



# State of Healthcare: Policy Considerations to Constrain Commercial Prices

## Executive Summary

Prepared by Catalyst for Payment Reform, Fall 2024

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# EXECUTIVE SUMMARY

Skyrocketing healthcare spending compels state policy leaders to consider price-restraining policies adapted to the specific economic, geographic, and sociopolitical needs of their residents. After publishing a [policy research paper](#) that profiled combinations of state-based policy interventions to rein in commercial health care prices and rebalance market power, Catalyst for Payment Reform (CPR) set out to test attitudes towards specific policy interventions in three states: Florida, Michigan and Nevada. These states were selected for their geographic, economic, and political diversity.

Thirty-four (34) stakeholders described their perspectives on challenges facing the healthcare system and on potential policy interventions to address high healthcare prices. This report summarizes participants' attitudes and perceptions and recommends three potential policy solutions for each state.

## National Landscape

Healthcare costs encompass 17% of the United States economy in 2022.<sup>i</sup> Personal healthcare costs amounted to \$3.7 trillion in 2022, or \$11,200 per capita. With administrative spending and insurance, this number increases to nearly \$4.5 trillion, or \$13,500 per capita. The average employer-sponsored health insurance premium for a family has risen from \$8,500 in 2002 to \$22,000 in 2022, rapidly outpacing wage increases.<sup>ii</sup> Increasing unit price of healthcare services,<sup>iii</sup> rising patient cost sharing,<sup>iv</sup> and the consequences of deferring care during the COVID-19 pandemic<sup>v</sup> together impose massive financial pressures on consumers. Circumstances within individual states are more nuanced.

## Florida's Landscape

Florida is demographically diverse, economically strong, and leans conservative in its politics. The state has numerous urban areas, with most non-metropolitan counties adjacent to at least one major metropolitan center. Among states, it has the fourth-highest rate of uninsured non-elderly residents, at 14%.<sup>vi</sup> Healthcare prices in the state are high and rising: Florida's employers pay the highest commercial hospital prices relative to Medicare in the nation.<sup>vii</sup> Employer-sponsored insurance premiums have risen from less than \$6,700 annually in 2018 to more than \$7,500 in 2022, with employers insulating employees from the brunt of the increase.<sup>viii</sup>

## Michigan's Landscape

Michigan is a geographically and culturally diverse state. [Sixty-one of Michigan's 83](#) counties are classified as rural. While manufacturing is the largest economic sector in the state, Michigan's economy includes a [broad range of industries](#), including finance, real estate, higher education, construction, and agriculture. Michigan also has a robust health care sector. Commercial hospital prices in Michigan average approximately twice those of Medicare, making them the third lowest in the nation.<sup>ix</sup> Only 6% of Michiganders are uninsured, far below the national rate of 10%.<sup>x</sup> More Michiganders are enrolled in employer-sponsored insurance compared to the nation as a whole. Insurance premium prices for individuals have risen from \$6,300 to \$7,300 between 2018 and 2022. Employers have shouldered most of the increase and rates remain below the national average.<sup>xi</sup>

## Nevada's Landscape

Nevada is a frontier state. Much of Nevada is sparsely populated, with a few cities featuring a robust gaming industry.<sup>xii</sup> Healthcare in the Silver State faces unique challenges. A substantial number of counties are designated as Medically-underserved Areas (MUA) indicating an insufficient number of primary care providers.<sup>xiii</sup> The Commonwealth Fund ranks Nevada 45th in

terms of healthcare access and affordability, and last for preventive services and treatment.<sup>xiv</sup> Hospital prices average approximately 2.5 times the Medicare rate, ranking Nevada close to the middle among all states.<sup>xv</sup> The uninsured rate of 13% exceeds the national rate of 10%.<sup>xvi</sup> An individual health plan in Nevada costs on average \$6,850 annually, lower than many other states.<sup>xvii</sup>

