

August 31, 2026

Kate Harris, Chair

Kevin Beagan, Vice Chair

Health Care Affordability and Mitigation (HCAM) Working Group

Re: Consumer Representatives Comments on HCAM Issue Brief Drafts

We appreciate the opportunity to submit comments on the six affordability issue brief drafts on behalf of the undersigned NAIC Consumer Representatives. We support the work of the Health Care Affordability & Mitigation Working Group (HCAM) to identify the cost drivers underlying the affordability challenges facing consumers. We believe the issue briefs will help policymakers and regulators identify solutions that will ultimately help consumers. We have included comments below on each issue brief, but believe there are overarching changes to the issue brief structure the drafting groups should consider.

First, each issue brief could benefit from a consistent definition of affordability applied uniformly across all of the topics. We believe this definition should be centered on consumers. We are concerned that some of the affordability “solutions” included in the briefs do not improve affordability for all consumers, but instead transfer costs. True affordability solutions must address the root causes of affordability challenges, including the underlying prices, and must ensure health care is affordable for all consumers, not just relatively healthy consumers.

Proposed definition: Affordability is defined as access to comprehensive health insurance coverage that enables all consumers to access medically necessary care with reasonable premiums, deductibles, and cost sharing.

As regulators consider policy interventions to improve affordability, they should take into account the underlying cost of health care and the need for a stable health insurance market.

Second, we recommend that each issue brief begin with a specific statement of the problem policymakers and regulators should solve. This problem statement must go beyond a topic summary, but instead center on the cost drivers causing consumer affordability challenges.

Third, we recommend that each issue brief articulate the pros and cons of each policy option discussed. Adding context for each policy option will help policymakers and regulators better weigh options. The discussion of each policy option must also include a description of the relevant evidence base. We recommend the briefs describe research regarding the impact on affordability of the potential policy options, and clearly specify when policy options are not supported by research (or have not been evaluated to date).

Finally, many of the issue briefs address topics are inextricably connected. We suggest cross-referencing issue briefs to one another to avoid duplication and to connect similar problems

and solutions. We include specific suggestions for where and how to make these connections below.

We have included specific comments on each issue brief draft below.

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

Problem statement

We recommend articulating a problem statement at the beginning of the brief. A problem statement would make it clearer how prior authorization impacts consumer affordability and would help focus the issue brief on policy solutions that will ultimately address the affordability challenges caused by prior authorization as opposed to prior authorization challenges writ large. A problem statement could include the following:

Prior authorization that is not tethered to an evidence-based clinical standard, or that creates unnecessary friction or delays for providers and/or consumers, creates consumer affordability challenges by foreclosing access to medically necessary care and treatment. Delaying access to needed healthcare often exacerbates health conditions, leading to more costly interventions later.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of inappropriate prior authorization as well as the affordability benefits of various prior authorization reforms:

Citation	Description
Lorraine T. Dean, Amy Stewart Nunn, Hsien-Yeb Chang, et al., Estimating The Impact Of Out-Of-Pocket Cost Changes On Abandonment Of HIV Pre-Exposure 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 buprenorphine-naloxone (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	Prior authorization requirements are associated with treatment delays and denials are associated with greater glucocorticoid exposure.

Policy options

We suggest a more nuanced discussion of policy options, including a summary of research demonstrating consumer and health system savings associated with increasing timely access to care and treatment based on evidence-based standards of care. We agree that prohibiting prior authorization for certain services and conditions, standardizing prior authorization processes, and implementing electronic prior authorization more uniformly are all important policy areas. However, we urge the working group to also consider reforms that better align prior authorization processes with evidence-based clinical standards of care. For example, Alaska's prior authorization law requires prior authorization standards to be based on peer-reviewed and evidence-based clinical review criteria (Alaska Statutes Title 21. Insurance § 21.07.110. Prior authorization standards. Similarly, Maryland requires utilization management criteria and standards be objective, clinically valid, and reflected in published peer-reviewed scientific studies and medical literature (Maryland Ins. 15-10B-05(a)(11)).

We also urge the drafting group to consider a description of the Regulatory Framework Task Force's extensive work on this topic, including reference to the issue brief released earlier this year.

