State Affordability Agenda

Addressing Rising Health Care Costs is Critical for Improving Health Care Affordability

The American dream has long been about the chance to build a better life: to support loved ones, stay healthy, and build financial security. For many people today, that sense of stability and opportunity feels increasingly out of reach as the cost of living continues to rise. Health care costs play an outsized role in this challenge — they shape what families can afford, what employers can offer, how states allocate limited resources, and ultimately how healthy our communities are. To improve health care affordability, we must address underlying health care costs. We cannot buy ourselves out of this crisis.

RISING COSTS ARE STRETCHING HOUSEHOLD BUDGETS

- Even people with insurance are paying more and worrying about whether they can afford care when they need it.
  - **The cost of a family insurance plan is almost $27,000**
  - **Family premiums grew** more than double inflation and nearly double wage growth last year
- **Families are facing difficult tradeoffs**
  - **More than one third of people** delay or skip needed care because of cost
  - **41% of adults** — including insured individuals — have medical debt or unpaid medical bills

RISING COSTS ARE SQUEEZING EMPLOYERS AND LIMITING WAGE GROWTH

- When health care gets more expensive, it eats into employers' margins. Workers face slower wage growth and higher out-of-pocket costs.
  - 2026 is projected to have the **largest increase** in health benefit costs in more than a decade, which will mark the **fourth year in a row** of higher-than-normal cost growth
  - Employers pay about **75% of health insurance premiums** for workers
- **Workers and employers are shouldering more**
  - Health care costs place pressure on employers' ability to **increase pay, hire additional staff, and expand business operations**
  - Three-quarters of employers say health care costs **constrain salary growth and limit competitiveness**
  - **More than half of large employers** expect to shift even more health care costs to employees in 2026

RISING COSTS ARE STRAINING STATE BUDGETS

- Medicaid and state employee health benefits are vital programs that states must manage carefully. Addressing rising health care costs across the system helps states afford both while continuing to fund other core responsibilities.
  - States are among the largest purchasers of health care, covering more than **15 million state employees** and their families
  - Premiums for state employees increased **35% between 2013 and 2022**
  - Medicaid, which provides health coverage for children, seniors, people with disabilities, and working families, is often the **second largest expenditure for states**
  - In 2026, states continue to contend with **Medicaid cost inflation** and face **added pressure from federal changes to how Medicaid is financed**, increasing strain on their budgets

- **State budgets are under pressure**
  - **Rising health care costs show up quickly in state budgets** because states pay for health care on behalf of millions of people
  - **Almost two-thirds** of Medicaid Directors thought the chance of a Medicaid budget shortfall in 2026 was "50-50," "likely," or "almost certain"
  - When health spending grows faster than revenues, states face **harder choices about investing in other community priorities, like schools, roads, and other public services**

RISING COSTS ARE NOT DELIVERING BETTER CARE

- Navigating the U.S. health care system — which costs families, employers, and taxpayers so much — is too complex and is not translating into better health outcomes.
  - **More than 70%** of Americans say the health care system is not meeting their needs — with cost, complexity, and access among their top concerns
  - **More than half** of patients with insurance face issues navigating care, including confusing benefits and difficulty finding providers and timely appointments
- **Health outcomes and experiences fall short**
  - The U.S. spends more per capita on health care than any other high-income country, yet our nation is **plagued by chronic disease, lower life expectancy, and more preventable deaths**
  - Fragmented care and red tape make it harder for people to get the right care at the right time which **increases patient frustration and costs over time**

Health care affects nearly every household, employer, and state budget. Addressing rising costs and making the system more accountable to patients is not about politics — it is about ensuring people can afford and access care.

