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ISSUE BRIEF | Healthy America

IT'S YOUR MONEY: MAKING YOUR HEALTH DOLLAR WORK FOR YOU, THE PATIENT

DEMAND YOUR PRICES (PT IV)

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"Most importantly, it will require any hospital or insurer who accepts Medicare or Medicaid to prominently post all prices at their place of business so that you are never surprised, and you can easily shop for a better deal or better care—you're going to get a better deal and better care."
-President Donald J. Trump

Give People Their Prices

Patients in one of the richest, most technologically advanced countries in the history of the world should not be told that it is not possible to get an accurate estimate for an item or service prior to receiving it. Healthcare purchasers, such as employers, should not be contractually prohibited from knowing the costs of items and services they purchase for their employees. Yet both occur in the current healthcare system (America First Policy Institute, 2026). Price information should not be held hostage, because it prevents patients from being able to use a health system that should work for them. Employers and other healthcare purchasers do not fare much better, often filing lawsuits to get pricing information that should be rightfully theirs (Deacon, 2025; Hansard, 2023). Without usable pricing transparency, both patients and purchasers are asked to blindly accept whatever quote is given to them. A 2023 analysis of just the insurance transparency rule projected that if patients had real, robust tools for shoppable services, then the rule could yield between $17.6-80.7 billion in annual savings by 2025 (Parente, 2023). Relative to roughly $1.1 trillion in commercial claims, even a 1% shift in prices could save about $11 billion per year (McKinsey & Company, 2024). This is why the Great Healthcare Plan prioritizes transparency- it has the incredible promise to drive down healthcare costs for patients.

Transparency for Patients

American consumers rely upon the availability of accurate and comparable pricing information as they make purchasing decisions. Despite being a significant portion of consumer spending, similar information is not available when it comes to healthcare prices. Instead, American patients are frequently led to believe that there is no way to provide real-time pricing information when comparing health costs.

Most healthcare costs are unknown to patients until after care is delivered. Thankfully, President Trump directed the Tri-Departments to enforce existing price transparency requirements that had languished under patients-last administrations (Trump, 2025). The first Trump Administration implemented regulations that required hospitals and health plans to provide consumers more information about the costs of their services. The No Surprises Act added requirements for health plans and providers to supply more information about costs to patients. Despite being signed into law in 2020, many of the transparency provisions were never implemented by the previous, patients-last administration (Letter to Tri-Agencies on the NSA, 2025). One of the most monumental reforms is the introduction of the advanced explanation of benefits—the requirement that a patient receives a quote for their service before it is provided to them. Yet five years later, patients are still incurring medical debt because they do not know the cost of the service before they get it. Thankfully, the Great Healthcare Plan makes these changes, ensuring that patients can negotiate the cost of their care.

Consider that roughly 55 million Americans have a high-deductible health plan. These Americans must pay out-of-pocket for medical services prior to hitting their deductible, which could be as high as $5,000. A patient who needs specialty care, such as a preventative visit to the cardiologist for a family history of AFib, might be given a variety of diagnostic tests without being told the prices or the necessity of the tests. Instead, the patient is just told that they need the tests and will be billed later. Those diagnostics could range from $8 to $800, depending on the contract with the insurer or choice of health provider. This patient does not know the price in advance and is unable to make an informed decision on value. For example, is an Electrocardiogram, with an average cash price of $178, enough for the patient? If the patient is instead asked to get an Echocardiogram, with an average cash price of $1,422, is that what the patient needs? Or does the patient need a Holter monitor, with an average cash price of $606 (Routine 12 Lead EKG with Report, 2026; Holter Testing - 48-Hour EKG, 2026; Wei, Milligan, Lam, Heidenreich, & Sandhu, 2024)?

Without prices, the patient knows less about what they need, why they need it, and the dilemma shifts accountability away from the patient. Instead, providers often test for what is normally covered by insurance, not for what is needed to properly prevent heart disease in a patient. Surprise bills, in this case, a bill of $2,000 for diagnostic testing without true

informed consent, only deter patients from going back for additional preventative care.

Patients should be able to shop around with cost data, including within the benefits of their health plan. If a patient does not know the full cost of a procedure or how different elements of the service could be priced differently at different facilities, he or she is not able to fully use this pricing information. In addition, patients should be able to understand the utilization management tools applied to each item or service in advance of scheduling a procedure. Patients should not learn that their health plan does not cover an item or service after they have scheduled and received the service. Patients and their health providers should be able to integrate pricing and utilization management tools into the front-end of decision-making, rather than reacting to new barriers after the fact. This pricing data should not be held behind a paywall or require a patient to go through a complex login or registration process. Thankfully, patients-first policymakers recently announced a shift in price transparency information, allowing doctors and patients to understand some of this information as it relates to their drug costs. For instance, a patient directing their doctor towards a specific pharmacy will now know the price of the drug under their insurance plan per specific pharmacy (U.S. Department of Health and Human Services, 2026).

