NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

State Options for Reducing Health Insurance Costs

NAIC Health Care Affordability and Mitigation (B) Working Group

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Introduction

The briefs included in *State Options for Reducing Health Insurance Costs* are intended to be short, informative briefings for regulators and policymakers on efforts states have undertaken in recent years to help make health insurance more affordable. They are intended to be high-level and are not an exhaustive resource on each issue. They also do not represent policy positions of the NAIC, a given state, author, or Working Group member.

These briefs intend to provide state policymakers with information on approaches designed to improve the affordability of health insurance and the health care services consumers pay for using insurance. The authors adopt a broad definition of affordability that seeks to consider total system costs. We recognize that improving affordability for one set of market participants, such as health care consumers, could shift costs to other participants. Our goal is to evaluate policy changes by how they affect total cost and we have tried to indicate where policies may instead shift costs to plan enrollees. Our primary perspective for viewing affordability is that of consumers; we seek to assess potential policy changes that may reduce or limit increases in consumer premiums as well as deductibles and other cost-sharing. However, we recognize that reducing or leveling consumer costs can have additional market effects. Affordability efforts can affect administrative burden, market competition, and access to health care services if they change incentives for insurers, providers, and other market participants. Secondary to our focus on consumer costs, we aim to identify how the policy ideas under discussion may improve or worsen competitive challenges or build barriers elsewhere in the health care system.

Section 1: Standardizing or Limiting Utilization Review to Reduce Administrative Costs

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Connection to Affordability

Prior authorization that is not grounded in evidence-based clinical standards or that introduces avoidable administrative delays can contribute to challenges for consumers. At the same time, when used appropriately, prior authorization can benefit consumers by supporting safe, clinically appropriate care and by reducing the use of medically unnecessary or duplicative services that can raise premiums and cost-sharing for patients Restricting or delaying access to medically necessary care can cause an exacerbation of health conditions or cause consumers to forgo treatment, leading to more costly intervention later. Also, when costs increase for providers because of unnecessary administrative burdens due to prior authorization, those costs are passed on to consumers.

Introduction

Utilization review, particularly the use of prior authorization, has become a major focus of health care affordability efforts across the United States. Prior authorization is a mechanism used to check that a service, treatment, or medication is covered by the health plan and is appropriate, medically necessary, safe, and cost effective. It is intended to ensure safety (e.g., prevent negative drug interactions), reduce utilization of medically unnecessary or ineffective treatments or services, and contain health care costs. Prior authorization is used for a broad range of services, treatments, and medications. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, prior authorization can achieve a balance between costs and benefits for both insurance carriers and their members. It can also provide needed assurance for consumers and providers prior to the provision of services. While prior authorization can benefit insurance carriers, providers, and consumers, the process has been criticized for burdening providers and delaying care for consumers.

This Health Care Affordability and Mitigation Working Group brief examines how states are responding to these concerns by adopting policies that simplify prior authorization processes while maintaining appropriate oversight of health care services. The brief identifies three primary policy approaches: adopting electronic prior authorization and interoperability systems, limiting the use of prior authorization for certain services, and standardizing prior authorization forms and information requirements. This brief is intended to build upon the information provided in the *Prior Authorization White Paper* adopted by the Health Insurance and Managed Care (B) Committee (Dec. 11, 2025).[1]

The first policy trend involves implementing electronic prior authorization (ePA) systems and improving interoperability between providers and insurance carriers. Recent federal regulations require certain insurance carriers to adopt application programming interfaces (APIs) and corresponding interoperability standards for prior authorization, enabling insurer and electronic health record systems to integrate with provider workflows and streamline data sharing. Several states, including Colorado, Kansas, Massachusetts, Michigan, Minnesota, Missouri, and Washington, have adopted requirements that insurance carriers establish ePA systems consistent with federal interoperability standards.

Beginning in 2027, federal rules require certain insurance carriers to implement the prior authorization application programming interfaces (APIs) to enable providers to determine whether prior authorization is required, electronically submit requests, exchange clinical information, and receive decisions more quickly. The Center for Medicare & Medicaid Services (CMS) has included ePA measures for providers in both the clinician Merit Based Incentive Payment System (MIPS) and hospital Promoting Interoperability Programs. The CY2027 Physician Fee Schedule Final Rule and the FY2027 Inpatient Prospective Payment System Final Rule show a slight trend towards CMS strengthening ePA measures with providers over time (i.e., optional to mandatory). States have stepped in and are actively including providers within ePA regulations. By automating these processes, ePA reduces administrative workload, minimizes delays in patient care, and improves communication throughout the health care system, if all parties use the capabilities.

The potential benefits of these reforms may extend beyond administrative efficiency. According to the 2025 CAQH Index, the U.S. health care industry could realize approximately $461 million in annual savings if prior authorization became fully electronic.[2] Although premium reductions are expected to be modest, policymakers anticipate significant indirect benefits through lower administrative expenses, faster access to medically necessary treatment, improved provider workflow, and a better patient experience. Electronic systems also improve consistency and transparency by providing standardized requirements and faster communication between insurance carriers and providers.

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[1] National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025. https://content.naic.org/sites/default/files/inline-files/PA%20white%20paper%20Adopted%2012.10.2025%20by%20Cmte.pdf

[2] Council for Affordable Quality Healthcare, 2025 CAQH Index® Report. https://s3.amazonaws.com/amo_hub_content/Association361/files/CAQH_2026%20eSolutions%20Xchange%20Slides.pdf

The second policy trend limits or prohibits prior authorization requirements for selected medical services, medications, and treatments. Some states have exempted emergency services, preventive care, behavioral health treatment, medication-assisted treatment for substance use disorders, cancer-related services, maternity care, rehabilitation therapies, and other services from prior authorization requirements. However, it is important to note prior authorization can support patient safety by helping ensure that care decisions are based on clinical evidence and tailored to individual needs. Examples may include overuse of opioids, antipsychotic medications in children, and high-risk medications for elderly patients. Additionally, prior authorization can help ensure that patients get care that is aligned with the latest evidence. For example, one study suggests that nearly 4 in 10 patients do not receive care that meets the latest medical evidence, which can negatively impact outcomes and may endanger patient safety.[3] Several states also require insurance carriers to annually review their prior authorization requirements and eliminate those that are routinely approved or no longer improve quality or reduce costs. These reforms are intended to reduce unnecessary delays in treatment while improving patients' access to medically necessary care.

The third policy trend focuses on reducing administrative complexity by standardizing prior authorization forms and required information. Historically, providers have had to complete different forms for each insurance carrier, creating inefficiencies and increasing administrative costs. To address this issue, many states now require insurance carriers to use uniform prior authorization forms that are typically limited to two pages and include standardized information fields. States such as Arizona, Colorado, Massachusetts, Nebraska, New Hampshire, Oregon, Texas, and Washington have adopted standardized forms that providers can submit electronically or on paper. Greater standardization of the clinical data requested for prior authorization can improve consistency and clarity in the criteria and data elements while reducing variability.

Overall, the policy trends outlined in the brief reflect states' efforts to modernize utilization review while preserving its role in promoting appropriate health care utilization. Rather than eliminating prior authorization entirely, states are focusing on expanding ePA systems, narrowing its use to certain services, and adopting standardized forms. A balanced approach to prior authorization reform can seek to reduce administrative burden and improve timelines while maintaining appropriate clinical safeguards that protect patients, promote high-quality care, and support responsible stewardship of health care resources.

Policy Approaches

This brief identifies three primary policy approaches states have adopted:

1) Implementing electronic prior authorization (ePA) and interoperability requirements. It explores the trend of adopting policies requiring or encouraging insurance carriers to use ePA systems and application programming interfaces (APIs) that integrate with electronic health records and conform to federal interoperability standards to automate

[3] Duff, J., Cullen, L., Hanrahan, K. et al. Determinants of an evidence-based practice environment: an interpretive description. Implement Sci Commun 1, 85 (2020). https://link.springer.com/article/10.1186/s43058-020-00070-0

and expedite the authorization process.

Pros

- By implementing such requirements, there will be greater clarity about submission of information and speed in processing information requests, helping to avoid treatment delays.
- By minimizing delays and ensuring appropriate utilization through evidence-based reviews, ePA can prevent disease progression and avoid more expensive interventions later.
- This will reduce ambiguity as visibility increases. Transparent requirements, notifications, and decision rationales can help providers and patients understand outcomes and appeal denials when necessary.
- State implementation of ePA and interoperability requirements that align with federal standards can also promote greater consistency across payers, reducing variation in prior authorization.

Cons

- Does not apply to all requests for services and providers must keep track where it applies and where it does not apply for the services that they deliver.
- Resource-limited practices or rural providers may lack the technical or financial capacity to fully adopt ePA, widening inequities in administrative efficiency.
- New technologies risk new complexities or bias, lack of seamless integration, shifting administrative burden and potential for exacerbated denial rates if algorithms prioritize efficiency over clinical nuance.
- For ePA to deliver savings, both providers and plans must use it effectively. Even with reduced administrative work, providers still face exceptions, denials, and appeals. And without unified adoption across payers, inconsistent workflows can heighten burnout.
- Change only impacts insurance products, so consumers, and their providers, in self-funded plans or with self-funded third-party administrators, may still face challenges with non-electronic prior authorization requests.

2) Prohibiting or limiting prior authorization for certain services, medications, or supplies. It summarizes policies in states that exempt services such as emergency care, behavioral health treatment, preventive services, medication-assisted treatment for opioid use disorder, cancer care, and other services from prior authorization requirements. New technologies risk new complexities or bias, lack of seamless integration, shifting administrative burden and potential denial rates if algorithms do not account for clinical nuance.

Pros

- Reduces unnecessary administrative processes, which take providers away from delivering care by reducing or eliminating unnecessarily burdensome processes, resulting in reduced provider burnout.

- Reduces denials, repeated documentation requests, and lessens the administrative burden of utilization management and appeals, may lower certain administrative cost, while enabling providers to focus more on patient care.
- Improves continuity of care by reducing potential delays associated with obtaining prior authorizations allowing providers to follow evidence-based treatment plans without interruptions tied to insurer approval cycles.
- Improves access to medically necessary care without unnecessary delays caused by prior authorization processes.
- Lower risk of abandonment; when delays are removed, patients are less likely to forgo recommended treatment.

Cons

- Does not eliminate all prior authorization and providers must keep track where it applies and where it does not apply for the services that they deliver.
- Change only impacts certain insurance products; unless adopted by self-funded third-party administrators, out-of-state plans, Medicare or Medicaid, providers will need to understand patient's coverage to know whether new administrative rules will apply to their patients.
- Limiting or eliminating prior authorization needs to be reviewed carefully to ensure that it does not lead to an increase in fraud, abuse, waste, or a reduction in patients receiving safe, effective, and guideline-aligned care. Safeguards are needed to reinstitute prior authorization if regulators find significant increases in unnecessary utilization.
- Less oversight of safety-sensitive treatments; prior authorization can help flag contraindications, duplicative services, or unsafe prescribing patterns. Limiting prior authorization might reduce safeguards that prevent patient harm.
- Higher costs passed to consumers; without prior authorization as a cost-control tool, insurance carriers may face increased spending on high-cost or overused services, which can lead to higher premiums or cost-sharing or insurance carriers may exclude certain non-mandated services from coverage.

3) Standardizing prior authorization forms and required information. It highlights states that require uniform prior authorization forms and standardized data elements to reduce administrative burden and streamline communication between providers and insurance carriers.

Pros

- By standardizing and limiting prior authorization questions, there will be greater clarity about what providers will need to submit for carriers to decide whether the care meets medical necessity criteria.
- Providers will spend less time navigating different payer forms and requirements, which streamlines workflows and cuts back-office workload.
- Standardized forms enhance the efficiency of the process, speeding up decisions.
- Improves accuracy and completeness of the data; standard formats reduce missing or inconsistent data, leading to fewer back-and-forth requests and faster

determinations.

Cons

- Does not apply to all requests for services and providers must keep track where it applies and where it does not apply for the services that they deliver.
- Change only impacts insurance products; unless adopted by self-funded third-party administrators, out-of-state plans, Medicare or Medicaid, providers will need to understand patient's coverage to know whether new administrative rules will apply to their patients.
- Reduced flexibility for unique clinical scenarios; standardized forms may not capture nuances for complex or rare cases, potentially leading to inappropriate denials or extra follow-up.
- Risk of oversimplification; uniform data elements may not align with all clinical specialties, forcing providers to submit supplemental information outside of the standardized process.

States with the Policy: Adopting requirements relating to electronic prior authorization and interoperability

Note: Federal requirements mandate insurance carriers use standardized application programming interfaces (APIs) to support electronic prior authorization through the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). The rule requires certain Medicare Advantage, Medicaid, CHIP, and ACA Marketplace plans on the federal Marketplace to implement FHIR-based APIs for prior authorization requests, decisions, and related patient and provider data exchange. Many state policies align with these adopted standards.

State	Implementation Date	Key Variations/Notes
Colorado	January 1, 2027	Requires insurance carriers to establish, maintain and use an API that automates the prior authorization request and approval process for providers. Requires the API to meet the most recent standards under U.S. Health and Human Services.
District of Columbia	January 17, 2024	Establishes shorter prior authorization determination timeframes when providers submit requests electronically through a portal rather than by mail, telephone, or facsimile.
Indiana	July 1, 2018	Requires providers to submit prior authorization requests through a secure electronic transmission and requires health plans to accept electronic submissions. Exceptions apply for financial hardship, limited internet access, or low provider volume.
Iowa	July 1, 2026	Requires health care providers to submit all requests for prior authorization to a health carrier electronically using a standards-based API by July 1, 2027.
Kansas	January 1, 2028	Requires utilization review entities to adopt and maintain a prior authorization API that aligns with the federal requirement at 45 C.F.R. 156.223 (b). Excludes drugs.

