurers pay for health care (e.g., to hospitals, physicians, or drug manufacturers), and the second is reducing health care *utilization* (e.g., how many visits enrollees make to hospitals or physicians and how many prescriptions enrollees fill). In what follows, I discuss opportunities in each domain in turn.

Policy opportunities to reduce health care prices

Let me start with prices. A fundamental challenge is that U.S. health care markets are often not very competitive. In almost half of U.S. metro areas, patients have only one or two competing hospital systems to choose from, and virtually all metro areas have hospital markets that would be considered "highly concentrated" under the criteria typically used by federal antitrust agencies.[3] In many areas, the market for physician services is also quite concentrated,[4] in large part because

[2] Throughout, I use the term "premiums" to encompass amounts that employers spend on self-insured health plans.

[3] Jamie Godwin et al., *One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022* (KFF, 2024), https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas-in-2022/.

[4] Brent D. Fulton, "Health Care Market Concentration Trends In The United States: Evidence And Policy Responses," *Health Affairs* 36, no. 9 (2017): 1530–38, https://doi.org/10.1377/hlthaff.2017.0556.

around half of physicians are affiliated with hospital systems.[5] Private insurers must negotiate prices with providers, so limited competition gives providers leverage to extract higher prices.[6]

One way that policymakers could lower the prices paid by private insurers is to make health care markets more competitive. While there are a number of specific steps that they could take toward this objective,[7] I want to highlight two steps that I see as especially ripe for action:

- *Increase scrutiny of health care mergers:* Mergers are an important part of how health care markets have become as concentrated as they are today. One recent study estimated that there were more than 1,100 hospital mergers from 2002 to 2020,[8] a sizeable number considering that there are currently only around 5,100 community hospitals in the United States.[9] Physician merger activity is harder to track because there are so many more physicians and because of the limitations of the available data, but one recent study examining 15 states found that practices accounting for around 1% of the physician workforce were acquired *every year* from 2015 to 2020; this pace of merger activity would likely generate substantial increases in market concentration over time.[10]

  Federal antitrust agencies challenged only 1% of the more than 1,100 hospital mergers highlighted above and likely an even smaller share of the physician mergers.[11] This is despite the fact that a substantial minority of mergers had characteristics suggesting that they could meaningfully reduce competition.[12] Indeed, a retrospective analysis of hospital mergers identified as likely to harm competition found that they did end up raising prices.[13]

  There are various ways to strengthen merger enforcement. One strategy would be to increase the budgets of the federal antitrust agencies (the Federal Trade Commission and the Department of Justice Antitrust Division), as resource constraints are a major reason

[5] For a survey of recent estimates, see Government Accountability Office, *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation* (2025), https://www.gao.gov/products/gao-25-107450.

[6] For a recent review of evidence on how market concentration affects the prices providers negotiate in private insurance, see Jodi L. Liu et al., *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets* (2022), https://www.rand.org/pubs/research_reports/RRA1820-1.html.

[7] For a review, see Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (2022), https://www.cbo.gov/publication/58222.

[8] Zarek Brot et al., "Is There Too Little Antitrust Enforcement in the US Hospital Sector?," *American Economic Review: Insights* 6, no. 4 (2024): 526–42, https://doi.org/10.1257/aeri.20230340.

[9] American Hospital Association, "Fast Facts on U.S. Hospitals, 2025," September 11, 2025, https://www.aha.org/statistics/fast-facts-us-hospitals.

[10] Daniel Deibler et al., "Physician Mergers Involve 38% of Doctors, Substantial Health System Participation, and Frequent Serial Acquisition," *Health Affairs Scholar* 3, no. 5 (2025): qxaf061, https://doi.org/10.1093/haschl/qxaf061. The methods used in this study may miss some acquisitions, so this estimate should likely be viewed as a lower bound on the level of merger activity in physician markets.

[11] For hospital mergers, see Brot et al. For physician mergers, Deibler et al. identify 2019 mergers in the states they examine during the 2015-2020 period, and there were only a handful of federal challenges to mergers involving physician practices during this period; see Sara Razi et al., *Physician Groups - The Next Enforcement Frontier for Healthcare Provider Mergers?* (Charles River Associates, 2021), https://www.crai.com/insights-events/publications/physician-groups-the-next-enforcement-frontier-for-healthcare-provider-mergers/.

