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Kate Harris, Chair
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NAIC Health Care Affordability and Mitigation (B) Working Group
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650 Washington, DC 20005

Submitted via Email: Joe Touschner (jtouschner@naic.org)

RE: BCBSA Comments on Drafting Group 1: Standardize or limit utilization review to reduce administrative costs

Dear: Ms. Harris and Mr. Beagan

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide feedback on the Standardizing or Limiting Utilization Review to Reduce Administrative Costs Brief developed by the Health Care Affordability and Mitigation (B) Working Group Drafting Group #1.

BCBSA is a national federation of 31 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 95% of hospitals and 91% of doctors across the country and serve individuals covered through Medicare, Medicaid, employer-sponsored coverage, and the individual market.

BCBSA believes that everyone deserves peace of mind when it comes to their health care. As health care costs continue to rise, families, employers, and public programs are facing increasing financial pressure. Consumers are experiencing higher premiums, increased cost sharing, and rising out-of-pocket expenses, underscoring the need for solutions that address the underlying drivers of health care costs. BCBS companies are focused on addressing the root causes of rising costs and advancing a [roadmap](#) that could reduce health care costs by nearly \$1 trillion over 10 years through targeted reforms designed to improve affordability and promote a more sustainable health care system.

Given this commitment to improving health care affordability, BCBSA appreciates the Working Group's efforts to develop issue briefs that serve as educational resources for regulators and policymakers. These resources provide a valuable overview of policy approaches being considered and implemented across states and can help inform ongoing discussions regarding strategies to improve affordability and access to coverage. BCBSA believes the briefs will be a useful resource for regulators seeking to better understand the range of state policy options, as well as the opportunities and tradeoffs associated with different approaches. BCBSA looks forward to working with the Working Group as it continues its examination of policies that can support affordable, high-quality health coverage and care.

As the Working Group continues to refine these resources, BCBSA encourages the adoption and maintenance of a standardized format across the issue briefs. A consistent structure, including the presentation of state examples, discussion of policy considerations, evaluation of available evidence, and identification of legal, operational, and implementation considerations, would strengthen the briefs and make it easier for regulators and other stakeholders to compare approaches across topics. In addition, BCBSA agrees with recommendations offered by our consumer representative colleagues that each brief clearly articulate the affordability challenge it is intended to address and explain how the featured state approaches are designed to respond to that challenge. Providing this context would enhance the educational value of the briefs and help readers better understand the relationship between specific policy interventions and affordability objectives.

BCBSA also encourages the Working Group to maintain the briefs as neutral educational resources consistent with their stated purpose. The briefs are most effective when they provide an objective assessment of state approaches, including implementation experiences, operational considerations, potential benefits and drawbacks, and any available evidence regarding outcomes. Because states face differing market dynamics, regulatory frameworks, and affordability challenges, the briefs can serve as a particularly valuable resource when they present information in a balanced and non-prescriptive manner, enabling regulators and policymakers to evaluate policy options within the context of their own markets.

Finally, we recommend that the briefs consistently identify when a highlighted policy, law, or regulatory approach is subject to ongoing litigation, legal challenge, enforcement stays, or other significant legal uncertainty. Providing this context is particularly important where legal proceedings may affect implementation, enforceability, or the ultimate viability of a policy approach. Including such information would help ensure regulators receive a complete and balanced understanding of the policy landscape and avoid inadvertently presenting unsettled approaches as established best practices.

In addition to the overarching comments outlined above, BCBSA has provided attached redlines and document-specific comments for the Working Group's consideration. These recommendations are intended to improve consistency across the briefs, enhance contextual information, support the briefs'

educational purpose, and ensure that relevant implementation and legal considerations are presented in a balanced manner.

Thank you for the opportunity to provide feedback. We appreciate the Working Group's continued efforts to develop these resources and look forward to continued engagement as the briefs evolve. If you have any questions or would like additional information, please contact Randi Chapman at randi.chapman@bcbsa.com.

Sincerely,

A handwritten signature in dark ink, reading "Clay S. McClure". The signature is written in a cursive, flowing style.