State	Implementation Date	Key Variations/Notes
Maryland	July 1, 2026	Requires health care providers to have e-prescribing or electronic health record systems capable of accessing electronic prior authorization functionality at the point of prescribing. Providers may obtain a waiver from compliance. Applies to prescription drugs.
Massachusetts	June 5, 2026	Allows an insurer to implement and maintain an API for the automated processing of prior authorization requests. Allows insurance carriers to use financial incentives to require a provider to participate in the use of an API.
Michigan	June 2023	Insurance carriers of health benefits that require prior authorization are required to make available a standardized electronic prior authorization request transaction process that uses an electronic, internet, and web-based system that can transmit clinical information. Providers and insurance carriers (or their utilization review organizations) must use this standard electronic PA transaction process unless the health professional is not able to because of a temporary technological or electrical failure.
Minnesota	January 1, 2027	Requires the use of an API for medical prior authorizations (i.e., does not apply to prescription drug PAs) that essentially mirrors the federal interoperability requirements. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems.
Mississippi	January 1, 2025	Requires all health care professionals and providers to use a standardized electronic prior authorization transaction process made available by insurance carriers by January 1, 2027. Requires insurance carriers to make the electronic process available by January 1, 2025.
Missouri	Electronic PA for Rx (January 1, 2021); API for prior authorization of health care services, excluding prescription drugs (January 1, 2028)	Requires utilization review entity to accept/respond to prior authorizations of drug benefits through electronic prior authorization. By July 1, 2028, health carriers must provide any provider, upon request, with contact information for any third-party vendor or entity they use to meet the prescription drug electronic prior authorization requirements. Any health carrier that fails to have an electronic process for Rx prior authorizations by July 1, 2028, cannot require providers to obtain prior authorizations for Rx, except if specified by the DCI by rule. By January 1, 2028, health insurance carriers and utilization review entities shall implement and maintain a prior authorization API that conforms with federal

State	Implementation Date	Key Variations/Notes
		law. If a health insurer cannot implement the prior authorization API by January 1, 2028, the health insurer shall provide written notice to the Department requesting an extension, accompanied by a documented plan to come into compliance. Starting January 1, 2028, an enrollee's health care provider may use the prior authorization API to submit requests for prior authorization of health care services, excluding prescription drugs. A health insurer shall accept prior authorization requests submitted through the API.
New Jersey	January 1, 2027	Requires prior authorization requests for prescription drug coverage to be submitted through secure electronic transmission using the NCPDP SCRIPT electronic prior authorization standard. Applies to pharmacy benefits.
Oklahoma	January 1, 2025	Requires health care providers to utilize electronic health record or practice management systems that are compatible with the health plan's prior authorization API.
Pennsylvania	January 1, 2023	Requires insurance carriers to establish a provider portal for electronic prior authorization submissions. Providers must submit prior authorization requests through the provider portal within 18 months after the portal is established, subject to limited exceptions.
Virginia	July 1, 2025	Requires participating providers to ensure their e-prescribing or electronic health record systems can access the carrier's electronic prior authorization process at the point of prescribing. Waivers are available for undue hardship. Applies to prescription drugs.
Washington	January 1, 2027	Requires insurance carriers to establish and maintain an interoperable electronic process or API that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The interoperable electronic process or API must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027.
West Virginia	June 6, 2023	Requires prior authorization requests and related communications to be submitted through an electronic portal and requires health insurance carriers to maintain a portal supporting electronic prior authorization submissions by providers.

States with the Policy: Prohibiting or limiting use of prior authorization for certain services, supplies and prescriptions

Note: Under federal law (Consolidated Appropriations Act, 2021; 45 CFR Part 149), if a group health plan covers emergency services, it must do so without the use of prior authorization. This has also been adopted into many states' laws.

State	Implementation Date	Key Variations/Notes
Colorado	Annual review by insurance carriers, restrictions on use for chronic maintenance drugs (August 7, 2024); Program to remove administrative burden (January 1, 2026)	Requires insurance carriers to: Perform annual reviews of the list of health care services, including prescription drugs, that require prior authorization and eliminate requirements that do not "promote health care quality or equity" or "substantially reduce health care spending" Adopt programs to eliminate or substantially modify prior auth requirements to remove the administrative burden for qualified providers. Prohibits insurance carriers or pharmacy benefit managers from imposing prior authorization requirements more than once every three years for FDA-approved chronic maintenance drugs if the carrier or PBM has previously approved a prior authorization for the covered person. Prohibits the use of PA for HIV medications (Colorado Revised Statutes § 10-16-152) and medications for the treatment of substance use disorders (Colorado Revised Statutes § 10-16-124.6).
Iowa	Prohibition on prior authorization: January 1, 2027; Annual review by insurance carriers: 2025	Prohibits prior authorization for: cancer-related screenings recommended by the person's health care provider based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology which are designated as category 2A or lower; the diagnosis and treatment of an emergency medical conditions that develops or becomes evident while the person is in inpatient care that meets inpatient care standard; if the emergency medical condition is reasonably determined by a health care professional to be a life-threatening condition unless the covered person receives immediate assessment and treatment. Requires insurance carriers to conduct an annual review and report on prior authorization, eliminate prior authorization requirements for services that are routinely approved and report on this, and justify any prior authorization that is in place where more than 80% were approved in the previous 12 months in their annual reporting.

State	Implementation Date	Key Variations/Notes
Maine	2023	Prohibits prior authorization for: 12 visits of rehabilitative or habilitative services
Massachusetts	June 5, 2026	Prohibits prior authorization for: emergency services, inpatient acute care services (including inpatient acute mental health treatment), post-acute care services provided on weekends or holidays, urgent care services, primary care services, preventive health services and vaccinations, abortion and abortion-related care, maternity services, physical therapy, occupational therapy, and speech therapy, outpatient substance use disorder services, medications for serious, persistent mental illness, specific chronic care medications identified (diabetes, heart disease, asthma, specific post-cancer diagnosis radiology imaging used to stage or determine treatment efficacy. Requires insurance carriers to annually review their prior authorization lists and survey patients about their experiences, giving the DOI additional data to evaluate progress, reduce waste, and improve patient experience.
Michigan	July 1, 2016	Prohibits prior authorization for: pediatricians for general pediatric care services; emergency health services; well woman visits.
Minnesota	January 1, 2026	Prohibits prior authorization for: outpatient mental health treatment or outpatient substance use disorder treatment, not including medications; antineoplastic cancer treatment consistent with National Comprehensive Cancer Network guidelines, not including medications; certain preventive services and immunizations; pediatric hospice services; and treatment delivered through a neonatal abstinence program.
Missouri	Emergency services (2018); MAT (2021)	Prohibits prior authorization for: emergency services, stabilization services, medication-assisted treatments (including pharmacological therapies).
New Hampshire	SUD: January 1, 2017; Data: January 1, 2025	Prohibits prior authorization for: medically necessary interfacility transports for services related to the treatment and diagnosis of mental illnesses, treatment of an emergency medical condition as defined in RSA 420-J:3, XV, at least one medication-assisted treatment therapy for treatment of substance use disorders, the first 2 routine outpatient visits of an episode of care for assessment and care relating to a substance use disorder, the first 24 hours of short-term inpatient withdrawal management and clinical stabilization services. Collects prior authorization metrics and posts them publicly by insurer.

State	Implementation Date	Key Variations/Notes
New Mexico	Medication treatment of an autoimmune disorder, cancer, a rare disease or condition, a serious mental illness or a substance use disorder, except in cases in which a biosimilar (2026); Gynecological and obstetric ultrasounds (2025); Mental health disorder and substance use disorder services, prescription drugs for SUD services (2023)	Prohibits prior authorization for: mental health and substance use disorder services, medication treatment of an autoimmune disorder, cancer, a rare disease or condition, a serious mental illness or a substance use disorder, except in cases in which a biosimilar, interchangeable biologic or generic version is available, emergency care, contraception, coverage for individuals with diabetes, and gynecologic and obstetric ultrasounds.
Nebraska	January 1, 2026	Prohibits prior authorization for: emergency confinement; pre-hospital transport for emergency health services or transfers between facilities as required by federal EMTLA; or services that have an A or B rating from the US Preventive Task Force, immunizations recommended Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screening provided to women as required by 45 C.F.R. 147.130.
North Dakota	December 31, 2025	Prohibits prior authorization for: medication-assisted treatment of opioid use disorder; prehospital transportation or for the provision of emergency health care services for an emergency medical condition.
Oregon	January 1, 2018	Prohibits prior authorization for: the first 60 days of treatment for medication assisted treatment for opioid or opiate withdrawal, HIV treatment and prevention medications, FDA approved medications for substance use disorder, additional medically necessary procedures discovered during an already authorized surgery.
Washington	Opioid use disorder: January 1, 2020; Substance use disorder: January 1, 2021; Human immunodeficiency virus (HIV) postexposure prophylaxis: January 1, 2025	Prohibits the use of prior authorization for at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes of opioid agonists, opioid antagonists, and opioid partial agonists. Prohibits the use of prior authorization for withdrawal management services or inpatient or residential substance use disorder services in a behavioral health agency. Prohibits prior authorization for drugs that comprise at least one regimen recommended by the centers for disease control and prevention for human immunodeficiency virus postexposure prophylaxis.

States with the Policy: Standardized forms for prior authorization

State	Implementation Date	Key Variations/Notes
Arizona	January 1, 2023	Requires DOI to approve a uniform request form for prescription drugs, devices or durable medical equipment and a uniform prior authorization request form for all other health care procedures, treatments and services. The forms must be 2 pages or less and meet the electronic submission and acceptance requirements prescribed under the law. Requires use by providers/plans.
Colorado	2013	Requires commissioner to develop, by rule, a standardized drug benefit prior authorization form, not to exceed two pages in length, for use in submitting electronic and nonelectronic drug benefit prior authorization requests. In developing the form, the commissioner shall take into consideration existing forms, including existing prior authorization forms established by CMS or the department of health care policy and financing.
Massachusetts	2012	Requires DOI to develop and implement uniform prior authorization forms for different health care services and benefits, including but not limited to post-acute care admissions and home health transitions. The forms must be 2 pages or less, be made electronically available, and be capable of being electronically accepted by the insurer after being completed. Requires insurance carriers to use and accept these forms.
Michigan	January 1, 2016	Requires the use of a standard prior authorization form when a policy, certificate or contract requires prior authorization for prescription drug benefits. This form is made available on the DIFS website to simplify exchanges of information between prescribers and health insurance carriers as part of the prior authorization process.
Nebraska	November 1, 2025	Requires department to approve a single uniform prior authorization request form for prescription drugs, devices, and durable medical equipment and a single uniform prior authorization request form for all other health care services.
New Hampshire	2017	Requires insurance carriers that require prior authorization for prescription drugs to use and accept the state's standard prior authorization forms (or the approved electronic standard).
New Mexico	2019	Requires DOI to adopt and insurance carriers to use a streamlined and uniform prior authorization form for medical care, pharmaceutical benefits or related benefits.
Oregon	July 1, 2015	Requires DOI to develop by rule a uniform form that providers must use to request a prior authorization for a prescription drug benefit. The form must not exceed 2 pages and be electronically available and transmissible

State	Implementation Date	Key Variations/Notes
		and include a provision under which additional information may be requested and provided.
Texas	2013; revised 2022	Requires DOI to prescribe a single, standard prior authorization request form and require issuers to accept and use this standard form.
Washington	2024	Requires Health Care Authority and OIC to develop a universal format accepted by all health insurance carriers and Medicaid managed care organizations for behavioral health agencies to use for service authorization requests with common data requirements and a standardized form and simplified electronic process.

Premium Impact and Savings Analysis

According to the 2023 CAQH Index, there is about $494 million per year in additional savings for the U.S. medical industry if prior authorization becomes fully electronic. Current evidence suggests that API-enabled electronic prior authorization generates meaningful administrative savings and workflow efficiencies. Any premium impact is expected to be modest and indirect, with the primary benefits accruing through reduced administrative burden, faster care, and improved interoperability.

Conclusion

These policy approaches demonstrate that states can pursue prior authorization reforms that reduce cost, administrative burden, and improve timely access to care while preserving appropriate utilization review. As states continue to implement and evaluate these reforms, policymakers should consider how best to balance administrative efficiency, affordability, patient access, and safeguards that support safe, evidence-based care.

Sources

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National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025. https://content.naic.org/sites/default/files/inline-files/PA%20white%20paper%20Adopted%2012.10.2025%20by%20Cmte.pdf

Further Reading

- For information relating to the AHIP's and Blue Cross Blue Shield Association's initiative to accelerate patient access to care and reduce administrative burdens for providers by having participating plans adopt a standardized approach for providers submitting electronic prior authorization requests for the majority of medical services. https://www.ahip.org/news/articles/health-plans-take-next-step-to-streamline-and-simplify-prior-authorization-for-patients-and-providers;

https://www.ahip.org/news/articles/health-plans-reduce-prior-authorization-support-continuity-of-care-and-enhanced-consumer-communications

- For information relating to federal policies relating to APIs and relevant standards and implementation guides. https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-standards/application-programming-interfaces-apis-relevant-standards-implementation-guides-igs
- For information relating to the affordability implications of inappropriate prior authorization, as well as the affordability benefits of various prior authorization reforms see:
    - Lorraine T. Dean, Amy Stewart Nunn, Hsien-Yeb Chang, et al., Estimating The Impact Of Out-Of-Pocket Cost Changes On Abandonment Of HIV PreExposure Prophylaxis. Health Aff (Millwood). 2024 Jan;43(1):36-45. Doi: 10.1377/hlthaff.2023.00808. Researchers found patients facing a high out-of-pocket cost for a medication that was denied prior authorization approval is likely to abandon the prescription at the pharmacy.
    - Tami L. Mark, William J. Parish, and Gary A. Zarkin, Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. JAMA Netw. Open. 2020 Apr 1;3(4). doi: 10.1001/jamanetworkopen.2020.3132. Removing prior authorization for buprenorphinenaloxone (a medication used to treat opioid use disorders) in Medicare was associated with an increase in the medication use and decreases in health care utilization and expenditures.
    - Zachary S. Wallace, Tyler Harkness, Xiaoqing Fu, et al., Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study. Arthritis Care Res (Hoboken). 2020 Nov;72(11):1543-1549. doi: 10.1002/acr.24062. Prior authorization requirements are associated with treatment delays and denials are associated with greater glucocorticoid exposure.

