INVESTIGATIVE REPORT

Healthcare Leadership Series | November 2026 | Midterm Election Edition

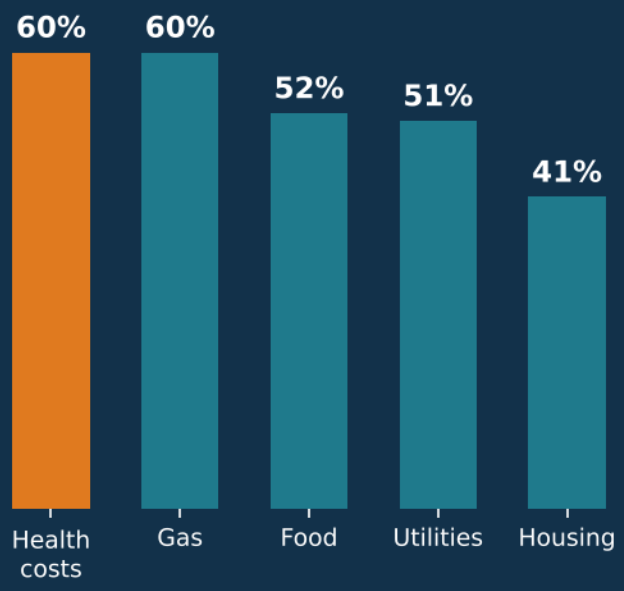
Sticker Shock at the Ballot Box

America's Number One Worry Is on Tuesday's Ballot, and Nobody Is Running on It

Six in ten voters are worried about affording care. One side is running on fraud and drug deals, the other on coverage cuts and subsidies. The evidence says the cost engine is prices, and the ballot does not have a line for that.

61%

of voters say health costs will shape which party's candidate they support



Share of voters worried about affording each (KFF, Sept. 2026)

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Polling: KFF Health Tracking Polls, April and September 2026

INVESTIGATIVE REPORT | MIDTERM ELECTION EDITION

Sticker Shock at the Ballot Box

America's Number One Worry Is on Tuesday's Ballot, and Nobody Is Running on It

An investigative report by Kelly Emrick, DHSc, PhD, MBA, BSRT(ARRT)R | Published Sunday, November 1, 2026, two days before the midterm election

Executive Summary

On Tuesday, November 3, Americans vote in a midterm election in which, according to KFF's September tracking poll, health care costs tie gasoline as the number-one household financial worry: six in ten registered voters worry about affording care, and 25 percent are very worried. In April, 61 percent of voters said health costs would strongly influence which party's candidate they support, and only 33 percent approved of the administration's handling of care costs. Democrats hold a 20-point trust advantage on the issue, up from 11 points in the spring. Among independents, the margin is 38 to 9, and more than four in ten independents trust neither party at all.

This report focuses on that last number. The two parties have run very different health care campaigns, and this report describes both as their own advocates would. Republicans have campaigned on fraud in government programs (a $2.2 billion recovery banner, a vice presidential task force, canceled enrollments, and withheld state Medicaid payments), on most-favored-nation drug pricing deals with 26 manufacturers, on the TrumpRx discount site, and on a $50 billion rural health fund. Democrats have campaigned on the coverage consequences of the 2025 reconciliation law (CBO's estimate of 10 million more uninsured by 2034, about $900 billion in federal Medicaid reductions), on the expiration of enhanced ACA tax credits that lifted the average subsidized enrollee's cost to keep the same plan by 114 percent, and on restoring those credits. By one Democratic strategy memo's count, Democrats have spent roughly $400 million on health care advertising, more than 1.5 times the Republican total.

Neither campaign leads with the mechanism. The best available cost data say price, not use, fraud, or subsidy design, drives the engine of American health spending. Hospitals accounted for 40 percent of the growth in national health spending in the most recent year. The Health Care Cost Institute finds price, not utilization, drove the 18.8 percent rise in employer-plan spending from 2019 to 2023. In about half of U.S. metropolitan areas, one or two health systems deliver all inpatient commercial hospital care. Insurers filing 2027 Marketplace rates cite a median 10 percent medical trend driven by provider contract increases, and Mercer projects the largest employer cost increase since 2003, with GLP-1 drugs, AI-enabled billing, and arbitration awards layered on top. Fraud is real and worth pursuing, but $2.2 billion is four hundredths of one percent of a roughly $5 trillion system. Subsidies are real and decisive for the people who lose them, but a subsidy is a way of paying a price, not a way of lowering one.

Both campaigns have a defensible answer to this critique, and the report gives each its due. Republicans can point to the Medicaid most-favored-nation model, which is a price policy, and to price transparency enforcement in the administration's Great Healthcare Plan. Democrats can point to Medicare drug price

negotiation, which now saves an estimated $6 billion a year and is growing, and to the Patients Deserve Price Tags Act, which has bipartisan support. But none of these is the message on the air in the final week, and none of them touches the largest line item, hospital prices, with anything like the force the data would justify.

For healthcare leaders, the election will not settle the question, and this report is written to be useful on Wednesday morning, whatever the result. It closes with the **Mechanism Map**, a one-page matrix of the five documented cost engines against what each party has actually proposed, and the **Wednesday Test**, three indicators that will tell leaders within 90 days whether the new Congress is addressing prices or still arguing about who pays them.