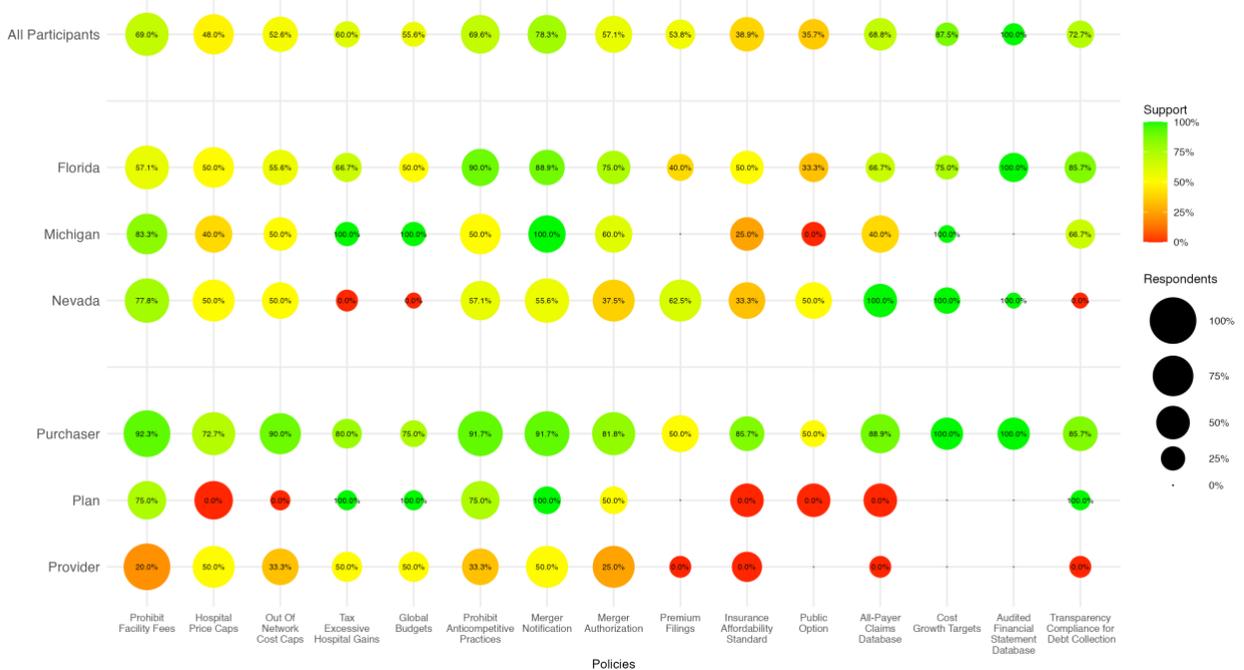
## Method

CPR conducted interviews with 34 stakeholders, including representatives of self- and fully-insured healthcare purchasers, health plans, physicians, hospital systems, and other experts familiar with the industry. Participants discussed their perceptions regarding rising healthcare prices, the health policy context in their respective states, and their support for, opposition or neutrality to specific price-constraining policies. In addition to evaluating attitudes toward specific policies, we conducted a thematic analysis organizing participant stances and views into common themes.

## Results

Participants almost unanimously recognized the burden high prices place on the healthcare system and on patients in Michigan but disagreed on the best methods to alleviate this pressure. (See Figure.)<sup>1</sup> However, some policy alternatives proved more popular than others. The themes below Figure 1 reflect common, but not unanimous, sentiments among participants.

Figure 1: Support for selected policies across states and stakeholders



[See full screen graph image here.](#)

<sup>1</sup> Green indicates generally supported policies while red reflects unpopular proposals. Larger and more opaque bubbles indicate a larger number of participants (as a percentage of all participants in that column) were asked about the policy.

## Themes

### Everyone feels the burden of healthcare costs

Almost unanimously, across all three states and stakeholders, participants indicated rising healthcare costs pose a burden to their organizations, their patients, and/or to the residents of their states.

### Healthcare is the Second Largest Expense Line-Item

Healthcare purchasers used the most emotionally charged language when describing the current healthcare landscape, suggesting a particular urgency. They frequently used the word “burden” and other negative descriptors to describe prices. While some purchasers are not immediately panicking, they said the pressure of rising prices is building, and they worry about the sustainability of being able to offer coverage for their employees and dependents.

### Most stakeholders have an appetite for policy changes

More than two thirds of participants expressed an interest in using state policy to lower healthcare prices. While health providers may benefit from high prices and health plans can distribute rising prices through premiums to their fully-insured book of business, self-funded purchasers are the most exposed to price increases. Appropriately, they expressed the greatest enthusiasm for policy interventions.

### Participants believe drugs, hospitals, public insurance, and rising wages are driving high prices

Participants held diverse explanations for rising healthcare prices. In particular, they attributed increases to rising pharmaceutical costs, to hospital prices, and to pressure from low reimbursement rates by public programs.

### Hospitals are unpopular among stakeholders, but hold substantial political power

Purchasers and health plans made substantial negative comments regarding hospitals, their business practices, and their motivations. In short, these stakeholders believe hospitals leverage the complexity of the healthcare system to overcharge patients for services and fight cost- and price-reducing policies. They view hospitals, not politicians or insurers, as the primary opponents of common-sense policies to constrain healthcare prices.

### Health plans hold notable political power, though less than hospitals

Participants also attributed insurers with noticeable power to influence policy. Whereas hospitals were frequently considered bad-faith actors, perspectives on health plans proved more complicated. While health plans sometimes supported cost- and price-reducing policies such as surprise billing protections, they also effectively defend their bottom line.

