2025 State Health Policy Snapshot

Glossary

HEALTHCARE VALUE HUB

Introduction

The Health Care Value Hub is pleased to launch the 2025 Health Care Affordability Policy Snapshot, which replaces the annual Health Care Affordability Scorecard. This resource allows legislators, consumer advocates, regulators, and other stakeholders to compare state policies that affect health care affordability and access. The Snapshot includes policies previously tracked in the Scorecard as well as new measures selected for their relevance to affordability and evidence of effectiveness. Each policy is categorized as active, partially implemented, or not active as of June 1, 2025, with sources provided in the downloadable Data and Source Document on the Dashboard page.

The 2025 Snapshot explores policies impacting health care affordability across several categories, including options to:

- Curb Excess Costs in the System
- Address Consolidation and Promote Competition
- Prevent Medical Debt
- Improve Oversight, Accountability, and Transparency
- Reduce Cost-Sharing for Patients
- Medicaid Services and Immigrant Coverage

The Hub supports users through analysis, translation, visualization, and engagement to strengthen state-level efforts to advance affordable, high-value health care. By connecting advocates, researchers, and policymakers, the Hub fosters collaboration and action toward a more patient-centered system. We encourage stakeholders to share and use the Snapshot's findings to improve affordability for consumers nationwide.

Key Terms and Acronyms

Centers for Medicare and Medicaid Services (CMS): A federal agency within the Department of Health and Human Services that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the federal Marketplace.

Children's Health Insurance Program (CHIP): A federal-state partnership that provides health coverage to children living in low– and middle-income households with incomes above Medicaid eligibility levels, administered by states within federal guidelines.

Consolidation: The merger, acquisition, or change of ownership (CHOW) through which hospitals and other health care entities come under common ownership.

Federal Poverty Level (FPL): The federal measure of household income used to determine eligibility for certain programs and benefits.

Health Spending Oversight Entity: A state agency that systematically tracks health care spending, prices, and quality, providing data and research to assess efficiency and resource use.

High-Value Care: Health care services with proven benefits that clearly outweigh risks and should be provided to all patients in a given population.

No Surprises Act (NSA): Federal legislation, effective January 2022, that protects patients from surprise medical bills for most emergency services, certain non-emergency services at in-network facilities, and out-of-network air ambulance services.

Out-of-Pocket Costs (OOP): Expenses not covered by insurance that consumers must pay directly, including copayments, coinsurance, and deductibles.

State-Based Exchange (Marketplace): Under the ACA, states have three Marketplace options: a state-based exchange; a state-based exchange that is hosted on the federal platform, where states are responsible for many of the Marketplace functions, and the federal government is responsible for eligibility and enrollment functions; or a federally-facilitated Marketplace, where the federal government performs all Marketplace responsibilities.

Strategies to
Curb Excess Costs in the System

Premium Rate Review

States can limit excessive health insurance premium increases through rate review, in which regulators assess proposed hikes to ensure they reflect accurate data and reasonable cost projections. The Affordable Care Act (ACA) set federal standards for effective review, and states meeting these are recognized by the Centers for Medicare and Medicaid Services (CMS). States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. Strategies examined in this section include:

- Effective Rate Review Per CMS
- Authority to Modify or Reject Premium Rate Increases
- Affordability Criteria Included in Premium Rate Review

Hospital Price Regulation

Some states have pursued hospital cost control through reference-based pricing or global budgets. Reference-based pricing sets payment at a fixed rate, typically a multiple of Medicare, while global budgets establish a prospective annual payment for defined services, shifting responsibility to providers and payers to manage costs within that limit. This section tracks states that utilize:

- Medicare Reference-Based Pricing
- Hospital Global Budgets

Affordable Coverage

States can expand access to affordable coverage by offering state-funded premium subsidies for Marketplace plans or by operating subsidized health coverage such as a Public Option or Basic Health Plan. Public Options are state-administered insurance programs designed to increase competition and control costs through negotiated provider rates. These program designs vary across states, with differences in cost-containment strategies, network adequacy requirements, and reimbursement structures. Strategies examined in this section include:

- Whether the State has Implemented a Public Option
- Whether the Public Option Includes a Provider Participation Mandate
- If the state Operates a Basic Health Plan
- If the State Provides State-Based Premium Subsidies for Marketplace Coverage

Prescription Drug Pricing

Rising prescription drug costs continue to strain households, employers, and state budgets, with specialty drugs driving a growing share of spending. Unlike most consumer goods, drug prices in the U.S. often increase year over year, even after launch, and lack of transparency across the supply chain enables sustained price escalation. Manufacturers and pharmacy benefit managers (PBMs) use rebates, coupons, and contracting practices that can obscure true costs and shift expenses to consumers.

