BRIEF

A 3-Part Strategy for Better Health Insurance

Reducing Costs, Complexity, and Corporate Abuses

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Introduction

Americans now rank health care costs above utilities, housing, and groceries as a source of financial stress.[1] For people with commercial market health insurance, whether obtained through an employer or the Affordable Care Act (ACA) Marketplace, cost growth trends over the last decade have significantly outpaced trends in Medicare and Medicaid.[2] Premiums and deductibles are rising well above the rate of inflation, and access to critical items and services often depends more on where you work than on a treatment's clinical effectiveness.[3] For individuals who purchase coverage through the Marketplace, costs have increased dramatically with the expiration of enhanced premium tax credits in 2026, forcing consumers to either absorb higher premiums or seek out plans with higher out-of-pocket exposure. Compounding affordability challenges are insurer utilization management practices that create barriers to clinically recommended care.[4] Regardless of their source of insurance, patients are too often tangled in an inexplicable maze of medical bills and red tape associated with an increasingly byzantine and corporatized health care system.[5]

As complex and intractable as these problems may seem, there are solutions. This issue brief outlines a 3-part package of federal-level policy changes intended to lower health care costs, reduce complexity for consumers and patients, and increase accountability for industry actors whose quest for profit renders them complicit in our current affordability crisis. In setting forth these policy ideas, we are guided by two basic principles. Taken together, these reforms are intended to:

1. Improve the affordability of health care services covered under commercial health insurance and reduce pain points for patients and the providers who serve them; and
2. Reduce, or at a minimum, hold steady premium costs for employers and consumers by lowering the underlying drivers of high commercial insurance costs.

Notes About this Paper's Scope

This paper focuses on a set of reforms to major medical commercial market health insurance–the coverage provided to an estimated 161 million Americans through their employer or directly purchased in the individual market, including health plans offered through ACA Marketplaces.[6] We recognize that the financing of, and patient experience with, other coverage programs, such as Medicare, Medicaid, and the Children's Health Insurance Program, are far from perfect, but reforms to those programs are outside the ambit of this paper. We focus here on reforms that could be pursued by federal-level policymakers. However, many of these policy proposals derive from successful state-level efforts to improve the access, quality and affordability of health insurance.

Given a blank slate, the authors of this paper would not have designed the overly complex, expensive, and fractured health coverage system that exists today in the U.S. We are, however, skeptical that sweeping away that system and replacing it with something wholly new would be feasible, at least in the short term. We similarly believe that a public option plan,[7] while it could offer many of the same consumer benefits outlined below, would require significant new infrastructure that would take time to stand up. We are instead outlining a package of reforms designed to immediately improve, without radically altering, the insurance people currently have and the access to services this coverage facilitates.

This issue brief focuses on the shortcomings of health insurance for those who currently have it. The authors of this paper recognize that millions of people are uninsured, and that number is expected to grow substantially in the next few years, thanks to recent policy changes such as the 2025 budget reconciliation bill, Congress's failure to extend the enhanced Marketplace premium tax credits, and federal regulatory actions. As a threshold matter, policymakers urgently need to reverse the 2025 actions that reduce access to and affordability of Medicaid, Medicare, and Marketplace coverage.

Our coverage system suffers from unnecessary complexity, a primary and behavioral health workforce shortage, unequal access to providers, a proliferation of misleadingly marketed "junk" insurance products, and many other challenges. The insurance reform proposals outlined in this issue brief will not solve every problem that people with commercial market health insurance currently face. It is primarily focused on policies that could, taken together, meaningfully lower what consumers spend on health care and reduce some of the more common coverage challenges that people experience.

COST IMPACTS

Some of the reforms outlined here increase the generosity of coverage and would, if adopted, place upward pressure on premiums. Other proposals would produce meaningful savings and reduce premiums by lowering the underlying drivers of high commercial market costs. Several reforms could also be "dialed" up or down, to ensure that the reforms, taken together, achieve policy or savings goals. A quantitative projection of the estimated costs or savings generated by this package of reforms is outside of the scope of this paper, but where available for specific proposals, we provide existing cost or savings estimates from the published literature.

Health Insurance in the U.S. Today: Increasingly Unaffordable, Difficult to Navigate, and Corporatized

Over the last 15 years, per enrollee spending for people with commercial health insurance has grown more quickly than spending for public health insurance programs, with per enrollee spending growing by 96.5 percent for private insurers compared to 59.5 percent and 51.6 percent, respectively, for Medicare and Medicaid.[8] Much of this growth is attributed to the high and rising prices private health insurers pay for health care services.[9,10] In addition to rising prices, changes in utilization and service intensity also contribute to increased commercial health care spending.[11] At the same time, the U.S. suffers from some of the worst health outcomes in the developed world, particularly among Black, Hispanic, Asian and Indigenous communities.[12]

The annual cost of health care for a family of four with the average employer-sponsored health plan reached nearly $38,000 in 2026.[13] Consumers and their families bear these high health care costs directly, through increased premiums and out-of-pocket payments, and indirectly, through forgone wages. The health costs that employees and their families bear directly have grown substantially, straining family budgets. The employee share of average annual premiums for employer-sponsored family coverage, for example, has increased by more than 37 percent over the last 10 years, and average deductibles for employer-sponsored single coverage have grown by almost 43 percent over the same period.[14] According to a recent poll by United States of Care Action, 81 percent of people with employer-based coverage believe health care is unaffordable.[15,16]

On top of health care costs, patients and families bear emotional and financial costs related to the administrative hurdles, such as prior authorization, that they must navigate in order to access care. Altogether, the complexity of the U.S. health care system, which is worsened by the opacity of health care pricing and billing and the lack of any meaningful navigation support for consumers, leaves patients with unexpected and unmanageable bills, barriers to care, and medical debt.

These challenges are compounded by a health care system that, over the past quarter century, has become dominated by conglomerates of providers, insurers, administrators, and other "middlemen" businesses whose financial interests are increasingly oriented towards delivering profits to corporate stakeholders rather than the best possible patient care. The complex web of interrelationships among these corporate actors results in price inflation, self-dealing, and conflicts of interest that lower quality and increase the overall cost of health services.[17]

At the same time, this costly, overly complex, and highly corporate system is failing clinicians and insurers by making it harder to provide high quality, efficient care. Health care professionals and health care facilities, such as hospitals and ambulatory surgery centers, find themselves building administrative bureaucracies to navigate payers' complex prior authorization requirements and pursuing unpaid bills from patients who cannot afford their deductibles or co-insurance, ultimately writing off uncollected fees as bad debt. At the same time, insurers find themselves unable to constrain health care unit costs in their network negotiations with highly consolidated health care systems. In response, payers rely on aggressive utilization management strategies to control costs—further frustrating providers, who must cope with the paperwork requirements of prior authorization, and patients, who experience delay and denial of necessary services.

A 3-Part Strategy

While commercial health insurance works poorly for too many Americans today, solutions are within reach. The following 3-part strategy focuses on the primary drivers of our health system dysfunction: out-of-control costs, unnecessary complexity, and the increasing corporatization that results in providers and payers placing profits over patient care. Taken together, the reforms below would make health care more affordable for consumers and remove obstacles that make using health insurance frustrating and too often restrict access to necessary care.

Part I: Reducing Health Care Costs

A 2026 Gallup poll found that a majority of Americans are now either "Cost Insecure" or "Cost Desperate" when it comes to their health care.[18] In Part I of this issue brief, we outline solutions that could meaningfully lower consumers' out-of-pocket costs for critical health care items and services while also reining in some of the most egregious drivers of cost growth in the commercial insurance market.

Lower Out-of-Pocket Costs Without Raising Premiums

Policy Proposals

- Limit deductibles to $1,000 and lower out-of-pocket maximums to $4,000 (annually for single coverage) in commercial-market coverage to make out-of-pocket costs more affordable and reduce uncompensated care.
- Cap hospital prices for commercial coverage at a multiple of Medicare rates to rein in high prices charged by consolidated health systems and enable meaningful reductions in out-of-pocket costs without increasing health insurance premiums.

DISCUSSION

Growth in annual deductibles in commercial coverage over the last decade has outpaced growth in workers' wages and inflation.[19] High deductibles and out-of-pocket maximums saddle many with medical debt and drive others to skip needed and preventive care.[20,21] High deductibles and out-of-pocket maximums also negatively impact providers by increasing uncompensated care and bad debt.

As payers face high and rising health care prices, with limited leverage to constrain them, they often resort to increasing deductibles to reduce utilization and shift greater financial responsibility to enrollees. Policymakers can step in with approaches that cap underlying prices to improve affordability for employers and reduce consumer out-of-pocket costs.

Cap deductibles and lower out-of-pocket maximums

Under the ACA, aggregate deductibles, coinsurance, and copayments are capped by a maximum out-of-pocket limit in most commercial market insurance plans. This helps protect people with significant health care needs from medical bankruptcy. However, the annual limit is so high–$10,600 for individuals and $21,200 for family coverage in 2026–that people with illnesses or injuries can still be exposed to staggering costs.

To provide meaningful relief, policymakers could cap deductibles and reduce the out-of-pocket maximum in commercial market insurance. Indexing these caps to wage growth, rather than medical inflation, could mitigate the risk of underinsurance. A possible policy approach would:

- Cap annual deductibles at $1,000 for single coverage and $2,000 for family coverage. This change would cut the average single deductible for job-based insurance ($1,886 in 2025)[22] roughly in half. Some people would see even greater relief, including workers at smaller firms and workers with high-deductible health plans, where average single deductibles exceed $2,600, and people in the Marketplace, where average single deductibles exceed $3,700.[23,24,25] In plans that have separate medical and pharmacy deductibles, the total across both should not exceed the cap; and
- Lower the annual out-of-pocket maximum to $4,000 for single coverage and $8,000 for family coverage, down from $10,600/$21,200 today. A cap at this level would protect a household at the median income (about $84,000 in 2024) from out-of-pocket costs exceeding 10 percent of income, which is a marker of underinsurance.[26] This limit also reflects typical employer-sponsored insurance (ESI) today, with 53 percent of workers in plans that have out-of-pocket maximums of $4,000 or less.