Key Findings at a Glance

60 percent. Registered voters worried about affording health care, tied with gas as the top household financial worry (KFF, September 2026). Food is 52 percent, utilities 51, housing 41.

61 percent. In April, voters said health costs would strongly influence which party's candidate they support; 55 percent said it would affect whether they vote at all.

33 percent. Approval of the administration's handling of the cost of care (April); 41 percent on prescription drug costs; 42 percent on fraud and waste.

42 to 22. Trust in health care costs, Democrats versus Republicans, in September, a 20-point gap up from 11 in April. Among independents, 38 to 9, with more than four in ten trusting neither.

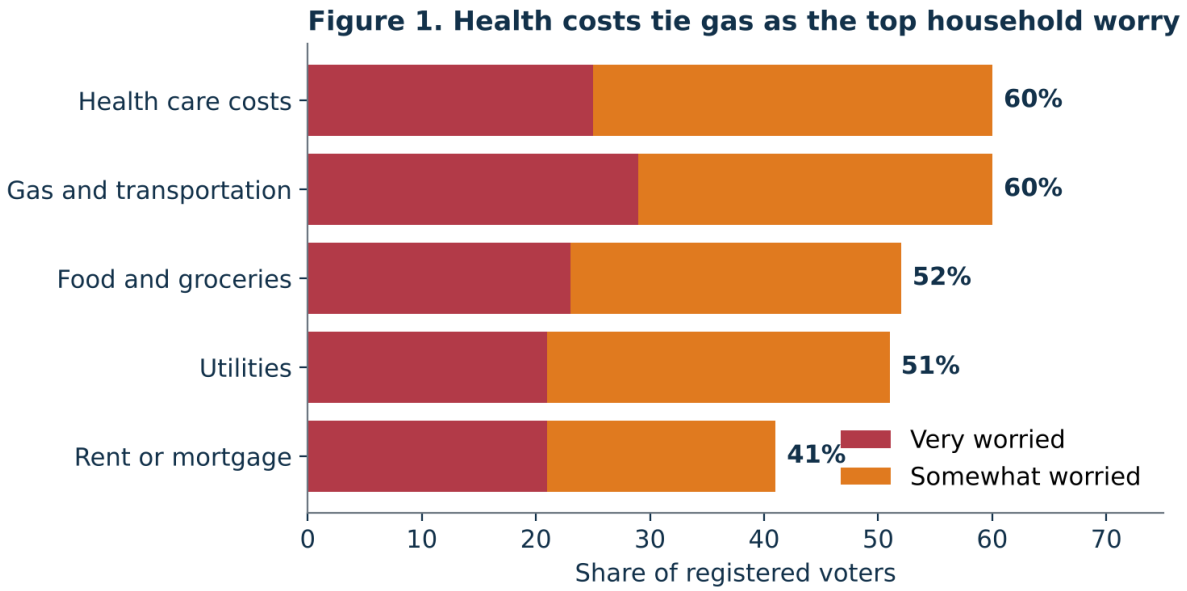
Republicans' lead issue. Fraud in government programs is the top issue Republican voters want discussed (54 percent say extremely important); the administration cites $2.2 billion recovered, 760,000 canceled ACA enrollments, and $2.5 billion in withheld state Medicaid payments.

Democrats' lead issue. Coverage: CBO projects 10 million more uninsured from the reconciliation law and roughly 14.2 million when the expired tax credits are included; Marketplace enrollment fell 2.6 million in one year.

The mechanism. Hospitals drove 40 percent of national spending growth; price, not use, drove employer spending growth; family premiums hit $28,303 with workers' share up 9 percent; 2027 employer costs are projected to rise 8.2 percent after cuts (11 percent without), the most since 2003.

The gap. Neither party's final-week message names hospital prices or consolidation as the primary problem.

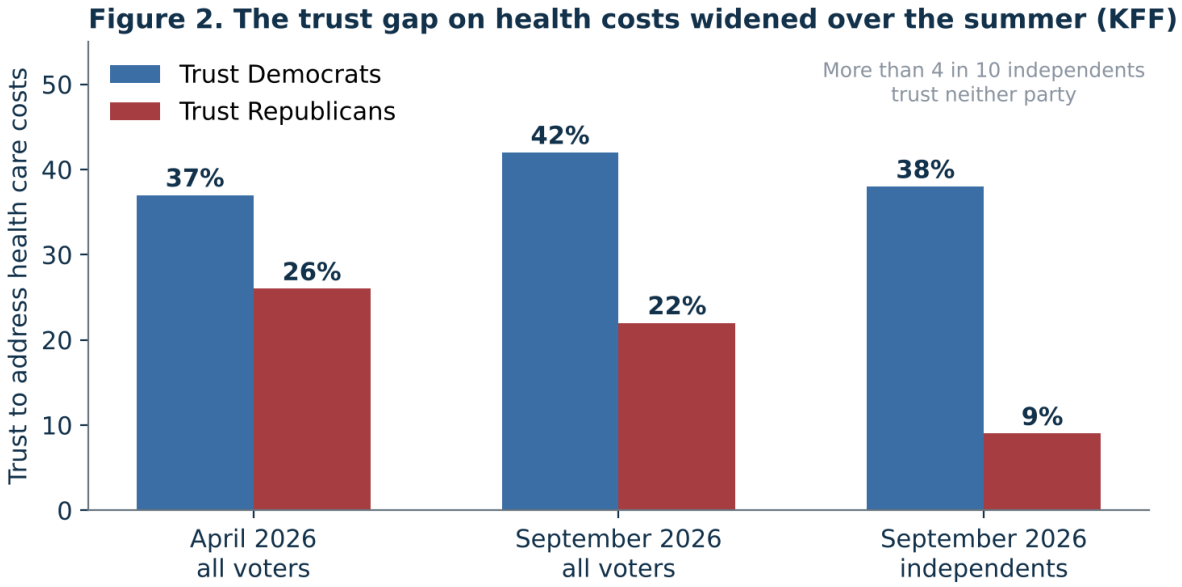
1. What Voters Are Saying



Source: KFF Health Tracking Poll, fielded September 16 to 21, 2026, 1,013 registered voters, margin of error plus or minus 4 points.