[12] Brot et al., "Is There Too Little Antitrust Enforcement in the US Hospital Sector?"; Deibler et al., "Physician Mergers Involve 38% of Doctors, Substantial Health System Participation, and Frequent Serial Acquisition."

[13] Brot et al., "Is There Too Little Antitrust Enforcement in the US Hospital Sector?"

that they do not challenge more mergers.[14] Another strategy would be to modify the antitrust laws to reduce the evidentiary burden that the agencies must meet, which could reduce the cost of challenging mergers, increase the likelihood that the agencies win when they do bring challenges, and perhaps deter some firms from attempting to merge in the first place.[15] A final strategy would be to require more merging entities to notify the federal government in advance of their planned mergers; at present, many health care mergers (including some that appear to pose a risk of competitive harm) are too small to trigger existing reporting requirements, which limits antitrust agencies' ability to intervene.[16]

- *Adopt site-neutral payment in Medicare:* Another potential target for reform is the way that Medicare pays for ambulatory services. Medicare typically pays much more when a service is delivered in a hospital's outpatient department than when the same service is delivered in a physician's office.[17] These payment differentials can encourage hospital systems to buy up physician practices and recast them as hospital outpatient departments.[18] This, in turn, increases how much of the market for physician services is controlled by large health systems and has been found to increase the prices paid by private insurers.[19]

  Policymakers could eliminate these incentives by implementing "site-neutral" payment for ambulatory services, under which Medicare would pay the same amount for these services regardless of where they are delivered. While lawmakers have previously implemented site-neutral payment for certain off-campus hospital locations, and the Centers for Medicare and Medicaid Services has done so administratively for certain specific types of services, Medicare is still a long way from comprehensive site-neutral payment.

  It is also worth noting that site-neutral reforms have the potential to reduce the prices paid in private insurance through a channel other than increasing competition, which may be more important in practice. Namely, research finds that when Medicare reduces the prices it pays for health care, private insurers are often able to negotiate lower prices as well.[20]

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[14] Martin Gaynor, *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work* (Brookings Institution, 2020), https://www.hamiltonproject.org/assets/files/Gaynor_PP_FINAL.pdf.

[15] Jonathan B Baker and Fiona Scott Morton, *Confronting Rising Market Power* (Economics for Inclusive Prosperity, 2019), https://econfip.org/wp-content/uploads/2019/05/Confronting-Rising-Market-Power.pdf; Gaynor, *What to Do about Health-Care Markets?*; Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*.

[16] Cory Capps et al., "Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene," *Health Affairs* 36, no. 9 (2017): 1556–63, https://doi.org/10.1377/hlthaff.2017.0054; Brot et al., "Is There Too Little Antitrust Enforcement in the US Hospital Sector?"; Gaynor, *What to Do about Health-Care Markets?*

[17] Medicare Payment Advisory Commission (MedPAC), *Medicare and the Health Care Delivery System* (2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

[18] Brady Post et al., "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," *Health Services Research* 56, no. 1 (2021): 7–15, https://doi.org/10.1111/1475-6773.13613.

[19] Cory Capps et al., "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001.

[20] Chapin White, "Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates," *Health Affairs* 32, no. 5 (2013): 935–43, https://doi.org/10.1377/hlthaff.2012.0332; Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy* 125, no. 1 (2016): 1–39, https://doi.org/10.1086/689772.

> Thus, if the direct federal savings from implementing site-neutral reforms were not fully reinvested in raising the prices that Medicare pays for other services, this offers another reason to expect site-neutral reforms to reduce the prices paid by private insurers.

While steps like these merit serious consideration from policymakers, they would likely fall well short of ensuring appropriate levels of competition and, in turn, prices. Health care markets are already highly concentrated, and while these steps may slow future increases in concentration, they are not well-suited to reducing concentration. Moreover, these steps may be only partly successful even in stemming further increases in concentration. The highly local nature of health care markets—particularly the fact that firms often serve narrow geographic areas but become dominant within those areas—poses challenges for merger enforcement, as it means that the absolute number of problematic mergers is much larger than in industries where dominant firms tend to have broader geographic scope. Similarly, hospital systems have many reasons to buy up physician practices beyond taking advantage of Medicare's site-of-service payment rules, not least the simple fact that it allows them to extract higher prices from private insurers.[21] Thus, steps toward site-neutrality (especially small ones) may have only modest effects on concentration.[22]

Consistent with this view, the Congressional Budget Office has estimated that a package of federal policy changes aimed at boosting competition (that would encompass steps like those described above in addition to other similar changes) would reduce prices by only 1 to 3%, at least over the first decade following enactment.[23] Even percentage changes in this range could correspond to correspond to tens of billions of dollars per year in premium savings, which makes changes in this vein very much worth considering. However, policymakers interested in achieving larger reductions in prices and premiums would likely need to look to other types of tools.

