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ON THE

2026 ECONOMIC REPORT OF THE PRESIDENT

CHAPTER 2 OF THE
CHAIRMAN'S VIEWS

An Update on Federal Healthcare Policy

MAY 13, 2026
CHAIRMAN DAVID SCHWEIKERT

CHAPTER 2: AN UPDATE ON FEDERAL HEALTHCARE POLICY

Since the start of the 119th Congress, healthcare reform has been at the forefront of Federal policy. Aimed at addressing increasing healthcare costs both for individuals and the Federal government, the 119th Congress, in tandem with the Trump Administration, has implemented a number of healthcare reforms. These have sought to reduce healthcare costs and improve the delivery of care while also rooting out waste, fraud, and abuse in our state and Federal health systems. The Joint Economic Committee is tasked with evaluating the recommendations made by the Administration in the *Economic Report of the President* (*Report*) and proposing additional policy recommendations as advisable. Accordingly, the intention of this chapter is to review and analyze the healthcare policy reforms implemented during the 119th Congress and overview further ideas for reform that can achieve the Chairman's goal of properly aligning incentives in healthcare to reduce costs and improve outcomes.

Review of health policy in the 119th Congress

The most significant healthcare policy action in the current Congress came with the enactment of P.L. 119-21 (H.R. 1 in the 119th Congress, commonly known as the Working Families Tax Cuts) on July 4, 2025.[69] The healthcare provisions in P.L. 119-21 are a positive development toward fiscal sustainability in the nation's healthcare programs, advancing a primary goal of the JEC under the leadership of Chairman Schweikert. This section will analyze the largest of those provisions and the extent to which they address structural issues in the U.S. healthcare system.

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[69] *An act to provide for reconciliation pursuant to title II of H. Con. Res. 14*, Pub. L. No. 119-21 (July 4, 2025), https://www.govinfo.gov/content/pkg/PLAW-119publ21/pdf/PLAW-119publ21.pdf.

Work requirements and eligibility verification

One of the core principles of healthcare reform in P.L. 119-21 is the elimination of waste, fraud, and abuse within the U.S. healthcare system. In a March 2025 report by the Government Accountability Office, they estimated that Federal improper payments totaled nearly $162 billion in FY2024.[70] Of that $162 billion, 70 percent was concentrated in four program areas: Medicare ($54.3 billion), Medicaid ($31.1 billion), the Earned Income Tax Credit ($15.9 billion), and the Supplemental Nutrition Assistance Program, or SNAP ($10.5 billion).[71] Due to the nature and magnitude of the payments, a significant portion of aggregate improper payments and fraud are concentrated in healthcare and nutrition programs. In addition to improper payments, the JEC estimates that administrative waste in Federal healthcare programs amounts to between $100 and $200 billion per year, or between 6 and 12 percent of total Federal healthcare spending.[72] In order to sustainably finance these programs, greater fiscal scrutiny is needed.

Fortunately, P.L. 119-21 made a number of program changes intended to prevent fraud and tighten eligibility. One key change was the increase in eligibility requirements for those enrolled in Medicaid. Effective at the end of 2026, new rules require adults in the Medicaid expansion population from ages 19 to 64 to complete 20 hours per week of either work, education, job training, or qualifying community engagement in order to maintain eligibility.[73] Additionally, P.L. 119-21 restricts Medicaid

[70] U.S. Government Accountability Office, "Fraud & Improper Payments," accessed March 17, 2026, https://www.gao.gov/fraud-improper-payments.
[71] U.S. Government Accountability Office, "Fraud & Improper Payments."
[72] U.S. Congress Joint Economic Committee, *The 2024 Joint Economic Report*, S. Rep. 118-183 (2024), p. 18, https://www.govinfo.gov/app/details/CRPT-118srpt183/CRPT-118srpt183.
[73] Pub. L. 119-21, § 71119.

eligibility for most non-citizens and also requires states to perform eligibility checks every six months instead of every year.[74]

Similar eligibility checks were implemented in the ACA Marketplace and nutritional assistance programs. In the ACA Marketplace, eligibility must now be verified before premium tax credits are paid in any given month.[75] Information such as income and residence must now be verified ahead of coverage, which, in turn, supports another provision of P.L. 119-21 that restricts premium tax credits to only specific lawfully present immigrants.[76] Now, premium tax credits are restricted to lawfully admitted permanent residents, certain Cuban and Haitian refugees, and individuals lawfully residing through the Compact of Free Association agreement.[77] Similar eligibility requirements for SNAP were also enacted. P.L. 119-21 tightened work exemptions for SNAP eligibility, narrowed the caregiver exemption, expanded age range requirements, and removed other exemptions.[78]

Prior JEC research has highlighted the benefits of modest work requirements in programs like SNAP.[79] Stable employment lessens dependence on government programs like SNAP and Medicaid, and it supports the intended goal of these programs, which is temporary assistance that leads to permanently improved outcomes.[80]

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[74] Pub. L. 119-21, §§ 71107, 71109.
[75] Pub. L. 119-21, § 71303.
[76] Pub. L. 119-21, § 71301.
[77] Pub. L. 119-21, § 71301.
[78] Pub. L. 119-21, § 10102.
[79] U.S. Congress Joint Economic Committee, *Reconnecting Americans to the Benefits of Work*, SCP Report no. 5-21 (2021), https://www.jec.senate.gov/public/index.cfm/republicans/analysis?id=50C6EBFB-B2C7-4AB2-BF64-DCDBC0C1E869.
[80] U.S. Congress Joint Economic Committee, *Inactive, Disconnected, and Ailing: A Portrait of Prime-age Men Out of the Labor Force*, SCP Report no. 3-18 (2018), https://www.jec.senate.gov/public/index.cfm/republicans/analysis?id=D72FFEAB-DE2D-4F2C-9BCD-670B9B1BE9C3.