The 2026 electorate's arithmetic is unusually simple. In September, when asked what they worry about affording, registered voters put health care costs and gasoline in a dead heat at 60 percent each, ahead of food (52 percent), utilities (51 percent), and rent or mortgage (41 percent) [1]. Gasoline is a new entrant: in January it ranked last among household worries, and its rise tracks the U.S. conflict with Iran. Health care has been at or near the top in every KFF wave for a year.

The worry translates into stated intent. In KFF's April poll, 55 percent of voters said health costs would have a major impact on their voting decision, and 61 percent said they would affect which party's candidate they support [2]. The issue is more salient on the left than the right (72 percent of Democratic voters, 63 percent of independents, 47 percent of Republicans say it will shape their candidate choice), but nearly half of Republicans is not a small number. Asked in September which issues candidates must discuss, 62 percent of voters said cost of living was extremely important, 47 percent said health care costs, and 44 percent said fraud in government programs. The partisan ordering is instructive: for Democrats, health costs rank second at 59 percent; for Republicans, fraud ranks first at 54 percent and health costs sixth at 31 percent [1].



Source: KFF Health Tracking Polls, April 14 to 19 and September 16 to 21, 2026. Shares not shown trust neither party or both equally.

Approval of the administration on the specific question of cost is low: 33 percent of voters approved of its handling of the cost of care in April, with 45 percent strongly disapproving; 41 percent approved on prescription drug costs; 42 percent on fraud and waste [2]. Within the Republican coalition, a notable split emerges for anyone reading Tuesday's results: MAGA-identified Republicans approve of the administration's cost record at 79 percent, while non-MAGA Republicans do at 36 percent.

On trust, the Democratic advantage on health costs widened from 11 points in April (37 to 26) to 20 points in September (42 to 22). Among independents, the September figure is 38 to 9, with more than four in ten trusting neither party [1]. Republicans hold a modest edge on fraud and waste (34 to 26 in April), and a third of voters trust neither party on that either. Two further September findings frame the mood: 36 percent of adults say the health system needs a complete overhaul, and 66 percent say they favor a national Medicare-for-all plan, the highest reading KFF has recorded since it began asking in 2016, including 72 percent of independents (support falls sharply when respondents hear about possible delays in care or tax increases) [1].

What voters say they want is narrower than any slogan. When asked which insurance change would matter most, 46 percent of insured adults chose paying less out of pocket; 22 percent chose eliminating prior authorization; 13 percent chose more value; and 12 percent chose more provider choice [2]. The voter's request is a smaller bill. The rest of this report asks whether either campaign is offering one.

2. The Republican Campaign: Fraud, Drug Deals, and the Rural Fund

The Republican health care message in the closing weeks has three parts, and each is best described on its own terms before evaluation.

Fraud in government programs

The administration has made fraud the organizing frame for its health care record. Vice President JD Vance chairs a Task Force to Eliminate Fraud and in September stood before a banner reading "$2.2 BILLION RECOVERED," describing fraud as making health care more expensive for everyone [3, 4]. CMS Administrator Mehmet Oz announced the cancellation of ACA enrollments covering about 760,000 people, which officials say included nonexistent consumers signed up through brokers, along with audits of state Medicaid fraud units and deferrals of federal Medicaid payments, including about $2 billion from California and more than $500 million from Minnesota. This year, the Justice Department has charged hundreds of people, including physicians, in alleged billing schemes. On October 3, the President called on Congress to mandate prison terms for Medicare and Medicaid fraud [4]. House Energy and Commerce Chairman Brett Guthrie has framed the 2025 law's eligibility and verification provisions as ending a "fraud free-for-all" [5].

The case has evidence behind it. GAO warned in March of significant fraud risk in Medicare, and a separate GAO probe succeeded in obtaining subsidized ACA coverage for fictitious enrollees. A June ASPE brief argued that zero-premium plans made improper broker enrollment easier, and CMS reported canceling 250,000 unauthorized enrollments and identifying 200,000 unauthorized plan switches in 2025 [6]. Fraud is also the issue Republican voters most want discussed, and the one on which the party holds its only trust advantage [1, 2]. Candidates such as Mike Lawler in New York have run on it directly, describing the law they voted for as removing able-bodied adults from Medicaid [7].

