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ISSUE BRIEF | Healthy America

IT'S YOUR MONEY: MAKING YOUR HEALTH DOLLAR WORK FOR YOU, THE PATIENT *PAYING PEOPLE, NOT PLANS (PT II)*

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“The government is going to pay the money directly to you. It goes to you, and then you take the money and buy your own healthcare... the big insurance companies lose and the people of our country win.”

-President Donald J. Trump

Making Americans Healthy Again Begins with Relinquishing Government Control of Health Dollars

Any reforms to the health insurance system must focus on driving increased value for patients. Increased value does not solely mean increased costs or more complicated care; instead, it is about the overall value of the health plan *as determined by patients*.

Patients-last reforms that let the government decide what is valuable to a patient—from reducing non-standard plan offerings to virtually eliminating short-term, limited-duration plans—have not worked to Make Americans Healthy Again. There is no one in the health system more incentivized to take hold of their health than the patient. Since one size does not fit all, patients need options.

Grievously, patient-last policymakers created fewer options for patients, since those plans lacked the flexibility to tailor offerings to patients. Fewer options mean that patients have little ability to shop around, make comparisons, and ultimately decide what is best for



their family. In fact, many families can only choose between a few plans offered by their employer (e.g., a High-Deductible Plan or a Standard Plan) or only one government-offered plan. Without true choice and competition, patients are often left with one of two options, which does little to improve quality or lower prices.

For example, a single mother who has access to the Children’s Health Insurance Program (CHIP) might have all the “coverage” she needs for her children (e.g., no premiums, little to no out-of-pocket costs), but the coverage limits her to only a few doctors in a geographic area. If she is working for hourly wages, she might need to take off work to pick up her child from school (~20-45 min), bring them to the doctor (~20-45 min), wait and be seen by the doctor (~1-2 hours), drop them back off (~20-45 min), and drive back to work (~20-45 min). If everything is closed and ends on time, the best-case scenario is two hours of lost wages. More likely, this mom is faced with the loss of a half day’s wages. That means that in order to access her “free” healthcare, she had to pay a tenth of her earnings for the week, which, for the sake of this illustration, would be \$100.¹

Patients-first policymaking understands this dilemma and advocates for greater choices—not to undermine the kids in the safety net, but to support them. Even making small changes to support the people in the safety net, like options for mom to pay a low cost for telemedicine, make her and the kids eligible for a tax-advantaged account, or to a DPC doctor she can text for a prescription, or even using a sliding scale to a clinic on a weekend, it would be cheaper than the very real-time cost she faces by taking time out of her workday. This gives mom and kids a better chance of going to the doctor, staying healthy, and getting health care at a lower price. However, these options require spending outside of the health insurance provided, so the dollars are trapped. This is what patients-last policymaking fails to recognize: fewer options hurt patients, raise costs, and keep them unhealthy.

Give People Their Money

Patients have the greatest skin in the game, so they have the most precise barometer of what is valuable to protect their health. For instance, each American patient is projected to spend, on a per capita basis, an average of

\$16,570 on healthcare by the end of 2025 ([Keehan et al., 2025](#)). If asked, most Americans would likely not be able to identify how they consumed \$16,570 of healthcare over the past year. In fact,

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¹ For the sake of this illustration, this paper used an average hourly wage of \$25.00/hour which is equivalent to an annual salary of \$52,000. Using CHIP federal eligibility guidelines, a mother of three in Texas, making \$52,000 a year, would qualify for the program.



based on consumer surveys, patients have a mistaken perception of how much they are spending per month on healthcare ([Collins & Gupta, 2024](#); [Mangan, 2016](#)). The likely reason for this is that for most Americans, the majority of their healthcare dollars are tied up in premium payments to their health insurance. Premium amounts are withheld from Americans' paychecks, such as federal and state income taxes or retirement contributions. Other health dollars are even more disconnected from the patient's perception, like the employer's additional contribution to a patient's health insurance premium payments. Instead of increasing an employee's salary, many employers put those dollars towards a patient's health insurance premium payments and are incentivized to do so by current law ([Internal Revenue Service et al., 2023](#)).

Because of this, Americans do not associate much choice or option with their healthcare dollars ([Mangan, 2016](#)). Their dollars are spent by third parties, such as insurance carriers or health plans, with little input from the actual patient. Patients should be able to spend this money however they choose, especially if their healthcare options are not working for them or providing adequate value.

Delinking Subsidy Dollars

Policymakers should allow patients more flexibility to choose how to spend or receive the healthcare dollars received through their employer or through the government as federal subsidy dollars. Two of these subsidies, Advanced Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSR) can only be used on the individual marketplace plans, and CSR payments only apply to certain individual marketplace plans, such as silver plans. Restrictions on these subsidies have dictated patient action rather than the other way around. For instance, the subsidies have maximum value when used by older, sicker, or low-income households purchasing silver plans, and have attracted those patients to silver plans. The subsidies increased premium costs, and skewed these purchases towards silver plans ([Fann & Cruz, 2023](#)). Patients are unable to afford insurance coverage because the purchasing power of their dollar in the individual market can no longer compete with the purchasing power of a subsidized individual. Instead of providing more opportunities for patient choices, the Biden Administration tried to reduce the premium cost of silver plans by auto-enrolling individuals in other plans into silver plans, hoping to reduce the overall premiums ([Centers for Medicare & Medicaid Services, 2023](#)).