TOPIC 2: Horizontal and Vertical Integration**Problem statement**

We recommend that drafters articulate the affordability problem more clearly at the beginning of the brief. A problem statement could include the following:

The healthcare market is becoming increasingly consolidated and uncompetitive. Horizontal and vertical integration among healthcare entities such as providers, hospitals, pharmacy benefit managers, and insurers 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.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of unchecked horizontal and vertical integration as well as the affordability benefits of various reforms in this area:

Citation	Description
Hayden Rooke-Ley, Anika Shah, Corrie Mook, and Erin Fuse Brown, Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration (May 2026).	This white paper discusses research regarding the impact of vertical integration of payers and providers on affordability, and analyzes legal and policy options for addressing risks of vertical integration.
Daniel Arnold and Brent Fulton, UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers (November 2025).	Study examined payments made by United Healthcare insurance products in the individual and group market to Optum providers (both owned by UnitedHealth Group) and found that “the relative price paid to Optum versus non-Optum providers is analyzed, UnitedHealthcare’s payments are 17 percent higher than the relative price of its competitors”.
Center for Advancing Health Policy through Research, Brown University, Estimated Impact of a Facility Fee Ban for Routine Services in Illinois (2026).	Researchers estimate that a facility fee prohibition on evaluation and management services and preventive services would save approximately \$348.3 million annually in the commercial insurance market across 149 hospitals in Illinois.
Yashaswini Singh and Erin Fuse Brown, The Missing Piece In Healthcare Transparency: Ownership Transparency (September 2023).	This commentary argues for transparency in ownership as a key ingredient in understanding the impact of changes in corporate ownership on the US health system, including affordability in the system.
Julia Burleson, State Spotlight: Oregon’s Multi-Pronged Approach to Corporate Influence in Physician Practices (April 27, 2026).	This blog explains how Oregon’s corporate practice of medicine law and transaction oversight laws work together to limit corporate influence over physician practices and protect patients from the potential harms of consolidation.
Julia Burleson, Vertical Integration in Health Care: Implications for Consumers, Employers, and Clinicians (May 12, 2026).	This blog defines vertical integration and examines its effects on three key stakeholders: consumers, employers, and clinicians.

Derek T. Lake, Lawrence P. Casalino, Michael R. Richards, Sean Nicholson, Rahul Fernandez, Manyao Zhang, and Robert Tyler Braun, Strategic Selection And Pricing Power: Optum’s Acquisitions Of Ambulatory Surgery Centers And Physician Practices (February 2, 2026).	This study evaluates Optum’s acquisition of physician practices and ambulatory surgery centers (ASCs). In commercial markets, prices at acquired ASCs rose by 11%, driven by higher facility fees and increased professional fees for Optum-employed physicians.
Zack Cooper, Catherine Ishitani, Elizabeth Jurinka, Christina Ramsay, Review of Expert and Academic Literature Assessing Vertical Integration in Health Care (June 9, 2026).	This memo synthesizes the academic literature on vertical integration and shows that hospital acquisitions of physician practices increase prices and lessen competition without corresponding improvements in health care quality.
Zack Cooper and Christina Ramsay, Review of Expert and Academic Literature Assessing Horizontal Mergers Among Hospitals and Providers (June 9, 2026).	This memo synthesizes the academic literature on horizontal integration and shows that mergers between hospitals increase prices and lessen competition without corresponding improvements in health care quality.
Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, Consolidation Trends In California’s Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices (September 4, 2018).	This article assesses the effect of hospital-physician integration on Marketplace premiums and prices of physician outpatient services in California. Increased vertical integration from 2013 to 2016 in highly concentrated hospital markets was associated with a 12% increase in Marketplace premiums. For physician outpatient services, the increase in vertical integration was also associated with a 9% increase in specialist prices and a 5% increase in primary care prices.
Jessica I Billig, Wen-Ching Lan, Kevin C Chung, Chang-Fu Kuo, and Erika D Sears, The Increasing Financial Burden of Outpatient Elective Surgery for the Privately Insured. Ann Surg. 2020 Sep 1;272(3):530-536 (2020).	This study finds that outpatient surgery payment rose sharply from 2011-2017, driven by higher facility fees and out-of-pocket expenses, while professional fees remained flat.
United States of Care, Reining in Hospital Prices: Modeling Reforms in Indiana, Massachusetts, and North Carolina (July 2025).	This report analyzes the expected cost savings for implementing site neutral payment, limits on facility fees, and reference-based pricing in Indiana, Massachusetts, and North Carolina.

Dilani Logan and Katie Gudiksen, [The Corporate Practice of Medicine: Time for a Reevaluation?](#) The Source on Healthcare Price & Competition (March 2025).

