catalyst
FOR PAYMENT REFORM

Issue Brief #1
The Case for Public Policy Intervention

NEWSFLASH: HEALTH CARE MARKETS ARE BROKEN

Everyone is tired of hearing about how broken our health care system is. We know: prices keep rising, hospitals keep merging, quality falters, disparities widen. Entrepreneurs promise disruption, health plans promise innovation, everyone points fingers but nothing moves the needle.

And over the next few years, the outlook remains bleak. Experts predict that health care premiums will jump 5.6 percentage points over the previous year. While this figure lags behind overall inflation (8.5 percent year over year), it's at best a temporary reprieve, born of the fact that health plans negotiate multi-year contracts with health care providers and cannot react in real time to fluctuations in the consumer price index (CPI).[1,2]

This isn't just speculative; there are clear indicators that health care costs are poised to spike. Rising labor and supply costs caused hospital overhead to increase by 15 percent in 2022; meanwhile, health plans underestimated service demand, incurring $1.3 billion in losses in large group markets.[3,4] Both sectors' efforts to recoup their losses will result in higher costs for employers and other health care purchasers – analysts predict that premiums will rise by 6.5 percent in 2023.[5] Some purchasers may try to pass this inflation on to their plan members, but already nearly one-third of American households lacks sufficient savings to pay the average deductible for the average employer-sponsored plan.[6] As of 2019, over 23 million Americans carry significant medical debt – and of those with medical debt, 26 percent owe more than $5000.[7] When the medical-industrial complex passes the buck, purchasers and their plan members are compelled to pick up the tab.

This issue brief, the first of six, lays out the case for *menus of state policy interventions* designed to place downward pressure on commercial prices and rebalance market power.

MARKET-BASED INTERVENTIONS HAVE NOT DELIVERED [ENOUGH]

Historically, purchasers and health plans tried to overcome failures in commercial health care with market-based interventions. They reasoned that with the right incentives and enough financial "skin in the game," individuals seeking health care would behave like traditional consumers and shop for doctors the way they shop for cars. Purchasers and health plans attempted to create consumer-like behavior by providing their health plan members with access to provider price and quality data (to the extent this information is available), and by attempting to introduce price sensitivity through insurance options like high-deductible health plans (HDHPs) or a requirement to pay for a percentage of allowed costs (i.e., co-insurance). It hasn't worked. Studies continuously demonstrate that even when patients have access to data about prices and quality, they rarely consult or act on it; instead of turning plan members into savvy health care consumers, HDHPs simply dissuade people from seeking care, including the preventive and condition management services they need.[8,9]

A small fraction of public and private employers attempt to curb prices through products and provider networks that aim to connect plan members with lower-cost providers and services. If a critical mass of purchasers adopted these strategies, they could theoretically compel providers to lower their prices, improve efficiency and take other steps to reduce the cost of care. Unfortunately, uptake for these strategies has been vanishingly small: less than 10 percent of employers offer a narrow network, according to the latest survey findings from the Kaiser Family Foundation.[1] Part of the problem is access and availability: in markets where a single health system dominates, narrow or tiered networks are infeasible. What's more, many powerful health systems have made it impossible for health plans to exclude them by mandating anti-tiering and anti-tiering clauses within their contracts. And finally, CPR's research into employers' efforts to band together to achieve better health care value finds that it's nearly impossible to convince employers to adhere to uniform purchasing strategies. Creating an organic national movement toward narrow networks – a strategy infeasible in some markets and unpalatable to many employers – starts to look like wishful thinking.

But what about alternative payment models (APMs)? Did those fail as well? The evidence from the Centers for Medicare and Medicaid Innovation (CMMI) is disappointing: Of the 50 APMs that CMMI developed following the passage of The Affordable Care Act, only six generated substantial net savings.[16] With time, there is hope that refining APM programs by making them mandatory and including downside risk will produce consistently stronger outcomes. But APMs operate on the theory that paying providers differently will change how they deliver care and result in greater efficiency, better care coordination, and reduced waste. That may be correct, but it's prices, not utilization that is driving about two thirds of health care cost inflation for commercial payers.[10] APMs are a necessary component of health care reform, but are not a cure-all.