Policy Agenda

Improve transparency and market oversight

1. Identify health care cost drivers
2. Expose hidden consolidation with ownership transparency
3. Limit further health care consolidation
4. Enhance health provider competition

Contain health care costs in the commercial market

5. Limit hospital prices in the commercial market
6. Limit drug prices in the commercial market
7. Implement site neutral payments in the commercial market
8. Slow commercial market drug price growth with inflation penalties
9. Enhance pharmacists' authority to substitute to lower cost drugs

Promote effective, affordable health care delivery

10. Strengthen primary care
11. Change hospital incentives with a global budget
12. Integrate Medicaid and Medicare benefits
13. Preserve Medicaid enrollment for eligible individuals

Balance constrained state budgets

14. Limit what the state employee health plan pays hospitals
15. Limit what the state employee health plan pays for high-cost drugs
16. Assess current Medicaid provider payment levels
17. Implement site neutral payments in Medicaid
18. Ensure Medicaid is appropriately paying managed care organizations
19. Ensure Medicaid is appropriately paying administrative vendors

Improve transparency and market oversight

1. **PROPOSAL: Identify health care cost drivers**

   a. **PROBLEM STATEMENT:** States lack insight into the drivers of health care spending. Fragmented data and limited transparency inhibit policymakers' ability to identify which services, populations, or market dynamics are contributing most to rising costs. Without a full picture of price and utilization patterns and variations, states may pursue reforms that fail to address root causes of the affordability issue or achieve meaningful savings.

   b. **RECOMMENDATION:** States can publish reports using state-level cost, quality, and utilization data to drive smarter oversight and reforms. For example, some states leverage All-Payer Claims Database (APCD) data to understand the landscape of health care spending, identify key drivers of health care spending, and build an evidence-based case for reform. Understanding how health care dollars are spent can also help states identify areas to redistribute spending towards or re-invest in depending on priorities, such as primary care.

2. **PROPOSAL: Expose hidden consolidation with ownership transparency**

   a. **PROBLEM STATEMENT:** Ownership and control of health plans, hospitals, physician groups, and other health care providers is increasingly opaque, given widespread consolidation and the complexity of corporate ownership structures. For example, some health plans own providers, care management groups, and vendors that directly provide care (in the case of provider ownership) and/or perform administrative functions like claims processing — this is sometimes referred to as vertical integration. This gives these organizations increased market power, allowing them to hide their true costs and profits and increase costs for the entire system. Often these organizations hide behind a complicated maze of corporate structure, and the lack of transparency limits the ability of policymakers to conduct appropriate oversight and regulation of health care markets. It also impedes policymakers' and regulators' ability to understand how consolidation and ownership changes affect the cost and quality of care and the structure of health care markets.

   b. **RECOMMENDATION:** States can strengthen ownership transparency to provide clarity on ownership and financial relationships across the health care system. Making these data more accessible to policymakers allows states to track consolidation trends, assess the impact of ownership changes on market competition, and evaluate how these dynamics influence health care costs and affordability.

3. **PROPOSAL: Limit further health care consolidation**

   a. **PROBLEM STATEMENT:** In many states, local health care markets are dominated by a few large, corporate hospitals and health systems, creating monopoly conditions that limit competition and drive up costs. Over the past decade, these corporations have aggressively acquired smaller hospitals and physician practices, consolidating control over both inpatient and outpatient care. As a result, most physicians now work for hospitals and health systems rather than independent practices. These corporations have significant market power that allows them to set excessive prices. When a single health system controls the majority of providers in a region, patients have limited choice where they can access care, employers and purchasers have little leverage to push back against anticompetitive behavior, and prices soar — ultimately leading to higher and higher health care costs. This concentration of market power not only inflates costs for patients, employers, and state budgets, but it also undermines consumer choice and access to care. Currently, many states lack the legal tools or regulatory processes to intervene when large health care corporations pursue transactions that reduce competition and drive up prices.

   b. **RECOMMENDATION:** States can strengthen competition in their health care markets and prevent local monopolies by broadening the scope of health care mergers and acquisitions subject to review, including those that currently fall below reporting thresholds but ultimately have anticompetitive effects. States can also strengthen

their authority to approve, disapprove, or impose conditions on proposed transactions, such as limits on future price increases. This can be done legislatively (e.g., National Academy for State Health Policy's model law) and/or via administrative policy changes, depending on approach. Expanding this authority allows states to proactively scrutinize and regulate these deals rather than reacting after the consolidation has occurred. Ultimately, greater oversight of health care markets promotes competition, protects patients from inflated costs, and preserves choice and access.

