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Testimony for the Record
Submitted to the
House Committee on the Judiciary
Subcommittee on Oversight
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
for the Hearing
"Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?"

December 8, 2025

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Chairmen Van Drew and Massie, Ranking Members Crockett and Correa, and Members of the Subcommittees:

Thank you for devoting your valuable time to focusing on Obamacare subsidy fraud. It is my honor to participate in today's hearing. I am grateful for the opportunity to share my testimony.

I am Ge Bai, a Certified Public Accountant, Professor of Accounting at the Johns Hopkins Carey Business School, and Professor of Health Policy and Management (joint) at the Johns Hopkins Bloomberg School of Public Health. My research focuses on health care accounting, finance, and policy. I am affiliated with the Johns Hopkins Center for Health Services and Outcomes Research, the Hopkins Business of Health Initiative, and the Johns Hopkins Drug Access and Affordability Initiative. From 2022 to 2023, I served as a visiting scholar at the Health Analysis Division of the Congressional Budget Office (CBO). I have published numerous research articles in leading academic journals examining healthcare affordability and incentive structures.

My testimony has three objectives: (1) to describe the growth of the Obamacare subsidy, (2) to explain Obamacare subsidy fraud, and (3) to discuss the effectiveness of various policy solutions, including the Administrative Procedure Act. I aim to provide an objective, evidence-

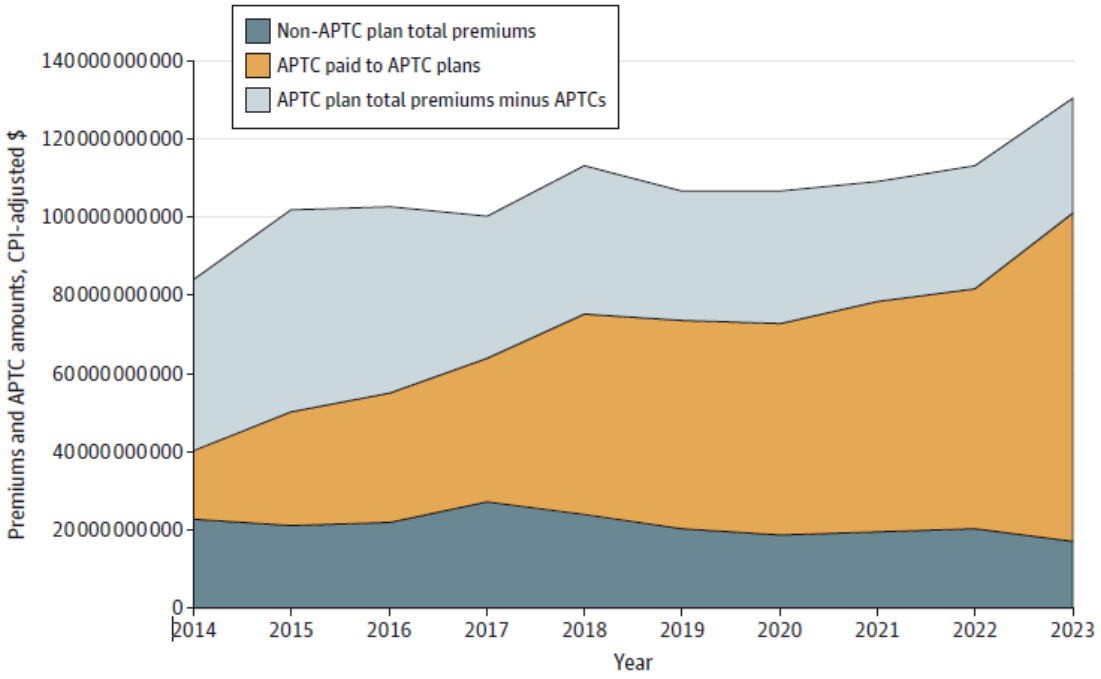
based summary of these issues. The opinions expressed are my own and do not represent the views of Johns Hopkins University or any affiliated entities.

