Milbank MEMORIAL FUND

Evidence for policymakers.
Better health for all.

Health Policy Ideas for 2027 — An Open Letter to Incoming Governors

November 5, 2026

This week, voters in 36 states elected a governor with a mandate to fix health care. Roughly three-quarters of Americans name premiums or out-of-pocket costs as the country's most important health problem, and there is no partisan gap in that answer.

We have served as the chief state health and human services executives under Republican and Democratic governors, in states large and small, rural and urban. We have led through a pandemic, major coverage policy changes, and now federal shifts in support for state-run health programs.

Building on our experience of how states can lead on affordable, high-quality, accessible health care, we offer the following ideas as a menu of options for improving health care to gubernatorial transition teams across the country.

HEALTH CARE AFFORDABILITY

Limiting patient bills. States have a number of tools to protect residents from large and surprise medical bills. This includes capping growth in deductibles and copays: Massachusetts in May 2025 limited increases in deductibles and cost-sharing to medical inflation. Some states have enacted truth in billing laws that require insurers and providers to provide itemized bills on request and good-faith estimates before scheduled care. California, New York, and Texas have surprise-billing protections that predate the federal No Surprises Act. Protection from medical debt include bans on reporting medical debt to credit bureaus (e.g., California, Colorado, New York), interest-free payment plans (e.g., Delaware and Maine), and enforceable charity-care standards (e.g., Illinois and Washington). North Carolina tied hospital participation in enhanced Medicaid payments to forgiving existing debt and screening patients for assistance, and every hospital in the state signed on. Florida restricted debt sales, credit reporting, and collection lawsuits.

Provider price alignment. States can improve commercial insurance affordability by implementing site-neutral payments, facility fee limits, reference-based pricing, and default out-of-network rates. Last year, Indiana enacted a law that charges hospitals a $10,000-per-day penalty if they fail to price their direct-to-employer health care contracts at or below 260% of Medicare rates, and puts their hospital non-profit status at risk if its commercial charges exceed the average. Oregon caps in-network hospital rates at 200% of Medicare rates in its state employee plan and saved $107.5M in the first 27 months; Montana's approach saved $47.8M over three years, and Vermont applied reference-based caps to all hospitals and all payers.

Consolidation and ownership transparency. States are positioned to address a key driver of high prices: profit opportunities through consolidation that limits competition. Additionally, private equity has become both an owner and an increasingly common source of capital behind mergers and acquisitions. Potential state responses include transaction notice-and-review authority, premerger notification, ownership disclosure, corporate practice of medicine doctrines, and bans on anti-competitive contracting terms. Arkansas enacted the first law banning pharmacy benefit manager (PBM) ownership of pharmacies, though enforcement is paused in litigation. Oregon bars dual ownership between management services organizations and the practices they manage, with new arrangements complying by January 2026 and existing structures by January 2029.

Drug costs through group purchasing. To tackle high prescription drug prices, states can align and pool their purchasing, tax or create transparent pharmaceutical benefit managers, and limit high commercial insurance drug costs through 340B policy. Nevada created the Nevada Health Authority, consolidating Medicaid, the state marketplace, and the public employees' benefit program into one agency explicitly to leverage the state's purchasing power. California and Colorado adopted delinking the compensation of PBMs from prices or rebate; and Arkansas, Georgia, Kentucky, West Virginia, and Iowa moved to national average cost plus dispensing fee reimbursement rather than linking them to a percent of prices. Alaska created a public-private partnership to create universal access to vaccines.

State Health Plans. Governors can leverage their state health plans to test policy reforms or as part of multi-payer alignment to drive broader market reforms. Montana and Oregon established reference-based pricing specific to state employee plans. Tennessee, Maine, Kentucky, and other states have implemented right-to-shop policies in their state health plans, which rewards patients with shared savings and credit toward their deductible when they find a cheaper cash-pay price.

