The CREDIT Act

Consumer Recognition for Eligible Direct Insurance Transactions

A Targeted Fairness Reform for Healthcare Cost-Sharing

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The Issue

When patients pay directly for medically necessary, covered healthcare services, such as imaging, lab tests or prescription drugs, those payments often do not count toward their deductible or annual out-of-pocket maximum, even when the price is lower than the cost through insurance.

Consumers who shop for affordable care can lose deductible credit, forcing them to choose between saving money upfront and making progress toward their plan's cost-sharing limits.

What the CREDIT Act Does

The CREDIT Act requires insurers to credit a member's direct payment toward their plan 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

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.

1. Recognizes legitimate out-of-pocket spending for covered care
2. Allows patients to shop for lower-cost services without losing deductible progress
3. Encourages use of services priced below insurers' negotiated rates
4. Complements federal price-transparency and No Surprises Act tools
5. 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 supports patient protection and healthcare price 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
- Denials are subject to existing state appeal protections
- 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
- Protects providers from penalties for offering lower direct-pay prices

Help Consumers Get Credit for the Care They Pay For

Advance the CREDIT Act in your state so qualifying direct payments for covered healthcare services count toward consumers' deductibles and out-of-pocket maximums.

Contact **legislative@nabip.org** to get started.

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