

# State Efforts to Control Healthcare Costs: Lessons Learned and Insights for the Future



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It is our great pleasure to present *State Efforts to Control Healthcare Costs: Lessons Learned and Insights for the Future*, a report designed to inform states as they grapple with one of their largest budgetary challenges.



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MAY 2024

This report builds on a high-level convening held May 30-31, 2023 at the Aspen Institute’s headquarters in Washington, DC, with the participation of KFF (formerly known as the Kaiser Family Foundation). We were honored to cochair this meeting, which brought together 18 health policy experts with diverse experience across settings and disciplines to explore state-level opportunities to bring healthcare costs under control. Marked differences in the political and fiscal climates of the states, and in the structure of their healthcare systems, preclude uniform solutions but participants eagerly shared innovative ideas and adaptable models. They also highlighted the importance of building multistakeholder coalitions, improving data systems and transparency, and respecting the equity imperative as pathways to change.

Three background papers informed the conversation, and are included as part of this report: “Competition as a Strategy for Controlling Health Care Costs,” by Benedic Ippolito of the American Enterprise Institute; “Regulation as a Strategy for Controlling Health Care Costs,” by Jodi Liu and Christine Eibner of the RAND Corporation; and “State Approaches to Infrastructure Building for Controlling Health Care Costs,” by Victoria Veltri, Maureen Hensley-Quinn, and Hemi Tewarson, of the National Academy of State Health Policy.

We are very grateful to all of the meeting participants, who gave so much of their time, as well as to Arnold Ventures, which supported this work. Thanks as well to Alan Weil, editor-in-chief of *Health Affairs*, who facilitated the discussion, and to Health, Medicine & Society communications consultant Karyn Feiden, who drafted this report. The commitments that made this program possible reflect a sense of urgency and the conviction that the right combination of regulation and policies that promote competition can make an important contribution to lowering healthcare costs. The winners will be the American public.

**Jim Douglas**  
*Cochair*

**Kathleen Sebelius**  
*Cochair*



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## Background Papers

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**A**cross the country, states have become laboratories, testing policy and programmatic ideas designed to address the high costs of healthcare and keep spending under control. The striking degree of state-level innovation is a response to a pressing mix of fiscal and structural challenges and speaks to urgent needs. Concerns about the impact of rising healthcare costs on employers, the sometimes-catastrophic consequences for individuals, and the significant state budget burden imposed by the requirement that states share the cost of Medicaid are particular motivators for action.

High prices are the primary drivers of the increased costs of healthcare<sup>1,2,3</sup> often reflecting provider consolidation and diminished marketplace competition. Private equity acquisitions and the broader corporatization of medicine are dominant influences.<sup>4</sup> Other cost drivers include greater use of costly medical technology; high treatment volume, including services that are unnecessary or wasteful; pharmaceutical costs; and excessively high administrative burdens.

The combination of these factors is engendering vigorous debate about the optimal balance between regulatory changes, including price regulation, and policies that promote competition. While most experts agree that regulation and competition both have meaningful roles, significant tension exists between them. Moreover, the unique profile of the states—with their widely varied political and economic climates and public and private sector interactions—precludes a consensus approach.

Overall cost concerns are influenced by the coverage that states choose to provide under the Medicaid program, beyond minimum federal requirements, and whether they participate in the Affordable Care Act expansion. Variations in state regulations and the authorities used to develop and enforce them, the types of employers, and the demographic and socioeconomic characteristics of the population further influence the direction of change and the mix of strategies that states are likely to consider. The characteristics of their healthcare delivery systems and insurance markets also contribute to a heterogenous response, as do ideology, the willingness to embrace regulation that alters private sector behavior, and the appetite for confronting powerful stakeholders, such as the dominant players within the hospital and financial industries.<sup>5</sup>

*“While most experts agree that regulation and competition both have meaningful roles, significant tension exists between them.”<sup>i</sup>*

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<sup>i</sup> Quotes throughout the document are synthesized from Working Group comments at the convening.

Clearly, there is no silver bullet here, but many experts agree broadly on the need for state action to tamp down on anticompetitive forces and test strategies for regulating prices and bringing down costs. Equally apparent is that government, employers, consumers, insurers, and healthcare systems are all stakeholders; that the many models already in place offer important lessons; and that there is a need for more evidence about what is most effective and for whom.

Underneath these broad statements lie countless details to be fleshed out. Doing so means taking a careful look at what is already happening on the ground and identifying, evaluating, and testing promising strategies and models.

To inform states as they consider opportunities for bringing healthcare costs under control, the Health, Medicine & Society (HMS) program of the Aspen Institute, with the participation of KFF (formerly known as the Kaiser Family Foundation), convened a Working Group in May 2023. Funding for the meeting was provided by Arnold Ventures. The meeting was cochaired by Jim Douglas, who served for eight years as the 80<sup>th</sup> governor of the State of Vermont (R), and Kathleen Sebelius, the 21<sup>st</sup> Secretary of the US Department of Health and Human Services and the 44<sup>th</sup> governor of the State of Kansas (D). The two also served as cochairs of the National Governors Association Health Committee.

Sixteen other participants with a broad range of health policy expertise in the public, private, nonprofit, and academic sectors joined the Working Group (see Appendix 1). Their charge was to review state-level experiences, identify learning and knowledge gaps, and summarize promising leverage points for advancing change, all with the goal of giving states fresh ideas for protecting their budgets and safeguarding the health of their residents.

During the day-and-a-half convening, it became evident that a sole focus on healthcare prices, important though it is, is not enough to produce the desired results of a healthier population at an affordable cost. Attention to access, service quality, health outcomes, and equity are also part of any equation to sustain useful structural change. The ever-present risk of unintended consequences—where action on one side of the ledger provokes a response on the other—also needs to be mitigated. Setting lower prices for healthcare services, for example, could constrain costs, but also has the potential to increase volume, diminish access, and harm quality. In addition, lowering prices can simply lead to increased volume as providers seek to preserve revenue, thereby undercutting the goal of reducing spending, unless countervailing forces are in place to discourage those responses.

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Effective cost control requires three-dimensional thinking and dynamic adaptability to meet the needs of its intended beneficiaries and use limited societal resources wisely.

The primary emphasis of the convening was on hospitals and other healthcare providers. Although other players also have considerable market power, the Working Group did not focus extensively on pharmaceutical companies, pharmacy benefit managers, or insurers.

To guide the conversation, experts were commissioned to prepare a package of background papers examining healthcare costs from three angles—competition, regulation, and infrastructure. Each author explored the design considerations, opportunities, and challenges embedded in each realm. Recognizing that there is no one-size-fits-all approach, they also presented examples of specific state activities that can inform other states as they tailor their own strategies. These papers ensured that Working Group participants entered the convening with a common baseline of knowledge and provided the springboard for further discussion.

Published in full as part of this volume, they are summarized as well later in this paper. Briefly, these are the topics covered:

**“Competition as a Strategy for Controlling Healthcare Costs,”** Benedic Ippolito of the American Enterprise Institute, explored the market inefficiencies that can lead to higher healthcare costs—notably, a lack of competition, structures that reduce sensitivity to cost, and the absence of information to guide decisions by both purchasers and patients. His paper reviewed state policies with the potential to address these deficits and to improve how markets function, while acknowledging the limits of what they can accomplish, especially in highly concentrated markets. “These policies,” he writes, “are designed to discourage additional consolidation in health markets, limit the mechanisms through which dominant firms leverage their market power, implement policies that expand the supply of providers where possible, and improve transparency in healthcare markets.”<sup>6</sup>

**“Regulation as a Strategy for Controlling Healthcare Costs,”** authored by Jodi Liu and Christine Eibner of the RAND Corporation, examined a variety of regulatory reforms that some states already have in place, and others are considering, to restrict healthcare pricing and spending more directly. Each approach—regulating rates, setting global budgets, establishing spending growth targets, and offering a public health plan option—has many possible variations, and none is mutually exclusive. “The extent to which these regulations can contain healthcare costs hinges on the scope of the policies, how well they are enforced, and whether they lead to unintended consequences,” state Liu and Eibner.<sup>7</sup>

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“State Approaches to Infrastructure Building for Controlling Healthcare Costs,” prepared by Victoria Veltri, Maureen Hensley-Quinn, and Hemi Tewarson of the National Academy for State Health Policy, considers the policy scaffolding needed to facilitate competition and regulated prices and spending, including appropriate oversight structures, mechanisms to gather input from diverse stakeholders, and optimal approaches to collecting, analyzing, and using data. “Multiple considerations inform state approaches to infrastructure design, including leadership and capacity to achieve specific goals, political will to invest limited resources, and industry and market considerations,” write the authors.<sup>8</sup>

The Working Group’s deep dive into the policy options laid out in these background papers underscores the conclusion that there is no rigid recipe for all states to follow. In an ideal world, well-functioning markets, with appropriate safeguards, could reduce the need for stricter regulation, especially given their capacity to process vast quantities of information and act on it quickly. But the highly concentrated nature of many markets—typically reflecting consolidated health systems, dominant health plans, or the lack of providers in rural areas—undermines attempts to introduce competition. Most likely, states will need to adopt some kind of hybrid model designed both to promote competition, where it is feasible, and to impose regulation. Differing healthcare spending structures and political environments will influence the weight assigned to each approach.

The next section of this paper offers a decision-making framework intended to guide states in their deliberations and presents three common elements that can inform any strategy under consideration. Then the paper provides further details about the opportunities and obstacles posed by competition and regulation and describes the infrastructure needed to accommodate the chosen mix.

## Essential Elements for Constraining Costs

An early step in considering how best to constrain costs at the state level is to assess the existing healthcare delivery system. Implementing change is likely to be an incremental process that builds on what is already in place, which means that baseline and potential leverage points first need to be identified.

Any significant systemic changes made by states will likely have effects that grow over time, as market forces take hold and regulatory approaches are implemented and modified through experience, making it difficult to measure impact over the short term. Equally uncertain is whether states will stay the course. Changes in the political environment can alter their willingness to sustain or enforce regulation, and the risks of regulatory capture—that is, the dominance of the healthcare industry over the public

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agencies charged with regulating it—can undermine or distort immediate and longer-term results. The position of many hospitals as major sources of employment in their communities gives them particular leverage to resist cost-containment efforts.

Nonetheless, based on their review of experiences around the country, the Working Group extracted three core elements that all states can build on as they consider strategies for controlling healthcare prices and lowering costs: building multistakeholder coalitions, improving data systems and transparency, and respecting the equity imperative.

## *Building Multistakeholder Coalitions*

Carrot-and-stick attempts to constrain state healthcare costs require champions in the legislative and executive branches, coupled with input from diverse coalitions that include employers, workers (some of them represented by unions), and consumers. To be effective, such coalitions need resources to overcome the power imbalances between purchasers and consumers on the one hand and the health system industry on the other. Leadership across the board is also crucial to navigate the maze of conflicting interests, make equity and inclusion a priority, and identify politically viable compromises. The voice of consumer advocates in cost conversations “matters in testimony to the legislature. It matters in explaining impact to individuals who are making choices. It matters at the insurance commissioner’s office,” said one Working Group member. “Without that voice, it is really hard to find the right balance.”

Consumer engagement can happen in many ways—union organizers bringing the rank-and-file to meet legislators at the state capitol, advocates gaining a seat on the insurance commission, a national body established to educate and seed spokespeople around the country. On-the-ground testimonials from patients and other individuals most directly affected by healthcare costs also add insight to policy debates. Dedicated resources, training, or new organizational structures may be necessary to elevate the voices of those who have historically been kept out of conversations about fiscal issues or made to feel they were too complex for a layperson to understand.

Buy-in from employers who have clear economic interests in cost control is also essential. Yet many self-insured businesses have outsourced the design and administration of their health plans to intermediaries and pay scant attention to a purchasing dynamic that sometimes rewards self-serving practices. Recently, however, the potential conflicts of interest among intermediaries have come into sharper focus, helping to raise employer awareness about the need for data as well as for contractual changes that

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support more effective purchasing. In particular, passage of the federal Consolidated Appropriations Act, 2021,<sup>9</sup> which includes provisions to expand the fiduciary responsibility of self-insured businesses for the healthcare services they purchase, is concentrating employer attention.<sup>10</sup>

“You may not be able to change the politics of the states from the top but you can change the politics of the state with all of those groups energized,” said one Working Group member. “They can be the force that determines whether or not action occurs and the nature of that action.”

In today’s heightened partisan climate, careful word choice can be essential to attract allies who might otherwise be on opposite sides of an ideological fence. “Don’t talk about regulation or government; talk instead about competitiveness,” said one Working Group member. “Political will is driven by what seems feasible and whether people think they are going to be attacked or not.”

The bipartisan support achieved for the No Surprises Act, which protects consumers from unexpected out-of-network medical bills, demonstrates the opportunities for cooperation.<sup>11,12</sup> By framing restrictions on surprise medical charges as a matter of fairness and humanizing the issue with patient stories, legislators were willing to work across the political aisle, with input from provider groups, insurance companies, and patient advocates.

## *Improving Data Systems and Transparency*

A vigorous system for collecting, analyzing, and sharing data on price, utilization, and costs can shed light on the changing nature of the marketplace, inform policy responses, and guide initial decision-making and subsequent refinements. Some data are already available. For example, the federal government has required cost reports from hospitals for many years, and state-level summaries published by the National Academy for State Health Policy have helped make these data more accessible. Many states have created all-payer claims databases (APCDs), which integrate provider encounter and claims data from public payers and some private payers into one database, and the federal government has begun to require pricing information from providers and health plans.