State public options. Three states now offer a public option on their marketplace. Washington launched in 2021 with 1% of marketplace enrollment and languished until the legislature required hospitals to contract with at least one public option plan; by 2025 it held 30% of the market and was the lowest-premium silver plan in 31 of 39 counties. Colorado's public option, launched in 2023, now covers roughly half of Colorado's marketplace enrollees and has met its premium targets, generating savings

for four consecutive years. Nevada launched for 2026 with about 10,800 enrollees — under a third of projections — and a statutory requirement to cut premiums 15% against the benchmark silver plan over the next four years.

EFFICIENT OPERATIONS

Program integrity. State budget savings can accrue from Medicaid program integrity efforts, both led by states and in partnership with the federal government. This includes provider enrollment screening, encounter data audits, and a detect-and-prevent posture rather than pay-and-chase. Recent initiatives include Ohio and South Carolina moving to immediately suspend payments to providers deemed "high risk" for waste, fraud, and abuse, and Louisiana conducting off-cycle reviews of all designated "high-risk" providers. Leveraging the Medicaid Fraud Control Unit, usually in the attorney general's office, data-sharing, and referral partnerships with the HHS Office of Inspector General can improve program integrity.

Medicaid stewardship and revenue. Incoming governors can identify opportunities and reduce duplication by conducting a strategic review of how opioid settlement dollars, social media settlements, and federal health block grants are being allocated and work together. New funding options could also be adopted. For example, New Jersey enacted a policy in June 2026 raising $145M annually by charging employers with 50 or more workers on Medicaid between $325 and $725 per enrolled worker and dependents, California passed a law directing the state to present fair-share options next year, and Connecticut passed a similar approach. Other revenue options include limiting state, local, and property tax loopholes for profitable health care companies as well as taxing artificial intelligence, sports gambling, and prediction markets. On the spending side, savings may result from value-based purchasing — global budgets, shared-savings arrangements, and outcome-tied managed care contracts.

Medicaid administrative burden and technology. In Medicaid, pending federal approval, states can simplify and automate eligibility determination using artificial intelligence, secondary data sources, and rule simplification, then redeploy eligibility workers to functions requiring human judgment. Michigan offers a customer-centric model for determination simplification; Maine and Oregon for state-employee management of payments and care. Merit protection requirements and workforce resistance may be a constraint, and a Section 1115 waiver may be needed.

Private insurance simplification and transparency. States can tackle private insurance complexities that are barriers to care and drive excess administrative costs. While this generally includes setting standards and limits on prior authorization processes, one of the most geographically bipartisan levers available is "gold-carding." Originating in Texas, gold-carding exempts providers with proven quality and efficiency from prior authorization, and is now law in at least 10 states. States have also tackled standardizing plan design and established all payers claims databases to further simplify, promote transparency, and reduce duplication.

ACCESS TO CARE

Primary care investment. Beyond affordability and efficiency initiatives, Governors can lead on timely access to quality, critical care. Improving access to primary care, while it may involve raising reimbursement, could have long-run savings. Some states have set spending targets enforced through insurance regulation, paired with Medicaid rate floors. Rhode Island and Connecticut are among nearly 20 states that have primary care initiatives. New Mexico moved some primary care service rates to 150% of Medicare rates effective January 2025. Eight states — including Alaska, North Dakota, and Wyoming — now reimburse primary care at or above 100% of Medicare rates.

Behavioral health capacity. States like Wisconsin, South Carolina, Ohio, and others all made recent investments in mental health services, including crisis. And they continue to leverage opioid settlement funds to invest in prevention and recovery. Missouri implemented a universal screening program to identify maternal depression and related disorders. Nineteen states approved Section 1115 reentry waivers allowing Medicaid to pay for services in the 90 days before the release of incarcerated people, improving their connection to behavioral health care and reducing recidivism. Other states have adopted an integrated clinical, social and family model to help high-acuity children in child welfare, juvenile justice and intellectual and developmental disability systems who cycle between emergency departments, residential placements, and out-of-state facilities. And states continue to join the certified community behavioral health clinics (CCBHCs) demonstration to advance comprehensive, integrated care.

