

EXECUTIVE SUMMARY

A Patients' Bill of Rights To Lower Health Care Costs

By Topher Spiro, Neera Tanden, Natasha Murphy, Neda Ashtari, Kierra B. Jones, and Brian Keyser
April 7, 2026

Health care costs in the United States are at a breaking point. Americans pay far more for care than people in other countries, not because they use more services but because prices are higher. Rising premiums and employee contributions over the past [five years](#), [growing deductibles](#), and increasing [out-of-pocket costs](#) are putting pressure on families and employers alike, slowing [wage growth](#) and making coverage [less affordable](#).

Read the full report:
[A Patients' Bill of Rights To Lower Health Care Costs](#)

These costs are driven in large part by highly concentrated and opaque health care markets, where dominant insurers and hospital systems can raise prices without corresponding improvements in quality. At the same time, existing oversight tools are too weak to prevent unjustified price increases or ensure that consumers receive value for their premium dollars.

While broader structural reforms remain important, they would take years to implement. In the near term, consumers need immediate relief from rising premiums, growing deductibles, and barriers to care.

The Center for American Progress proposes “A Patients’ Bill of Rights To Lower Health Care Costs,” a targeted reform agenda designed to restore accountability and reduce costs. The plan would:

- Limit excessive premium increases.
- Lower deductibles by reducing outlier hospital prices.
- Prevent price gouging by health insurance companies.
- Ban and replace prior authorization.

These policies would deliver substantial, measurable savings for consumers and workers. Limiting excessive premium increases would reduce average premiums by \$415 for individuals in affected Affordable Care Act (ACA) markets and by \$1,156 for employer-sponsored family coverage in affected states. Reducing outlier hospital prices would lower deductibles roughly in half in concentrated markets and lower

employer family premiums by \$1,308 per year by 2032. Strengthening limits on insurer profits would reduce premiums by up to \$132 per enrollee per year, totaling about \$6 billion annually.

This agenda is designed to curb industry abuses that drive up costs, ensure that savings flow to consumers in the form of lower premiums and out-of-pocket costs, and provide near-term relief in a system where affordability has reached a breaking point.

Limit excessive premium increases

Health insurance premiums are reviewed by state and federal regulators, but current oversight standards are too weak to stop unjustified rate hikes. The ACA took an important step toward protecting consumers by requiring federal review of unreasonable premium increases in states without effective oversight. However, federal regulators currently only review premium increases that exceed [15 percent](#)—and even when proposed premium increases are excessive, they lack the authority to modify or reject them.

CAP proposes shifting the burden of proof. Premium increases above medical trend, as determined by the Centers for Medicare and Medicaid Services' Office of the Actuary, would be presumed excessive unless insurers can publicly justify them with independent actuarial analysis. A strengthened federal backstop would ensure consistent oversight while preserving state authority.

If this policy had been in place in recent years, it would have reduced average individual market premiums by approximately \$415 in 14 states and reduced employer family premiums by about \$1,156 in 11 states.

Lower deductibles by reducing outlier hospital prices

The only way to lower deductibles without significantly increasing premiums is to reduce the underlying cost of care. From 2022 to 2024, hospital costs accounted for nearly [40 percent](#) of private insurance spending and were the main driver of premium growth. Commercial insurers and employers pay hospitals, on average, about [2.5 times](#) Medicare rates, and prices vary widely both across and within markets. For example, in the San Francisco metro area, prices for cesarean section delivery vary from about [\\$15,000 to about \\$40,000](#). These wide price differences are not explained by higher quality or better outcomes. Instead, in many markets, hospital consolidation has allowed dominant systems to charge [prices far above](#) what Medicare pays for the same services, contributing to higher out-of-pocket costs for consumers.

CAP proposes limiting the prices of hospitals with the highest commercial prices:

- Hospital prices in highly concentrated markets would be limited to three times what Medicare pays.
- Hospitals with above-median prices would have annual price growth limited to inflation plus 1 percentage point.

Health insurers would be directed to use the savings to lower deductibles, and deductible and copay increases would be limited to medical trend. In concentrated markets, this policy would cut average employer deductibles in half and lower average family premiums for employer coverage by \$1,308 per year by 2032.

Prevent price gouging by health insurance companies

The ACA's [medical loss ratio](#) (MLR) was designed to limit insurer profits by requiring insurers to spend [80 percent to 85 percent](#) of premium dollars on medical care and return excess profits to consumers. But in practice, it has not worked as intended. Because profits are calculated as a share of premiums, insurers can increase profits by raising both premiums and spending, rather than by lowering costs. For example, if an insurer charges a \$5,000 premium and spends \$4,000 per person on care, its MLR is 80 percent—just meeting the requirement. If the insurer raises the premium to \$6,000 and spending to \$4,800, the MLR remains 80 percent, but profits increase.

CAP proposes fixing this by setting a clear limit on insurer profits and administrative costs on a per-enrollee basis, rather than as a share of premiums. The limit would be benchmarked to the Federal Employees Health Benefits (FEHB) Program, which delivers coverage more efficiently with [lower premiums](#). The proposal also extends the limit on profits to insurers administering employer plans.

Together, these reforms would return up to \$132 per enrollee annually, approximately \$6 billion.

Ban and replace prior authorization

Prior authorization requires clinicians to obtain approval from a patient's insurer before delivering services. Originally intended as a targeted tool to prevent unnecessary care, it has expanded across routine and ongoing treatments, becoming a widespread administrative barrier that can delay or deny medically necessary care. It also fuels [significant administrative costs](#) for both insurers and providers and is one of the largest sources of [excess health care spending](#).

CAP proposes banning prior authorization and replacing it with independent clinical review grounded in evidence-based guidelines. High-cost and widely overused services could be subject to 48-hour review, while routine, emergency, and preventive care would proceed without preapproval.

The proposal also calls for integrating real-time clinical decision support into electronic health records. These tools would help physicians follow appropriate-use guidelines at the point of care, reducing unnecessary services without delaying treatment.