But concerns linger about the usefulness of price transparency tools in their current form, the reliability of the available data, and the absence of consensus specifications for what should be transmitted via an APCD. Moreover, for states to use the vast amount of available information demands significant capacity. “In order to be successful, you need the ability to actually use what you can get from hospitals and any other data sources,” said one Working Group member. “In some states, the expertise to handle all of the complexities of these data is lacking.”

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Strengthened price transparency tools and refined quality measures could inform consumers, employers, workers, and third-party payers as they consider costs. Insurers might be able to learn where their payments to hospitals fall along a continuum and use that information at the negotiating table. Employers might discover that one hospital is far more costly than another and consider dropping it from their provider networks. Workers, or their unions, might accept or promote such a decision when they review the numbers, especially if they have an opportunity to share in the resulting savings.

However, the ideal of transparency as a mechanism to reduce costs is marred in many markets by the absence of competition and the inability of states to require self-insured plans to provide the data necessary for price comparisons (although federal reporting requirements can help reduce this barrier). For their part, insurers often resist price transparency to protect their provider contracts. There is also a risk of unintended consequences, such as when a provider learns that its prices are lower than those of competitors and attempts to raise them. Nonetheless, price transparency is widely considered essential, if insufficient, by itself.

Beyond its importance as a purchasing tool, transparency can reveal the impact of health system consolidation and the power that rests with large providers, helping to pinpoint areas in which more regulation may be needed. It can also be an asset in negotiations over high drug prices. For example, bipartisan support exists for legislation that would establish reporting requirements for pharmacy benefit managers, a move towards transparency designed to give health plans more information about pricing and thus foster greater competition.<sup>13</sup>

“Transparency is not just about helping the consumer shop for a cheaper MRI,” said one Working Group member. “It is also about shining a light on the power providers have and telling the story of regulatory capture.”

### *Respecting the Equity Imperative*

Despite the prominence of equity as a goal for the health system, the topic has not always been central to conversations about price and spending. Yet the burden of excessively high healthcare costs invariably falls hardest on those with the least ability to afford them. Research, for example, has demonstrated that high deductibles and copayments, which disproportionately impact populations of color, are associated with less adherence to medication regimens.<sup>14</sup> Medical debt likewise has the greatest consequences for those populations.<sup>15</sup>

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In considering the best ways to balance support for market forces and regulation, the question must be asked: Who is supposed to benefit from lower costs? Without specific attention to the answer, healthcare will not necessarily become more affordable to purchasers or consumers. Rather, new opportunities to game the system may surface, allowing any savings to be pocketed by third-party administrators, pharmacy benefit managers, or other intermediaries. “If you don’t do something to recapture savings, those who are more sophisticated inside the system will figure out how to absorb them,” one Working Group member said ruefully. A comparable equity concern arises in the redistribution fights likely to be associated with spending and growth caps. For example, specialists may hold more sway in healthcare systems than primary care providers and thus be better positioned to dodge spending limits.

In the multipayer environment of the United States, many potential solutions to promote equity—such as mandating more uniform reimbursement levels across public and private insurance plans, regulating self-insured plans under the Employee Retirement Income Security Act of 1974, and changing how Medicare pays specialists and hospitals—are either beyond the reach of states or politically challenging to implement. The value of other strategies is often uncertain. For example, is it equitable to allow narrow network plans because they lower costs, potentially expanding access to coverage, or inequitable, because they make certain providers unavailable?

Still, states do have some important levers. A starting point is to acknowledge that a broad health equity agenda should be at the foundation of conversations about pricing and spending, and to embed that construct into decision-making. Emphasizing the importance of capturing Race, Ethnicity, Ancestry and Language (REAL) and Sexual Orientation and Gender Identify (SOGI) data<sup>16</sup> is crucial to identifying key areas of inequity. States can also act on research that calls for closing coverage gaps as a way to address racial and ethnic disparities,<sup>17</sup> adjusting reimbursement rates to encourage providers to care for patients with social risk factors, and setting population-based payments for historically disadvantaged groups above current levels.<sup>18</sup> Elevating population health measures as a priority is another possible way to save money while having a broader impact.

Together, commitments to coalition building, transparency built on good data, and equity form the backbone of any successful cost-containment effort. Whatever the balance between market-based solutions and regulation that a state chooses to strike, the Working Group believes these elements will bind its approach.

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## Hybrid Solutions: Blending Competition and Regulation

Ideological and pragmatic debates invariably arise as states navigate the tension between promoting competition and imposing price and other cost-lowering regulations. Well-functioning markets have some clear advantages that are arguably difficult to replicate through regulation, which requires conceptually challenging scrutiny of pricing, incentives, technology, access, site of service, and enforcement. Regulatory solutions also need to evolve with changing circumstances.

But generating competition is often unrealistic. In some settings, providers have created a monopoly, consolidating market share with anticompetitive tactics that have driven others out. Elsewhere, notably in rural areas, provider scarcity or a marketplace that cannot support more than one provider fosters a lack of competition, contributing to commercial prices that exceed those of urban areas.<sup>19,20,21</sup> And in some markets with multiple providers, competition is more viable but prices remain stubbornly high.

In general, progressive states are more open to using regulatory tools than conservative ones, but this is not entirely predictable. As well, the landscape becomes more complicated if the governorship and legislature are controlled by different parties.

### *Competition: Opportunities and Obstacles*

The forces that impede competition within the healthcare sector originate in many places but have the generally uniform effect of driving up prices.<sup>4</sup>

Consolidation is a key culprit. As health systems pursue growth—swallowing up competitors; building new facilities; and adding physician practices, ambulatory surgery centers, and other clinical sites to their palette of offerings—their market power continues to increase. In less profitable markets, consolidation can also lead to hospital closures or the loss of specific services, such as maternity care.

Stronger antitrust action can help prevent some of this by imposing more oversight on the mergers and acquisitions among providers that are driving higher costs. A similar response to mergers and acquisitions involving other healthcare entities, including insurers and pharmacy benefit managers, also merits consideration.

Another strategy being actively debated in Congress is the use of site-neutral payments, which would require insurers to reimburse services at the same level regardless of the setting in which they are delivered.<sup>22</sup> Site-neutral payments would reduce the incentives for mergers between hospitals and physician groups because health systems could no longer receive higher rates than physician practices for providing the same

*“The forces that impede competition within the health-care sector originate in many places but have the generally uniform effect of driving up prices.”*

outpatient services. Some states have also enacted reforms that eliminate or regulate the facility fees that are often imposed when care is provided in outpatient settings.<sup>23</sup> Predictably, such moves are strongly opposed by hospitals which argue that they are not adequately compensated for high acuity care, surge capacity, charity care, and other unreimbursed expenses. Some also contend that they struggle to negotiate fair reimbursements in markets in which dominant health plans have gained substantial leverage.

The penetration of private equity firms into healthcare by large investors is another trend driving the consolidation that can undermine competition. An infusion of investment capital is already causing market upheaval as investors add ever-more specialty physician practices and outpatient facilities to their portfolio, in addition to continuing acquisitions of hospitals and nursing homes. As they extend their reach into dentistry, behavioral health, telehealth, hospice care, and elsewhere, the impact will only accelerate. While in some instances private equity firms have brought in needed primary care or mental health services to poorly served rural areas, there is also some concern that private equity ownership may lead to diminished access to care in other instances. Further, private equity firms that finance their acquisitions with large amounts of debt and seek fast returns often increase costs to patients or payers, and there is some evidence that private ownership is associated with a loss of quality.<sup>24, 25, 26</sup>

Many of the mechanisms that could be used to curb some of the more aggressive practices of private equity firms are in the hands of the federal government—for example, requirements for ownership transparency supported by a modernized data system,<sup>27</sup> lower transaction thresholds for public reporting, and limits on the debt used in acquisitions. The broader debate about retaining or eliminating the 20 percent carried interest loophole, which reduces the taxes businesses pay on their income, could also influence investment decisions, although it is unlikely to significantly alter the appeal of the vast healthcare market.

States do have levers of their own. In the realm of consolidation and private equity, opportunities exist to impose notification requirements, tamp down on anticompetitive contract provisions, and empower state attorneys general or health departments to monitor purchases more vigorously. Such monitoring could help prevent buyouts likely to have negative impacts on cost, quality, access, equity, or competition. States can also strengthen their prohibitions of the corporate practice of medicine, which in theory prohibits lay ownership of medical practices, by closing loopholes and regulating contractual and business arrangements between physicians and investors.<sup>28</sup> A recent settlement between the Colorado attorney general's offices and a large anesthesia practice highlights the opportunities states have to remediate aggressive practices.<sup>29</sup>

*“The penetration of private equity firms into healthcare by large investors is one of the trends driving the consolidation that can undermine competition.”*

In his paper, “Competition as a Strategy for Controlling Healthcare Costs,” Benedic Ippolito groups opportunities to foster competition into the four broad categories presented below. In discussing this paper, Working Group members added some of their own insights, which are also incorporated here:

***Policies to discourage further anticompetitive consolidation:*** To increase the transparency of merger and acquisition activity, states can require prior notification at transaction thresholds that fall below the notification level required under federal law. Additionally, states could require advance approval of mergers and acquisitions based on their likely effects on market competition and prices.

States can also reconsider their use of certificates of public advantage (COPA). As currently constructed, COPAs allow mergers deemed to have an overall benefit to proceed without antitrust challenges. In theory, state oversight is intended to mitigate concerns about anticompetitive impact, but the Federal Trade Commission and others have criticized the absence of follow-through.<sup>30</sup> Rather than COPAs, states could limit price increases, prohibit certain contracting practices, or impose other regulations designed to mitigate the adverse outcomes of consolidation. Importantly, states that already have COPAs in place should not repeal them, as doing so would remove any state regulation of the merged entity.

***Policies to expand supply:*** Broadening scope-of-practice laws to enable nurses, nurse practitioners, physician assistants, and other providers to work more independently and provide more services can help lower costs, maintain or improve quality, and enhance access to care. Although physician groups have often opposed such expansions, and appropriate consumer protections are imperative, research on nurse practitioners suggests that giving them broader authority can generate cost and quality benefits.<sup>31,32</sup> While data on other providers are more limited, the findings are likewise favorable.<sup>33,34</sup>

Another approach is to reconsider state-level certificate of need laws. While originally developed to control costs by monitoring investments in new healthcare facilities and other large capital expenditures, certificate of need laws can reduce competition by limiting providers from entering the marketplace or expanding services.<sup>35,36</sup> Another pathway to improving access and controlling costs is to revise antiquated laws that limit the practice of medicine across state laws and curb the reach of telehealth.

***Policies to limit anticompetitive behavior of consolidated entities:*** Dominant providers and insurers have a variety of ways in which they can use contract negotiations to limit competition. For example, providers can

*“States can require advance approval of mergers and acquisitions, broaden scope-of-practice laws, and reconsider state-level certificate of need laws.”*

negotiate on an all-or-nothing basis or insist on antitiering or antisteering clauses that prohibit a health plan from using price or quality criteria to determine the network tier in which they are placed. Insurers, for their part, can insist on most-favored-nation clauses that guarantee them the best price a provider gives to any other insurance company. States have the option to bar the use of these and other clauses they deem likely to keep competitors out of the marketplace.

*Policies to improve price transparency:* While price transparency—what one pays for what one gets—is an assumption in virtually every other marketplace, it has been remarkably absent in healthcare. Likewise, limited data have been available to gauge provider quality. However, this is changing. The Centers for Medicare & Medicaid Services now makes hospital performance data readily available.<sup>37</sup> As well, the federal government now requires hospitals to make public the prices insurers pay for their services, and a number of states are looking at ways to enforce that requirement. Likewise, health plans are mandated to disclose their negotiated rates with each provider. All-payers claims databases are another mechanism for broadening access to information. More than half the states have already implemented APCDs or are in the process of doing so. However, self-insured plans are not obliged to participate, which limits their value, as does the inconsistent availability and reporting of the data.

## *Regulation: Opportunities and Obstacles*

Support for regulation builds on the recognition that vigorous competition within healthcare markets is often impossible, in part because many markets are already highly concentrated. “Innovation requires regulation,” said one Working Group member. “When innovation is allowed to thrive, it can lower costs and improve access.”

Regulating markets requires mechanisms that either slow spending growth or constrain pricing. Either approach can easily devolve into disagreements about how much to hold down spending, which services will be most affected, and who will see declining revenue as a result. There is also some risk that providers will use a variety of offsetting actions to preserve their bottom lines. Price regulation, for example, can motivate providers to increase service volume, substitute higher-cost services (e.g., a more costly MRI instead of a CT scan), upcode procedures or patient risk scores, change the patient mix, or shift the site of care to garner a higher facility fee.

Whatever the approach, regulators must decide what services will be covered; consider enforcement, compliance, and incentive strategies; and identify the best ways to ensure accountability. Rewarding improved

*“Regulating markets requires mechanisms that either slow spending growth or constrain pricing.”*

health outcomes and other quality measures, tracking variations in practice patterns, and integrating appropriateness of services into the value equation are all potential supplements to regulation that targets either spending or price alone.

In their paper, “Regulation as a Strategy for Controlling Healthcare Costs,” Jodi Liu and Christine Eibner detailed four potential regulatory pathways. In discussing this paper, Working Group members added some of their own insights, which are also incorporated here:

**Rate regulation:** States can choose to set prices, cap prices, or cap growth in prices for healthcare services. To do so, they need to identify an independent agency, commission, or some other entity to establish the rates or caps; consider which services, providers, or insurers are subject to the regulations; and define the geographic regions in which they will apply. Rates established by Medicare, a percentile of commercial prices within a given market, or historical prices indexed to the consumer price index can all inform decision-making. Many state insurance departments already review insurance carrier rates annually, but strengthening that process could also help control costs.<sup>38</sup>

**Global budgets:** Global budgets break the link between the volume of healthcare services provided and payments received by limiting total spending for a specific provider, such as a hospital or accountable care organization, or for a discrete set of services. By factoring in both volume and price, they are designed to reward efficiency while making reimbursement more predictable for payers and providers. Global budgets can be combined with incentives to ensure quality of care.