Section I: Obamacare Subsidy Growth

In a forthcoming study in *JAMA Health Forum*, Professor Elizabeth Plummer, Mr. Joshua Brooker, Professor Mark Meiselbach, and I document the explosive growth of Obamacare premium subsidies. Using mandatory Medical Loss Ratio reports from health insurers, our study provides more accurate quantification than previous analyses. As shown below, Obamacare premium subsidies (the orange area) totaled less than $20 billion (in 2024 dollars) in 2014. By 2022, they had grown to $83 billion. For subsidized plans, the taxpayers' share of premium payments jumped from 29% in 2014 to 74% in 2023.[1]

Obamacare premium subsidies were originally available only to Americans with incomes up to 400% of the federal poverty level. In March 2021, at the height of the pandemic, the American Rescue Plan Act temporarily extended premium subsidy eligibility to those with incomes above 400% of the federal poverty level, thereby eliminating any income limit. In August 2022, the Inflation Reduction Act extended those subsidies through December 2025. Our chart below clearly demonstrates the impact of Covid-era enhanced subsidies.

Figure 2. Total Premiums and Advanced Payment Tax Credits (APTCs) for APTC and Non-APTC Plans From 2014 to 2023[a]



[1] In the chart, subsidized plans are labeled at APTC (Advance Premium Tax Credit) plans. Taxpayers' share of premiums is represented by the height of the orange area divided by the combined height of the orange and light grey areas.

As more people became eligible for Covid-era enhanced subsidies, enrollment grew. However, the amount of premiums paid by enrollees themselves (the light grey area) fell from over $40 billion in 2014 to approximately $30 billion in 2023. This occurred because the American Rescue Plan Act lowered the maximum percentage of income that households between 100–400% of federal poverty level were required to pay for Obamacare. As a result of greater subsidy generosity, many plans had $0 or near $0 premiums.[2]

Unsubsidized Obamacare plans have become increasingly unpopular. The size of the unsubsidized market (the dark grey part) shrank by 23% from $23 billion in 2014 to $17 billion in 2023. This represents the actual size of the Obamacare market if no taxpayer subsidies existed.

Section II: Obamacare Subsidy Operational Fraud

Taxpayers have spent hundreds of billions of dollars subsidizing Obamacare premiums, yet substantial evidence indicates widespread fraud. Because these activities diverted taxpayer dollars intended to pay insurers to subsidize eligible Obamacare enrollees' premiums, I categorize them as *operational fraud*. Examples of operational fraud are listed below.

- An undercover investigation by the Government Accountability Office found that 18 of 20 fictitious applications were approved and retained for Obamacare enrollment, with insurers collecting taxpayer subsidies while incurring no medical spending.[3]

- A marketing company CEO and an insurance brokerage executive were convicted in $233 million scheme that targeted vulnerable people with bribes.[4] An executive vice president of insurance brokerage pled guilty to $133 million scheme involving the fraudulent enrollment of ineligible individuals.[5]

- Paragon Health Institute estimated that 6.4 million ineligible enrollees in 2025 (up from 5.0 million in 2024) misrepresented their income to qualify for fully subsidized Obamacare coverage ($0 premium), costing taxpayers over $27 billion in 2025 alone.[6]

- Paragon Health Institute also found that zero-claim enrollees in Obamacare individual markets tripled from 2021 to 2024, reaching nearly 12 million and accounting for 40% of

[2] https://www.kff.org/affordable-care-act/where-aca-marketplace-enrollment-is-growing-the-fastest-and-why/
[3] https://www.gao.gov/products/gao-26-108742
[4] https://www.law360.com/articles/2412091/2-execs-found-guilty-in-233m-aca-fraud-scheme
[5] https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud
[6] https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/?utm_source=chatgpt.com

total enrollees. Meanwhile, zero-claim enrollees remained stable in Obamacare small-group markets, suggesting significant fraudulent enrollment in individual markets.[7]

These examples are neither accidental nor exhaustive. They represent only the tip of the iceberg. Operational fraud persists because regulatory oversight is insufficient to ensure program integrity. More importantly, brokers and insurers, compensated per enrollment, have strong incentives to chase enrollment volume while ignoring integrity. For example, insurers rarely terminate fraudulent brokers in order to preserve subsidy payments from taxpayers.[6] Additionally, the subsidy structure—particularly the proliferation of $0-premium plans enabled by Covid-era enhanced subsidies—is easily exploitable. Operational fraud will continue to grow in the fertile environment created by Obamacare's subsidy design and incentive structure.

