Savings Estimates for Solutions to Reduce Spending on Health Care and Private Insurance Premiums: 2025 Update

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Executive Summary

In January 2023, the Blue Cross Blue Shield Association (BCBSA) released its Affordability Solutions for the Health of America, which detailed actions policymakers could take to attack the root causes of rising health care costs. An accompanying report by Phil Ellis, Ph.D., a former senior economist with the Congressional Budget Office (CBO), detailed estimated savings from these proposals.

BCBSA retained our HDH team (encompassing Harmonic Consulting, Dare Actuarial Consulting, and Helse Consulting Group) to update the original savings estimates and evaluate savings estimates for three additional public policy proposals, as follows:

- Requiring hospitals to report their administrative costs relative to a benchmark;
- Requiring provider participation in two-sided value-based contracts as a condition for participating in Medicare;
- Requiring the use of 340B claims modifiers by all 340B covered entities.

We estimate that this updated package of proposals will generate **NEARLY $1 TRILLION IN SAVINGS IN THE FORM OF LOWER HEALTH CARE COSTS** over the next decade. As noted in the table below, from 2026 through 2035, the 10 public policy proposals we modeled would generate estimated federal savings of $524 billion, reduce private insurance premiums by $389 billion, and save consumers $180 billion in out-of-pocket (OOP) costs.

Proposal	Savings
1. **Adopt site-neutral payment in Medicare** so that providers receive the same payment for the same service, regardless of the site of service	**$484 billion**
2. **Require a provider identifier** for off-campus hospital facilities that differs from the identifier used for on-campus facilities	**$11 billion**[i]
3. **Expand antitrust enforcement** of provider mergers	**$78 billion**
4. **Prohibit anti-tiering provisions** in payer-provider contracts	**$16 billion**
5. **Facilitate the entry of generic biosimilar drugs** by constraining various efforts by manufacturers to delay that entry	**$53 billion**
6. **Shorten the exclusivity period for biologics** from 12 years to 7 years	**$134 billion**
7. **Eliminate the tax-deductibility of spending on direct-to-consumer drug advertising** for manufacturers	**$137 billion**
8. **Require hospitals to report administrative costs** relative to new standards for cost efficiency	**$40 billion**
9. **Require provider participation in two-sided value-based care arrangements** in traditional Medicare	**$54 billion**
10. **Require the use of 340B modifiers** on all medical and pharmacy claims across all markets to improve transparency in this program	*****
TOTAL	**$996 billion**

i. Due to overlap between proposals 1) and 2), proposal 2) not included in total to prevent double-counting
** Not estimated given difficulty of modeling impact. See full analysis below for details on the proposal.*

Introduction

Given the significant challenges created by rising healthcare costs, in January 2023, the Blue Cross and Blue Shield Association (BCBSA) released a proposal to improve the affordability of health care for Americans entitled Affordability Solutions for the Health of America. BCBSA also issued a report by Phil Ellis, Ph.D., a former CBO senior economist, that estimated budgetary and spending effects associated with six of the recommended public policy proposals.[1]

BCBSA retained our HDH team to update the estimates from the Ellis report and to estimate the impact of three additional proposals:

- Require hospitals to report their administrative costs relative to a benchmark;
- Require provider participation in two-sided value-based contracts as a condition for participating in FFS Medicare;
- Require the use of 340B claims modifiers by all 340B covered entities.

Additionally, BCBSA requested an estimate for savings associated with a proposal being considered by the U.S. Congress that would require every off-campus hospital outpatient department to use a unique billing identifier that is separate from the identifier used for on-campus services.

For the proposals already analyzed by Ellis, we conducted a literature review of materials published during 2023 and 2024 to determine the extent to which assumptions and methodologies should be updated. We then built a model for each proposal to calculate updated savings estimates. For the three new proposals, we conducted a literature review and built new models to calculate estimated savings.

For all the issues analyzed, we sought to maintain the rigorous methods used by Ellis. For baseline spending projections, we used both CBO projections and projections from the Centers for Medicare and Medicaid Services (CMS) contained in its National Health Expenditure (NHE) reports.

As Ellis noted in his original report, publicly available data does not exist for every aspect of each proposal. To develop our estimates, we relied on a combination of publicly available data and reports, while also using our decades of combined experience pricing health coverage.

[1] Ellis Health Policy. *Savings Estimates for Options to Reduce Spending on Health Care and Private Insurance Premiums.* January 2003. Mr. Ellis passed away in January 2024.

The table below summarizes the estimated impact for each proposal on the federal budget, private insurance premiums, and consumer out-of-pocket costs, over the 10-year budget window covering 2026 through 2035. **Those 10 proposals would generate an estimated federal savings of $524 billion, would reduce private insurance premiums by an estimated $389 billion, and would save consumers $180 billion in out-of-pocket costs. The combined estimated savings would be $996 billion.**[2]

Summary of Estimates

10-Year Effects ($Billions)

Number	Proposal	2025 Estimates (2026-2035) Federal Savings	Private Premium Savings	Enrollee OOP Savings	Combined Savings
Options that Generate Savings by Changing Current Law					
1	Adopt Site-Neutral Payment Policies	269	127	120	484
2	Require Unique Provider Identifier (NPI)*	3	9	1	11
3	Expand Antitrust Funding & Enforcement	17	68	10	78
4	Prohibit Anti-Tiering Provisions	4	14	2	16
5	Facilitate Entry of Generic/Biosimilar Drugs	29	24	6	53
6	Limit the Exclusivity Period for Biologicals	69	66	16	134
7	Tax Spending On Direct-to-Consumer Drug Ads	75	62	16	137
8	Require Hospital Administrative Efficiency Reporting	27	12	4	40
9	Incentivize/Mandate Value-Based Contracts	35	17	6	54
10	Implement 340B Claims Modifiers	**	**	**	**
	TOTAL, Provisions 1-10*	**524**	**389**	**180**	**996**

*Due to overlap between proposals 1 and 2, proposal 2 is not included in the total to prevent double-counting.

**Due to the difficulty in estimating savings for this proposal, we are not including any savings estimate.

To avoid double-counting, combined savings exclude the effects of private premium savings on federal revenues.