In my view, the most feasible path to more substantial savings would be to expand the public role in determining health care prices. Consider experience in the Medicare program. Traditional Medicare sets prices administratively via formulas established in law, which eliminates providers' ability to use their market power to extract high prices. Correspondingly, traditional Medicare pays less than half as much as private insurers for hospital services, and a bit more than three-quarters as much for physician services, as depicted in Figure 2.[24] Yet Medicare beneficiaries do not appear to enjoy notably worse access to health care providers. Provider participation in traditional Medicare is nearly universal, whereas the networks of commercial insurance plans typically exclude at least some providers.[25] Similarly, in surveys, Medicare beneficiaries report—if anything—having an easier time obtaining physician care than the privately insured.[26]

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[21] Capps et al., "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending."

[22] Brady Post et al., "Site-Neutral Payment Reform: Little Impact On Outpatient Medicare Spending Or Hospital-Physician Integration," *Health Affairs* 44, no. 6 (2025): 659–67, https://doi.org/10.1377/hlthaff.2024.00972.

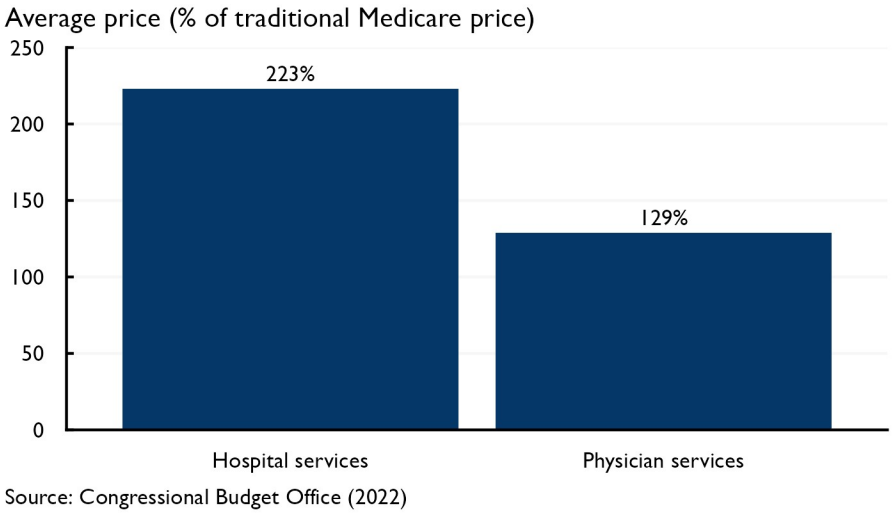
[23] Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*.

[24] Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* (2022), https://www.cbo.gov/publication/57422.

[25] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy* (2025), https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/; John A. Graves et al., "Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets," *JAMA Network Open* 3, no. 12 (2020): e2029419, https://doi.org/10.1001/jamanetworkopen.2020.29419.

[26] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy*.

Figure 2. Average Provider Prices in Commerical Insurance



Source: Congressional Budget Office (2022)

A larger public role could take a couple of different forms. One approach would be to cap the prices that providers can charge in private insurance markets; steps like these have begun to attract some interest from state policymakers, with both Indiana and Vermont enacting laws that would cap hospital prices during 2025.[27] Another approach would be to create a publicly run insurance plan (sometimes called a "public option") that would set the prices it pays using methods similar to Medicare's; a public option could directly offer enrollees a lower-cost option and place competitive pressure on private insurers that might also allow them to negotiate lower prices.[28]

Importantly, these types of steps would involve more risk than boosting competition. Whereas strengthening competition is unlikely to drive prices so low that providers cannot continue operating or must cut costs in ways that greatly reduce quality of care, that would be possible under these types of proposals. For this reason, if policymakers elected to go down this road, it would be imperative that they proceed thoughtfully. However, if policymakers want to greatly reduce prices in private insurance markets, these approaches are the only realistic path to that outcome.