Right care, right place, right time. Governors face critical service gaps, especially for maternity and rural emergency care. A growing number of states now cover pregnancy-related doula services in Medicaid and are using Rural Health Transformation Program (RHTP) funds to support free-standing and mobile birthing centers in rural maternity-care deserts. States are deploying mobile clinics and making use of the Rural Emergency Hospital designation to meet access needs in rural communities.

Workforce pipeline. Many states are using RHTP funds to support the health care workforce. Maine, West Virginia, and Mississippi are creating high school certification programs. Several states have created new residency programs, are developing paraprofessional credentialing programs, such as peer support specialists and community health workers, and are investing in childcare and housing supports to make educational attainment for health care workers possible. Cross-state licensure compacts are becoming commonplace, increasingly justified by extreme weather events that move patients and clinicians across state lines. Another approach is modernizing scope of practice to allow clinicians to work at the top of their licenses. Leveraging trust, community health workers are key for many states to expand access to care in rural communities.

Emergency preparedness. Most state health emergency preparedness plans predate COVID-19, and many have not been revised for what that experience taught. Texas provides one model for acting on those lessons: after outdated public health data

systems left local health officials struggling to keep pace with the tens of thousands of daily COVID test results, its Department of State Health Services began developing a new State Health Analytics & Reporting Platform (SHARP) in 2022 to improve the efficiency, reliability, and dissemination of health data. Incoming governors should build on this approach by ordering a review in the first year covering surge capacity, supply chains, data-sharing agreements with neighboring states, available waivers, and the licensure flexibilities that let clinicians move across state lines during a disaster.

SIGNATURES

Sarah Adelman, New Jersey 2021-2026

Eric Friedlander, Kentucky 2019-2025

Elizabeth Hertel, Michigan 2021-2026

Christopher Jones, North Dakota 2017-2023

Kody Kinsley, North Carolina 2022-2025

Jeanne Lambrew, Maine 2019-2024

Daniel Rusyniak, Indiana 2021-2025

Marylou Sudders, Massachusetts 2015-2023

Anne Zink, Alaska 2019-2024

Appendix: Table of State References by Policy

Health Policy Ideas for 2027 - Table Summary		
HEALTH CARE AFFORDABILITY		
Limiting patient bills	Capping growth in deductibles and copays	Massachusetts
	Surprise-billing protections	California New York Texas
	Prohibition from reporting medical debt to credit bureaus	California Colorado New York

	Interest-free debt payment plans	Delaware Maine
	Enforceable charity-care standards	Illinois Washington
	Leveraging State Directed Payments for medical debt relief and improved billing practices	North Carolina
	Restricting debt sales, credit reporting, and collection lawsuits	Florida
Provider price alignment	Site-neutral payments	New York
	Facility fee limits	Alaska Colorado Connecticut Florida Georgia Illinois Indiana Louisiana Maine Maryland ...And 11 more states
	Reference-based pricing (using a multiple of Medicare as an upper limit)	Delaware Indiana Montana New Mexico Oklahoma Oregon South Carolina Vermont Washington
	Reference-based pricing (using Medicare as a payment floor)	Colorado Indiana Montana Nevada Vermont West Virginia
	Default out-of-network rates	Oregon Washington
	Transaction notice-and-review authority	California Colorado

Consolidation and ownership transparency		Connecticut Maryland Massachusetts Michigan Mississippi Nebraska Oregon Pennsylvania ...And 5 more states
	Pre-merger notification	California Connecticut Massachusetts Washington
	Ownership disclosure	Indiana Massachusetts New Mexico Washington
	Corporate practice of medicine doctrines	Arkansas Kansas Minnesota Montana Nevada North Dakota Oregon Tennessee Texas Washington ... and 21 more states
	Bans on anti-competitive contracting terms	Arkansas Idaho Indiana Maryland Massachusetts Minnesota Nevada New Jersey North Dakota Texas ... and 12 more states
	Barring dual-ownership	Arkansas Oregon
	Leveraging state purchasing power	Nevada Alaska