[2] To avoid double-counting of savings when combining the three figures, it is necessary to subtract the effects of reductions in private insurance premiums on the federal budget – that is, to subtract 25 percent of the savings on private premiums from the sum of the three components. Note also that the figures for OOP savings include reductions in premiums for Medicare enrollees.

Proposals and Detailed Analysis

1. Adopt Site-Neutral Payment Policies

Background

Outpatient services can be provided at a range of provider facilities, including outpatient departments that are connected to a hospital, outpatient departments that may be owned by a hospital but located off campus, ambulatory surgery centers, and physician offices. Generally, health systems demand a higher reimbursement rate when outpatient services are performed in hospital-owned outpatient departments, even if the services are the same as those provided at physician offices. This payment differential has become more costly due to the recent trend of hospital systems purchasing physician practices. Once these practices are a part of the hospital system, the hospital secures the higher reimbursement rates resulting in higher out-of-pocket cost sharing for patients.

Because there is little or no evidence that the quality of care is higher for outpatient services in a hospital setting,[3] private payers, policymakers, and regulators have evaluated ways to adopt "site-neutral payment" policies that would reimburse providers the same rate for certain outpatient services irrespective of the site-of-service. Proposals differ on which outpatient services are captured [e.g., the Medicare Payment Advisory Commission (MedPAC) uses a list of 66 services][4] and which provider sites are captured (e.g., whether on-campus outpatient departments are captured or only off-campus outpatient departments). Both the Obama and Trump administrations included site-neutral reforms in their budget requests to Congress demonstrating this policy's bipartisan appeal.

Proposal Details

The proposal we evaluated mirrors a portion of the proposals the CBO analyzed in its March 2020 and December 2024 publications identifying alternatives for reducing the federal budget deficit.[5,6] Some of these proposals build on site-neutral reforms included in the Balanced Budget Act of 2015, which requires hospital outpatient departments (HOPDs) to bill at lower rates. However, the law included several caveats and a grandfathering provision, exempting HOPDs that were already in existence or in the process of being built

[3] Journal of Arthroplasty. *Outpatient Total Hip Arthroplasty Performed at an Ambulatory Surgery Center vs Hospital Outpatient Setting: Complications, Revisions, and Readmissions.* December 2019.
[4] MedPAC. *Annual report to Congress. Medicare and the Health Care Delivery System*. June 2023.
[5] CBO. *Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget*.
[6] CBO. *Options for Reducing the Deficit: 2025 – 2034.* 2024.

or acquired. This has led to only 2.3% of Medicare outpatient spending being paid at site neutral rates—meaning public and private payers are currently reimbursing providers at a higher rate.[7] The proposals examined in this analysis would change Medicare to ensure that providers would receive the same reimbursement for services that are commonly supplied in physicians' offices—irrespective of the site-of-service—including both off-campus and on-campus outpatient departments as well as hospital-owned physician offices. The rate paid in all settings would be at the lower physician office rate.

Assumptions and Sources

The 2024 CBO report noted above calculated savings for the Medicare program at $156.9 billion over the 2025-34 budget window for hospital outpatient departments.[8] This estimate is generally consistent with other estimates, including a 2024 report from the Actuarial Research Corporation (ARC), which projected $126.8 billion savings for the Medicare program and $18.7 billion in beneficiary cost savings—over the same 2025-34 budget window—for a proposal encompassing the 66 services recommended by MedPAC for all types of outpatient departments (including those on a hospital campus).[9] The 2020 CBO report noted above estimates the impact of paying all hospital-owned physician offices at the physician office rate to be $39.1 billion for the 2021-2030 budget window.[10]

While the proposal is limited to Medicare, private payers have wanted to similarly implement site-neutral payments. If Medicare were to make additional site-neutral payment changes, private payors would have a stronger ability in negotiations to implement a similar, more balanced payment model.

To determine the extent to which this proposal would result in savings in the private insurance markets, we used a methodology similar to the one used in the original Ellis report. That report used a study by Clemens and Gottlieb that evaluated several years of data and concluded that an increase in Medicare's fees of $1.00 led to an increase in private payment rates of an average of $1.16. The authors applied this finding to the fact that private payment rates average 45% higher than Medicare's rates to conclude that approximately 80% of Medicare's price changes ($1.16/$1.45) were ultimately passed through to private prices.[11]

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[7] CMS Site-Neutral Payments Affect Small Share of Spending | Avalere

[8] Ibid.

[9] Actuarial Research Corporation. *Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals*. 2024.

[10] CBO. *Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget*.

[11] Journal of Political Economy. *In the Shadow of a Giant: Medicare's Influence on Private Physician Payments*. February 2017.

Ellis notes that recent studies indicate private payers and Medicare pay for a similar proportion of outpatient services at hospital outpatient departments.[12, 13] However, given increasing consumer cost-sharing in private plans that encourages utilization in lower cost settings, he said it would be reasonable to assume that the proportional effects of site-neutral payments on private insurance spending would be half as large as those estimated for Medicare. Adding in the additional effect of contract renegotiations between insurers and hospitals, he reduced the effect on private insurance to about 40% of the effect for Medicare. Consequently, if site-neutral payments would reduce overall Medicare spending on hospital services by about 4%, then the estimated effect on private-sector hospital spending would be a reduction of about 1.6%.

Results

Using those assumptions, site-neutral payments would yield an estimated reduction in costs for Medicare and private insurance plans of $484 billion over 10 years, as shown in the table below.

Proposal 1: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	17.3	19.1	22.1	22.2	26.3	27.9	30.0	32.8	34.6	37.1	269.3
Private Premium Savings	10.2	10.7	11.2	11.8	12.4	12.9	13.5	14.1	14.6	15.2	126.7
Enrollee OOP Savings	8.2	8.9	9.7	10.3	11.4	12.2	13.2	14.4	15.3	16.4	120.0
Combined Savings	33.2	36.0	40.2	41.4	46.9	49.8	53.3	57.7	60.9	64.9	484.4

[12] For private insurance, see: Health Care Cost Institute. *Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices*. April 2019.

[13] For Medicare, see Table 3-8 on page 76: Medicare Payment Advisory Commission. *Annual report to Congress. Medicare Advisory Committee*. March 2014.

2. Require Unique Provider Identifier for Off-Campus Services

Background

Under current billing practices, hospital systems often use a single national provider identifier (NPI) to capture both on-campus and off-campus sites-of-service. This practice makes it difficult for payers to identify when services are being rendered off-campus, where they would typically pay a lower rate than for services being rendered on-campus.