Provider taxes

P.L. 119-21 established additional measures aimed at reducing Federal spending on healthcare in areas where dollars are not being spent on additional care. One such measure was the modification of provider taxes, which are a mechanism by which states can draw down additional Federal dollars to fund their state Medicaid program. States are able to levy taxes on certain classes of healthcare providers such as hospitals, nursing homes, or managed care organizations to help state Medicaid financing.[81] This revenue is matched by the Federal government and then states, through a number of mechanisms, can transfer back the tax revenue to providers. In effect, states use an accounting trick to shift more of the Medicaid cost burden to the Federal government.[82] Before P.L. 119-21, states were able to levy provider taxes at a maximum of 6 percent of net patient revenue for a given provider class. The law gradually lowers this threshold to 3.5 percent.[83]

Medicaid is a state-run program that was intended for the indigent population and designed to be administered at the state level,[84] and states are better positioned to understand the healthcare needs of their population than the Federal government. Using an

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[81] Hannah Kim, "How Medicaid Provider Taxes Work: An Explainer," National Association of Medicaid Directors, September 25, 2025, https://medicaiddirectors.org/resource/how-medicaid-provider-taxes-work-an-explainer/.
[82] David Ditch, "Reconciliation Option: Tackling 'Provider Tax' Gimmick in Medicaid," Economic Policy Innovation Center, February 19, 2025, https://epicforamerica.org/social-programs/reconciliation-option-tackling-provider-tax-gimmick-in-medicaid/.
[83] Chani Seals, Eric Levine, and Drew Wood-Palmer, "OBBBA Provider Tax Provisions Impact on Medicaid Stakeholders," Avalere Health, July 22, 2025, https://advisory.avalerehealth.com/insights/obbba-provider-tax-provisions-impact-on-medicaid-stakeholders.
[84] *Social Security Amendments of 1965*, Pub. L. No. 89-97, Title XIX, 79 Stat. 343–353, https://www.govinfo.gov/content/pkg/STATUTE-79/pdf/STATUTE-79-Pg286.pdf.

accounting loophole to shift spending to the Federal government does not necessarily improve care or outcomes, especially when the Federal government has less oversight than states do to ensure program integrity and fraud prevention.[85]

Misaligned incentives continue to drive healthcare costs

Since 2000, the inflation of medical care services has outpaced overall inflation by approximately 56 percentage points.[86] These rising costs are reflected in the premiums individuals pay for health insurance as well as through cost-sharing measures such as co-pays and deductibles.[87] These rising healthcare costs create financial strain for both individuals as well as the U.S. government. Medicare and other healthcare programs made up almost 30 percent of total Federal spending in FY2025 and are projected to demand an increasing share of Federal spending over the next ten years.[88]

Previous legislative efforts, such as the *Affordable Care Act* of 2010 (ACA), have failed to reduce costs for either individuals or the Federal government, as evidenced by the increase in average healthcare spending for individuals' post-ACA and real Federal healthcare spending.

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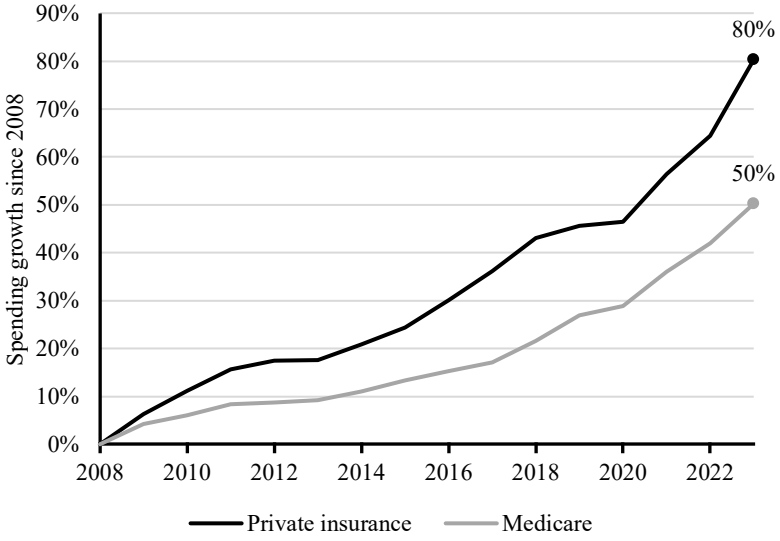
[85] Elizabeth Hinton, Jessica Mathers, and Robin Rudowitz, "5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse, and Improper Payments," KFF, March 18, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-program-integrity-fraud-waste-abuse-and-improper-payments/.
[86] Bureau of Labor Statistics, "Consumer Price Index," https://www.bls.gov/cpi/data.htm; JEC calculations.
[87] Jared Ortaliza et al., "How much and why ACA Marketplace premiums are going up in 2026," Peterson-KFF Health System Tracker, August 6, 2025, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/.
[88] Congressional Budget Office, *The Budget and Economic Outlook: 2026 to 2036* (February 2026), https://www.cbo.gov/publication/61882.