Capping out-of-pocket costs as proposed would have implications for several other health care policies. Policymakers would need to restructure the metal-level tiers in the Marketplace because plans' actuarial values would rise. In addition, the cap on deductibles would effectively eliminate traditional HSA-qualified high-deductible health plans, which require a minimum $1,700 single/$3,400 family deductible in 2026. This would affect a sizeable minority of workers and employers. In 2025, 31 percent of firms that provide coverage offered an HSA-qualified high-deductible plan option, and 29 percent of workers were enrolled in such plans.[27] Ending HSA tax breaks, which overwhelmingly benefit wealthy people, could help reduce the federal deficit.[28] HSA tax breaks are projected to cost the federal budget $15 billion in 2026 and result in lost revenue totaling $182 billion in the ten-year period from 2026 to 2035.[29]

Cap hospital prices

Hospital services account for the largest share of national health care spending and are a major driver of overall spending growth.[30] Rampant hospital consolidation has allowed large health systems to use their market power to demand prices well in excess of the actual cost of delivering care, but without clear improvements in quality.[31,32] Prices paid to hospitals by commercial health plans are higher and have grown faster than those paid by Medicare or Medicaid, driving up premiums for private insurance.[33] This growing discrepancy reflects the different ways rates are set. Commercial rates are set in negotiations between hospitals and insurers and reflect their market power, while rates in traditional Medicare are set administratively. Medicare payments are based on hospital cost data, adjusted for variation, and sufficient to cover costs at efficiently operated hospitals.[34,35] On average, prices paid by commercial insurance to hospitals were more than two-and-a-half times (267 percent) the rates paid by Medicare, with wide variation across hospitals and localities.[36]

Some states have begun reining in hospital prices by pegging them to a multiple of Medicare rates, making health plan premiums more affordable. Oregon and Washington both cap the amount their state employee health plans pay hospitals at 200 percent of the Medicare rate. Oregon's cap, implemented in 2019, brought down state employee plan spending by 4 percent in the first two years and lowered enrollee out-of-pocket costs.[37,38] Laws enacted in Indiana and Vermont in 2025 go further.[39,40] These states cap what hospitals can charge, pegging the cap to a percentage of Medicare rates and extending the price cap to the state's entire commercial market.

Implementing a Medicare-referenced price cap could produce substantial savings in commercial market premiums and reduce the federal deficit. Savings depend on a range of policy choices, such as where policymakers peg the cap and whether to provide some financial cushion for safety-net hospitals, rural hospitals, or other critical providers. Various analyses of a commercial-market hospital price cap set at 200 percent of Medicare rates estimate that it would lower average amounts paid by commercial plans by 7.6 percent and produce savings of about $88 billion per year to commercial market premiums, along with lowering enrollee cost-sharing by $10 billion per year.[41,42,43] In addition, a cap at 200 percent of Medicare would reduce the federal deficit by $216 billion over a decade (2021-2030) by cutting spending on Marketplace subsidies and increasing tax revenue.[44]

Reducing out-of-pocket costs in isolation would drive up premiums. It is crucial for policymakers to take this step in conjunction with capping hospital prices and other cost containment policies detailed below, in order to reduce the underlying cost of health care. Policymakers could "dial" deductible and out-of-pocket caps up or down and establish a narrow or more expansive list of services that are available before the deductible (see the following policy options) to achieve higher value coverage within savings generated. Given limited competition and issues with self-dealing, Congress should also take steps discussed below (see Part III: Protecting Patients from Corporate Abuses) to ensure that insurers and third-party administrators pass savings from a hospital price cap on to policyholders.

Make High-value Services and Prescription Drugs More Affordable

Policy Proposals

- Eliminate cost-sharing in all commercial health insurance for a defined set of services that advance value, equity, and access to care.
- Reduce prescription drug costs by extending Medicare-negotiated prices and the Medicare inflation rebate for prescription drugs to commercial health insurance.

DISCUSSION

One of the principles of the ACA, embedded in requirements such as coverage of essential health benefits and preventive services without cost-sharing,[45] is that insurance should cover the critical services enrollees need to stay healthy and manage their health risks. Section 2713, for example, requires private health insurance plans—including high-deductible health plans—to cover certain preventive services without cost-sharing. This provision, which encompasses services from well-child care to cancer screenings to preventive medications, provides consumers with access to many of the screenings, health guidance, and other services they need to manage their health without incurring a significant bill. Approximately 100 million individuals—six out of ten private health insurance enrollees—use ACA preventive care in a typical year.[46]

However, consumers must navigate financial barriers for other services that are essential to high-quality, cost-effective care, such as primary care and prescription drugs.[47,48] For example, only half of workers with ESI have plans that cover primary care visits before they meet their general annual deductible. These consumers may still face a copayment; however, others must first meet their deductible before their health coverage pays for a primary care visit.[49] The picture is only somewhat better for prescription drug coverage. While more health insurance enrollees enjoy pre-deductible coverage for prescription drugs than for primary care, high and growing outpatient prescription

drug prices increase underlying premiums.[50,51] In addition, individuals who must pay their general deductible or a separate prescription drug deductible before their health insurance covers their medication face high prescription drug costs should they need a prescription before meeting their deductible.

Eliminate cost-sharing for high-value services

Section 2713 of the ACA requires all private health insurance plans to cover certain preventive services that have been recommended by federal advisory panels or that conform to comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).[52] Similarly requiring plans to provide coverage without cost-sharing for other critical services that are broadly recognized as offering significant value would improve access to care and the value of health coverage for millions of enrollees. Specific services could include:

- Up to three primary care visits per year
- Up to two urgent care visits per year
- Up to three behavioral health visits per year
- High value generic prescription drugs
- Prescription drugs necessary to manage chronic conditions

Enabling consumers to access up to three primary care visits and up to two urgent care visits per year without cost-sharing will ensure that all consumers, regardless of income, have financial access to both a relationship with a primary care provider—one of the foundations of a high-functioning health care system—and a cost-effective alternative to emergency department care. Covering up to three behavioral health visits without cost-sharing will ensure that consumers can initiate critical behavioral health interventions without financial considerations creating a barrier to care. Similarly, coverage of generic medications without cost-sharing gives patients greater access to a wide range of medications and enables them to complete necessary courses of treatment. Finally, coverage of prescription drugs for chronic disease management without cost-sharing will improve access to important maintenance drugs, improve medication adherence and patient outcomes, and provide significant financial relief to patients with chronic conditions. The chronic diseases eligible for this cost-sharing relief should be identified based on factors such as disease prevalence, impact on health equity, and public health implications.

Some states have taken steps to reduce financial barriers to additional services. Massachusetts, for example, requires fully insured health plans, including those participating in the Massachusetts Health Connector, to cap copayments for insulin and certain medications used to treat asthma and heart conditions.[53] Some state-based Marketplaces, such as those in California, Colorado, and the District of Columbia, require participating health insurers to use benefit designs that reduce out-of-pocket costs for conditions with outcome disparities related to race and ethnicity, including diabetes, behavioral health, heart conditions, and maternal health.[54] Federal policymakers could consider these examples and require plans to cover services related to these conditions without cost-sharing as a strategy for improving health equity.

Reduce prescription drug costs

Prescription drug prices are increasing at rates significantly higher than inflation. From 2008 to 2021, average launch prices for new prescription drugs increased 20 percent per year. At the same time, a greater proportion of new medications carry steep price tags, with 47 percent of new drugs launching at prices of more than $150,000 per year in 2020 and 2021, compared to 9 percent between 2008 and 2013.[55,56,57] These price increases carry through to commercial health insurance premiums, the prices consumers must pay for their prescriptions when they have not yet met their deductible, and the cost-sharing charges they face post-deductible, which can exceed 30 percent of the drug's cost for drugs in the highest cost-sharing tier.[58]

Recent steps by the federal government to reduce prescription drug prices in the Medicare program could serve as a foundation for prescription drug price reforms in the commercial market. First, Medicare has begun to directly negotiate prices for high-expenditure medications that do not have generic equivalents. Maximum prices negotiated by the Centers for Medicare & Medicaid Services (CMS) currently apply to the first 10 medications subject to the Medicare Drug Price Negotiation Program, with another 15 medications joining the program in 2027. Second, Medicare's Inflation Rebate Program for retail prescription drugs covered under Part D and certain Part B drugs—physician-administered, single-source drugs and biologics—began invoicing drug manufacturers for the rebates they owe Medicare, based on price increases for these medications that exceed inflation, in late 2025.[59]

Legislation already pending in Congress would apply these Medicare drug pricing reforms to drugs purchased in the commercial market.[60] Policymakers could also explore how to incorporate international pricing into price negotiations. External estimates suggest that applying price inflation rebates to prescriptions filled by commercial plans could have resulted in savings of up to $8.1 billion in 2021.[61]

Ban Unfair Facility Fees and End Abusive Billing

Policy Proposals

- Prohibit hospitals from charging, and insurers from paying, facility fees for office visits in on- or off-campus hospital outpatient departments.
- Adopt site-neutral payment for outpatient services in commercial insurance.

DISCUSSION

Anecdotes and press reports abound with stories of patients who find that a visit to their doctor's office is far more expensive than they expected—often because their doctor's practice is owned by a hospital. When patients receive care in a freestanding physician's office, the service will result in a single bill that covers the physician's time and office overhead. But if a hospital or health system owns the office where a patient receives care, it may be licensed as a hospital outpatient department (HOPD). In that case, the same service will prompt a bill for the physician's time and a separate bill for the system's overhead costs.[62] The addition of this second bill, the facility fee, can result in an overall price that is three times higher, or more, than a freestanding office visit for the exact same care.[63] Because many health plans feature high deductibles or higher cost-sharing for hospital services, patients can end up paying much of this higher price.[64]

Over the past few decades, hospitals and health systems have steadily acquired physician practices.[65] This practice, known as vertical integration, gives health systems greater leverage in contract negotiations with payers, resulting in price increases.[66,67] Finally, because outpatient facility fee increases consistently outpace professional fee increases, hospitals' incentive to purchase physician practices has grown over time.[68,69]

Neither patients nor insurers should pay an additional fee or make a higher total payment for routine outpatient care simply based on whether the patient receives care in a hospital-owned setting, an independent physician's office, or an ambulatory surgery center (ASC). Nor should health care payment systems create incentives for consolidation and integration that only drive prices higher.

Prohibit facility fees for routine outpatient care

To protect consumers from higher out-of-pocket costs when they receive routine outpatient care in a hospital-owned setting, and to address incentives that encourage further industry consolidation, Congress could prohibit hospitals from charging, and insurers from paying, facility fees for office visits that take place on or off the hospital campus, with an office setting defined as a location where a health care practitioner routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. This focus on office visits would prohibit hospitals from charging excessive overhead for outpatient visits that do not require hospital-level care, but would still allow hospitals to charge facility fees for procedures best provided in a hospital-based setting. This approach mirrors Maine's prohibition on facility fees for services provided in an office setting.[70] Policymakers could also choose to define specific services included within this ban.

Adopt site-neutral payment in commercial insurance

A prohibition on facility fees for office visits protects patients from out-of-pocket costs related to these fees, but does not fully address incentives for vertical integration inherent in today's payment practices. Nor does a facility fee prohibition, on its own, fully protect patients from excessive charges for hospital-based outpatient care or lower total spending on these services. Site-neutral payment for outpatient services can accomplish these goals. In contrast to current commercial payment for outpatient care, which is determined by negotiations between, and the relative market power of, providers and insurers, site-neutral payment ensures that reimbursement for a given service is similar or the same across care settings, regardless of whether the patient receives care in an HOPD, a freestanding doctor's office, or an ASC. This payment policy is grounded in the belief that payments should reflect the resources health care professionals need to provide care in the most efficient setting that is safe and clinically appropriate for that service.[71]

Congress could prohibit outpatient providers from charging, and insurers from paying, more than a defined, site-neutral amount for outpatient services that can be safely provided outside of a hospital. This amount would approximate the payment needed to adequately cover the costs of providing care in non-hospital settings. While this payment would be less than the typical amount paid for outpatient care in a hospital setting, it may be more than what some independent practitioners receive today.