President Trump, in his Great Healthcare Plan, gives people more of their money. The Plan stops extra subsidy payments to large insurance companies and instead sends money directly to eligible Americans, while also funding a cost-sharing reductions (CSRs). This approach would save taxpayers at least \$36 billion and reduce common Obamacare plan premiums by more than 10% according to CBO ([Congressional Budget Office, 2025](#)).

Delinking these subsidy dollars from individual marketplace coverage would be the first step in driving stronger value for patients' healthcare coverage. Patient-last policymakers required these subsidy dollars to go to insurance companies, rather than to the patients



directly. Instead, policymakers could amend the ACA and allow CMS discretion where these dollars flow, including directly to the patient. Additionally, these dollars could be transformed into tax-preferred dollars, given to patients as a contribution to their HSA or FSA. This way, as Americans take greater accountability for their health, their dollars can follow.

Similarly, some enrollees in Obamacare get cost-sharing reductions (CSRs) to help support the high-deductible amounts in Obamacare plans. Patients-first policymakers could consider funding these CSRs through direct contributions into a tax-preferred account to help offset the high-deductible amounts that patients need to pay.

Policymakers could also use waiver authority, such as Section 1332 of the ACA, to deliver subsidy-like amounts to individual marketplace recipients. Rather than send the dollars to insurance companies, CMS could design templates to show how states could deliver direct-to-consumer funds for these patients to use on their healthcare, whether that is through DPC, purchases through TrumpRx, or preventative wellness items. This allows them to gain greater accountability and control of their healthcare dollars while enhancing flexibility and options for patients to shop around.

Employer-Based Healthcare

Outside of the individual market, employees at small companies often do not receive health benefits because of restrictions on how small companies are able to purchase small-group coverage. Small employers (10 to 199 employees) are increasingly not offering health benefits to their employees, with 59% offering some workers coverage in 2025, down from 67% in 2020 and 82% in 2010 ([Kaiser Family Foundation, 2025](#)). Employers cite the cost of insurance as their primary reason for not offering coverage. For those small companies that continue to offer health insurance to their employees, it is increasingly unaffordable ([Altman, 2023](#)). To promote access to more affordable healthcare options, Congress could consider changes to Health Reimbursement Accounts to make them easier to use for small business owners and patients alike.

Finally, policymakers should consider amending the rules surrounding minimum essential coverage (MEC) to allow a shift to a defined contribution, rather than a defined benefit. The MEC is a definition within the ACA on private health insurance, which dictates whether or not a health plan is compliant with the ACA for the purposes of the “employer shared responsibility,” which is a tax on employers who do not want to provide health coverage for their employees. The MEC effectively eliminated employers’ ability to customize a benefit for their employees and instead requires employers to follow the same list of requirements as the individual market. In the statute, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, has the authority to recognize other types of health spending as “minimum essential coverage.” Policymakers could consider reforms that would allow businesses to offer MEC as a defined contribution, as in a set pot of money for each participant and beneficiary, rather than a defined benefit. This could also be piloted, with the new regulatory definition only recognizing defined contribution plans that are offered alongside traditional defined benefit plans.



When lawmakers finally trusted people with their own retirement dollars, shifting employer-based benefits from a defined benefit (*e.g.*, pension plans) to a defined contribution (*e.g.*, a 401(k) or a Roth IRA), individual retirement accounts boomed ([Employee Benefit Research Institute, 2024](#); [National Alliance of Healthcare Purchaser Coalitions, 2025](#); [Poterba et al., 2002](#)). Similarly, giving American patients their health dollars directly in order to purchase their own health plans will do the same to Americans' health. The President knows this, which is why he included it as part of the Great Healthcare Plan.

Policy Recommendations

- ★ Amend the Internal Revenue Code (IRC) to allow the Tri-Departments to direct the Advanced Premium Tax Credit (APTC) for each Qualified Health Plan (QHP) into a tax-advantaged account (*e.g.*, HSAs).
- ★ Congress should fund CSR payments for QHPs, as well as allow the conversion into HSA contributions for eligible enrollees.
- ★ Congress should amend the IRC to codify the 2019 final regulations authorizing Individual Coverage HRAs and excepted benefit HRAs, giving Trump-era HRA flexibilities permanent statutory authority, including by enacting CHOICE-style provisions that rename and update ICHRAs while preserving their core features.
- ★ CMS and Treasury should develop and publish Section 1332 waiver guidance and model templates that enable states to redirect federal subsidy pass-through amounts into portable, patient-controlled health accounts (to “Pay People, not Health Insurance Companies”) as announced in the Great Healthcare Plan.
- ★ The Tri-Departments should contemplate piloting new flexibilities surrounding the definition of minimum essential coverage to broaden access to care for the underinsured.

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