Clay S. McClure, BCBSA
Senior Director, State Affairs

NAIC Health Care Affordability and Mitigation Working Group: Horizontal and Vertical Integration in Health Care

The Health Care Affordability and Mitigation Working Group Briefs are intended to be short, informative briefings for regulators and policymakers on various affordability efforts states have undertaken in recent years to help make health insurance more affordable. They are intended to be high-level and not an exhaustive resource on each issue. They also do not represent policy positions of the NAIC, a given state, author, or workgroup member.

Overview

Contributors

Contributor(s)	Title(s) of Contributor(s)	State(s) of Contributors
Julie Holmes	Director, Rate and Form Compliance	Kansas
Megan Mason	Associate Commissioner, Life & Health	Maryland
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Gabrielle Lessard	Attorney, Health Equity and Access Office	California
Stesha Hodges	Assistant Chief Counsel and Chief, Health Equity and Access Office	California

Commented [BCBSA1]: Overarching Comment: The primary concern is that the draft disproportionately emphasizes risks and criticisms of integration while providing limited discussion of potential benefits, existing regulatory safeguards, and the distinctions among different forms of integration. To better align with the brief's stated purpose as an objective educational resource, the paper should more clearly differentiate among integration models, present both benefits and tradeoffs, and acknowledge existing oversight frameworks applicable to affiliated transactions.

Executive Summary

Definitions

1. Medical Loss Ratio or "MLR" is a ratio of how much of the premium goes towards 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. Horizontal integration refers to organizations at the same stage in the supply chain merging. Simply put it is the merger of like providers or similar entities.

Commented [BCBSA2]: The brief would benefit from greater recognition of the longstanding state insurance regulatory framework applicable to transactions within insurance holding company systems. NAIC Model #440 (Insurance Holding Company System Regulatory Act) and Model #450 (Insurance Holding Company System Model Regulation) provide state insurance regulators with significant authority to review affiliate transactions, monitor holding company structures, and assess arrangements that may affect insurer solvency or policyholder interests. Including this as a reference would help readers understand that many vertically integrated arrangements involving insurers are already subject to regulatory oversight.

3. Vertical integration refers to the integration of providers and/or insurers along the continuum of care and can be accomplished via common ownership or through contractual relationships.

Examples of integration:

1. Staff-model HMOs (Vertical and Horizontal Integration): This is the most long-standing form of integration and has been a successful model for certain carriers, with Kaiser Permanente being perhaps the best known. Kaiser provides health care services in eight states through its three primary entities - the non-profit Kaiser Foundation Health Plan (KFHP), its subsidiary hospitals and the state-level Kaiser Permanente Medical Groups. A majority of its non-physician workforce is employed by its hospitals with physicians employed by the Medical Groups.

In its home state of California, Kaiser is regulated by multiple agencies, which complicates enforcement issues. The health plan is managed by California's Department of Managed Health Care (DMHC), hospital facilities are generally regulated by California's Department of Public Health and the Medical Groups are regulated by California's medical licensing board. DMHC has repeatedly cited KFHP for failure to oversee its medical providers and in 2023 entered into a major settlement agreement with the KFHP regarding its failure to provide adequate mental health services.¹ The organization has also been criticized for maintaining substantial reserves in its tax-exempt entities rather than increasing employee salaries or reducing member premiums.²

There are no special or different MLR reporting rules for issuers that operate a staff-model HMO, so it is important to be sensitive to the opportunities that these carriers have to inflate claims and Quality Improvement Activities, and thus their MLRs.

2. Insurance Companies that own large provider systems such as hospitals or group practices (Vertical Integration): United Healthcare Group pairs the country's largest insurance provider, United Healthcare, with a portfolio of healthcare, data analytic, and pharmacy services called Optum. Divisions of Optum include Optum Health, which combines medical and associated services, including financing, skilled nursing facility and hospice care, Optum Rx, a pharmacy benefit manager and Optum Insight, which provides diversified data analytic services.
3. Insurance Companies that own PBMs and Pharmacies (Vertical Integration): According to a 2024 Federal Trade Commission (FTC) interim staff report, the top three PBMs

¹ See, California Department of Managed Health Care, DMHC, Kaiser Permanente Reach Settlement Agreement to Transform Plan's Behavioral Health Care Delivery System and Improve Behavioral Health Statewide, <https://www.dmhca.ca.gov/Resources/Newsroom/PressReleases/October12,2023.aspx>

