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ISSUE BRIEF | Healthy America

It's Your Money: Making Your Health Dollar Work For You, The Patient

Patients First, Not Last (Pt V)

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"It is the policy of the United States to put patients first."
-President Donald J. Trump

Promoting a Patients-First Health System

The patients-first focus of the Great Healthcare Plan started under the first Trump Administration. Patients-first policymakers required hospitals and health plans to publish negotiated rates, out-of-pocket estimates, and other key cost information in both machine-readable and consumer-friendly formats. Patients and their clinicians were given practical tools to compare options before care is delivered, not after the bill arrives. And the United States was no longer going to suffer from global freeloading in prescription drugs (Trump, 2020). President Trump took leaps to make patients first, and the Great Healthcare Plan is just a continuation of that.

Patients-First Drug Pricing

President Trump has taken unprecedented action to put patients first when it comes to drug costs, whether that is negotiating the cost of drugs by ending global freeloading (Executive Office of the President, 2025; Katebi, 2025), creating TrumpRx (White House, 2026; Anderson, 2026), increasing pressure on the middlemen to disclose their costs (Katebi, 2024), or increasing the tools they have to know their costs (Hood, 2026). Because of these patients-first actions by President Trump, American patients have gained greater health, cheaper drugs, and benefited from greater transparency into their care.

For instance, under TrumpRx.gov, Americans have access to hundreds of drugs at Most-Favored-Nation pricing (for branded drugs) and cash prices (for generics). The Trump Administration eliminated the middlemen and allowed patients greater choices in where they buy their prescription drugs (Anderson, 2026).

Unlike other medical costs, American patients are aware of the cost-sharing for their drugs at the point of purchase. They can seek lower-cost options in real time, since patients-first policymakers removed gag clauses so pharmacists can promote lower-cost options at the pharmacy counter (e.g., if a patient's cash pay would be less than their insurance co-pay). Development of real-time benefit tools, like the ones developed by patients-first regulators at HHS, ensures that patients and their physicians have full insight into their treatment options and costs as they make treatment decisions with their providers (U.S. Department of Health and Human Services, 2026).

Patients are often not aware of utilization management tools, such as step therapy (where a patient has to "step" through another drug before accessing the preferred drug) or prior authorization (where a patient is required to get authorization from an insurance plan prior to a medical service), until after the treatment is prescribed and sent to the pharmacy. Prescription drugs are placed on a formulary, which is a tool used to tier drugs based on contractual agreements between the pharmacy benefit manager (PBM) and the drug manufacturer. The placement of drugs on the formulary impacts the patient, steering a patient toward a certain drug or increasing cost-sharing on a non-preferred drug (Katebi, 2024).

For instance, if a patient is prescribed a drug that does not have preferred placement on the formulary, the insurance company may require the patient to "step through" another drug before getting access to the drug the doctor prescribed. However, patients may not know this until they are at the pharmacy counter or told by the insurance company to go back to their doctor and seek another prescription. Patients-first policymakers should ensure that Americans have all the necessary information about their options *before* their drug is sent to the pharmacy.

In addition to more options for existing drugs, Americans need more options for lifesaving, curative treatments. As more of these personalized treatments come to market, more flexible contracting models need to come with them. Patients-first policymakers could contemplate making payments for these therapies over multiple years, rather than a single plan year. Other contracting authorities could include:

- **Therapeutic warranties**, which are insurance-based instruments funded by manufacturers that provide recourse to the warranty holder if a product does not meet predefined expectations. The warranty holder is entitled to the complete amount guaranteed by the manufacturer as stipulated in the warranty policy. Unlike value-based pricing, the warranty holder can be anyone, not just the health plan.

- **Value-based or outcomes-based pricing**, where the price of the drug is tied to patient outcomes. For instance, if a drug does not work for a given population, the payer can be refunded.
- **Gain-sharing or shared savings**, where patients and manufacturers alike have a financial incentive to reduce costs.
- **Direct-to-consumer pricing**, where manufacturers sell directly to a patient (like TrumpRx), without going through the health insurance plan.

Patients-first policymakers could also contemplate reforms that allow issuers and health plans to purchase drugs in a variety of different ways, separate from the traditional medical or pharmacy benefit. These reforms could consider the creation of a separate benefit, allowing health plans to purchase a contract option to provide coverage should a patient be prescribed an expensive, personalized treatment. In addition, policymakers and regulators could consider how to incorporate the relative costs of the drug over a ten-year window, rather than force an assessment across the normal single plan year. This is an artificial barrier to uptake; if plans cannot measure the relative costs over a longer window, they have a disincentive to provide coverage.