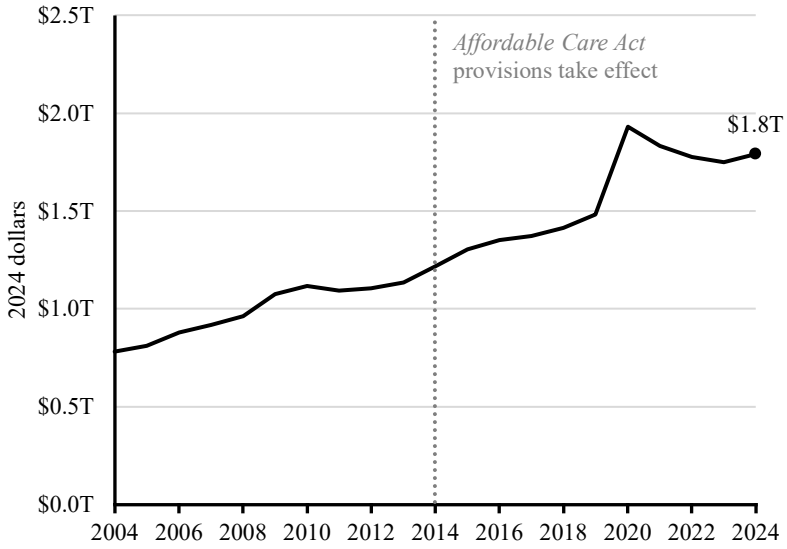
Figure 2-1: Cumulative Growth in Per-Enrollee Spending



Source: KFF[89]

[89] Cynthia Cox et al., "Health Care Costs and Affordability," KFF, October 8, 2025, https://www.kff.org/health-costs/health-policy-101-health-care-costs-and-affordability.

Figure 2-2: Federal Healthcare Expenditures



Source: Centers for Medicare and Medicaid Services[90]

The recent debate surrounding healthcare affordability has focused on the financing of payments rather than meaningful ways to improve aggregate health and subsequently reduce costs. Instead of debating the ratio at which individuals or payers bear healthcare costs, systems should be designed so that payers are incentivized and rewarded for improving long-run health outcomes. Unfortunately, existing structures within our healthcare system fail to reward improved care and, in turn, disincentivize insurers from lowering premiums or other healthcare costs.

Affordable Care Act Marketplace premium tax credits

The ACA created or exacerbated many of these disincentives. For example, the Federal government provides a number of subsidies,

[90] Centers for Medicare and Medicaid Services, "National Health Expenditure Data" (2024), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data.

including premium tax credits, which are given to individuals with the intention of lowering premiums and overall healthcare costs. These subsidies are typically available for individuals with incomes between 100 and 400 percent of the Federal poverty level; however, eligibility and the value of the benefits were dramatically expanded following the enactment of the *American Rescue Plan Act* (ARPA) in 2021.[91]

ARPA expanded the premium tax credits to increase the monetary value of benefits and expanded eligibility to those with higher incomes.[92] These enhanced premium tax credits, which expired at the end of 2025, were a temporary measure during the COVID-19 pandemic intended to serve as a backstop during a time of healthcare uncertainty. JEC research has found that these had a distortionary effect on the ACA Marketplace and failed to efficiently achieve their goal of lowering premiums. Because premium tax credits are calculated based off the second-lowest-cost premium plan in an area, plans have responded to the credits by loading costs into Silver plans. In 2018, the average premium for the lowest-cost Gold plan was $52.08 higher than the second-lowest-cost Silver plan, but as of 2025 it was only $1.94 higher.[93]

The enhanced premium tax credits were also ineffective at providing premium relief. The JEC found that, for every one dollar spent on the enhanced premium tax credits that ultimately benefitted consumers, two dollars either went to insurers or