This brief provides an overview of CPOM laws in states and provides policy options for updating existing CPOM laws to ensure they are working as intended.

Policy options

We think the list of policy options to address the affordability challenges resulting from horizontal and vertical integration could be strengthened. For example, we suggest adding the following policy options and have included resources:

- **Facility fees**

Facility fees laws restrict the settings and services for which facility fees can be charged. Nearly half of states have enacted laws that prohibit, rein in, study, or track outpatient facility fee billing. We urge the drafting group to refer to the comment letter submitted by Professor Christine Monahan at Georgetown’s Center on Health Insurance Reforms (CHIR) for a more detailed discussion of how states have structured facility fee reforms. For additional information on this policy option please see [Georgetown’s Center on Health Insurance Reforms \(CHIR\), The Latest Research and Action on Facility Fee Reform](#). We also suggest moving this topic from issue brief four on reference-based pricing as the increased frequency and amount of facility fee charges has been linked to provider consolidation, and the reforms states have enacted to date to regulate facility fee billing do not involve reference-based pricing.

- **Site-neutral payment reforms**

Site-neutral payment reforms require that hospitals be paid no more than a set proportion (typically tied to what Medicare pays) for services that can be provided safely and effectively in non-hospital settings. Site-neutral reforms have been thus far focused on Medicare, and the Medicare Payment Access Commission (MedPAC) has proposed site-neutral policies in Medicare along with a list of 66 services able to be safely and appropriately delivered in non-hospital settings ([MedPAC, June 2023 Report to the Congress: Medicare and the Health Care Delivery System](#)). While states have not yet applied site-neutral reforms to the commercial market, several have introduced bills to do so, and research indicates that site-neutral reforms in the commercial market could have significant consumer affordability benefits depending on how the reform is structured. Site-neutral reforms also remove incentives for hospitals to acquire independent physician practices. We urge the Working Group to consider the comment letter submitted by Professor Christine Monahan at Georgetown’s Center on Health Insurance Reforms (CHIR) for a more detailed discussion of how states are considering structuring site-neutral reforms in the commercial market.

- **Anti-competitive contracting**

States could also consider regulation of anti-competitive contracting terms that enable dominant providers or insurers to distort market competition and inflate prices. Several

states have banned forms of anti-competitive contracting, including all-or-nothing, anti-tiering, anti-steering, gag, and most favored nations clauses. For additional information on this policy option please see [Georgetown's Center on Health Insurance Reforms \(CHIR\), Anti-Competitive Contract Restrictions](#).

- **Pre-merger review and oversight**

States should consider expanding requirements for healthcare entities to notify regulators of planned mergers and additional state review processes for those mergers. These requirements place important guardrails that prohibit consolidation that ultimately creates monopolies and impacts patient access and affordability. State review may also include assessment of transactions beyond providers such as those that include private equity or management service entities. For additional information on this policy option please see [Georgetown's Center on Health Insurance Reforms \(CHIR\), Hospital Transaction Oversight](#).

- **Corporate practice of medicine laws**

States should consider updating existing state laws that prohibit corporate practice of medicine (or adopting new laws) that reflect the complex corporate ownership structures that have come to dominate the U.S. health care system. For additional information on this policy option please see [University of California, College of the Law San Francisco, Corporate Practice of Medicine Bills: The Source on Healthcare Price & Competition](#).

- **Unique National Provider Identifier (NPI)**

States should consider requiring off-campus hospital outpatient departments (HOPDs) to use a unique NPI when billing commercial claims. While a transparency measure (which could be cross-referenced in issue brief five on transparency), this policy is necessary because of the vertical integration of hospitals and physician practices. Without a unique NPI or other location-based identifier, it is not possible to tell the actual brick-and-mortar location where hospital-based care is provided. This undermines facility fee and site-neutral payment reforms, as well as payer tiering and steering. For additional information on this policy option please see Christine Monahan, [Unique National Provider Identifiers And A Push For Transparency](#), Health Affairs Forefront, March 25, 2026.

- **Transparency requirements on ownership of regulated health care entities**

Data on ownership of health care entities is critical for policymakers and regulators to understand how consolidation is operating in their markets. The horizontal and vertical integration issue brief could cross reference issue brief five on transparency, which we are suggesting be amended to include transparency policies regarding ownership structure of regulated healthcare entities (see recommendation in section five below).