4. **PROPOSAL: Enhance health care provider competition**

   a. **PROBLEM STATEMENT:** Across the United States, large, consolidated corporate health systems hold significant monopoly or near-monopoly market power within regional and local health care markets. As a result of this dominance, these large systems can leverage their market power to engage in anticompetitive behavior to increase the prices they charge for care. In particular, these systems can impose anticompetitive contracting terms on payers during contract negotiations, limiting payers' ability to negotiate lower prices, restricting consumer choice and access to certain providers, and undermining healthy markets.

   b. **RECOMMENDATION:** States can prohibit anticompetitive contracting terms to prevent dominant health systems from wielding their market power in abusive or anticompetitive ways. More specifically, bans on anticompetitive contracting practices prohibit powerful health systems from exploiting their market power to restrict insurers from negotiating lower prices. These bans typically focus on anticompetitive contracting terms such as most-favored-nation, all-or-nothing, gag, and anti-tiering or anti-steering clauses. A bipartisan group of states has banned these practices — including recently in Connecticut and Texas.

Contain health care costs in the commercial market

5. **PROPOSAL: Limit hospital prices in the commercial market**

   a. **PROBLEM STATEMENT:** The prices that hospitals charge privately insured Americans for care are much higher than the prices paid in public programs, since private payers have less of an ability to constrain the prices charged by hospitals with substantial market power than government payers do. On average, hospitals charge privately insured patients more than 2.5 times what Medicare pays for the same service, with some hospitals charging over 5 times what Medicare would pay.

   b. **RECOMMENDATION:** States can cap excessive provider prices across the commercial insurance market. States can design this in different ways: by focusing solely on hospitals, expanding to other providers, or targeting the highest-priced hospitals or the most consolidated health care markets. States could also implement a more incremental cap on out-of-network prices to achieve fairer pricing by balancing negotiating dynamics between corporate health systems and plans.

6. **PROPOSAL: Limit drug prices in the commercial market**

   a. **PROBLEM STATEMENT:** In addition to high hospital prices, high prices paid for brand name prescription drugs are a major driver of escalating commercial insurance costs. As a result, premiums are increasing, employers and states are paying more, and patients are facing higher out-of-pocket costs.

   b. **RECOMMENDATION:** States can implement reference pricing or set upper payment limits (UPLs) for high-cost brand-name prescription drugs. These payment limits would limit the amount commercial purchasers and payers would reimburse for a drug. UPLs could be set by benchmarking against Maximum Fair Prices negotiated by Medicare or international prices.

7. **PROPOSAL: Implement site-neutral payments in the commercial market**

   a. **PROBLEM STATEMENT:** When large corporate hospitals and health systems buy up local physician practices, they rebrand them as hospital-owned offices and clinics and increase prices for the same services and care. They can also add facility fees to patient bills. This commercial market distortion leads to higher costs for employers and patients. Moreover, it incentivizes large health systems to buy up additional physician offices, increase prices, and generate more revenue.

   b. **RECOMMENDATION:** States can enact site-neutral payments in the commercial market to protect patients from paying hospitals more than they would pay an independent physician's office for the same routine medical services. States may also consider eliminating facility fees at hospital-owned offices or clinics, which is a more incremental approach to price parity. Both policy solutions reduce financial incentives for health care corporations to purchase local physician practices.

8. **PROPOSAL: Slow commercial market drug price growth with inflation penalties**

   a. **PROBLEM STATEMENT:** Prescription drug prices are high and rising rapidly. In the Medicaid and Medicare programs, if a drug manufacturer increases a drug's price beyond the rate of inflation, they must pay a financial penalty (rebate) to the government. However, the commercial market lacks similar protections — drug manufacturers face no financial penalties for steep price increases for brand-name drugs. As a result, there is no limit on how fast prices for brand-name drugs can rise in this market, leaving employers and consumers vulnerable to greater year-over-year price increases.

   b. **RECOMMENDATION:** States can implement an inflation penalty mechanism similar to that used in Medicaid and Medicare to disincentivize excessive drug price increases in the commercial market. Under this approach, if a manufacturer raises the price of a drug beyond the rate of inflation, states could require the manufacturer pay a financial penalty (rebate). This policy would create a strong disincentive for steep price hikes and align price growth containment strategies across public and private markets.