The Centers for Medicare & Medicaid Services Innovation Center is experimenting with this model through its Advancing All-Payer Health Equity Approaches and Development.<sup>39</sup> This program funds state demonstration projects that provide lump-sum payments to hospitals that cover all inpatient and outpatient care to a defined patient population.

**State-level targets for spending growth:** Spending growth targets are used to monitor total state spending with the goal of capping it at a specific percentage over time. Providers and payers are expected to meet those benchmarks, although enforcement mechanisms to ensure accountability have to date tended to be weak or limited. Important considerations here include how to set target growth rates and what spending gets included in the overall target (e.g., services that are not covered by traditional insurance, such as vision, dental, and long-term institutional care, are often excluded).

**State-level public insurance options:** A public health insurance plan is designed to be a competitive alternative to private insurance, ideally

*“States can choose to set prices, cap prices, or cap growth in prices for healthcare services; require global budgets, set targets for spending growth, or develop public insurance options.”*



offering more affordable coverage to consumers. Whether administered by the state itself or through a contract with a private insurance carrier, public plans are viable only when provider networks are adequate. States are taking various approaches to their public option plans, including setting reimbursement at a multiple of Medicare rates, mandating participation by any insurance carrier that offers other plans in the region, and mandating premium reductions. In addition to Washington State, Colorado, and Nevada, which already have relevant laws on the books, Maine, Minnesota, and New Mexico have laid the groundwork to move forward, and other states are weighing various approaches to public options.<sup>40</sup>

## *Building the Infrastructure*

To respond to rising costs and shape policy, states need to erect and house the infrastructure necessary to promote competition and inform regulatory decision-making. While their designs will differ, each state needs a platform to facilitate the effective use of data, accommodate appropriate oversight, allocate the necessary resources, and ensure that the expertise needed to bring stakeholders together and drive action is available.

In their paper, “State Approaches to Infrastructure Building for Controlling Healthcare Costs,” Victoria Veltri, Maureen Hensley-Quinn, and Hemi Tewarson highlight four foundational efforts being used to build infrastructure. In discussing this paper, Working Group members added some of their own insights, which are also incorporated here:

***All-payer claims database:*** As noted in the Ippolito paper on competition, an APCD integrates claims and enrollment data into one database. Depending on a given state’s authority, the detailed information can be used to map service patterns and cost drivers, foster competition, track the impact of consolidation, and inform regulatory decisions. States with existing APCDs can make their data more accessible and refresh policies on transparency. States that are moving to create new APCDs will need to define their purpose, determine where they are to be housed, establish parameters for data governance, and ensure adequate funding.

***Hospital and health systems financial reporting:*** The current financial reporting requirements for hospitals and health systems are vast but fragmented. While much of the data are publicly available, they cover different time periods; are submitted to different agencies; and include disparate, though often overlapping, information. Creating a more comprehensive system to collect and analyze these data can better enable states to track trends, promote competition, and shape cost-containment policies. Design considerations include determining where to locate the financial reporting system, defining the scope of data collection and reporting and how data will be released, and identifying funding sources.

*“States need to erect and house the infrastructure necessary to promote competition and inform regulatory decision-making.”*

**Healthcare cost oversight offices:** An existing state agency, or a newly created one, can be explicitly empowered to monitor and report on healthcare spending, recommend cost control strategies, analyze the impact of policy changes, and enforce rate regulation and procompetition policies. Decisions about its degree of independence, scope of authority, interface with other state entities, and access to resources will influence how much it can accomplish.

**Cost growth benchmarks/targets:** As noted in the Liu and Eibner paper on regulation, states can establish benchmarks for reasonable cost increases and then develop an approach for meeting them to limit spending growth. This requires mechanisms to guide data collection, analyses, and enforcement, including deciding where to house the work and establishing an advisory body to oversee it. Design considerations also include determining the authority used to establish a program and identifying the stakeholders to be involved. Support from the executive and legislative branches and a means of securing adequate resources, possibly by assessing payers and providers, are the steel needed to keep the structure intact.

## Moving Forward

Clearly, there is no single roadmap for constraining healthcare costs, given the limited evidence to demonstrate what is most effective, and under what circumstances. While lessons can be learned from states that have long experience with measures designed to reduce their economic burdens, the evidence to demonstrate what is most effective and under what circumstances is limited. The individual characteristics and circumstances of states that are relatively new to the search for solutions will steer their decisions, making a uniform guideline impossible to establish. The disparate nature of their healthcare systems, the shifting role of the marketplace, their ideological leanings, and the shake-up engendered by the COVID-19 pandemic all point to heterogenous approaches.

“There is no solution that can encompass rural and urban, safety-net and non-safety net providers, red and blue states,” said one Working Group member. “There won’t be a singular answer.” Moreover, the pace at which health systems are evolving could well mean that optimal approaches in the future will look entirely different than they do now.

But if it is early in the knowledge journey, the mere recognition that states have a central role to play in helping address healthcare spending and promote market competition represents new thinking in many places. Rising costs, tight budgets, and the unique platform occupied by the states are contributing to a sense of both urgency and possibility. Many of the core elements needed for action have already been identified—notably,

*“Rising costs, tight budgets, and the unique platform occupied by the states are contributing to a sense of both urgency and possibility.”*

leadership, data, infrastructure, and broad stakeholder representation, including by employers and consumers. A commitment to equity, a willingness to take on vested interests, and a charge to experiment, evaluate, and adapt are also fundamental.

Next steps will include expanding the available research so that states can learn more about which regulatory and market-based approaches are most promising and for whom, what to consider in crafting new policies, and which metrics are most appropriate for assessing the impact of change. The National Governors Association and other national organizations have opportunities to share best practices and promote conversations among the states about how best to tackle healthcare costs. Developing model contract language for employers to use in their negotiations with health plans and sharing resources and early learnings from around the country are other useful additions to the toolbox. Models that are already being implemented for primary care, pharmaceutical benefit managers, and maternal health merit watching. There may also be regional opportunities to pool data or build analytic and benchmarking capacity for states that need such support.

While all of this is developed, the message to the states will remain clear: act now despite the evidence gaps. “Congress never does anything before the states do it,” said one Working Group member. “In any big policy, states try it, they figure out what works and what doesn’t, and then maybe the feds will come along. But there is no way the federal government, and particularly the federal divided government, is going to be the lead on this.”

*“The message to the states remains clear: act now despite the evidence gaps.”*



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## Background Papers

- **Competition as a Strategy for Controlling Healthcare Costs**  
Benedic Ippolito, PhD, MS
- **Regulation as a Strategy for Controlling Healthcare Costs**  
Jodie Liu, PhD, MSPH, MSE, and Christine Eibner, PhD
- **State Approaches to Infrastructure Building for Controlling Healthcare Costs**  
Victoria Veltri, JD, LL.M, Maureen Hensley-Quinn, MPA, and Hemi Tewarson, JD, MPH

## Competition as a Strategy for Controlling Healthcare Costs

Benedic Ippolito, PhD, MS

### Introduction

The high cost of health care is a burden for patients, workers, and the government alike. Government spending on public programs, such as Medicare and Medicaid, creates budgetary pressures on state and federal governments, stressing tax bases and crowding out other potential uses of government revenues, especially in states with balanced budget requirements. High costs in the commercial market are similarly consequential because they erode potential wage growth of employees, increase premiums and out-of-pocket spending, and reduce income tax revenues. Moreover, these costs increase the federal government's outlays for subsidies to purchase insurance on the individual market. Thus, slower growth in health spending has broad potential benefit.

Evidence suggests that a significant portion of health care expenditures reflect market inefficiencies owing to factors that include limited competition, moral hazard (because insurance protection can make individuals less sensitive to costs), or a lack of information. In some cases, these inefficiencies represent natural features of health care markets (e.g., medical emergencies limit the ability of consumers to shop for the best care). In others, they are the result of government policies (e.g., those that reduce cost-sharing requirements for some patients, making them less likely to shop for lower prices).

Policymakers can take multiple approaches to address high costs that are divorced from value. One approach is to regulate outcomes that stem from market inefficiencies, such as high price. Another is to attempt to address the market imperfections, such as limited competition or opaque pricing, that underpin inefficiently high spending. This paper focuses on the latter approach, highlighting policies that help improve the underlying functioning of markets.

### *Value of Competition Policy*

There are a number of potential advantages to policies that promote competition, in part because well-functioning markets can be difficult to replicate. For example, the costs of providing services and the preferences of consumers can change significantly over time, making it difficult to identify the right price or spending level for various services. Setting prices too low, for instance, can lead providers to underinvest in services or quality that people would value.

Substituting regulation for market competition can also raise a number of practical challenges. Directly regulating prices or utilization requires regulators to police strategic responses that may undercut regulatory goals. For example, providers might respond to price regulation by increasing the amount of care delivered. Even when identified, altering policy in response can be a deliberate process that puts regulators at a disadvantage. Price and spending regulation are also subject to regulatory fatigue and political pressure from dominant market actors over time. This is a particularly noteworthy feature in health care, in which large hospitals or provider systems are often among the largest and most powerful economic actors in their communities. Prior health care regulatory efforts provide insights into these challenges. State all-payer rate-setting systems—arrangements in which states directly regulate hospital prices for all insurers—were once relatively common in the US. While their effects on cost containment

are the subject of some debate, they highlight potential administrative challenges. Political pressure from hospitals was a common obstacle. In Maryland, for example, efforts to constrain costs through a volume-adjustment system were abandoned after pressure from hospitals (Murray & Berenson, 2015). More broadly, Murray and Berenson (2015) highlight administrative complexity as a challenge in Massachusetts, New Jersey, and New York, where systems “become so complex that only a small group of regulators and hospitals fully understood how the systems functioned.” These examples are not meant to diminish these efforts but rather highlight the practical challenges that can arise in such systems. Policies that instead improve market functioning have the potential to alleviate some of these challenges and involve less administrative complexity. There are also limits to what procompetitive policies can accomplish. For example, some markets can effectively support only one supplier (e.g., acute care services in some rural areas), so competition will always be inherently limited. A subset of health care is urgent by nature, limiting the prospect of meaningful choice by consumers in those settings. Some markets are already very highly concentrated, limiting the recourse of policymakers. In such cases, there may be a greater role for active regulatory approaches. Indeed, a comprehensive response to high health costs could involve a hybrid approach—harnessing markets where possible and deploying more active interventions when that is not feasible. The remainder of this paper outlines policies that states can employ to improve the functioning of health care markets. These policies are designed to discourage additional consolidation in health markets, limit the mechanisms through which dominant firms leverage their market power, implement policies that expand the supply of providers where possible, and improve transparency in health care markets.

## Policies to Discourage Further Anticompetitive Consolidation

Well-functioning markets require competition. A large body of literature shows that consolidation between potential competitors in health care markets increases consumer costs and, while the focus of less research, has not been clearly linked to improvements in the quality of care (Beaulieu et al., 2020; Cooper et al., 2019; Dafny et al., 2019; Koch et al., 2018). This is particularly true of competitors in the same geographic market, but mergers across markets within a given state tend to increase costs as well (Dafny et al., 2019). Recent evidence suggests that vertical consolidation—such as a hospital’s acquisition of physician practice—also contributes to rising costs (Godwin et al., 2021; Post et al., 2018; Saghafian et al., 2023). Beyond raising health care costs, mergers that meaningfully increase consolidation may also lower competition for workers within the hospital sector, leading to slow wage growth (Prager & Schmitt, 2021).

States have a number of options for deterring further anticompetitive consolidation.

### *Increase Transparency Surrounding Merger and Acquisition Activity*

States can improve oversight of consolidation within health care markets by requiring notification from providers, insurers, and other health care firms in advance of mergers or acquisitions. Doing so can aid both state and federal oversight in cases of potential antitrust concerns, particularly when federal reporting requirements limit oversight.

Federal law requires premerger notification of federal antitrust agencies only if the transaction exceeds \$111.4 million (adjusted annually for inflation) (Federal Trade Commission, 2023). This means that



a very large number of mergers and acquisitions goes unnoticed until the merger has been finalized. Acquisitions of physician practices are particularly likely to fall into this group (Capps et al., 2017), but even among hospitals, the median value of mergers was below this threshold from 2016 to 2020 (Fulton et al., 2021), which greatly reduces the odds that a merger or acquisition is challenged (Wollmann, 2020). This is a significant omission because small mergers can meaningfully contribute to consolidation. While a single acquisition may not raise competitive concerns on its own, a series of such transactions may. Indeed, private equity investors often acquire large market shares through a series of smaller acquisitions (Fuse Brown et al., 2021).

States can improve oversight by requiring that these transactions be reported to the state attorney general and health agency—including transactions that fall below federal reporting thresholds. As Fuse Brown (2020) notes, many states currently require that all hospital mergers be reported to agencies, an approach that could be expanded to cover physician practices. A few states, such as Washington and Massachusetts, have recently passed legislation expanding reporting requirements along these lines (R.C.W. 19.390; Massachusetts General Laws Part I, Title II, Chap. 6D § 13).

### *Increase Oversight of Mergers and Acquisitions*

Rather than challenging potentially anticompetitive mergers or acquisitions, states could require proactive approval by the attorney general. Under such an approach, states would establish formal criteria for evaluating transactions, including the likely effects on market competition and prices (particularly in the commercial market). States could also attach conditions to the mergers or acquisitions they allow, such as reporting requirements to monitor the effects of the merger or the divestiture of specific services for which the resulting consolidation would be particularly pronounced. In principle, these conditions could impose rate controls on the postmerger entity (for a discussion of potential trade-offs to such a policy, see the section on certificates of public advantage below). In some cases, states have distinguished between oversight of transactions involving for-profit and nonprofit entities. However, empirical analysis confirms that transactions involving nonprofit providers can raise meaningful anticompetitive concerns (e.g., Tenn, 2011; Vita & Sacher, 2003), suggesting a unified approach may be warranted.