Finally, we suggest that the drafting group reference the work of the Prescription Drug Coverage Working Group and urge it and other parts of the NAIC to continue to examine PBMs, including their relationship to payers and industry consolidation.

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

Problem statement

We suggest a specific statement at the beginning of the issue brief articulating the problem that state-defined plans are meant to solve and tying this problem to consumer affordability. A problem statement could include the following:

Consumers are facing increases in marketplace premiums as result of the expiration of enhanced premium tax credits (PTCs), 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.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of rising premiums and deductibles as well as the affordability benefits of various reforms in this area:

Citation	Description
Sabrina Corlette & Karen Davenport, Recommendations for States' Efforts to Mitigate Harms Caused by Federal Policy Actions (2026).	This report describes state policy levers to stabilize the individual market in the wake of volatility caused by federal policy shifts. The report offers a menu of options for state legislatures and regulators that balance affordability provisions to lower premiums with the need to preserve consumer access to comprehensive coverage.
Gary Claxton et al., Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA , Kaiser Family Foundation, (December 2016).	Authors estimated that 27% of adult Americans under the age of 65 had health conditions that would likely leave them uninsurable if they applied for individual market coverage under pre-ACA underwriting practices that existed in nearly all states. If regulators are considering policies that encourage pre-ACA market dynamics (including limited benefits, pre-existing condition exclusions,

	and medical underwriting), they should consider citing additional research from the time period prior to the ACA to articulate the affordability harms to consumers that were rampant at that time.
Dane Hansen, Gabriela Dieguez, Milliman Research Report, The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market (February 2020).	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.

Policy options

Regulators should consider adding a discussion about the pros and cons of different policy options. We are concerned that as written, the two major policy options discussed (state public options and mandate-lite plans) are offered up as two reasonable ways to solve the same problem. This is an apples to oranges comparison. State public option plans target premium savings without reducing the comprehensiveness of coverage and can in fact be a tool to enhance the comprehensiveness of coverage through benefit design (see the [Colorado Option benefit design](#)). In contrast, while mandate-lite options may have lower premiums, by their very definition, they simultaneously reduce the comprehensiveness of coverage. Their savings are achieved by not covering services that some consumers may need, leaving those consumers underinsured, and thereby exposed to higher costs.

In several states, mandate-lite products are medically underwritten and not part of the individual risk pool. Opening up mandate-lite options may also negatively impact the health of the ACA-regulated market by siphoning off good risk, and thereby increasing affordability problems for the state's individual market. Healthier consumers may be drawn to mandate-lite products which expose them to high costs when they need to use care. Consumers with complex or chronic conditions who remain in the ACA-regulated market will experience increased costs as carriers increase premiums and cost sharing to account for fewer healthier consumers. One study, referenced above, found that the average consumer out-of-pocket spending after a serious diagnosis was significantly higher with a short-term plan versus a comprehensive plan (in the case of a heart attack, approximately \$8,000 versus \$51,000), and that states without short-term plan regulations premiums were on average 5% higher. If regulators want to keep both policy options, then adding context for how each policy operates would be helpful, and a discussion of the pros and cons of each option would enhance the utility of the paper.

TOPIC 4: Reference-Based Pricing

Problem statement

We suggest a specific statement at the beginning of the issue brief articulating the problems that referenced-based pricing policy solutions are meant to solve and tying these problems to consumer affordability. A problem statement could include the following:

Hospital and drug prices are two areas that contribute to bloated health care spending in the United States, largely driven by horizontal and vertical integration and other anti-competitive market dynamics. Unchecked prices in these areas are responsible for increased premiums, deductibles, and coinsurance.

Framing the problem in these terms also helps to streamline the rest of the brief. For instance, we suggest removing fixed indemnity and non-network plans from this brief, as these products are not solving the problem articulated and are fundamentally not examples of reference-based pricing solutions.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of unchecked horizontal and vertical integration as well as the affordability benefits of various reference-based pricing reforms:

Citation	Description
Sabrina Corlette, Jason Levitis, and Lindsey Murtagh, What's Worse than a Ghost Network Plan? A No-Network Plan . Center on Health Insurance Reforms (March 18, 2026).	This commentary discusses risks associated with no-network plans.
Roslyn C. Murray, Christopher M. Whaley, Commercial prices relative to Medicare were lower under an Employer-Based Reference Pricing Program , Health Affairs Scholar, Volume 4, Issue 7, (July 2026).	This study examined self-funded employers' use of a reference pricing program and found the program was associated with significantly lower prices than those paid by other commercial payers.
Roslyn C. Murray, Zach Y. Brown, Sara Miller, et al., Hospital Facility Prices Declined as a Result of Oregon's Hospital Payment Cap . Health Aff (Millwood). 2024;43(3):424–432 (2024).	This study examined the impact of Oregon's state employee health insurance plan's cap on hospital payments, and estimated \$107.5 million in savings to the state employee plan during the first two years.