² See, The Truth About Why We Are Striking: Health Care Professionals to Strike October 14 for Fair Wages, Real Voice in Patient Care, and True Frontline Collaboration with Kaiser Permanente, <https://unacuhcp.org/news/press-statement-the-truth-about-why-we-are-striking/>

Commented [BCBSA3]: The brief would benefit from a clearer distinction among the various forms of horizontal and vertical integration. Provider consolidation, hospital acquisition of physician practices, insurer-provider integration, insurer-PBM integration, and PBM-pharmacy integration each raise different economic, clinical, and regulatory considerations. Combining these arrangements into a single discussion risks oversimplifying a complex subject.

Commented [BCBSA4]: The discussion of horizontal integration would benefit from a more comprehensive examination of hospital and provider consolidation, which has been a significant focus of affordability and competition debates. As drafted, the brief primarily highlights integration involving insurers, PBMs, and private equity entities. We recommend adding discussion of evidence showing that hospital and provider consolidation can increase health care prices without consistently producing corresponding improvements in quality. Including this perspective would provide a more balanced overview of the various forms of horizontal integration affecting health care affordability.

We recommend including [IN HB 1004](#) which limited certain hospital outpatient billing practices and restricting the use of facility fees in off-campus settings, reflecting a state's ability to act on affordability concerns associated with provider consolidation and site-of-service payment differentials.

We also recommend including [WA RCW 70.01.040](#) which requires disclosure and reporting of hospital facility fees and has adopted policies addressing facility fee practices in provider-based clinics.

Commented [BCBSA5]: The statement that staff-model HMOs have opportunities to inflate claims and quality improvement activities may be interpreted as implying inappropriate conduct or manipulation of Medical Loss Ratio calculations. We recommend either providing additional evidence and regulatory findings to support this assertion or revising the language to more neutrally note that vertically integrated organizations may present unique considerations for MLR oversight and reporting.

As drafted, the statement appears to identify a potential concern without providing sufficient context regarding whether such issues have been observed broadly across integrated delivery systems. A more balanced approach would describe how integration may create unique reporting and oversight considerations without presuming misconduct.

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.³ According to the FTC interim report five of the six largest PBMs are “vertically integrated with some of the largest health insurers in the country.” Aetna (CVS Caremark), Cigna (Express Scripts), UnitedHealth Group (OptumRx), Humana (Humana Pharmacy Solutions) and Blue Cross Blue Shield Plans (Prime). As PBMs and insurers become more integrated, the financial results become bundled, masking the profit margins of PBMs.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 The company began producing its first product, Hyrimoz, a biosimilar for Humira, when that product’s patent expired in 2024⁶

While vertical integration could theoretically improve efficiency and care coordination, it has been criticized for limiting consumer choice, increasing the cost of care and creating significant challenges for independent pharmacists, ultimately increasing health care spending.⁷ In addition, research suggests integration has often enables profit extraction through self-dealing and higher prices, demonstrating a need for legal regulatory responses.⁸

Commented [BCBSA6]: There is substantial evidence that certain forms of vertical integration lead to improved efficiencies and care coordination as cited here. We suggest a more neutral framing that does not implicitly take a policy position.

The current paragraph would benefit from additional context regarding existing regulatory safeguards. State insurance departments have longstanding authority to oversee affiliated-party transactions, including review of arrangements that could adversely affect an insurer’s financial condition or policyholders. Acknowledging these safeguards would provide a more balanced discussion and avoid implying that affiliate transactions occur in the absence of meaningful regulatory oversight.

Commented [BCBSA7]: We recommend acknowledging the role of NAICs Statement of Statutory Authority Principles No. 25 (Affiliates and Other Related Parties), which establishes statutory accounting requirements governing affiliated transactions and related-party arrangements. These standards, which are incorporated into state solvency oversight and the NAIC accreditation framework, include expectations that transactions and compensation arrangements be fair and reasonable. This existing regulatory structure is an important consideration when discussing integrated entities and affiliate relationships.