Efforts to increase oversight of merger and acquisition activity are likely to generate opposition from provider and investment groups who often argue that increased administrative costs and uncertainty can dissuade beneficial transactions (e.g., Boerger, 2020).

These policies also impose some administrative burdens on states. This is particularly true if policies require state agencies to review every proposed transaction based on specified criteria, rather than allowing them to selectively challenge transactions. Beyond efforts to simplify reporting requirements, states can limit review periods so that they have enough time to complete a reasonable review without unduly delaying transactions that do not raise competitive concerns. These are common features of existing policies, though wait times after pretransaction notices vary across states (King et al., 2020). Moreover, states can decide to reduce reporting requirements or exempt very small transactions from some review (though at a lower level than federal reporting thresholds).

## *Reconsider Use of Certificates of Public Advantage*

Certificates of public advantage (COPA) laws are designed to replace competition between health care providers with state oversight. Under such laws, states can approve the merger of two hospitals if they believe the benefits will outweigh potential costs from reduced competition. Potential benefits could, in principle, include better coordination of care or avoiding the closure of a hospital. In addition, the postmerger hospital can be subject to regulatory oversight, such as through rate regulation or commitments to improve quality (US Department of Health and Human Services, US Department of the Treasury, & US Department of Labor, 2018) that are intended to lessen the costs of reduced competition. By issuing a COPA, these mergers are shielded from federal antitrust enforcement under the state action doctrine (Federal Trade Commission, 2022).

Critics of COPAs argue that they may allow for anticompetitive mergers that, in practice, can increase health care costs (Federal Trade Commission, 2022; Gaynor, 2020; US Department of Health and Human Services, US Department of the Treasury, & US Department of Labor, 2018; US Department of the Treasury, 2022). In particular, if state oversight of the postmerger hospital is ineffective or is abandoned, the hospital may be able to use its market power to increase prices. This is particularly concerning if the merger would have otherwise been challenged by federal antitrust authorities.

The one peer-reviewed study that has empirically evaluated mergers that were shielded because of COPAs found that half of the studied hospitals did not comply with the terms of the COPA (e.g., by raising prices), and nearly all agreements were abandoned in response to lobbying efforts (Garmon & Bhatt, 2022).

Eighteen states have laws that allow merging hospitals to apply for a COPA, while five states have repealed such laws (Gu, 2021). States that have a COPA law, but no active COPAs currently in place, can consider repealing their laws. If states do have active COPAs, they could consider retaining the law but not approving further COPAs (since repealing the underlying law can eliminate oversight of previous mergers).

## Policies to Expand Supply

Beyond deterring further consolidation, states can consider policies that seek to expand the supply of providers or allow existing ones to offer a greater range of services as a means of increasing competition.

### *Expanding Scope of Practice*

States can consider expanding their scope-of-practice (SOP) laws as a way to increase competition among health care providers. SOP laws regulate the tasks that various health care providers—including nurses, nurse practitioners, and physician assistants—can perform. These laws can limit both the types of services a given health care professional can provide and the extent to which they can work independently. They are motivated by the desire to protect patients by preventing providers from delivering services that extend beyond their training. However, some worry that they may also limit competition if they unduly restrict the ability of providers to deliver services that are within their training.

SOP laws vary substantially across states. For example, twenty-eight states allow full practice for nurse practitioners, which includes evaluating and diagnosing patients and independently prescribing

medications (American Association of Nurse Practitioners, 2022). Similarly, states vary in the extent to which they require physician collaboration or supervision of physician assistants and whether their SOP is determined by the state or, at the practice level, by the physician assistant and supervising physician (NCSL Scope of Practice Policy, 2023b). States may also allow pharmacists to administer COVID-19 vaccines and dispense products such as tobacco cessation aids (NCSL Scope of Practice Policy, 2023a; NCSL Scope of Practice Policy, 2023c). In general, efforts to expand SOP laws have been opposed by physician groups. Recently, COVID-19 prompted many states to temporarily relax their SOP laws to increase flexibility and access to health care (Bae & Timmons, 2022).

Several studies have evaluated the effect of expanding the SOP for nurse practitioners and have typically found that doing so lowers costs and maintains or improves quality, and it may increase some measures of access to care (for a review see Bae & Timmons, 2022, and Liu et al., 2022). While there have been fewer studies of other providers, the limited research results tend to be consistent (e.g., Dulisse & Cromwell, 2010; Markowitz et al., 2017).

## *Reconsider Certificate of Need Laws*

Health care regulators were historically wary that excessive investment in new health care facilities could raise total health care costs. This reflected concerns that providers might encourage excessive use of unneeded services (supplier-induced demand) or that unchecked capital expenditures would encourage hospitals to attract patients by investing in costly amenities that had low clinical value (medical arms race). In response, the federal government required states in 1974 to implement certificate of need (CON) laws, which require permission from the state before new construction or other large capital expenditures could be undertaken by health care providers (Ohlhausen, 2015). Beyond cost control, CON laws were seen as a mechanism to ensure that investments targeted genuine areas of need, potentially improving access to care in relatively underserved areas. The federal mandate was repealed in 1986, but thirty-five states and the District of Columbia still maintain a CON law (National Conference of State Legislatures, 2023). In states with a CON law, a health agency or other entity reviews potential market entry or new capital expenditures based on criteria such as the projected need for a service within an area or the effects on costs (National Conference of State Legislatures, 2023). States vary in both the types of activities and the facilities they monitor. As with SOP laws, a number of states relaxed these laws in response to COVID-19 (Erickson, 2021).

Critics have argued that CON laws reduce competition, choice, and innovation while leading to higher prices (Statement of the Federal Trade Commission, 2018). CON laws can reduce market entry in two ways. First, the state may directly block a provider from entering the market or offering new services. Critics have argued that this process has sometimes been subject to regulatory capture by dominant, incumbent providers seeking to retain their control over a given market (Ohlhausen, 2015). Second, CON laws impose administrative burdens on potential entrants, who must spend time and resources to navigate this process (e.g., incurring legal or consulting fees).

Empirical analysis of CON laws tends to find that they are associated with fewer health care facilities, may increase health care spending, and have unclear effects on quality. There is relatively limited evidence on how they impact access to care (for a review of empirical work, see Liu et al., 2022).

States have multiple options for revising their CON laws (Mitchell, 2021). Fifteen states have fully repealed them, but states can also consider more limited or gradual approaches. For example, some states have repealed CON requirements for certain services or taken steps to lower the administrative burden associated with current applications (e.g., by reducing fees or simplifying applications). States can also gradually remove CON laws by scheduling them to sunset, either all at once or in stages. In general, opposition to such a policy change is likely to come from existing hospitals or other medical providers, particularly those that have a large market share.

## Policies to Limit Anticompetitive Behavior of Consolidated Entities

Providers or insurers with large market power can use their leverage to impede potential rivals. Policymakers can consider options that would limit this type of behavior and encourage more competition in health care markets.

Dominant providers can demand favorable contract terms with insurers that limit competition from other providers or make it difficult for new providers to enter the market. For example, dominant providers can require that insurers place them in the highest network tier with the lowest cost-sharing requirements (antitiering or antisteering clauses), thereby preventing insurers from steering patients toward lower-cost or higher-quality competitors. Dominant providers can also demand that insurers include every provider affiliated with their health system in their network (all-or-nothing contracting). This can allow a provider with a dominant position in one part of the market to extend that market power to other parts. Such provisions can be particularly powerful where network adequacy laws effectively require the inclusion of certain providers. Together, these favorable contract provisions make it difficult for potential competitors to enter the market or offer new services.

Dominant insurers can also exert their market power in ways that suppress market entry. Notably, they can use most-favored-nation clauses, which stipulate that a provider will not give any other insurer a lower rate than the dominant insurer. This makes it difficult for smaller insurers to compete on price, even if they pursue a narrow network plan that is meant to funnel patients to a given provider. In turn, this also reduces the competitive pressure on hospital prices.

Entrenched providers and insurers are likely to be the main opponents of proposals to limit anticompetitive contract provisions, perhaps noting that such provisions exist in some other markets. Indeed, these types of provisions are not inherently problematic in competitive markets. For example, a contract between an insurer and hospital could include an antisteering or antitiering provision in exchange for the hospital offering a lower price to that insurer. Doing so could increase patient volume at that hospital and help reduce plan premiums. However, critics generally argue that these contracting tools can be used to stifle existing or potential competitors where a provider or insurance market is already relatively consolidated.

While anticompetitive contracting has received state and federal policy attention, the research directly evaluating its effect on health care costs is limited. One recent study of the twenty states that have restricted the use of most-favored-nation clauses indicated that doing so lowers hospital expenditures (Arnold et al., 2022). The Congressional Budget Office has also indicated that limiting these types of contract clauses would likely reduce premiums for private insurance (Congressional Budget Office, 2019).

States could challenge or restrict the use of anticompetitive contracting clauses in an effort to spur more competition in provider and insurer markets. One approach is for states (and the federal government) to use antitrust enforcement, though doing so is relatively resource intensive (Fuse Brown, 2021). Alternatively, states could consider passing legislation that restricts anticompetitive provisions in contracts. The National Academy for State Health Policy has a model act designed to ban the provisions' use (National Academy for State Health Policy, 2021). Nineteen states currently ban the use of most-favored-nation clauses (The Source on Healthcare Price and Competition, 2023). Only a few states, including Nevada and Massachusetts, currently restrict antisteering, antitiering, and all-or-nothing clauses, though a handful of others are considering such legislation (The Source on Healthcare Price and Competition, 2023).

## Policies to Improve Price Transparency

Health care prices are often opaque, which can impede market functioning and raise costs. This section outlines policy options to improve price transparency in health care markets that could reduce health care spending through a number of channels. For example, consumers can potentially use this information to select lower-cost providers. With greater insight into the prices paid by their insurers, employers could alter their choice of health insurance plans (e.g., selecting contracts that steer enrollees away from higher-cost hospitals), while insurers could use the information to bargain for lower prices with providers. More knowledge could also inform a broad array of policies aimed at lowering costs.

Despite the potential benefits of greater price transparency, some features of health care markets are likely to limit its effects on health care costs. First, a significant portion of health care is urgent (e.g., emergency care), which limits consumers' ability to respond to prices (Frost & Newman, 2016). Second, the structure of insurance can blunt the incentives for patients to actively shop for care (e.g., if their cost sharing does not vary across providers). Third, research has shown that consumers tend to use price transparency tools relatively infrequently, even when they are available (Mehrotra et al., 2017; Sinaiko & Rosenthal, 2016). In addition, greater transparency could also lead to higher prices if providers are reluctant to accept low prices from an insurer lest it prompt others to demand similar pricing (Fiedler & Linke Young, 2020).

One way to improve transparency in hospital markets is for states to build on the recent federal Hospital Price Transparency Rule (45 C.F.R., Part 180), which requires hospitals to publicly post data files that include the prices paid by individual insurers for hospital services. In addition, they are required to post prices for shoppable services in a consumer-friendly format. These data can be directly useful to consumers, employers, and insurers. In principle, they could also underpin consumer-facing transparency tools (existing examples of such websites include the "NH HealthCost" website in New Hampshire).

However, hospital compliance has been incomplete (Turquoise Health, 2023). States can consider legislation that would encourage hospitals to fully comply with these transparency efforts. For example, states could levy administrative penalties or disallow collection activity if hospitals are noncompliant, an approach that has been included in some model legislation (American Legislative Exchange Council, 2022). They could also make compliance a condition of state licensure. Some states have already taken steps along these lines. For example, Texas effectively codified the hospital transparency rule with

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additional administrative penalties in 2021 (Texas S.B. 1137). Legislators in other states have recently introduced similar bills (e.g., New Hampshire H.B. 389, Virginia H.B. 481).

States could also consider establishing an all-payer claims database (APCD), which combines claims and enrollment data across nearly all entities that purchase health care within a state. These include prices as well as other information such as characteristics or diagnoses of patients receiving care. Twenty-six states have or are implementing APCDs with required data contribution, and several other states currently have voluntary APCDs (APCD Council, 2023). There are some drawbacks to all-payer claims databases, however. Notably, states cannot compel data submission from self-insured plans (which cover roughly two-thirds of workers with employer-sponsored health insurance) due to a US Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company*, which limited some of their value.

Finally, it is worth noting that there is limited direct research on the influence of state-level price transparency tools on health care spending. The one empirical paper studying the introduction of a state website that provided insurer-specific prices found a 4 percent reduction in spending on imaging services (Brown, 2019).



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## Regulation as a Strategy for Controlling Healthcare Costs

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### Introduction

Despite significant gains in insurance coverage since the Patient Protection and Affordable Care Act (ACA) was signed into law in 2010, health care affordability remains a significant concern for the American public. In a KFF Health Tracking Poll conducted in December 2022, nine out of ten adults reported being somewhat or very concerned about increases in health care prices, and nearly one in ten respondents thought health care affordability should be the top priority for policymakers (KFF, 2022). State legislatures have responded to these concerns by introducing a range of bills aimed at reducing health care costs (Chernew et al., 2021). This legislation encompasses a wide variety of reforms, including approaches that attempt to reduce health care costs by fostering greater competition in health care markets and regulatory approaches that directly cap prices or limit growth in overall health care spending. In this paper, we discuss regulatory approaches, focusing on four related reforms that have gained attention among state policymakers:

1. **Rate regulation** sets prices, price caps, or price growth caps for some or all health care services. Prices can be determined in several ways, such as based on Medicare rates or historical prices indexed to the Consumer Price Index.
2. **Global budgets** provide entities such as hospitals or accountable care organizations (ACOs) a fixed payment for a defined population or set of services. The entity is typically at risk for any spending in excess of the fixed payment.
3. **Spending growth targets** set an annual growth target for health care spending for a defined population, such as all state residents. Enforcement mechanisms vary, from naming and shaming poorly performing providers to mandating performance improvement plans or penalties.
4. **A public option** is a health plan offered or regulated by the government with the goal of creating a more affordable option, typically on the ACA marketplaces.