Proposal Details

The proposal we evaluated mirrors legislation introduced in Congress that would require every off-campus hospital outpatient department to use a unique billing identifier that is separate from the identifier used for on-campus services.[14]

Assumptions and Sources

If these billing requirements were in place, payers would have the ability to differentiate between hospital and non-hospital settings and apply the correct payment rates and patient cost-sharing, lowering costs for employers and consumers.

Our analysis uses the same assumptions reflected in CBO's analysis of H.R. 3561 (2023). In that analysis, the CBO expected that enacting the provision would result in total savings of $2.3 billion from 2024-33.[15] Trended forward to 2026-35, estimated savings would be $2.7 billion. We expanded the scope of the CBO estimate to include private premium savings and consumer out-of-pocket savings (consistent with our analysis for all proposals).

Whether savings for such a proposal would be in addition to—or already captured by—a site-neutral payment proposal depends upon the details of the proposal and how it is implemented. Our analysis for site-neutral payments reflected in Proposal 1 above is for a broad proposal that would include off-campus and on-campus outpatient departments, and thus there is likely overlap between our savings estimates and the savings estimates for this NPI proposal. However, if there was not overlap, savings from the two proposals would be additive.

[14] H.R. 3561 from 2023 and additional similar legislation in 2024
[15] CBO. *Cost Estimate for H.R.3561, the PATIENT Act of 2023*.

Results

Using those assumptions, the NPI proposal would yield an estimated combined savings of $10.8 billion over 10 years, as shown in the table below. Due to the potential for overlap between Proposals 1 and 2, Proposal 2 is not included in the totals reflected in the Summary section of this report, to prevent double-counting.

Proposal 2: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.1	0.2	0.3	0.4	0.4	0.4	0.3	0.3	0.2	0.2	2.7
Private Premium Savings	0.3	0.7	1.0	1.3	1.3	1.2	1.0	0.9	0.7	0.6	8.9
Enrollee OOP Savings	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1	1.4
Combined Savings	0.4	0.8	1.2	1.6	1.6	1.4	1.2	1.0	0.9	0.7	10.8

3. Expand Antitrust Funding and Enforcement

Background

One key factor contributing to high healthcare prices in the U.S. is the concentration of providers – particularly hospitals. This dynamic increases market power and can give providers more leverage in negotiations with payers, yielding higher prices and creating an anti-competitive market. In nearly half of metropolitan areas in 2022, one or two health systems controlled the entire market for inpatient hospital care.[16]

There are two main types of provider consolidation that can increase prices in a geographic area: 1) horizontal mergers between providers that offer similar services, and 2) vertical integration, where two systems merge that offer different services, such as hospitals purchasing physician practices. The role of private equity financing in health care has been cited as a driver of this consolidation.[17] In general, there are four entities that can potentially challenge either of these two types of provider consolidations on antitrust grounds: the federal Department of Justice, the Federal Trade Commission (FTC), state Attorneys General, and state commissions/agencies empowered by state law to review

[16] Kaiser Family Foundation. *One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2022.* October 2024.
[17] Commonwealth Fund. *Private Equity in Health Care*. October 18, 2024.

provider consolidations. These entities have overlapping authority, but the FTC is the entity that typically addresses provider consolidations.

Proposal Details

The proposal we evaluated would require the FTC to increase scrutiny on provider consolidations that are likely to increase prices.

Assumptions and Sources

To determine the extent to which provider concentration is increasing over time, we relied on a 2020 study that concluded there was a 5% increase in concentration from 2010 to 2016, which equates to 0.8% per year.[18]

We reviewed literature on the extent to which consolidations are not being challenged, focusing specifically on consolidations that would be likely to increase prices and could be challenged using reasonable review criteria. One analysis concluded there were 1,164 hospital mergers between 2002 and 2020, and the FTC could have flagged 20% for being likely to reduce competition and increase prices—but only took an enforcement action for 1%.[19]

To determine the price impacts associated with reduced concentration, we used a CBO analysis that concluded a 10% decrease in concentration reduces prices by 1.3% for hospital services and 0.8% for physician services.[20]

It is important to note that existing consolidations have already resulted in geographic areas where a single provider can wield significant market power in negotiations with payers. We did not assume there would be an increase in authority that could result in an unwinding of existing consolidations. Such an approach, however, could yield even larger savings. For example, if concentration decreased by 10% from *existing* levels, the savings could be roughly equivalent to the savings identified below (over $78 billion over 10 years), and it could be higher if federal agencies focused first on the geographies where providers have a true monopoly for certain services and use that leverage in a significant way in negotiations with payers.

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[18] The Hamilton Project. Brookings Institute. *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work*. March 2020.
[19] Tobin Center for Economic Policy. *Is There Too Little Antitrust Enforcement in the US Hospital Sector?* December 2024.
[20] CBO. *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*. September 29, 2022.

Results

Using those assumptions about reducing future growth in provider concentration, the proposal would yield an estimated combined savings of $78 billion over 10 years, as shown in the table below.

Proposal 3: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.6	0.8	1.0	1.3	1.5	1.8	2.1	2.4	2.7	3.0	17.1
Private Premium Savings	2.5	3.2	4.1	5.0	6.0	7.1	8.2	9.4	10.7	12.0	68.3
Enrollee OOP Savings	0.4	0.5	0.6	0.7	0.9	1.1	1.2	1.4	1.6	1.8	10.2
Combined Savings	2.8	3.7	4.7	5.8	6.9	8.1	9.4	10.8	12.3	13.8	78.5

4. Prohibit Anti-Tiering Provisions

Background

Hospitals can exert their market power described above in a wide variety of ways that go beyond simple price increases. This includes 1) “all or nothing” contracting where hospitals require contracts with all affiliated hospitals as a condition of contracting with one hospital, and 2) contract provisions that prevent insurers from using benefit designs that incentivize consumers’ use of hospitals in the payer’s network that offer high quality care at lower prices (e.g., differentiated co-pays based on cost and quality).

Policymakers at the federal and state levels have introduced legislation to prohibit these types of contract provisions that increase costs for consumers and purchasers of health benefits.