Depending on the precise policy parameters, site-neutral payment in the commercial market has been estimated to generate significant savings in national health spending over time, with estimates ranging from $458 billion over ten years to $900 billion over ten years.[72,73] Legislation authorizing site-neutral payment requirements would need to address a range of policy choices, such as which services to include and whether to exempt safety-net hospitals, rural hospitals, and other critical facilities from these payment rules.[74]

Part II: Reducing Unnecessary Complexity

Patients and providers alike are increasingly confounded by insurer utilization management practices that increase paperwork and add barriers to obtaining medically necessary care. At the same time, federal minimum standards for coverage adequacy vary widely, depending on the type of insurance. This complexity, combined with the opacity of health care billing, increases administrative costs and adds to consumer confusion and frustration. In Part II of this issue brief, we discuss solutions that will reduce barriers to care, better align federal standards across coverage programs, and arm patients with better cost information, before they receive services.

Reduce Red Tape and Hassles

Policy Proposals

- Extend recent updates to federal prior authorization standards to commercial health coverage.
- Adopt commonsense measures from state prior authorization and other utilization management reforms to further reduce hassles, ensure clinical appropriateness, and improve transparency.

DISCUSSION

Health plans' use of utilization management techniques, including prior authorization, step therapy, and retroactive claims denials, is a major source of frustration for patients and providers alike. When services or medications require prior authorization, patients often have to wait for needed care, sometimes allowing their conditions to worsen, and may have to shoulder costs that insurance refuses to cover. Nearly 70 percent of consumers find prior authorization burdensome. Consumers cite prior authorization as the biggest frustration they face when trying to get health care, beyond costs.[75]

In addition, prior authorization places a heavy administrative workload on provider practices, diverting time from patient care and adding administrative costs. Physicians report that they and their staff spend an average of 13 hours a week managing prior authorizations.[76]

Actuaries estimate that eliminating prior authorization would increase premiums by 3 to 5 percent.[77] However, this estimate does not account for potential savings from reduced administrative costs for insurers and providers, nor longer-term savings that could result from timely care. Given expected premium impacts, reform efforts have focused on making prior authorization less onerous, rather than eliminating it. States have passed a wide range of policies to rein in prior authorization, and federal rules have extended uniform prior authorization standards to plans in Medicaid, Medicare Advantage, and the federal Marketplace. These approaches, however, do not apply to self-insured employer health plans that cover most workers. Consumers with employer-sponsored insurance may benefit from recent voluntary commitments made by health insurance industry associations to improve prior authorization.[78] Nevertheless, these commitments do not carry the force of law, may not be applied consistently, and do not go far enough to address frustrations.

Extend updated federal standards to commercial plans

A trio of CMS interoperability and prior authorization rules, one adopted in 2020, a second in 2024, and a third proposed in 2026, will largely establish uniform standards for aspects of prior authorization for medical and prescription benefits across CMS-regulated coverage.[79,80,81] Key standards in the rules include:

- **Electronic and automated processes.** Plans must facilitate electronic prior authorization through the standardized, automated exchange of information related to services subject to prior authorization, document submission, and status updates;
- **Uniform prior authorization decision timeframes.** Prior authorization decisions must be rendered within certain timeframes depending on the market, type of service, and type of request. For example, for plans on the federal Marketplace, decisions for non-drug services must be made within 72 hours for expedited requests and 7 days for standard requests; and for drugs within 24 hours for expedited requests and 72 hours for standard requests;
- **Denial reasons.** Plans must communicate the specific prior authorization reason for a denial to providers and patients; and
- **Transparency.** Plans must allow patients and providers to access real-time coverage information, including prior authorization details, and annually post on their websites a list of services and items subject to prior authorization, along with outcome metrics (e.g., the aggregate number and percentage of requests approved and denied, and the average time to decision).

These recent rules do not apply to most commercial coverage. Instead, federal regulations that have not been updated since 2000 establish timeframes for prior authorization decisions for self-funded group health plans: 72 hours for expedited requests and 15 days for standard requests.[82,83] These timeframes are generally longer than the uniform standards in place or proposed for other markets. Patients and providers would benefit if federal

policymakers extended recent prior authorization rules to the commercial market, creating a uniform federal floor. This change would likely not be a major "lift" for many group insurers and third-party administrators, as they are already implementing systems to comply with these standards across their other product lines.

Adopt commonsense state reforms

Recent federal rules focus on streamlining the prior authorization process and providing a basic level of transparency, but they stop short of addressing many sources of patient and provider frustration. Nearly every state has regulated prior authorization to some degree, and many have enacted extensive reforms aimed at balancing patient and provider protections with cost-control goals. Federal policymakers could consider adopting additional commonsense measures found in state prior authorization reforms, including:[84,85]

- **Chronic condition protections.** Establish 12-month validity periods for prior authorization approvals for treatment for chronic conditions and require valid approvals to be honored across payers. Prohibit use of prior authorization for certain conditions where there are significant harms from treatment delays.
- **Evidence-based clinical criteria.** Require plans to use evidence-based clinical review criteria for utilization management. Require plans to post criteria online, update them annually, and reference criteria in any adverse determination, along with the denial reason.
- **Denials by clinicians with requisite expertise.** Require that only a clinician with requisite expertise in the clinical area can make an adverse determination through utilization management.
- **Peer-to-peer access in appeals.** When appealing a denial, ensure the treating provider has the opportunity to engage in a peer-to-peer dialogue with a clinician in the same or a similar specialty before a denial is considered final.
- **Improved transparency.** Require centralized and more granular reporting of prior authorization and other utilization management metrics, such as denial rates, rates of decisions overturned on appeal, and decision timeframes, by item, service, and drug category.
- **Artificial intelligence.** Prohibit the use of artificial intelligence as the sole basis for an adverse prior authorization decision and require transparency on how and when artificial intelligence is used.
- **Honoring authorizations.** Prohibit the retrospective denial of services that have received prior authorization, except in cases of fraud or misrepresentation.

A Market-wide Minimum Benefit Standard

Policy Proposals

- Extend the ACA's minimum essential health benefits standard to all commercial market health insurance, including standards that ensure enrollee access to clinically recommended prescription drugs.
- Eliminate the "firewall" between employer-sponsored insurance and Marketplace premium tax credits that prevents low-income workers from accessing affordable Marketplace coverage.

DISCUSSION

The U.S. is unique in the world in that, for most people under age 65, the quality and comprehensiveness of their health coverage is entirely dependent on where they work. Most large employers offer health benefits because they recognize doing so is essential to recruit and retain a skilled, healthy workforce. But that is not the case for all employers, particularly those that operate in sectors that are not unionized or that employ a low-wage, high-turnover workforce.[86] To the extent they offer coverage at all, some of these employers provide relatively skimpy coverage options simply to avoid the ACA's employer mandate penalty.[87] For example, strategies adopted by employers with low-wage workers include offering "minimum essential coverage" plans that include only the ACA's preventive services benefit alongside a plan that meets the ACA's "minimum value" standard (which requires coverage of at least 60 percent of total costs).[88,89] The end result is that low-income workers must choose between a plan with a premium they can't afford or a plan that leaves them without access to care. These plans not only fail to meet employees' basic health care needs but, in many cases, also render employees ineligible for comprehensive, more affordable coverage through the ACA Marketplace due to the ACA's "ESI firewall."

Even employers that offer comprehensive benefits can choose to exclude certain prescription drugs and other high-cost items and services from plan benefits, regardless of clinical benefit. One of the most talked-about recent examples is the GLP-1 category of drugs. Only 19 percent of firms covered such drugs for weight loss in 2025.[90] Employers have also acted to exclude high-cost drugs that are essential to treating serious, life-threatening diseases such as cancer and cystic fibrosis.[91,92]

Extend essential health benefit and formulary design standards

The ACA's requirement that plans cover a set of 10 essential health benefits (EHB) currently applies only to individual and small-group market health plans.[93] Extending EHB across the

commercial insurance market, including to large-group and self-funded employer plans, would ensure that all plans meet a basic minimum standard, reduce consumer confusion during coverage transitions, and for many low-income workers, improve their access to services.

EHB regulatory standards also require plans to maintain prescription drug formularies that are grounded in clinical evidence and establish processes to ensure enrollees can access medically necessary prescription drugs. Specifically, under federal rules, to meet EHB standards plans must:

- Cover the greater of at least one drug in every U.S. Pharmacopeia category and class or the same number of drugs per category and class as the state's EHB benchmark plan;
- Maintain a Pharmacy & Therapeutics (P&T) Committee that:
  - Is composed of people with appropriate clinical expertise, the majority of whom are practicing health care professionals and at least one of whom is a patient representative; and
  - Determines formulary drug inclusion and utilization management through evaluation of the scientific evidence and ensures appropriate access to drugs that are included in broadly accepted treatment guidelines.
- Offer enrollees an accessible and efficient exceptions process to enable access to medically necessary off-formulary drugs.[94]
- Ensure that plan designs do not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.[95]

These standards could be updated to reflect medical advances and, to the extent not already required, extended to all commercial health plans. Aligning minimum standards across coverage sources can help ensure that a patient's access to medically necessary prescription drugs is grounded in clinical evidence, and not solely dependent on their choice of workplace.[96]

Requiring coverage of EHB and adherence to minimum formulary design and access standards would be a federal guarantee that that all commercial insurance plans meet basic minimum standards of comprehensiveness. For the majority of employers, setting such a floor would require few changes, but for some, primarily low-income workers, these standards would significantly improve their access to treatments. The ACA requires the EHB standard to be equal to the "typical" employer plan in each state, and many employer-based plans already require their pharmacy benefit managers to meet minimum standards for the management of drug benefits.[97,98,99]

Eliminate the "firewall" between ESI and the Marketplace

The ACA includes a "firewall" that blocks people with an offer of ESI from obtaining a premium tax credit (PTC) in the Marketplace, if their employer plan meets federal standards for "minimum value" and affordability. Minimum value is defined as covering 60 percent of total costs for covered benefits, including inpatient hospitalizations and physician services.[100] ESI coverage is considered "affordable" if the employee's premium contributions do not exceed a specified percentage of their income, amounting to 9.96 percent in 2026.[101] In other words, a worker earning just $23,000 per year could be paying as much as $190 per month towards their ESI premiums, and their coverage would be considered "affordable" under the ACA. By comparison, an individual earning that same income who is eligible for Marketplace PTCs would be expected to contribute about 4 percent of their income towards Marketplace plan premiums, or $77 per month for a silver-level (benchmark) plan.[102]

Many workers with ESI receive better benefits and, through the employer tax exclusion, get a financially better deal than coverage through the Marketplace.[103] However, others, particularly those with lower incomes, work for employers who offer skimpy coverage and provide minimal help defraying the cost of premiums. Although the proposal to extend EHB and improve drug coverage would raise the bar for ESI, many workers would still find better coverage at a more affordable price if they were eligible for PTCs through the Marketplace.[104]

Eliminating the ACA's ESI firewall would allow employees to select the coverage option that works best for them and, according to Urban Institute estimates, save affected consumers approximately $4.4 billion annually in premiums and out-of-pocket health care costs. This policy would, however, result in a cost shift from employers, whose spending on health coverage would be reduced by an estimated $8.1 billion, to the federal government. As more workers choose Marketplace plans, federal spending on premium tax credits would increase by an estimated $17.8 billion annually.[105]

Arm Consumers with Cost Information

Policy Proposals

- Prohibit group health plans and insurers from using coinsurance in benefit design.
- Require group health plans and insurers to provide patients with clear and helpful cost estimates prior to receiving scheduled services.

