HEALTH

Addressing Commercial Health Care Prices

POLICY SNAPSHOT

Health care spending is highly scrutinized by consumers, employers and state and federal policymakers, and will likely continue to be a hot topic for years. National health spending is projected to grow at an average annual rate of 5.4%, growing more rapidly than gross domestic product and reaching $6.2 trillion by 2028.

Health care spending per person has grown across all service categories from 2015-2019. The largest category of health spending was inpatient and outpatient care, according to 2018 Kaiser Family Foundation data, which includes payments to hospitals, outpatient clinics and physicians for services such as specialist visits, surgical care, and facility and professional fees. Many experts attribute the rise in spending to increases in prices for services and fees, rather than high utilization of services.

Prices paid by commercial health insurance plans are comparatively higher than those paid by public plans. For example, commercial insurers paid an average of 199% of Medicare rates for hospital services and an average of 143% of Medicare rates for physician services. Researchers have also found wide variation in health care prices; prices paid for services sometimes differ within the same state, locality or even hospital. Many health care providers maintain legitimate reasons may exist to set higher and varying prices, such as negotiating higher rates with private insurers to make up for lower Medicare and Medicaid reimbursements and losses because of uncompensated care. However, some studies challenge this cost-shifting theory, asserting no strong correlation exists between higher prices and the number of patients covered by non-private payers.

State Policy Options

State legislators may consider the following options, among several others, related to commercial health care prices:

- Develop a cost growth benchmark.
- Implement value-based payment arrangements.
- Increase price transparency requirements and reporting.
- Leverage premium rate review.
- Consider a public option plan.
- Assess health care market consolidation.

POLICY OPTIONS	STATE EXAMPLES
Develop a cost growth benchmark to identify and address high prices. Cost growth benchmarks peg annual health cost growth to a specific target, often between 2.4% to 3.8% per capita. State agencies or other authorities collect aggregate spending data from payers to identify cost growth trends and drivers of health spending. States can implement various strategies—such as public reporting or financial penalties—to ensure payers and providers are meeting cost growth benchmarks.	**Eight states** have established cost growth benchmarks, either via legislation or executive order. **Massachusetts** sets its benchmark based on expected state economic growth, aiming to ensure overall health cost growth does not exceed the growth of the state economy. The Massachusetts Health Policy Commission, which operates the cost growth benchmark, has the authority to require performance improvement plans for entities with "excessive spending growth."
Implement value-based payment arrangements for private payers. Value-based purchasing links payments to improved health outcomes, spending targets and provider performance instead of traditional "fee-for-service" models, which reimburse for individual services. Value-based purchasing arrangements are a strategy targeting both costs and health care use. Value-based payment arrangements vary in design, but some common models in the commercial sector include: • Population-based payments/capitation reimburses a provider on a fixed per-member per-unit of time basis rather than for a specific service. • Bundled or episode-based payments assign a fixed payment to covered set of services for the entire course of treatment for a specific illness, condition or medical event. • Accountable Care Organizations coordinate care via a team of doctors, hospitals and other health care providers, with the goal of improving quality and reducing costs.	**Tennessee's** state employee benefits administration incorporated bundled payments for five different services and procedures, including maternity care and hip and knee replacements, as part of the Tennessee Health Care Innovation Initiative. After showing modest cost savings and improvements in the overall quality of care, the program plans to roll out additional episodes of care. Blue Cross Blue Shield of **North Carolina**'s Blue Premier Program shifts toward value-based payments with five of the state's major health systems and their Accountable Care Organizations coordinating care and tying provider payments to the value of services that improve patient health. The **Arkansas** Health Care Payment Improvement Initiative is a multi-payer, statewide payment and delivery system leveraging both episode-based payment and population-based payments via patient-centered medical homes. The initiative is led by Medicaid with private, self-insured employer participation.
Increase price transparency requirements and reporting, through all-payer claims databases (APCD), among others. APCDs are large state-based databases which collect health care claims data from Medicare, Medicaid, state employee health plans and state-regulated private insurers. Policymakers, insurers, employers and other stakeholders can use claims data to make informed health policy decisions addressing health care prices. States can also use APCD information to develop consumer-facing price comparison tools.	Currently, **25 states** have enacted legislation to implement an APCD system and five states have existing voluntary efforts. States use this data in a variety of ways, including reporting on health care spending, use and performance. For example, **Florida** enacted legislation in 2020 requiring its APCD to report annually on health care services with significant price variation both statewide and regionally. **Nine states** use APCD claims data for consumer-facing price comparison tools, which allow individuals to compare prices for shoppable health services—such as a CT scan. However, some limitations to such tools may exist, like the potential to not accurately reflect the actual out-of-pocket costs for health plan enrollees. Some states established shared-savings, or Right to Shop, programs to incentivize patients to use price comparison tools and seek out affordable, high-quality providers. **New Hampshire**, **Kentucky** and **Utah** established shared-savings programs as part of their state employee health plans.