9. **PROPOSAL: Enhance pharmacists' authority to substitute in lower cost drugs**

   a. **PROBLEM STATEMENT:** States have varying policies regulating how and if pharmacists can substitute biosimilars — which are typically lower cost — for their more expensive reference biologics at the pharmacy counter. Even though non-interchangeable biosimilars are clinically similar and often less expensive, some states may require prescriber approval before substitution, which creates administrative burden and barriers to savings for patients.

   b. **RECOMMENDATION:** States can ensure their substitution laws provide maximum ability for pharmacists to substitute the lowest cost biologic for patients at the pharmacy counter.

Promote effective, affordable health care delivery

10. **PROPOSAL: Strengthen primary care**

    a. **PROBLEM STATEMENT:** Primary care at its best is the backbone of a high-quality, efficient health care system. Better continuity in primary care is associated with reduced mortality, lower health care expenditures, and fewer hospitalizations. However, primary care has historically been undervalued and underinvested in — the United States spends just 5 to 7 cents of every health care dollar on primary care. In addition, the predominant fee-for-service (FFS) payment system fails to give primary clinicians the flexibility they need to deliver personalized, high-quality care.

b. **RECOMMENDATION:** States can bolster access to comprehensive primary care by changing how primary care clinicians are reimbursed and redistributing spending towards primary care (i.e., restraining specialist rates and increasing primary care rates). States can increase primary care investment through targets or requirements on insurers paired with hospital price controls to ensure overall spending does not increase. States can also change how primary care clinicians are reimbursed to move away from FFS (e.g., towards population-based payments) by leveraging their roles as health care purchasers for state employees and in Medicaid. Employee health plans and Medicaid agencies can change contracts with clinicians or implement new requirements on managed care plans or plan administrators.

11. PROPOSAL: Change hospital incentives with a global budget

a. **PROBLEM STATEMENT:** Hospitals are typically paid on a "fee-for-service" (FFS) basis, meaning they are reimbursed based on the number and types of services delivered. This motivates clinicians to focus on providing more care regardless of its necessity or effect on patient outcomes. FFS payment makes it harder to control spending and does little to promote care coordination, higher-quality care, or better management of chronic disease. As a result, states face rising health care costs without corresponding improvements in patient outcomes.

RECOMMENDATION: States can implement global budgets, under which hospitals receive a pre-determined, fixed annual budget to cover inpatient and outpatient care based on their historical revenue. Global budgets help limit unnecessary spending and give hospitals greater flexibility to allocate resources according to patients' needs. This incentivizes hospitals to avoid unnecessary services including avoidable hospitalizations and to coordinate with primary care providers and specialists to manage the health of their patients. Global budgets can also ensure a more predictable revenue stream for hospitals, which could be particularly helpful for rural hospitals.

12. PROPOSAL: Integrate Medicaid and Medicare benefits

a. **PROBLEM STATEMENT:** People who are dually eligible for Medicare and Medicaid — including older adults and people with disabilities — are one of the most expensive populations that states provide insurance coverage to, and they are more likely to end up living in a nursing home or be hospitalized in comparison to people who are eligible for Medicare alone. Forced to navigate 2 separate government programs, dual-eligible individuals face a mountain of red tape, waste, and a lack of coordination — resulting in higher costs and worse health outcomes. The fact that the Medicaid and Medicare programs were never intended to work together drives some of these poor outcomes and inefficiencies for patients, the providers that serve them, and the state. For example, there can be overlaps in Medicare and Medicaid benefits, like dental benefits for people enrolled in a Medicare Advantage plan, which means states may be paying for a benefit that people already have access to.

b. **RECOMMENDATION:** Depending on the utilization patterns within a given state, states can pursue a range of policies to promote integration, which could include aligning benefits, coordinating care management, or implementing integrated delivery or financing models such as a Fully Integrated Dual Eligible Special Needs Plan, to reduce fragmentation and eliminate redundancies. Better alignment between Medicare and Medicaid can improve access to care and ensure state resources are used more effectively.