Regulation in health care markets may be justified based on the existence of market failures. For example, insurance contracts insulate consumers from the full cost of health care services, limiting their incentive to look for the best price. The ability to shop around is further stymied by the fact that health care services can be complex and required on an urgent basis, making it difficult or impossible for consumers to judge value. Consolidation has also led to significant market power among providers, pushing prices above competitive levels (Antitrust applied, 2021; Gaynor & Town, 2011). Other factors, such as preferential tax treatment for some types of health care and the existence of large monopsony buyers (e.g., Medicare and Medicaid) may further distort markets.

While the reforms discussed in this paper aim to address market failures through regulation, they can vary in the scope of the population and services that are affected, the mechanisms for holding providers and payers accountable, and the anticipated impact. Table 1 provides a rough sense of where each reform has historically fallen on the spectrum of scope and accountability.

**Table 1. Scope and Accountability of Regulatory Approaches as Historically Implemented in the US**

Reform	Scope	Accountability	Rationale
<b>Spending growth targets</b>	Broad	Low	Typically encompass all spending in the state but with weak enforcement mechanisms
<b>Global budgets</b>	Medium-High	High	Often limited to hospitals or specific subpopulations, such as Medicaid enrollees; providers are typically at risk for any excess spending
<b>Rate regulation</b>	Low-Medium	High	Scope can be limited because not all services face price setting or caps, and volume is not regulated; prices or price growth are set administratively
<b>Public option</b>	Low	Low	Health insurance plans are offered or regulated by the government but typically limited to marketplace enrollees; may be difficult to ensure participation among providers and plans

Note: The table describes reforms as historically implemented in the US; it is possible that states could implement reforms differently in the future, with different results.

In the subsequent sections, we discuss each of the four reforms in more detail, including a discussion of the impact they have had to date.

## Rate Regulation

State and federal governments can directly affect health care prices by regulating payment rates. Rate regulation can take the form of setting prices, capping prices, or capping price growth.

Health care spending in the United States is high relative to other countries, driven by high prices (Anderson et al., 2003, 2019). Those prices differ depending on whether they are paid by public or private insurance. In public insurance programs, such as Medicare and Medicaid, payment rates are set administratively (though many Medicare and Medicaid beneficiaries receive their benefits through private plans that establish rates paid to providers). For example, the Centers for Medicare & Medicaid Services establishes Medicare payment rates through annual rulemaking processes based on the underlying costs of providing services. In contrast, prices in private insurance are typically negotiated between providers and insurers. In the US, prices in public insurance programs are lower and have grown more slowly than prices in private insurance (Lopez et al., 2020; Selden et al. 2015; Whaley et al., 2022).

States have a long history of using rate regulation to reduce health care costs. In the 1960s and 1970s, many states set rates for hospitals, but most of them deregulated hospital rate setting in the two decades that followed (McDonough, 1997; Murray & Berenson, 2015; Sommers et al., 2012). The only remaining statewide hospital rate regulation approach is Maryland's all-payer system (Haber et al., 2019).

### *What States Are Doing*

Maryland's long-standing all-payer hospital rate-setting program has been in effect since 1977 and has evolved into all-payer global budgets for hospitals in 2014 and a Total Cost of Care Model in 2019 (Haber et al., 2019; Murray & Berenson, 2015). The Maryland Health Services Cost Review Commission is an independent state agency established to set hospital rates for all payers, including both Medicare and Medicaid, through a federal waiver.

States have also applied regulation to the rates paid by their state employee health plan to providers. Oregon's public employee plan has a cap on hospital payments of 200 percent of Medicare for inpatient services and 185 percent for outpatient services (Reimbursement Methodology for Payment to Hospitals, n.d.).

Other states regulate the growth of health care prices. For example, Rhode Island has created affordability standards for all commercial insurers that include a cap on the growth of inpatient and outpatient prices paid to hospitals equal to the urban Consumer Price Index (less food and energy) plus 1 percent (Rhode Island Office of the Insurance Commissioner, 2022). One study found that the cap on price growth—along with other affordability standards implemented by the state, such as a required transition to hospital payments based on diagnostic-related groups—reduced prices and total spending growth without affecting health care utilization (Baum et al., 2019). Delaware has also established price growth caps, which reflect the greater of 3 percent (in 2022, and subsequently reduced to 2 percent) or the core Consumer Price Index plus 1 percent for nonprofessional services (State of Delaware Department of Insurance, Office of the Commissioner, 2022).

States have also proposed broader reforms that include rate regulation. For example, public options (discussed later) often involve rate regulation.

## *Key Design Considerations*

Policies to regulate rates can be designed in a variety of ways. Each of these design considerations has important implications for the magnitude of effects on spending, access, and quality as well as distributional implications, including for providers that have different initial price levels. Key considerations for policymakers include the type of regulation (e.g., price setting, price caps, or price growth caps), how to establish the rates or cap, and the scope of the regulation (e.g., what providers, services, payers, network status, and geography are to be covered).

Relative to price setting, capping prices could have a narrower scope as it would not directly affect rates below the cap. Market forces would still determine rates below the cap, but the existence of that cap might affect provider-insurer price negotiations. Capping price growth would not directly alter existing price differentials across providers but would instead limit price changes going forward, perhaps in a more gradual way. By contrast, price setting would raise rates for providers currently paid less than the set level.

State rate regulation has typically involved establishing an independent state agency with authority to determine rates or caps. Regulation could be based on existing rates, such as those paid by Medicare or commercial insurers. For example, the state employee plans in Oregon use multiple Medicare rates. Rate caps could be applied at an aggregate level (e.g., to the average rate for a given payer or provider) or to individual services. While using Medicare rates as the basis of regulation provides established fee schedules and payment systems that are already developed, it also locks in existing payment differentials in Medicare payment systems. These could include site-of-service differentials in which payments for the same services differ depending on where they are provided (e.g., procedures at a hospital outpatient department compared to an ambulatory surgical center) or payments favoring procedural services over cognitive services. Alternative proposals include using percentiles of commercial prices at the service level (Chernew et al., 2020). Establishing rates based on existing commercial prices would reflect market conditions and lock in price differentials that exist as a result of price negotiations and market power.

Rate regulation could be applied broadly or targeted toward certain payers, providers, services, or regions or on the basis of network status. Regulations could focus on commercial insurers, whose prices are high and growing fastest, or on both private and public payers, which would require federal waivers to include Medicaid and Medicare, as Maryland has done. Similarly, policymakers would need to consider the scope of providers and services to be included. Historically, much of the experience states have had with rate setting has been with hospital prices. Other proposed policies focus on limiting out-of-network billing. For example, some policies restrict balance billing, in which out-of-network providers bill patients for the difference between the charged amount and the amount paid by the insurer. With a more limited scope, attention has also been paid to surprise medical bills for emergency services or nonemergency services provided by out-of-network providers at in-network facilities. Although restrictions on surprise billing have been the subject of recent legislation and face less political opposition, regulating only surprise bills would have a smaller impact than regulating all prices, although there could be spillover effects on in-network prices. Finally, policymakers could consider whether regulations would apply to all geographic areas or if there would be different rates or caps for certain regions, such as rural areas or areas with high market concentration. For example, researchers have proposed a cap based on median Medicare Advantage rates for hospitals with greater than 15 percent market share and with a Herfindahl-Hirschman Index (a measure of market concentration) above 4,000 (Roy, 2020).

## *Challenges and Unintended Consequences*

Implementing rate regulation policies can be complex. State agencies or commissions tasked with establishing such policies have several decisions to make about the scope and details of setting rates or caps. Furthermore, regulation involving public payers (e.g., all-payer policies) require federal waivers to incorporate Medicare and Medicaid. Another challenge is that providers could have undue influence with the state agencies intended to regulate them—regulatory capture could limit the extent to which state agencies restrain prices, benefit some provider groups over others, or lead to price increases.

Historically, provider groups have been strongly opposed to proposals to reduce rates (Murray & Berenson, 2015). For example, in North Carolina, the Clear Pricing Project of the health plan for state employees paid providers an average of 177 percent of Medicare rates in 2020 (State Employees Association of North Carolina, n.d.), but major hospital systems did not join the network, leaving them untouched by price reductions (Havlak, 2019). Recent rulemaking for the federal No Surprises Act that aimed to reduce out-of-network payments and consumer cost sharing for surprise medical billing has faced several lawsuits from provider organizations (Keith, 2022).

On the other hand, rate setting can provide financial stability to providers. For example, hospitals in Maryland’s all-payer rate-setting system were financially stable and received higher Medicare and Medicaid payments under the waiver than they would have otherwise (Murray & Berenson, 2015).

Rate regulation can affect both access to care—by affecting the financial viability of providers and the volume of services they are willing to provide—and the amount that providers invest in quality improvements. Possible consequences of rate regulation could include providing too few or too many health care services. If rates and provider participation are too low, fewer services could be available in underserved or rural areas; allowing higher rates could be a safeguard against such adverse effects. State agencies tasked with controlling rate regulation could monitor health care access and quality to assess and adjust rates or caps as necessary.

Another possibility is that providers could increase volume to make up for low rates, which could partially or fully offset any cost decreases associated with lower prices. For example, research has found that, before Maryland implemented global budgets and introduced the Total Cost of Care Model, its all-payer rate-setting program reduced prices per hospital admission and kept cost growth below the national average—but the volume of hospital admissions and services grew faster than the national average when volume adjustments were not in place (Murray, 2009; Murray & Berenson, 2015).

## Global Budgets

Global budgets limit spending for a defined population or set of services over a specific period of time (Health Care Transformation Task Force, n.d.; Pany et al., 2022). Providers or other entities responsible for managing the global budget (such as an ACO) are typically provided a fixed budget amount each year. The approach focuses on total spending, addressing both price and volume, and makes costs and revenue predictable for both payers and providers. It also breaks the link between providing services and getting paid, thus rewarding providers for efficiency. Global budgets are typically paired with quality performance incentives and other guardrails to encourage the provision of high-quality care and account for population changes (Health Care Transformation Task Force, n.d.).

## *What States Are Doing*

In the United States, the most prominent global budget approach is the Maryland Total Cost of Care Model, in which each hospital has a fixed annual budget. A variety of additional reforms include payment incentives to promote quality of care among nonhospital providers and additional hospital payment adjustments based on total costs of care (Machta et al., 2021). Maryland's current model evolved out of a series of reforms dating back to the hospital all-payer rate-setting approach that it initiated in the 1970s. Under rate setting, the state wrestled with controlling volume and avoiding upward pressure on costs. To address this concern, the state moved to a global budgeting approach for rural hospitals in 2010 and expanded the approach to all hospitals in 2014. The current Total Cost of Care Model began in 2019 and retains the hospital global budgeting approach initiated in 2014 alongside additional reforms.

Under the current global budgeting approach in Maryland, the Health Services Cost Review Commission sets a target budget for each hospital based on historical volume, quality performance, and other factors. Hospitals then charge payers all-payer rates, adjusting prices up or down over time to meet the target budget (Rotter et al., 2022). Currently, per capita growth in hospital spending is set at 3.58 percent annually (Maryland Health Services Cost Review Commission, n.d.). Evaluations of the model have suggested that it reduces hospital utilization and spending (Rotter et al., 2022), but there is less evidence that it has reduced total health spending in the state (Morrison et al., 2021), partly due to increased nonhospital health care spending.

Another example of a global budgeting approach is the Pennsylvania Rural Health Model, which offers participating hospitals a fixed payment for all inpatient and outpatient services based on historical revenue and other adjustments. The model is voluntary, and uptake to date has been relatively low; five of sixty-seven eligible participants joined in the first year of the model (2019), growing to thirteen in the following year and eighteen in 2023 (Centers for Medicare & Medicaid Services, n.d.; Knudson, 2022). Participating hospitals had tended to experience declining financial performance in the period before employing the model, perhaps making fixed payments an attractive source of stability for them. The impact of the model on total spending and utilization has not yet been evaluated.

Additionally, in 2012, Oregon initiated global budgeting through its Medicaid program (Oregon Health Authority, 2018). Under Oregon's approach, networks of providers and community members, known as coordinated care organizations, take responsibility for managing enrollee spending and ensuring quality (Oregon Health Authority, n.d.). These organizations bear full financial responsibility for the total cost of patient care, and one study found that they led to reduced spending (McConnell et al., 2017).

Coordinated care organizations are similar to ACOs, which are groups of providers that voluntarily join together to share responsibility for providing high-quality care to patients (KFF, 2018). ACOs usually have a target spending goal and may share in both savings and losses if spending diverges from the target. Since the ACA was passed, the Centers for Medicare & Medicaid Services has tested a range of ACO models that have varied depending on share of risk that they take on, the extent to which payments are adjusted to reflect quality of care, and the maximum gain or loss they are allowed to incur. In the state-partnered Vermont All-Payer ACO Model, ACOs take on risk that varies from 30 to 100 percent, depending on the payer, with savings and losses capped at 4 to 6 percent of the anticipated total cost of



care for attributed beneficiaries. Unlike global budgets, ACOs typically do not put providers at full risk for all losses if spending exceeds the target, although ACOs may take on 100 percent of risks up to a cap. To date, provider participation in ACO models has also been voluntary.

