

The CREDIT Act

Consumer Recognition for Eligible Direct Insurance Transactions

A Targeted Fairness Reform for Healthcare Cost-Sharing






The Issue

Under current state law, when insured individuals pay out-of-pocket for medically necessary, covered healthcare services, such as imaging, labs, behavioral health visits, outpatient procedures, or prescription drugs, those payments often do not count toward their deductible or out-of-pocket maximum.

Patients in high-deductible plans must choose between paying less upfront or paying more through insurance just to receive deductible credit. Consumers who shop for lower-cost care are often penalized and may pay twice.

What the CREDIT Act Does

The CREDIT Act requires insurers to credit a member's direct payment toward their deductible and annual out-of-pocket maximum when:

-  The service is medically necessary and covered under the plan
-  No claim is submitted for insurer reimbursement
-  The amount paid is less than or equal to the insurer's applicable in-network benchmark amount for the applicable region

This applies to both in-network and out-of-network services.

The Act does not require insurers to pay anything; it only requires insurers to recognize what the member has already paid.

Why It Makes Sense

The CREDIT Act is a measured consumer-protection reform that reinforces existing transparency and affordability efforts.

- Recognizes legitimate out-of-pocket spending for covered care
- Allows patients to shop for lower-cost services without losing deductible progress
- Encourages use of services priced below insurers' negotiated rates
- Complements federal price-transparency and No Surprises Act tools
- Does not create new benefits or alter cost-sharing structures

Why This Matters

- High-deductible health plans are common, and consumers increasingly pay upfront for care
- Cost-conscious patients should not be penalized for choosing affordable options
- Without this reform, consumers must choose between short-term affordability and long-term financial protection
- The Act builds on the state's leadership in patient protection and transparency
- It ensures consumers do not pay twice for the same care

Built-In Safeguards

- Applies only to fully insured plans regulated by the state
- No reimbursement obligation for insurers
- Requires limited documentation from consumers
- Prohibits balance billing from any party to enforce a higher negotiated rate when a lower cash price is negotiated
- Insurers must approve or deny credit within 30 days with written explanation
- Denials are subject to existing state appeal protections
- Protects providers from penalties for offering lower direct-pay prices

The Bottom Line

If a state resident pays for a medically necessary, covered healthcare service at or below what their insurance plan would typically allow, that payment should count toward their deductible and out-of-pocket maximum.