States are adopting a range of strategies to improve transparency, promote generic utilization, and curb excessive pricing. These include regulating PBM practices such as spread pricing, restricting the use of manufacturer coupons, requiring rebate transparency, and establishing collaborative purchasing or rebate arrangements. This section examines whether states have implemented tools to lower drug prices, enhance accountability, and expand access to affordable medications through:

- Prescription Drug Pricing Consortiums
- Prohibitions on Drug Manufacturer Coupons for Specialty Drugs
- Prohibitions on Copay Accumulator Programs
- Biologic Substitution Laws to Increase Generic Utilization
    - Authorization Flexibilities
    - Notification Requirements
- Drug Carve Outs in Medicaid Managed Care
- FFS Policies to Promote Generic Utilization
    - Mandatory Generics
- Supplemental Rebate Programs or Arrangements
- Drug Rebate Transparency and Reporting Requirements
- Spread Pricing Restrictions
- Prohibitions on Retroactive Claims Reductions or “Clawbacks”
- Prohibitions on Cost-Disclosure and Gag Clause Restrictions

Medicaid Costs

Medical Loss Ratio remittance ensures managed care organizations (MCOs) spend a minimum percentage of premium revenue on actual medical care and quality improvement rather than administrative costs or profit. If they fail to meet the threshold, excess funds are returned to the state. By enforcing MLR standards, states help guarantee that Medicaid beneficiaries receive value for the funds allocated to their care, improving transparency and trust in managed care systems. Returned funds can be reinvested into Medicaid programs, expanding coverage or enhancing benefits without increasing state budgets.

Site-neutral policies standardize reimbursement rates across care settings (e.g., hospital outpatient departments vs. physician offices), reducing incentives for providers to steer patients toward higher-cost settings. Aligning payments helps curb unnecessary spending and mitigates cost growth in Medicaid programs, which is critical for states managing tight budgets.

- States Utilize Medical Loss Ratio Remittance
- Medicaid Site Neutral Requirements

Strategies to
Address Consolidation and Promote Competition

Consolidation Oversight

Consolidation oversight refers to the processes by which state regulators review mergers and acquisitions of health care entities to ensure they do not harm competition or increase consumer costs. This section examines whether state law or statutes require increased oversight of hospital consolidation transactions that exceed federal notification requirements, such as whether the state has the authority to approve, reject, or impose conditions on health care transactions to protect affordability and competition or if the state review standards require regulators to assess the impact of a consolidation on health care prices and affordability, not just market concentration. Specific strategies examined include:

Transaction Notification Requirements

Authority to Modify or Reject Consolidation Transactions

Affordability Criteria Included in Transaction Review

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees are becoming increasingly more common as the rate of health system consolidation has accelerated. As hospitals acquire more outpatient practices, these fees are increasingly applied, raising patient costs and disproportionately affecting communities already facing financial challenges, such as rural and minority populations. States may prohibit facility fees outright, or impose other regulatory mechanisms such as facility transparency laws, requiring hospitals to disclose facility fees separately from professional service charges, or establishing limits on patient cost-sharing for facility fees. The strategies examined in this section include:

Prohibitions on Facility Fees

Facility Fee Transparency Laws

Limits on Facility Fee Cost-Sharing

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system, including:

Restrictions on All-or-Nothing Contract Provisions: These clauses require plans to contract with all providers in a health system or none of them, even if those providers are low-value or high-cost.