To align with the stated goal of providing an objective educational resource, the brief should discuss both potential benefits and potential drawbacks associated with integration. Many integrated organizations cite improved care coordination, enhanced data sharing, alignment of financial and clinical incentives, population health management, and support for value-based care arrangements as reasons for integration.

Commented [BCBSA8]: We recommend revising language suggesting a need for specific regulatory interventions to instead describe the range of policy responses states have considered. This approach would better align with the brief’s stated role as an informational resource rather than a policy advocacy document.

References suggesting a “need” for legal or regulatory intervention move beyond the stated purpose of the brief as an informational resource. A more neutral approach would describe findings from the literature and summarize the range of policy responses states have considered.

States with the Policy: Efforts to Regulate Vertical Integration

State	Implementation Date	Key Variations/Notes
Arkansas	January 1, 2026	Currently Stayed: Prohibits (PBMs) from owning or opera

³ [Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies](#) See also [FTC Releases Interim Staff Report on Prescription Drug Middlemen | Federal Trade Commission](#)

⁴ [2026-01-pbm-profitability.pdf](#)

⁵ CVS Health launches Cordavis, (August 23, 2023), <https://www.cvshealth.com/news/pbm/cvs-health-launches-cordavis.html>

⁶ [Lillian Karabaic](#) The biggest middleman in the prescription drug supply chain now makes drugs (May 14, 2024), accessed at <https://www.marketplace.org/story/2024/05/14/cvs-pharmacy-prescription-benefit-manager-drug-supply-chain-manufacturing>

⁷ 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/>

⁸ Ibid.

State	Implementation Date	Key Variations/Notes
		but enforcement of this statute is stayed pending the outcome of litigation. This has not stopped other states from introducing legislation.
Arizona	December 31, 2026	Proposed: Prohibits PBMs from directly or indirectly, pharmacy permits in the state. SB 1545
Oklahoma	November 1, 2026	Proposed: Establishes a new regulatory framework for PBMs by prohibiting PBMs and their directly or indirectly affiliated entities from holding pharmacy licenses to sell retail drugs in Oklahoma. This would be accomplished through the Board of Pharmacy's licensing authority. HB 4457
Tennessee	July 1, 2028	Prohibits a PBM from directly holding, controlling, or other ownership or beneficial interest over, a pharmacy license or a including through any contract transfers operational control or economic benefit to the pharmacy benefits manager. This prohibition applies regardless of the percentage of ownership interest. Compliance with the prohibition is made a condition of the issuance, renewal, and continued validity of a pharmacy license. Pub. Ch. 1111

Commented [BCBSA9]: Suggest a clearer identifier that this bill is currently stayed pending litigation

Commented [BCBSA10]: We recommend either removing or adding a note that this reflects the introduced version of the legislation, rather than the version that passed the first chamber. The summary appears to rely on provisions from an introduced bill that was never passed. Readers may otherwise assume the provisions described were adopted as introduced.

States with the Policy: Efforts to Regulate Horizontal Integration

State	Implementation Date	Key Variations/Notes
Massachusetts	January 8, 2025	Establishes restrictions and reporting requirements on private equity firms involved in provider transactions and gives the Health Policy Commission power to monitor the impact of these acquisitions. Chapter 343 of the Acts of 2024
Oregon	For entities incorporated or organized after effective date:	Prohibits management services organizations (MSOs) and their affiliates from owning or controlling a majority stake

State	Implementation Date	Key Variations/Notes
	January 1, 2026; For entities incorporated or organized before effective date: January 1, 2029	in professional medical entities, serving on their boards, or directly influencing clinical decisions, from hiring and scheduling to pricing and payor negotiation. Chapter 295, 2025 Laws.

Premium Impact and Savings Analysis

As a result of vertical integration and joint contracting, a [HealthAffairs](#) study found a direct impact on physician prices at medium and large systems (medium system led to a price increase of 7.7% for primary care physicians and 2.4% for specialists; large system led to a price increase of 12.0% for primary care physicians and 6.0% for specialists). These findings suggest that policy makers may need to consider taking steps to mitigate price effects, with a particular focus on large health systems.