For hemophilia B, the current standard of care involves lifelong prophylactic replacement of missing factor IX replacement ("factor") at an annual drug cost that typically exceeds $600,000 and can approach $900,000 for adults in U.S. commercial and Medicaid plans. Over an approximately 50-year treatment horizon, which is consistent with contemporary life expectancy for individuals maintained on effective prophylaxis, this translates to lifetime factor-related spending on the order of $30-45 million per patient. However, a one-and-done gene therapy could have an initial cost of $3.5 million, with thousands in other maintenance costs throughout the course of a patient's life (Sarker et al., 2024). Should a health provider want to switch, using gene therapy for a Hemophilia B patient could mean that the patient is going to be healthier, and the taxpayer will save money. But the current design of health insurance incentivizes the usage of yearly treatment, because of the high startup costs.

One barrier is that intermediaries in the pharmaceutical supply chain, such as pharmacy benefit managers, do not have the incentives to provide these new models of care. Patients-first policymakers should ensure that there are no regulatory or contracting barriers to these innovative designs and empower employers and other health purchasers to adopt them. Employers and payers should be able to have the freedom to purchase drugs for their employees in a way that is best for them, outside of the traditional rebate model.

Making Healthcare Easier to Access

Almost a fifth (18.3%) of the U.S. GDP is represented by health care spending (Centers for Medicare & Medicaid Services, 2026). In all other sectors of the economy, the American consumer has a plethora of tools to help them shop. But when the American consumer is

a patient looking for health care services, he or she no longer has the suite of tools they rely on to become an informed consumer.

Patients Cannot Use the Internet to Shop for Health Care

An important tool of the American consumer is the ability to shop around for care, compare prices, and for businesses to be able to seek them out in order to market their services. But many of these practices are restricted, in part, because of the lack of transmittable pricing information or because of antiquated health data requirements. Patients should be able to easily search online for their healthcare services, including pricing and quality information for specific providers and services. The health system is already using patients' browsing history to make inferences about what they would like to buy, but the patient cannot use a web browser to shop around for care the way they would like (Muoio, 2023).

Health data is held by large, third-party data brokers. Similar to other access rules, patients should be able to access their claims information directly from the entities that hold it all – the clearinghouses. This would lead to greater transparency and increase the availability of longitudinal health records.

Patients Jump Through Too Many Hoops

Health plans and payers often employ utilization management as a means to control costs and ensure that patients are getting the right treatment or care. However, in certain cases, the widespread use of utilization management tools can prevent patients from getting needed services or treatments and care in a timely manner.

Utilization management tools should be targeted and not supersede a physician's medical recommendation or add unnecessary administrative burden. Patients-first regulators at HHS have taken a huge step forward towards this goal, announcing a voluntary agreement across major health plans to reform prior authorization and other burdensome practices (U.S. Department of Health & Human Services, 2025). Oftentimes, responsibility for approvals or overrides of these utilization management tools is inappropriately mismatched to a provider who may not have the clinical background to make a decision for a certain service or is incorrectly decided by artificial intelligence. Policymakers should consider additional reforms that ensure that these decisions are made by their physician, in concert with other providers who understand the clinical decision-making by their physician. Patients should also be well-informed about the comprehensive set of utilization management tools applied to their care, so they can make decisions with their healthcare provider without delay or interruption.

Payers and Providers Have Too Much Red Tape

Health plans and payers are faced with thousands of hours of compliance requirements, which require them to spend time and money on complying with sometimes outdated and

unnecessary requirements. For instance, some health plans are required to send paper copies of a patient's explanation of benefits (EOB), rather than being able to default to electronic disclosures of EOBs and medical bills. Patients-first regulators should request more information from health plans and providers to understand what requirements could be struck in order to decrease the red tape that increases administrative burden and unnecessarily adds costs to the healthcare system.

Ending the Perverse Incentives

Patients are Penalized for Good Health

Many of the requirements in the Affordable Care Act were intended to bring down the cost of care for patients. Some of these requirements backfired, resulting in higher premiums for all patients. The individual marketplace exchanges failed to attract younger and healthier participants, as these individuals opted to pay the penalty rather than join the exchanges, increasing premiums and deductibles for all patients. Even after the penalty was eliminated, these young and healthy patients opted not to pay for health insurance.