Section III: Obamacare Structural Fraud

Operational fraud, as discussed in the previous section, diverts taxpayer dollars away from their intended purpose: subsidizing Obamacare premiums. A fundamental weakness of Obamacare is its unaffordability. As I wrote in the *Wall Street Journal*, "premiums have increased by nearly 80% since 2014 and more than doubled since 2011. They are projected to rise another 15% to 20% next year. Despite record taxpayer spending on premium subsidies—exceeding $130 billion annually—enrollees still pay average deductibles of $5,000 and out-of-pocket maximums of $21,000 while 1 in 5 of their medical claims are denied." [8]

The unaffordability of Obamacare—the direct and predictable consequence of Obamacare's own design—created both the need for taxpayer subsidy and the conditions for widespread operational fraud. Subsidies feed the growing and hungry "dragon," and the dragon's underlying unaffordability was intentionally obscured from the American public at the time of Obamacare's passage. I refer to this phenomenon as Obamacare's *structural fraud*.

Simply put, structural fraud—the root cause—has spawned operational fraud, its derivative problem.

<u>Insurance Regulation</u>

Insurance regulations imposed by Obamacare in the name of protecting patients and improving affordability have instead undermined insurance markets. Main examples include:

1. Essential Health Benefits. As Dr. David A. Hyman and I, along with our coauthors, have written in *JAMA Internal Medicine*, *JAMA Health Forum*, and the *Journal of General*

[7] https://paragoninstitute.org/paragon-prognosis/the-rise-of-phantom-obamacare-enrollees-biden-covid-credits-drive-massive-increase-in-individual-market-enrollees-with-no-medical-claims/?utm_source=chatgpt.com
[8] https://www.wsj.com/opinion/let-the-obamacare-enhanced-premium-subsidies-expire-16ef7e1b

Internal Medicine, insurance exists to protect enrollees against the financial risks of rare, high-cost events.[9,10,11] That is why car insurance does not cover oil changes and property insurance does not cover faucet replacement. Plans that cover routine, low-cost services would require much higher premiums and would hold little appeal to consumers. The same logic applies to health insurance.

When patients use health insurance for routine care, they do not benefit directly from lower prices and are typically limited in their choice of providers. As a result, patients are less mobile and care less about prices than they would in cash transactions, thus reducing downward pricing pressure and inhibiting competition and innovation. Cash prices are often lower than negotiated prices, and medical products and services not covered by insurance have experienced persistent price deflation and improving quality similar to most other commodities.[12,13,14,15,16]

Additionally, insurance generates administrative expenses for processing, adjudicating, and paying each claim, as well as a profit margin for insurers. Coverage also imposes administrative burdens on physicians, reducing the time available for patient care.

Despite these economic realities, Obamacare forced insurance to cover ten Essential Health Benefits, such as mental health services, substance abuse treatment, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness care, and gender affirming care. This rule inflated both service prices and plan premiums, and impeded innovation in care delivery.

2. Medical Loss Ratio. Obamacare requires insurers to spend at least 80% of premium revenues on medical services for individual and small-group plans (85% for large-group plans), a rule known as the Medical Loss Ratio (MLR) requirement. As my coauthors and I recently wrote in *Health Affairs Forefront*, this rule ignored important realities of insurance markets.[17] First, when profit and administrative expenses are capped, insurers are forced to grow profit by increasing medical spending. Second, large insurers, with diverse business units and markets, can better stabilize claim volatility, manage intercompany eliminations, and more easily meet the MLR requirement than small or regional insurers. Third, innovative plans, which require greater strategic investment, and more affordable plans, which cover relatively fewer

[9] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2814226
[10] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2827713
[11] https://link.springer.com/article/10.1007/s11606-025-09541-3
[12] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787285
[13] https://jamanetwork.com/journals/jamasurgery/fullarticle/2817652
[14] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00977
[15] https://www.washingtonpost.com/opinions/2023/04/11/hospital-prices-health-insurance-high-costs/
[16] https://www.hoover.org/research/patient-centered-healthcare
[17] https://www.healthaffairs.org/content/forefront/unintended-consequences-aca-s-medical-loss-ratio-requirement

services, face greater challenges meeting the MLR requirement because of their relatively high administrative costs.