Proposal Details

The proposal we evaluated would prohibit hospitals from requiring contract terms with payers that 1) require payers to include all affiliated hospitals in the network and 2) prevent benefit designs that create incentives for consumers to use certain in-network providers over other in-network providers.

Assumptions and Sources

To determine the extent to which these changes would reduce costs as compared to current law, we relied heavily upon a CBO analysis from November 2024 that evaluated H.R. 3120.[21] This bill would have prohibited contracts between private payers and providers that contain language 1) restricting steering enrollees to specific providers, or 2) requiring the payer to contract with affiliated providers. The CBO methodology has a strong analytical basis, including evaluating states and markets for their unique dynamics and treating them differently in the analysis. It also adjusted savings estimates downward to reflect the limited likelihood of enrollment in tiered networks.

Following the CBO savings estimates—while acknowledging the reality of multi-year payer/provider contracts and payers needing time to implement new strategies—we estimate savings of 0.05% in 2026, increasing linearly to 0.1% at the end of the budget window in 2035.

Results

Using those assumptions, the proposal would yield an estimated combined savings of $16 billion over 10 years, as shown in the table below.

Proposal 4: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.5	0.6	3.6
Private Premium Savings	0.7	0.9	1.0	1.1	1.3	1.5	1.6	1.8	2.0	2.2	14.3
Enrollee OOP Savings	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	2.1
Combined Savings	0.9	1.0	1.1	1.3	1.5	1.7	1.9	2.1	2.3	2.6	16.4

[21] CBO. *Health Care Legislation Reported by the House Committee on Education and the Workforce on September 11, 2024.* November 2024.

5. Facilitate the Entry of Generic and Biosimilar Drugs

Background

Under existing law, manufacturers of brand drugs/biologics engage in several tactics that delay the market entry of lower-cost generics/biosimilars, including:

1) **"Pay for Delay"** arrangements between brand and generic/biosimilar manufacturers where generic/biosimilar manufacturers receive financial compensation for delaying entry of their lower-cost, equally-effective prescription drugs;
2) **"Citizen petitions"** where manufacturers can file petitions with the FDA asking the agency to delay or reject a generic manufacturer's request for approval;
3) **"Patent Thickets"** where manufacturers file multiple overlapping patents to existing brand drug/biologic formulations for the purpose of delaying generic competition;
4) **"Exclusivity parking"** where generic drug manufacturers use 180-day exclusivity periods to block subsequent generic that could reduce drug prices.

To address the rising cost of drugs, policymakers in recent years have regularly proposed legislation that would prohibit or mitigate these tactics and expedite approval of generics and biosimilar products.

Proposal Details

The proposal we evaluated would address each of these issues noted above in the following ways:

1) Prohibit pay for delay arrangements as included in the Preserve Access to Affordable Generics and Biosimilars Act (H.R. 2891/S. 142).[22]
2) Create a process to quickly deny citizen petitions that are designed to delay the entry of low-cost drugs, as included in the Ensuring Timely Access to Generics Act (S. 1067) or the Stop STALLING Act (S. 148). Specifically, S. 1067 would allow the FDA to deny citizen petitions that were submitted primarily to delay approval or fail to raise valid scientific or regulatory issues. Additionally, S. 148 would allow the FTC to sue entities submitting baseless citizen's petitions to impede approval.[23]
3) Limit the number of patents that may be included in infringement claims for biosimilar licenses, as included in the Affordable Prescriptions for Patients Act of 2023 (S.150).[24]

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[22] CBO. *Cost Estimate for S. 142, Preserve Access to Affordable Generics and Biosimilars Act*. March 2024.
[23] CBO. *Cost Estimate for S. 148, Stop STALLING Act*. March 2024.
[24] CBO. *Cost Estimate for S. 150, Affordable Prescriptions for Patients Act of 2023*. June 2024.

4) Allow the FDA to address exclusivity parking by permitting a generic manufacturer that is not a first filer to receive 180-day exclusivity if the first filer does not come to market after a specified timeframe, as included in the Expanding Access to Low-Cost Generics Act of 2023 (S.1114).[25]

Assumptions and Sources

Of these four proposals, we estimate Pay for Delay as having the largest potential impact. To estimate the savings, we reviewed a pre-publication study developed by ARC.[26] We agree with their approach and estimates for the 2024-2033 budget window. After adding out-of-pocket savings, and rolling estimates forward to the 2026-35 budget window, our total savings estimate is $44.9 billion.

For the other proposals, the CBO released reports (cited above) that provide estimated drug cost savings for each proposal (for the fourth proposal, we used a CBO estimate for the proposed policy change in a 2019 bill, as the most recent available). We incorporated these savings estimates into our model, alongside the Pay for Delay estimate approach described above.

Results

Using those assumptions, the four proposals would yield an estimated combined savings of $53 billion over 10 years, as shown in the table below.

Proposal 5: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	2.2	2.4	2.5	2.7	2.8	3.0	3.1	3.2	3.4	3.5	28.8
Private Premium Savings	1.8	1.9	2.0	2.1	2.3	2.4	2.6	2.8	2.9	3.1	24.0
Enrollee OOP Savings	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.8	6.1
Combined Savings	4.0	4.3	4.6	4.9	5.2	5.4	5.7	6.0	6.3	6.6	53.0

[25] CBO. *Cost Estimate for H.R. 938, Bringing Low Cost Options and Competition while Keeping Incentives for New Generics Act of 2019*. 2019.
[26] Actuarial Research Corporation. *Pay for Delay: Historic and Future Costs of Delayed Generic Entry.* Draft provided by BCBSA.

6. Limit the Exclusivity Period for Biologics

Background

Under existing law, manufacturers of biologics have a 12-year exclusivity period before biosimilars can enter the market. This compares to a 5-year exclusivity period for traditional drugs. In response to cost concerns, policymakers have recently evaluated reducing the timeframe for biologic exclusivity.

Proposal Details

The proposal we evaluated would shorten the 12-year exclusivity period for biologics to 7 years.