DISCUSSION

The cost of health care goods and services in the U.S.–and the prices paid for those goods and services–are uniquely opaque. Many are not "shoppable," in the sense that patients have little discretion over when, how, or where they receive them. But for those goods and services where patients do have such discretion, it is often impossible to ascertain their cost prior to receiving care. More than one-third of Americans report delaying or forgoing health care services due to costs.[106] Well over two-thirds report they've been surprised by a medical bill for a routine service, even after checking with their insurer or provider to ask the cost in advance.[107]

Ban coinsurance

Coinsurance, a form of cost-sharing that is based on a percentage of the insurer's "allowed amount" (often the negotiated price) for the service, significantly contributes to consumer uncertainty. Patients cannot readily ascertain, prior to receiving the service, what their health plan's allowed amount is, and thus have no way to calculate what their out-of-pocket cost will be for a service subject to coinsurance. Coinsurance can lead to unexpected medical bills that can contribute to medical debt, prompt people to abandon treatment, and worsen health outcomes.[108]

Copayments, on the other hand, are predictable. Patients can know in advance the dollar amount they will be required to pay towards a doctor's visit, lab test, or prescription drug. Eliminating the use of coinsurance will give patients more cost certainty, but will undoubtedly prompt insurers to increase the amount enrollees are expected to contribute in the form of copayments. However, lowering the maximum annual out-of-pocket amount that patients must pay for care, as proposed above, will help limit enrollees' total liability in any given year.

Implement the advance explanation of benefits

Patients deserve to know what their financial liability will be for scheduled health care services. It is for this reason that Congress required group plans and insurers to provide enrollees with an advance explanation of benefits (AEOB) by January 1, 2022. The AEOB would give patients, prior to a scheduled health care service, information about whether their chosen provider is in-network and a good-faith estimate of the total out-of-pocket costs they will face once services have been delivered. As of the writing of this issue brief, AEOBs remain unavailable to the American people.

CMS, which is responsible for implementing the AEOB, has blamed technical challenges for the delay.[109] Industry foot-dragging is likely another factor. Bipartisan legislation now pending before Congress would double down on the AEOB by requiring that health plans and insurers, after receiving a claim for services from a provider, send an EOB to consumers using the same format as the AEOB, to facilitate before and after cost comparisons.[110]

Help Consumers Navigate Insurance and Billing Issues

Policy Proposals

- Support robust state consumer assistance programs through a permanent appropriation and dedicated funding source.
- Adequately fund benefit advisors at the Department of Labor, who provide consumer assistance when people with ESI encounter problems.

DISCUSSION

Health insurance is often difficult to understand and use. More than half of Americans with ESI have trouble understanding their coverage, including what it will and won't cover.[111] In addition, 60 percent had a problem using their insurance in the prior year, such as insurance paying less than expected or denying care. Expert assistance can help consumers overcome these common barriers, but declining federal support for unbiased consumer assistance that is free from financial conflicts of interest leaves many commercial-coverage enrollees with nowhere to turn for help.

Consumer Assistance Programs (CAPs)

Consumer Assistance Programs help consumers facing problems with health insurance understand their rights, respond to denials, file appeals, address surprise bills, and navigate related issues.[112] These programs save consumers millions of dollars annually.[113] Congress established a grant program in the ACA to help states create and run CAPs that assist consumers with private coverage.[114] The ACA appropriated $30 million in seed money for CAP grants to states, which went to 35 states and D.C.[115] While the ACA authorized "such sums as may be necessary" to support CAP grants moving forward, Congress has not made subsequent appropriations. With the loss of

federal funding, many CAPs closed or scaled back services.[116]

More than half of Americans have private health insurance. The ACA's initial funding for CAPs was woefully insufficient for such a large target population.[117] To ensure that consumer assistance is available, Congress needs to appropriate sufficient funding on an ongoing basis. This may be best accomplished if Congress establishes an ongoing funding mechanism for the program. One proposal calls for annual funding of $400 million generated by a small but broad federal assessment of 0.0005 percent of premiums on all health plans, including self-insured plans that states cannot assess, yet whose members still benefit from CAPs.[118]

In addition, CAP programs, ACA Navigators, and Employee Benefit Security Administration (EBSA) benefit advisors (discussed below), should coordinate with each other and ensure warm handoffs when appropriate, based on a consumer's type of coverage or need.

EBSA benefit advisors

EBSA, within the Department of Labor, enforces federal requirements for employer-sponsored benefit plans that cover 155 million Americans.[119] When workers encounter problems with ESI, such as denied claims or surprise medical bills, they can contact EBSA's benefit advisors for help. Benefit advisors help plan members understand their rights, resolve disputes, and recover benefits due. In 2025, they helped consumers recover $469 million in benefits through informal complaint resolution alone.[120]

The agency's responsibilities have increased under the ACA, the No Surprises Act, and other laws that expanded consumers' rights and benefits related to health coverage, while the number of benefit advisors held roughly steady at around 110 from 2011 to 2020.[121,122] That number has since fallen as low as 74, before EBSA's recent action to hire 40 new benefit advisors in response to being "flooded with thousands of calls" related to the No Surprises Act.[123] Congress can ensure that EBSA's direct consumer assistance and related investigative functions have the necessary workforce and resources to quickly and effectively respond when Americans with ESI encounter problems. Further, Congress could broaden the authority of benefit advisors so they could serve as advocates on behalf of plan members during benefit disputes.

Part III: Protecting Patients from Corporate Abuses

Rising consolidation among providers, payers, and other health industry entities, combined with the entry of private equity investors and other actors motivated to pursue short-term profits, has contributed to deteriorating patient care, provider burnout, and higher health care costs. In Part III of this issue brief, we discuss several reforms that will protect patients from some of the worst abuses of a corporatized health care system and rein in the egregious self-dealing that has become increasingly common.

Replace the Abuse-prone System for Resolving Surprise Bills and Close Gaps in Protections

Policy Proposals

- Replace the No Surprises Act's (NSA's) costly and abuse-prone independent dispute resolution process with a fair and noninflationary payment standard.
- Close gaps in the NSA that continue to expose consumers to surprise medical bills.

DISCUSSION

Surprise medical bills–unexpected costs from out-of-network care, in some cases stemming from profit-boosting strategies of private-equity-backed providers–were a common source of frustration for patients before Congress passed the bipartisan No Surprises Act (NSA) in 2020.[124,125] The NSA has been successful at protecting consumers from some of the most common sources of surprise bills, such as out-of-network emergency care services and services from out-of-network providers (such as anesthesiologists and radiologists) at certain in-network facilities. But, in other ways, the law has come up short. Gaps in protections leave consumers exposed to surprise medical bills in other scenarios where they have no way to avoid out-of-network care, including ground ambulance services. Ground ambulances are frequently out-of-network, and the average commercial price for a trip in one exceeds $1,000, exposing consumers to the risk of large surprise bills and medical debt.[126,127]

In addition, while the NSA aimed to hold down overall health care costs, it appears to be doing the opposite. When Congress prohibited surprise bills, it needed to determine a fair payment for out-of-network care that had previously been foisted on consumers. Policymakers debated several approaches and ultimately chose independent dispute resolution (IDR) as a mechanism to determine a binding payment amount for contested bills.[128] Although IDR was not the lowest-cost approach Congress considered, the Congressional Budget Office (CBO) anticipated modest savings to employer premiums and the federal budget.[129] However, an onslaught of litigation eroded guardrails meant to keep payment rates reasonable and non-inflationary, and the volume of disputes and costs to the system have far exceeded expectations, raising concerns that IDR could drive up employer premiums.[130,131,132] In addition, the

IDR process appears highly profitable for private-equity-backed providers and middlemen, who initiate a substantial share of disputes and secure particularly high award amounts, often many times higher than median contracted rates.[133] Findings from research on the first few years of IDR show:

- The IDR system has added an estimated $2-$2.5 billion per year to overall health system costs since it started, with more than half coming from fees and administrative costs borne by participants, and the remainder from payments to providers above the median contracted rate.[134]
- While agencies estimated that 17,000 disputes would go to IDR each year, providers brought more than 1 million disputes in the first half of 2025 alone, and won 88 percent of them, often collecting awards that are many multiples of median contracted rates.[135,136]
- Average IDR awards for imaging, for example, are far higher than either in- or out-of-network prices before the NSA was passed.[137] The median contracted rate for imaging services in IDR in 2024 was 150 percent of the Medicare rate, while the average award was 790 percent of Medicare.

Use a noninflationary payment standard

Mounting evidence suggests that the NSA IDR process is not working as intended and is instead driving up prices for affected services as private equity-backed entities and middlemen use IDR to extract significant payments. CBO's estimates that the NSA would modestly reduce employer premiums assumed IDR would produce more modest awards, putting downward pressure on rates in contract negotiations.[138] With experience showing the opposite outcomes from IDR, the NSA is unlikely to be reducing prices and employer premiums, and may be driving them up, contrary to Congress' intention.[139,140]

Congress debated whether to set a fair payment standard or use IDR to determine payments, and the CBO anticipated significant differences in the cost to premiums and the federal deficit depending on the policy details.[141] In general, the CBO anticipated that IDR would save less than setting a payment standard, and that payments that hew closer to *median* in-network rates would reduce costs and premiums, while those pegged to *average* in-network rates (or higher) would be inflationary.

If Congress reforms the NSA by replacing the costly IDR system with a non-inflationary payment standard, it could increase savings to commercial premiums and the deficit while still ensuring a fair payment for services. Using a commercial benchmark, such as the median in-network rate, is an option. This approach was proposed by the House Energy and Commerce Committee and passed by the Senate Health, Education, Labor, and Pension Committee.[142] The CBO expected it to generate greater savings to premiums and the deficit than the NSA as enacted.[143] Using a payment standard that is a multiple of Medicare rates instead could produce even greater premium savings, depending on the multiple selected.[144]

Short of replacing IDR, Congress could focus on addressing abuses of and issues with the IDR system that increase the number of disputes and inflate awards well beyond median contracted rates.