Critics, including Democrats and several independent analysts, make three objections. First, scale: CMS itself corrected a claim about New York personal-care beneficiaries from more than 5 million to about 450,000, and Oz's argument that 35 percent of ACA enrollees never used their coverage is contested on the ground that young, healthy enrollees routinely use little care [4]. Second, consistency: the administration cut about 200 ACA oversight staff, recertified brokers suspended in 2024, and the President pardoned health executives convicted of large frauds. Third, geography: the largest deferrals have fallen on Democratic-led states, and disenrollment is concentrated in Florida and Texas, which hold a large share of Marketplace enrollees [4]. Families USA's Anthony Wright calls the strategy a way to reframe the cuts. KFF Health News assesses that the fraud push may help redirect voter concern about costs and Medicaid and ACA changes, and that it is landing with the voters it targets.

Drug prices: most favored nation and TrumpRx

The second plank is drug pricing. Since a May 2025 executive order, the administration has signed most-favored-nation agreements with 26 manufacturers that it says cover 89 percent of the branded drug market, extended MFN pricing to all 50 state Medicaid programs through the GENEROUS payment model (with a Council of Economic Advisers estimate of $64.3 billion in Medicaid savings over a decade and $600 billion across all deals), launched TrumpRx.gov in February 2026 with a claimed $700 million in patient savings, and in July began offering seniors without GLP-1 obesity coverage those drugs for $50 a month, which it says 600,000 seniors have used [8]. The January Great Healthcare Plan would codify the MFN

deals, replace federal insurance subsidies with direct payments into health savings accounts, require insurers to publish claims-versus-profit and denial data, and enforce the price transparency rules finalized in the President's first term [9].

Independent reviewers have been skeptical of the magnitude. A Penn LDI panel of Rachel Sachs, Marta Wosińska, and Avik Roy noted that the MFN deal terms are confidential and unenforceable as policy, that TrumpRx prices are cash prices that may not count toward deductibles, and that most insured patients are unlikely to save by buying outside their coverage; the uninsured and people buying drugs insurers do not cover, such as weight-loss GLP-1s and fertility medications, can see real savings [10]. KFF Health News found that most TrumpRx listings were Pfizer products, many with far cheaper generics or biosimilars (Humira at $950 a dose on TrumpRx against biosimilars at $207.60), and that the discounts are GoodRx-style coupons [11]. The same review noted that the largest realized drug savings in 2026 came from Medicare price negotiation under the 2022 Inflation Reduction Act, with the first ten negotiated prices in effect since January at an estimated $6 billion a year and more than $20 billion a year projected as later rounds take effect. NBC's October analysis of TrumpRx described a mixed bag. The administration has not answered detailed questions about the site [11].

The rural fund and the defense of the 2025 law

The third plank is the $50 billion Rural Health Transformation Program in the reconciliation law, which paid $10 billion in its first round at $147 million to $281 million per state. Republican ads credit members with securing hundreds of millions for rural hospitals: Susan Collins with $190 million for Maine, Jon Husted with $200 million for Ohio, and Mariannette Miller-Meeks with millions for Iowa. Other Republican ads, including those from Ashley Hinson and Miller-Meeks, blame insurers and drug companies for costs and promise to work with the President to lower them [7, 12]. FactCheck.org's assessment is that the fund is real and the dollar figures are accurate, but the ads omit that CBO projects about $900 billion in federal Medicaid reductions over the decade and KFF estimates a $137 billion reduction in rural areas, which the fund does not replace because most of its money cannot pay for existing services or uncompensated care [12].

3. The Democratic Campaign: Coverage, Subsidies, and the Cuts

The Democratic message is simpler because it is almost entirely about one law and one expiration date.

The reconciliation law

Democrats describe the 2025 reconciliation law as the largest health care cut in American history. The numbers they rely on are CBO's: about 10 million more people uninsured by 2034 from the law alone, including 7.5 million from Medicaid changes (community engagement requirements beginning in 2027 for about 20 million enrollees, more frequent eligibility redeterminations, and the medical frailty rule described in this series' October report) and 2.1 million from Marketplace changes, with roughly $900 billion less in federal Medicaid spending over the decade [13, 14]. Democratic-aligned ads from VoteVets

and House Majority Forward have translated this into hospital counts: 20 Iowa rural hospitals "on the brink," 25 Pennsylvania hospitals threatened. FactCheck.org finds these counts came from pre-existing at-risk lists, not projections attributable to the law, and that the law's closures are unpredictable, though it is expected to increase them [12].

The expired tax credits

The enhanced premium tax credits enacted in 2021 expired at the end of 2025 after Congress left town without a deal. For the average subsidized Marketplace enrollee, the cost of keeping the same plan rose about 114 percent; average premium payments rose 58 percent and deductibles 37 percent, more than $1,000 per person [6, 15]. Enrollment fell from 21.8 million in February 2025 to 19.2 million in February 2026, the steepest one-year decline since the exchanges opened, and analysts expect 16.5 to 17.5 million by year-end; HealthCare.gov fell 18.7 percent on average, compared with 6.3 percent in state-run exchanges [6]. For 2027, insurers have requested a median 15 percent increase across 276 filings in all 50 states, the second straight year of double-digit increases, and they attribute roughly four points of it to the departure of healthier enrollees after the credits ended [16]. Open enrollment for 2027 began today, November 1, with insurers exiting several markets [17].

The Democratic remedy is to restore the enhanced credits the House has voted to extend and reverse the Medicaid provisions. Democratic candidates such as Texas Senate nominee James Talarico have pledged to reverse the cuts and confront health care companies, and the party's October strategy memo from Leslie Dach and Brad Woodhouse instructs candidates to run on "cancel the cuts, lower the costs, save your health care" [18]. By the memo's own accounting, citing the Cook Political Report and the Washington Post, health care is the top issue in Senate advertising and second in House advertising, and Democrats have outspent Republicans on it by more than one and a half to one, about $400 million [18]. That memo is partisan advocacy, and its figures are not independently verified here; however, its polling citations match public KFF, NBC, Quinnipiac, and AP-NORC findings.