Assumptions and Sources

To estimate baseline spending for biologics, we relied on a 2023 analysis by the health intelligence firm, IQVIA, that estimated biologic spending in the U.S. at $260 billion in 2021.[27] We estimated that of this $260 billion, rebates and discounts represent almost 20%, which reduces the baseline spend after rebates and discounts to $209 billion in 2021.[28] We then projected that estimate forward using an annual trend assumption of 7.6%, drawn from estimates calculated by consulting firm Towards Healthcare.[29]

To estimate the extent to which a reduction in the exclusivity period would increase the proportion of biologics subject to competition, we followed the same assumption as Ellis, who notes that because biopharmaceutical companies must take many steps to bring a biosimilar to market, the impact of this policy change would be delayed. He assumed the policy change would not yield any increased competition until the fifth year of the budget window (2030), where there would be 10% more biologics subject to competition, increasing to 60% at the end of the budget window (2035).

To estimate the savings associated with increased competition, we used the same assumption as Ellis, who noted that biosimilar entry is estimated to save 12% for the drugs involved.

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[27] IQVIA Institute. *Biosimilars in the United States 2023-2027*. January 2023.
[28] IQVIA Institute. *Biosimilars in the United States 2020-2024.* October 2020.
[29] Towards Healthcare. *Biologics Market Size to Expand USD 845.78 Billion by 2033*. February 2024.

Definitive public data does not exist for the distribution of biologic spending (net of rebates) by segment, so we used Ellis' mix of total savings by program as a reasonable assumption: 40% Medicare, 10% Medicaid and 50% for private plans.

Results

Using these assumptions, the estimated total savings on biological products would be about $134 billion across the U.S. health care system over the 2026-2035 period, as shown in the table below.

Proposal 6: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.0	0.0	0.0	0.0	2.6	5.5	8.9	12.7	17.1	22.1	68.8
Private Premium Savings	0.0	0.0	0.0	0.0	2.4	5.2	8.4	12.1	16.3	21.0	65.5
Enrollee OOP Savings	0.0	0.0	0.0	0.0	0.6	1.2	2.0	2.9	3.9	5.0	15.6
Combined Savings	0.0	0.0	0.0	0.0	5.0	10.7	17.2	24.7	33.2	42.9	133.6

7. Tax Spending on Direct-to-Consumer Drug Advertising

Background

The U.S. is one of only two countries in the world that allows drug manufacturers to market directly to consumers (DTC). Studies have found such advertising increases total sales of drugs within a therapeutic class, particularly in the case of broadcast advertising.[30] Studies have also shown manufacturers are more likely to use DTC advertising for drugs that are rated as having a low clinical benefit.[31]

Concerns regarding DTC marketing have led to significant regulation of the content of advertising, and policymakers regularly introduce legislation to prohibit the practice or discourage it by changing the tax treatment of DTC advertising spending for manufacturers.

[30] National Bureau of Economic Analysis. *The Impact of Direct-to-Consumer Advertising on Pharmaceutical Prices and Demand*. May 2010.
[31] JAMA. *Association Between Drug Characteristics and Manufacturer Spending on Direct-to-Consumer Advertising*. February 2023.

Proposal Details

The proposal we evaluated would eliminate the ability of manufacturers to receive a tax deduction for expenses associated with DTC advertising.

Assumptions and Sources

To determine the baseline amount of existing DTC advertising, we used a 2021 U.S. Government Accountability Office (GAO) report, which concluded manufacturers spent a relatively constant $6 billion per year on advertising from 2016 – 2018.[32] We assumed that—under current law—DTC would remain consistent at this level.

To determine the extent to which DTC advertising would be reduced as a result of this policy change, we followed Ellis' logic and assumed the reduction in DTC spending would be roughly equivalent to the increase in tax liability to manufacturers—approximately 25%.

Based on the GAO report, we assumed that 58% of drug spending would be impacted, given 58% of drug spending is on drugs that are advertised.

To determine the extent to which drug spending is reduced when advertising is reduced, we used a recent CBO analysis that estimated that a 10% increase in DTC advertising yields an increase in drug spending ranging from 1.0 to 2.3%.[33] We chose the mid-point of this range (1.65%) as a reasonable estimate.

While the initial Ellis report assumed that a significant portion of the reduced advertising spending would be replaced by other forms of promotion, we did not include that assumption due to a lack of evidence that such a substitution would occur and the fact that the CBO analysis appears to reasonably capture the full impact.

[32] Government Accountability Office. *Medicare Spending on Drugs with DTC Advertising*. May 2021.
[33] CBO. *Alternative Approaches to Reducing Prescription Drug Prices*. October 2024.

Results

Using these assumptions, disallowing tax deductions for DTC drug ads would yield an estimated savings of $137 billion over the 2026-2035 period.

Proposal 7: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	5.6	6.1	6.6	7.0	7.4	7.7	8.0	8.4	8.7	9.1	74.6
Private Premium Savings	4.7	4.9	5.2	5.5	5.9	6.3	6.7	7.1	7.6	8.0	62.1
Enrollee OOP Savings	1.2	1.3	1.4	1.5	1.5	1.6	1.7	1.8	1.9	2.0	15.8
Combined Savings	10.3	11.1	11.8	12.6	13.3	14.1	14.8	15.5	16.3	17.0	137.0

8. Require Hospitals to Report Administrative Costs relative to Benchmark

Background

Policymakers at the federal and state levels have implemented a variety of programs aimed at controlling administrative costs in the healthcare sector. Minimum Medical Loss Ratio (MLR) requirements for insurers have been in place for decades at the state level—and since 2011 at the federal level. These requirements aim to cap insurer administrative costs as a share of premium revenue and generally require 80 or 85% of premium revenue to be spent on medical benefits.

Other parts of the healthcare sector do not currently face similar caps on administrative costs. There is some policymaker interest in targeting hospital costs given rising costs relative to overall inflation. A recent analysis shows hospital costs from July 2023 to June 2024 increased by 6.9% while inflation for all goods was 3.0% for that period.[34] One recent analysis concluded that from 2019 to 2020, hospital administrative costs grew by 6.2% while clinical expenses only increased by 0.6%.[35]

While CMS requires Medicare-certified hospitals to submit cost reports, the size and complexity of these reports have resulted in frustration, with researchers resorting to seeking data from third party vendors.[36]

[34] Peterson-KFF. *How does medical inflation compare to inflation in the rest of the economy?* August 2024.
[35] Journal of General Internal Medicine. *U.S. Hospitals' Administrative Expenses Increased Sharply During COVID-19.* June 2023.
[36] Healthcare Analytics. *Democratizing insights into hospital cost reports*. October 2023.