It's time to admit what is painful but obvious: health care doesn't adhere to the laws of economics, and well-meaning market-based interventions cannot exert enough pressure to right this capsized ship. An adage, often attributed to W. Edward Deming, says that "every system is perfectly designed to get the results it gets." The fact that health care costs in the

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[1] https://www.kff.org/report-section/ehbs-2022-section-13-employer-practices-telehealth-provider-networks-and-coverage-for-mental-health-services/

U.S. rise faster than the rate of inflation year after year without any commensurate increase in quality or value indicates fundamental flaws in system design. What we see before us is an uneven playing field, about to get rockier, and the only balancing force that may be powerful enough to countermand this trend is the government.

THE CASE FOR STATE GOVERNMENT INTERVENTION

The federal government issued new laws and regulations over the last year such as the No Surprises Act, the Hospital Price Transparency Rule, and the Health Plan Price Transparency Rule, which (if hospitals and health plans comply) could start to shift the competitive landscape – or at least provide policymakers and other stakeholders with better data for decision making.[18,19,20]

But states also have a unique and profound role to play in shaping health care policy. They can tailor their policy agendas to the specific needs, conditions, and mores of their constituents; they can launch smaller-scale experiments that would be impractical or impossible to pass nationally; and they can use their own purchasing power to command lower prices, new payment models, and higher standards of care. Innovation springs from state laboratories across the country, from the first reference-based pricing program in Montana, to the first full-scale bundled payment program from Tenncare (Tennessee Medicaid), to the health care coverage model that inspired the Affordable Care Act out of Massachusetts.[21,22,23]

Having established that (a) health care markets are broken and (b) state governments are best positioned to rebalance them, the next question is *which policy interventions and why?* To answer this question, CPR leveraged the insight of some of the nation's foremost experts in health economics, health care policy, and state government administration to wade through the ocean of states' efforts to reform commercial health care markets. The panel of experts created a consensus view around which existing policies have proven most impactful, and also contributed new ideas based on nascent pilots or their own prescriptions for rebalancing market power. It's useful to look at this curated list of state health care policies through a lens of *levers of power,* i.e., the means by which state governments can rebalance health care market power:

1. **Ban or punish bad behavior:** Examples include banning anticompetitive contracting practices; taxing excessive provider prices or wealth; or constraining the behavior of newly consolidated entities.
2. **Shore up competition and/or protect the market from further erosion:** Examples include expanding antitrust law to prevent mergers and other acquisitive activity; introducing a new supply of providers or health plans; or requiring health plans to guide plan members toward higher-value providers.
3. **Directly regulate provider prices and/or insurance premiums:** Examples include placing caps on provider prices, caps on insurance rate increases, or setting global revenue targets for hospitals and health systems.
4. **Build regulatory infrastructure*:*** Examples include creating a repository of claims data, hospital financial data, and creating government infrastructure to monitor market trends and recommend policy interventions.

The list of expert-endorsed policy options, organized by lever of government power, can be found in ***Figure 1.***

Figure 1: Universe of Policy Options by Lever of Government Power

BAN (PUNISH) BAD BEHAVIOR	PREVENT FURTHER EROSION OF COMPETITION	REGULATE COSTS /PRICES	BUILD INFRASTRUCTURE
Ban anti-competitive contracting	Horizontal Merger Notification/Approval	All-payer Rate setting	All-Payer Claims Database
Prohibit Hospitals from Collecting Medical Debt if Non-Compliant with Federal Hospital Price Transparency Rule	Expanded Powers of the office of the Attorney General to Approve Acquisitive Activity and Pursue Anticompetitive Behavior	Global Budgets	Health Policy Commission
Prohibit Unwarranted Facility Fees that result from Vertical Consolidation	Review of Cross-Market Mergers	Cap Commercial Prices for State Employee Health Plans	Cost Growth Benchmarks or Total Cost of Care Targets
Tax Excessive Hospital Prices/Wealth OR Revoke State Not-for-Profit Tax Exemption	Public Option	Cap Commercial Provider Prices & Rate Increases	Database of Hospital Audited Financial Statements
	Require Large Employers to Offer Narrow Network Option	Cap Out-of-Network Prices	
		DOI Commercial Insurance Rate Regulation and Affordability Standards	