Restrictions on Anti-Tiering and Anti-Steering Contract Provisions: These clauses require insurers to place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Restrictions on Most Favored Nation Clauses: These clauses require health systems to agree to not to offer lower prices to competing insurers, preventing them from providing services at a lower price. These provisions may allow insurers and providers to collude to raise prices.

Restrictions on Physician Non-Competes: Physicians noncompete clauses restrict providers ability to work at other health systems in an area, minimizing providers ability to practice medicine.

Strategies to
Prevent Medical Debt

Balance Billing and Short-Term Insurance

The federal No Surprises Act (NSA) protects patients from surprise medical bills (also referred to as "balance bills"), which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or limit the number of short-term, limited duration health plans available in the state, which traditionally cover fewer services putting enrollees at greater risk of incurring balance bills. Strategies examine in this section include:

Prohibitions on Balance Billing for Ground Ambulance Services

Prohibitions on Short-Term, Limited Duration Health Plans

Charity Care and Community Benefit Requirements

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. Strategies examined in this section include:

Mandated Hospital Charity Care

Hospital Charity Care Screening Requirements

Hospital Charity Care Notification Requirements

Hospital Community Benefit Reporting Requirements

Reducing Financial Consequences

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. States can mitigate the financial harm of medical debt by regulating how and when providers and collection agencies pursue repayment or by limited aggressive collection actions. Strategies examined in this section include:

Mandated Waiting Period Prior to Sending a Bill to Collections

Limits on Liens or Foreclosures due to Medical Debt

Limits on Wage Garnishment due to Medical Debt

Limits on the Amount of Interest Charged to Medical Debt

Strategies to
Improve Oversight, Accountability, & Transparency

Health Care Spending Oversight

Health care spending oversight entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, some have established oversight entities with enforcement powers. Strategies tracked include:

Health Care Spending Benchmarks

Authority to Enforce Health Care Spending Benchmarks

Hospital or Primary Care Spending Oversight Entities

Prescription Drug Affordability Boards

Some states have established independent entities charged with reviewing high-cost prescription drugs and recommending strategies to improve affordability. In certain cases, these boards are authorized to set upper payment limits to curb excessive drug prices. Strategies examined in this section include:

Prescription Drug Affordability Board Established

Prescription Drug Upper Payment Limits Established

All-Payer Claims Databases

All-payer claims databases (APCDs) compile diverse health care data that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight. Strategies examined in this section include:

All-Payer Claims Database Established

All-Payer Claims Database Operated by the State

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. Strategies examined in this section include:

Price Transparency Tool Established

Prescription Drug Price Transparency Tool Established

Strategies to
Reduce Cost-Sharing for Patients

Reduced Cost-Sharing for Prescription Drugs

This section examines whether states have passed legislation to reduce the amount consumers pay out-of-pocket for select prescriptions drugs including insulin, epinephrine, and asthma inhalers, and specialty drugs. Strategies examined in this section include:

- Waived or Reduced Cost-Sharing for Diabetes Medications
- Waived or Reduced Cost-Sharing for Asthma Inhalers
- Waived or Reduced Cost-Sharing for Epinephrine Auto-Injectors
- Waived or Reduced Cost-Sharing for Specialty Drugs

Reduced Cost-Sharing for Behavioral Health Services

High out-of-pocket costs can limit access to behavioral health care. To address this, some states require insurers to waive or reduce cost-sharing for an annual behavioral health visit, ensuring more affordable access to essential mental health services. This section examines whether states have implemented reduced cost-sharing requirements through:

- Waived or Reduced Cost-Sharing for an Annual Behavioral Health Office Visit

Reduced Cost-Sharing for Preventive Care

Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) are critical to early detection and management of health conditions. States can improve access by requiring insurers to waive or reduce cost-sharing for these services. Strategies examined in this section include:

- Waived or Reduced Cost-Sharing for United States Preventive Services Task Force (USPSTF) Recommended Preventive Services

Reduced Cost-Sharing for Maternal and Reproductive Health Services

Some states expand access to reproductive health care by requiring coverage of services such as fertility treatments, doula support, and abortion care without high cost-sharing barriers. These policies aim to improve maternal health outcomes and ensure equitable access to reproductive services. Strategies examined in this section include mandates requiring:

- Individual and Small Group Health Plans to Cover Fertility Treatments
- Individual and Small Group Health Plans to Cover Doula Services
- Individual and Small Group Health Plans to Cover Abortion Services

Reduced Cost-Sharing for Cancer Screening and Testing Services

Early detection of cancer improves outcomes but cost-sharing can be a barrier to recommended screenings. States may require insurers to waive or reduce cost-sharing for services such as colorectal, breast, cervical, lung, prostate, and ovarian cancer screenings, as well as biomarker testing. This section examines whether such requirements are in place to promote timely and affordable cancer screening. Strategies examined in this section include mandates requiring:

- Waived or Reduced Cost-Sharing for Colorectal Cancer Screenings
- Waived or Reduced Cost-Sharing for Follow-Up Colorectal Cancer Screenings
- Waived or Reduced Cost-Sharing for Lung Cancer Screenings
- Waived or Reduced Cost-Sharing for Breast Cancer Screenings
- Waived or Reduced Cost-Sharing for Supplementary Breast Cancer Screenings
- Waived or Reduced Cost-Sharing for Cervical Cancer Screenings
- Waived or Reduced Cost-Sharing for Ovarian Cancer Screenings
- Waived or Reduced Cost-Sharing for Prostate Cancer Screenings
- Waived or Reduced Cost-Sharing for Biomarker Testing

Strategies to
Medicaid Services and Immigrant Coverage

Medicaid Administration

States design their Medicaid programs using different administrative structures and oversight mechanisms. Approaches may include the use of managed care, medical loss ratio requirements, site-neutral payment policies, vendor partnerships for enrollment, and coordination with Medicare. This section assesses how states administer Medicaid to balance efficiency, oversight, and consumer protections. Strategies examined in this section include:

States Utilize Medicaid Managed Care

States Partner with Vendors for Medicaid Enrollment and/or Eligibility

Medicaid-Medicare Integration

Medicaid Covered-Services

State Medicaid programs vary in the range of services they cover beyond federal minimum requirements. Some states have expanded coverage to include fertility treatments, doula services, abortion care, gender -affirming services, hearing aids, vision care, and dental services. This section reviews the extent to which states provide enhanced benefits to improve access and health outcomes. Strategies examined in this section include:

Medicaid Coverage for Fertility Services

Medicaid Coverage for Doula Services

Medicaid Coverage for Abortion Care

Medicaid Coverage for Gender Affirming Care

Medicaid Coverage for Hearing Aids

Medicaid Coverage for Eye Exams and Glasses

Medicaid Coverage for Dental Services

Medicaid Eligibility

Eligibility rules determine who can access Medicaid coverage and the scope of their benefits. States can expand eligibility through Medicaid expansion, extend postpartum coverage, provide continuous eligibility, and adjust asset and income rules for specific populations. Some states also provide coverage to individuals reentering the community after incarceration. This section examines how states structure Medicaid eligibility to promote access and continuity of care. Strategies examined in this section include:

- Medicaid Expansion
- Retroactive Medicaid
- Continuous Eligibility for Adults Enrolled in Medicaid
- 12-Month Postpartum Coverage
- Medicaid Coverage for Re-Entry Populations
- Expanded Asset Limits for Adults Enrolled in a Medicaid Aged, Blind, or Disabled Program
- Life Insurance Exemptions for Eligibility in Medicaid for Aged, Blind and Disabled Program
- Retirement Account Exemptions for Eligibility in Medicaid for Aged, Blind and Disabled Program

Immigrant Coverage

States may extend coverage to immigrants who are otherwise excluded from federal programs, such as undocumented children or adults. Additional policies include state-funded options for prenatal, postpartum, or child health coverage, as well as coverage for lawfully present immigrants without a five-year waiting period. This section evaluates state actions to close coverage gaps for immigrant populations. Strategies examined in this section include:

- Coverage Options for Pregnant Immigrants (FCEP and Postpartum Coverage)
- Coverage for Immigrant Children without a Five-Year Bar
- State-Funded Coverage Options for Undocumented Children
- State-Funded Coverage Options for Undocumented Adults

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