Section 2: Horizontal and Vertical Integration in Health Care

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Connection to Affordability

Vertical and horizontal integration of insurers with other parts of the health care delivery system has the potential to reduce administrative costs, make the system more efficient, and coordinate care. It may also lead to improved data sharing, alignment with financial and clinical incentives, increased population health management, and support for value-based care arrangements. However, there is a concern that the health care market is becoming increasingly consolidated and uncompetitive. Horizontal and vertical integration among health care entities such as providers, hospitals, pharmacy benefit managers, and insurers may create incentives that encourage anticompetitive practices, decreased competition, monopolistic pricing, and self-dealing, which drive up the cost of care, including premiums and out-of-pocket costs for consumers. Each form of integration raises different economic, clinical, and regulatory considerations.

Introduction

This brief examines the increasing prevalence of horizontal and vertical consolidation within the health care industry and analyzes how these organizational models affect health care affordability, market competition, and regulatory oversight. It also identifies enacted laws and legislative proposals that illustrate how states are attempting to mitigate rising health care costs associated with industry integration.

Definitions

1) Medical Loss Ratio or "MLR" is a ratio of how much insurer spending goes toward paying medical claims and activities that improve the quality of care compared to how much the insurer collects in premiums minus any taxes and regulatory fees. The difference may be used to pay administrative expenses such as marketing, salaries, profits, and commissions. The Affordable Care Act requires insurance companies covering individuals or small groups to meet or exceed an 80% MLR. Large groups must meet or exceed an 85% MLR.

2) Organizational integration refers to the common ownership or control of entities in the health care ecosystem. It is accomplished via common ownership, contractional relationships, and company mergers.
    a) Horizontal integration: refers to integrated organizations at the *same stage* in the supply chain.
    b) Vertical integration refers to integrated organizations at *different stages* of the supply chain.

Examples of Integration[1]:

1) Health Maintenance Organizations (HMOs) (Vertical Integration): HMOs are one of the longest-standing forms of integration, in which the payer and providers are combined in a single corporate structure, subject to state laws that require a separate legal entity for physicians. There are no special or different MLR reporting rules for issuers that operate a staff-model HMO. It can be difficult to parse laws such as MLR when a single entity is involved in both the delivery and insurance side of health care; however, these entities are still subject to state and federal audit requirements. Members receive services from a select group of physicians, who see patients in the HMO's facilities.

   HMOs have been a successful model for certain carriers, including Kaiser Permanente. Kaiser is the largest private, non-profit integrated health care delivery system in the United States, delivering health care to members in nine states and the District of Columbia. Kaiser comprises Kaiser Foundation Health Plan, Inc., its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals; and the Permanente Medical Groups, which are self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries.

   In its home state of California, Kaiser is regulated by multiple agencies, which presents complex oversight issues. Kaiser Foundation Health Plan is licensed as a health care service plan regulated by California's Department of Managed Health Care; hospital facilities are generally regulated by California's Department of Public Health and California licensed physicians are regulated by the Medical Board of California.

2) Provider Sponsored/Provider Owned Health Plans (Vertical Integration): These are health insurance plans that are owned, operated, or significantly controlled by health care providers, such as hospitals or integrated health systems. In these arrangements, the health care providers function not only as a care delivery network but also as the payer.

[1] Integrated arrangements involving insurers may also be subject to state insurance holding company and affiliated transaction requirements. NAIC Models #440 and #450 provide state insurance regulators with authority to review holding-company structures and certain transactions among affiliated entities, including arrangements that could affect an insurer's financial condition or policyholder interests.

3) Insurance Companies that own Pharmacy Benefit Managers (PBMs) and Pharmacies (Vertical Integration): According to a 2024 Federal Trade Commission (FTC) interim report, five of the six largest PBMs are "vertically integrated with some of the largest health insurers in the country," and include Aetna (CVS Caremark), Cigna (Express Scripts), UnitedHealth Group (OptumRx), Humana (Humana Pharmacy Solutions) and certain Blue Cross Blue Shield Plans (Prime).[2] That same interim staff report noted the top three PBMs processed almost 80% of prescription claims in the United States, while the top six processed more than 90% of prescription claims in the United States. As PBMs and insurers become more integrated, the financial results become bundled, masking the profit margins of PBMs.[3] Regulation of PBMs is further complicated by Employee Retirement Income Security Act preemption issues and conflicting federal circuit court opinions.[4]

4) Insurance Companies that Own Drug Manufacturing Companies (Vertical Integration): CVS Health, a conglomerate that owns Aetna insurance and Caremark PBM, has established a wholly owned subsidiary pharmaceutical supplier called Cordavis. Based in Ireland, Cordavis works with manufacturers to commercialize and/or co-produce biosimilar products for the U.S. pharmaceutical market.[5]

5) Hospital System and Provider Consolidation (Vertical Integration): Hospital systems are increasingly purchasing private provider practices. The U.S. Government Accountability Office noted the number of physicians consolidated under a hospital system increased from 20% in 2012 to 47% in 2024.[6] A recent survey by the American Medical Association reported that physicians most often sell their practices to strengthen their negotiating leverage with insurers, gain access to expensive resources, or lessen administrative and regulatory pressures.[7] Consolidation between hospitals and physicians can lead to higher payments when provider services occur in a hospital setting and facility fees apply.[8]

6) Hospital Consolidation (Horizontal Integration): Two or more independent hospitals or health care systems can combine their corporate structures, assets, or operations into a single combined facility or a newly formed corporate entity. Between 2012 and 2021, the share of independent general acute care hospitals decreased from 31.5% to 22.3%.[9] During that same period, the share of system-affiliated hospitals rose

[2] Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, July 2024. See also FTC Releases Interim Staff Report on Prescription Drug Middlemen | Federal Trade Commission
[3] Karen Mulligan, PhD Darius Lakdawalla, PhD, Hidden Profits? How Accounting Conventions and Vertical Consolidation Can Obscure PBM Profitability, 2026-01-pbm-profitability.pdf
[4] NAIC Guidance Document: ERISA Preemption and State PBM Laws (Draft)
[5] CVS Health, CVS Health launches Cordavis, (August 23, 2023), https://www.cvshealth.com/news/pbm/cvs-health-launches-cordavis.html
[6] United States Government Accountability Office, GAO-25-107450, HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation
[7] See Carol Kane, Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties (Chicago, Ill.: American Medical Association, 2025). https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf
[8] United States Government Accountability Office, GAO-25-107450, HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation
[9] Jessica Y Chang, Kathryn Martin, Commercial inpatient hospital price growth driven by system affiliation and nonprofit-status hospitals, Health Affairs Scholar, Volume 2, Issue 11, November 2024, qxae140, https://doi.org/10.1093/haschl/qxae140

23.4%, from 50.6% to 62.5%.[10] Another study found that a large majority of hospitals and hospital services are being provided by large health systems. During that same period, inpatient prices among affiliated non-profit hospitals grew at a faster pace (45.2%) than affiliated for-profit hospitals (35.8%) and independent hospitals (35.2%).

Policy Options for States

1) Regulating anti-competitive contracting terms: Anti-competitive contracting terms enable dominant providers or insurers to distort market competition and inflate prices.
2) Transparency disclosures: To understand how consolidation is operating, access to data on ownership of health care entities is critical for policymakers and regulators.
3) Enhanced pre-merger notification and review requirements: Requiring health care entities to notify the appropriate state regulators of planned mergers and putting in place guardrails for review of those mergers could prevent consolidation that ultimately creates monopolies and impacts patient access and affordability.
4) Unique National Provider Identifiers (NPIs): To ensure that off-campus hospital outpatient departments are not being billed as hospital charges, a state could adopt requirements that providers use unique NPIs when billing.
5) Restrict facility fees: Adopt laws to restrict the settings and services for which facility fees may be charged.[11]
6) Adopt site-neutral payment reforms: Site-neutral payment reforms require hospitals be paid no more than a set amount for services that can be provided safely and effectively in non-hospital settings. Site-neutral reforms remove incentives for hospitals to acquire independent physician practices.[12]

States Efforts to Regulate Vertical Integration

State	Implementation Date	Key Variations/Notes
Arkansas	January 1, 2026	Prohibits PBMs from owning or operating pharmacies in the state, but enforcement of this statute is stayed pending the outcome of litigation. (Act 624)[13]
Indiana	January 1, 2026	Prohibits insurers and third-party administrators from requiring an employer plan to contract with a particular PBM.
Tennessee	Pending: July 1, 2028	Prohibits a PBM from directly or indirectly acquiring, holding, controlling, or otherwise possessing any ownership or beneficial interest in, or exercising control over, a pharmacy license or a pharmacy license holder, including through any contract or arrangement that transfers operational control or economic benefit to the pharmacy benefits manager. This prohibition

[10] Chang and Martin.
[11] See also Section 4: Reference Based Pricing, RBP and Facility Fees.
[12] See also Section 4: Reference Based Pricing, RBP and Site Neutral Payments.
[13] Tess Vrbin, Arkansas suspends enforcement of law preventing limits on which pharmacies can sell medications, Arkansas Advocate, July 29, 2026. https://arkansasadvocate.com/2026/07/29/arkansas-suspends-enforcement-of-law-preventing-limits-on-which-pharmacies-can-sell-medications/

State	Implementation Date	Key Variations/Notes
		applies regardless of the percentage of ownership interest. Compliance with the prohibition is a condition of the issuance, renewal, and continued validity of a pharmacy license. There is current litigation regarding this Act. (Pub. Ch. 1111)[14]

States Efforts to Regulate Horizontal Integration

State	Implementation Date	Key Variations/Notes
Maine	Effective January 1, 2027	Requires health care entities with a threshold presence in Maine to file copies of any premerger notifications required under the Hart-Scott-Rodino (HSR) Act with the Maine Attorney General (H.P. 1481, 2026)

Premium Impact and Savings Analysis

While vertical integration could theoretically lead to improvements in efficiency and care coordination,[15] it has been criticized for limiting consumer choice, increasing the cost of care, creating significant challenges for independent pharmacists, and ultimately increasing health care spending.[16] In addition, research suggests integration often enables profit extraction through self-dealing and higher prices.[17] A Health Affairs study found a direct impact on physician prices at medium and large systems (consolidation into a medium system led to a price increase of 7.7% for primary care physicians and 2.4% for specialists; into a large system led to a price increase of 12.0% for primary care physicians and 6.0% for specialists).[18]

Horizontal integration can generate economies of scale that lower costs, but research shows it may also expand market power and drive prices upward. For instance, one study found that hospitals without competitors within 15 miles charge 12% more than hospitals facing four or more competitors.[19] A 2022 report from the American Medical Association's Council on Medical Services similarly concluded that prices often rise after hospital mergers

[14] Dae Y. Lee and Lucas W. Morgan, Tennessee's FAIR Rx Act Litigation: Why Independent Pharmacies Should Watch This PBM Fight Closely, Buchanan Ingersoll & Rooney, June 25, 2026. https://www.bipc.com/tennessees-fair-rx-act-litigation-why-independent-pharmacies-should-watch-this-pbm-fight-closely

[15] Rachel Ekaireb, Anna Yap, Robert Kucejko, Vertical integration and market consolidation in healthcare: Policy drivers and impact on physicians and patient care, Seminars in Colon and Rectal Surgery, Volume 35, Issue 3, 2024, 101038. https://www.sciencedirect.com/science/article/pii/S104314892400037X

[16] Julia Burleson. Vertical Integration in Health Care: Implications for Consumers, Employers, and Clinicians, Georgetown University Center on Health Insurance Reforms, May 2, 2026. https://chir.georgetown.edu/vertical-integration-in-health-care-implications-for-consumers-employers-and-clinicians/; Sinaiko AD, Curto VE, Ianni K, Soto M, Rosenthal MB. Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems. JAMA Health Forum. 2023;4(9):e232875. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808890

[17] Zack Cooper, Stuart V. Craig, Aristotelis Epanomeritakis, Matthew Grennan, Joseph R. Martinez, Fiona Scott Morton, and Ashley T. Swanson, "Are Hospital Acquisitions of Physician Practices Anticompetitive?," NBER Working Paper 34039 (2025), https://doi.org/10.3386/w34039.

[18] Vilsa Curto, Anna D. Sinaiko, and Meredith B. Rosenthal, Price Effects Of Vertical Integration And Joint Contracting Between Physicians And Hospitals In Massachusetts, Health Affairs 2022 41:5, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00727

[19] American Medical Association, REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-22). https://www.ama-assn.org/system/files/i22-cms-report-03.pdf

because larger systems gain greater leverage in negotiations with insurers and can shift patients to higher cost facilities.[20]

Conclusion

Horizontal and vertical integration in health care can create efficiencies and improve care coordination, but growing consolidation may also reduce competition, increase prices, and contribute to higher health care spending. As health care markets continue to evolve, states may consider a range of policy approaches—including enhanced transparency and merger oversight, restrictions on anticompetitive practices, and payment reforms—to preserve competition and promote affordability for consumers.