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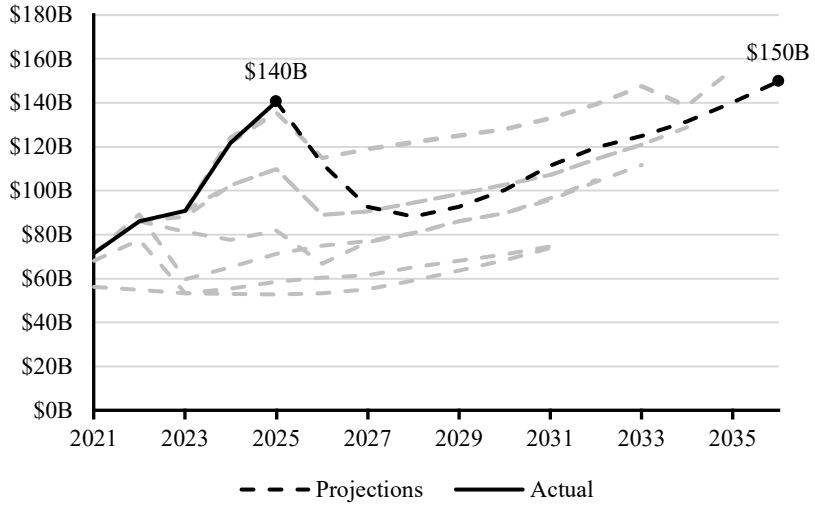
[91] Paul D. Jacobs, "Take-Up of Marketplace Coverage Increased After Enhanced Premium Subsidies," *Journal of Health Care for the Poor and Underserved* 37, no. 1 (2026): 206–18, https://dx.doi.org/10.1353/hpu.2026.a982965.
[92] Committee for a Responsible Federal Budget, "Understanding the ACA Subsidy Discussion," November 5, 2025, https://www.crfb.org/blogs/understanding-aca-subsidy-discussion.
[93] Centers for Medicare and Medicaid Services, Data for 2025 QHP Choice and Premiums in HealthCare.gov States – Appendix Tables, accessed October 2025, https://www.cms.gov/files/document/2025-qhp-premiums-choice-appendix.xlsx.

intermediaries or were wasted due to market inefficiency.[94] Because the subsidies have increased the number of individuals paying $0 premiums in the ACA Marketplace, this has lowered the amount of competition to lower prices in other plans and thus led insurers to increase gross premiums on net.[95] Even without accounting for the fiscal cost to the Federal government, insurers and consumers benefit about equally, with an additional amount lost due to market inefficiency.[96] As a result, premium tax credits ultimately generate negative economic value, and when considering the financing costs of the subsidies, this effect grows even larger.[97]

The money spent on premium tax credits that is going to insurers or being lost to market inefficiencies is money being spent that is not necessarily providing patient care. On top of the opportunity cost, spending on enhanced premium tax credits dramatically exceeded expectations, as shown in Figure 2-3.

[94] U.S. Congress Joint Economic Committee, "Long Overdue: Enhanced Premium Tax Credits Should Expire" (November 2025), https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/issue-briefs/Enhanced%20Premium%20Tax%20Credits%20Should%20Expire.pdf.
[95] U.S. Congress Joint Economic Committee, "Long Overdue."
[96] Maria Polyakova and Stephen P. Ryan, "Subsidy Targeting with Market Power," NBER Working Paper no. 26367 (October 2019), pp. 3, 29–31, https://doi.org/10.3386/w26367; JEC calculations.
[97] Polyakova and Ryan, "Subsidy Targeting with Market Power," pp. 3, 29–31; JEC calculations.

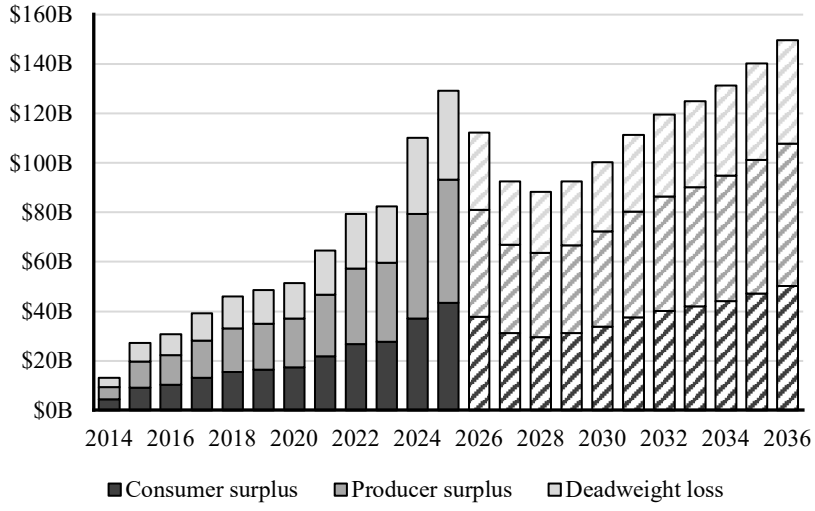
Figure 2-3: Projected Spending on ACA Premium Tax Credits Compared to Actual Spending



Source: Congressional Budget Office[98]

[98] Congressional Budget Office, *The Budget and Economic Outlook: 2021 to 2031* (February 2021), https://www.cbo.gov/publication/56970; Congressional Budget Office, *Additional Information About the Budget Outlook: 2021 to 2031* (March 2021), https://www.cbo.gov/publication/56996; Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2021 to 2031* (July 2021), https://www.cbo.gov/publication/57218; Congressional Budget Office, *The Budget and Economic Outlook: 2022 to 2032* (May 2022), https://www.cbo.gov/publication/57950; Congressional Budget Office, *The Budget and Economic Outlook: 2023 to 2033* (February 2023), https://www.cbo.gov/publication/58848; Congressional Budget Office, *An Update to the Budget Outlook: 2023 to 2033* (May 2023), https://www.cbo.gov/publication/59096; Congressional Budget Office, *The Budget and Economic Outlook: 2024 to 2034* (February 2024), https://www.cbo.gov/publication/59710; Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2024 to 2034* (June 2024), https://www.cbo.gov/publication/60039; Congressional Budget Office, *The Budget and Economic Outlook: 2025 to 2035* (January 2025), https://www.cbo.gov/publication/60870; Congressional Budget Office, *The Budget and Economic Outlook: 2026 to 2036* (February 2026), https://www.cbo.gov/publication/61882.