Close surprise billing gaps

Congress excluded ground ambulances from NSA protections, opting instead to further study the issue. The study committee recommended a federal ban on ambulance surprise billing, but rejected the use of IDR to determine payments due to concerns about its suitability for an industry largely made up of small-scale, locally operated providers.[145] Instead, it recommended a tiered payment standard that defers first to any state surprise billing system, followed by any state or locally set rate with sufficient guardrails to control costs.[146] Where those do not exist, the payment would be benchmarked to an unspecified percentage of the Medicare rate. Twenty-four states have passed ground ambulance surprise billing protections. Many state laws also favor locally set rates and default to a percentage of Medicare where local rates do not exist.[147]

Congress should protect consumers from ground ambulance surprise bills and take care not to set an out-of-network ambulance payment standard that is inflationary. It can look to states that have worked toward this end. For example, North Dakota and Maine limit payments to 250 percent and 180 percent of the Medicare rate, respectively, which are lower than most states' benchmarks.[148,149] Oregon defers first to locally set rates, but requires localities to publicly justify them to guard against arbitrary or inflated prices.

In addition, federal policymakers should close other NSA gaps and clarify gray areas in consumer protections, including:

- Expanding the list of care settings to which NSA protections apply to include birthing centers, clinics, hospices, addiction treatment facilities, nursing homes, and urgent care centers;[150]
- Extending protections to out-of-network services stemming from referrals by in-network providers, such as lab and imaging services;
- Improving consumer protections for emerging non-network health insurance plans, in which all services are provided on an out-of-network basis;[151] and
- Strengthening continuity of care protections included in the NSA to improve access to ongoing care during coverage disruptions.[152]

Rein In Health Care Financialization and Profit-seeking Middlemen

Policy Proposals

- Prohibit anti-competitive and problematic financial relationships among and between health care middlemen, providers, and insurers.
- Prohibit common financial extraction practices in private equity health care transactions.

DISCUSSION

The actors in our health care system have become increasingly financially interdependent. Consolidation and financialization throughout the sector are creating incentives that drive up health care costs without adding clinical value. Insurers, providers, third-party administrators (TPAs), and other "middleman" companies use a complex array of ownership, contracting arrangements, and financial deals that create conflicts of interest and extract profit, often to the detriment of patient care.[153] To take one example, there is increasing evidence that TPAs frequently do not act in the best interest of the employer-sponsored health plans they are supposed to serve, instead engaging in questionable practices such as paying inflated claims and then charging employers a "recovery fee" when they later correct their own errors, or using employer plan funds to settle debts or legal obligations incurred via their fully insured business, known as "cross-plan offsetting."[154] Ultimately, these inflated costs get passed onto workers and their families in the form of suppressed wage growth and/or higher premiums and cost-sharing.

Meanwhile, while private equity investment can provide a critical injection of capital into financially strapped hospitals and other providers, that investment comes at a steep price. Private equity is a business model that relies on financial engineering and debt financing to drive up short-term profits.[155] Private equity's growing involvement in the health care sector–from nursing homes and hospitals to, increasingly, physician practices and other ancillary services–has resulted in these providers primarily pursuing short-term profit objectives that drive up costs while stinting on patient care, clinical quality, and physician autonomy.[156] Further, private equity's practice of loading debt onto its acquisitions too often results in the target entity's ultimate bankruptcy.[157] When a hospital system goes bankrupt, it not only puts patients at risk but also has a devastating economic impact on often vulnerable and underserved communities.[158]

Rein in self-dealing and profit-extracting middlemen

In addition to rationalizing payment rates in highly consolidated health care ecosystems (see above), policymakers should consider greater regulation of the self-dealing caused by the proliferation of a cadre health care middlemen that contribute to rising costs but contribute nothing to patient care.[159] Detailing all the types of profit-extracting health care middlemen in our health care ecosystem is beyond the scope of this issue brief, but they include TPAs, pharmacy benefit managers (PBM), revenue cycle managers, claims management companies, claims re-pricers, point solution vendors, and medical service organizations, to name a few.[160] Policies to rein in the most abusive practices could include, for example, limiting or prohibiting:

- Common ownership across conflicted stakeholders, such as insurers owning providers or operating TPAs;
- TPAs generating revenue from side deals, hidden fees, and vendor kickbacks, limiting them to per-member-per-month fees alone, so that employers have an opportunity to engage in apples-to-apples price comparisons;
- Anti-competitive contracting practices such as requiring employers to use their TPAs' chosen vendors, all-or-nothing clauses, and provider revenue neutrality agreements; and
- Shared savings agreements and certain revenue-generating practices that constitute self-dealing, such as incentives for physicians to send patients to insurer-owned imaging facilities.

Rein in harmful financial tactics

Policymakers can rein in financial practices that prioritize profits over patient care by prohibiting practices, all common in private equity health care transactions, that serve to maximize short-term profits but leave providers financially vulnerable, divert resources from patient care, and increase health system costs.[161] These include, for example:

- High levels of debt financing and other financial tactics that hollow out critical health care infrastructure;
- Ownership of conflicted entities by a single firm; and
- Low staff-to-patient ratios that result in reduced quality of care and worse health outcomes.

Further, several states have begun requiring the public reporting of health entity ownership and greater transparency over the financial health of hospitals and other critical health care entities; federal lawmakers could do the same.[162]

Reduce Medical Debt

Policy Proposal

- Create a Hospital Fair Billing Certification program to strengthen hospital financial assistance policies, restrain financially ruinous collection practices, and prevent the accumulation of medical debt.

DISCUSSION

One of the most common symptoms of the extractive financial practices characteristic of American health care is the prevalence of medical debt, which is closely related to high prices for health care services and high deductibles and other excessive cost-sharing requirements. Families with medical debt can experience aggressive debt-collection tactics from their health care provider or a debt collector and may avoid needed care for fear of accumulating further debt. In 2022, more than 40 percent of American adults reported holding debt related to medical or dental bills, and more than 15 percent of American adults live in families with past-due medical debt.[163,164,165] Unlike other types of debt, consumers do not willingly decide to take on the obligation of medical debt—instead, a health crisis or unexpected health care bills force them to assume this debt. Almost three-quarters of adults with medical debt report owing at least some of their debt to acute care hospitals; to ameliorate some of this burden, states have sought to protect consumers by requiring hospitals to offer financial assistance and reasonable payment plans, and by limiting the interest rates hospitals can charge on medical debt.[166] The federal government also requires non-profit hospitals to provide some degree of free or discounted services as a condition of receiving tax-exempt status. Nevertheless, individuals who owe unpaid bills to hospitals report higher total amounts of medical debt than those whose unpaid medical bills are owed to non-hospital providers. In addition, most adults with past-due hospital bills report being contacted by a collection agency about their debt.[167] People with medical debt report draining their savings, reducing their spending on essential items such as food, clothing, and household basics, and borrowing from friends and family as they try to manage their debt.[168]

Create a Hospital Fair Billing Certification program

A Hospital Fair Billing Certification program—managed by an accrediting body or by the Department of Health and Human Services (HHS)—could create new incentives for hospitals to minimize patients' risk of incurring significant medical debt from hospital-based care and to improve patients' experience with hospital billing. Depending on policymakers' choices, these incentives could be financial or administrative. For example, fair billing-certified hospitals could receive an incentive bonus as part of Medicare reimbursement, or hospitals that fail to become certified could incur a financial penalty. Alternatively, hospitals could be required to obtain certification as a Condition of Participation for the Medicare program. Specific criteria for certification, which would be defined at a more granular level by HHS, would apply to all private (non-profit and for-profit) and public hospitals, and could encompass:

- Provision of at least a minimum level of patient financial assistance in the form of free and discounted care, with discounted care calculated from the hospital's lowest negotiated rate;
- Patient eligibility for financial assistance based on income, insurance status, and adequacy of coverage, with patients whose income is within specific federal poverty levels eligible for free and discounted care;
- Streamlined financial assistance eligibility processes, such as presumptive eligibility and self-declaration of income and/or assets;
- Application of clear and understandable billing standards, including consolidated billing requirements;
- A six-month limit on delayed billing;
- Limits on the interest rates hospitals can charge for medical debt;
- Restrictions on selling medical debt to third-party collection agencies or filing suit against patients to collect unpaid bills unless patients have been screened for financial assistance eligibility and offered a payment plan;
- New consumer-disclosure requirements for debt collection agencies, such as the clear identification of each bill the agency is trying to collect by service, provider, and service date;
- Prohibition against garnishing patients' wages or seizing patients' assets in an effort to collect medical debt; and
- Prohibition on reporting medical debt to credit reporting agencies.

Conclusion

The approximately 161 million people who receive health insurance coverage in the commercial market, whether through their employer or the ACA Marketplaces, are increasingly struggling with rising costs, a confusing tangle of red tape and complexity, and health industry actors who can no longer be trusted to prioritize patient outcomes over profits. These individuals deserve urgent and meaningful action to improve health care affordability and lower barriers to high-quality health care. Although the challenges can feel intractable, there are policy solutions. The reforms presented here provide a roadmap

to improve the value of health insurance and reduce costs for employers and those enrolled in coverage.

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The Center on Health Insurance Reforms is an independent and trusted policy and research center at Georgetown University's McCourt School of Public Policy. Our team of nationally recognized experts collaborates with policymakers and others who have a stake in health care to make health insurance work for everyone.

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Endnotes

[1]Kearney A, et al., "KFF Health Tracking Poll: Health Care Costs and the Midterms," KFF, Apr. 29, 2026, https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-and-the-midterms/.

[2]Rakshit S, et al., "How Has U.S. Spending on Healthcare Changed Over Time?" Peterson-KFF Health System Tracker, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#:~:text=On%20a%20per%20enrollee%20basis,and%2051.6%25%2C%20respectively.

[3]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey*, KFF, Oct. 2025, https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf.

[4]Pollitz K, Pestaina K, Lopes L, Wallace R, Lo J, "Consumer Problems with Prior Authorization: Evidence from KFF Survey," KFF, Sept. 2023, https://www.kff.org/affordable-care-act/consumer-problems-with-prior-authorization-evidence-from-kff-survey/.

[5]Fuse Brown EC, Rooke Ley H, "Health Care Financialization," *J. Health Care Law and Policy* 29, no. 1 (2026), http://dx.doi.org/10.2139/ssrn.5384530.

[6]KFF, "Health Insurance Coverage of the Total Population: 2024," https://www.kff.org/state-health-policy-data/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed Apr. 11, 2026).

[7]Reich RB, "Why We Need a Public Option Plan," *Wall Street Journal*, Jun. 24, 2009, https://www.wsj.com/articles/SB124580516633344953.

[8]Rakshit S, et al., "How has US spending on health care changed over time?"

[9]Health Care Cost Institute, *2022 Health Care Cost and Utilization Report*, Apr. 2024, https://healthcostinstitute.org/images/pdfs/HCCI_2022_Health_Care_Cost_and_Utilization_Report.pdf.

[10]Anderson GF, Hussey P, Petrosyan V, "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs (Millwood)* 38 no. 1 (2019): 87-95. https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05144.

[11]Hartman M, et al., "National Health Care Spending Increased 7.2 Percent in 2024 as Utilization Remained Elevated," *Health Affairs (Millwood)* 45, no. 2 (2026): 110-120. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01683.