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Section 3: Develop State-defined Plans with Premium Reduction Targets

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Connection to Affordability

Consumers are facing increases in Marketplace premiums as a result of the expiration of enhanced premium tax credits (EPTCs), making it more difficult to find affordable care. At the same time, the small group market is contracting, with employers struggling to be able to offer competitive, affordable, and comprehensive benefits packages. Consumers with higher health care needs are faced with no-win choices between absorbing additional premium costs, absorbing the higher deductibles and cost sharing that come with lower premium options, or dropping coverage entirely. A number of states have worked to achieve more affordable plans by encouraging or mandating health insurers to offer plan designs that might not otherwise be available in the market or that offer pre-deductible or low-cost services.

Introduction

States are adopting a variety of strategies with the goal of improving health insurance affordability, including public option models with premium reduction targets, mandate-light plans with fewer required benefits, and limited- or tiered-network products that lower costs through more efficient provider networks. States such as Colorado, Nevada, and Washington have pursued public option approaches aimed at the affordability of the ACA-regulated market, while Florida, Kansas, Louisiana, and Texas have expanded lower-cost mandate-light options aimed at the non-ACA regulated market, and Massachusetts has emphasized market-based plan designs that provide premium discounts through limited networks and lower-cost sites of care. These approaches illustrate the range of policy options states are using in an attempt to lower premiums while balancing affordability,

consumer choice, and access to care. However, the evidence is mixed as to the success of these programs.

Pros

- Gives options for groups/consumers shopping for coverage.
- With premium and co-payment incentives, covered persons can obtain care from less costly providers.
- With state-defined plans, covered persons enroll in plans where providers agree to reduced reimbursements that may lead to lower premiums and lower out-of-pocket costs.
- With "mandate-light" plans, covered persons choose plans that don't cover certain otherwise-mandated benefits.

Cons

- Benefit options provide short-term solutions that have not yet demonstrated significant savings and do not address the underlying growth in the cost of care. They may also have longer-term implications for provider participation, network adequacy, consumer choice and service availability.
- Benefit options shift cost to the rest of the commercial market
    - Sicker patients using more expensive services pay more for health coverage.
    - Persons not using mandated services or expensive providers switch to richer plans only when they need them, thereby further increasing the overall cost of the richer plans.
- To date, premium reduction targets for many products have not been reached and more research is necessary to evaluate their impact on the overall cost of care in the market, especially options associated with limited network/tiered products and mandate-light products.

Policy Approaches

States are increasingly pursuing innovative strategies to improve the affordability of health insurance. One popular approach is establishing state-defined health plans with premium reduction targets or authorizing lower-cost alternative coverage options. These approaches generally fall into three categories:

1) Public option models that establish premium reduction targets and health plans with standardized benefit designs,
2) Mandate-light products that allow insurers to offer plans with fewer state-mandated benefits in exchange for lower premiums, and
3) Limited- or selective-network products that reduce costs by directing enrollees to more efficient provider networks or sites of care.

Public option models adopted in states such as Colorado, Nevada, and Washington seek to reduce premiums while maintaining Affordable Care Act (ACA) benefit standards through enhanced regulatory oversight, standardized plan designs, and premium reduction targets.

Colorado's program, for example, established phased premium reduction goals accompanied by the authority to lower hospital/provider payment rates, while Nevada requires participating carriers to offer plans at least 15 percent below benchmark premiums through a combination of administrative efficiencies and provider payment strategies. However, early findings suggest that some of these programs have not yet improved affordability. In addition, the Nevada Battle Born State Plan achieved approximately 10 percent of Marketplace enrollment in 2026, demonstrating that most consumers have determined commercially-defined plans are a better value for themselves and their families. Finally, Minnesota has also considered legislation to implement a public option.

Other states have focused on expanding consumer choice through mandate-light plans, which permit insurers to offer products that exclude certain state-required benefits in exchange for lower premiums. Florida, Kansas, Louisiana, and Texas have adopted variations of this approach, generally requiring clear consumer disclosures regarding omitted benefits so purchasers understand the tradeoff between lower premiums and reduced coverage.

Massachusetts has pursued affordability through market-based plan design by requiring carriers to offer limited- or tiered-network products with meaningful premium discounts compared to comparable full-network plans and by establishing standards for site-of-service plans that encourage the use of lower-cost care settings while maintaining transparency for consumers.

Collectively, these state initiatives demonstrate a range of policy tools states hope will address health insurance affordability while balancing consumer protections, market competition, provider participation, and access to care. Although the approaches differ in design and implementation, they share the common objective of reducing premium costs and expanding access to affordable health coverage. However, additional study is needed to definitively assess the success of these programs.

Developing State-defined Plans with Premium Reduction Targets State Policy Options

State	Implementation Date	Key Variations/Notes
Colorado	January 1, 2023	*Public Option – Private/Public Partnership:* Requires all insurers to offer a state-designed, standardized health plan (Colorado Option) in all areas where they offer non-Colorado Option plans (on and off-exchange). Issuers are required to reduce premiums on these plans. These premium rate reduction (PRR) requirements are incorporated into “target premiums” each year, which are authorized by Colorado’s 1332 waiver. The targets are based on adjusted 2021 baseline premiums and represent a 5% reduction in 2023, 10% reduction in 2024, and 15% reduction in 2025. Starting in 2026, Colorado Option plan premium increases are limited to the rate of medical inflation. Issuers must notify the Division by March 1 each year if they are

State	Implementation Date	Key Variations/Notes
		able to meet the PRR targets for the upcoming plan year. Failure to meet these PRR targets establishes the "trigger" by which a Colorado Option public hearing may be initiated. The public hearing process can require issuers and hospitals to lower reimbursement rates by the maximum allowable amount, which is the greater of either a 20% reduction from the prior year's negotiated rate, or a reduction to a hospital-specific floor. The hospital floor is set in statute at 165% of Medicare with adjustments for hospital characteristics, and each hospital floor is updated by the Division each year.
Kansas	July 1, 2013	*Mandate-light Products:* Defines and allows "Mandate-Light" policies. Insurers can offer these at lower prices, provided buyers sign a notice acknowledging which benefits are missing. Under KS Stat § 40-2,192 (2024), insurers must provide a written list of the mandated benefits not included in the policy.
Louisiana	August 15, 2023	*Mandate-light Products:* "Flexible health benefit plans" plans are state-approved policies that do not include all state-mandated health benefits. These are budget-friendly policies that bypass state-mandated coverage rules, allowing for lower premiums at the cost of reduced benefits. By opting out of certain mandated services, these flexible plans offer more affordable options for small business employees and individuals who might not need comprehensive, major medical care. RS 22:1048
Massachusetts	Limited-network: April 1, 2013; Site of Service: November 24, 2023	*Limited-network or tiered-network plans costing 14% less than full-network plan:* Requires commissioner of insurance to annually determine a base premium rate discount of at least 14 per cent for the reduced or selective or tiered network plan compared to the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. *Site of Service Plans*: Requires if a Carrier offers a Site of Service Plan, the Carrier must prominently and clearly specify on the cover of the Evidence of Coverage and related promotional materials that care delivered by certain Network Providers or at certain Network locations may only be available when deemed medically necessary for the patient's condition. In addition, prior to offering Site of Service Plans, the Carrier is to provide notice to covered members and to Network Providers prior to the Site of Service Plan being issued or renewed
Nevada	January 1, 2026	*Public Option – Private/Public Partnership:* The Battle Born State Plans Program operates through private-public partnerships and requires participating carriers to offer premiums that are at least 15% lower than standard benchmark plans, while providing all standard ACA-required benefits. The only difference between the Battle Born plans and others is they must meet premium reduction targets, with the goal of lowering overall health insurance costs. Insurance carriers offering the plans are required to align their networks with Medicaid managed care networks to ensure sufficient access to care. To meet the required targets, officials with the Nevada Health

State	Implementation Date	Key Variations/Notes
		Authority said carriers have two options: One is to reduce administrative costs, such as salaries, overhead, and broker costs, and the other is to reduce medical costs, such as provider reimbursements.
Texas	September 1, 2003	*Mandate-light Products:* "Consumer Choice" health plans are state-approved policies that do not include all state-mandated health benefits. Insurers offer these to lower monthly costs. In exchange, the plan covers fewer benefits, charges higher deductibles, or limits visits. By Texas law, any company selling a Consumer Choice plan must also offer a standard, state-mandated plan.[1]
Washington	November 1, 2020	*Public Option – Private/Public Partnership:* Required the state Health Care Authority, in consultation with other agencies, to provide state-designed plan (Cascade Select) offered by private insurance companies for purchase through the marketplace. Washington enacted legislation in 2021 changing provider participation requirements and capping provider payments at 160% of Medicare rates. The state's public option plan rates increased by 5% in 2024, compared with an 8% for nonpublic option plans.

Premium Impact and Savings Analysis

Colorado

The Brown University Center for Advanced Health Policy Through Research found that the addition of Colorado Option plans to the individual market led to a statistically significant premium reduction of over $100 per enrollee per month, even for non-Option plans.[2] CAPHR also found that prices at hospitals targeted for rate reductions through the public hearing process declined by approximately 10% in non-Colorado Option plans, showing a broader market impact of the program's cost controls.[3] A Mathematica study of the Colorado Option found that Marketplace consumers who selected Colorado Option plans paid lower premiums and had lower out-of-pocket costs than consumers in non-Colorado Option plans.[4]

Conclusion

States have pursued a range of strategies to improve health insurance affordability, including public option models with premium reduction targets, mandate-light products, and limited- or tiered-network plans, each presenting different tradeoffs among premium savings, consumer choice, access to care, and market stability. While these approaches offer potential tools for reducing premiums, experience to date has produced mixed results, underscoring the need for continued evaluation of their long-term effects on consumers and the broader health insurance market. However, many of these approaches are still in the initial years of implementation and may take time to realize greater services.

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Researchers found that across 5 different disease diagnoses, a consumer enrolled in a short-term plan will experience significantly higher cost-sharing than with an ACA-compliant plan in the first six months after diagnosis. Additionally, in states that had not regulated short-term plan availability in 2019, rate filings show that insurers set premiums an average of 5% higher compared to rates filed in states that banned or significantly restricted these policies.

Section 4: Reference-Based Pricing

Contributors

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Connection to Affordability

The level of insurer payments to health care providers is a key part of pricing a health insurance policy. Reference-based pricing (RBP) largely means setting payment levels for covered services by reference to a third-party standard, rather than through payer-provider negotiations. RBP is often used for non-network services, such as emergency or urgent services, or when a network provider is unavailable or inaccessible. Some states and self-funded plans have set prices for their plans as a cost containment mechanism, either through reference-based pricing or other limits on prices, referred to in this section as reference-based pricing adjacent policies.

Introduction

Regulators and others have looked at Reference-Based Pricing (RBP) in health care to try to answer two complex questions: “What amount of payment is too little?” and “What amount of charge is too much?” The far ends of balance between these questions can facilitate fraud, waste, and abuse, inflating premiums, draining resources, and reducing quality of care.

Insurers and other payers often seek contracted payment rates with health care providers, but when such a payment arrangement cannot be reached, a payment amount must be determined. Payers do not typically pay the billed charge. Reference price standards may set thresholds for network contracts but also provide a minimum or maximum payment in the absence of a network contract. This may be applicable in emergency situations, where network adequacy is lacking, or where state laws require coverage for out-of-network benefits. A reference price establishes a payment threshold; it does not, by itself, establish the quality, appropriateness, or value of care.

Reference-based pricing is a tool used by health plans to set health care payment rates using a reference price, rather than a negotiated rate. The reference price could be a percentage of the Medicare rate or another publicly-available source, or a proprietary rate established by the health plan. Payments that differ from a reference amount may recognize

variations within clinical outcomes, patient complexity, access, continuity of care, geography, and other factors.

Some reference-based pricing models establish a reimbursement benchmark without requiring providers to accept the payment amount as payment in full. In these arrangements, patients may remain exposed to balance bills if a provider does not accept the reference-based payment amount.

Policymakers evaluating reference-based pricing strategies may wish to consider safeguards designed to minimize patient confusion and unexpected financial liability, including clear enrollee disclosures, patient advocacy services, and protections against balance billing where appropriate. As a result, reference-based pricing models can present both opportunities for cost containment and consumer protection considerations that should be evaluated together.

Traditional major medical plans

Traditional major medical indemnity plans paid on an expenses-incurred basis up to a limit—typically the "usual and customary rate" (UCR). The UCR represented what payers felt was a fair market price, based on what health care providers in a market normally charged.

Out-of-network payment standards

When managed care plans emerged, payers negotiated in-network rates and continued using UCR as an out-of-network payment methodology. As billed charges moved further away from negotiated rates, plans looked for alternative out-of-network payment methodologies, with many plans using a percentage of the Medicare rate. For out-of-network care governed by the No Surprises Act, in the absence of a state-regulated payment standard, plans must consider the qualifying payment amount (QPA) when calculating consumer cost sharing, which is generally the plan's median contracted rate on January 31, 2019, increased for inflation. This amount is also part of the federal independent dispute resolution process.