Policy opportunities to reduce health care utilization

I turn next to utilization. There is little question that people with private insurance commonly receive services that have little health benefit.[29] But it is not always clear what to do about it.

Insurers have strong incentives to root out overutilization and use a range of tools to do so. For example, insurers can set coverage criteria and then enforce those criteria by requiring prior authorization before care is delivered or denying claims for care that does not meet their standards.

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[27] Nathan Hostert et al., "How States Are Using Hospital Price Caps To Save Money," *Health Affairs Forefront*, ahead of print, October 9, 2025, https://doi.org/10.1377/forefront.20251008.247769.

[28] For an overview of potential approaches, see Matthew Fiedler, *Capping Prices or Creating a Public Option: How Would They Change What We Pay for Health Care?* (Brookings Institution, 2020), https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/; Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*.

[29] See, for example, Health Care Cost Institute, *Focusing on Seven Services Could Eliminate More Than Two-Thirds of Low-Value Care in HCCI's ESI Data* (2023), https://healthcostinstitute.org/wp-content/uploads/images/pdfs/HCCI_LVC_April1923.pdf.

They can also apply cost-sharing requirements in hopes of deterring enrollees from receiving services that they do not value. Insurers use these tools extensively in practice. Indeed, it is common to hear complaints that insurers are *too aggressive* in applying these types of tools. Perhaps consistent with this concern, research finds that insurers' efforts to manage utilization frequently end up reducing utilization of both high- and low-value care.[30]

Thus, while insurers do often fall short in addressing overutilization, the problem does not appear to be a lack of effort. Rather, distinguishing low- and high-value care may often be challenging. Or enrollees (and their providers) may disagree that care is wasteful, making it hard for insurers to limit utilization in practice. These obstacles may often be hard for federal policy to address.

There are, however, a couple of opportunities for addressing unnecessary utilization in private insurance that I believe merit consideration from policymakers:

- *Encouraging use of services that generate downstream cost savings:* Insurers' incentives may lead them to be too stingy in covering services that generate downstream cost savings, such as certain preventive and curative therapies. While an enrollee's current insurer bears the upfront costs of a service, some or all of the downstream cost savings may accrue to the enrollee's future insurer, which may not be the same company. Indeed, in recent years, around one in five people with commercial insurance left their insurer each year.[31] If enrollees undervalue the long-term health benefits generated by these types of services, that could reinforce insurers' incentives to underinvest in these areas.

  In practice, opportunities to actually save money by encouraging delivery of these types of services may be relatively limited, as services that reduce costs on net after accounting for the upfront cost of delivering them appear to be relatively rare.[32] But there are exceptions. Vaccines commonly administered to children are a notable one.[33] Another example is treatment of Hepatitis C with direct-acting antivirals.[34] Moreover, even where cost savings are infeasible, these types of services may offer low-cost ways of improving health.

  If policymakers wished to encourage greater use of services that generate downstream cost savings, they have several options. They could consider requiring insurers to cover certain services with strong evidence of (cost-)effectiveness or to cover them on generous terms.

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[30] See, for example, Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," *The Quarterly Journal of Economics* 132, no. 3 (2017): 1261–318, https://doi.org/10.1093/qje/qjx013; Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 11, no. 2 (2019): 302–32, https://doi.org/10.1257/app.20170295.

[31] Hanming Fang et al., "Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006-2018," *JAMA Network Open* 5, no. 2 (2022): e220320, https://doi.org/10.1001/jamanetworkopen.2022.0320.

[32] Katherine Baicker and Amitabh Chandra, "Can Prevention Save Money?," *JAMA Health Forum* 6, no. 4 (2025): e251464, https://doi.org/10.1001/jamahealthforum.2025.1464.

[33] Fangjun Zhou, "Health and Economic Benefits of Routine Childhood Immunizations in the Era of the Vaccines for Children Program — United States, 1994–2023," *MMWR. Morbidity and Mortality Weekly Report* 73 (2024), https://doi.org/10.15585/mmwr.mm7331a2; Michael L. Anderson et al., "Real-World Effectiveness of the Influenza Vaccine in Young Children," Working Paper no. 33856, Working Paper Series (National Bureau of Economic Research, May 2025), https://doi.org/10.3386/w33856.