[12]Munira GZ, Gumas ED, Williams RD, "U.S. Healthcare from a Global Perspective, 2026," *Commonwealth Fund*, May 2026, https://www.commonwealthfund.org/publications/issue-briefs/2026/may/us-health-care-global-perspective-2026.

[13]Bell D, "2026 Milliman Medical Index," Milliman, May 2026, https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/2026_Milliman-Medical-Index.pdf.

[14]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[15]United States of Care, "The Affordability Gap: When Employer Coverage Isn't Enough," Jun. 2026, https://unitedstatesofcare.org/wp-content/uploads/2026/06/USofCare_ESIAffordabilityPoll_FactSheet.pdf.

[16]Kearney A, et al., "KFF Health Tracking Poll: Health Care Costs and the Midterms."

[17]Blumberg LJ, Lucia K, Watts K, "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, Oct. 2025, https://georgetown.app.box.com/file/2029658870349?s=rtmi4pbcyz2wav084pphsmvof9085ibp.

[18]Maese E, "U.S. Adults' Ability to Afford Healthcare at a Five-Year Low," Gallup, Jun. 18, 2026, https://news.gallup.com/poll/710942/adults-ability-afford-healthcare-five-year-low.aspx.

[19]Claxton G, Rae M, Winger A, "Employer-Sponsored Health Insurance 101," KFF, Apr. 15, 2026, https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/.

[20]Collins SR and Gupta A, "The State of Health Insurance Coverage in the U.S.: Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey," Commonwealth Fund, Nov. 21, 2024, https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey.

[21]Agarwal R, Mazurenko O, Menachemi N, "High-deductible health plans reduce health care cost and utilization, including use of needed preventive services." *Health Affairs* 36, no. 10 (2017): 1762-1768, https://doi.org/10.1377/hlthaff.2017.0610.

[22]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[23]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[24]Bureau of Labor Statistics, "High-Deductible Health Plans and Health Savings Accounts," Last modified Apr. 11, 2025. https://www.bls.gov/ebs/factsheets/high-deductible-health-plans-and-health-savings-accounts.htm.

[25]KFF, "Deductibles in ACA Marketplace Plans," Nov.6, 2025, https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/.

[26]The Commonwealth Fund's definition of underinsurance classifies households as underinsured if they meet indicators including out-of-pocket costs in the prior 12 months that exceed 10 percent of household income. See Collins SR and Gupta A, "The State of Health Insurance Coverage in the U.S." The Commonwealth Fund, Nov. 21, 2024, https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey. Income data from the Kollar M, Scherer Z, Income in the United States: 2024. Current Population Reports, P60-286. Washington, DC: U.S. Census Bureau, Sept. 2025. https://www.census.gov/library/publications/2025/demo/p60-286.html.

[27]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[28]Lukens G, "Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care." Center on Budget and Policy Priorities, Jun. 22, 2023, https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care.

[29]U.S. Treasury Department, Fiscal Year 2027 Tax Expenditures, https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures (accessed May 1, 2026).

[30]Godwin J, Levinson Z, Neuman T, "Hospital Spending Accounted for 40% of the Growth in National Health Spending Between 2022 and 2024," KFF, Feb. 11, 2026, https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/.

[31]Levinson Z, Godwin J, Hulver S, "One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas," KFF, Jan. 4, 2024, https://www.kff.org/health-costs/issue-brief/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas/.

[32]Levinson Z, et al., "Ten Things to Know About Consolidation in Health Care Provider Markets," KFF, Apr. 19, 2024, https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/.

[33]Levinson Z, et al., "Key Facts about Hospitals: Hospital Prices and Price Growth by Payer," KFF, Feb. 19, 2025, https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=hospital-prices-price-growth-by-payer.

[34]Medicare Payment Advisory Committee, "Report to the Congress: Medicare Payment Policy, Hospital inpatient and outpatient services," Mar. 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

[35]Berenson RA, Murray RC, "Guiding the Invisible Hand: Practical Policy Steps to Limit Provider Prices in Commercial Health Insurance Markets," Urban Institute, May 2023, https://www.urban.org/sites/default/files/2023-05/Guiding%20the%20Invisible%20Hand.pdf.

[36]Whaley CM, et al., *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative*, RAND Corporation, Dec.10, 2024, https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.

[37]Murray RC, et al., "Hospital Facility Prices Declined As A Result Of Oregon's Hospital Payment Cap: Study examines hospital facility prices under Oregon's payment cap," *Health Affairs* 43, no. 3 (2024): 424-432.

[38]Murray RC, Norton EC, Ryan AM. "Oregon's Hospital Payment Cap and Enrollee Out-of-Pocket Spending and Service Use." In *JAMA Health Forum* 5, no. 8 (2024): e242614-e242614. American Medical Association, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2822684.

[39]Indiana Pub. L. No. 216-2025 (May 6, 2025), https://iga.in.gov/legislative/2025/bills/house/1004/details.

[40]Vermont Acts No. 68 (June 12, 2025), https://legislature.vermont.gov/bill/status/2026/S.126.

[41]Liu JL, Levinson ZM, Qureshi N, Whaley CM, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans*, RAND, Feb. 2021. https://www.rand.org/pubs/research_reports/RRA805-1.html

[42]Murray RC, Whaley CM, Fuse Brown EC, Ryan AM. "Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy" *Health Affairs* 43, no. 12 (2024): 1680-1688, https://doi.org/10.1377/hlthaff.2023.01021. Estimates that a hospital price cap set at 200 percent of Medicare rates would have saved $88 billion in the commercial market in 2022.

[43]Committee for a Responsible Federal Budget, "Capping Hospital Prices," Feb. 23, 2021, https://www.crfb.org/papers/capping-hospital-prices. Estimates that capping hospital prices at 200 percent of Medicare would reduce commercial market premiums by $889 billion and enrollee cost-sharing by $99 billion over a decade (2021-2030).

[44]Committee for a Responsible Federal Budget, "Capping Hospital Prices." Tax revenue increases as employers shift compensation from non-taxable health benefits to taxable wages in response to lower premiums.

[45]42 U.S.C. § 300gg-13.

[46]Amin K, et al., "Preventive Services Use Among People with ACA Coverage," Peterson-KFF Health System Tracker, Mar. 20, 2023, https://www.healthsystemtracker.org/brief/preventive-services-use-among-people-with-private-insurance-coverage.

[47]Institute of Medicine Committee on the Future of Primary Care, Donaldson MS, Yordy KD, Lohr KN, et al., editors, "The Value of Primary Care," *Primary Care: America's Health in a New Era*, 1996, https://www.ncbi.nlm.nih.gov/books/NBK232636.

[48]Kesselheim A, et al., "Prescription Drug Insurance Coverage and Patient Health Outcomes: A Systematic Review," *Am J Public Health* 105 no. 2 (Feb. 2015):e17–e30, https://pmc.ncbi.nlm.nih.gov/articles/PMC4318289/.

[49]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[50]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[51]Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, "Prescription Drug Spending, Pricing Trends, and Premiums in Private Health Insurance Plans," Nov. 2024, https://aspe.hhs.gov/reports/nsa-drug-pricing-rtc.

[52]42 U.S.C. § 300gg-13.

[53]Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance, "Q&A Chapter 342 of the Acts of 2024 Coverage for Certain Prescription Drugs to Treat Certain Chronic Conditions," n.d., https://www.mass.gov/info-details/qa-chapter-342-of-the-acts-of-2024-coverage-for-certain-prescription-drugs-to-treat-certain-chronic-conditions (accessed May 23, 2026).

[54]Swindle R, Clark J, Giovanelli J, Schwab R, "ACA State Marketplace Models and Key Policy Decisions," updated Mar. 14, 2025, The Commonwealth Fund, https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions.

[55]Bipartisan Policy Center, "Prescription Drug Affordability: Examining Select Price Drivers," Apr. 2026, https://bipartisanpolicy.org/issue-brief/prescription-drug-affordability-examining-select-price-drivers/.

[56]Agboola F, et al., "Launch Price and Access Report," Institute for Clinical and Economic Review, Oct. 2025, https://icer.org/assessment/launch-price-and-access-2025/#overview.

[57]Rome B, et al., "Trends in Prescription Drug Launch Prices, 2008-2021," JAMA 327, no. 21 (2022): 2145-2147, https://jamanetwork.com/journals/jama/fullarticle/2792986.

[58]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey.*

[59]Martin K, "How Inflation Rebates Can Curb Drug Price Increases," The Commonwealth Fund, Oct. 28, 2025, https://www.commonwealthfund.org/publications/explainer/2025/oct/how-inflation-rebates-can-curb-drug-price-increases.

[60]"Lowering Drug Costs for American Families Act," H.R. 6166, 119th Congress, https://www.congress.gov/bill/119th-congress/house-bill/6166/text.

[61]Reitsma R, et al., "Estimated Savings From Extending Prescription Drug Inflationary Rebates to All Commercial Plans," *Health Affairs* 44, no. 3 (2025): 256-264, https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00724.

[62]Monahan C, et al., "Protecting patients from unexpected outpatient facility fees," Georgetown University Center on Health Insurance Reforms, 2023, https://facilityfeereform.chir.georgetown.edu/wp-content/uploads/Full-Report-Protecting-Patients-from-Unexpected-Outpatient-Facility-Fees-2023.pdf.

[63]Chang J, Sarfo L, "Prices in Hospital Outpatient Departments are Consistently Higher than Physician Offices among Site-Neutral Services," Health Care Cost Institute, Aug. 13, 2025, https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings/.

[64]Monahan C, et al., "Protecting patients from unexpected outpatient facility fees."

[65]Avalere Health, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment, 2019-2023," Physician Advocacy Institute, Apr. 2024, https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d.

[66]Capps C, Dranove D, Ody C, "The effect of hospital acquisitions of physician practices on prices and spending," Journal of Health Economics 59 (2018): 139–152, https://doi.org/10.1016/j.jhealeco.2018.04.001.

[67]Neprash HT, et al., "Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices," *JAMA Internal Medicine* 175, no. 12(2015):1932-1939, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591.

[68]Cooper Z, et al., "Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14," *Health Affairs* 38, no. 2 (2019): 184-189, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424.

[69]Health Care Cost Institute, *2022 Health Care Cost and Utilization Report*, Apr. 2024, https://healthcostinstitute.org/images/pdfs/HCCI_2022_Health_Care_Cost_and_Utilization_Report.pdf.

[70]24-A Maine Rev. Stat. §§ 1912, 2753, 2823-B, 4235.

[71]Medicare Payment Advisory Committee, "Aligning fee-for-service rates across ambulatory settings," Report to the Congress: Medicare and the Health Care Delivery System, Jun. 2023, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

[72]Parente ST, "Impact of Site-Neutral Payments for Commercial and Employer-Sponsored Plans," *Inquiry* 61 (Aug. 2024) https://pmc.ncbi.nlm.nih.gov/articles/PMC11348360/.

[73]Committee for a Responsible Federal Budget, "Moving to Site Neutrality in Commercial Insurance Payments," Feb. 2023, https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

[74]Georgetown University Center on Health Insurance Reforms and West Health, "Site-Neutral Payment Reform and the Commercial Market," Apr. 2026, https://chir.georgetown.edu/site-neutral-payment/#introduction.