ERISA plans and state employee plans

Recognizing that broad variation in in-network reimbursement rates results in unnecessary claims costs, some self-funded plans use reference pricing as a strategy to maintain broad networks, while steering enrollees towards high value care. For specific services where price variation leads to unnecessary spending and where it is feasible for enrollees to shop in advance of care, the plan sets a reference price as the maximum payment amount. If an enrollee chooses a higher cost provider, they are responsible for any cost beyond the reference price. CMS and DOL provide guidance on how a plan can maintain compliance with ACA requirements in the CMS FAQs About Affordable Care Act Implementation Part XIX and Part XXI.[1]

[1] CMS and DOL guidance applicable to PHSA 2707(b). Additional requirements apply to individual and small group market plans.

Fixed indemnity excepted benefit plans

In states that permit per-service fixed indemnity plans, some plans base the fixed payment amount on a reference price, with granular service definitions down to the CPT code level. The reference prices are designed to approximate expenses incurred, often using Medicare rates or an approximation of what providers accept as cash prices. Some states have not approved these plans as excepted benefit plans because the reference prices are not "regardless of expenses incurred."

Non-network major medical plans

Some states have approved non-network major medical plans that pay for medical expenses based on proprietary reference prices that are designed to align with what most health care providers accept as cash prices. Starting in 2027, CMS rules permit these plans to be offered as QHPs on state-based exchanges and on the federal marketplaces in plan year 2028, subject to state approval.[2] Enrollees have the flexibility to use any provider, but any costs beyond the payment amount are not covered by the plan or counted towards the out-of-pocket maximum. This model places the full burden of price discovery and cost calculation on the enrollee at the point of care.

Premium Impact and Savings Analysis

The following matrix includes a description of broad policy savings resulting from reference-based pricing.

State	Value/Metric	Description
California	Lower health care spending for the state employee health plan	After implementing a reference-based payment program, CalPERS saved $7.0 million on spending for colonoscopies in the first two years of implementation (2011-2012).[3]
Montana	Lower health care spending for the state employee health plan	Montana's reference-based payment program is estimated to have saved $30.3 million in inpatient hospital services and $17.5 million in outpatient services for a combined total savings of $47.8 million from state fiscal year (SFY) 2017 to 2019.[4]
Oregon	Lower health care spending for the state employee health plan	Over 27 months, Oregon saved $107.5 million, equivalent to 4% of plan spending, by capping in-network payments at 200% of Medicare and out-of-network payments at 185% of Medicare. Out-of-pocket spending was reduced by 9.5%.[5]

[2] Federal Register. (2026, May 20). Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program. URL: https://www.federalregister.gov/documents/2026/05/20/2026-10050/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and#page-29875

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Reference-Based Pricing State Policy Options

States with Reference-Based Pricing Policies and Reference-Based Pricing Adjacent Policies

Across the United States, states have adopted a wide range of strategies aimed at improving the affordability and transparency of health care prices. Although these initiatives vary considerably in scope, structure, and regulatory authority, many share a common objective: to slow the growth of hospital and professional service prices and reduce unwarranted variation in what purchasers pay. Programs differ in the mechanisms they employ — some establish explicit benchmark-indexed reimbursement limits, while others rely on regulatory oversight, transparency tools, payment reform models, or cost-growth targets to influence prices indirectly. To organize this landscape, the following section identifies states with policies that reflect or incorporate elements of Reference-Based Pricing (RBP) or RBP-Adjacent strategies. The definitions below outline these categories, and the accompanying matrix summarizes the states, program characteristics, and key policy design features relevant to each.

Reference-Based Pricing Policies

RBP is a payment approach in which a purchaser or payer sets a fixed, transparent maximum or minimum reimbursement level ("ceilings" or "floors") for specific health care services, explicitly tied to an external reference benchmark—most commonly the Medicare fee schedule. Traditionally under RBP, the benchmark (e.g., 180% or 220% of Medicare, or a defined "reference price" for a procedure) serves as the upper limit of what the payer will reimburse. Providers may not bill above that amount when patient protections apply, and members face limited or no balance billing exposure. In the absence of patient protections, consumers may be balance billed amounts above the reference-based price.

RBP is defined by uniform benchmark-indexed rates, predictable pricing, and substantial reductions in unwarranted price variation across providers. However, a uniform benchmark may not fully account for differences in local labor and operating costs, patient complexity, service mix, geography, specialized capacity, or a provider's role in maintaining access for enrollees. These issues in particular may be more pronounced in rural, underserved, or otherwise constrained markets where consumers have fewer alternative sources of care. Broad benchmark-based standards may also limit flexibility for value-based contracts, bundled payments, quality incentives, and other arrangements that do not fit neatly within a uniform fee-for-service methodology.

RBP-Adjacent Policies

RBP-Adjacent policies are cost containment or regulatory strategies that use Medicare or other external benchmarks as comparative reference points but do not establish binding reimbursement "ceilings" or "floors" tied directly to those benchmarks. These models may incorporate reference values into rate review, transparency initiatives, out-of-network payment rules, regulatory hearings, or oversight of provider contracting. They also include policies—such as site-neutral payment requirements, facility-fee restrictions, and payment-parity rules—that reduce unwarranted price variation by standardizing

reimbursement across care settings or limiting add-on fees not justified by clinical complexity.

Although these approaches do not set payments at a fixed percentage of Medicare or another benchmark, they influence prices indirectly through transparency, parity-based standards, or regulatory leverage, rather than through a formal reference-priced reimbursement structure.

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
Rhode Island	2010	RBP-ADJACENT Inflation-indexed growth caps using benchmark comparisons	Commercial fully insured (individual, small group, large group) Does not apply to self-funded, Medicare, Medicaid	Caps annual hospital price growth at inflation + 1% Rate review examines trends vs. historical and national benchmarks Primary care investment mandates (33%+ increase since 2008) Alternative Payment Model (APM) adoption targets across carriers 2010–2024 program evolution: RI has gradually strengthened its affordability standards by tightening hospital price-growth caps, expanding benchmark comparisons, and increasing scrutiny of commercial insurer rate filings. RI has also integrated primary care investment requirements and introduced APM adoption targets across carriers. These updates have shifted the program from a static inflation-indexed cap into a broader, more coordinated cost-containment framework.
California	2011-2012	RBP (Sets "Ceiling")	Self-funded: CalPERS PPO plans for state workers/retirees	Applies to high-variation procedures: joint

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
		Shoppable procedure reference pricing	Not applicable to broader commercial markets	replacement, cataract, colonoscopy, arthroscopy Reference ceilings based on high-value providers; enrollees pay difference One of the earliest large purchaser RBP models in the U.S. 2022–2023 program evolution: CalPERS strengthened its RBP strategy by integrating procedural reference pricing with site-of-service steering, specialty pharmacy contracting, and targeted bundles. It also expanded the use of analytics to identify additional shoppable service lines, reflecting a continued modernization of its RBP framework rather than a static legacy program.
Vermont	2014	RBP-ADJACENT Hospital budget caps referencing benchmarks	Hospitals statewide: annual budget submission and cap Commercial fully insured: rate review aligned with budget decisions Medicare and Medicaid: integrated under the Vermont All-Payer Model Not applicable to self-funded ERISA directly	Green Mountain Care Board (GMCB) sets allowable Net Patient Revenue growth (e.g., 3–4%) Unified payer oversight enhances cross-market alignment Public hearings and transparency dashboards Controls hospital financial growth but not Medicare-indexed caps One of the most comprehensive cost-regulation environments in the U.S. 2023–2025 program evolution: The GMCB refined the state's

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				hospital budget review process by incorporating payer-specific growth targets, more granular service-line reporting, and updated all-payer cost growth benchmarks. VT also advanced a redesign of its all-payer model to strengthen alignment across Medicare, Medicaid, and commercial markets. This evolution moves VT toward a more integrated, benchmark-referenced regulatory model.
Montana	2016–2017	RBP (Sets "Ceiling") Medicare-indexed uniform hospital contracting	Self-funded: State Employee Health Plan No applicability to fully-insured, Medicaid, Medicare, or ACA markets	State negotiated 220–250% of Medicare for hospital inpatient/outpatient services Critical Access Hospitals (CAH) exempt; rural and specialty adjustments applied Replaced variable negotiated rates with statewide uniform contracts 2023 program evolution: MT's State Employee Health Plan transitioned to a new third-party administrator (BCBSMT), introducing a hybrid payment structure that blends Medicare-indexed RBP rates with supplemental network discounts and alternative contracting tools. This shift maintains Medicare-anchored pricing but allows the administrator more flexibility in meeting

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
				savings targets and supporting provider participation. The transition signaled an evolution from strict RBP to a more mixed model, while retaining RBP as the core reference framework for facility payments.
Oregon	2019–2020	RBP (Sets "Ceiling") Medicare-indexed hospital payment caps	Self-funded; Public Employees' Benefit Board and Oregon Educators Benefit Board No applicability to commercial fully insured, individual/small group, Medicare, Medicaid	200% Medicare cap (in-network), 185% (out-of-network) Rural hospital exemptions: CAH, Type A/B hospitals Hospital overpayments (i.e., exceeding the Medicare cap established) must be returned; no balance billing allowed (i.e., hospitals cannot pass any unpaid balance to patients) 2023–2024 program evolution: OR updated its PEBB/OEBB hospital cap management process to incorporate blended verification audits, improved monitoring of out-of-network claims, and alignment with broader state Cost Growth Target initiatives. While the core RBP model remains intact, OR began exploring integration of RBP hospital caps with value-based purchasing contracts and incentives for ambulatory shifts, reflecting a gradual evolution from simple rate capping to a more comprehensive affordability strategy.

State	Implementation Date	Type	Market Applicability	Key Variations/Notes
Washington	2020-2022	RBP-ADJACENT Site-neutral reforms + Medicare-based benchmark oversight	Commercial fully insured: individual & small group (rate review) Medicaid MCOs: subject to cost-growth benchmark Large provider systems: required cost reporting Not applicable to self-funded ERISA plans	Statewide cost-growth benchmark program Identifies systems exceeding allowable growth; can require corrective action plans Evaluates provider pricing against Medicare and peer benchmarks Early site-neutral policies limit add-on hospital fees in off-campus sites Cascade Care public option uses aggregate reimbursement limits
Indiana	2020-2024	RBP-ADJACENT Site-neutral payment + Medicare benchmark comparison	Commercial fully insured: individual, small group, large group Regulated hospital systems: facility fee oversight Not applicable to self-funded ERISA unless voluntarily aligned No direct applicability to Medicaid/Medicare	Restricts off-campus hospital facility fees; promotes payment parity with independent clinics[6] Uses RAND studies (Medicare multiples) to evaluate high commercial prices APCD launched 2024 enabling uniform benchmarking Transparency dashboards allow employers to compare hospital price positions
Alaska	2024	RBP (Sets "Floor") Medicare-referenced OON minimums (carrier-driven)	Commercial fully insured: Premera dominant market share Self-funded Administrative Services Only (ASO) clients: adopting	Replacement of 80th percentile rule (from 2004) with out-of-network (OON) payment tied to ~125–200% of Medicare[7] Eliminates inflationary charge-based minimum payments (which were less stable and more

[6] Arnold Ventures. (2023, May 25). Indiana takes a step forward on site neutral payments. URL: https://www.arnoldventures.org/stories/state-policy-win-snapshot-indiana-takes-a-step-forward-on-site-neutral-payments/

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State	Implementation Date	Type	Market Applicability	Key Variations/Notes
			same out-of-network policies Not a state mandate; no applicability to Medicaid/Medicare	influenced by provider price inflation) Represents market-driven shift toward Medicare benchmarking (which is more stable and less influenced by provider price inflation) Major carrier policy decision, not a statute– creates partial RBP dynamics in OON care Legislature continues to explore state mandated OON minimums
Delaware	2026	RBP Primary Care reimbursement cap	Primary Care providers in the fully insured market	2028 and thereafter, cost per service for health benefit plans may not exceed 250% of Medicare reimbursement for comparable services, or a rate set by regulation, unless operating under a federal or state global budget model approved by the Department. Carriers issuing plans in the commercial market for 2 consecutive years and that cover more than 5,000 members must meet minimum percentages of alternative payment model contracting, as specified.

Discussion of Policy Levers to Consider

There are multiple policy levers states can consider when pursuing reference-based pricing or reference-based pricing adjacent state policy options. Two specific areas in which reference-based pricing approaches can be applied are facility fees and site-neutral payments.

RBP and Facility Fees

Facility-fee reform is one policy lever states may consider when examining health care affordability and site-of-care payment differences. When a hospital or health system

acquires a physician practice or designates an outpatient location as hospital-based, routine services may be billed with an additional facility charge even when the clinician, location, and care provided have not materially changed. These charges can increase health plan claims, consumer cost-sharing, and ultimately premiums without necessarily reflecting additional clinical value or hospital-level resources. While generally associated with Medicare, site neutral payments are used by other healthcare payers.

States have taken different approaches depending on their markets, regulatory authority, and affordability priorities. Available policy options include enhanced disclosure and reporting requirements, accurate identification of the site of care on claims, limits on facility fees for specified services or locations, and site-neutral payment requirements for services that can be safely and appropriately delivered in multiple settings.

Where a state chooses to pursue facility-fee reform, relevant design considerations may include:

- Whether the policy applies to particular services, locations, or both;
- Whether it regulates provider billing, insurer reimbursement, or consumer cost-sharing;
- How claims will identify the actual site where care was delivered;
- Whether prohibited amounts may be billed to the consumer;
- How emergency, trauma, rural, safety-net, or essential-access services are treated;
- How existing contracts transition; and
- What reporting, audit, repayment, and enforcement mechanisms are appropriate.