## *Key Design Considerations*

The impact of global budgeting approaches depends critically on the range of services included in the budget. Key considerations include the scope of the global budget, enforcement mechanisms, and the process for setting the budget amount.

Some countries apply the budget to the entire health system. In the US, it is more common to limit the global budget to a specific population, such as to Medicaid beneficiaries, or to a specific set of providers, such as hospitals. Limiting the scope of the global budget limits the impact on health spending and can lead to offsetting spillover effects for services that are not included in the budget. In Maryland, for example, nonhospital spending has risen in parallel with declines in hospital spending.

Another key consideration is how adherence to the budget is enforced. In many cases, providers (such as hospitals) or entities in charge of managing the budget (such as coordinated care organizations) are given a fixed budget and assume the risk for any spending above this amount. However, some payment arrangements could involve variations on this approach. For example, ACOs are related to global budgets but do not typically take on full risk for spending in excess of the target budget. Capping providers' financial loss, as is done under the ACO approach, may be necessary to encourage participation and to ensure that global budgets do not adversely affect small or rural providers with limited ability to manage financial risk.

A third consideration relates to how the budget is determined. Often, it is based on past spending patterns for a given population or facility. However, that approach risks penalizing providers that have historically provided care efficiently by offering them a lower total amount than less efficient providers. Budget amounts may also be adjusted to allow for market and population changes or to reward providers with high-quality ratings (Health Care Transformation Task Force, n.d.).

## *Challenges and Unintended Consequences*

Because providers or accountable entities make a profit if their total costs fall below the global budget, there could be an incentive to stint on needed care, turn away high-risk patients, or cut corners in other ways that are detrimental to patients. Global budgeting is often coupled with incentives to improve quality as well as risk adjustment to ensure that providers are adequately compensated for high-risk patients. While most studies show that quality of care has remained stable or improved under global budgeting approaches (Cattel & Eijkenaar, 2020; Rotter et al., 2022), some have raised concerns that there could be adverse consequences for outcomes that are not explicitly measured (Mullen et al., 2010). It is also possible that providers or other accountable entities may game risk-adjustment procedures by aggressively recording as many diagnoses as possible to enhance their remuneration (Geruso & Layton, 2020; Meyers & Trivedi, 2021).

## Spending Growth Targets

Spending growth targets are closely related to global budgets and aim to cap total state spending at a specific percentage growth rate each year. As implemented in the US, spending growth targets have tended to take a broader lens than global budgeting approaches, generally encompassing all health spending in a state (as opposed to spending for specific providers or payers). Relative to global budgeting, spending growth targets tend to have fewer and less-powerful levers available to hold providers accountable should spending growth exceed the target. However, these options exist on the same continuum—a global budget can be viewed as an extreme version of a spending growth target, in which providers or other accountable entities take on substantial risk if the target is exceeded.

### *What States Are Doing*

Massachusetts implemented the first spending growth target in the country in 2012. Under the Massachusetts approach, the Health Policy Commission (HPC) sets growth targets for total health care expenditures in the state, monitors spending growth relative to these benchmarks, and can implement performance improvement plans (PIPs) if providers or payers fall short of expectations (Massachusetts Health Policy Commission, 2022). A sister agency, the Center for Health Information and Analysis, collects data on health spending and shares a role in monitoring performance.

The Center's most recent annual report indicates that state spending exceeded benchmark growth rates in five out of nine years (Center for Health Information and Analysis, 2023). However, annual per-person health care growth in Massachusetts fell below the national average after the state implemented the total health care expenditure model. The HPC estimated that the state would have spent an additional \$7.2 billion on health care between 2013 and 2018 if growth had trended at the US average (Massachusetts Health Policy Commission, 2020).

One factor in Massachusetts's mixed performance in meeting the proposed benchmarks is that the HPC did not exercise its authority to put providers and payers on PIPs until 2022 and even then required a PIP of only one institution, Mass General Brigham (Lipson et al., 2022). Although providers that fail to demonstrate improvement after being put on a PIP can be subject to fines, the limited experience to date makes it difficult to gauge whether the HPC will follow through with imposing penalties. A 2022 study concluded that the limited use of PIPs has led some stakeholders to “minimize or dismiss the importance of PIP reviews” (Lipson et al., 2022). Because Mass General is a large institution, its experience with the PIP—and any related fines that may be imposed—may influence how other providers respond to this process in the future.

Several other states, including Delaware, Oregon, Rhode Island, and Washington, have also implemented spending growth targets, and California is in the process of doing so. Because these programs are more recent, less data are available to gauge their effects. Annual reports from both Delaware and Rhode Island found that the states failed to achieve benchmark growth targets in 2019, the first year their programs were in effect (Delaware Health Care Commission, n.d.-a; Rhode Island Executive Office of Health and Human Services, 2022). However, even without achieving benchmarks, the reforms may have slowed growth relative to what otherwise might have occurred. While both states achieved spending targets in 2020, the impacts of COVID-19 make it difficult to draw conclusions for that year (Delaware Health Care

Commission, n.d.-b; Rhode Island Executive Office of Health and Human Services, 2022). In addition to the large and unexpected changes in health care utilization spurred by the pandemic, Rhode Island noted that it was unable to include federal spending related to COVID-19 (a large fraction of total COVID-19 spending) in its analysis.

Oregon and Washington set initial spending growth targets for 2021 and 2022, respectively. While it is still too early to evaluate their performance, these states have already faced some challenges in holding providers accountable. For example, in January 2023, Oregon's Cost Growth Target Advisory Committee opted to delay holding providers accountable for one year, with PIPs now taking effect in 2025 (Oregon Health Authority, 2023). Penalties will not be levied until 2027.

## *Key Design Considerations*

Key design considerations for implementing spending growth targets include determining what spending is included in the target, setting growth rates, and holding providers and payers accountable for meeting targets.

Developing a spending growth target requires determining which types of health care costs should be considered. Vision, dental, and long-term nursing home care, for example, are not covered by many health insurance plans (including traditional Medicare) and could potentially be excluded from a health spending target. Washington state explicitly includes long-term care spending in its benchmark (Health Care Cost Transparency Board, 2020), while Oregon does not (Health Planning, n.d.). Policymakers would also need to determine whether and how to account for care provided to state residents by out-of-state providers and care for nonresidents provided within the state. Other nuances include whether and how to account for spending on health promotion, such as public health campaigns, and whether to include incentive payments to improve health care quality or encourage healthy behaviors.

In addition to determining scope, policymakers would need to determine how to set target growth rates. States have used various approaches, including delegating authority to an independent commission, as in Massachusetts, or setting up a steering committee, as in Oregon. In many cases, states set different targets over time. For example, in Washington state, the benchmark growth rate was 3.2 percent for 2022 and 2023 but will fall to 2.8 percent in 2026. While states have typically set an overall growth rate for all spending in the state, it would be possible to set additional targets by provider type or line of service, an approach that could be useful if technological change, supply constraints, or other factors influenced expectations about growth across various parts of the economy.

Another consideration relates to the process for holding payers and providers accountable if targets are not met. While states commonly have the authority to put providers or payers on PIPs, to date there is little experience with enforcing this approach. In some cases, the consequences of failing to comply with a PIP may be relatively weak. For example, in Massachusetts, the maximum fine for noncompliance with a PIP is \$500,000, which may not give the state significant leverage with large providers or health plans.

States may also publicly post information about underperforming organizations, but it is unclear whether this would significantly reduce demand for these providers. In Massachusetts, the HPC also has the ability to review changes in market structure, such as mergers and acquisitions, and refer findings to other state agencies (Massachusetts Health Policy Commission, n.d.), a process that could influence antitrust regulation and enforcement.

## *Challenges and Unintended Consequences*

States may have limited ability or willingness to hold providers and payers accountable for complying with spending targets, which may reduce the impact of this policy approach. The political power of hospitals and provider organizations, which are often among the largest employers in a state, could affect policymakers' willingness to enforce accountability. If states do act aggressively to enforce the target, concerns similar to those described under global budgets could arise. Specifically, without strong monitoring systems in place, quality and access could be affected if providers attempt to meet growth targets by reducing needed care.

Furthermore, some types of spending are largely outside the control of state actors—for example, evaluators analyzing cost trends in both Rhode Island and Massachusetts noted that rising drug costs could threaten the state's ability to control health care costs (Lipson et al., 2022; Rhode Island Office of the Health Insurance Commissioner & Rhode Island Executive Office of Health and Human Services, 2020). Spending targets may also be costly to administer, given the need to set target amounts, monitor progress, and enforce compliance (Frist & Hamburg, 2023).

For small states or states with large populations near state borders, care provided out of state may present a challenge to achieving the desired benchmark. For example, the Vermont All-Payer ACO Model originally aimed to enroll most Vermonters in an ACO that would be responsible for meeting a statewide total cost-of-care benchmark. However, the Centers for Medicare & Medicaid Services later determined that the original targets were unattainable because a large share of residents received primary care outside the state (Loganathan, 2022).

## Public Option

Public option has been used to describe a range of public health insurance plans that are offered or regulated by the government and compete with private insurance. A goal is to create a more affordable option for consumers, often by using regulation to achieve lower payments and premiums. Since the implementation of the ACA, proposals have typically focused on offering public option plans on the individual or small group marketplaces. Although earlier proposals involved plans that would be administered by the government, recent initiatives have also included approaches in which state governments contract with private carriers to offer plans, subject to various regulations.

## *What States Are Doing*

Three states are implementing or are in the process of implementing state-based public options plans (Monahan et al., 2022a):

- The State of Washington has contracted with private carriers to offer public option plans on the individual marketplace since 2021.
- Colorado is contracting with private carriers that already offer plans on the individual and small group markets to add a public option plan starting in 2023.
- Nevada will contract with private carriers and managed care organizations to offer public option plans starting in 2026.

As of 2021, 16 other states were considering legislation that would establish public option plans (Carlton et al., 2021).

Washington was the first state to introduce a public option, with plans available starting in 2021. Under Washington’s approach, the state contracts with private insurance carriers through a bidding process and requires that provider payment rates be capped at 160 percent of Medicare rates, that primary care payments be at least 135 percent of Medicare rates, and that rural hospital payment rates be at least 101 percent of Medicare rates (Individual Health Insurance Market—Standardized and State-Procured Plans, 2019). Although several insurance carriers offered a public option plan in the first year, the public option was offered in only some counties, and many providers opted not to participate, resulting in inadequate provider networks (Monahan & O’Brien, 2023). Additional legislation was passed to require participation by hospitals that participate in other state programs if public option plans were not available in all counties in 2022. For the 2023 plan year, public option plans are offered in thirty-four of thirty-nine counties, providing access to 98 percent of marketplace enrollees (Washington State Health Care Authority, 2022).

In Colorado, public option plans were available for the first time in 2023 (Monahan et al., 2022b). The Colorado public option pays hospitals a base rate equal to 155 percent of Medicare rates, with increases for independent hospitals (20 percent), critical access hospitals (20 percent), those with a high share of Medicare and Medicaid patients (up to 30 percent), and those managing underlying cost of care (up to 40 percent); other providers have a rate floor of 135 percent of Medicare rates (Colorado Department of Regulatory Agencies Division of Insurance, n.d., 2020). Colorado law mandates that insurance carriers offer the public option in every county where they offer an individual or small group market plan. As such, public option plans are available in all counties in Colorado in 2023 (Monahan & O’Brien, 2023). If insurance carriers in Colorado cannot meet requirements for provider network adequacy and premium reduction targets, then public hearings will be held in 2024, and the state can set rates and require providers to participate.

Finally, Nevada has enacted legislation that will introduce public option plans in 2026 through contracts with private insurers. Nevada requires that Medicaid managed care organizations participate in the bidding process to offer a public option plan and that providers participating in Medicaid or other state plans contract with at least one public option plan. Nevada does not set rates or caps for the public option but requires that the contracted insurers pay rates that are “in the aggregate, comparable or better than reimbursement rates available under Medicare” (S.B. 420, 2021).

## *Key Design Considerations*

State policymakers considering the design of a public option would need to make decisions that affect the scope and impact of the public option. Key considerations include which entities administer the plan, requirements for provider participation, and provider payment levels.

One key consideration is whether the government would administer the public option plan or contract with private insurance carriers to do so. While federal proposals for a public option have typically called for the government to directly administer a public option plan, the three state public option plans currently in effect are all administered by private insurance carriers. Government administration may

allow for lower administrative costs, but states may not have the infrastructure and finances to manage plans on their own. Where contracted carriers are involved, the government would need to consider the procurement process and whether to mandate participation by carriers already in the marketplaces. The current state public options take different approaches in how they select carriers. Washington, for example, uses a bidding process, while Colorado requires all carriers offering plans on the marketplaces to also offer a public option (Monahan & O'Brien, 2023).

Achieving adequate provider networks has been a key challenge for the three existing state public option plans. Each state has approached this differently. After Washington's experience in the first year of its public option program, when provider networks were inadequate, Washington augmented its approach to require providers participating in other state programs to offer at least one public option plan. Colorado's legislation allows for mandatory provider participation if certain premium reduction targets are not met, beginning in 2024. Nevada requires providers to contract with at least one public option plan if they participate in Medicaid.<sup>1</sup>

Like rate regulation more broadly, a key consideration for the public option is whether to set or cap prices or cap price growth. This decision would involve trading off lower rates with the challenges of ensuring provider participation in the plan.

## *Challenges and Unintended Consequences*

The extent to which a public option can reduce payment rates determines its impact on health care costs and affordability. Researchers have suggested that the three existing state public options may be too modest in rate controls to achieve substantial change (Fuse Brown et al., 2021; King et al., 2021).

