EXECUTIVE SUMMARY

A 3-Part Strategy for Better Health Insurance

Reducing Costs, Complexity, and Corporate Abuses

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September 2026

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Executive Summary

Americans rank health care costs above utilities, housing, and groceries as a top financial stress. Over the past 15 years, per-enrollee spending in private commercial health insurance grew by 96.5 percent, compared to 59.5 percent in Medicare and 51.6 percent in Medicaid. This rapid cost growth is driven primarily by excessive hospital prices and profits extracted by an increasingly corporatized health care system, rather than by improved patient care.

The Policy Dilemma: Health plans have historically responded to rising provider prices by shifting costs onto families via high deductibles, which have grown 43 percent in the last decade, and aggressive prior authorization strategies. Meanwhile, vertical integration and private equity are inflating unit costs. This report outlines a pragmatic set of federal policies built on two principles: (1) lowering direct out-of-pocket spending and administrative complexity for patients, and (2) constraining the underlying drivers of commercial market cost growth to reduce premiums.

Part I: Reducing Health Care Costs

Patients need relief from high deductibles that force them to skip needed care or face medical debt. To prevent lower out-of-pocket spending from driving up insurance premiums, that relief needs to be paired with hospital price caps and prescription drug cost containment.

CAP OUT-OF-POCKET COSTS AND LIMIT HOSPITAL PRICE INFLATION

Policy Action: Mandate Federal Caps on Deductibles and Out-of-Pocket Maximums

In 2026, maximum out-of-pocket (MOOP) limits are **$10,600 for individuals** and **$21,200 for families**, while single deductibles average $1,886 in employer plans and over $3,700 in the ACA Marketplaces. To protect families from excessive and financially ruinous out-of-pocket costs:

- **Cap annual deductibles** at **$1,000 single/$2,000 family.**
- **Lower MOOP** to **$4,000 single/$8,000 family.** Index caps to wage growth rather than inflation.

Capping deductibles would sunset high deductible health plans and tax-favored HSAs, which overwhelmingly benefit high earners. Ending HSA tax preferences saves the federal budget **$15 billion in 2026** and **$182 billion over 10 years**.

Cost Impact

Capping commercial hospital prices at 200 percent of Medicare rates would save employers and consumers **$88 billion/year in premiums** and **$10 billion/year in out-of-pocket costs**. It would reduce the federal deficit by **$216 billion over 10 years**.

Policy Action: Establish a Medicare-Referenced Hospital Price Cap

Unchecked hospital consolidation has led hospital systems to charge commercial insurers an average of **267 percent of Medicare rates**, well above the cost of delivering care. States like Indiana, Oregon, Washington, and Vermont have introduced price caps pegged to a Medicare reference price.

MAKE HIGH-VALUE SERVICES AND PRESCRIPTION DRUGS MORE AFFORDABLE

Policy Action: Eliminate Cost-Sharing for High Value Primary & Chronic Care

Congress should require all commercial health plans to cover essential high-value services pre-deductible with **$0 cost-sharing**:

- **Primary & Urgent Care:** Up to 3 primary care visits and 2 urgent care visits per year.
- **Behavioral Health:** Up to 3 outpatient mental health or substance use visits per year.
- **Chronic Disease Management:** No cost-sharing for high-value generic medications and maintenance drugs necessary to manage chronic conditions.

Policy Action: Extend Medicare Prescription Drug Negotiation and Inflation Rebates to Commercial Plans

Average launch prices for new drugs rose **20 percent annually** from 2008 to 2021, with 47 percent launching above $150,000/year. Congress should extend Medicare Price Negotiation and Part D/Part B Inflation Rebates to commercial health insurance.

Cost Impact

Applying Medicare price inflation rebates to commercial prescriptions would have generated **$8.1 billion** in savings in 2021 alone, curbing premium growth and protecting patients from high cost-sharing.

END ABUSIVE BILLING PRACTICES

Policy Action: End Facility Fees & Establish Site-Neutral Payment

Hospitals acquiring physician practices reclassify doctors' offices as hospital outpatient departments (HOPD), adding a separate "facility fee" that can make identical care three times more expensive.

- **Prohibit Facility Fees.** Ban hospitals from billing, and commercial plans from paying, facility fees for routine office visits in on-campus or off-campus hospital outpatient settings.
- **Site-Neutral Payment Standard.** Require commercial payment for outpatient services that are safely provided in non-hospital settings to be reimbursed at site-neutral rates.

Cost Impact

Commercial site-neutral payment reform is projected to reduce total national health expenditures by **$458 billion to $900 billion over 10 years** and reduce financial incentives for provider vertical integration.

Part II: Reducing Unnecessary Complexity

Overwhelming paperwork and fragmented standards burden patients and providers alike. Part II reduces barriers to care, aligns standards across coverage programs, and improves transparency.

REDUCE RED TAPE AND RAISE BENEFIT STANDARDS

Policy Action: Extend Updated Federal Prior Authorization Standards and Adopt Commonsense State Reforms

Physicians spend an average of 13 hours per week navigating prior authorization (PA). Centers for Medicare & Medicaid Services (CMS) PA rules apply to Medicare Advantage and Marketplace plans but exclude employer-based plans. Congress should apply modern federal rules across all commercial coverage.

- **Electronic Standards and Timeframes.** Require automated PA workflows and uniform decision time limits.
- **Commonsense State Reforms.** Mandate 12-month PA validity for chronic care; require peer-specialist review for denials; prohibit AI from making final adverse decisions; ban retrospective denials of pre-approved care.