Disclosure requirements can improve transparency, but policymakers may also evaluate whether disclosure alone is sufficient when consumers have limited ability to select an alternative provider or site of care. From the payer perspective, policies that directly address unjustified facility charges may have a greater affordability impact than disclosure-only requirements, while still allowing narrowly tailored exceptions where hospital-level resources are demonstrably necessary.

RBP and Site Neutral Payments

In response to facility fees, Medicare and some states are exploring site neutral payments. Site Neutral Payments are the concept of paying the same amount for services regardless of whether the patient is treated in an inpatient hospital or in an outpatient setting.

Site-neutral payments are a policy implemented by the Centers for Medicare and Medicaid Services that aims to reduce health care costs by aligning payment amounts for services provided in different care settings. One goal of site-neutral payments is to eliminate the incentive for providers to acquire facilities, such as physician offices or surgical centers, that Medicare reimburses at the lower non-facility rate and convert those settings into hospital outpatient departments, where Medicare reimburses at the higher facility rate. Although initiated by Congress to address payment disparities in Medicare, similar payment discrepancies can be seen in the commercial market where individual and employer-

sponsored health plans often pay more for certain outpatient services depending on their location.

Facility-fee restrictions and site-neutral payment policies address overlapping but distinct affordability issues. Facility-fee policies generally focus on whether an additional institutional charge may be billed or collected. Site-neutral payment policies focus more broadly on whether the total payment for a service should differ based on the setting in which it is furnished. Both approaches respond to circumstances in which a change in hospital ownership or billing designation may increase the cost of care even when the underlying service, location, quality of care, and resources involved have not materially changed.

Accurate identification of the location where a service was furnished is an important prerequisite for evaluating or administering facility-fee and site-neutral payment policies. When a hospital and multiple off-campus outpatient departments bill under the same National Provider Identifier, claims data may not clearly distinguish the main hospital campus from the individual locations where care was delivered. This can make it more difficult to identify facility fees, compare payments across settings, and evaluate the effects of hospital acquisitions or changes in provider-based status.

These billing and identification gaps can have direct affordability consequences. When routine outpatient services are reimbursed at higher hospital outpatient rates or include additional facility fees primarily because of hospital ownership or site designation, medical costs can increase without a corresponding change in the care delivered. These higher allowed amounts contribute to overall medical cost trends and, over time, can be reflected in higher premiums and increased consumer cost-sharing. Clear, site-specific claims information can help regulators and market participants determine whether payment differences reflect legitimate clinical or resource needs or are driven primarily by ownership and billing status.

RBP and Industry Concerns

Affordability policies should address the underlying drivers of health care costs while preserving competition, consumer access and choice, and potential movement toward value-based care. Considerations include:

- Preserving negotiated commercial arrangements. Broad payment ceilings or requirements tying commercial reimbursement to a fixed percentage of Medicare may displace negotiations that account for network participation, access, service availability, quality expectations, and local market conditions.
- Avoiding unintended pricing and access effects. A ceiling that is not appropriately calibrated may affect provider participation, network stability, or the availability of particular services. A payment floor may increase costs where negotiated rates are already below the benchmark. Either may also become a negotiating anchor rather than simply an outer payment limit.
- Maintaining flexibility to reward quality and value. RBP methodologies generally focus on the price of individual services and may not inherently account for clinical

outcomes, patient experience, care coordination, efficiency, or total cost of care. Uniform fee-for-service benchmarks may also be difficult to reconcile with bundled payments, shared savings, population-based payments, quality incentives, and other value-based arrangements unless those models are expressly accommodated.
- Matching the policy to the identified cost driver. Depending on the issue being addressed, more targeted tools—such as facility-fee limitations, unique site-level NPIs, accurate claims submission, honest-billing requirements, price transparency, competition policy, or consumer protections—may address specific affordability concerns without establishing a uniform commercial payment level.
- Protecting consumers and supporting workable implementation. Any RBP structure should clearly address balance billing, provider availability, continuity of care, clinical exceptions, appeals, treatment of amounts above the reference price, reliable claims data, and dispute resolution.
- Evaluating broader market effects. Assessment should extend beyond initial payment reductions to include premiums, consumer cost-sharing, access, quality, utilization, network participation, administrative burden, provider responses, and the continued development of value-based care.

Conclusion

The above policy approaches to reference-based pricing and RBP adjacent policies implemented by various states. Questions remain regarding the appropriate levels of RBP for different states and markets. RBP is typically limited to specific types of services (non-network, emergency, etc.) or specific plans such as a state-employee health benefits plan. This brief provides examples of RBP policies by different markets and states, but it is beyond the scope of this brief to identify other market or program factors that may simultaneously impact costs.

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Section 5: Enhanced Health Care Price Transparency

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Connection to Affordability

The lack of accessible information about health care prices, including what consumers can expect to pay for covered services, makes it difficult for consumers to anticipate and plan for health care costs and for policymakers to target affordability reforms. Competition among providers could help to improve affordability and reduce total system costs if those who purchase health care services were able to compare the price and quality of providers before making a decision to purchase. However, the prices of health care services are often hidden or unknown to consumers, employer plan sponsors, and others. Enhanced price transparency efforts aim to allow market forces to bring greater efficiency and affordability for health insurance. Federal and state policies have begun to mandate greater disclosure of prices in a growing number of settings.

Introduction

Health care costs represent a major driver of escalating commercial insurance premiums. To combat market inefficiencies, the US Departments of Labor, the Treasury, and the Centers for Medicare & Medicaid Services (CMS) issued the Hospital Price Transparency (HPT) Rule (effective 2021)[1] and the Transparency in Coverage (TiC) Rule (effective 2022),[2] mandating

[1] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public," Final Rule with Comment Period, 84 Fed. Reg. 65524 (Nov. 27, 2019) (CMS-1717-F2). URL: https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and

[2] Centers for Medicare & Medicaid Services, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model," Final Rule with Comment Period, 86 Fed. Reg. 63941 (Nov. 16, 2021) (CMS 1753-FC). URL: https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#page-63941

public release of gross charges, negotiated in-network rates, and out-of-network historical allowed amounts. In February 2025, a new Executive Order, "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information,"[3] directed federal agencies to continue the initiative for price transparency. CMS responded in May 2025 with guidance for new and updated HPT requirements, issued a final rule modifying HPT requirements November 25, 2025 (CMS-1834-FC),[4] and issued a final rule modifying TiC requirements October 6, 2026 (CMS-9882-F).[5]

States are also taking action to improve price transparency in health care. Structural barriers have, however, historically limited state-level oversight. As of 2025, 24 states operate All-Payer Claims Databases (APCDs), but states do not have authority to require submission of claims information from employer-sponsored, self-insured plans due to federal ERISA preemption. This preemption creates a significant blind spot in state health care spending data. Early market data also indicates that published pricing information may drive price convergence among providers. However, this convergence on its own does not necessarily produce consumer savings.

This brief details some of the ways state Departments or Divisions of Insurance (DOIs) have moved beyond passive consumer-facing tools. State insurance regulators and state employee health plans have worked to address cost drivers by integrating standardized HPT and TiC data, leveraging APCD data where available, protecting employer access to claims data under the Consolidated Appropriations Act (CAA) of 2021,[6] and supporting structural plan designs, such as reference-based pricing, tiered networks, site-of-care steering, and direct payment rate constraints. Most of the initiatives described below are facilitated by enhanced price transparency.

Health care price transparency rules aim to empower consumers to make informed health care decisions, increase market competition, and ultimately slow the rising costs of medical care and insurance by bringing clarity and standardized access to health care pricing. This brief examines the current state of federal and state health care price transparency initiatives, the technical and legal barriers to effective data utilization, and the strategies available to state insurance regulators and institutional purchasers to leverage price transparency data for systemic cost containment and overall improved health care affordability. Despite federal price transparency mandates, persistent structural barriers, some of which this brief discusses, have constrained the practical impact on health care costs. States are responding with an expanding range of strategies, such as hospital price

[3] White House, "Executive Order 14221: Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information," (February 2025). URL: https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information/

[4] Centers for Medicare & Medicaid Services, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity to Apply for Available Slots," Final Rule with Comment Period, 90 Fed. Reg. 53,448 (Nov. 25, 2025) (CMS-1834-FC). URL: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc

[5] U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, "Transparency in Coverage," Final Rule, 91 Fed. Reg. 63,748 (Oct. 6, 2026) (CMS-9882-F). URL: https://www.federalregister.gov/documents/2026/10/06/2026-20447/transparency-in-coverage

[6] 116th Congress (2019-2020), "H.R. 133 - Consolidated Appropriations Act, 2021," (2020, December 2). URL: https://www.congress.gov/bill/116th-congress/house-bill/133/text

transparency enforcement mechanisms, All-Payer Claims Database (APCD) modernization, and data-driven consumer initiatives.

Premium Impact and Savings Analysis: Driving Downstream Affordability Structures

While evidence is limited for increased affordability due to price transparency reforms alone, making prices available can support other state affordability efforts. Research supports limiting provider payment rates as one of the most effective strategies for containing costs[7], and several states have acted in this area.

Oregon

The State Employee Health Plan capped hospital reimbursements at twice the Medicare rate beginning in 2019. A subsequent peer-reviewed analysis in Health Affairs[8] found that this policy led to measurable reductions in hospital facility prices paid by the plan. While this approach requires a self-funded purchaser with sufficient market leverage and direct contracting authority, it offers a replicable model for other large public purchasers seeking to contain cost growth without narrowing provider networks.

Minnesota (State Employee Group Insurance Program) and Massachusetts (Group Insurance Commission)

State employee health managers in Minnesota (SEGIP) and Massachusetts (GIC) use clinical claims data to tier primary care practices based on total cost of care. Members receive substantially lower out-of-pocket costs when choosing top-tier providers, creating financial incentives for practices to remain cost-competitive to retain patients.

California (California Public Employees' Retirement System) and Utah (Public Employees' Health Program)

State plans in California (CalPERS) and Utah (PEHP) use benefit tiering to guide patients from higher-cost hospital outpatient departments to lower-cost independent diagnostic facilities for routine services, reducing per-episode spending without limiting clinical access.

Kansas (State Employee Health Plan) and Utah (PEHP)

Programs in Kansas (SEHP) and Utah (PEHP) use price transparency data to offer direct cash incentives to members who choose high-value providers, aligning individual cost-sharing decisions with broader plan cost-containment goals.

Price Transparency State Policy Options

Because consumers rarely know the price of health care services in advance, providers face limited pressure to compete based on price. States have responded with a range of

[7] Health Affairs Council on Health Care Spending and Value, A Road Map for Action: Recommendations of the Health Affairs Council on Health Care Spending and Value, February 2023. URL https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf

[8] Roslyn C. Murray, Christopher M. Whaley, Erin C. Fuse Brown, and Andrew M. Ryan, "Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy," Health Affairs (December 2024). URL: https://doi.org/10.1377/hlthaff.2024.00691

approaches, including the development of public tools, increased reporting, and other policies related to enhanced price transparency, some of which are summarized below.

State	Implementation Date	Key Variations/Notes
Arkansas	2023	Imposes state-level financial penalties on hospitals that fail to comply with federal HPT requirements, supplementing federal enforcement.
Arizona	2022	Designated the Department of Health Services as responsible for overseeing hospital compliance with federal HPT rules; requires public posting of noncompliant hospitals.
California	2017	Passed SB 17, requiring drug manufacturers to report price increases over a specific percentage.
Colorado	2024	Works with third parties to transform complex machine-readable files (MRFs) into an accessible consumer portal. Prohibits hospitals from initiating debt collection against patients for services rendered during any period of HPT noncompliance.
Indiana	2024	Administers an All Payer Claims Database (APCD) housing over 2.3 billion records across 7.7 million unique members. Includes an interactive mapping of procedure cost variations across ZIP codes.
Massachusetts	2025	Uses a centralized data hub to inform tiered provider networks where enrollees pay lower cost-sharing for high-value tiers.
Minnesota	2021	Expanded transparency requirements beyond hospitals to include outpatient surgical centers, large imaging/laboratory providers, and dental service providers.
New Hampshire	2019	Leveraged its APCD to host the "NH Health Cost" tool, which successfully reduced insurer prices for imaging services and other categories.
Oklahoma	2025	Enacted SB 889 (2025), requiring hospitals to publicly post consumer-friendly, machine-readable price lists for 300 common services, including standard gross charges, payer-specific negotiated rates, and discounted cash prices.
Texas	2019	Passed HB 2536, requiring drug manufacturers to report price increases over a specific percentage. Texas has codified federal HPT rules into state statute with enhanced penalties, extended TiC requirements to short-term limited duration plans, and issued state standardization guidance to improve data usability.
Washington	2025	Passed HB 1382 (2025) to modernize its APCD, removing statutory "proprietary financial information" protections to permit the disclosure of actual contract pricing and payer-negotiated rates.

The Current Health Care Price Transparency Landscape

Health care pricing in the United States historically operated behind confidential proprietary protection provisions, largely shielding employers and state regulators from the negotiated contractual prices of covered procedures. The implementation of the federal Hospital Price Transparency (HPT) regulation (2021) under Section 2718(e) of the Public Health Service Act, and the Transparency in Coverage (TiC) rules (2022), sought to dismantle this paradigm

by mandating the public disclosure of standard, cash-discounted, and third-party negotiated rates. Despite bipartisan support and federal administrative penalties of up to $5,500 per day for large non-compliant facilities, the mandated public cost data continues to face significant friction in producing measurable impacts to the costs of health care.