Commented [BCBSA11]: We recommend referencing this Health Affairs study earlier in the brief in the section discussing vertical integration. The study's findings that physician prices increased following integration provide a more concrete and evidence-based discussion of the potential affordability implications of vertical integration than some of the broader statements regarding self-dealing and profit extraction. Incorporating this evidence earlier would help ground the discussion in observed market outcomes and provide readers with a more complete understanding of both the potential benefits and potential price impacts associated with integrated delivery systems.

Brief write up

This brief examines the growing trend of horizontal and vertical integration in the health care industry and the implications of these business structures for health care affordability, market competition, and regulatory oversight.

The brief identifies several policies states have enacted. Arkansas enacted legislation prohibiting PBMs from owning or operating pharmacies, although enforcement is currently stayed pending litigation. Tennessee enacted a similar prohibition, effective January 2027, barring PBMs from acquiring or controlling pharmacy licenses as a condition of pharmacy licensure. Massachusetts enacted a law strengthening oversight of private equity involvement in provider transactions by expanding reporting requirements and empowering the Health Policy Commission to review acquisitions. Oregon enacted legislation limiting the influence of management services organizations (MSOs) and their affiliates over physician practices by restricting ownership, governance, and interference with clinical decision-making. These enacted laws reflect differing approaches to increasing transparency, reducing corporate influence over health care delivery, and preserving competition.

The brief also discusses proposed laws that have not yet been adopted. Arizona has proposed legislation that would prohibit PBMs from directly or indirectly owning pharmacy permits within the state. Oklahoma has proposed legislation establishing a new regulatory framework that would prohibit PBMs and affiliated entities from holding retail pharmacy licenses through the state's Board of Pharmacy licensing authority. These proposals reflect a broader legislative trend toward separating PBM operations from pharmacy ownership in response to concerns about conflicts of interest and market concentration.

Sources

Select statutes and regulations in states identified in the brief.

National Conference of State Legislatures Health Costs, Coverage, & Delivery Database, <https://app.powerbi.com/view?r=eyJrJoiNDNINTJjNzltNjQyNS00NjVmLTk4MjltZDYzZjBlNTQ0ZDA2IiwidCI6IjM4MmZiOGlwLTRkYzMtNDEwNy04MGJkLTM1OTViMjQzMmZhZSIsImMiOiZ9>

Further Reading

[How Insurers That Own Providers Can Game the Medical Loss Ratio Rules](#)

Julia Burleson. [Vertical Integration in Health Care: Implications for Consumers, Employers, and Clinicians](#). Georgetown University, Center on Health Insurance Reforms, May 2026.

Hayden Rooke-Ley, Anika Shah, Corrie Mook, and Erin Fuse-Brown. [Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration](#). Brown University, Center for Advancing Health Policy Through Research, May 2026.

Linda J. Blumberg, Kevin Lucia, and Kennah Watts. [The Complex Web of Health Care Financial Interests and Their Implications for Ever Higher Spending: An Expert Perspective](#). Georgetown University, Center on Health Insurance Reforms, October 2025.

CHIR Faculty. [How Has Corporatization Transformed Your State's Health Care Market?](#) Georgetown University, Center on Health Insurance Reforms, March 2026.

Erin C. Fuse Brown, Hayden Rooke-Ley. [Health Care Financialization](#). Journal of Health Care Law and Policy, 29:1, January 2026.

Jonathan Kanter, Martin Gaynor. [The Rise of Health Care Platforms](#). JAMA, April 2025.

Hayden Rooke-Ley, Soleil Shah, and Erin C. Fuse Brown. [Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All](#). The New England Journal of Medicine, July 2024.

Erin C. Fuse Brown. [State Strategies to Improve Health Care Market Oversight](#). Milbank Memorial Fund. February 2026.

Julia Burleson. State Spotlight: [Oregon's Multi-Pronged Approach to Corporate Influence in Physician Practices](#). Georgetown University, Center on Health Insurance Reforms, April 2026.

Stacey Pogue, Kennah Watts. [State Spotlight: New Massachusetts Law Enhances Oversight of Private Equity in Health Care](#). Georgetown University, Center on Health Insurance Reforms, March 2025.

Abigail Knapp and Sabrina Corlette, [Beyond Benchmarks: Strengthening State Strategies to Contain Health Care Prices | Center on Health Insurance Reforms](#), Georgetown University, Center on Health Insurance Reforms, February 2026.

DRAFT