Proposal Details

The proposal we evaluated would establish a federal requirement for hospitals to report administrative costs relative to a new benchmark for cost efficiency ("administrative cost efficiency benchmark"). Under this proposal, a federal agency would establish reporting requirements for hospitals to report administrative costs as a share of hospital revenue and establish a target level for efficiency, as well as information on their total cost of care. The Department of Health and Human Services (HHS) would publicly report comparative information on hospital performance. Importantly, unlike the minimum MLR requirement on insurers, the proposal would not include the authority to fine hospitals that report administrative cost ratios above the target benchmark or require rebates to patients.

Assumptions and Sources

While this proposal only requires reporting and would not establish a punitive system that includes fines or rebates, there is evidence that public reporting and scrutiny can result in behavior changes. Economists refer to this phenomenon as "nudging" and consider it an alternative to a government mandate that can result in behavior change.

In the healthcare sector, several states (CA, CT, DE, MA, NV, NJ, OR, RI, and WA) have implemented global cost increase targets without a built-in mechanism to automatically fine entities or recover cost amounts over the benchmark. These programs typically require providers and insurers to report data to calculate year-over-year cost increases, and they are scrutinized if cost increases are above an established benchmark.

Massachusetts' (Mass.) cost target program has been in place the longest. Established in 2012, the program sets overall cost increase targets for each year, ranging from 3.1% to 3.6%. The Mass. Health Policy Commission requires entities to report data to calculate each entity's year-over-year cost increase. For entities over the target, there is a progressive mechanism for enforcement that begins with meetings, hearings, and applying public pressure. While the Commission has the authority to levy fines, it has not yet done so as of the writing of this report and has implemented only one performance improvement plan in the history of the program.[37]

While this program is not a perfect corollary for the hospital reporting proposal we are analyzing, it sheds some light on the extent to which administrative costs can potentially be reduced through government-required reporting and comparison to a government-set benchmark. Transparency on administrative costs and total cost of care could encourage hospitals to be more efficient.

[37] Milbank Memorial Fund. *The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanisms: Implications for State Policymakers*. 2022.

To determine the extent to which the Mass. program has reduced cost growth, we evaluated a 10-year comparison of Mass.' year-over-year cost increases for healthcare costs as compared to other states (the vast majority of which had no similar program). From 2012 to 2021, in 9 out of 10 years, cost growth in Mass. was below the U.S. average, in the range of 0 to 2%.[38] We used the midpoint of this range, 1%, as an assumption for the extent to which hospital administrative costs would be reduced (compared to baseline projections) as the result of reporting and scrutiny. We assume the impact would phase-in over the first three years of the program. The overall impact on hospitals would be 0.3% of their total costs.

Results

Using these assumptions, requiring hospitals to report administrative costs would yield an estimated savings of $40 billion over the 2026-2035 period.

Proposal 8: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.7	1.5	2.4	2.6	2.8	2.9	3.2	3.4	3.6	3.8	26.7
Private Premium Savings	0.3	0.7	1.1	1.2	1.2	1.3	1.3	1.4	1.5	1.5	11.6
Enrollee OOP Savings	0.1	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6	4.4
Combined Savings	1.1	2.3	3.6	3.9	4.1	4.4	4.7	4.9	5.2	5.5	39.8

9. Incentivizing or Mandating Provider Participation in Two-Sided Value-Based Contracting in Medicare

Background

As health care expenditures have increased rapidly over the last few decades, payers and policymakers have been working to shift payments from the Medicare fee-for-service model to alternative models that pay for value. Paying for value is often referred to as value-based contracting (VBC), where value-based agreements financially reward providers for improving quality and patient outcomes. VBCs can be "one sided" where a provider only gets financially rewarded, or "two sided" where a provider can also be penalized if quality metrics and/or financial outcomes fall below benchmarks outlined in the contract.

[38] Mass. Health Policy Commission Presentation to the California Department of Health Care Access and Information. April 2023.

For traditional Medicare, CMS has implemented a large number of programs that aim to pay providers for value, including the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACO), Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH), the Hospital Value-Based Purchasing Program, and the Hospital Readmission Reduction Program. With rare exceptions, provider participation in CMS' value-based payment programs is voluntary.

The goal of many proposals in this area is to increase provider system participation in VBCs, particularly two-sided risk VBC models that have the strongest potential to incentivize providers to maximize health outcomes and reduce overall costs. A study of Medicare Advantage patients under the care of physicians with two-sided risk arrangements found patients had "lower rates of hospitalizations, observation stays, and emergency department visits" than individuals in plans with fee-for-service reimbursement structures.[39] Proposals to increase VBC participation range from incentives to mandates.

Proposal Details

The proposal we evaluated would require provider system participation in two-sided VBCs as a condition of participating in Medicare. The proposal would encompass both traditional Medicare and Medicare Advantage (MA). This proposal is stronger than other voluntary proposals being considered, and thus the estimated savings is intended to represent the full universe of potential savings. Savings associated with proposals that employ more modest incentives for provider participation would be expected to yield lower levels of savings.

Recognizing the administrative efforts needed for providers to implement two-sided VBC arrangements, the proposal would include low-interest loans to independent, rural and/or primary care providers for the purpose of supporting infrastructure needed in VBC participation.

Assumptions and Sources

To determine the savings associated with providers participating in two-sided risk models in the Medicare program, we used CMS' calculated savings associated with providers participating in the ACO REACH model, a two-sided arrangement where ACOs can earn financial rewards and incur penalties. For the 2023 calendar year, CMS calculated the net savings to CMS for these providers at 2.6%.[40] We also used CMS' net savings for the subset of ACOs participating in MSSP with two-sided risk arrangements. For the 2023 calendar

[39] JAMA Network. *Analysis of Value-Based Payment and Acute Care Use Among Medicare Advantage Beneficiaries.* March 2022.
[40] CMS. *ACO Realizing Equity, Access and Community Health (ACO REACH) Model: Performance Year 2023 Financial and Quality Performance Results' Highlights*. November 2024.

year, net savings for ACOs with two-sided agreements was 1.6%.[41] For the expected savings associated with providers participating in two-sided risk arrangement, we started with the average of these estimates, or 2.1%. However, it is logical to assume that providers drawn in to VBC contracting through a mandate would exhibit reduced savings as compared to providers that voluntarily participated. We therefore assumed that there would a 50% reduced level of net savings associated with incremental providers participating in two-sided VBCs.