Early empirical data from analysis of published machine-readable file (MRF) data suggests that price transparency is beginning to affect market behavior, though not necessarily by reducing overall costs. A 2024 Turquoise Health analysis[9] examined inflation-adjusted commercially negotiated rates at over 200 hospitals across the 10 largest U.S. metro areas, covering 37 common services from December 2021 to June 2024. The analysis found that 82.8% of markets showed price convergence: rates in the top quartile fell approximately 6.3% (annualized, inflation-adjusted) while rates in the bottom quartile rose approximately 3.4%. Convergence was substantially more pronounced in outpatient services (87.4% of markets) than inpatient services (62.5% of markets). The study's author noted that converging rates are 'an encouraging sign that health care markets are responding to price transparency with increased market competition,' while cautioning that convergence toward a market equilibrium does not mean that prices are lower for consumers. The equilibrium point may itself be above the prior median for markets that were previously lower cost. The study does not establish causality between the transparency regulations and the observed convergence, and the author identifies this as an area requiring further research.

Research on consumer engagement with price transparency tools documents consistently low utilization rates. New Hampshire's APCD-based consumer price tool, for example, was used by approximately 8% of patients seeking imaging services and was associated with a 4% decline in imaging prices over five years.[10] These effects, however, do not extend meaningfully to hospital and physician services, where provider switching is substantially less common.

There are several primary reasons why consumer engagement with price transparency tools remains low:

1) Lack of Financial Incentive for Insured Patients: Because most patients have health insurance, they are largely insulated from the full cost of their care. Since out-of-pocket costs typically represent only a small fraction of the total negotiated or list price, insured patients often lack a strong financial motivation to price shop. By contrast, self-pay patients (who bear the full out-of-pocket cost) are significantly more likely to use price information and choose lower-priced hospitals for elective procedures. Patients also become much more responsive to price transparency when they face higher cost-sharing or reference-pricing programs (where they must pay the difference if their care exceeds a set benchmark).

[9] Forrest Xiao, "Examining the Health care Market Response to Transparency Regulations," Turquoise Health White Paper (October 2024). URL: https://turquoise.health/resources/blog/examining-rate-trends-by-annualized-rate-change-over-time

[10] Zach Y. Brown, "Equilibrium Effects of Health Care Price Information," The Review of Economics and Statistics (2019). doi: https://doi.org/10.1162/rest_a_00765

2) Poor Usability and Complexity of Data: The price data published by hospitals is often inconsistent, difficult to interpret, and fundamentally not consumer-friendly. Consumers struggle to accurately determine what their actual out-of-pocket expenses will be based on the raw data files provided. In one experimental study, only 19% of participants were able to successfully retrieve cost information directly from hospital websites because the task was so complex.[11]

3) Lack of Awareness: A major barrier to usage is simply that many patients are unaware that price transparency data or tools even exist. One study found that 64% of participants had never heard of the federal price transparency legislation, despite overwhelmingly agreeing that knowing the cost of a service beforehand is important.[12]

4) Reliance on Non-Price Factors: Patients often base their health care decisions on factors entirely unrelated to price. Provider reputation and physician referrals are often more critical to a patient's decision-making than cost, with physicians often referring patients to providers within their own hospital system even when cheaper alternatives exist. Furthermore, when patients do not know what services they need or require emergency care, they do not have the time or ability to price shop.

Summary of Key Challenges for Achieving Price Transparency

This matrix includes a list of key challenges to achieving price transparency.

Data Category	Observation/Finding	Source/Context
Stakeholder Feedback	America's Health Insurance Plans (AHIP) expressed concern about states adding unnecessary burdens on health plans by requiring additional transparency work in addition to the federal requirements.	AHIP (stakeholder comment)
Implementation Challenges	Insurers and Third-Party Administrators (TPAs) frequently assert proprietary intellectual property protections over contracted rate data.	CAA of 2021 (anti-gag and TiC provisions)
Implementation Challenges	Insurer TiC files are often extremely large and duplicative, making them unwieldy to parse, and hospitals have used placeholder values in HPT files, making the data unreliable.	CMS Price Transparency Fact Sheets (2025–2026)
Legal/Regulatory Issues	Under the Supreme Court's ruling in *Gobeille v. Liberty Mutual Insurance Co. (2016)*, states cannot compel self-insured ERISA plans to report claims data to state APCDs, leaving a blind spot in state health care spend tracking.	Gobeille v. Liberty Mutual Ins. Co., 577 U.S. 312 (2016)
Legal/Regulatory Issues	State DOIs have direct regulatory authority over risk-bearing insurance carriers but lack direct jurisdiction over health care provider systems and self-funded employer plans.	Maanasa Kona and Nadia Stovicek (Health Affairs Forefront) (2024)

[11] Maleki N, Padmanabhan B, Dutta K. Usability of Health Care Price Transparency Data in the United States: Mixed Methods Study. J Med Internet Res 2024;26:e50629 URL: https://www.jmir.org/2024/1/e50629

[12] Maleki et al.

Data Category	Observation/Finding	Source/Context
Unexpected Outcomes	A notable market effect of publishing negotiated price data is rate convergence rather than across-the-board cost reduction. See 2024 Turquoise Health analysis of 200+ hospitals across the 10 largest U.S. metro areas.	Forrest Xiao (Turquoise Health) (2024)

Deficiencies of Current Machine-Readable File and Transparency in Coverage Data Pipelines

The primary operational barriers to effective price transparency under current federal requirements include the large number of files, the size of data, inconsistent formatting, and variations in file structure. Insurers' and hospitals' machine-readable files are frequently very large and contain substantial superfluous information. Some of these deficiencies are being addressed by federal rulemaking, as noted below.

A specific and well-documented data quality problem compounds the volume challenge. Hospitals were permitted to enter the numeric placeholder "999999999" for any service lacking sufficient historical claims data; CMS found this practice was used far more broadly than intended, sometimes appearing across many listed services within a single hospital file and rendering those entries non-comparable. CMS's May 2025 guidance and November 2025 Final Rule (CMS-1834-FC, 90 Fed. Reg. 53,448 (November 25, 2025)) directed hospitals to discontinue the placeholder and instead report the actual 10th, median, and 90th percentile allowed amounts drawn from electronic remittance data covering the prior twelve to fifteen months.

TiC files have presented parallel issues: they frequently include unlikely provider-rate combinations (such as a cardiac surgery rate attached to a podiatrist) and they are required to be updated monthly regardless of whether the underlying rates change, generating unwieldy and often duplicative datasets by plan. The US Departments' *Transparency in Coverage Final Rule* (CMS-9882-F, 91 Fed. Reg. 63,748 (Oct. 6, 2026)) aims to address these and other related issues. Beginning March 6, 2027, plans and issuers must remove unlikely rate combinations, post one In-network Rate File for each provider network rather than for each plan, and update the In-network Rate and Out-of-network Allowed Amount Files quarterly rather than monthly.

Compounding this technical challenge are the structural validation issues. Parallel comparison audits evaluating insurer-posted TiC rates against hospital-disclosed lists identify wide, unexplainable discrepancies. Data integrity, inconsistent naming conventions, and limited provider details such as location can also contribute to the deficiencies of MRFs. These underlying inconsistencies fundamentally devalue the utility of the files, since market analysts cannot rely on their accuracy. Locating the files has also been difficult. Beginning September 6, 2027, plans and issuers must post a plain-text file in the root folder of their website identifying where their machine-readable files are located and providing a monitored contact for questions, and must add a homepage footer link labeled "Price Transparency" or "Transparency in Coverage."

State DOI Strategies: Activating Data for Market Redesign

Historically, direct consumer shopping has produced limited and inconsistent impacts on overall health care spending. The most valuable and impactful uses of enhanced price transparency lie with institutional purchasers, large employers, state employee health plans, and state regulators rather than individual consumers.

Individual states often lack direct statutory authority to hold health care facilities accountable for pricing practices; however, there are measures that states can take to promote market efficiency:

1) Enforcing TiC and HPT compliance promotes value-based purchasing and competitive pricing. Increasing visibility and enforcement allows DOIs an opportunity to make impactful changes using standards that are already in place. By promoting these data elements, states can empower consumers to make more informed health care decisions.
2) Supporting APCD infrastructure promotes data visibility, enhanced value-based purchasing, policy development, consumer empowerment, and fosters competition and cost control. Enhanced APCD tools, like those used in Indiana, can give consumers the ability to research and utilize real-time pricing data within an APCD database and have more control over their health care.
3) Enforcing employer access to data under the CAA of 2021 promotes trust, data integrity, informed decision making, and greater bargaining power, while also reducing administration costs.

Several states have developed independent enforcement measures that supplement or go beyond federal HPT requirements:

1) Arizona designated its Department of Health Services as responsible for overseeing hospital compliance with federal HPT rules and requires the agency to publicly post information about noncompliant hospitals, creating a public accountability mechanism not present at the federal level.
2) Arkansas imposes state-level financial penalties on hospitals that fail to comply with federal HPT requirements, supplementing federal enforcement resources.
3) Colorado prohibits hospitals from initiating debt collection against patients for services rendered during any period of HPT noncompliance, linking a hospital's billing rights directly to its transparency compliance.
4) Texas has codified the federal HPT rules into state statute with enhanced penalties, extended TiC disclosure requirements to short-term limited duration plans not otherwise covered by federal rules, and issued detailed state standardization guidance designed to improve the usability of disclosed pricing data.

State-level APCD tools provide comprehensive multi-market tracking, but their coverage is substantially constrained by ERISA preemption. As of 2025, 24 states operated APCDs. The Supreme Court's ruling in Gobeille v. Liberty Mutual Insurance Co., 577 U.S. 312 (2016),

held that states cannot compel self-insured employer plans, regulated under ERISA, to report data to state APCDs. Because approximately 67% of workers with employer-sponsored insurance (ESI) are enrolled in self-insured plans, this constraint creates a significant reporting gap: in some states, the share of ESI lives reported to the APCD is as low as 25%.[13] States can partially address this gap by offering voluntary participation incentives, such as providing participating employers with access to aggregated benchmark data in return for submission.

These varied state mechanisms demonstrate that DOIs and state health agencies have meaningful tools available to expand the availability of price information.

Approaches for Realizing the Promise of Consumer Price Transparency

Health care price transparency has long been a challenge, and it has garnered increased attention in the past five years as insurance premiums have continued to rise. There are several ways that regulators, insurers, and providers may support increased transparency to assist consumers in utilizing appropriate health care.

- Focus on Out-of-Pocket Costs: Policies and tools should prioritize showing out-of-pocket expenses rather than just hospital list prices or negotiated net prices. Because most patients are insured, out-of-pocket costs are the most relevant factor in their decision-making process.
- Standardize Data Formats: Hospitals currently use inconsistent data schemas, making it difficult for developers and machines to process the information. Enforcing a uniform schema with "master field names" across all health systems would significantly improve the ability of third parties to build accurate estimation tools.
- Provide Clear Documentation: Data files should include comprehensive documentation that clearly explains column meanings, coverage limits, and contracting methods (e.g., whether a price is a per-diem cost), so that consumers and developers can accurately calculate final costs.
- Combine Price and Quality Data: Tools should merge hospital pricing files with quality ratings (such as CMS Hospital Compare) and insurance details, allowing patients to make side-by-side comparisons of both cost and quality simultaneously.
- Implement Reference Pricing: Research shows that consumers are much more responsive to price transparency when it is combined with stronger financial incentives. Programs like "reference pricing"— where an insurer sets a benchmark price for a procedure, and the patient must pay the difference if they choose a more expensive provider — have been shown to actively encourage price shopping. See Section 4.
- Increase Public Awareness: Because most patients do not even know price transparency legislation exists, targeted awareness campaigns are necessary to educate consumers about their right to access cost information before receiving care.

[13] Katherine Grace Carman; Michael Dworsky; Sara Heins; Dan Schwam; Shoshana Shelton; Christopher Whaley The History, Promise and Challenges of State All Payer Claims Databases, June 2021. URL: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/200696/apcd-background-report.pdf

Other Price Transparency Data for Consideration

This matrix includes other price transparency data for consideration.

Key Data Point	Value/Metric	Description
Impacted Population	222,700,000	Number of citizens with private health coverage in 2024. Private health insurance includes employer or union sponsored, coverage purchased directly, or TRICARE.
Commercial Health care Spending	~$1.644 trillion	Direct annual health care spending managed by private and public commercial plan purchasers. CMS National Health Expenditure Accounts (2024) report private insurance spending at $1.644 trillion.
Site-of-Care Cost Difference	1.27 to 13.5 times higher	Increased cost of routine services at a hospital outpatient setting compared to the cost of the same service at an independent physician office.
Hospital Price Transparency (HPT) Compliance Issues	46%	Percent of hospitals that did not comply with the HPT rule.
Consumer Engagement	Less than 10%	Percent of consumers who utilize existing carrier price transparency tools.
Commercial Cash-Price Arbitrage	47%	Percentage of instances where a hospital's self-pay/cash price is lower than the median in-network commercial negotiated rate for the identical shoppable service.
Market Price Convergence	About 80% of markets showed convergence	Percentage of hospital markets (across 10 largest U.S. metros, 37 services) showing inflation-adjusted rate convergence between Dec. 2021 and June 2024. Top-quartile rates fell ~6.3%; bottom-quartile rates rose ~3.4% (annualized). Stronger in outpatient (87.4%) than inpatient (62.5%) settings.

Conclusion

Competition based on price helps to maintain affordability in many sectors, but it has been less effective in containing health care costs because prices are often hidden or unknown to consumers. While factors other than price influence consumers' health care choices, enhanced price transparency could introduce greater efficiency in health care markets and make health insurance more affordable. To date, evidence for this effect is limited, with some experience showing prices may converge rather than lower overall when they are more widely known. Nonetheless, several states have worked to build on federal price transparency requirements and their own all-payer claims databases. States have taken steps to increase compliance with hospital price transparency rules and used their state employee health plans to incentivize the use of higher-value providers. Making provider prices accessible to market participants and regulators can also provide critical support for

other health insurance affordability policies, like reference-based pricing, price caps, or oversight of provider integration.