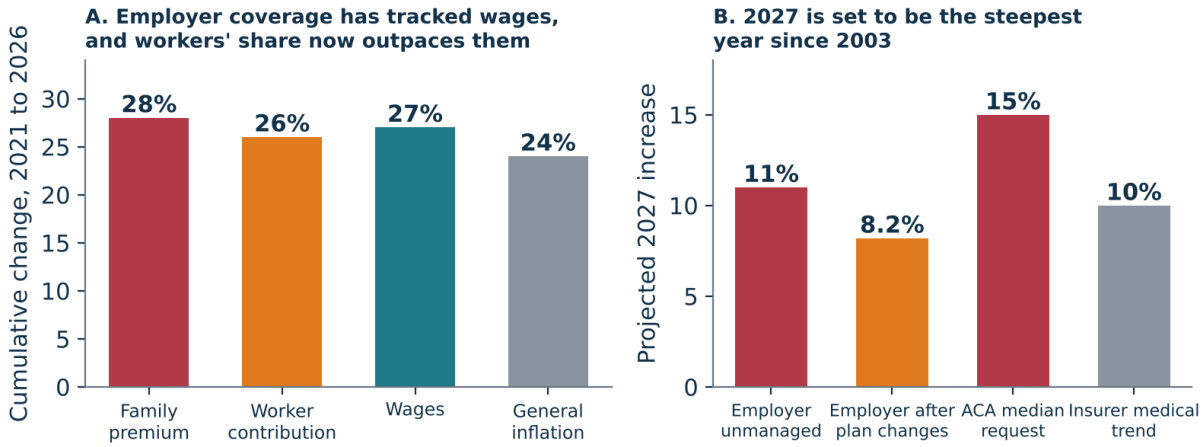
The Republican reply

Republicans argue that the enhanced credits were temporary pandemic relief, that the administration has since canceled zero-premium plans that invited broker fraud, and that the law's eligibility rules remove people who should not be enrolled rather than people who need care [4, 5]. The Fortune analysis of the 2.6 million enrollment drop concluded that both the fraud removals and the price shock were real, and that the price shock played the larger role [6]. On the Medicaid provisions, Republicans point to the rural fund and the work-requirement exemptions; the administration's own rule, upheld against a preliminary injunction in July, narrows the medical-frailty exemption, which Democrats contest.

4. The Mechanism: What Actually Drives the Bill

Step back from both campaigns and ask the question voters are actually asking: Why does my coverage cost more every year? The evidence base is unusually consistent across sources that don't share a politics.

Figure 3. What households are actually paying, and what is coming



Sources: KFF 2026 Employer Health Benefits Survey (panel A, cumulative change 2021 to 2026); Mercer National Survey of Employer-Sponsored Health Plans, preliminary September 2026; Peterson-KFF Health System Tracker analysis of 2027 Marketplace rate filings (panel B).

What households pay

The average employer family premium reached $28,303 in 2026, up 5 percent, with the worker's share up 9 percent to $7,471; workers at small firms contribute $9,687. The average single deductible is $1,955. Since 2021, family premiums have risen 28 percent, worker contributions 26 percent, wages 27 percent, and general inflation 24 percent [19]. This covers about 157 million Americans under 65, far more than the 19 million in the Marketplaces or the roughly 70 million in Medicaid, and either campaign has barely accounted for its costs. KFF's Drew Altman made the point when the survey was released: the debate has focused on ACA and Medicaid cuts, while the employer market quietly absorbs the same forces.

The outlook is worse. Mercer's preliminary survey of more than 1,800 employers projects an 8.2 percent increase in per-employee health benefit cost for 2027 after planned cost-reduction measures, and 11 percent without them, the largest increase since 2003 and the fifth straight year of elevated growth; about two-thirds of large employers expect to raise workers' share of premiums [20]. Marketplace insurers requested a median 15 percent for 2027 on top of a finalized 20 percent median for 2026 [16]. Stand-alone Medicare Part D premiums will rise sharply for many enrollees who do not switch plans after a stabilization subsidy ended, as this series reported last month.

Where the money goes

Hospitals accounted for 40 percent of national health spending growth in the most recent year measured, and hospital care is 46 percent of employer-plan spending [21, 22]. The Health Care Cost Institute, analyzing employer-insured claims from 2019 to 2023, found that spending rose 18.8 percent and that price, not utilization, drove the increase every year, including the 2021 rebound in use. HCCI's Katie Martin describes that consistency across reports as the news: policy debates keep overlooking hospitals, drug spending, and price [22]. Employers pay hospitals roughly 2.5 times what Medicare pays for the same services, according to RAND's hospital price transparency work [23]. The structural reason is market power: in about half of U.S. metropolitan areas, one or two health systems delivered all inpatient commercial hospital care in 2023 [21]. Insurers filing 2027 Marketplace rates cite a median 10 percent medical trend, up from about 8 percent in recent years, and attribute it to provider contract increases, labor costs, and claims severity; provider consolidation appears in only a handful of filings by name, but it is the condition under which those contracts are negotiated [16].