[75]Kirzinger A, Montalvo III J, Hamel L. "KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care," KFF, Feb. 2, 2026, https://www.kff.org/public-opinion/kff-health-tracking-poll-prior-authorizations-rank-as-publics-biggest-burden-when-getting-health-care/.

[76]American Medical Association, *2024 AMA Prior Authorization Physician Survey*, Feb. 2025, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[77]Busch FS, Muller SV, *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*, Milliman, Mar. 30, 2023, https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf.

[78]AHIP, "Health Plans Take Action to Simplify Prior Authorization," [press release] Jun. 23, 2025, https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.

[79]Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access, etc.," 85 Fed. Reg. 25510, May 1, 2020, https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

[80]Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes, etc.," 89 Fed. Reg. 8758, Feb. 8, 2024, https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[81]Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Electronic Health Information Exchange, etc.," 91 Fed. Reg. 21450, Apr. 14, 2026), https://www.federalregister.gov/documents/2026/04/14/2026-07205/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-standards.

[82]29 CFR 2560.503-1(f)(2). The ACA applied these ERISA-plan standards to most individual and group health plans

[83]estaina K, Wallace R, Long M. "Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain," KFF, Oct. 8, 2025, https://www.kff.org/private-insurance/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/.

[84]National Association of Insurance Commissioners, Prior Authorization White Paper, Adopted by the Health Insurance and Managed Care (B) Committee, Dec. 11, 2025 https://content.naic.org/sites/default/files/inline-files/PA%20white%20paper%20Adopted%2012.10.2025%20by%20Cmte.pdf.

[85]Sullivan L, Celik Z, Killelea A, "Prior Authorization Reform Heats Up," *Health Affairs Forefront*, Nov. 24, 2025, https://www.healthaffairs.org/content/forefront/prior-authorization-reform-heats-up.

[86]Claxton G, et al., *Employer Health Benefits: 2025 Annual Survey*.

[87]Claxton G, et al., "How Employers Support Lower Waged Workers' Access to Health Insurance Options," KFF, Apr. 2026, https://www.healthsystemtracker.org/chart-collection/how-employers-support-lower-waged-workers-access-to-health-insurance-options.

[88]Magnacare, "What is Minimum Essential Coverage (MEC) and is it Right for Your Workforce?" Aug. 29, 2025, https://www.magnacare.com/blog/minimum-essential-coverage-for-your-workforce/#:~:text=Major%20medical%20plans%20typically%20cover,needed%20to%20satisfy%20ACA%20rules.

[89]Woodman S, "'Skinny' Health Insurance Plans are Letting Large Employers Continue to Deny Basic Medical Care to Their Workers," Vice.com, Jan. 5, 2015, https://www.vice.com/en/article/skinny-health-insurance-plans-might-be-the-worst-thing-about-2015/#:~:text=That%20veto%20could%20have%20had,are%20considering%20offering%20these%20plans.

[90]Cotter L, et. al, "Perspectives from Employers on the Costs and Issues Associated with Covering GLP-1 Agonists for Weight Loss," Peterson-KFF Health System Tracker, Oct. 22, 2025, https://www.healthsystemtracker.org/brief/perspectives-from-employers-on-the-costs-and-issues-associated-with-covering-glp-1-agonists-for-weight-loss/.

[91]Cystic Fibrosis Foundation, "CF Responds to a Request for Information on Access in Employer-sponsored Health Insurance," Mar. 15, 2024, https://www.cff.org/statements/2024-03/cf-foundation-rfi-response-access-employer-sponsored-health;

[92]The Lever, "Why Drugs are Disappearing from Your Insurance Coverage," Nov. 9, 2023, https://www.levernews.com/why-drugs-are-disappearing-from-your-insurance-coverage/.

[93]42 U.S.C. § 18022. The 10 categories of EHB are: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

[94]45 C.F.R. § 156.122.

[95]45 C.F.R. § 156.125.

[96]For example, to ensure that formulary standards reflect current clinical evidence, policymakers should consider shifting from using the U.S. Pharmacopeia Medicare Model guidelines to the U.S.P Drug Classification System. The latter is more frequently updated and better reflects the needs of an under-65 population. The standard could also be modified to require coverage of "all or substantially all" drugs in certain specified classes that are critical to vulnerable populations, similar to a requirement imposed on Medicare Part D insurers.

[97]42 U.S.C. § 18022; 45 C.F.R. §§ 156.100, 156.111.

[98]Centers for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," Dec. 16, 2011, https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

[99]Kogut SL, "A Primer on Quality Measurement and Reporting in Pharmacy Benefit Plans," *J. of Managed Care & Specialty Pharmacy* 30, no. 4 (2024):386-396, https://www.jmcp.org/doi/10.18553/jmcp.2024.23240.

[100]26 C.F.R. § 1.36B-6.

[101]Internal Revenue Service Rev. Proc. 2025-25, July 18, 2025, https://www.irs.gov/pub/irs-drop/rp-25-25.pdf.

[102]KFF, "Health Insurance Marketplace Calculator," 2026, https://www.kff.org/interactive/subsidy-calculator/ (accessed Apr. 28, 2026).

[103]Blumberg LJ, Buettgens M, Feder J, Holahan J, "Implications of the Affordable Care Act for American Business," Urban Institute, Oct. 2012, https://www.urban.org/sites/default/files/publication/25906/412675-Implications-of-the-Affordable-Care-Act-for-American-Business.PDF.

[104]Straw T, "Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers," Center on Budget and Policy Priorities, Dec. 3, 2019, https://www.cbpp.org/sites/default/files/atoms/files/12-2-19health.pdf.

[105]Banthin JS, Skopec L, Ramchandani U, "Improving Affordability of Insurance for Consumers by Eliminating the Firewall Between Employer and Individual Markets," The Commonwealth Fund, June 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/improving-affordability-insurance-consumers-eliminating-firewall#:~:text=Eliminating%20the%20firewall%20would%20save,people%20enrolling%20in%20marketplace%20coverage.

[106]Sparks G, et al., "Americans' Challenges with Health Care Costs," KFF, Apr. 30, 2026, https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.

[107]Lee J, "Medical Price Transparency: How Cost Confusion Delays Care," The Intake, Feb. 2, 2026, https://www.tebra.com/theintake/healthcare-reports/medical-price-transparency-survey.

[108]Doherty B, et al., "Patient Perspectives on Health Insurance Design: A Mixed-Methods Analysis," *J. Market Access and Health Policy.* 2025 Nov 14;13(4):56. https://pmc.ncbi.nlm.nih.gov/articles/PMC12641685/.

[109]Centers for Medicare & Medicaid Services, "Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation (December 2024 Update)," https://www.cms.gov/files/document/progress-aeob-rulemaking-december-2024-update1pm.pdf.

[110]S. 2355, 119th Cong. §§10, 11 (Jul. 17, 2025).

[111]Pollitz K, et al., "KFF Survey of Consumer Experiences with Health Insurance." KFF. Jun. 15, 2023. https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/.

[112]Centers for Medicare & Medicaid Services, "Summary of Consumer Assistance Program Grant Data from October 15, 2010 through October 14, 2011," n.d., https://www.cms.gov/cciio/resources/files/downloads/csg-cap-summary-white-paper.pdf (accessed Apr. 16, 2026).

[113]Fish-Parcham C, Benjamin ER, "Congress Should Appropriate Funds for Consumer Assistance Programs in Every State," Families USA, Jul. 2021, https://familiesusa.org/wp-content/uploads/2021/07/COV-2021-210_Fund-Consumer-Assistance-Programs-in-Every-State-Issue-Brief_v2.pdf.

[114]Section 1002 of the Affordable Care Act, codified as Section 2792 of the Public Health Services Act, 42 US Code § 300 gg-93.

[115]CMS, "Summary of Consumer Assistance Program Grant Data."

[116]Kliff S, "How Congress Quietly Killed Health Reform's Consumer Assistance Program," *The Washington Post*, Jan. 3, 2012. https://www.washingtonpost.com/blogs/ezra-klein/post/how-congress-quietly-killed-health-reforms-consumer-assistance-program/2012/01/03/gIQAwDi6XP_blog.html.

[117]Grob R, et al., "The Affordable Care Act's Plan for Consumer Assistance with Insurance Moves States Forward but Remains a Work in Progress," *Health Affairs* 32, no. 2 (2013): 347, https://doi.org/10.1377/hlthaff.2012.1090.

[118] .Fish-Parcham C, Benjamin ER. "Congress Should Appropriate Funds for Consumer Assistance Programs in Every State."

[119]Employee Benefits Security Administration, "About EBSA," U.S. Department of Labor, n.d., https://www.dol.gov/agencies/ebsa/about-ebsa (accessed May 31, 2026).

[120]Employee Benefits Security Administration. "EBSA Restores $1.4 Billion to Employee Benefit Plans, Participants, and Beneficiaries," U.S. Department of Labor, n.d. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/ebsa-monetary-results (accessed Apr. 17, 2026).

[121]U.S. Government Accountability Office, *Employee Benefits Security Administration: Systematic Process Needed to Better Manage Priorities and Increased Responsibilities*, GAO-24-105667, Oct. 24, 2023, https://www.gao.gov/products/gao-24-105667.

[122]U.S. Government Accountability Office, Employee Benefits Security Administration: Enforcement Efforts to Protect Participants' Rights in Employer-Sponsored Retirement and Health Benefit Plans, GAO-21-376, May 27, 2021, https://www.gao.gov/products/gao-21-376.

[123]American Society of Pension Professionals & Actuaries, "Aronowitz Discusses Litigation, Investment Selection Proposal," Apr. 10, 2026, https://www.asppa-net.org/news/2026/4/aronowitz-discusses-litigation-investment-selection-proposal/.

[124]Cooper Z, Scott Morton F, Shekita N, "Surprise! Out-of-network billing for emergency care in the United States," Journal of Political Economy 128, no. 9 (2020): 3626–3677. https://doi.org/10.1086/708819.

[125]Lopes L, Kearney A, Hamil L, Brodie M, "Data Note: Public Worries About And Experience With Surprise Medical Bills," KFF, Feb. 28, 2020, https://www.kff.org/health-costs/data-note-public-worries-about-and-experience-with-surprise-medical-bills/.

126

[127]Health Care Cost Institute, "Ground Ambulance Cost and Utilization, 2017-2021," [presentation] May 2023, https://healthcostinstitute.org/wp-content/uploads/images/pdfs/HCCI_Ambulance_Slides_2023.pdf.

[128]The NSA IDR process first allows providers and plans to negotiate directly to find a payment rate. If negotiations fail, the provider and plan can enter into IDR, a baseball-style arbitration process. In arbitration, both parties submit offers, expressed as a percent of the qualifying payment amount (QPA), the median in-network rate for a service in a given geography, as calculated by each plan. A third-party arbitrator will then select an offer and bind both sides to that amount.