Drug costs through group purchasing	Delinking	California Colorado
	Moving reimbursement to national average cost plus dispensing fees	Arkansas Georgia Iowa Kentucky West Virginia
State health plans	Establishing reference based pricing specific to state employee plans	Montana Oregon
	Implementing right-to-shop policies	Kansas Kentucky Maine Massachusetts New Hampshire Utah Florida Oklahoma Tennessee Nebraska
State public options	Public option in the state's individual health insurance marketplace	Colorado Nevada Washington
EFFICIENT OPERATIONS		
Program integrity	Provider enrollment screening	Ohio
	Encounter data audits	Arizona California Michigan New Jersey Oregon Texas
	Detect-and-prevent posture rather than pay-and-chase	Louisiana Ohio South Carolina

Medicaid stewardship and revenue	Employer "fair share" of responsibility for Medicaid	California Connecticut New Jersey
	Limiting state, local, and property tax loopholes for profitable health care companies	Arkansas Florida Texas Pennsylvania
	Taxing artificial intelligence, sports gambling, and prediction markets	Illinois Kentucky North Carolina
	Value-based purchasing	Colorado Idaho Maine Maryland Minnesota Montana Ohio Pennsylvania Vermont Washington
Medicaid administrative burden and technology	Simplify and automate eligibility determination using artificial intelligence	Louisiana Ohio
	Customer-centric model for simplifying determination	Michigan
	State-employee management of payments and care	Maine Oregon
Private insurance simplification and transparency.	Prior authorization "gold-carding"	Arkansas California Colorado Illinois Louisiana Michigan Texas Vermont Virginia West Virginia

		Wyoming
	Standardized plan design	California Colorado Connecticut Maine Massachusetts New York Oregon Vermont Washington New Mexico
	All-payer claims databases	Arkansas California Colorado Connecticut Delaware Florida Georgia Indiana Kansas Maine ...and 14 more states
ACCESS TO CARE		
Primary care investment	Reimbursing primary care at or above 100% of Medicare rates	Alaska Indiana Maryland Montana New Mexico North Dakota Vermont Wyoming
Behavioral health capacity	Implementing universal screening program to identify maternal depression and related disorders	Missouri
	Section 1115 reentry waivers	Arizona California Colorado Hawaii Illinois Kentucky

		Maryland Massachusetts Michigan Montana ...and 9 more states
	Adopting an integrated clinical, social and family model	Illinois New Jersey North Carolina New York Ohio
	Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration Program	Alaska Colorado Hawaii Louisiana Maryland Mississippi Montana North Dakota Washington West Virginia ... and 21 more states
Right care, right place, right time	Covering pregnancy-related doula services in Medicaid	Arizona California Colorado Connecticut Delaware Illinois Kansas Louisiana Maryland Massachusetts ...and 16 more states
	Supporting free-standing and mobile birthing centers	Iowa Virginia
	Deploying mobile clinics	Alabama Arizona Arkansas Connecticut Delaware Florida Georgia Idaho

		Illinois Iowa ...and 12 more states
	Leveraging rural emergency hospitals	Alabama Arkansas Georgia Idaho Kansas Kentucky Louisiana Minnesota Michigan Mississippi ...And 12 more states
Workforce pipeline	Creating high school certification programs using RHTP funds	Maine West Virginia Mississippi
	Using RHTP funds to create new medical residency programs	Delaware Iowa Minnesota Nevada
	Using RHTP funds to develop paraprofessional credentialing programs (including community health workers)	Delaware Kansas Kentucky Montana Nebraska New Hampshire New Jersey New York Ohio South Dakota Tennessee Wisconsin
	Using RHTP funds to invest in childcare and housing supports to make educational attainment for health care workers possible	North Dakota Washington Missouri Delaware Arizona Alaska Wisconsin New Hampshire Oregon Maryland

	Cross-state licensure compacts	Alabama Arizona Arkansas Colorado Connecticut Delaware Florida Georgia Hawaii Idaho ...and 31 more states
	Modernizing scope of practice	Alabama Alaska Arizona Arkansas California Colorado Connecticut Delaware Florida Georgia And 37 other states...
Emergency preparedness	Updating public health data systems	Texas
	Data-sharing agreements	Washington