California Health Care Foundation

SEPTEMBER 2026

Policy Options to Improve Health Care Affordability: What California Can Learn from Other States

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Appendix

Appendix A. Summary of Health Care Affordability Policy Proposals

PROPOSAL	ACTION	TIME FRAME	NOTES
Uniform companion guides (HIPAA standardization)	Eliminate payer-specific companion guide and require use of single, standardized guide.	Longer-term	Minnesota achieved through statute; Massachusetts achieved through voluntary collaboration.
Standardized administrative contract terms	Standardize administrative terms of contracts. May include claim submission timelines, clean claim definitions, timely payment obligations, appeal rights and procedures, amendment notification requirements, and termination notice periods.	Near-term	May be achieved through regulation or legislation. Small practices would likely benefit the most.
Credentialing reciprocity	Require plans to accept a completed credentialing decision from another DMHC- or CDI-licensed plan, where that decision was made within a defined lookback window.	Near-term	Existing law establishes strong foundation. May be possible to advance within existing regulatory authority.
Health plan Billing Complexity Index	Establish and publish index measuring issues such as auto-adjudication rate for clean claims, average days to payment, denial rates by category, nonstandard proprietary claim edits, and staff hours per provider required for credentialing and contracting.	Longer-term	Only some data infrastructure exists. Requires new reporting mandates.
Shortened prior authorization response timeframes	Shorten prior authorization response time frames in alignment with other states to 24 hours for urgent cases and 72 hours for non-urgent cases.	Near-term	Multiple state precedents. DMHC/CDI have existing authority to act by regulation. Mostly impacts timeframes for prior authorization and not volume.
Minimum authorization duration – chronic conditions	Establish a minimum authorization duration for stable chronic conditions.	Near-term	No requirement under existing California law. Consider implementation through regulatory action. May be especially impactful in behavioral health.
Same-specialty clinical review	Require prior authorization denials or appeals be reviewed by a clinician in the same or similar specialty as the treating physician.	Near-term	Primarily a quality intervention; administrative benefit is secondary.
Prohibition on retroactive denials	Prohibit denials in which a plan approves a service, the service is rendered, and the plan subsequently rescinds approval or denies payment.	Near-term	Existing California law has no statutory prohibition on retroactive prior authorization denials. Prevalence data unavailable but likely to be low; per-incident harm may be significant.
Electronic prior authorization standards (CMS-0057)	Require DMHC and CDI to exercise existing authority to require prior authorization API standards aligned with CMS FHIR requirements.	Near-term	Existing law already grants authority. Federal infrastructure investments underway.
Community benefit spending floor	Adopt community spending floor to ensure tax-exempt hospitals appropriately direct dollars toward community benefits, including financial assistance.	Near-term	Multiple states enacted versions. Impact depends on whether California hospitals already exceed any reasonable floor.

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Two-tier FAP structure (free care/discounted care)	Adopt a two-tier structure, ensuring that the lowest-income patients receive free care while those with moderate incomes receive meaningful discounts.	Near-term	Existing law sets a single eligibility limit of 400% FPL for financial assistance but does not distinguish between free care and discounted care.
Explicit financial protections for UIS patients	Explicitly prohibit discrimination in FAP eligibility based on immigration status.	Near-term	Unclear how statutory change would impact behavior.
FAP expansion	Extend FAP requirements beyond acute care hospitals to include large medical groups, ambulatory surgical centers, and other provider types, consistent with the National Consumer Law Center's Model Medical Debt Protection Act.	Longer-term	No state precedent.
Increased FAP awareness (navigator program)	Require Covered California insurance navigators to provide education on hospital FAPs, including eligibility and application processes.	Near-term	May require budgetary resources if requiring as new mandated program.
Income passport (simplified FAP application)	Establish fast-tracked FAP applications, allowing patients to establish eligibility for financial assistance through a single verified credential that also serves as proof of eligibility for other safety-net programs in California.	Longer-term	No state precedent. High implementation complexity across agencies.
Expanded presumptive eligibility	Adopt presumptive eligibility for FAP application process tied to criteria that hospitals may not currently screen for, including enrollment in CalFresh, WIC or other programs.	Near-term	AB 1312 already implementing. Expanding trigger to Oregon model is incremental. Marginal population is likely small.
Medical debt definition expansion (credit cards/loans)	Expand definition of medical debt to include medical credit cards and medical loans in order to exclude medical debt from appearing on consumer credit reports.	Near-term	Enacted in multiple states.
Prohibition on civil action for medical debt	Prohibit civil action to collect medical debt based on consumer income and/or dollar-value of debt.	Near-term	Existing precedent in New Mexico, New York, and Maryland.
Prohibition on bank account seizure	Prohibit bank account seizure for medical debt collection for people who meet certain income and/or asset thresholds.	Near-term	Delaware enacted broader version.
Extending prohibition on sale of medical debt	Ban sales of medical debt to third-party collectors to reduce patient exposure to aggressive debt collection practices.	Near-term	Maryland, New York, and Vermont banned.
Explicit private right of action	Provide civil recourse for consumers when hospitals fail to comply with FAP screening, billing, and collection requirements by establishing an explicit private right of action within the Hospital Fair Pricing Act.	Near-term	Connecticut and Colorado enacted. Primarily a deterrent against bad actors.
Statewide medical debt relief program	Establish statewide program that directly purchases and forgives patient medical debt.	Near-term	Nine states via Undue Medical Debt partnership.

