Federal Health Care Affordability Policy Solutions

Americans deserve access to affordable, high-quality health care, yet our system falls short. Despite spending more than any other country, the U.S. continues to face worse outcomes. A system meant to promote health and innovation is instead squeezing family, employer, and taxpayer budgets. This threatens patient access to care and the long-term sustainability of the health care programs that we rely on. To make health care more affordable, policymakers should promote competition and reduce the cost of health care for patients, taxpayers, and employers. We cannot spend our way out of this crisis.

Increase transparency and accountability

The U.S. health care system lacks transparency into prices, ownership, and control of hospitals, physicians, and other health care entities, which limits consumers and purchasers from making well-informed decisions about health care that meets their needs. More complete and transparent information would empower patients, press, and purchasers and enable policymakers to design effective policies that address the true drivers of high health care costs.

POLICY OPTIONS INCLUDE:

- Enhancing price transparency in the commercial market by ensuring access to accurate and complete pricing information for health care services and employer access to their own claims data is critical. These data allow patients, employers, and policymakers to make better decisions about the care they receive and the levers that would lower health care costs.
- Ownership transparency would improve accountability and help policymakers ensure health care market competition by making it easier to track consolidation impacts as large insurers, health systems, and private equity firms merge and acquire independent physicians and hospitals.

Improve competition and address market distortions

Health care markets are highly consolidated after decades of unchecked mergers and acquisitions, allowing dominant players, including large, consolidated health systems, insurers, and drug manufacturers, to use anticompetitive tactics to raise prices and limit competition from rivals. Limiting further consolidation and addressing anticompetitive tactics would lower costs and increase access.

POLICY OPTIONS INCLUDE:

- Enacting "site-neutral" payment policies to protect patients from being charged more for routine services based on where they receive them and save employers and taxpayers billions in overpayments. 84% of voters across the aisle and diverse stakeholders (patient/consumer groups, employers, physicians) support site-neutral reforms; both the Obama and Trump Administrations have been supportive of reforms as well. Comprehensive site-neutral would save Medicare about $150B over 10 years, reduce Medicare beneficiaries' out-of-pocket costs by $80B, and limit the incentives driving health care consolidation, which drives up costs for the privately insured.
- Limiting anticompetitive behaviors by pharmaceutical manufacturers (e.g., product hopping, patent thickets [evergreening], pay-for-delay settlements, sham citizen petitions) would enhance competition, reduce prescription drug spending, and expand access to affordable treatments — putting patients over industry profits. Bills addressing these issues have been passed out of the Senate Judiciary Committee; CBO estimates savings of $5B over 10 years.
- Banning facility fees in the commercial market for routine services provided in hospital-owned offices and clinics would lower costs for patients, employers, and taxpayers while disincentivizing consolidation. Hospitals are purchasing physician offices and increasingly charging facility fees for routine services (e.g., wellness and telehealth visits, labs, imaging) on top of the physician professional fee. This increases patient cost-sharing and employer and taxpayer spending for outpatient services. CBO estimates banning certain facility fees would save the federal budget $2.2B over 10 years; commercial-market patients and employers would see additional savings.

Eliminate fraud, waste, and abuse

Health care corporations exploit loopholes and distortions in our current system to increase profits without delivering meaningfully better care or a better product. Reining in wasteful spending and abusive practices can create a more efficient, affordable health care system for patients and taxpayers without undermining quality.

POLICY OPTIONS INCLUDE:

- Addressing abusive — and sometimes fraudulent — billing practices used by big insurers would protect Medicare's integrity and curb billions in wasteful taxpayer spending — including $22B in 2026 alone. Many major insurers in the Medicare Advantage (MA) program aggressively code diagnoses to make beneficiaries appear sicker than they are — sometimes reporting diagnoses for which patients receive no care — thereby increasing the payments the insurers receive from the government. The introduced No UPCODE Act would address excess payments to MA plans due to aggressive diagnosis coding; policies in the bill would save $124B over 2025-2034 (CBO), $170B over 2027-2036 (CRFB).
- Reforming other design features of MA that increase waste and abuse, causing all Medicare beneficiaries to pay higher premiums. These include reforming quality measurement, addressing MA plans attracting healthier beneficiaries, and improving competition among plans and between MA and Traditional Medicare.

Limit the prices that Americans are charged for care in certain cases

Health care costs — driven by high prices charged by powerful, consolidated players, including pharmaceutical companies, consolidated hospital systems, insurers, and other powerful entities — are often unaffordable for millions of privately insured Americans, leading people to delay and skip needed care and accumulate medical debt. Reforms that directly lower the underlying prices patients pay can meaningfully reduce cost-sharing and premiums while lowering costs borne by employers and taxpayers.

POLICY OPTIONS INCLUDE:

- Reforms that directly limit hospital prices to a reasonable rate (e.g., a multiple of what Medicare pays for the same service) would substantially lower out-of-pocket costs and premiums in the private market. Price limits could be applied to specific services (e.g., in hospital-owned physician offices), to specific markets (e.g., the individual market), or broadly to hospital prices across the private market. Ideas that could be considered include a public option that incorporates more affordable prices to compete with private insurers; Medicare Prices for All; and all-payer rate-setting.
- Inflation penalties on brand-name prescription drugs bought by patients with private insurance when the price of a drug rises faster than the rate of inflation. Both Medicaid and Medicare have inflation penalties, wherein drugmakers are required to pay a rebate to the government if their drug price increases faster than the rate of inflation.

Maintain and improve access to affordable coverage

Right now, many Americans are faced with unaffordable coverage options, sometimes remaining uninsured, or find that when they go to use care, they face high out-of-pocket costs even with insurance. Reforms to improve affordability should address the underlying drivers of high health care costs rather than simply shifting costs onto patients or reducing coverage.