Similarly, patients (and their purchasers) should know the number of claims denied by their health plan. The Great Healthcare Plan requires this information to be publicly available, and patients-first policymakers should include it in the Notice of Benefit and Payment Parameters for CY28. This way, patients will know that some health plans are easier to work with than others.

The lack of transparent pricing information continues to put more and more Americans into medical debt, as they have little to no ability to know or prepare for the high cost of care they are about to receive. One third of working-age adults report having medical or dental debt, and 67% of those with medical or dental debt report making those payments directly to the provider, rather than a debt collection agency. Small-dollar, unplanned costs play a significant role in medical debt, with 51% of those with medical or dental debt reporting total debt under $2,000, and 36% reported the debt was because of a doctor's office visit (Collins & Gupta, 2024; Collins et al., 2023). While there are undoubtedly many factors that contribute to individuals accruing medical or dental debt, it is likely that the absence of clear pricing and coverage information for even routine office visits contributed to the accrual of debt.

In the recently passed transparency legislation for PBMs, Congress required both group health plans and patients to get price information (Anderson, 2026a). Patients are required, on request, to get de-identified and aggregate pricing data so that they are able to understand whether or not their group health plan is abiding by their role as a fiduciary. These reports also include spread pricing data; for instance, a patient in the high-deductible

stage of their health insurance might consider requesting this report to understand if their health plan is using spread pricing as part of its contract. If it is, and spread pricing increases the cost, the patient might consider shopping for alternative options—like TrumpRx or paying cash at the pharmacy counter.

Transparency for Purchasers (e.g., Employers)

Given that around half of Americans get their insurance from their employer, patients often rely on third-party purchasers and negotiators in order to get the best value for their dollar. Patients trust their employer to be their advocate, but if employers do not have the best information available to make decisions on behalf of their employees, patients' health will suffer. The Great Healthcare Plan recognizes this and ensures that employers and unions are getting the information that they need to make decisions on behalf of their employees or members.

Employers & Taft-Hartley multiemployer plans who choose to self-fund their health benefits have the statutory flexibility under the Employee Retirement and Income Security Act (ERISA) to design healthcare benefits for their employees, including the design of provider networks, the cost-sharing, and ultimately, the benefits that are offered.

However, recent lawsuits have shed light on the challenges employers have with their service providers (Hansard, 2023; Deacon 2025; Herman, 2023). Service providers should not be restricting employers from receiving medical or pharmacy claims data, which rightfully belongs to the employer, and Congress should contemplate reforms that ensure greater transparency and accountability in the delivery of claims data to the employer. Greater scrutiny over contracting practices has revealed that insurers pay higher prices for common services when acting as a TPA for an employer compared to when they bear the risk of claims themselves. Employers are incentivized to drive down costs, for both themselves and their employees, but cannot if they lack the leverage to negotiate lower prices (Silver & Hyman, 2018; Sen, Chang, & Hargraves, 2023). In fact, one-third of employers still cannot get complete health data[1], and four in ten employers say that service providers refused to provide the data (National Alliance of Healthcare Purchaser Coalitions, 2025). This has implications for their fiduciary duty as well; if the plan sponsor (i.e., the employer) of the group health plan does not know the costs of the care, they run the legal risk of noncompliance with their fiduciary duty to manage the benefit properly for the participants and beneficiaries of the group health plan (The Investopedia Team, 2025). Thankfully, DOL has taken a step forward to provide accountability, enhancing B2B reporting between PBMs and the group health plan by mandating fee disclosures as well as direct and indirect compensation between

[1] Health data refers to de-identified health data as allowed by federal privacy laws; plan sponsors are allowed access to limited identified data sources but are required to put firewalls into place to limit access to identifiable data to one or two individuals with penalties associated with unlawful use or disclosure.

group health plans and service providers (U.S. Department of Labor, 2026). In addition, reforms passed by Congress ensure that PBMs are covered service providers as defined by the Employee Income Retirement Security Act of 1974 (Consolidated Appropriations Act, 2026).

Patients-first policymakers should recognize that middlemen are holding the receipts hostage in order to prevent lower-costs (and more options) for patients. Regulators at the Federal Trade Commission (FTC) should consider evaluating these actions as anti-competitive, reviving Bush administration reports on anti-competitive behavior in the healthcare industry (Federal Trade Commission and the Department of Justice, 2004).