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Proactive hospital audit program	Establish proactive audits and regular statewide reporting of hospital compliance with the Hospital Fair Pricing Act.	Longer-term	Shifts burden from patients to regulator. Stronger deterrence model. High resource requirements.
FAP screening documentation as collection precondition	Establish specific documentation to ensure hospital compliance with FAP screening is thorough and fair.	Near-term	Tightens existing requirement.
Stronger enforcement in courts (judicial training)	Ensure adequate judicial training on recognizing and correctly classifying medical debt by requiring courts to verify that collectors have met medical debt prerequisites of the Hospital Fair Pricing Act before allowing collection actions to proceed.	Near-term	Medical debt miscategorized as general consumer debt. Consider collaboration with Judicial Council as means of implementation.
CalPERS/CalSTRS hospital price cap	Leverage CalPERS/CalSTRS contracting to enact hospital price caps, which would limit hospital payments to a specified benchmark.	Near-term	Oregon and Washington enacted for state employee plans.
Broad commercial hospital price cap (all payers)	Enact hospital price caps broadly across all commercial payers through all relevant health coverage and purchaser regulators, including HCAI, DMHC, and/or CDI.	Longer-term	Vermont and Indiana first states to attempt in 2025. Requires new rate-setting authority.
Hospital global budgets with regulated growth caps	Within current regulatory authority, establish hospital global budgets (fixed payment amounts made to hospitals for a set of defined services) and mandate hospital compliance.	Longer-term	No broad commercial precedent. CMMI AHEAD model creates federal vehicle. Maryland model is most relevant.
Site-neutral payment	Require the same rate for the same service whether it is provided in a hospital outpatient department, ambulatory surgical center, or freestanding physician office. Subject to patient safety and quality safeguards.	Longer-term	Vermont enacted for outpatient drugs in 2025.
Facility fee bans	Prohibit hospitals and health systems from charging extra, mandatory fees for outpatient services provided at an institution-owned site.	Near-term	Connecticut, Maine, Indiana, and others enacted versions. Modeling suggests saves at most one-third of what site-neutral payment would.
Ownership and financial transparency	Require health care entities to report information annually and publicly on owners, controlling entities, and business structure – including parent entities, subsidiaries, entities under common control, and any MSOs.	Near-term	Massachusetts, Indiana, Washington models. Precursor to action rather than direct cost control. Data infrastructure would need to be built.
OHCA independent transaction authority	Authorize OHCA to block or impose conditions on health care transactions, such as mergers and acquisitions, which may have harmful effects on patients and providers.	Longer-term	Oregon and New Mexico models. May have influence on consolidation landscape.
All-or-nothing clause prohibition	Ban contracting tactic used by hospitals that requires insurers to contract with all facilities in a health system if they want to access any single facility.	Near-term	These clauses prevent selective contracting and narrow networks.

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Anti-steering clause prohibition	Ban contracting tactic used by hospitals that restricts insurers from directing enrollees toward lower-cost and/or higher-quality competitors.	Near-term	Potentially lower impact strategy as these clauses govern how an insurer treats a provider once they are already in the network.
Anti-tiering clause prohibition	Ban contracting tactic used by hospitals that restricts insurers from placing providers on different tiers based on cost or quality.	Near-term	Potentially lower impact strategy as these clauses govern how an insurer treats a provider once they are already in the network. Focuses on benefit structure rather than base unit price.
Most-favored-nation clause prohibition	Ban contracting tactic used by insurers that prohibits providers from offering any other payer a lower price.	Near-term	May help prevent price competition between insurers.
Gag clause prohibition/ enforcement	Enforce ban on contracting tactic used by hospitals and insurers that prohibits contracting parties from disclosing information, such as negotiated reimbursement rates, to outside entities, including employers or consumers who are ultimately paying for the coverage.	Near-term	Already prohibited federally and under California law. Additional enforcement may be helpful.
Prohibition against all-or-nothing, anti-steering, anti-tiering, and most-favored-nation clauses	Enact all prohibitions described above together.	Near-term	Strongest impact when prohibiting all; when banning only some types of clauses, hospitals can use other clause types as workarounds.

Source: Authors' analysis of state health care affordability policies, July 2026.

Note: *DMHC* is the California Department of Managed Health Care; *CDI* is the California Department of Insurance; *API* is Application Programming Interface; *CMS* is the US Centers for Medicare & Medicaid Services; *FHIR* is Fast Healthcare Interoperability Resources; *FAP* is financial assistance program; *UIS* is unsatisfactory immigration status; *WIC* is the Special Supplemental Nutrition Program for Women, Infants, and Children; *CalPERS* is the California Public Employees' Retirement System; *CalSTRS* is the California State Teachers' Retirement System; *HCAI* is the California Department of Health Care Access and Information; *CMMI* is the US Center for Medicare and Medicaid Innovation; *AHEAD* is Achieving Healthcare Efficiency through Accountable Design; *MSO* is management services organization; *OHCA* is the California Office of Health Care Affordability.

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Bailit Health is a health policy consulting firm that assists state agencies and their partners with strategy development and implementation, program design, multistakeholder process management, project management, and health policy research and analysis.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.