Drugs are the fastest-growing category per person, and the U.S. spends about twice the per-capita amount of peer nations [21, 22]. GLP-1 weight-management drugs are the newest driver: Mercer attributes about one point of 2027 employer growth to them, 18 percent of large employers now cover them for weight loss, and more than half of those report a significant or moderate impact on pharmacy spending [19, 20]. Then there is billing intensity, the subject of this series' last report: Mercer lists AI-enabled billing software that raises claim volume and claim levels among its newer drivers, and Blue Cross Blue Shield plans reported $942 million in added costs over two years from more intense coding without a matching rise in treatment [20, 24]. Arbitration awards under the No Surprises Act appear in both the Mercer drivers and at least one insurer's rate filing.

Documented driver	What the evidence shows	Source
Hospital prices and consolidation	40% of national spending growth; 46% of employer-plan spending; price, not utilization, drove the 18.8% rise in employer spending from 2019 to 2023; 1 or 2 systems serve all commercial inpatients in about half of metro areas; employers pay about 2.5x Medicare	KFF; HCCI; RAND
Prescription drugs including GLP-1s	Fastest-growing category per person; U.S. spends about 2x peers per capita; GLP-1s about 1 point of 2027 employer growth; some insurers cite tariff-driven drug cost expectations	HCCI; Peterson-KFF; Mercer
Billing intensity	AI coding and ambient scribes raising claim levels; $942M added to Blue plans over two years; No Surprises Act arbitration awards	Mercer; BCBSA
Subsidy expiration and risk pool	About 4 points of 2027 Marketplace premiums; 114% rise in cost to keep the same plan for subsidized enrollees; 2.6M enrollment drop	Peterson-KFF; KFF; CMS

Documented driver	What the evidence shows	Source
Fraud and improper enrollment	$2.2B recovered (administration); 760,000 ACA enrollments canceled; GAO confirms real vulnerabilities; against roughly $5 trillion in annual national health spending, $2.2B is about 0.04%	White House; CMS; GAO

Table 1. The engine room. Each driver is stated in its own source's unit; they are not additive.

The ordering matters. Fraud is a genuine problem with genuine recoveries, and GAO's findings are not disputed here. But at $2.2 billion against a system that spends about $5 trillion a year, it is a rounding error on the household bill, yet it is being presented as the explanation for that bill. Subsidies matter enormously to the roughly 19 million people who depend on them, and the 114 percent increase is the single sharpest price shock any group of Americans absorbed in 2026. But a subsidy is a transfer that pays a price; restoring it returns the bill to where it was, growing at 15 percent a year. The two campaigns argue, with real evidence on both sides, over who pays and who should not be enrolled. The data show the bill is set in hospital contracts and drug list prices, and neither closing message goes there.

5. The Mechanism Map

The matrix below is this report's contribution: the five documented cost engines against what each party has actually proposed or enacted, as of the final week. It is deliberately even-handed. Each cell records a real policy, with its stated mechanism, and the independent assessment of its scale. Readers can disagree with the assessments; the policies are a matter of record.

Cost engine	Republican and administration policy	Democratic policy	What independent evidence says about scale
Hospital prices and consolidation	Enforce first-term price transparency rules (Great Healthcare Plan); site-neutral payment proposed in CY 2027 Medicare rules; no antitrust or price regulation proposed	Patients Deserve Price Tags Act (bipartisan cosponsors); site-neutral support among some members; Medicare for all endorsed by some candidates; no hospital price regulation in the national message	Largest driver by every measure; transparency has shown little price effect on its own; neither party's closing message names it
Prescription drugs	MFN deals with 26 manufacturers; GENEROUS Medicaid model; TrumpRx; $50 GLP-1 program for seniors; codify MFN in Great Healthcare Plan	Defend and expand Medicare negotiation (first 10 drugs saving about $6B a year; 15 more in 2027); extend negotiation to more drugs and earlier	Medicare negotiation is the largest realized saving; MFN terms confidential and unenforceable per analysts; TrumpRx helps uninsured and self-pay GLP-1 and fertility buyers most
Billing intensity	No specific proposal; fraud enforcement partly overlaps (upcoding prosecutions)	No specific proposal beyond opposing AI-driven denials; some support for prior authorization limits	A new and growing driver; policy from both parties is silent