The trade-off for more substantial rate controls is provider opposition and willingness to participate in the public option. A key challenge for state public option approaches is to ensure that enough providers participate while making the plan affordable by constraining reimbursement rates. As noted, early experiences in Colorado and Washington suggest that states may need to require participation among certain providers to navigate this trade-off.

Both a government-administered public option and a government-regulated public option with contracted carriers would require new state administrative activities and costs. Furthermore, for a state to administer a traditional government-sponsored public option, substantial infrastructure and finances would be needed to process claims and pay providers.

One unintended consequence is that public option plans may affect the calculation of premium tax credits available to individuals below a given income threshold through the ACA (as amended by the American Rescue Plan Act of 2021 and Inflation Reduction Act of 2022). A state would need a federal waiver

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<sup>1</sup>Nevada's approach is similar to some federal public option proposals that require providers participating in Medicare to also accept the public option; however, state governments have less leverage with excluding providers from Medicaid compared to the federal government, which can exclude providers from Medicare.

to recoup federal funds for the tax credits that would have been provided to the state in the absence of the public option. These tax credits are based on the premium of the second lowest-cost silver plan available on the individual marketplace, which could decrease if the public option plan has a relatively low premium, as intended.

## Considerations for State and Federal Policymakers

Table 2 shows the four types of regulation discussed in this paper and compares them based on their key design considerations, challenges, and opportunities. These approaches sometimes overlap with one another, and states may combine multiple approaches. For example, Maryland's Total Cost of Care Model includes rate regulation, global budgets, and spending growth targets, among other requirements. Public option plans typically incorporate some form of rate regulation.

Most critically, the extent to which these regulations can contain health care costs hinges on the scope of the policies, how well they are enforced, and whether they lead to unintended spillovers, such as volume increases. All of these regulations would entail administrative expenses for the state to design, implement, and monitor. An additional concern relates to how payers and providers respond to the regulation and whether there could be longer-term effects with adverse consequences for patients, such as providers exiting the market or reducing investments in quality improvement. Although there have been successful examples of state regulation, most of the evidence comes from only two states—Maryland and Massachusetts. Both have long and unique histories with health care reform that may make their experiences less generalizable to other states.



Table 2. Types of Regulation for Reducing Health Care Costs

	Description	Key design considerations	Challenges and opportunities
<b>Rate regulation</b>	Setting rates, capping rates, or capping rate growth	<ul style="list-style-type: none"> <li>Type of regulation</li> <li>How to establish the rate or cap</li> <li>Scope of the regulation (i.e., what payers, providers, network status, and geography are covered)</li> </ul>	<ul style="list-style-type: none"> <li>Reduces price per service</li> <li>Can reduce spending if there is attention to volume</li> <li>Provider group opposition</li> <li>Ensuring provider participation and network adequacy</li> <li>Could under provide services if rates are too low</li> <li>Could reduce investments in quality improvement</li> </ul>
<b>Global budgets</b>	Paying providers or accountable entities a fixed amount for a defined population or set of services	<ul style="list-style-type: none"> <li>What is included in the budget</li> <li>How is the budget set</li> <li>How the budget changes overtime</li> </ul>	<ul style="list-style-type: none"> <li>Can lead to declines in spending on services included in the budget</li> <li>Avoiding cost increases in services not subject to the budget</li> <li>Ensuring quality and maintaining access</li> </ul>
<b>Spending growth target</b>	Setting a target for total health spending growth for a defined group, such as all state residents	<ul style="list-style-type: none"> <li>How to set the target growthrate</li> <li>What services are included in the denominator</li> </ul>	<ul style="list-style-type: none"> <li>Potential to slow spending growth across the health sector</li> <li>Holding providers and payers accountable for meeting the benchmark</li> <li>Administrative costs associated with setting targets, monitoring performance, and enforcing compliance</li> </ul>
<b>Public option</b>	A health plan offered or regulated by the government with a goal of creating a more affordable option	<ul style="list-style-type: none"> <li>How the plan would be administered by the government or contracted private insurance carriers</li> <li>Requirements for provider participation</li> <li>Provider payment levels</li> </ul>	<ul style="list-style-type: none"> <li>Can create a more affordable insurance option for consumers</li> <li>For states that contract with private insurance carriers, ensuring plans are offered</li> <li>Ensuring provider participation and network adequacy</li> <li>For state-administered plans, infrastructure and finances needed to process claims and pay providers</li> <li>Federal waivers needed to recoup funds for ACA taxcredits</li> </ul>



Price and spending reductions can be achieved directly through regulation or indirectly through policies that promote competition, such as those that improve market conditions or increase price transparency to encourage consumer price shopping. Regulation could potentially achieve substantial savings but would need to be weighed against potential adverse effects, including decreased access to care and provider supply and erosion of provider investments in quality. Regulation also tends to be viewed as a relatively draconian approach and, as such, tends to face staunch political opposition, particularly from provider groups. Policy options that would increase price transparency and market competition might face fewer political challenges and could lower prices without necessarily reducing quality of care, but the extent to which these policies achieve savings may be limited. For example, provider and insurer markets are already extremely consolidated, and antitrust strategies to promote competition typically cannot undo consolidation that has already occurred. Furthermore, evaluations of price transparency strategies have found that consumer use of price comparison tools tends to be low (Benavidez & Frakt, 2019).

Regulation and competition are not mutually exclusive strategies (Berenson & Murray, 2022). For example, some proposals would apply rate regulation only in areas with high levels of market concentration, including rural areas where natural monopolies may arise (Frist & Hamburg, 2023). Policies to cap prices or price growth would allow market forces to determine prices below the cap, where competition would continue to play a role. Finally, even where rates are regulated, enhancing market competition may increase the incentive of providers to improve quality of care and thereby attract patients.

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## State Approaches to Infrastructure Building for Controlling Healthcare Costs

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### Introduction

Health care accounts for nearly 20 percent of the US gross domestic product, and hospital costs represent approximately 40 percent of US health care spending (Centers for Medicare & Medicaid Services, 2023). Rising health care costs are an economic issue facing both the public sector and the private sector. State governments are positioned to understand the key economic conditions and the impact of increasing health care costs on the residents they serve.

State policymakers approach the challenge of health costs as purchasers and regulators, which includes assuming responsibility for protecting consumers against unfair trade and insurance practices. State leadership develops the economic agendas, budgets, and tax and health care policies that affect the willingness and ability of residents, businesses, and employers to participate in their state economies. Executive and legislative leaders are directly accountable to their state residents through the political process and hold considerable authority in the process of designing programs and strategies to address health care costs.

Through its Hospital and Health System Costs Center, the National Academy for State Health Policy (NASHP) works with state officials who have multiple and diverse responsibilities and differing perspectives, all of which cannot be represented in a single paper. In this paper, we explore four foundational efforts that some states are using to build an infrastructure that provides information and can support efforts to respond to rising health care costs. Essentially, these infrastructure options are platforms for further policy development and state action. States may pair these options with policies that directly address cost containment and competition:

- All-payer claims databases (APCDs) allow states to collect payers' health claim information to compare and report the prices of services by provider and health plan across the state over time. The information from APCDs may be used to help states regulate prices and provider and payer competition.
- Hospital and health system financial reporting includes collecting and analyzing diverse key financial indicators of hospital and health system performance that can be tied to market competitiveness and prices in the state. Financial reporting can provide states with data critical to regulating market competition and help inform how it will affect hospital performance.
- Health care cost oversight offices can bring a market-wide view to bear by employing policy officials that can use available data on health care costs and recommend multiple strands of policymaking to regulate prices or competition.

- Cost growth benchmarks/targets seek to limit the statewide growth of per capita health spending and importantly use data to identify the cost drivers within a particular year. Most states using these programs engage health care market participants that include payers, providers, and patient representatives within steering committees or boards to collaborate with the state in providing oversight of the market, ensuring that multiple perspectives are considered in cost containment strategies.

Multiple considerations inform state approaches to infrastructure design, including leadership and capacity to achieve specific goals, political will to invest limited resources, and industry and market considerations. Some states use the approaches outlined in this paper, while others use alternative structures and strategies to address rising health care costs and encourage competition. Regardless of policy choices made by states to control health care costs, infrastructure and the capacity to use data to inform action are fundamental considerations.

## All-Payer Claims Database

An All-Payer Claims Database (APCD) collects health care claims data and encounter data from public payers, including Medicare, Medicaid, state employee health plans, and some private payers. As a result of *Gobeille v. Liberty Mutual Insurance Company* (APCD Council, n.d.), self-insured employer health plans are not required to submit data to a state's APCD. Although some do voluntarily, these data do not represent all claims. APCDs can be used to compare prices, patterns and types of services, and utilization longitudinally as well as to support competition and spending regulation policies.

### *Facilitating Cost Containment or Competition*

An APCD is one of the few tools a state can use to track cost and prices paid by payers at a detailed level across individual health providers, including hospitals and health systems.

- **Promoting Competition.** For states with authority to review and approve provider market changes, APCDs can provide a window into current price and utilization patterns. Such data can help determine the appropriateness of a proposed market transaction (e.g., a hospital acquisition of a physician practice) or to condition approval of a transaction by limiting price increases or improving service delivery (National Academy for State Health Policy, 2020b). APCDs can map service patterns across the state to determine geographic areas in which to promote competition in service utilization or to determine the potential loss of services based on market activities (e.g., loss of services after a transaction). Even states without market transaction authority can use APCDs to compare prices pre- and post-transaction and to analyze service utilization over time to determine the impact of consolidation.
- **Facilitating Price or Spending Regulation.** States can use price information in APCDs to establish out-of-network payment caps, to limit price increases, or to adopt a reference-based pricing payment model (Chernew et al., 2019; National Academy for



State Health Policy, 2022c; Rakotoniaina, 2023). APCD data are often used in states with cost-growth benchmark/target programs as a companion to benchmark data collection to identify specific cost drivers in states (Sales et al., 2021).

## *Key Design Considerations*

- **Purposes of an APCD.** Is the purpose of the database to help patients shop for care? To inform employers about provider prices? Provide data for researchers? Drive competition? Promote efficiency and quality? The purposes will drive the remaining key considerations.
- **Housing an APCD.** States house APCDs in different entities with varying regulatory authority over the collection and use of APCD data (McAvey, 2022). A state may consider housing an APCD in a health care oversight entity with the regulatory authority to act or to recommend policy. Alternatively, a state may house an APCD in a statewide data organization.
- **Data Governance and Scope.** States can create an advisory body of industry and other agency data experts to assist the APCD. However, the state will likely want to preserve its authority to design data collection parameters, determine appropriate releases of APCD data for policymaking and research, develop tools to use the data, and suggest analyses. APCDs abide by data security, federal and state data privacy, and data-sharing regulations.
- **APCD Funding.** States must consider how to fund resource-intensive APCDs. Options include direct appropriations, industry assessments, or other vehicles, recognizing that they require both initial and sustained support.

## *Challenges*

- **Absence of Self-Funded Data.** In some states, self-funded market enrollment far exceeds fully insured market enrollment, possibly representing as many as 65 percent of employees in the state (KFF, 2022). States can encourage employers to submit self-funded data to an APCD and may be able to leverage employers' interest in comparing data because of their obligations under the Consolidated Appropriations Act, 2021 (Corlette et al., 2022). However, there is a continued challenge of collecting data from such a large share of health care markets in states.
- **Industry Challenges.** States may want to guarantee support from health plans and providers to ensure a robust APCD that reaches its full potential. However, plans and providers may object to an APCD because of existing cost growth benchmark reporting or federal price transparency regulations, although neither dataset is the same as APCD data. States may also face national insurer opposition because of inconsistent collection criteria across states.

- **Late or Missing Data.** While APCD data are nearly current in many states, Medicare data often lag by a year, and APCDs do not have data for uninsured patients because they do not generate claims.
- **Sharing Data for State Policy.** States may consider how APCD data can be shared across agencies or within an overarching policy agency to inform cost containment and competition policies.

## *State Experiences*

As of June 2022, 18 states (Arkansas, Colorado, Connecticut, Delaware, Florida, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Vermont, Virginia, and Washington) and Washington, DC, operate APCDs. Another eight states are considering developing APCDs or are actively doing so (McAvey, 2022).

The work in Maine is noteworthy. The Maine Health Data Organization started collecting claims data in 2003, and its robust dataset promotes transparency and is used to inform policy. Its APCD includes claims data from commercial insurers, third-party administrators, pharmacy benefit administrators, dental benefit administrators, MaineCare (Medicaid), and Medicare. The Maine Health Data Organization creates online public dashboards and makes datasets available upon request as well as provides reports to the public and to the legislature (Maine Health Data Organization, n.d.). The Maine Health Data Organization and the Maine Quality Forum developed a publicly accessible website, CompareMaine (<https://www.comparemaine.org>), that uses APCD data to allow residents, employers, and stakeholders to compare the average dollar amounts paid for health care at different facilities across the state. Employers can use these data to exert influence in contract negotiations with health plans.

## Hospital and Health Systems Financial Reporting

To lower health care costs while maintaining access to care, policymakers need to balance patient price management with supporting the overall financial health of hospitals and health systems. However, many state policymakers are challenged to understand the true financial status of hospitals and health systems in their states (Whaley et al., 2023). In addition to payments for patient care, hospitals have multiple revenue sources that include supplemental federal funds, state and municipal bonding, the 340B Drug Pricing Program, hospital-owned businesses, stock market investments, and more (National Academy for State Health Policy, 2022a). APCDs provide insights on patient prices from fully insured health plans but do not have hospital or system data on their profits, losses, and so on.