[34] Congressional Budget Office, *Budgetary Effects of Policies That Would Increase Hepatitis C Treatment* (2024), https://www.cbo.gov/publication/60407.

The Affordable Care Act took this approach with respect to many preventive services by requiring private insurance plans to cover those services and do so without cost-sharing. That approach could be extended to other types of services, for example, certain generic maintenance drugs for chronic conditions. Another approach might be for the government to reimburse insurers for part of the cost of such services or even to carve them out of private insurance contracts and deliver them directly; these strategies could be particularly relevant for high-cost services where insurers worry that offering generous coverage will tend to attract large numbers of enrollees who need those services.[35]

- *Continuing efforts to move away from fee-for-service payment in traditional Medicare:* Recent years have seen extensive efforts to reduce Medicare's use of fee-for-service payment methods (i.e., methods in which providers are paid for each service they deliver) in favor of other methods, notably accountable care organization (ACO) models. Under ACO models, providers that reduce their patients' overall spending below a target level get to keep part of the savings (and, in some models, must pay money back to the federal government if spending exceeds the target). Unlike fee-for-service payment, ACO models give providers financial incentives to identify and find ways to eliminate wasteful utilization. More than half of traditional Medicare beneficiaries are now served by providers that participate in an ACO model or another similar payment arrangement.[36]

  The most direct goal of these efforts is to improve the efficiency of the care received by traditional Medicare beneficiaries, and they appear to have been modestly successful in doing so.[37] But models like these could, at least in principle, generate savings for other payers as well if they cause providers to change how they treat all of their patients, not just those covered by the payment arrangement in question.[38] Medicare's efforts could also facilitate adoption of similar payment arrangements by other payers by allowing providers to spread the fixed costs associated with participating in ACO-like models across a broader patient base or by catalyzing a broader system-wide focus on reducing overutilization.[39] Thus, expanding use of ACOs in Medicare could generate savings in private insurance.

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[35] Matthew Fiedler and Richard G. Frank, *Assessing CMMI's Proposals on Medicaid Payment for Cell and Gene Therapies* (Brookings Institution, 2023), https://www.brookings.edu/articles/assessing-cmmis-proposals-on-medicaid-payment-for-cell-and-gene-therapies/; Matthew Fiedler and Richard Frank, "Response to a Request for Information on Ensuring Access to Cell and Gene Therapies," January 22, 2024, https://www.brookings.edu/articles/response-to-a-request-for-information-on-ensuring-access-to-cell-and-gene-therapies/.

[36] Center for Medicare and Medicaid Services, "CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives," January 15, 2025, https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives.

[37] Congressional Budget Office, *Medicare Accountable Care Organizations: Past Performance and Future Directions* (2024), https://www.cbo.gov/publication/60213.

[38] J. Michael McWilliams et al., "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With a Commercial ACO Contract," *JAMA* 310, no. 8 (2013): 829–36, https://doi.org/10.1001/jama.2013.276302; Liran Einav et al., "Randomized Trial Shows Healthcare Payment Reform Has Equal-Sized Spillover Effects on Patients Not Targeted by Reform," *Proceedings of the National Academy of Sciences* 117, no. 32 (2020): 18939–47, https://doi.org/10.1073/pnas.2004759117.

[39] Melinda B. Buntin et al., "The Value Zeitgeist — Considering the Slowdown in Health Care Spending Growth," *New England Journal of Medicine* 392, no. 15 (2025): 1463–66, https://doi.org/10.1056/NEJMp2413472.

A major ongoing challenge for Medicare's ACO models is that they are voluntary for providers. As a result, many providers have declined to participate, and the Centers for Medicare and Medicaid Services has had to design these models in ways that make them less effective in improving efficiency.[40] Creating additional payment bonuses for providers that participate in these models and penalties for providers that do not participate could make these models "less voluntary" and, thus, help address both of these problems.