Anti-competitive clauses are found throughout contracts between the employer and the middleman. Patients-first policymakers should review the various contract clauses that employers face while purchasing administrative services from a TPA, which may be anti-competitive. Examples include:

- Prohibitions on benchmarking and comingling claims data from multiple companies ("You can have the data, but you cannot realistically use it for anything").
- Prohibitions on using data to develop or use any type of price transparency tool ("You can have the data, but you cannot use it to inform patients").
- Prohibitions on using claims data to create any type of healthcare comparison data base ("Do not submit this data to a think tank or an All-Payers Claims Database").
- Prohibitions on using claims data to do any cross-carrier comparisons ("Do not use this data to assess our performance").
- Prohibitions on using claims data to run any type of Request For Proposal (RFP) or Request For Information (RFI) process to shop carrier services ("Do not use this data to select a better vendor").
- Prohibitions on using claims data to contract with business coalitions, accountable care organizations, or centers of excellence ("Do not use this data to drive value").
- Prohibitions on using data to "steer" members between providers of the same service type or category ("Do not use this data to implement value-based plan design").
- Prohibitions on performing certain analytical procedures on claims data include reverse engineering of pricing, margins, etc. ("Do not use this data to figure out what we are NOT telling you").
- Upon terminating a carrier, prohibitions on maintaining the company's own historical claims data or sharing historical claims data with the company's new carrier ("You can look at this data, but we still own it").

In addition, these contracts will often include all-or-nothing or tying clauses, which also leave the employer with less leverage in tailoring care towards their specific patient population. An employer might want to design a network that includes paying a capitated rate for access to a certain physician practice, but contracting mechanisms prohibit

them from making any amendments to the provider networks as designed by the TPA. Tying clauses require employers to agree to a comprehensive list of terms and conditions by virtue of agreeing to one term or condition. For example, an employer might be required to administer the pharmacy benefit through the same TPA that has agreements with the TPA that offers the medical benefit. Then, an employer is required to follow the terms and conditions of the PBM, including clauses that require the employer to prefer certain pharmacy or provider networks. The net result of these clauses may mean that employers are overpaying for healthcare for their employees and higher costs for patients (H. Anderson, personal communication, 2025).

Private employers should be free to engage in a variety of contracting mechanisms, including participation in contracts which deliver specific cost-savings to the patient. However, patients-first policymakers should contemplate reforms which allow for a fair playing field between employer and service provider when designing contracts—ensuring that everyone is moving towards the goal of a patient's health. The Great Healthcare Plan bans a common anti-competitive practice, where kickbacks are paid by PBMs to the brokers designing benefit packages (Anderson, 2026b).

Patients-first policymakers can also reevaluate regulatory requirements on the design of these plans, allowing for more flexibility for employers to design consumer-friendly plans. These options could include expanding the utility of network adequacy requirements, allowing employers greater options to negotiate these requirements with their TPA, while ensuring that access is maintained.

Recent legislation on PBM transparency also required renewed focus on hospital price transparency; the legislation requires all off-campus hospital outpatient departments (HOPDs) to have a separate and distinct National Provider Identifier (NPI) from their main hospital. This allows payers to better negotiate costs on behalf of the patient (Consolidated Appropriations Act, 2026). In the upcoming Medicare payment rules, regulators should ensure that this is quickly effectuated.

Policy Recommendations

- ★ CMS can immediately begin to undo the damage of the Biden Administration's lack of implementing the No Surprises Act, including the Advanced Explanation of Benefits and the Gag Clause Attestation.
- ★ CMS can promulgate requirements for all health providers and insurers to publicly post prices, ensuring that patients have real-time price information.
- ★ ASTP/ONC can encourage regulated entities to adhere to future EHR regulations earlier than anticipated—accelerating front-end information for patients, rather than surprises at the pharmacy counter.

- ★ CMS can include, as part of the CY28 NBPP, that patients should know the number of claims denied by the health plans, as well as the percentage of revenue paid out to claims.
- ★ EBSA can swiftly finalize and implement the regulations and new PBM transparency law that require enhanced transparency between PBMs and plan sponsors.
- ★ The Tri-Departments, along with the Office of Personnel Management (for the Federal Employees Health Benefits Program), can quickly support and align federal plan rules with the Express Scripts settlement agreement (Federal Trade Commission, 2026).
- ★ The Federal Trade Commission should revive a Bush Administration report on anti-competitive practices in the healthcare industry, including practices between group health plans and their service providers.
- ★ The Tri-Departments can quickly promulgate guidance as part of recently passed PBM legislation for patients to get aggregate pricing information from their employer or labor union.

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