

August 28, 2026

Kate Harris
Chair
Health Care Affordability and Mitigation Working Group (B)
National Association of Insurance Commissioners
1100 Walnut St., Ste. 1500
Kansas City, MO 64106

RE: AMA Feedback on Draft Affordability Briefs

Dear Chair Harris and Members of the Health Care Affordability and Mitigation Working Group:

On behalf of the physician and student members of the American Medical Association (AMA), thank you for the opportunity to submit comments on the Draft Affordability Briefs (issue briefs). It is clear a great deal of time and research went into developing each of these issue briefs. After reviewing, we have several suggestions that we think will help improve the usability of these documents by policymakers and other stakeholders considering policy reforms to increase the affordability of healthcare.

Very broadly, we suggest that all of the issue briefs could be improved with greater consistency in structure, including a clearer purpose statement in each. These purpose statements could highlight the issue, explain how the policies in each of the issue briefs were chosen, and the ways in which each of the briefs could and should be utilized by policymakers and other stakeholders. Additionally, where possible and available, we recommend that each issue brief offer research and/or other evidence of success related to the identified policies in increasing affordability or healthcare coverage for patients.

We offer some additional suggestions on several of the individual issues briefs for your consideration.

Issue Brief #1: Standardizing or Limiting Utilization Review to Reduce Administrative Costs

Utilization management programs, including and especially prior authorization, continue to be a leading source of frustration for patients and physicians, often resulting in treatment delays, denials of medically necessary care, and, ultimately, poorer patient health outcomes. In an [AMA's 2025 prior authorization physician survey](#), 95 percent of physicians cited care delays linked to prior authorization, 79 percent reported that it sometimes causes patients to abandon recommended treatment, and more than one in four physicians witnessed prior authorization leading to a serious adverse event for a patient, including hospitalization, disability, or death. The consequences are particularly acute for patients with complex or life-threatening conditions, such as cancer. A [recent survey of oncology professionals](#) found that nearly all participants reported patients experiencing harm due to prior authorization delays, including disease progression (80 percent) and even loss of life (36 percent).

In addition to the threat to patients' health outcomes, utilization management, despite claims to the contrary, fails to lower costs. Drug utilization management alone costs \$93.3 billion annually, according

to a [study](#) published in *Health Affairs*. The study estimates that utilization management requirements cost payers \$6 billion, manufacturers \$24.8 billion, physicians \$26.7 billion, and patients \$35.8 billion annually.

Physicians and their staff spend substantial time navigating utilization management programs, including prior authorization requirements, that often provide little clinical value while imposing significant operational costs on physician practices. Reducing unnecessary administrative burdens in health insurance programs represents an important opportunity to improve efficiency and reduce system-wide healthcare spending.

As such, the AMA appreciates that the Health Care Affordability and Mitigation Working Group (Working Group) appropriately connected utilization management reform and affordability and identified these as priority issues in its drafting effort. While the three reforms included in the issue brief (limiting prior authorization for certain care, standardizing prior authorization forms and information, and electronic prior authorization) are very important, we strongly suggest that the issue brief incorporate additional reform efforts that have gained national momentum and have been adopted by several states. These reforms include:

- **Requiring utilization management programs to use standardized and evidenced-based clinical criteria that align with nationally recognized standards of care developed by national medical specialty societies.** Efforts to increase automation of prior authorization are very important, however, automation will only lead to the *wrong* decision faster if the clinical criteria used to make the determinations are not grounded in established medical evidence and reflect current standards of care. Consistent use of evidence-based clinical criteria developed by physician experts will promote appropriate, high-quality care, lessen unnecessary variation in coverage decisions, and reduce delays and administrative burden.
- **Requirements that denials be determined by a licensed physician in the same specialty as the treating physician, and with the training, knowledge, and experience of providing the healthcare services under review.** Many states are now requiring these types of qualifications of the plan reviewer to help reduce inappropriate initial denials and increase access to timely, medically necessary care. Too often unqualified reviewers make erroneous adverse determinations that are infrequently appealed, reducing access to needed care and increasing financial stress on patients. Notably, 75 percent of physicians report that denials have increased in the last five years, but only one in five say that they always appeal due to the perceived outcome of the appeal, lack of resources to complete the appeal, or the urgency of care that necessitates timely treatment.
- **Mandated health plan data reporting to the public and regulators on prior authorization at the individual services/drug level.** Many states have recognized the potential to take meaningful steps toward increasing the transparency of prior authorization requirements by requiring reporting of data both at the individual health plan level and to regulators. This type of data reporting has become increasingly important in state reform efforts across the country, as little data is available to patients, physicians, and policymakers about what services are most targeted for prior authorization requirements, how quickly decisions are made, how frequently services are approved versus denied, etc. Increased access to meaningful data will help patients make informed decisions about their health plans. Additionally, this information can inform more targeted policies that protect patients and increase efficiency.
- **Continuity of care requirements, including ensuring a prior authorization is valid for at least a year or the length of treatment, and that there should never be repeated prior authorization requirements for the treatment of chronic or long-term conditions.** Forcing patients to obtain prior authorization for care that has already been previously authorized