Policy Action: Establish a Market-Wide Minimum Benefit Standard

The ACA's Essential Health Benefits (EHB) currently apply only to individual and small-group plans. Large employer plans can offer skimpy benefits or exclude critical high-cost drugs (e.g. GLP-1s, oncology, cystic fibrosis therapies).

- **Universal EHB Floor.** Extend EHB standards to large-group and self-funded employer health plans.
- **Formulary Protections.** Require plans to maintain clinician-led and patient-informed Pharmacy & Therapeutics committees, cover minimum USP categories, and provide efficient exception processes.

Policy Action: Eliminate the ESI Firewall

The ACA "firewall" prevents low-wage workers offered employer-sponsored insurance (ESI) from obtaining Marketplace Premium Tax Credits (PTC) unless ESI costs exceed 9.96 percent of income (2026). A worker earning $23,000 may pay $190/month for skimpy ESI, whereas comprehensive Marketplace coverage with PTCs would cost $77/month.

Cost Impact

Eliminating the ESI firewall allows low-income workers to enroll in affordable Marketplace plans, saving affected consumers **$4.4 billion annually** in out-of-pocket costs and **reducing employer health spending by $8.1 billion**. Federal PTC outlays would increase by $17.8 billion annually.

IMPROVE TRANSPARENCY AND CONSUMER SUPPORT

Policy Action: Ban Coinsurance and Enforce Advance Explanation of Benefits (AEOB)

Coinsurance leaves patients unable to calculate pre-treatment costs. Congress should **prohibit coinsurance** in favor of fixed

copayments. Additionally, Congress must compel enforcement of the AEOB and give patients binding out-of-pocket estimates prior to scheduled care.

Policy Action: Permanently Fund State Consumer Assistance Programs (CAPs) & Department of Labor Advisors

Over 60 percent of enrollees experience insurance billing errors or denials. Initial ACA seed funding for state CAPs expired after 2010. Congress should establish a dedicated annual fund of **$400 million** to restore state CAPs and boost funding for Department of Labor benefit advisors.

Part III: Protecting Patients from Corporate Abuses

REFORM THE NO SURPRISES ACT (NSA) & CLOSE PATIENT PROTECTION GAPS

Policy Action: Replace Abuse-Prone Independent Dispute Resolution (IDR) and Expand Consumer Protections

The NSA protected consumers from surprise emergency bills, but its IDR process has been abused by private equity-backed groups. Over 1 million disputes were filed in early 2025 alone, with providers winning 88 percent of cases. The IDR process has **added $2.0–$2.5 billion annually** to overall health system costs.

- **Set a Non-inflationary Benchmark.** Replace IDR with a statutory payment standard pegged to median in-network contracted rates or a defined multiple of Medicare rates.
- **Close Protection Gaps.** Extend surprise billing bans to **ground ambulances** (where out-of-network trips average more than $1,000), and expand NSA coverage to birthing centers, urgent care, addiction facilities, and out-of-network lab referrals.

CURTAIL HEALTH CARE FINANCIALIZATION AND PRIVATE EQUITY ABUSES

Policy Action: Prohibit Anti-Competitive Self-Dealing & Restrain Private Equity Asset Stripping

Massive vertical and horizontal consolidation has combined insurers, providers, and a wide range of profit-extracting administrative middlemen into corporate behemoths. These entities are riddled with conflicts of interest, raise costs, and reduce the quality of patient care. Meanwhile, Private Equity (PE) firms load health facilities with debt, strip real estate assets, jack up rates, and reduce clinical staffing.

- **Ban Self-Dealing & Anti-Competitive Contracts.** Restrict common ownership between insurers, third-party administrators (TPA), and provider groups. Limit TPA compensation strictly to transparent per-member-per-month fees. Prohibit all-or-nothing contracting and provider revenue neutrality clauses.
- **Restrict PE Financial Tactics.** Limit debt-loading in PE acquisitions of health providers, ban dividend recapitalizations that drain capital, enforce minimum staffing ratios, and mandate public disclosure of entity ownership.

REDUCE MEDICAL DEBT: HOSPITAL FAIR BILLING CERTIFICATION

Policy Action: Establish a Federal Hospital Fair Billing Certification Program

Over **40 percent of American adults** hold medical debt, with 75 percent of these individuals owing at least some of their debt to acute care hospitals. Hospitals frequently deploy aggressive collection agencies, wage garnishments, and credit bureau reporting.

Mandatory Certification: Create a new **Fair Billing Certification** program for hospitals, tied to either Medicare payment incentives or Conditions of Participation. Hospitals would be required to:

- Provide free/discounted care for low-income patients based on explicit Federal Poverty Level (FPL) thresholds.
- Use presumptive financial assistance screening before initiating billing or collection activities.
- Prohibit wage garnishment, asset seizure, home liens, and credit bureau reporting for medical debt.
- Cap interest rates on patient payment plans and ban selling debt to third-party collectors without prior screening.

The 161 million Americans with health insurance in the commercial insurance market are struggling with rising costs, a tangle of red tape, and health industry actors who put profits over patients. The reforms outlined in this issue brief provide a roadmap to improve the value of health insurance and reduce costs for employers and consumers.

rwjf **Support for this work was made possible thanks to a grant from the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of RWJF.**