Therefore, the MLR rule, purportedly intended to curb insurers' greed and administrative waste, has driven up medical spending and undermined small, regional, innovative, and affordable plans. These anticompetitive effects have contributed to insurance market consolidation and further premium increases.

3. Community Rating. Prior to Obamacare, medical underwriting was used to determine a person's premiums based on their individual health risks, similar to how car insurance considers a driver's record. Under Obamacare, insurers are required to charge the same premium to all enrollees of the same age and geographic area, a requirement known as community rating. Moreover, it limits premium variation by age to a 3:1 ratio—older enrollees cannot be charged more than three times the premiums of younger enrollees in the same region.

   Community rating undermines incentives for individuals to engage in healthy activities, following the same logic as higher car insurance premiums discouraging reckless driving. More importantly, it discriminates against younger and healthier individuals by effectively taxing them through higher premiums than their risk profile would justify, in order to subsidize older and sicker enrollees. This rule violates fundamental actuarial and economic principles and directly contributed to the premium increases experienced by many Americans,[18] imposing financial burdens and discouraging entrepreneurship.[16] Because this group was deterred by unaffordable premiums from enrolling in Obamacare, the risk pool deteriorated, driving premiums even higher, as observed.

4. No Annual/Life Limit. Obamacare prohibits health plans from capping the total dollar amount they pay for covered services for an enrollee in a year or over the enrollee's lifetime. This requirement exposes insurers to potentially unlimited medical spending, restricts their ability to steer patients to more affordable alternatives, and incentivizes hospitals and drug manufacturers to raise prices, knowing that insurers have to pay anyway. Not surprisingly, very expensive individual claims (e.g., exceeding $1 million) grew rapidly,[19] driving up premiums for both marketplace plans and employer-sponsored plans, which are also subject to this rule.

5. Premium Price Sensitivity. After the Covid-era enhanced subsidies were implemented, all Americans, regardless of income level, are potentially eligible for Obamacare subsidies. This shift of financial responsibility from individual enrollees to taxpayers eliminates enrollees' price sensitivity and interest in seeking more affordable, higher value options—why

[18] https://www.johnhcochrane.com/research-all/after-the-aca-freeing-the-market-for-health-care
[19] https://sunlife.showpad.com/share/G9vemnF3cmEx0h70xC7bo

economize when someone else is footing the bill? As a result, insurers have little incentive to contain premiums for existing plans or design more affordable options. Prospective entrants face a closed market, which stifles innovation and competition and undermine the health and function of the insurance market.

Provider Regulation

Obamacare imposed significant regulatory burdens and skewed the competitive landscape in the provider market, contributing to health system consolidation, the decline of independent physician practices, and ultimately higher prices and insurance premiums. Several examples are listed below:

1. Ban on Physician-Owned Hospitals. Obamacare prohibits the formation of new physician-owned hospitals and limits the expansion of existing ones. Prior research found that physician-owned hospitals enhance physician engagement, provide higher-quality care, and incur lower costs compared with other hospitals.[20] My coauthored research, published in *JAMA Network Open*, shows that both commercial negotiated prices and cash prices in physician-owned hospitals were about one-third lower than their competitors in the same referral region.[21] As my coauthors and I explained in *Health Affairs Forefront*, this restriction is anti-competitive in nature, enabling incumbent hospitals to preserve market power and command high prices while depriving patients of affordable hospital care options.[22]

2. The 340B Drug Pricing Program. This program, created by Congress in 1992, allows eligible nonprofit and government hospitals to purchase outpatient drugs from pharmaceutical companies at steep discounts and sell them at full prices, retaining the difference.[23] Obamacare substantially expanded 340B program eligibility, fueling its subsequent explosive growth.[24] While hospitals benefit substantially from this lucrative "buy-low-sell-high" program, independent physician practices are not eligible. This differential treatment incentivizes hospitals to acquire physician practices in order to capture 340B program profits, contributing to market consolidation and the decline of independent physician practices, and ultimately leading to higher medical spending and insurance premiums.