POLICY OPTIONS	STATE EXAMPLES
Leverage premium rate review to minimize increases in premium rates for state-regulated health insurance plans. Most states operate a rate review process. Those with approval authority assess whether premium rate increases are "unreasonable" or "excessive" by looking at factors like benefits in relation to premiums, previous premium rates, a carrier's reserves and more. Some states have established requirements for provider-insurer contracting, particularly relating to price increases, to improve premium affordability.	**Rhode Island** uses "affordability standards" when assessing premium rates, including minimizing price increases for inpatient and outpatient services in provider-insurer contracts to no more than annual inflation plus 1%. The affordability standards look at other cost containment strategies, such as primary care investment and alternative payment model adoption. **Delaware** enacted legislation in 2021 establishing a similar rate review process to Rhode Island's. The legislation limits price increases for inpatient and outpatient services to a certain percentage, and establishes minimum spending requirements for primary care and alternative payment models.
Consider a public option plan to tie reimbursement to a certain rate, often Medicare rates, in attempts to control costs. While public option models vary, generally, a public option is a government-run health plan that competes with commercial plans on the health insurance marketplace. They may be offered as a new publicly insured plan, through an option to buy into an existing public plan (like Medicaid), or through a public-private partnership where private insurers administer a government regulated plan. Proponents of public options plans hope plans will provide more affordable coverage and increase choice and competition. Others worry private plans may not be able to compete with a public option, disrupting the overall private insurance market.	**Washington** became the first state to enact legislation requiring the implementation of a public option in 2019. The bill required Washington's Health Care Authority, in consultation with other agencies, to provide a state-designed plan, offered by private insurance companies for purchase through the marketplace. In attempts to increase availability of the public option after some initial challenges, Washington enacted legislation in 2021 implementing policy changes including provider participation requirements and reimbursement rates. **Colorado** and **Nevada** each enacted public option legislation in 2021. The plans will be offered on the individual and small group marketplace in 2023 and 2026, respectively. Public option program elements in each states program vary, like provider participation requirements and provider reimbursement protections.
Assess health care market consolidation and a transaction's effects on prices. Various studies have found increased consolidation can lead to higher health care prices. This includes horizontal consolidation (i.e., between the same types of organizations like hospitals) and vertical consolidation (i.e., across different types of providers, like hospitals acquiring physician practices). Providers often maintain that consolidation enhances the quality of care and the financial stability of health facilities, particularly for smaller providers. Opponents argue that increased prices are not associated with significant improvements in quality of care. Additionally, some policy experts argue larger health systems may use their market power to pursue "anticompetitive contract terms" during the provider-insurer contracting process, potentially leading to overall higher prices.	**Oregon** enacted legislation in 2021 establishing an enhanced merger review process for "material change transactions" between certain entities. The state can approve, disapprove or approve with conditions transactions based on various criteria, such as a transaction's effect on health care cost growth. **Eighteen states** maintain Certificate of Public Advantage (COPA) laws, which shield merging entities from state or federal antitrust enforcement in exchange for increased state oversight after a merger occurs. **Indiana** enacted COPA legislation in 2021, requiring the state to assess a proposed COPA application's effect on health service prices and quality, among other measures. The state will annually review the approved COPA application and ensure merged entities are meeting state requirements. In addition to COPA legislation, **Indiana** enacted legislation in 2020 prohibiting provider contract provisions that limit an insurer's ability to disclose health care claims data to employers (i.e., gag clauses). State legislators enacted additional legislation in 2021 to prohibit contracts that limit an insurance carrier or health care provider's ability to disclose charges, fees and out-of-pocket costs to a patient.

Federal Action

Health Care Market Consolidation and Competition—President Joe Biden signed an executive order in July 2021 to promote competition throughout multiple economic sectors, including requiring federal antitrust regulators to review and reassess hospital merger guidelines. Additionally, the Department of Health and Human Services released first of its kind data in April on hospital and nursing home consolidation. Federal officials noted the data will help state and federal enforcement agencies, researchers and the public, "understand the impacts of consolidation on health care prices and quality of care."

Price Transparency—Federal rules requiring hospitals to post pricing information for items and services went into effect January 2021. However, several reports have found a majority of hospitals are not in compliance with the federal rules. In response, federal officials increased penalties for larger hospitals not in compliance, resulting in a maximum penalty of $2 million for a full calendar year of non-compliance.

Separately, federal price transparency requirements for private insurers were set to go into effect January 2022, including disclosing in-network negotiated rates and out-of-network allowed amounts and billed charges. However, the Biden administration delayed enforcement for these rules until July 2022.

Additional Resources

- Health Costs, Coverage and Delivery State Legislation (NCSL)
- Health Costs 101: What's a State to Do? (NCSL, May 2022)
- Lowering Health Care Costs to Consumers (NCSL, June 2021)
- Bringing Health Care Prices to Light (NCSL, February 2021)

NCSL acknowledges the Arnold Ventures for their support of this publication.

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