Figure 2-4: Incidence of Enhanced Premium Tax Credit Subsidy



Source: Congressional Budget Office;[99] JEC calculations

Crafting effective healthcare policy requires carefully weighing fiscal cost with anticipated outcomes. Premium tax credits fail to effectively improve health or lower individual healthcare costs and come at a significant fiscal cost to the Federal government.

Medical loss ratio

Other aspects of the ACA also distort the healthcare marketplace. The medical loss ratio (MLR) is a requirement for health insurers to spend a portion of their premium revenues on patient services.[100] Smaller plans must spend 80 percent of their premium revenues on patient services or quality improvements, and larger groups must meet a ratio of 85 percent. The MLR, in effect, caps insurers' profit margins. Therefore, given a static number of

[99] *Ibid.*
[100] Centers for Medicare and Medicaid Services, "Medical Loss Ratio," last modified March 13, 2026, https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio.

beneficiaries, the MLR leaves increasing premiums as the only way for insurers to increase revenue. Research suggests that the MLR discourages plans from lowering or containing premiums.[101] In fact, because many plans are already compliant with the MLR, there is pressure to move spending away from patient care to get closer to the MLR cap and maximize profit.[102]

Insurance brokers

As Federal healthcare spending continues to rise, it becomes increasingly important for policymakers to assess spending that does not directly improve patient care or contribute to reducing healthcare costs. It is estimated that between 15 and 30 percent of all healthcare spending in the U.S. is administrative in nature and that at least half of this spending is ineffective at providing care or is explicitly wasteful.[103] Even beyond administrative costs, which are typically associated with billing and authorization, a significant amount is spent procuring patients in the form of advertising or insurance brokers.

Insurance brokers play a large and growing role in determining the plans in which individuals enroll, with aggregate broker fees totaling over $11 billion in 2024 alone.[104] Insurance brokers play an especially large role in the ACA Marketplace, where fees

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[101] Randolph W. Pate et al., "The Unintended Consequences Of The ACA's Medical Loss Ratio Requirement," *Health Affairs Forefront* (2025), https://doi.org/10.1377/forefront.20251014.467242.
[102] Sandra Renfro Callaghan, Elizabeth Plummer, and William F. Wempe, "Health Insurers' Claims and Premiums Under the Affordable Care Act: Evidence on the Effects of Bright Line Regulations," *Journal of Risk and Insurance* 87, no. 1 (2020), https://doi.org/10.1111/jori.12272.
[103] Health Affairs, "The Role Of Administrative Waste In Excess US Health Spending," October 6, 2022, https://www.healthaffairs.org/content/briefs/role-administrative-waste-excess-us-health-spending.
[104] Centers for Medicare and Medicaid Services, "Medical Loss Ratio Data and System Resources" (2024), last modified March 13, 2026, https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources; JEC calculations.

totaled over $4.5 billion in 2024. Given the substantial amount spent on brokers every year, it is important to evaluate whether brokers provide commensurate value to consumers, especially as broker fees are healthcare dollars not directly going toward patient care.

Insurance brokers can add value by improving plan choices and helping to match consumers with various plans, which helps to lower transaction costs for consumers. This can be especially beneficial for enrollees who face language barriers, have lower levels of formal education, or have other difficulties navigating complex insurance choices. The purpose of insurance brokers is therefore to help individuals who are typically unfamiliar with the intricacies of health insurance navigate various insurance marketplaces and match them with plans.

However, brokers also face incentives against making the best recommendations for the beneficiary. They have a distortionary impact on insurance marketplaces by artificially influencing plan choices and each risk pool. In order for a health insurance marketplace to function properly, a sufficient number of healthier, often younger, people are needed to offset the costs of sicker people. Brokers are typically paid by insurance carriers and may be incentivized to push in healthier people or push out sicker individuals from certain plans. In a 2025 Department of Justice investigation, prosecutors alleged that insurance brokers were paid hundreds of millions of dollars over the course of several years to illegally place certain individuals into Medicare Advantage plans.[105] In this case, two insurers conspired with brokers to

[105] U.S. Department of Justice, Office of Public Affairs, "The United States Files False Claims Act Complaint Against Three National Health Insurance Companies and Three Brokers Alleging Unlawful Kickbacks and Discrimination Against Disabled Americans," May 1, 2025, https://www.justice.gov/opa/pr/united-states-files-false-claims-act-complaint-against-three-national-health-insurance.

discriminate against disabled Medicare beneficiaries who would have been less profitable and directed them into other plans.