3. Accountable Care Organizations (ACOs). Obamacare created ACOs and the Medicare Shared Savings Program. Although targeted at Medicare, these programs have reshaped

[20] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-4-Letter-to-Verma-re-2021-OPPS-FINAL.pdf
[21] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806510
[22] https://www.healthaffairs.org/content/forefront/rationalizing-physician-regulation
[23] https://waysandmeans.house.gov/wp-content/uploads/2025/09/2025WM_Bai_FinalFinalFinal.pdf
[24] https://www.cbo.gov/publication/61730

provider markets. To participate effectively, hospitals sought greater control over patient volume through vertical integration (purchasing physician practices) and horizontal consolidation (merging or acquiring hospitals). These consolidations strengthened hospital market power, raised commercial prices, and undermined independent physician practices. As commercial prices increased, Obamacare plan premiums rose.

4. Value-Based Payment Modifier. Obamacare mandated the Value-Based Payment Modifier, which adjusted Medicare physician payments based on reported quality and cost measures. As my coauthors and I noted in *Health Affairs Forefront*,[25] this program substantially increased administrative burdens for physicians—especially small and independent practices—and created incentives for them to integrate into larger health systems with the infrastructure to handle quality reporting. This mechanism contributed to vertical consolidation, higher prices, and elevated premiums for Obamacare and other commercial plans. Importantly, the mandate did not improve quality but fostered a quality industrial complex that profits from expanding quality measures that add friction to care delivery.

Taken together, Obamacare distorted both insurance and provider markets, contributing to consolidation and driving up healthcare prices and insurance premiums. Some analysts have blamed inadequate Federal Trade Commission (FTC) oversight of mergers and acquisitions, while overlooking this fact: by the time numerous transactions reach the FTC, it's already too late—the competitive landscape has already been so poisoned by Obamacare that only big players can survive.

Obamacare has deprived the American people of broad access to high-quality, innovative, and dynamic healthcare markets, saddled businesses, entrepreneurs, and innovators, and threatened our nation's global leadership.[26] It represents a highly inefficient approach to finance care for low-income, high-risk Americans. A dedicated risk pool—backed by state-sponsored reinsurance and direct subsidies to patients—would cost far less and provide far more robust and sustainable protection.[16,27]

Obamacare was promised to the American people as exactly the opposite of what it has become—for example, President Barack Obama promised that it would reduce premiums by $2,500. In essence, American taxpayers are defrauded three times: they pay for rapidly expanding Obamacare subsidies; they suffer from disrupted healthcare markets and shoulder high commercial prices, and they fund operational fraudsters. Congress must recognize this structural fraud.

[25] https://www.healthaffairs.org/content/forefront/reforming-medicare-quality-measurement
[26] https://gjia.georgetown.edu/2025/04/07/a-patient-centered-approach-to-improving-the-return-of-investment-in-us-healthcare/
[27] https://direct.mit.edu/itgg/article/14/1-2/90/134017/Improving-Health-Care-Affordability-Access-and

From this perspective, the framing and promotion of the Covid-19 enhanced subsidy without addressing Obamacare's underlying structural fraud also constitutes a form of consumer deception and taxpayer fraud. It lures higher-income Americans into unaffordable plans—by using taxpayer dollars—that they would not otherwise purchase and sets them up as political pawns for a looming premium cliff.

Section IV: Policy Solutions

Operational Fraud: Close Loopholes and Open the Books

To combat operational fraud in Obamacare subsidies, agency oversight should be strengthened. CMS's 2025 Marketplace Integrity and Affordability Rule includes key provisions for this purpose: stricter income and eligibility verification, a $5 monthly premium for auto-reenrolled fully subsidized plans, tighter checks on enrollment periods, disqualification from future subsidies for failure to reconcile tax credits, shortened open enrollment periods, and other measures intended to reduce improper payments.[28]

Although CMS estimated that this rule would effectively address operational fraud and save up to $12 billion in 2026 subsidy payments,[29] a U.S. District Court issued a preliminary injunction partially blocking it in August 2025.[30] The Administrative Procedure Act (APA) was central to the legal challenge, with plaintiffs arguing that the rule was arbitrary and capricious, exceeded ACA statutory authority, and conflicted with the statute's goals. Given the APA's central role in legal debates over Obamacare implementation, only Congress can enact the provisions included in 2025 Marketplace Integrity and Affordability Rule.