Reducing Underlying Premiums is Not a Substitute for Extending the Enhanced PTCs

Congress faces an imminent choice about whether to extend the enhancements to the premium tax credit that were first enacted in 2021 and are scheduled to expire at the start of 2026. Prior estimates indicate that, if the enhanced credits expire, Marketplace enrollees will pay around $1,000 more per year for their coverage and around 4 million people will become uninsured.[41]

Importantly, steps to reduce underlying premiums like those discussed above could not prevent these adverse effects on Marketplace enrollees. One issue is simply timing. These steps would often take years to have meaningful effects, while the enhanced credits expire in less than a month.

But the problem is more fundamental. Unless the reduction in underlying premiums were extremely large—larger than would be plausible under even aggressive versions of the options I discussed above—that reduction would deliver little or no benefit to the large majority of Marketplace enrollees, much less a benefit large enough to offset the loss of the enhanced credits.

To see why, recall that the premium tax credit limits what an enrollee is required to pay toward a benchmark plan (the second-lowest cost silver plan available to the enrollee) to an amount that varies based on income; if the actual benchmark premium is higher, then the tax credit covers the rest. This means that a reduction in pre-subsidy premiums can only reduce the enrollee's cost to enroll in the benchmark plan if it pushes the benchmark premium below the enrollee's income-based limit. Thus, to fully offset the loss of the enhanced credits, the pre-subsidy premium of the benchmark plan would need to fall below the income-based limits that apply under the enhanced credits. And to even partly offset the loss of the enhanced credits, the benchmark premium would need to fall below the income-based limits that apply under the pre-2021 rules.

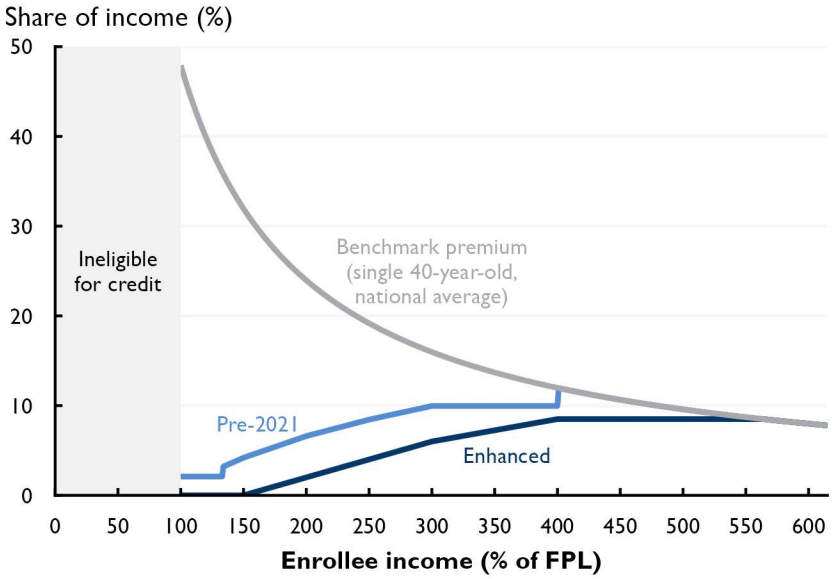
Even a cursory look at the data shows that this is very unlikely for the large majority of Marketplace enrollees. To illustrate this fact, the blue lines in Figure 3 depict the percentage of income that an enrollee is expected to pay toward the benchmark plan under the pre-2021 tax credit rules and the enhanced credits at different income levels, with income expressed as a percentage of the federal poverty level (FPL). The silver line depicts the benchmark premium as a percentage

[40] "Medicare Physician Payment Reform after Two Years: Examining MACRA Implementation and the Road Ahead," with Matthew Fiedler, May 8, 2019, https://www.finance.senate.gov/imo/media/doc/08MAY2019FIEDLERSTMNT.pdf; J. Michael McWilliams et al., *From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments* (Brookings Institution, 2021), https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/; Congressional Budget Office, *Medicare Accountable Care Organizations*.

[41] Justin Lo et al., *ACA Marketplace Premium Payments Would More than Double on Average Next Year If Enhanced Premium Tax Credits Expire* (KFF, 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/; Congressional Budget Office, "Estimated Budgetary Effects of S. 3385, the Lower Health Care Costs Act," December 10, 2025, https://www.cbo.gov/system/files/2025-12/s3385.pdf.

of income for a single 40-year-old who lives in an area with premiums that match the 2026 national average.[42] (Below, I consider how the situation would differ for other types of enrollees.)