[129]Congressional Budget Office, "H.R. 133, Estimate for Divisions O Through FF Consolidated Appropriations Act, 2021 Public Law 116-260," Jan. 14, 2021, https://www.cbo.gov/publication/56962.

[130]Keith K. "No Surprises Act Litigation Status Check," *Health Affairs Forefront*, May 4, 2026, https://www.healthaffairs.org/content/forefront/no-surprises-act-litigation-status-check.

[131]Hoadley J, Watts K. "The Substantial Costs of the No Surprises Act Arbitration Process." *Health Affairs Forefront*, Aug. 25, 2025. https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process.

[132]Congressional Budget Office, "A Call for New Research on the No Surprises Act," Jun. 15, 2026, https://www.cbo.gov/publication/62491.

[133]Hoadley, Watts, "Substantial Costs." Median contracted rates in this section are as represented by the qualifying payment amount (QPA), the median in-network rate for a service in a given geography, as calculated by each plan.

[134]Hoadley, Watts, "Substantial Costs."

[135]Sanger-Katz M, Kliff S, "Doctors and Insurers Are in a Billion-Dollar Fight Over Arbitration," *New York Times*, Apr. 22, 2026, https://www.nytimes.com/2026/04/22/us/politics/doctors-insurers-arbitration.html.

[136]Hoadley J, Watts K, Keith K, DeGarmo E, "The No Surprises Act IDR Process: An Early Look At 2025 Data," *Health Affairs Forefront*, Mar. 20, 2026, https://www.healthaffairs.org/content/forefront/no-surprises-act-idr-process-early-look-2025-data. While the number IDR disputes is far higher than anticipated and growing, it may still represent a small share of out-of-network services subject to the NSA, with most payments determined in informal negotiation. See Pelech D, "CBO's Approach to Estimating the Budgetary Effects of the No Surprises Act of 2021" [presentation], Mar. 7, 2024, Congressional Budget Office, https://www.cbo.gov/publication/59878.

[137]Adler L, Fiedler M, Agarwal V, "No Surprises Act Arbitration Databook," Brookings. Apr. 20, 2026, https://www.brookings.edu/articles/no-surprises-act-arbitration-databook/.

[138]Hoadley, Watts, "Substantial Costs."

[139]Senate Committee on Health, Education, Labor and Pensions, "Congressional Committee Leaders Announce Surprise Billing Agreement," [press release] Dec. 11, 2020, https://www.help.senate.gov/dem/newsroom/press/congressional-committee-leaders-announce-surprise-billing-agreement.

[140]Some early evidence suggests IDR costs are contributing to certain premium increases. See Congressional Budget Office, "A Call for New Research on the No Surprises Act," Jun. 15, 2026, https://www.cbo.gov/publication/62491; Sanger-Katz M and Kliff S, "Doctors and Insurers Are in a Billion-Dollar Fight Over Arbitration," *New York Times*, Apr. 22, 2026, https://www.nytimes.com/2026/04/22/us/politics/doctors-insurers-arbitration.html; and McGough M, et al. "How much and why ACA Marketplace premiums are going up in 2027," KFF, Jul. 8, 2026, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027.

[141]Pelech D, "CBO's Approach to Estimating the Budgetary Effects of the No Surprises Act of 2021" [presentation], Mar. 7, 2024, Congressional Budget Office, https://www.cbo.gov/publication/59878.

[142]The Senate HELP-passed bill required plans to reimburse out-of-network providers at their median in-network rate for a service for a given provider type and geographic area. S. 1895, 116th Cong. (Reported to Senate July 8, 2019).

[143]The CBO score for the Senate HELP bill shows deficit reduction of $25 billion and premium reduction of just over 1 percent; compared to the NSA's score of $17 billion in deficit reduction and premium reduction of 0.5 to 1 percent. Congressional Budget Office, "S. 1895, Lower Health Care Costs Act, Cost Estimate," Jul. 16, 2019, https://www.cbo.gov/publication/55457.

[144]Using in-network rates as a benchmark could lock in excess costs that a Medicare-based benchmark could avoid. Surprise billing is concentrated in physician specialties where patients lack choice over their treating provider. Because these providers can credibly threaten to leave insurance networks without losing patient volume, they are able to negotiate much higher contracted rates than other peer physicians relative to what Medicare would pay. See Adler L et al., "Comments on the House Energy and Commerce Committee's Discussion Draft to Address Surprise Medical Bills," USC-Brookings Schaeffer Initiative for Health Policy, May 2019, https://www.brookings.edu/wp-content/uploads/2019/05/Energy-and-Commerce-Discussion-Draft-Comments.pdf; and Adler L. "Policy Approaches to Addressing Surprise Out-of-Network Billing." [Presentation] USC-Brookings Schaeffer Initiative for Health Policy, Mar. 22, 2019. https://www.brookings.edu/wp-content/uploads/2019/01/Surprise-Billing-2-20-event-presentation_Adler.pdf.

[145]Ground Ambulance and Patient Billing Advisory Committee, *Report of the Advisory Committee on Ground Ambulance and Patient Billing: Prevention of Out-of-Network Ground Ambulance Emergency Service Balance Billing*, Mar. 29, 2024, https://www.cms.gov/files/document/report-advisory-committee-ground-ambulance-and-patient-billing.pdf.

[146]Hoadley J, Stovicek N, "Expanding the No Surprises Act to Protect Consumers from Surprise Ambulance Bills," The Commonwealth Fund, Feb. 15, 2024, https://www.commonwealthfund.org/blog/2024/expanding-no-surprises-act-protect-consumers-surprise-ambulance-bills.

[147]Harden-Stein M, Hoadley J, "Consumers Still Face Surprise Bills for Ground Ambulances — States Are Trying to Protect Them," The Commonwealth Fund, Feb. 18, 2026. https://www.commonwealthfund.org/blog/2026/consumers-still-face-surprise-bills-ground-ambulances-states-are-trying-protect-them.

[148]Harden-Stein, Hoadley, "Consumers Still Face Surprise Bills."

[149]Harden-Stein M, "Expanding the No Surprises Act to Protect Consumers from Surprise Ambulance Bills: Map of State Laws," The Commonwealth Fund, updated Jun. 16, 2026, https://www.commonwealthfund.org/publications/maps-and-interactives/expanding-no-surprises-act-protect-consumers-surprise-ambulance. In Maine, ambulance service providers in rural areas can receive additional Medicare-based payments above the 180% of Medicare reimbursement cap.

[150]Pollitz K, "No Surprises Act Implementation: What to Expect in 2022," KFF, Dec. 10, 2021. https://www.kff.org/affordable-care-act/no-surprises-act-implementation-what-to-expect-in-2022/.

[151]As federal guidance makes clear, consumers are not protected from the full range of NSA-covered surprise bills in plans that lack networks. See U.S. Department of Labor, U.S. Department of Health and Human Services, and U.S. Department of the Treasury, "FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 implementation Part 55," Aug. 19, 2022, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf.

[152]Corlette S, Kona M, "The State of State Protections: Maintaining Access to Services After Transitioning from Medicaid," Commonwealth Fund, Feb. 6, 2023. https://doi.org/10.26099/srxn-ed89.

[153]Blumberg LJ, Lucia K, Watts K, "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, Oct. 2025, https://georgetown.app.box.com/file/2029658870349?s=rtmi4pbcyz2wav084pphsmvof9085ibp.

[154]Monahan C, "Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators," Georgetown University Center on Health Insurance Reforms, Mar. 24, 2023, https://chir.georgetown.edu/questionable-conduct-allegations-insurers-acting-third-party-administrators/#:~:text=The%20lawsuit%20alleges%20that%20Elevance,for%20itself%2C%20or%20it%20is

[155]Blumberg LJ. Watts K, "Evidence on Private Equity Suggests That Containing Costs and Improving Outcomes May Go Hand-In-Hand," *Health Affairs Forefront*, Apr. 23, 2024, https://www.healthaffairs.org/content/forefront/evidence-private-equity-suggests-containing-costs-and-improving-outcomes-may-go-hand.

[156]Fuse Brown E, Rooke-Ley H, "Health Care Financialization," *J. Health Care L. & Policy* 29, no. 1 (2026), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5384530.

[157]Flores J, "Private Equity Bankruptcy Tracker," Private Equity Stakeholder Project, Feb. 20, 2026 (finding that private equity played a role in 54 percent of the largest U.S. corporate bankruptcies in 2025), https://pestakeholder.org/reports/private-equity-bankruptcy-tracker/.

[158]Goldstein A, Agarwal V, "Lessons from the Collapse of Steward Health Care: A Case Study," Brookings, Oct. 2, 2025, https://www.brookings.edu/articles/lessons-from-the-collapse-of-steward-health-care/.

[159]Burleson J, "Vertical Integration in Health Care: Implications for Consumers, Employers, and Clinicians," CHIRblog, May 12, 2026, https://chir.georgetown.edu/vertical-integration-in-health-care-implications-for-consumers-employers-and-clinicians/.

[160]Blumberg LJ, Lucia K, Watts K, "The Complex Web of Health Care Financial Interests."

[161]Georgetown University Center on Health Insurance Reforms, "Untangling the Complex Web of Health Care Financial Interests," [webinar] Apr. 10, 2026, https://chir.georgetown.edu/events/untangling-the-complex-web-of-health-care-financial-interests-2/.

[162]For example, California maintains a comprehensive reporting framework that includes requiring detailed financial reports from health care entities and a team of auditors and data analysts who verify the information and create publicly available charts and reports. California also requires annual ownership reporting for all entities who have a five percent or more interest in the hospital. See California Department of Health Care Access and Information, "Hospital Financials," https://hcai.ca.gov/data/cost-transparency/hospital-financials/ (accessed May 20, 2026) and "Accounting and Reporting Manual for California Hospitals, Second Edition," https://hcai.ca.gov/data/submit-data/financial-reporting/#accounting-and-reporting-manual-for-california-hospitals-second-edition (accessed May 20, 2026).

[163]Sparks G, et al., "Americans' Challenges with Health Care Costs," KFF, April 30, 2026, https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.

[164]Karpman M, "Most Adults with Past-Due Medical Debt Owe Money to Hospitals," Urban Institute, Mar. 2023, https://www.urban.org/sites/default/files/2023-03/Most%20Adults%20with%20Past-Due%20Medical%20Debt%20Owe%20Money%20to%20Hospitals_0.pdf.

[165]Consumer Financial Protection Bureau, "Medical Debt Burden in the United States," Feb. 2022, https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

[166]Georgetown University Center on Health Insurance Reforms, "Hospital Consumer Financial Protections," Nov. 2025, https://chir.georgetown.edu/state-oversight-of-hospitals/; https://www.urban.org/sites/default/files/2023-03/Most%20Adults%20with%20Past-Due%20Medical%20Debt%20Owe%20Money%20to%20Hospitals_0.pdf.

[167]Karpman M, "Most Adults with Past-Due Medical Debt Owe Money to Hospitals."

[168]Undue Medical Debt, "Medical Debt, Money, and Mental Health," Sept. 2024, https://unduemedicaldebt.org/medical-debt-money-and-mental-health/.