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National Academy for State Health Policy (NASHP) Hospital Cost Tool (HCT 5.0), housing structural cost reports and commercial breakeven calculations across 5,000+ general acute hospitals: https://tool.nashp.org/

Section 6: Alternative Drug Channels: Coupons, Discount Cards, and Direct-to-Consumer

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Connection to Affordability

Prescription drugs account for a significant share of overall health care costs, ranging from an estimated 11% of personal expenditures to over 25% of commercial health insurance premium dollars. With the advent of online drug platforms and the overall increase in the use of telehealth services since the COVID pandemic, more consumers are shopping around for prescription discounts that may or may not coordinate with their insurance plan. If the spending associated with these online delivery methods can be integrated into a consumer's coverage, then a fuller picture of usage and out-of-pocket costs can be seen. This transparency can lead to more competitive pricing, more cohesive care, and acknowledgement of health care costs that are currently unaccounted for.

Introduction

This document seeks to address three different types of drug purchasing pathways currently available, how those options do or do not interact with the pharmacy benefits typically available through health insurance, and the impact on overall health care affordability. State policy options will be presented along with their benefits and disadvantages.

The creation, distribution, and purchasing of drugs is exceedingly complicated and involves many different players. Other NAIC groups are investigating areas such as Pharmacy Benefit Managers and Prescription Drug Affordability Boards, so they will not be addressed here.

To fully investigate alternative drug channels, regulators should understand three different ecospheres of prescription drug distribution: discount cards, manufacturer coupon cards, and true direct-to-consumer platforms.

Discount Cards

Discount pharmacy plans and cards offer pre-negotiated cash prices for prescriptions. Discount card vendors often contract with PBMs to provide consumers ("members") with

access to discounted prices at participating pharmacies. Discount card transactions often include an administrative fee that is reflected in the amount paid by the "member" at the point of sale. Because the transaction occurs outside the health plan's benefit structure, consumer payments generally are not applied toward plan deductibles, out-of-pocket maximums, or other cost-sharing accumulators. Significant discounting raises questions about drug pricing transparency and the extent to which negotiated prices accurately reflecting underlying market costs.

Manufacturer Coupon Cards

Manufacturer coupon cards provide patients with cost savings on brand name medications. The card applies a set amount toward the patient's cost share and may be valid for one-time or multiple uses, subject to manufacturer limits.

Manufacturer coupon cards are typically available only for a limited period and may not provide a sustainable long-term solution. Consumers are often unaware that these programs have expiration dates or other eligibility limitations. States may want to consider requesting additional transparency of these programs so that consumers understand their limitations, and regulators can better understand the impact they are having on health care affordability in their state.

Additionally, accumulator adjustment programs (AAPs) are used by plans and PBMs to prevent manufacturer assistance from being applied toward the consumer's deductible or out-of-pocket maximums. Twenty-five (25) states, D.C. and Puerto Rico have addressed this practice by passing laws requiring that any copay assistance be applied to a patient's cost-sharing limits.[1] In these cases, the consumer has incurred little or no direct cost because the manufacturer, rather than the consumer, is funding the assistance.

While these programs typically lower consumers' out-of-pocket costs at the point of sale, they may steer consumers toward higher-cost brand name drugs when clinically appropriate lower-cost generic alternatives are available. Some commentators believe that such programs suppress the use and ultimately the development of lower-cost products.

Direct-to-Consumer Platforms

Direct-to-Consumer pharmacies provide consumers with access to medications at a cash price that is not adjudicated through their health insurance coverage. These pharmacies may offer lower prices for certain drugs; however, because the transaction occurs outside the health plan's benefit structure, consumer payments generally are not applied toward plan deductibles, out-of-pocket maximums, or other cost-sharing accumulators. While new online platforms have generated public attention to Direct-to-Consumer sales, many chain pharmacies have long-standing discount programs that operate similarly.

Direct-to-Consumer sales offered by pharmaceutical manufacturers involve providing medication to consumers at a discounted cash price. Consumers create an online account

[1] Mark Gooding; Zachary Klein; Leah Porter, State copay accumulator bans now affect at least 17% of commercial lives, Avalere Health, December 10, 2025.

to obtain prescription medications at prices that may be cheaper cash prices, with the medications mailed to their homes via mail order pharmacy. Because the transaction occurs outside the health plan's benefit structure, consumer payments generally are not applied toward plan deductibles, out-of-pocket maximums, or other cost-sharing accumulators.

Direct-to-consumer telehealth platforms provide telehealth medical appointments and mail order drug purchases to patients. Some platforms accept insurance; however, the model we are exploring in this paper does not accept insurance. Because the transaction occurs outside the health plan's benefit structure, consumer payments generally are not applied toward plan deductibles, out-of-pocket maximums, or other cost-sharing accumulators.

A commentator notes that Direct to Consumer sales can limit the visibility of the consumer's full medication regimen to their health plan, potentially interfering with care coordination, medication adherence and the ability to identify potential interactions or duplicative treatment.

Premium Impact and Savings Analysis

The effects of direct-to-consumer drug platforms, discount pharmacy cards, and manufacturer coupon cards on health insurance affordability are complex. They depend on the specific products purchased, their value, the prices available through each pathway, as well as how the programs impact the behavior of consumers and other market participants. These programs could reduce overall health costs if they provide affordable access to effective medications that consumers would not otherwise find affordable. However, they may raise overall health costs if they lead to the use of more drugs or more expensive drugs without commensurate health benefits. Because they operate outside of existing pharmacy benefits, they may shift spending away from insurance providers without reducing overall system costs.

The impact of these drug programs also varies from person to person. For the uninsured, these programs may provide valuable discounts on drugs. The savings are harder to quantify for consumers with insurance, and may depend on the specific medication, the plan's formulary and benefit design and whether the consumer has met their deductible. If a drug isn't covered by a consumer's plan, these drug programs *may* save the consumer money. It is important to remember there may be an alternative medication, such as a generic alternative, available that is covered by the plan or an exceptions process that could allow coverage for a drug excluded from a plan formulary. By using one of these programs instead of using a covered alternative, a consumer may incur out-of-pocket costs that are not applied to their deductible or out-of-pocket maximum.

It is important to distinguish between direct-to-consumer pharmacy programs, discount pharmacy cards, and manufacturer coupon cards. When a direct-to-consumer pharmacy or discount pharmacy card is used, the consumer pays the cost of the prescription out of pocket, often at a discounted cash price. These payments generally are not credited toward the consumer's deductible or out-of-pocket maximum because the claim is not processed through the health plan, thus the consumer incurs an actual financial expense.

Manufacturer coupon cards reduce or eliminate the consumer's out-of-pocket cost through financial support provided by the drug manufacturer. In states that do not require the value of the coupon card to be applied toward the consumer's deductible or out-of-pocket maximum, the consumer has incurred little or no cost because the manufacturer, rather than the consumer, is funding the coupon card.

If a drug is covered by a consumer's plan, direct-to-consumer pharmacies and discount pharmacy cards may provide lower upfront costs. These programs could, however, ultimately work against consumers because amounts paid for drugs purchased using direct-to-consumer pharmacies or discount pharmacy cards are typically not counted towards the consumers' deductibles. As a result, a consumer may continue to incur cost-sharing obligations for other covered services, such as physician visits or medical procedures, for a longer period than if the prescription had been obtained through the health plan.

Manufacturer coupons are issued for brand name drugs to keep them competitive with generic alternatives by offering consumers short-term savings at the point of purchase. Consumers pay less out of pocket, which encourages them to use a brand-name drug, even when a less expensive generic alternative or biosimilar might be available through their plan. Some insurers say this encourages the unnecessary use of more expensive brand name drugs which results in higher premiums and overall costs to consumers.

To mitigate the effect of manufacturer coupons on formulary design, some insurers use copay adjustment programs. The two most common types are Copay Accumulators and Copay Maximizers. In both of these situations, consumers may use drug coupons, but the value of the manufacturer assistance is not applied to the plan's deductible or out-of-pocket maximum. As a result, consumers may not reach those limits and may face out-of-pocket costs if manufacturer assistance is exhausted before the end of the plan year. Some maximizer programs are designed to address this possibility by using a third party to spread the value of the manufacturer's assistance over the course of the benefit year, reducing the likelihood the assistance will be depleted prematurely.

State Policy Options

State policy options for addressing alternative drug channels depend on policymakers' goals and the regulatory tools available for each of the pathways. States have established extensive regulation of health insurance issuers and pharmacy benefit managers but have less authority and regulatory experience regarding drug manufacturers and drug discount programs. States may wish to ensure out-of-pocket spending limits distinguish between costs paid by the consumer and amounts funded by a manufacturer or other third party and recognize the potential for manufacturer coupons to encourage consumers to use higher cost products.

States have taken several actions to direct how health insurance issuers apply spending to cost-sharing obligations and to make drugs available to consumers. States considering policies that credit consumer expenditures made outside the health plan benefit toward

deductibles or annual out-of-pocket limits should consider balancing consumer access to lower prescription drug prices with issuer administrative and actuarial considerations. Key considerations include ensuring credit for legitimate out-of-pocket expenditures, preserving patient-safety and care-coordination mechanisms, maintaining appropriate formulary incentives, limiting opportunities for circumvention by manufacturers or other market participants, and avoiding unintended premium impacts for the broader insured population.

Rules on Out-of-Pocket Calculations

Twenty-five states, the District of Columbia, and Puerto Rico have laws to require any payment or discount made by or on behalf of a consumer to be applied to the consumer's annual out-of-pocket cost-sharing requirement. Some examples include:

Colorado
Beginning on January 1, 2028, a health insurance carrier shall account for and credit an out-of-pocket expense that the covered person incurs by purchasing a prescription drug directly from a pharmacy or direct-to-consumer platform when calculating a covered person's contribution to an out-of-pocket maximum or cost-sharing requirement. To receive a credit, an enrollee must provide proof of payment for a direct purchase of a prescription drug, such as an itemized receipt or pharmacy record, within 90 days after making the purchase. The carrier may request additional information or documentation if the proof of payment is insufficient or incomplete. The carrier shall not apply a contribution credit if the amount of a covered person's out-of-pocket expense is greater than the amount the covered person would have incurred if they had obtained the same prescription drug in the same plan year from an in-network pharmacy and pursuant to the terms of their plan or if the enrollee does not comply with the carrier's utilization management processes, including prior authorization and step therapy protocols required under the plan.

Connecticut
Beginning July 1, 2026, Connecticut health carriers must credit to an enrollee's cost-sharing requirement any in-network out-of-pocket prescription drug payments made directly to a pharmacy or health care provider, as long as no claim for the drug was submitted to the carrier, the drug is a covered benefit, and the drug's price is below the plan's or policy's average in network discounted rate. Carriers must also create a proof-of-payment form for out-of-pocket prescription drug purchases, post the form online, and provide annual instructions to enrollees on how to access and submit it.

Maryland
Beginning on January 1, 2026, when calculating an enrollee's contribution to out–of–pocket costs, insurers shall include any discount, financial assistance payment, product voucher, or other out–of–pocket expense made by or on behalf of the enrollee for a prescription drug. The drug must be either covered under the plan and not have an AB–rated generic equivalent drug or an interchangeable biological product preferred under the health benefit plan's formulary or have an AB–rated generic equivalent drug or an interchangeable

biological product preferred under the health benefit plan's formulary and the insured or enrollee originally obtained coverage for that product through prior authorization, a step therapy protocol, or the exception or appeal process of the issuer.

State Bulk Purchasing

While not directly addressing the distribution pathways discussed above, state bulk purchasing of drugs is another option to drive down consumer costs. This comes with a large effort on the part of the state to legislate and implement such a program, but can be beneficial if drugs are chosen wisely and offered at lower prices to consumers.

California

CalRx: The California Affordable Drug Manufacturing Act of 2020, also known as CalRx, authorizes the state Health and Human Services agency to enter into contracts and partnerships for the purpose of making pharmaceuticals more affordable. The statute authorizes the creation of a California-branded label for generic drugs, with the goals of ensuring access to generic prescription drugs and lowering health care costs through savings to public health care programs and private health insurance coverage. To date, the state has implemented two drug delivery models, promoting access to a biosimilar insulin injection product and a naloxone nasal spray.

- Insulin: Californians with diabetes often struggle to afford needed insulin. CalRx, in partnership with Civica, provides Glargine biosimilar insulin pens through participating pharmacies. CalRx Insulin is eligible for health insurance coverage and is available to patients with an existing prescription for similar insulin products. The product is currently priced at $55 for a 10-pack of 3 milliliter pens. The product is not currently available in other formats, such as vials.
- Naloxone: While Naloxone is currently available without a prescription throughout the U.S., it unaffordable for many consumers. California's CalRx program provides a twin pack of naloxone nasal spray to state residents through participating pharmacies and direct online sales. The product is provided free of charge to first responders, health care providers, schools and community organizations and at a reduced cost, currently $19, to individuals.

The CalRx naloxone program is managed by the state Department of Health care Services (DHCS), through a partnership with a manufacturer, Amneal. The program receives financial support from an opioid settlement fund.

Conclusion

The ability for consumers to access prescriptions through online and mail order platforms has changed the traditional landscape of pharmacy services. These alternative methods are likely to increase and it is important to coordinate with insurers to understand the total cost of care and ensure patient safety. Many of the state options listed above are new, so it is imperative to track the progress of implementation to see how much impact these tools make on the affordability of the plans and the drugs themselves.

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