Because the techniques used to commit operational fraud are constantly evolving, ongoing and adaptive oversight efforts are essential. As Professor David A. Hyman and I argued in *STAT News*, it would be a mistake for HHS to be the only "cop in town" tasked with detecting and deterring operational fraud.[31] HHS should make de-identified data on Obamacare widely available, allowing researchers, analysts, journalists, and concerned citizens to constantly discern irregularities, uncover fraud, and explore solutions. HHS can and should minimize information barriers on spending and taxpayer subsidies under Obamacare and other taxpayer-funded programs, and leverage the collective efforts of the public to maximize oversight efficiency and effectiveness. They can do a far better job of identifying and deterring fraud and ensuring program integrity, at no cost to taxpayers, than any government agency, regardless of its size or staffing.

[28] https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability
[29] https://www.cms.gov/newsroom/press-releases/cms-finalizes-major-rule-lower-individual-health-insurance-premiums-americans?utm_source=chatgpt.com
[30] https://www.courtlistener.com/docket/70684987/city-of-columbus-v-kennedy/
[31] https://www.statnews.com/2025/09/26/health-care-spending-data-de-identified-claims-aca-medicaid/

Structural Fraud: Invigorate Markets

Opening alternative healthcare markets for Americans would mitigate Obamacare's structural fraud. This approach does not impose new regulations that dictate market operations; rather, it would remove existing regulatory barriers that have hindered these markets from emerging organically in the first place. For example, the Biden Administration's restrictions on the eligibility for association health plans and limits on the duration of short-term plans have significantly narrowed patient access to affordable non-Obamacare options. Similarly, constraints on the eligibility and usage of health savings accounts (HSAs) and providers' ability to offer or disclose cash prices prevent many Americans from taking advantage of tax benefits and accessing low-cost cash-pay markets.[10] Eliminating these barriers would foster bottom-up innovation and competition in care delivery and payment models, providing much-needed relief to Americans.

To fundamentally fix the structural fraud of Obamacare, Congress should adopt a four-pronged approach.[16] First, *free patients*. Directly subsidizing Americans in need would unleash market forces to achieve nondiscriminatory, affordable prices and higher quality through competition and innovation. Empowering patients to choose providers and insurance plans would align incentives throughout the system, forcing all players to focus on attracting and retaining patients rather than regulatory compliance. Insurance-based access restrictions, such as prior authorization and network requirements, would largely vanish for routine care, disproportionately benefiting low-income populations.

Second, *free providers*. Health systems did not accidentally become conglomerates, swallowing independent physician practices and driving up prices and premiums—they did exactly what Obamacare and other regulations incentivized. Congress should level the playing field by removing anticompetitive regulations, allowing physician practices and alternative facilities to enter and compete. Free market competition is unforgiving to underperforming providers, leaving little room for price gouging, low quality, shortages, stagnation, or other behaviors contrary to patients' best interests. Market discipline, driven by self-interested consumers, is more powerful and effective than any regulation.

Third, *free insurers*. Obamacare mandates have banned or restricted insurance choices and undermined competition by dictating insurance operations. Vertical and horizontal integration in the insurance market is not a market failure but a survival strategy for insurers capable of complying, scaling, and exerting political influence amid policy failures. Congress should free insurance markets from regulatory strangleholds, allowing competition to drive all players to innovate, improve, and offer insurance products that consumers want.

Fourth, *deregulate and unburden*. Healthcare regulations that restrict behavior typically advantage incumbents, suppress competition, and ultimately harm patients and society. Bad policies persist because regulators and special interest groups benefit from their implementation, maintenance, and the perpetual efforts to "fix" the problems they create. Over time, the expansion of bureaucracy and crony relationships has made healthcare regulations extremely complex. More Band-Aid solutions will only worsen this complexity, threatening the survival of small players, deterring aspiring entrants, and further protecting special interests.[16,26,27] The solution is not more or better regulations, but fewer. Congress must recognize that only the collective wisdom of all market participants—not a small group of experts or bureaucrats—can determine the "right" behaviors that truly benefit patients. Regulatory power must be permanently constrained to allow markets to survive and thrive.

Obamacare fraud is created by Congress and can only be fixed by Congress. The power to transform U.S. healthcare lies with tens of millions of Americans who want control over their healthcare dollars and access to affordable care they choose, along with countless "builders" eager to compete for patients and earn returns. Yes, their hands have been tied by Obamacare.

Release American dynamism in healthcare to benefit all.

Thank you again for giving me the opportunity to participate in this hearing. I would be pleased to answer any questions you may have.