The Centers for Medicare and Medicaid Services (CMS) has reported widespread concerns about improper broker activity in the ACA Marketplace. Between January and August 2024, CMS received more than 90,000 complaints regarding unauthorized plan switches and over 180,000 complaints related to unauthorized enrollments.[106] In response, CMS implemented new safeguards to limit unauthorized enrollment changes and suspended hundreds of brokers suspected of fraudulent or abusive conduct.[107] While this may not reflect the conduct of most brokers, the large and increasing sums spent on broker fees, coupled with limited evidence of sufficient value added, make this an important area for policymakers to address. Congress must ensure that brokers provide value to both beneficiaries and taxpayers, and do not distort insurance marketplaces in ways that raise costs for other enrollees.

Brokers represent a major administrative cost for plans and highlight a structural problem in healthcare: excessive plan switching, or "churn." It is estimated that around 15 to 20 percent of privately or publicly insured individuals either change or drop insurance plans in a given year.[108] This rate varies by type of insurance and is common in Medicare Advantage, where it is

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[106] Centers for Medicare and Medicaid Services, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," October 17, 2024, https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-broker-marketplace-activity.

[107] Centers for Medicare and Medicaid Services, "CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity," January 28, 2026, https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.

[108] Ezekiel J. Emanuel and John A. Graves, "How churn threatens Americans' health," *Stat News*, September 3, 2025, https://www.statnews.com/2025/09/03/health-insurance-churn-deadly-americans/.

estimated that nearly half of enrollees will switch plans within five years of enrollment.[109] While some plan switching will always be necessary, excessive churn creates a number of problems for insurers and, in turn, beneficiaries. Insurance companies constantly compete for beneficiaries, which drives up advertising costs, broker fees, and re-enrollment costs. This is money being spent on administrative costs that could instead be going to patient care.

Additionally, high churn disincentivizes insurers from making investments in patient health. It is often in an insurer's interest to make large upfront investments in a patient's health to prevent larger health problems in the long term and increase the likelihood of savings after years of enrollment. However, if enrollees frequently switch plans, insurers are less likely to adopt this long-term outlook for a given enrollee's health. There is precedent for preventative care that has long-term cost savings, such as in the case of hepatitis C treatment.[110] Even lower-cost preventative treatments such as cancer screenings may no longer be a profitable investment for plans if they anticipate that individual is likely to switch plans soon.[111] If the time horizon for an insurer to profit off a beneficiary is shorter, they have less financial incentive to invest in preventative care or address the root causes of poor health. The following chapter will explore in more detail ways to address these disincentives, including proposals for longer plan years and streamlined enrollment, both of which lessen the need to spend on administrative outlays which do not go directly towards patient care.

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[109] Emanuel and Graves, "How churn threatens Americans' health."
[110] Congressional Budget Office, *Budgetary Effects of Policies That Would Increase Hepatitis C Treatment* (June 2024), https://www.cbo.gov/publication/60237.
[111] Emanuel and Graves, "How churn threatens Americans' health."

While these problems are significant, technology may soon make much of the traditional broker model obsolete. Even six years ago, research found that artificial-intelligence-based decision tools improved plan choice and reduced consumer losses where skilled agents often failed.[112] Given the pace of improvement in the six years since that research, consumers now have access to tools that can likely outperform brokers on the core task of matching people to plans, at lower cost and without incentive problems. As that progress continues, the case for paying large broker fees will continue to grow weaker and may eventually fade into the rearview mirror altogether.

An update on obesity and nutrition

As outlined in the *2025 Joint Economic Report* (*Response*), two of the largest drivers of healthcare spending are chronic diseases and obesity. The JEC calculated that obesity alone is projected to cost between $8.2 and $9.1 trillion over the next ten years due to excess medial expenditures.[113] Obesity and other chronic diseases affect far more than just direct healthcare spending; other JEC research has explored their adverse impact on life expectancy, labor force participation, and labor supply.[114] As more individuals become afflicted by chronic disease, more strain is placed on insurance risk pools, which in turn drives up healthcare costs for everyone. Addressing chronic disease and obesity not only improves outcomes for individuals directly suffering from these diseases but also drives down aggregate costs, which leads to lower premiums.

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[112] Jonathan Gruber et al., "Managing Intelligence: Skilled Experts and AI in Markets for Complex Products," NBER Working Paper no. 27038 (April 2020), https://doi.org/10.3386/w27038.

[113] U.S. Congress Joint Economic Committee, *The 2025 Joint Economic Report*, H. Rep. 119-9 (2025), p. 94, https://www.govinfo.gov/app/details/CRPT-119hrpt9/CRPT-119hrpt9-pt1.

[114] U.S. Congress Joint Economic Committee, "Chapter 4: Reaching Fiscal Solutions Through Healthcare Innovation" in *The 2024 Joint Economic Report*, S. Rep. 118-183 (2024): 359–81, https://www.govinfo.gov/app/details/CRPT-118srpt183/CRPT-118srpt183.