For the baseline proportion of Medicare beneficiaries in two-sided risk arrangements, we used 31.7% for traditional Medicare, based on numbers published by CMS in January 2025.[42] We assumed a similar proportion of MA beneficiaries are being served in two-sided risk arrangements based on a McKinsey report concluding that a similar proportion of beneficiaries in MA are being served in two-sided risk arrangements.[43] We then assumed there would be natural growth in voluntary downside program participation (absent the mandate proposal) to the point where 50% of traditional Medicare and MA enrollment would be served by providers in such arrangements by 2035.

To determine the extent to which medical spending in Medicare would shift to providers engaging in two-sided risk arrangements if providers were required to participate in such arrangements, we assumed some providers would be exempt due to their smaller size or due to being rural or independent providers. We assume the maximum enrollment in providers with downside risk would be 80%, achieved in 2035.

While the proposal does not include a mandate for provider participation in the commercial market, it is logical to expect that there would be some spillover to the commercial market once providers have more experience with two-sided risk arrangements and have made investments associated with needed infrastructure. We assumed the rate of growth for two-sided risk arrangements in the commercial market would be half of what it would be in Medicare with mandatory participation.

[41] CMS. *Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care*. October 2024.
[42] CMS. *CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives*. January 2025.
[43] McKinsey & Company. *Investing in a New Era of Value-Based Care*.

Results

Using these assumptions, requiring two-sided value-based contracting would yield estimated savings of $54 billion over the 2026-2035 period, as shown in the table below.

Proposal 9: Estimated Effects ($ Billions by Calendar Year)

Year	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2026-35
Federal Savings	0.4	0.9	1.5	2.1	2.8	3.6	4.5	5.4	6.4	7.5	35.1
Private Premium Savings	0.2	0.5	0.8	1.1	1.4	1.8	2.2	2.6	3.0	3.5	17.1
Enrollee OOP Savings	0.1	0.2	0.3	0.4	0.5	0.6	0.8	0.9	1.1	1.3	6.0
Combined Savings	0.7	1.4	2.3	3.3	4.3	5.5	6.8	8.3	9.8	11.4	53.9

10. Adding a Claims Modifier for Drugs Purchased through the 340B Program

Background

Under the 340B program, qualifying providers (known as "covered entities") serving low-income and uninsured patients can purchase outpatient drugs from manufacturers at a discount. Covered entities include 340B hospitals which qualify by treating a disproportionate share of Medicaid patients and low-income Medicare patients (except for Critical Access Hospitals) and grantees, which qualify on the basis of receiving a particular grant from the federal government.

The 340B ceiling price provides a discount from the average manufacturer price: a minimum of 23.1% for most brand-name prescription drugs, 17.1% for brand-name pediatric drugs and clotting factor, and 13% for generic and over-the-counter drugs. Manufacturers must offer greater discounts under certain conditions.[44]

Under the 340B program, covered entities can use an unlimited number of contract pharmacies and provide drugs procured at 340B prices to all of its patients irrespective of income or coverage type. Additionally, 340B covered entities can designate an unlimited number of off-campus locations as "child sites" to extend their reach. This structure can result in 340B providers earning a profit by securing drugs through the 340B program and receiving standard reimbursement for patients covered by Medicare or commercial coverage. A study in 2022 found that 340B hospitals marked-up oncology drugs by an

[44] 340B Health. *340B Drug Pricing Overview*. January 2025.

average of 4.9 times their acquisition costs. The study also found that for commercially insured patients treated at the 340B hospitals, the median spread on the drugs studied was 7.4 times that for a Medicare patient.[45]

The volume of drugs purchased at 340B discounts has increased significantly in the last few years. The Health Resources and Services Administration reported that under the 340B program, drug purchases at 340B prices reached $66.3 billion in 2023, representing a 24% year-over-year increase from 2022. In 2015, the total was $12 billion.[46]

CMS requires 340B providers that submit Medicare claims to CMS for Part B drugs to include a note ("modifier") on the claim if the drug was acquired at a 340B discount. This requirement was fully effective on January 1, 2025, and is expected to help bring transparency to the program. However, there is no similar requirement for claims sent to payers in the commercial market.

Proposal Details

The proposal we evaluated would require the use of 340B modifiers on all medical benefit and pharmacy benefit claims across all markets as a requirement for being a 340B covered entity. The goal of the proposal is to add transparency for MA and commercial payers to know when providers are securing drugs at discounted prices, which would allow health plans to work with providers to more accurately reimburse providers for drugs, leading to more accurate rates and bids.

Assumptions and Sources

In its recent report containing estimates for options to reduce the deficit, CBO presented savings estimates for two options that would reduce Medicare payments for drugs secured at 340B discounted prices: 1) reducing payment rates to a drug's Average Sales Price; and 2) reducing payments to the average sales price minus 22.5%, which mirrors a recent HHS rule that was invalidated by a federal court. CBO estimates that the first option would save $15.4 billion over 10 years and the second option would save $73.5 billion over 10 years.[47]

While CBO identified a large savings opportunity associated with reducing payments in Medicare, it did not perform any analysis that would shed light on the extent to which additional transparency for MA or commercial claims would help payers in those markets secure savings. Theoretically, payers would like to know when covered entities are securing 340B discounts on drugs to inform contract negotiations with providers, but it would be difficult to estimate the extent to which that information would result in reduced growth in

[45] Community Oncology Alliance. *Examining 340B Hospital Price Transparency, Drug Profits, and Incentives*. September 2022.
[46] Avalere. *340B Purchase Data Highlights Continued Program Growth*. October 2024.
[47] CBO. *Options for Reducing the Deficit: 2025-2034*. December 2024.

negotiated rates with providers (or even whether it would reduce growth at all). Due to the difficulty in estimating savings in this area, we are not including any estimated savings. Further work with payers and providers may increase the ability to develop estimates in this area.

Results

Overall, the results are inconclusive, as explained above, and we have not provided a savings estimate.