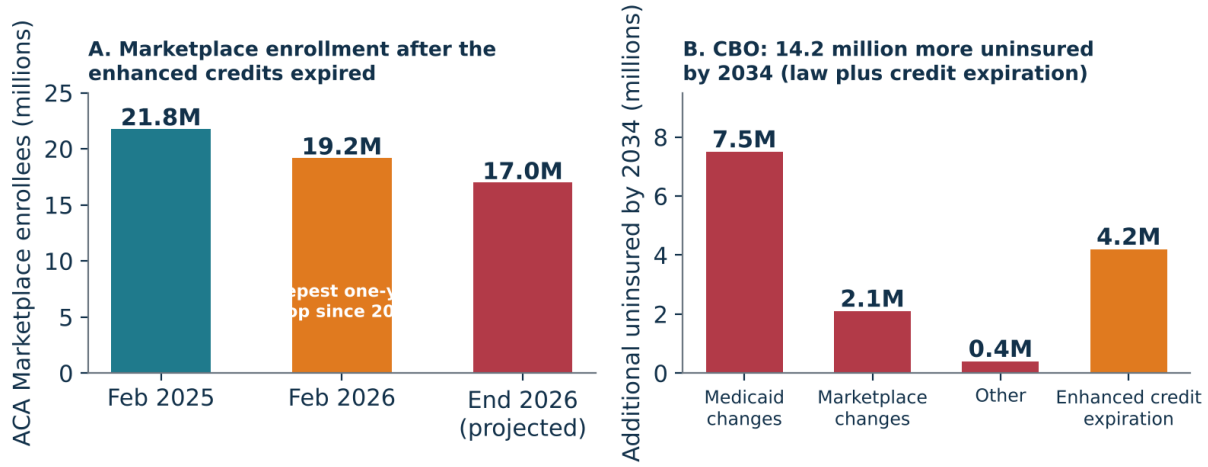
Cost engine	Republican and administration policy	Democratic policy	What independent evidence says about scale
Subsidies and risk pool	Let enhanced credits expire; replace subsidies with direct payments to HSAs; Marketplace Integrity rule; tighter verification	Restore enhanced credits (House has voted to extend); reverse Marketplace Integrity rule	Decisive for 19M enrollees; does not change underlying premium trend of 15% a year
Fraud and improper enrollment	Task force; $2.2B recovered; 760,000 cancellations; state deferrals; mandatory prison terms proposed	Supports fraud enforcement in principle; argues administration figures are inflated, and oversight staff were cut	Real but small relative to spending; GAO vulnerabilities confirmed; some administration figures corrected downward

Table 2. The Mechanism Map, as of November 1, 2026. Policies are stated as each party describes them; the final column summarizes independent sources cited in this report.

Read across the rows, and a pattern appears. On drugs, both parties have real policy, and the honest argument is about which works at scale: statutory negotiation with published results, or confidential deals with large claimed savings. On subsidies and fraud, the parties have opposite policies, and both have evidence for their framing. On the two largest and fastest-growing engines, hospital prices and billing intensity, the map is nearly empty on both sides. This report's finding is not partisan.

6. Coverage: The Part Both Parties Are Talking About

Figure 4. Coverage is the part of the story both parties are talking about



Sources: CMS effectuated enrollment data via Fortune (panel A); CBO estimates allocated by KFF (panel B). CBO's 14.2 million combined figure does not include the Marketplace Integrity rule.

Coverage is a cost question for the people who lose it and for the providers who treat them. The 2.6 million who left the Marketplaces in 2026 did not stop getting sick; the hospitals that treat them will book the care as uncompensated, and the employer plans in the same markets will be asked to absorb it in the next contract. CBO estimates 14.2 million more uninsured by 2034 when the law and the credit expiration are combined, concentrated in Florida, Texas, and California by headcount and in Louisiana, Florida, and

Arizona by rate [14]. Community health centers are preparing for a surge. This is a legitimate campaign issue, and both parties are right to engage; this report isn't saying coverage doesn't matter, but coverage policy, either way, doesn't change the price of a day in a hospital.

7. The Wednesday Test

The election will produce a Congress and a narrative on Tuesday night, and health care leaders will be asked by their boards on Wednesday what it means. The honest answer is that the campaigns were about who pays, and the operating environment is about what things cost, and the two will not reconcile on election night. This report proposes three indicators that will tell leaders within 90 days whether the new Congress is addressing prices or still arguing about transfers.

Indicator	What to watch	Why it matters	Signal of a price agenda
1. The subsidy vote	Whether Congress restores, replaces, or lets stand the enhanced credits before the January coverage cliff deepens	Decides 2027 Marketplace enrollment and uncompensated care; does not touch the 15% trend	Restoration paired with a price condition (site-neutral, transparency enforcement, or contract disclosure) rather than restoration alone
2. Hospital price action	Movement on site-neutral payment, the Patients Deserve Price Tags Act, facility fee rules, or FTC merger enforcement	The 40% driver; the only lever that changes the bill rather than the payer	Any bipartisan floor action on hospital pricing within 90 days
3. The billing intensity response	Whether payers, CMS, or Congress act on AI-driven coding, prior authorization, and No Surprises Act arbitration	The fastest-emerging driver, invisible in both campaigns	CMS or congressional attention to coding intensity rather than only to fraud prosecutions

Table 3. The Wednesday Test: three indicators for the 90 days after the election.

For leaders inside health systems, the test has a mirror. If campaigns did not name prices, the market will: employers facing an 8.2 percent increase, with two-thirds shifting costs to workers, will negotiate harder, and the Purchaser Business Group's Elizabeth Mitchell already tells Congress it has a very limited understanding of the commercial market [25]. Insurers are writing provider contract increases into rate filings that regulators read. A system whose price position depends on local market power should assume that someone will eventually fill the trust gap voters report (more than four in ten independents trusting neither party) by naming the number. Leaders who do the pricing arithmetic themselves, and can explain it, will be better positioned than those who wait for Washington to do it for them.

8. The Honest Counterarguments

Coverage is the cost mechanism for the people who lose it. True, and this report says so. For a family whose cost to keep the same plan rose 114 percent, the subsidy is the whole story, and the price trend is

an abstraction. The report distinguishes between policies that shift the bill between payers and policies that change the bill, and both parties' closing messages overwhelmingly favor the former.