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 2024 43:12, 1680-1688 (2024).	This study estimated the potential savings that could be realized if state employee health plans adopted hospital payment caps across the nation.
United States of Care, Reining in Hospital Prices: Modeling Reforms in Indiana, Massachusetts, and North Carolina (July 2025).	This report analyzes the expected cost savings for implementing reference-based pricing, site neutral payment, and limits on facility fees in Indiana, Massachusetts, and North Carolina (also referenced above).

Policy options

We recommend additional discussion in the issue brief regarding how reference-based pricing policies fit into a larger landscape of policies that aim to limit the growth of overall health costs for consumers to reasonable amounts that do not inhibit access to services. When paired with broader tools to limit price growth (such as health care cost-growth targets or price growth caps), reference-based pricing policies allow regulators to target their efforts to important drivers of cost within certain health care sectors and ensure that any growth in overall cost of health care for consumers remains reasonable.

We also suggest adding a clarification to differentiate between reference-based pricing policies that set a limit on hospital and prescription drug payments across payers and policies that place a limit on payments by state-regulated issuers and showing the pros/cons of each approach. Establishing limits on provider and prescription drug payments statewide has a broader reach and would benefit more consumers than establishing limits on the issuer side, which would apply only to plans over which each state's DOI has authority.

As we noted in our comments to the horizontal and vertical integration issue brief above, we think that facility fee reforms are better placed in the horizontal and vertical integration issue brief. While site-neutral policies could be framed as reference-based pricing reforms, we think it may be confusing to house them in the reference-based pricing issue brief as both facility fee and site-neutral reforms are aimed at reducing the incentives to consolidate. Another option for the drafting groups is to consolidate the horizontal and vertical and integration and reference-based pricing issue brief into one. Unlike unchecked hospital consolidation, consolidating these two issue briefs will create efficiencies for the issue brief audience.

We also note that [Delaware](#) has reference-based pricing policies that could be included in the brief.

TOPIC 5: Transparency

Problem statement

We suggest a specific statement at the beginning of the issue brief articulating the problem that transparency policy solutions are meant to solve and tying this problem to consumer affordability. A problem statement could include the following:

The lack of accessible information about health care prices, including the anticipated consumer cost of covered services, makes it difficult for consumers to anticipate and plan for health care costs. There are other aspects of transparency that are also critical to patient treatment decisions, including whether the plan requires step therapy or prior authorization. Lack of transparency, especially with regard to provider ownership data and site-of-service price differentials, also makes it impossible for policymakers to tailor pricing and affordability reforms.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of opaque health care pricing information as well as the affordability benefits of various reforms in this area:

Citation	Description
Yashaswini Singh and Erin Fuse Brown, The Missing Piece in Health Care Transparency: Ownership Transparency (2023).	Discusses how price, site-of-service, and ownership transparency work together to lower costs and improve accountability
Stacey Pogue and Nadia Stovicek, Advancing Health Care Transparency: A Menu of Options for State Policymakers (2024).	Discusses benefits of ownership, billing, and price transparency
Yashaswini Singh, Nandita Radhakrishnan, and Loren Adler, Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications . JAMA Health Forum 2025;6(1):e244935 (2025).	Primary care physicians are increasingly owned by hospitals or private equity firms, and ownership by these entities results in higher prices for primary care in the commercial market.
Vilsa Curto, Anna Sinaiko, and Meredith Rosenthal, Price Effects of Vertical Integration and Joint Contracting Between Physicians and Hospitals in Massachusetts . Health Aff (Millwood). 2022 May;41(5):741-750 (2022).	Hospital ownership and joint contracting with physicians increases the price of physician care in the commercial market.
Sneha Kannan, Joseph Dov Bruch, and Zirui Song,	Private equity acquisition of hospitals is associated

Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition . JAMA. 2023;330(24):2365–2375 (2023).	with a greater risk of hospital-acquired adverse events, indicating private equity ownership may have negative implications for patient outcomes.
Karen Davenport and Kennah Watts, Georgetown’s Center on Health Insurance Reforms (CHIR), Hollowed Out: How Private Equity Destabilized Safety-Net Hospitals in Pennsylvania, Connecticut, and Rhode Island (2026).	Highlights the risks to patient access to care that private equity ownership of hospitals can generate
Christine Monahan, Unique National Provider Identifiers and a Push for Transparency , Health Affairs Forefront (2026).	Discusses the benefits of site-of-service billing transparency, and how states can build on recent federal legislation.