13. PROPOSAL: Preserve Medicaid enrollment for eligible individuals

a. **PROBLEM STATEMENT:** Medicaid provides essential health coverage to millions of eligible individuals, but many people lose coverage not because they are no longer eligible, but because of administrative barriers in enrollment and renewal processes. Complex applications, duplicative verification requirements, limited use of available data, and frequent eligibility checks can result in coverage interruptions, particularly for individuals with unstable housing, fluctuating incomes, or involvement in the justice system. These coverage gaps disrupt access to

care, increase uncompensated care costs, and often lead to higher downstream spending when individuals re-enroll after lapses in coverage. As states manage heightened fiscal pressure, inefficient eligibility systems create unnecessary administrative costs while undermining continuity of coverage for eligible populations.

b. **RECOMMENDATION:** States can modernize and streamline Medicaid eligibility, enrollment, and renewal systems to ensure that eligible individuals can enroll and remain covered with minimal administrative burden. This includes maximizing the use of existing data sources to verify eligibility, expanding automated and ex parte renewals, simplifying application and renewal forms, and reducing unnecessary documentation requirements. States should also collaborate with public safety agencies, including county jails and state prisons, to coordinate Medicaid enrollment for individuals transitioning from incarceration to the community to support continuity of coverage during reentry. Loss of coverage during this critical juncture not only has significant negative implications for health care costs but also for mortality and public safety outcomes. Streamlined eligibility processes improve access to care, reduce coverage churn, and lower administrative costs by limiting repetitive eligibility reviews and avoidable disenrollment. By making it easier for eligible individuals to obtain and maintain coverage, states can improve health outcomes while using Medicaid resources more efficiently.

Balance constrained state budgets

14. PROPOSAL: Limit what the state employee health plan pays hospitals

a. **PROBLEM STATEMENT:** State employee health plans are becoming increasingly unaffordable, creating financial strain both for states in providing coverage and for employees who rely on it for accessing care. A major driver of these escalating costs is the high prices paid to health care providers, particularly hospitals and health systems that have consolidated into large networks. These health care corporations often wield significant market power, enabling them to negotiate prices far above competitive levels. As a result, states are paying more, and state employees are shouldering a growing share of the burden. This trend threatens the financial sustainability of state health plans.

b. **RECOMMENDATION:** States can limit what the state employee health plan pays to hospitals through reference pricing, where commercial prices are tied to a percentage of Medicare or another benchmark. Medicare rates are widely regarded as a reasonable benchmark because they are based on standardized methodologies and reflect the actual cost of delivering care. Capping payments reins in excessive hospital prices and lowers costs for enrollees while still ensuring providers receive appropriate compensation. This strategy has been successfully implemented in other states, for example Oregon, which saw $107M in savings to the state in the first 2 years without any disruptions to hospital operations or care delivery.

15. PROPOSAL: Limit what the state employee health plan pays for high-cost drugs

a. **PROBLEM STATEMENT:** State employee health plans are becoming increasingly unaffordable, creating financial strain both for states in providing coverage and for employees who rely on it for accessing care. In addition to high hospital prices, high prices paid for brand name prescription drugs are a major driver of escalating costs. As a result, premiums are increasing, states are paying more, and state employees are facing higher out-of-pocket costs. This trend threatens the financial sustainability of state health plans.

b. **RECOMMENDATION:** States can implement reference pricing or set upper payment limits (UPLs) for high-cost brand-name prescription drugs that significantly impact state health plan budgets and patient access. These payment limits would limit the amount state-based purchasers and payers would reimburse for a drug. UPLs could be set by benchmarking against Maximum Fair Prices negotiated by Medicare or international prices.