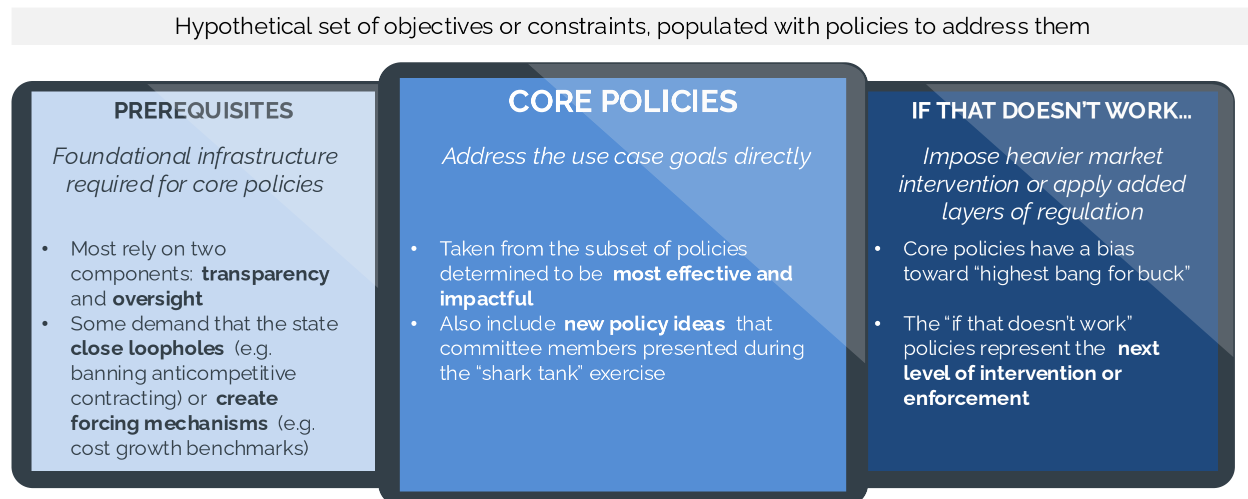
THE CASE FOR POLICY "MENUS"

There is no single policy robust and comprehensive enough to deliver meaningful corrections of market failures. Health care is a *four trillion-dollar* industry, comprising 20 percent of the nation's GDP and 14 percent of its labor market.[11,12,13] Plenty of entities within the health care ecosystem profit from the status quo and will do all they can to find loopholes and workarounds to preserve it. Moreover, most policy interventions require data infrastructure, oversight and enforcement lest they become purely symbolic.

Consequently, we need *suites* or *menus* of policies working in tandem to erect infrastructure, close loopholes, and guard against externalities. Within state government, each state can carve a unique path to place downward pressure on commercial health care prices, matching a policy agenda to its unique political climate, geography and economy.

The scenario-based policy "menus" provide states with options to address common sources of market failures; they identify the prerequisite policies that build infrastructure and supply data; and they offer an array of alternative "next steps" if the core policies do not achieve their intended effects, or if the state wishes to take a heavier hand in regulating the market.

Figure 2: Template for Policy Menus



The briefs that follow in this series will each cover a different policy menu, organized by the following goals**:**

1. **Prevent/punish bad behavior**
2. **Shore up competition**
3. **Empower existing balancers of power**
4. **Regulate provider prices**
5. **Select the lowest-hanging fruit**

Each issue brief builds the case for a scenario-based policy menu, describes the policies contained within it – including major considerations states will need to weigh to determine feasibility and appropriateness - and explains how the groupings of policies build upon and reinforce each other.

CONCLUDING THOUGHTS:

As market-based interventions have provided insufficient relief from rising commercial health care costs, state governments may want to examine the opportunity to enact policies that place downward pressure on unit prices and rebalance market power toward health care purchasers and consumers. The geographic, political, and economic diversity across the 50 United States means state governments will be eager to shape their own policy agendas; however, states will likely find that a single piece of legislation proves insufficient to effect meaningful relief, and/or will create vulnerabilities that are easily exploited by stakeholders who benefit from the status quo. State legislators will therefore want to consider *suites* or *menus* of policy options to create complementary infrastructure, close loopholes and plan for contingencies. As a society, we cannot allow health care markets to fail. American businesses, their employees, and their families cannot absorb the coming wave of commercial health care cost inflation. Public policy rarely produces a panacea, but when private markets fail, policy can offer corrective measures to re-level the playing field. In the eloquent words of Dr. Atul Gawande: "Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."

ENDNOTES

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and improve the functioning of the health care marketplace.

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