### Stakeholders fear limiting their healthcare choices

When considering healthcare reforms, participants frequently questioned the impact of new policies on their ability to choose between networks, differentiate among healthcare providers of varying quality, and design cost-sharing structures which fit their needs.

### Most stakeholders acknowledge having limited familiarity with specific healthcare policy proposals.

Health plans and providers demonstrated greater general knowledge of state policy interventions than employers, reflecting the extent to which these policies directly impact their business practices. This is not surprising, given that health policy is not a full-time focus for employers as it is for health plan and provider advocates.

## Recommendations

Based on the quantitative and qualitative analysis of the interviews, the following policies received the most support among stakeholders in the respective states.<sup>2</sup>

| Policies  | Florida <sup>3</sup> | Michigan           | Nevada  |
|---|----------------------|--------------------|---|
| Mandatory Merger Notification or Authorization                          | ✓<br>Notification    | ✓<br>Authorization | Nevada requires merger notification for healthcare entities |
| Prohibiting facility fees for outpatient services                       | ✓                    | ✓                  | ✓   |
| Prohibiting anti-steering and anti-tiering clauses in network contracts | ✓                    | ✓                  | Nevada prohibits anti-competitive contracting practices     |
| Capping out-of-network prices   |                      |                    | ✓   |
| Informing the implementation of the public option                       |                      |                    | ✓   |

Download the full report [HERE](#).

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<sup>i</sup> Hartman, M., Martin, A. B., Whittle, L., Catlin, A., & The National Health Expenditure Accounts Team. (2024). National Health Care Spending In 2022: Growth Similar To Prepandemic Rates. *Health Affairs*, 43(1), 6–17. <https://doi.org/10.1377/hlthaff.2023.01360>

<sup>ii</sup> AHRQ. (2024). *Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)*. <https://datatools.ahrq.gov/meps-ic/>

<sup>iii</sup> HCCL. (2023, April). *2021 Health Care Cost and Utilization Report*.

[https://healthcostinstitute.org/images/pdfs/HCCL\\_2021\\_Health\\_Care\\_Cost\\_and\\_Utilization\\_Report.pdf](https://healthcostinstitute.org/images/pdfs/HCCL_2021_Health_Care_Cost_and_Utilization_Report.pdf)

<sup>iv</sup> KFF. (2023, December 22). Deductibles in ACA Marketplace Plans, 2014–2024. *KFF*. <https://www.kff.org/affordable-care-act/issue-brief/eductibles-in-aca-marketplace-plans/>

<sup>v</sup> Gertz, A. H., Pollack, C. C., Schultheiss, M. D., & Brownstein, J. S. (2022). Delayed medical care and underlying health in the United States during the COVID-19 pandemic: A cross-sectional study. *Preventive Medicine Reports*, 28, 101882.

<https://doi.org/10.1016/j.pmedr.2022.101882>

<sup>vi</sup> CB. (2024). *Census.gov*. Census.Gov. <https://www.census.gov/en.html>

<sup>vii</sup> Whaley, C. M., Briscoombe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*. RAND Corporation. [https://www.rand.org/pubs/research\\_reports/RRA1144-1.html](https://www.rand.org/pubs/research_reports/RRA1144-1.html)

<sup>viii</sup> KFF. (2024). *State Health Facts*. <https://www.kff.org/statedata/>

<sup>ix</sup> Whaley, C.M., Briscoombe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. *RAND*. [https://www.rand.org/pubs/research\\_reports/RRA1144-1.html](https://www.rand.org/pubs/research_reports/RRA1144-1.html)

<sup>x</sup> United States Census Bureau. (2024). <https://data.census.gov/>

<sup>xi</sup> KFF. (2024). *State Health Facts*. <https://www.kff.org/statedata/>

<sup>xii</sup> Haas, G. (2024, May 29). *April ups and downs as Nevada casinos report \$1.24 billion win*. *KLAS*.

<https://www.8newsnow.com/news/local-news/april-ups-and-downs-as-nevada-casinos-report-1-24-billion-win/>

<sup>xiii</sup> HRSA. (2024). *MUA Find*. <https://data.hrsa.gov/tools/shortage-area/mua-find>

<sup>xiv</sup> Radley, D. C., Baumgartner, J. C., Collins, S. R., & Zephyrin, L. C. (2024). *U.S. Healthcare Rankings by State 2023*. Commonwealth Fund. <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>

<sup>xv</sup> Whaley, C.M., Briscoombe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. *RAND*. [https://www.rand.org/pubs/research\\_reports/RRA1144-1.html](https://www.rand.org/pubs/research_reports/RRA1144-1.html)

<sup>xvi</sup> United States Census Bureau. (2024). <https://data.census.gov/>

<sup>xvii</sup> KFF. (2024). *State Health Facts*. <https://www.kff.org/statedata/>

<sup>2</sup> There were 16 interviewees in Florida, 10 in Nevada, and 8 in Michigan.