Figure 3. Enrollee Cost and Benchmark Premium, 2026



Note: Eligibility range reflects the situation in states that have not expanded Medicaid.

Consider first an enrollee at 200% of the FPL ($31,300 per year for a single person), an income level that 65% of Marketplace enrollees were at or below during 2025 open enrollment. The benchmark premium equates to 24% of this enrollee's income ($7,500 per year), whereas the enrollee pays only 2% of income ($626 per year) under the enhanced credits. Thus, to fully compensate for the loss of the enhanced credits, the benchmark premium would need to fall by 92%. To even partially compensate for their loss, the benchmark premium would need to fall below 6.6% of income ($2,067 per year), a decline of more than 72%. Premium declines of this magnitude are clearly implausible; even an aggressive intervention like introducing a public option that would pay providers Medicare rates is only estimated to reduce premiums by 28%.[43]

The premium declines required to offset the loss of the enhanced credits would be implausibly large even at higher income levels. Consider an enrollee at 400% of the FPL ($62,600 per year for a single person), an income level that 90% of Marketplace enrollees were at or below during 2025 open enrollment. The benchmark premium equates to 12.0% of the enrollee's income, whereas the enrollee pays only 8.5% of income under the enhanced credits. Thus, to fully compensate the enrollee for the loss of the enhanced credits, the benchmark premium would need to fall by 29%.

Importantly, the reason that the required declines are so large is not that Marketplace coverage is uniquely expensive. To the contrary, after adjusting for differences in cost-sharing and the age mix

[42] KFF, "Marketplace Average Monthly Benchmark Premiums," December 13, 2025, https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/.

[43] John Holahan and Michael Simpson, *Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets: Updated Estimates* (Urban Institute, 2021), https://www.urban.org/sites/default/files/publication/103817/introducing-a-public-option-or-capped-provider-payment-rates-into-private-insurance-markets.pdf.

of enrollment, Marketplace plans tend to have lower premiums than employer plans,[44] which may partly reflect the fact that Marketplace plans tend to have narrower networks and pay providers less.[45] In short, Marketplace plans are expensive because health care is expensive.

The exact implications of premium declines would vary based on enrollees' circumstances. For enrollees who are older than the 40-year enrollee I consider here or who live in areas with above-average premiums, premiums would need to fall by more than I estimate above to offset the loss of the enhanced credits; for younger enrollees or enrollees living in areas with below-average premiums, premiums would need to fall by less. Similarly, households with more than one person would generally require larger premium declines to be held harmless.[46] And enrollees who purchased plans with premiums below that of the benchmark plan (e.g., bronze plans) would typically require larger premium declines to be held harmless, while those who purchased plans with premiums above that of the benchmark plan would require smaller declines. Regardless, it is clear that the required declines would be implausibly large in the large majority of cases.

In closing, I note that steps to reduce underlying premiums would have other benefits. They would typically directly reduce costs for people who get coverage from an employer. They would also reduce the *federal* cost of subsidizing both Marketplace coverage (via the premium tax credit) and employer-based coverage (via the tax exclusion for employer-provided coverage). The resulting savings could, if policymakers wished, be used to offset the roughly $30 billion annual cost of extending the enhanced credits.[47] But reducing underlying premiums would not, in itself, address the near-term cost increases looming for Marketplace enrollees.

[44] John Holahan and Erik Wengle, *How Do Marketplace Premiums Compare with Premiums in the Large- and Small-Group Markets?* (Urban Institute, 2024), https://www.urban.org/research/publication/how-do-marketplace-premiums-compare-premiums-large-and-small-group-markets.

[45] Graves et al., "Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets"; Caroline Hanson et al., "Providers Paid Substantially Less By Marketplace Nongroup Insurers Than By Employer Small-Group Plans, 2021," *Health Affairs* 43, no. 12 (2024): 1672–79, https://doi.org/10.1377/hlthaff.2024.00913.

[46] This is because premiums grow linearly with household size (at a fixed age), while the income corresponding to a given FPL ratio and, thus, the enrollee's expected contribution, grows less than proportionally with household size.

[47] Congressional Budget Office, "Estimated Budgetary Effects of S. 3385, the Lower Health Care Costs Act."