Policy options

An additional policy option that the drafting group should consider is requiring health care entities to provide more granular data to state regulators on ownership. This policy dovetails nicely with issue brief four on horizontal and vertical integration. Increased disclosure requirements on ownership could include regular reporting to regulators across relevant entities (carriers, PBMs, hospitals, health systems), including when ownership changes and ownership structure. For example, Indiana requires hospitals to report annually entities or individuals holding at least 5% ownership stake

Access to Real Time Benefit Tools (RTBT) can bring more transparency about both cost and utilization management to patients. Many payers have their own RTB tools and there are other tools that exist, depending on the enrollee’s type of insurance, but uptake and knowledge and trust about them is varied.

TOPIC 6: Direct-to-Consumer Platforms

Problem statement

We suggest a specific statement at the beginning of the issue brief articulating the problem that direct-to-consumer (DTC) policy solutions are meant to solve and tying this problem to consumer affordability. Given how narrow this topic is, it may make sense to articulate the problem in equally narrow terms. A problem statement could include the following:

DTC platforms can sometimes provide an option for insured consumers to access medications at a lower cost than a consumer would pay when using their insurance plan. However, many insurance plans do not count consumer costs paid to DTC platforms toward the consumer’s out-of-pocket maximum and deductible.

We believe this narrow tailoring allows the brief to zero in on DTC platforms in the context of insurance coverage without touting these platforms as an overall affordability solution to the much broader problem of consumer access to affordable high-cost drugs. For example, almost all the drugs on these platforms are generic, rather than brand name drugs.

We believe this tailoring also excludes manufacturer copay assistance cards from this conversation. While copay assistance cards are important to consumer affordability, they are outside of the scope of DTC platforms. However, if the drafting group opts to include information on these programs in the final brief, we believe there are factual inaccuracies in how copay assistance cards are described and we suggest reference to a glossary of terms similar to the one proposed below to avoid confusion.

Additional research citations

We recommend adding the following citations to articulate the affordability implications of DTC consumer payment exclusions from insurance out-of-pocket maximum and deductible calculations as well as the affordability benefits of various reforms in this area:

Citation	Description
John K. Lin, et al. Identifying Meaningful Patient Savings on Generics: Direct-to-Consumer Prices Versus Commercial Insurance Cost Sharing . Annals of Internal Medicine (May 2026)	Compares cost savings for generic Rx purchased via DTC platform vs. insurance co-pay; outlines challenges and tradeoffs of DTC for insured consumers.
Brooke McCormick, Patients Face New Care Complexities as DTC Options Expand . The American Journal of Managed Care (November 2025).	Presents advantages and disadvantages of DTC for consumers including limited options and out-of-pocket costs.

Policy options

A straightforward policy option to address the proposed narrowly tailored consumer affordability problem presented by DTC platforms is a state law requiring health insurance plans to count consumer payments to DTC platforms toward the consumer's out-of-pocket maximum and deductible. The brief should describe the different ways these laws could be structured. [Colorado](#) and [Connecticut](#) have passed or introduced legislation that could serve as an example. It may also be helpful to review the [FTC ExpressScripts settlement](#) that requires the PBM to "[p]rovide covered access to TrumpRx as part of its standard offering upon relevant legal and regulatory changes." The drafting group may also want to consider adding pros and cons of each policy option. For example, easing access to DTC platforms may open up a pathway to more affordable medication in limited circumstances where the DTC platform provides a better price than the consumer can get using their insurance. However, the simplest way to ensure consumers have access to medically necessary care and treatment at affordable

costs is by requiring their insurer to have a comprehensive formulary with affordable tiering. Relying heavily on DTC platforms requires consumers to search out the lowest-cost option and fragments healthcare delivery. Allowing consumers to count DTC costs toward plan cost sharing may help alleviate an immediate affordability pain point, but does not address the underlying issues driving affordability challenges, including prescription drug prices set by manufacturers and rebate gaming from pharmacy benefit managers (PBMs).