Fortunately, significant developments in the past year have been aimed at addressing obesity and chronic diseases. Glucagon-like peptide-1 (GLP-1) is a natural hormone that is key in regulating blood sugar and appetite, and receptor agonist drugs that mimic this hormone can be used for weight loss. Since the *2025 Response*, notable progress has been made to lower the costs of and improve accessibility to these and other prescription drugs. As was projected in the *Response*, the average price of GLP-1 drugs has fallen dramatically and there have been a number of major technological improvements.[115]

TrumpRx

One of the biggest factors in the reduction of the price of GLP-1 drugs was the launch of the direct-to-consumer prescription drug platform TrumpRx in November 2025.[116] TrumpRx offers discounted prescription drugs by allowing consumers to purchase prescriptions with cash directly through the manufacturer or other approved distribution channels. This had a notable impact on the price of various GLP-1 drugs as the White House specifically negotiated the price of these drugs.

The prices of GLP-1 drugs, for example Ozempic, Wegovy, Zepbound, and Orfoglipron, were reduced from between $1,000 and $1,350 to around $350 per month for individuals purchasing with cash.[117] Additionally the recently approved Wegovy oral GLP-1 drug will also be available for purchase for $150 per

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[115] U.S. Congress Joint Economic Committee, *The 2025 Joint Economic Report*, p. 105.
[116] The White House, "Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients," November 6, 2025, https://www.whitehouse.gov/fact-sheets/2025/11/fact-sheet-president-donald-j-trump-announces-major-developments-in-bringing-most-favored-nation-pricing-to-american-patients/.
[117] The White House, "Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients."

month. The White House also negotiated GLP-1 drug prices for Medicare and Medicaid. The Medicare price for the major GLP-1 drugs will be $245 per month with a Medicare co-pay of $50 per month, and state Medicaid programs will also be able to offer them at this price. As of January 2026, only 13 states offer GLP-1 drugs within their Medicaid program, but this negotiation is likely to have a considerable impact on the number of states offering them.[118] As outlined in the *2025 Response*, Medicaid coverage of GLP-1 drugs presents potential for large savings as state Medicaid programs can target these prescriptions to individuals who are severely obese and may be displaced from the workforce due to their condition. This can lead to significant lifetime savings as individuals become healthier and more connected to the workforce and therefore may no longer remain reliant on other Medicaid services.[119]

GLP-1 drug advancements

In addition to the reduced costs of GLP-1 drugs, there have been significant advancements in anti-obesity technology that will likely have a positive impact on uptake and price. Approved by the FDA in April 2026, oral GLP-1 drugs are a daily pill alternative to the weekly self-administered GLP-1 drugs that currently make up the majority of GLP-1 prescriptions.[120] These may offset needle-related discomfort that may also be influencing

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[118] Elizabeth Williams, "Medicaid Coverage of and Spending on GLP-1s," KFF, January 16, 2025, https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/.

[119] U.S. Congress Joint Economic Committee, *The 2025 Joint Economic Report*, p. 109.

[120] https://investor.lilly.com/news-releases/news-release-details/fda-approves-lillys-foundayotm-orforglipron-only-glp-1-pill; "GLP-1 Agonists," Cleveland Clinic, last updated July 3, 2023, https://my.clevelandclinic.org/health/treatments/13901-glp-1-agonists.

the uptake and adherence of GLP-1 therapies.[121] Survey data estimating the prevalence of trypanophobia (fear of needles) suggest that approximately 20 to 30 percent of adults experience this fear, and roughly 16 percent report avoiding certain vaccinations as a result.[122] Comparable concerns may affect the use of self-administered GLP-1 injections. The availability of an oral GLP-1 formulation could therefore improve uptake and adherence and accelerate the positive health and fiscal outcomes the JEC has projected in prior *Responses*.

Innovation in GLP-1 drugs has continued to accelerate over the past year, with pharmaceutical companies developing new formulations designed to extend dosing intervals. In particular, companies have experimented with longer-acting GLP-1 injectables intended to be used once a month instead of once a week.[123] Small-molecule GLP-1 drugs, which have the advantage of being easier to produce at scale and not requiring injection, have also been going through clinical trials.[124] These developments highlight a broader industry push to make anti-obesity medication more effective and affordable, which is a response to the overwhelming demand for these drugs over the past decade.

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[121] Kimberly Alsbrooks and Klaus Hoerauf, "Prevalence, causes, impacts, and management of needle phobia: An international survey of a general adult population," *PLoS One* 17, no. 11 (2022), https://doi.org/10.1371/journal.pone.0276814.
[122] Jennifer McLenon and Mary A. M. Rogers, "The fear of needles: A systematic review and meta-analysis," *Journal of Advanced Nursing* 75, no. 1 (2019), 30-42, https://doi.org/10.1111/jan.13818.
[123] Pfizer, "Pfizer's Ultra-Long-Acting Injectable GLP-1 RA Shows Robust and Continued Weight Loss with Monthly Dosing in Phase 2b Trial," February 3, 2026, https://www.pfizer.com/news/press-release/press-release-detail/pfizers-ultra-long-acting-injectable-glp-1-ra-shows-robust.
[124] Oana Cristina Seremet et al., "Small Molecule GLP-1 Receptor Agonists: A Promising Pharmacological Approach," *Medicina* 61, no. 11 (2025), p. 1902, https://doi.org/10.3390/medicina61111902.