APPENDIX: Additional Notes on Assumptions and Methodology

In addition to assumptions and methodologies noted in the preceding sections of the report, we provide the following additional details.

Allocating Savings between Federal, Private Premium, and Enrollee Out of Pocket (OOP) Costs

The following methodologies and assumptions were used to allocate savings between federal, private premium, and enrollee OOP costs:

- **Federal vs. private premium savings:** For private premium savings, we agree with Ellis' assumption that 25% of savings would go towards federal savings. Health benefits may be purchased with pre-tax dollars, which is essentially a federal subsidy. Reductions to these costs would likely be offset by increases in other forms of employee compensation to maintain an equivalent total compensation, which would be taxed at an estimated marginal rate of around 25%. Because of this, we assume 25% of private market savings accrues to the federal government as additional revenue and have included this in the federal line item for each provision. As a result of this assumption, the combined savings row subtracts 25% of the private market savings to avoid double counting.
- **Enrollee OOP cost calculations:** To allocate the proportion of savings that would flow to premiums vs. OOP costs, we assumed 13% of private market savings would flow to OOP costs, consistent with Phil Ellis's assumptions. For Medicare, we assumed 10% of savings would flow to out-of-pocket costs based on updated program parameters, including the Inflation Reduction Act impact on Part D cost sharing. Medicare recipients also may experience reductions in premiums, such as for Part B, Part D, Medigap, or MA coverage.

Medicaid

We have not included Medicaid savings in any of the analyses. For several of the proposals that aim to generally reduce the cost of health care, there would likely be significant Medicaid savings that would accrue to federal and state governments.

Proportion of Medicare Beneficiaries in MA

Consistent with recent estimates and growth projections, we assume that 50% of Medicare beneficiaries are currently in MA and that this proportion grows by 1% each year.

Speed of Implementation

The analysis assumes that the proposals under consideration would be implemented relatively quickly, with impacts generally beginning in 2026. Some of the proposals have impacts which phase in over time, while others take effect within a few years. These timeline assumptions may differ from actual results, but the impacts are reasonably representative of the level of savings possible from the various proposals.

Who We Are

Our HDH team includes Harmonic Consulting, Dare Actuarial Consulting, and Helse Consulting Group. This group includes individuals with actuarial, public policy, and government budgeting expertise. The following three individuals were the lead contributors to this report:

Tony Mader, President, Harmonic Consulting

Tony Mader is the former V.P. of Public Policy for Elevance Health (formerly Anthem), where he worked for 15 years and led a team that reviewed federal and state legislation and regulation and developed public policy proposals. Prior to his roles at Anthem, he worked as a budget analyst for California's Department of Finance, where he specialized in Medi-Cal, the state's Medicaid program, preparing the Governor's Budget and reviewing legislation and regulation related to the program. Tony holds an MA in Economics from University of California, Santa Barbara, and a BS in Economics from Willamette University.

Andy Dare, President, Dare Actuarial Consulting

Andy Dare is healthcare actuary with 20 years of experience in the actuarial and health insurance industries. He is a Fellow of the Society of Actuaries and a Member in the American Academy of Actuaries, which has served as the foundation for his work assessing impacts of legislation and benefit design changes, evaluating healthcare cost trends, forecasting financial results, and pricing insurance products. Andy has held prominent roles as Chief Actuary of BlueCross BlueShield of Mississippi, the Chief Actuary of Havarti Risk, and the lead actuary of commercial business for Anthem's Missouri plan. Andy holds an MS in Operations Research and Industrial Engineering from the University of Texas at Austin and a BS in Mechanical Engineering from the University of Missouri at Rolla.

Scott Allen, President, Helse Consulting Group

Scott Allen has nearly 30 years of actuarial and underwriting experience in managed care. Prior to starting Helse Consulting Group in 2013, Scott served as Chief Actuary of three organizations (Sentara Health Plans/Optima Health, Medical Card System, and Harvard Pilgrim Health Care). He has also held senior actuarial positions with Coventry Healthcare and WellPoint (currently Elevance Health), as well as a managerial position with Blue Cross Blue Shield of Illinois / HCSC. He is a Fellow of the Society of Actuaries and a Member in the American Academy of Actuaries. Scott holds an MA in Economics from Northwestern University and a BA in Economics from Wheaton College.

DISCLOSURE & RELIANCE

Purpose and Scope of the Report

This report has been prepared at the request of the BCBSA for the purpose of updating estimates of the budgetary and spending effects over a ten-year planning horizon associated with six public policy proposals to reduce healthcare spending and with two insurance industry practices that protect against cost increases. This report builds upon prior work prepared for BCBSA in 2023 by Phil Ellis, formerly with the CBO, with updated assumptions and methodologies based on new information published during 2023 and 2024. The report is intended for the use of the BCBSA and should not be used or relied upon for purposes other than those explicitly stated herein.

Data and Information Reliance

In conducting this analysis, we relied upon data and analysis conducted by Ellis in the prior report, historical and projected spending and budgetary impacts provided by the CBO, and other data and projections from the CMS contained in its NHE reports. We reviewed the data for reasonableness and consistency, but did not audit or independently verify its accuracy. The findings in this report depend on the completeness and accuracy of the data provided.

We have worked closely with and relied upon expertise from BCBSA's staff regarding the appropriate scope of the project, input on trend and other assumptions, and feedback on reasonableness of overall results. We also relied upon various studies and government documents to check for reasonableness.

The report relied heavily upon publicly available research and data, which often required general assumptions and limits the ability to confirm the accuracy of estimated results. Further, given the rapidly changing healthcare landscape, the results of this analysis may be rendered inappropriate as time passes.

Assumptions and Estimates

This analysis incorporates numerous assumptions and estimates, including: health cost trends, enrollment changes, out of pocket cost sharing; behavioral responses to legislative changes; and others. These assumptions are based on available information as of the date of this report, along with professional judgment. Given the inherent uncertainty in predicting future events, actual results may differ significantly from the estimates presented.

Qualifications and Adherence to Actuarial Standards of Practice (ASOPs)

Andy Dare and Scott Allen are Members of the American Academy of Actuaries. Each are qualified to prepare the analyses contained within this report. The methodologies used in this analysis adhere to relevant ASOPs, including ASOP 23 (Data Quality), ASOP 41 (Actuarial Communications), and ASOP 56 (Modeling).