Republicans do have a price policy: most favored nation. Also true, and it is a price policy for drugs, which are the second-largest driver. The report records the administration's claimed savings and an independent assessment that the terms are confidential and that realized consumer savings are concentrated among uninsured and self-pay buyers. If the GENEROUS Medicaid model delivers measured rebates, it deserves credit as this administration's first structural drug price action.

Democrats do have a price policy: Medicare negotiation. True, and it is the largest realized drug saving in 2026. It is not in the closing message, which focuses on the cuts, and it doesn't address hospitals.

Fraud enforcement is worth doing at any scale. Agreed, and GAO's findings make it a legitimate priority. The report objects to presenting it as the explanation for household costs rather than as program integrity.

Campaigns are not white papers. Fair. Voters asked for a smaller bill, and campaigns answer in the terms that move votes. This report argues that the terms that move votes in 2026 don't include the term that moves the bill, and that someone, probably not a politician, will have to say it.

9. Conclusion

Two days before the midterm, health care costs sit at the top of the household ledger, tied with gasoline and ahead of food and rent. Sixty-one percent of voters say the issue will decide which party they support. One party is running on fraud, drug deals, and a rural fund; the other on coverage losses and expired subsidies. Both have evidence and omissions, and this report has tried to present each as its own advocates would.

The omission they share is the one the data will not let go of. Hospitals drove 40 percent of spending growth. Price, not use, drove employer spending. Consolidation set the price. Drugs and billing intensity are stacking. The 2027 increases are the largest in two decades. A subsidy pays that bill; a fraud recovery trims it by four hundredths of a percent; a drug deal of confidential terms may or may not touch it. None of them names it.

On Wednesday the campaigns will be over, and the contracts will still be in force. The question for the next Congress, and for every health care leader who has to explain a premium increase to a workforce, is whether anyone will say the price out loud.

References

1. KFF. KFF Health Tracking Poll: Health Care Issues in the Lead-Up to the 2026 Midterm Election. Published October 6, 2026; fielded September 16 to 21, 2026.
2. KFF. KFF Health Tracking Poll: Health Care Costs and the Midterms. Fielded April 14 to 19, 2026.
3. Breitbart News. Vance Announces $2.2 Billion Recovered in Obamacare Fraud. September 22, 2026.
4. Armor S. GOP Focuses on Fraud, Seeking To Redirect Voters' Ire Over Healthcare Costs. KFF Health News. October 19, 2026.
5. Guthrie B. Republicans Are Ending the Healthcare Fraud Free-for-All. House Energy and Commerce Committee op-ed. 2026.
6. Fortune. 2.6 million Americans dropped ACA coverage as subsidies expired: fraud or price shock? July 14, 2026. Citing CMS effectuated enrollment data (June 26, 2026), KFF, HFMA, CBPP, and the June 2026 ASPE brief.
7. NPR. Ahead of midterms, Republicans run ads after cutting healthcare funds. July 31, 2026.
8. The White House. Fact Sheet: President Donald J. Trump Announces Lower Drug Prices for All 50 State Medicaid Programs. September 2026.
9. American Journal of Managed Care. Trump Announces The Great Healthcare Plan, Proposing Direct Payments, Price Transparency, Insurance Reform. January 15, 2026.
10. Penn Leonard Davis Institute. Unpacking the Federal Drug Price Reduction Struggle. Panel of January 16, 2026 (Sachs, Wosinska, Roy; Werner moderating).
11. KFF Health News. TrumpRx Reality Check: Drugs Not Always Cheaper. 2026. NBC News analysis of TrumpRx.gov prices, October 2026.
12. FactCheck.org. Midterm Ads Clash Over GOP Law's Impact on Rural Healthcare. September 2026.
13. Congressional Budget Office estimates of the 2025 reconciliation law's coverage effects, as reported by FactCheck.org and KFF, 2025 to 2026.
14. KFF. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? 2026.
15. The Hill. Health insurance premiums are set to rise sharply for millions of Americans. 2026. NBC News. Congress leaves town until 2026 with no health care deal, forcing premium hikes. December 2025.
16. Peterson-KFF Health System Tracker. How much and why ACA Marketplace premiums are going up in 2027. 2026.
17. AARP. Key Changes Coming to 2027 ACA Open Enrollment. 2026. NBC News. Many with ACA coverage face a new crisis in 2027: insurers fleeing the market. 2026.
18. Dach L, Woodhouse B. Health Care Election Memo. Protect Our Care. October 14, 2026. (Partisan advocacy document; figures not independently verified.)
19. KFF. 2026 Employer Health Benefits Survey. Released October 22, 2026.
20. Mercer (Marsh). Employers expect health benefit costs to jump in 2027. Preliminary survey results, September 2, 2026.
21. Peterson-KFF Health System Tracker. Eight Trends Shaping 2026 Healthcare Costs. 2026.
22. Managed Healthcare Executive. The relentless rise in healthcare spending: prices vs. utilization. A conversation with Katie Martin, Health Care Cost Institute. October 13, 2026.
23. RAND Corporation. Hospital Price Transparency Study, rounds 4 and 5 (employer prices as a percent of Medicare).
24. Niasse A. AI tools generated nearly $1 billion in extra costs, Blue Cross insurers say. Reuters. September 24, 2026.
25. STAT News. How employer health care costs are shaping midterm elections. October 29, 2026.

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This report describes each party's positions as its own advocates present them and draws its assessments of scale from the independent sources cited. It takes no position on how readers should vote. The Mechanism Map and the Wednesday Test are original frameworks developed for this report.