Premiums have continued to increase in both the individual market and employer-based market, as insurers tried to keep up with new requirements. These premium increases have disproportionately impacted younger patients who elected to become covered, as the law allowed insurers little variation in premium rates between adults from 21 to 63 (Keisling, 2016). Patients-first policymakers should ensure this requirement does not have the unintended consequence of disincentivizing coverage for young, healthy individuals and increasing premiums for all patients. Policymakers could seek to understand if there are reforms to the age-based community rating requirements of the ACA that would protect the cost of coverage for all Americans, young and old. As Secretary Kennedy said, one person should not be penalized for the bad health of someone else (The U.S. Senate Committee on Health, Education, Labor, & Pensions, 2025).

Patients are Penalized for Spending Less

Patients-last policymakers intended to control the profits of health plans by creating the medical-loss ratio (MLR), which dictates how much a plan's revenue has to be spent on healthcare versus going towards profit or administrative costs. The MLR requires insurers to spend a specified percentage (80% for individual and small group markets and 85% for the large group market) of total premiums on medical costs and expenses that improve healthcare quality. If these requirements are not reached, the insurers must issue rebates to their customers. The MLR has unintended consequences, like increasing premiums. To overcome paying rebates and build up these needed reserves to pay high-dollar claims, insurance companies may need to increase premiums. This has resulted in higher health costs, greater consolidation of health plans (and fewer choices for patients), and ironically, greater profits to health plans (Pate et al., 2025).

Patients-first policymakers should also consider whether the MLR has fulfilled its mission of directing health spending on patients and consider reforms to more appropriately ensure that health plans are directing sufficient spending on patient care. This is why the Great Healthcare Plan requires renewed transparency by the MLR; plainly stating the overhead costs of the health plan.

Patients are Paying for Social Goals, Not Health Goals

Health plans, payers, and providers have been encouraged (and at times, required) to absorb costs and pass them along to patients as part of ancillary goals. For instance, the Biden Administration encouraged health plans and providers to become 100% carbon neutral, which requires them to make costly changes that are absorbed by the patients (Centers for Medicare & Medicaid Services, 2022; Department of Health and Human Services, 2022) One of these health plans, Kaiser Permanente, has become 100% Carbon Neutral in part by the purchase of carbon offsets, which only drives up the cost of care for patients (Kaiser Permanente, 2020).

Publicly traded health companies faced pressures from both the U.S. Securities and Exchange Commission (SEC) and their largest asset managers to focus their time and resources towards goals that are not in the best direct interests of their patients (and shareholders). Regulations promulgated by former patients-last regulators at the SEC would impact publicly-traded health companies, requiring them to report the Greenhouse Gas (GHG) emissions that are embedded in the supply chain of services (e.g., emissions from the manufacturing, transportation, and/or disposal of medical supplies, pharmaceuticals, and food). The SEC estimated the plan would raise the cost to businesses to comply with existing SEC disclosure rules from $3.9 billion to $10.2 billion. This is an extraordinary additional cost, which will ultimately get passed along to the end user: the patient (Eaglesham & Kiernan, 2022).

Policy Recommendations

- Congress should codify Most Favored Nation pricing reforms, such as TrumpRx and Medicare MFN pricing agreements.
- Congress should consider reforms to exempt certain contracting models, like multi-year contracts or warranties, from traditional insurance requirements so that health plans have a greater suite of tools to choose from to finance expensive therapies.
- The Tri-Departments should release a Request for Information (RFI) on how they should approach the regulation of contracting mechanisms for gene therapies.

Making Healthcare Easier to Access

- Regulators should build on the voluntary commitments made by health insurance carriers for utilization management reform and convene a public meeting to publish the results on how care has gotten easier for patients.

Ending the Perverse Incentives

- ★ Regulators should evaluate Obamacare requirements to ensure that they do not have the unintended consequence of disincentivizing coverage for young, healthy individuals and increasing premiums for all patients.
- ★ Regulators should consider whether the MLR has fulfilled its mission of directing health spending on patients and consider reforms to more appropriately ensure that health plans are directing sufficient spending on patient care. This is why the Great Healthcare Plan requires renewed transparency by the MLR; plainly stating the overhead costs of the health plan.
- ★ End the inclusion of costly social goals; requiring that climate accounting has to be counted as part of profit within the MLR.

Conclusion

American patients need to be healthy again, and patients-first policymakers have an opportunity to help patients both take back their health and take back their healthcare dollar. The Great Healthcare Plan, as laid out by President Trump, will give patients their healthcare dollar, more control over their healthcare, and more transparency into their prices.

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