Nutrition policy

Efforts to improve public health outcomes can be further strengthened by making reforms to nutrition programs to ensure that they are effectively improving health. Improving nutrition and promoting healthy behaviors have been a priority for the Trump Administration, which has been supportive of proposals to reform nutritional programs. Since May 2025, the Secretary of Agriculture has approved waivers allowing 22 states to remove unhealthy foods from their state SNAP programs.[125] Specific restrictions vary by state, but the waivers allow states to restrict a number of food and beverage purchases, including soda, fruit and vegetable drinks comprised of less than half natural juice, energy drinks, and candy.[126]

Restricting SNAP purchases to only nutritious foods has a two-fold impact. As outlined in the *2024 Response*, before obesity rates began to rise rapidly in the 1980s, poor nutrition was mostly driven by a lack of calories rather than a surplus.[127] Today, poor nutrition

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[125] U.S. Department of Agriculture, Food and Nutrition Service, "Secretary Rollins Signs Six New State Waivers to Make America Healthy Again by Removing Unhealthy Foods from SNAP in Hawai'i, Missouri, North Dakota, South Carolina, Virginia, and Tennessee," December 10, 2025, https://www.fns.usda.gov/newsroom/usda-0241.25; Catherine Douglas Moran, "USDA approves SNAP waivers for 4 more states," Grocery Dive, March 5, 2026, https://www.grocerydive.com/news/usda-approves-4-more-state-snap-waivers/813886/.

[126] U.S. Department of Agriculture, *Waiver Summary: Iowa SNAP Healthy Choice Waiver Demonstration Project* (2025), https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-foodrestriction-waiverApproval-Iowa.pdf; Health Eating Research, "The Current State of Knowledge on SNAP Restrictions and Disincentives" (September 2025), https://healthyeatingresearch.org/wp-content/uploads/2025/09/HER-SNAP-Waivers-Brief.pdf.

[127] Institute of Medicine, *Front-of-Package Nutrition Rating Systems and Symbols: Phase I Report*, ed. Ellen A. Wartella, Alice H. Lichtenstein, and Caitlin S. Boon (National Academies Press, 2010), https://doi.org/10.17226/12957; Chris Edwards, *SNAP: High Costs, Low Nutrition*, Cato Institute Briefing Paper no. 163 (September 1, 2023), https://www.cato.org/briefing-paper/snap-high-costs-low-nutrition.

is more often caused by a surplus, leading to obesity.[128] Restricting SNAP funds to specific food items ensures that nutrition funding is not actively being spent on foods that are known to worsen health outcomes. Restricting SNAP purchases also can help to prevent fraud as a disproportionate amount of fraud occurs at stores more likely to sell mostly unhealthy food. In 2021, the U.S. Department of Agriculture (USDA) estimated that, from 2015 to 2017, there was around $1.0 billion in fraudulent SNAP transfers in each year.[129] Given that SNAP spending has risen dramatically since then, it is likely that the current figure is higher.[130] The USDA found that small and medium-sized grocery stores and convenience stores "accounted for about 15 percent of all redemptions but were estimated to account for just over 95 percent of all trafficking redemptions (99 percent under the current definition)."[131] Smaller stores and convenience are more likely to carry unhealthy food and beverages and shopping at those stores is linked to poorer health outcomes.[132] Restricting SNAP purchases may lower demand for these types of stores which may, in turn, lower fraud and improve outcomes. Some studies have linked SNAP participation to worse health outcomes, although a causal link has not been established.[133] That said, insofar as the

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[128] Dietary Guidelines Advisory Committee, *Scientific Report of the 2020 Dietary Guidelines Advisory Committee* (2020), https://www.dietaryguidelines.gov/2020-advisory-committee-report.
[129] Hoke Wilson, *The Extent of Trafficking in the Supplemental Nutrition Assistance Program: 2015-2017*, U.S. Department of Agriculture (2021), https://fns-prod.azureedge.us/sites/default/files/resource-files/Trafficking2015-2017-3.pdf.
[130] Matthew Dickerson, "Food Stamp Spending is Skyrocketing," Economic Policy Innovation Center, May 17, 2024, https://epicforamerica.org/social-programs/food-stamp-spending-is-skyrocketing/.
[131] Wilson, *The Extent of Trafficking in the Supplemental Nutrition Assistance Program*, p. iv.
[132] Timothy Barnes et al., "Healthfulness of Foods Advertised in Small and Nontraditional Urban Stores in Minneapolis–St. Paul, Minnesota, 2014," *Preventing Chronic Disease* 13 (2016), http://dx.doi.org/10.5888/pcd13.160149.
[133] Danielle Duran and Nasim Ferdows, "A Longitudinal Study on SNAP Participation and Self-reported Health among Diabetic and Non-diabetic Individuals," *Innovation in Aging* 7 (2023): 977–78, https://doi.org/10.1093/geroni/igad104.3141.

Federal government continues to fund a nutrition program, it should ensure that the funds are being used legitimately and on nutritious foods.