threatens patient outcomes, reduces patient stability, and wastes resources. [AMA survey data](#) show that 88 percent of physicians report that prior authorization interferes with continuity of care and 61 percent report that prior authorization at least sometimes destabilizes a patient previously stabilized on a specific treatment plan.

The AMA would be happy to provide additional information about any of these reforms, our physician survey, or the physician experience with prior authorization requirements and other utilization management programs.

Issue Brief #2: Horizontal and Vertical Integration in Health Care

We appreciate the Working Group's focus on vertical and horizontal integration in healthcare and its impact on affordability and competition. As the Working Group finalizes this issue brief, the following are a few suggestions to improve the content and its usability.

- **Definitions:** We recommend refining the definitions of horizontal and vertical integration in this issue brief. Specifically, consistency in verbiage in the definitions is necessary to assist the reader in clearly understanding the different types of integration (e.g., horizontal integration involves organizations at the same stage in the supply chain and vertical integration involves organizations at different stages in the supply chain). Additionally, the definition of horizontal integration implies that such integration can only happen through mergers; however, it can also be accomplished via common ownership or through contractual relationships (e.g., an Independent Physician Association (IPA) is not merged but is partially integrated).
- **Examples of integration:** To better frame the discussion on horizontal integration, we suggest identifying clear horizontal integration cases such as the merger of two hospitals or two insurers. Under the same section, we suggest adding additional examples of simultaneously vertically and horizontally integrated entities, such as ACOs, which readers of the issue brief may find more familiar.
- **Efforts to regulate vertical integration:** We suggest limiting examples in this section to only enacted laws or established policies, rather than proposed efforts. Additionally, we suggest you consider identifying the challenges to regulating vertical integration, including preemption challenges to the highlighted pharmacy benefit manager (PBM) laws, and providing more information on litigation. Much of this could be accomplished by simply linking to existing NAIC resources, including the recently adopted Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage Working Group's guidance document on ERISA preemption and PBM laws.
- **Efforts to regulate horizontal integration:** In this section, we understand why these laws are identified, but suggest that they are not necessarily about integration as much as they are about protecting patients and physicians from the inappropriate influence of private equity (PE) and management services organizations (recognizing that there are horizontal concerns when PE firms "roll-up" multiple practices, for example). As such, we would like to posit that state merger notification laws could be more relevant in this section to identify and discuss – with the caveat that depending on how state merger notification laws are structured, they could address both horizontal and vertical mergers.

Because integration in healthcare is rightfully part of the conversation on competition and prices, we wanted to offer two AMA studies looking at competition and consolidation in the health insurance and PBM markets that may be useful to the Working Group and policymakers, as well as an additional AMA study on the ownership of physician practices.

- The AMA recently published our 24th edition of “[Competition in health insurance: A comprehensive study of U.S. markets](#).” This study presents information on market concentration in the U.S. health insurance industry and is intended to help researchers, policymakers, and federal and state regulators identify markets where mergers and acquisitions involving health insurers may cause competitive harm. The most recent study found that 97 percent of commercial health insurance markets in metropolitan statistical areas (MSA) were highly concentrated. High market concentration tends to lower competition and facilitates the exercise of market power. Where health insurers exercise market power, [patient premiums tend to be higher](#), impacting healthcare affordability for patients.
- The AMA also recently published [Competition in PBM Markets and Vertical Integration of Insurers with PBMs](#) to consider if PBM markets are competitive and the extent of vertical integration between PBMs and insurers. The study found that the four largest PBMs collectively had a 67 percent share of the national PBM market and that 77 percent of commercial and Part D enrollees were in a prescription drug plan where the insurer and PBM were vertically integrated.
- The [AMA’s 2024 Physician Practice Benchmark Survey](#) shows that physicians increasingly work in practices owned by hospitals or other organizations and not by physicians. Physicians reported that the lack of negotiating leverage is a longstanding and important driver of this change. Consolidation in the healthcare industry exacerbates the vulnerability of independent physician practices which historically have provided personalized and locally responsive healthcare services.

We are happy to provide more information on this research and discuss the studies with the Working Group and policymakers at any time.