Clarifying definitions

Finally, we believe that this issue brief could benefit from a set of clarifying definitions that describe various elements referenced. These definitions could include:

- **Direct-To-Consumer Prescription Models**

Direct-to-consumer (DTC) prescription drug platforms offer medication fulfillment outside of traditional pharmacies and health insurance prescription drug benefits. DTC models utilize flat-fee or cash-pay payment methods *usually outside* of health insurance. There are generally three types of DTC platforms: telehealth consultations with prescriptions filled through an affiliated or compounding pharmacy; pharmaceutical manufacturer-owned programs for specific drugs or conditions; and general discount drug platforms.

- **Telehealth consultation focused on prescribing**

This model often bypasses traditional health insurance and operates outside of the consumer's team of medical providers. These platforms usually offer a consultation with a prescriber for a limited selection of prescriptions that are filled with affiliated or compounding pharmacies. Many of these sites do not accept insurance while a few do accept insurance (see, e.g., Suzanne Bollmeier, Emily Stevenson, Patrick Finnegan, Scott Griggs, [Direct to Consumer Telemedicine: Is Healthcare From Home Best?](#) Mo Med. Jul-Aug 2020). Examples include Hims & Hers or Nurx.

- **Pharmaceutical manufacturer-owned programs**

Manufacturers sell specific drugs directly to consumers on their own platforms at a discounted price. These programs can operate in a variety of ways: Some platforms include telehealth in order to obtain a prescription, while others require an existing prescription to purchase the drug; Most popular drugs are cash-purchase, while other drugs can be used with insurance. Examples include LillyDirect.

- **Discount drug platforms**

These programs act as a wholesaler and distributor with a focus on transparent pricing for prescription drugs. These programs use a fixed mark-up and offer discounts mostly on generic drugs, and do not take insurance. Examples include Cost Plus Drugs.

- **Discount Cards**

Discount cards are programs created by PBMs whereby they negotiate discounted prices with pharmacies and then market the cards to consumers online. These cards are

used *outside* of prescription drug coverage, solely as cash transactions, and are available for brand and generic drugs. Examples of discount cards include GoodRx, or ScriptSave WellRx (see, e.g., Olga Hilar, PharmD, MPH, BCPS, BCGP, FASCP, U.S. Pharmacist, [Affordable Medicines, A Pharmacist’s Primer on Prescription Discount Cards](#), October 15, 2021).

- **Copay Assistance**

Manufacturer assistance programs are offered by pharmaceutical manufacturers for brand-name drugs to help offset high copays and coinsurance (see, e.g., Michelle Long, Meghan Salaga, Kay Pestaina, [Copay Adjustment Programs: What Are They and What Do They Mean for Consumers?](#) (October 24, 2024). Depending on the insurer, they may or may not count towards a beneficiary's out-of-pocket obligations. Twenty-six states, DC and PR have passed laws requiring the copay assistance to count. Copay assistance programs can also be offered through charitable foundations and are not drug-specific. These offer a limited value and are used *with* health insurance. Examples of copay assistance programs include Hemlibra Co-Pay Program for hemophilia, and the [Patient Advocate Foundation](#) (formerly PAN Foundation).

- **Patient Assistance**

Patient assistance programs (PAPs) are offered by manufacturers to uninsured and underinsured consumers. PAPs usually have strict income and insurance coverage eligibility criteria and are sometimes referred to as “free drug programs,” although the drugs are not always free, but offered at a very low cost. These programs are used *outside* of health insurance. Examples include [MyAbbVie Assist](#).

We appreciate the important work the HCAM Working Group is doing to address the growing affordability crisis consumers face. If we can be of any assistance as the Working Group finalizes the issue briefs, please don’t hesitate to reach out to Amy Killelea (aek35@georgetown.edu) or Lucy Culp (lucy.culp@bloodcancerunited.org).

Submitted on behalf of the following Consumer Representatives:

Theresa Alban
Ben Anderson
Kellan Baker
Laura Colbert
Lucy Culp
Deborah Darcy
Elizabeth Hagan
Stephanie Hengst
Marguerite Herman

Claire Heyison
Anna Hyde
Janay Johnson
Amy Killelea
Lindsey Murtagh
Carl Schmid
Jennifer Snow
Deborah Steinberg
Silvia Yee