16. **PROPOSAL: Assess current Medicaid provider payment levels**

    a. **PROBLEM STATEMENT:** Institutional providers like hospitals and nursing homes are often paid through multiple Medicaid payment streams. Currently, many states do not have a clear picture on health systems', providers' and health plans' financing. For example, many state Medicaid agencies do not know how many total Medicaid dollars a particular hospital receives, inclusive of all forms of Medicaid payments (e.g., from managed care, fee-for-service, disproportionate share hospital, supplemental payments, and state directed payments). These payments — and the rates underneath them — can be based on legacy formulas and political negotiations rather than the actual cost of delivering care or achieving a specific outcome. These fragmented payment structures can result in inefficiencies and overpayments.

    b. **RECOMMENDATION:** States should comprehensively assess provider payments across all Medicaid funding streams and financing arrangements — including managed care, fee-for-service, disproportionate share hospital (DSH) payments, supplemental payments, and state-directed payments. This assessment can help identify potential overpayments and misaligned incentives that come from fragmented payment structures and funding arrangements. By gaining a full picture of how Medicaid dollars flow to institutional providers, states can better align payments with the cost of care and their program goals.

17. **PROPOSAL: Implement site neutral payments in Medicaid**

    a. **PROBLEM STATEMENT:** In some states, Medicaid pays providers more depending on where a patient receives care, even when the services are the same. When large hospitals buy and consolidate smaller physician practices, they can rebrand these physician practices as hospital-owned offices and clinics, allowing them to charge higher rates — even when patients see the same doctors they saw before the takeover.

    b. **RECOMMENDATION:** States should implement site neutral Medicaid payment policies for outpatient services to eliminate unnecessary cost variation based on care setting. This involves reviewing hospital-based outpatient rates and managed care rate-setting methodologies to eliminate disparities based on outdated Medicare or commercial pricing structures. By aligning payments across settings — so that identical services are reimbursed at comparable rates regardless of whether they are delivered in a hospital-owned clinic or an independent physician office — states can also reduce incentives for provider consolidation driven by payment advantages and loopholes.

18. **PROPOSAL: Ensure Medicaid is appropriately paying managed care organizations**

    a. **PROBLEM STATEMENT:** Most states leverage Medicaid managed care organizations (MCOs) to deliver benefits to enrollees, and states pay these entities a capitated amount for delivering these benefits. While this approach can promote budget predictability and incentivize care management, it can also introduce challenges for states who must ensure these payments translate into meaningful access and quality care. At the same time, states face the complex task of setting rates, monitoring performance, and enforcing compliance with contractual requirements. For example, states may also layer additional programs on top of managed care contracts, creating situations where multiple entities are paid to perform similar functions. For example, payments to managed care plans typically include funding for care management services, yet some states also separately pay community-based organizations or state contractors to provide additional care management for the same populations, which can result in overlapping responsibilities and administrative costs. Without adequate oversight and accountability, states may overpay and managed care plans may underdeliver on benefits.

    b. **RECOMMENDATION:** States should regularly assess the effectiveness of managed care organizations, identify efficiencies, and scrutinize capitation rates to eliminate overpayments. This includes considering the functions MCOs are contracted to perform (e.g., care management) and ensuring those functions are not duplicative with other state-funded programs. To avoid overpayment or duplication of services, states can consider carving out and eliminating some functions from managed care or further specifying the MCO's function.

19. PROPOSAL: Ensure Medicaid is appropriately paying administrative vendors

a. **PROBLEM STATEMENT:** State Medicaid agencies rely heavily on a wide range of administrative vendors including claims processors, pharmacy benefit managers, eligibility and enrollment vendors, consulting firms, actuarial vendors, and technology contractors to carry out core program functions. While these arrangements can bring specialized expertise, many of these vendors have significant market power, which gives them substantial leverage over states. This power imbalance creates a risk of states being overcharged for substandard services. Moreover, many Medicaid administrative functions qualify for an enhanced match (90%) to incentivize modernization, and without strong oversight of vendor pricing and contract structure, states may face fragmented contracts, duplicative services, limited transparency into subcontracting arrangements, and inefficient spending.

b. **RECOMMENDATION:** States should assess rate appropriateness and effectiveness of all their administrative vendors at a regular cadence. These vendors should also be assessed for unnecessary duplication across contracts. When procuring these vendors, states should encourage transparency in pricing to ensure they select vendors who use taxpayer dollars most efficiently. States should also actively monitor these contracts and implement accountability measures in the event of noncompliance to ensure states are leveraging these contracts to the greatest extent possible.