Issue Brief #3: Develop State-Defined Plans with Premium Reduction Targets

The AMA supports universal access to health insurance while preserving patient choice and appreciates that the Working Group prioritized patient choice in this issue brief. We are concerned, however, by a focus on “mandate-lite” products as a potential solution to unaffordability. While lower premiums may appear to improve affordability, plans that achieve premium reductions by limiting covered benefits or increasing cost-sharing may instead shift costs onto patients and create new barriers to care. Moreover, pulling younger and healthier patients away from comprehensive coverage options is likely to result in increased costs, including increased premiums, for those needing comprehensive coverage.

As such, we suggest that “state-defined plans” included in the issue brief as potential solutions to affordability challenges should be evaluated not only on premium levels, but also on total patient out-of-pocket costs and whether the proposal genuinely improves affordability without compromising patient access. While transparency on benefit limitations is extremely important and appreciated, it is our position that this cannot make up for the potential cost-shift onto patients and the challenges to affordability that these coverage options may present.

Issue Brief #4: Reference-Based Pricing

We appreciate the Working Group's attention to policy outcomes and research evaluating the impact of reference-based pricing (RBP) or RBP-adjacent policies. Additionally, we are encouraged by the placeholder in the issue brief that would allow for stakeholder input and concerns on RBP policies. Given this opportunity, we thought it might be useful to offer AMA policy in the form of suggested guardrails for RBP efforts to ensure success. Generally, the AMA supports the use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, when the following protections are in place:

- Practicing physicians are actively involved in the identification of services that are appropriate for a reference pricing system.
- The focus is on elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during treatment, and the sufficient availability of providers in a geographic region.
- Reference prices are reflective of current market conditions and ensure that patients have access to a choice of physicians and providers. Prices should be reviewed annually and adjusted based on changes in market conditions.
- Information about the services subject to reference pricing and the potential patient cost-sharing obligations should be transparent and accessible to patients, physicians, and other providers, prior to and at the point of care.
- Health plans should notify patients of all services subject to reference pricing at the time of enrollment and patients should be indemnified against any charges to reference pricing policies for the balance of the contract period.
- Health plans that use reference pricing should maintain systems that permit patients to compare prices, including systems that help patients calculate their estimated costs for each provider prior to care.
- Health plans and policymakers should continually evaluate the effect of policies on access to quality care and ensure that procedures are in place to make modifications.

Additionally, as the Working Group moves forward with finalizing this issue brief, we think it is important to evaluate the success of RBP policies not solely from a premium reduction or cost-savings perspective but also in the context of affordable access to medically necessary care for patients, including access to a sustainable physician workforce. For example, reference prices that are based on Medicare rates may reduce premiums initially but, given [Medicare's failure to keep pace with the costs of running a practice](#), the mid- and long-term impact could be cost shifting onto patients and increasing provider consolidation, insurer and hospital ownership of practices, and infusion of PE funding into practices when independent physician practices are unable to maintain financial viability. These outcomes are likely to decrease affordability of care.

Issue Brief #5: Enhanced Health Care Price Transparency

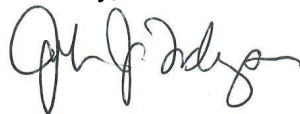
Price transparency can help empower consumers to make informed decisions about their care and improve the overall efficiency and cost effectiveness of our healthcare system; however meaningful price transparency can be difficult to achieve. We appreciate that this issue brief explores many of the challenges to meaningful price transparency and consumer engagement with price transparency tools and think even more exploration of the barriers would be useful to identify the best policy solutions. For example:

- In the section discussing challenges to consumer engagement with price transparency tools, it may be helpful to expand on “poor usability and complexity of data” to discuss how many existing price transparency efforts’ lack access to pricing data that are individualized for consumers and reflective of out-of-pocket costs.
- In the same section, it may be helpful under “reliance on non-price factors” to consider that patients may also be making decision based on of quality and consider how qualify data can be incorporated into many of these decision-assisting tools.
- Additionally, we suggest including a discussion about existing challenges to ensure that electronic health records include features that assist in facilitating price transparency for physicians and patients.

Finally, given the impact of prescription drug prices on the affordability of healthcare, we suggest that the Working Group consider including drug price transparency as a policy objective in this issue brief.

In conclusion, the AMA appreciates the opportunity to provide feedback on these issue briefs and engage in this important effort. We are interested in continuing our dialogue and providing feedback as you consider policy solutions to affordability challenges in healthcare. Please do not hesitate to reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,

A handwritten signature in black ink, appearing to read "John Whyte", written in a cursive style.

John Whyte, MD, MPH