Hospitals and health systems are required to report different financial information for different purposes to different interested parties, creating a mix of available data representing different time periods. For instance, while federally required Medicare cost reports provide information on hospital expenses and revenues, some states also collect detailed audited financial statements of hospitals and health systems to gather more timely data and detailed measures of liquidity, profitability, and solvency. Because audited financial statements include data on hospital-owned providers and businesses, they can be used to understand a consolidated system's holdings, which is essential to inform competitive policies and evaluate pricing regulation on operating and total margins. Additionally, quarterly municipal bond

reporting provides another lens on hospital and system financials that includes the timeliest data on their investments. Collecting and analyzing information from these reports provides a true financial picture, allowing the performance of individual hospitals in a state to be compared and providing data on the fiscal relationships with a parent hospital system.

## *Facilitating Cost Containment or Competition*

Collecting hospital and health system data is the first step, but states that support analytic staff with responsibility for tracking trends over time create an infrastructure to inform effective cost containment policies. A growing number of states have taken steps to use hospital and health system data to launch new policies intended to lower health system costs.

- **Transparency.** Making accurate and uniform financial data collection from hospitals and health systems transparent through public reporting is the first step in using the data to promote competition or inform cost containment policy.
- **Facilitating Competition via Market Review.** States that have paired transparency with data analytics better understand their health market and can target policy. For instance, many states are not alerted to provider mergers, but audited financials or bond reports will disclose a hospital or health system's acquisition of a provider office. A state can then use APCD data to assess the potential cost, price, and service impacts of horizontal and vertical acquisitions (National Academy for State Health Policy, 2020b). If the data suggest that this type of consolidation increased patient costs or resulted in the loss of needed services, states can adopt or change their certificate of need programs or may consider pursuing increased authority over mergers and acquisitions. Passing legislation is challenging without such evidence.
- **Understanding Pro-competitive Legislation.** States can use hospital financial data, especially multiyear trend information, to determine the potential impact of pro-competitive legislation. State legislatures are increasingly considering banning anti-competitive contracting terms between hospitals and health plans so that plans can guide patients to high-quality but lowercost providers—something current contracts may not permit (National Academy for State Health Policy, 2021b, 2022b, 2023). There is also interest at the state and federal level in banning facility fees or moving to site-neutral payments that would minimize the opportunity for hospitals to add their fees to outpatient treatments at provider offices they have acquired (National Academy for State Health Policy, 2020c). In considering such strategies, policymakers benefit from analyses of a hospital's financial data to ensure that hospitals can participate in cost containment efforts without sacrificing access to necessary care services.
- **Facilitating Price or Spending Regulation.** By combining hospital financial data with APCD data, states can monitor the historical impact of price increases on a hospital's financial performance. What is the connection between a hospital's profit margin and its price increases? Are the hospital's costs of providing services driving the price increase, or is it something else, such as acquiring external providers or new real estate for an expansion or countering stock market losses? This type of analysis

can allow a state to assess how potential price restrictions, such as capping out-of-network payments or adopting reference-based pricing, could impact the solvency of the hospital (National Academy for State Health Policy, 2022c; Rakotoniaina, 2023). Will setting reimbursement at a multiple of Medicare that is lower than the hospital's current price but higher than its costs impact its ability to provide existing services? States can also use detailed financial data to design, implement, and assess the impact of a global budget as a strategy for predictable spending and improved quality (National Academy for State Health Policy, 2020b).

## *Key Design Considerations*

- **Housing Data Collection.** In some states, hospital and health system financial reporting resides in an overarching health policy agency or data agency established under legislative authority. In other states, state Medicaid agencies may gather limited hospital financial data to determine hospital supplemental payments or other Medicaid payments.
- **Scope of Data Collection.** States will need to answer questions about the data they collect, such as what and how much data should be collected, and are the data already being reported and to whom, via what source—tax filings, audited financials, or something else? Working with state officials and national hospital financial experts, NASHP designed a reporting template to leverage existing hospital reporting that captures data in an organized way (National Academy for State Health Policy, 2020a).
- **Scope of Reporting and Release.** States can decide whether and how to share their data publicly and how to protect confidentiality. Data can be shared through a portal on an agency website, a detailed report, or by other means.
- **Funding.** States may need to consider budgetary support for collecting, managing, and analyzing financial data. To date, states fund their transparency efforts differently, including through industry assessments, direct appropriations, grants, and other mechanisms.

## *Challenges*

- **Expertise.** One of the challenges of hospital financial reporting may be expertise deficits in state agencies. States considering data collection may need to avoid an imbalance in expertise to prevent challenges to adopting policies based on financial data.
- **Data Errors.** Depending on the scope and how the data are being collected, there may be errors in financial reporting, missing data, and accounting inconsistencies.
- **Data Lags.** Hospital data often lag—state, federal and hospital fiscal years may not align, and the completion of end-of-year filings across different data sources often takes up to six months after a fiscal year ends. (Medicare cost reports lag even further.) Such data lags can hinder policy changes.

## *State Experiences*

As of 2020, at least 14 states required some level of hospital financial data reporting: Arizona, California, Colorado, Connecticut, Florida, Georgia, Indiana, Maine, Maryland, Massachusetts, Missouri, New Jersey, Oregon, and Washington. The data reporting varied widely from state to state, with some states gathering detailed data to inform state health system cost containment policies and others geared solely toward public transparency (Hensley-Quinn et al., 2020). States that want to leverage hospital financial reporting have invested in staff capacity to regularly review reports both to ensure accuracy and to analyze financial trends over time. Further, pairing an understanding of hospital financial trends with APCD price data provides a more complete picture of the state's hospital market. Together, these data can inform state policymakers about the effect of providing patient care as well as external financial pressures (e.g., stock market performance and inflation) that influence overall health care spending.

Using detailed hospital financial reporting, researchers found that major financial losses that hospitals incurred in 2022 were tied to declines in stock market investments and not from providing patient care. States that collect financial data drew similar conclusions that are vital to policymakers as they consider policies to contain hospital spending growth and pro-competitive policies (Whaley et al., 2023).

The experience in Oregon illustrates some of these issues. Under legislative mandate, the Oregon Health Authority includes an office of data and statistics that, among other data, collects hospital financial information, pairs them with the state's APCD, and shares easy-to-read hospital profiles, payment reports, capital project reports, and hospital financial and utilization quarterly summaries on its website. Financial and utilization dashboards keep the public and policymakers up to date on hospital performance (Oregon Health Authority Office of Health Analytics, n.d.). Using these reports, Oregon documented an annual average rise in state health spending of 6.5 percent per person from 2013 to 2017, compared to a 4.5 percent annual increase nationwide. This discrepancy between federal- and state-level costs catalyzed Oregon to develop cost containment strategies, including adopting a cost growth target and Medicare reference-based pricing for its state employee health plans (National Academy for State Health Policy, 2021a; Rakotoniaina, 2023).

## Health Care Cost Oversight Offices

Ensuring comprehensive, affordable health care demands a complicated balance between addressing high costs that continue to rise and maintaining access to health care services. Some states are approaching this challenge with targeted policies aimed at increasing competition, such as prohibiting anti-competitive contracting, and are leveraging existing authorities in their insurance departments. Other states are seeking a more holistic statewide approach and are establishing offices to build a broader infrastructure that can coordinate across existing health care agencies (e.g., the state's department of insurance, Medicaid, the state's employee health plan, and the APCD) and advise and implement policies.

Several states have passed legislation to empower an existing state agency/health care authority or to create a new office with statutory authority to directly monitor, report on, and oversee health care spending and recommend cost containment policies. Most states with a health care cost oversight office are cognizant of the overall health care market in their states and can directly implement policymaking on cost containment and competition. While the scope of these agencies varies, they are well positioned to

achieve state goals of cost containment while improving quality of care and addressing inequities across their health care delivery systems. For instance, they can use data and understand the nuanced effects of policy change on different types of providers (e.g., independent hospital or those operating within a larger system; primary care provider or hospital) and in different areas of the state (e.g., rural or urban). Several states embed the infrastructures discussed elsewhere in this paper within their oversight entities.

## *Facilitating Cost Containment or Competition*

Ideally, an office with authority to advise the state on health cost containment is established in statute rather than gubernatorial executive order. Given that such an office is inherently politically charged and requires time to identify appropriate steps and to realize the impact of any changes, legislation may provide more sustainability than an executive order, which can be annulled at the end of a governor's term.

- **Facilitating Competition.** Health care cost oversight offices may oversee proposed material health care transactions, such as acquisitions and mergers. While some retain control of the transactions, as in Connecticut, Oregon, and Washington, others, such as Massachusetts, may weigh in on transactions or conduct cost and market impact reviews. State oversight offices use their data leverage, including some of the capabilities described above, to address price impacts and competition policy (National Academy for State Health Policy, 2020b).
- **Facilitating Price Regulation.** Oversight offices use administrative policy to address costs and propose legislative changes to address high prices and anti-competitive conduct. These offices can conduct major analysis, report on cost drivers and overall health care spending, and drive statewide solutions, such as global budgets or other alternative payment models to contain costs and address consolidated markets (National Academy for State Health Policy, 2020b).

## *Key Design Considerations*

- **Creating the Office.** A state may create a new office with an explicit statutory charge that coordinates across existing state agencies or identify an existing office to which it adds explicit authority over health care costs.
- **Scope of Authority.** States may consider the following questions to help define the office's scope of authority and determine whether to use an existing office or create a new one: What are the office's duties? Will it have regulatory power? Can it compel performance? Does it have enforcement authority? Will it be built all at once or gradually? Will it include an APCD, hospital reporting, market oversight, or the ability to regulate or develop policy? Will its duties be confined only to policymaking? Will it advise the governor's office or the legislature? These decisions depend heavily on political will, budgetary issues, and interested parties.

- **Independent or Inside State Government.** An independent office can establish a new structure with a board to advise on policies and be given power to enforce rate regulation or competition policy. It may need to work closely with existing agencies, such as the public health department or the attorney general's office, which have established roles in state government. Most state oversight offices reside inside the executive branch, which may make coordination across agencies easier but increase political pressure.
- **Resources.** States may need ongoing resources to establish an oversight office, depending on the scope of its authority and where it is located. While it may be possible to leverage current resources, additional funding may be needed. States may use industry assessments or funds for discrete activities or ongoing funding for an oversight office.

## *Challenges*

- **Proof of Action.** It is difficult to launch an office and expect action in short order, so states may want to consider how best to develop initiatives or make policy recommendations that demonstrate immediate efficacy. Some of the long-term strategies that existing state entities deploy, such as addressing market impacts, do not bear fruit immediately.
- **Degree of Independence.** A state executive branch oversight office may need to retain a level of independence to maintain credibility and build trust with legislators, industry, and consumers.
- **Data.** How will an oversight office access data to support its scope of authority? Without timely and credible data, it is difficult for the office to take effective action that builds credibility.
- **Flexibility.** An oversight office may need to embrace flexibility to respond to changes in administrations or legislatures that affect its powers or authority.

## *State Experiences*

At least 14 states have, or will be establishing, oversight entities: California, Colorado, Connecticut, Delaware, Maine, Maryland, Massachusetts, New Jersey, Nevada, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington (Maryland Health Services Cost Review Commission, n.d.; Rapfogel & Murphy, 2022). There are both similarities and significant differences in function, size, authority, structure, and funding. Massachusetts and Rhode Island offer examples of states that approach health care cost oversight within different types of offices. While their goals are similar, their policy and regulatory infrastructure differs.

Created by law in 2004, the Rhode Island Office of the Health Insurance Commissioner (OHIC) was established as a separate agency from the state's Department of Insurance. OHIC focuses on protecting consumers and improving the healthcare system as a whole, with explicit language in its authorizing statute that establishes responsibility for affordability. While the core of its mission is regulatory oversight

of the commercial insurance market, OHIC has authority to regulate reimbursement rates paid by health plans to hospitals, effectively keeping the hospital portion of health care cost growth close to the inflation rate (Butler, 2021). This practice predates the establishment of Rhode Island's statewide, overall cost growth benchmark, but the experience of holding health plans made OHIC the obvious oversight choice. Because its primary role is as an insurance regulator, OHIC does not oversee the state's certificate of need program. Instead, the state's Department of Public Health collects information on hospital requests to expand services and makes certificate of need determinations, while OHIC monitors financial data and patient prices.

Massachusetts created its Health Policy Commission (HPC) in 2012 specifically to establish and provide oversight of a health care cost growth benchmark using data to measure the annual total cost of care. HPC is an office of professional policy analysts who work closely with the state's Center for Health Information and Analysis, which houses the APCD, to monitor the state's health costs. The office is funded through assessments of the participants in the health market, including health plans and hospitals. In addition to analyzing growth in the state's costs, HPC identifies and monitors the market's cost drivers and can provide significant data analyses to the state Department of Health and the attorney general, which review proposed market transactions. HPC also oversees providers participating in the state's health care delivery and payment reforms. HPC does not have the same authority to regulate health plans as Rhode Island's OHIC; rather, it works collaboratively with the state Department of Insurance and others, including Medicaid and the state employee health plan.

## Cost Growth Benchmarks/Targets

Establishing a cost growth benchmark or target, which is an upper limit at which the state's per capita, total health care spending should grow on an annual basis, requires significant infrastructure and can also contribute to that infrastructure. A successful cost growth benchmark/target program requires substantial data from participants in the market; analytic capacity, whether it exists within a state agency or from a contractor; authority from a health cost oversight office, as described above; and collaboration among interested parties. Since the goal is to identify market entities that exceed the target, this strategy requires their participation to report state spending annually to inform and catalyze cost containment policies (Angeles, 2023). Given this, states with these programs have sought to include commissions or steering committees of health market representatives to advise and collaborate with the state oversight officials. By leveraging data and health market participation supported by cost oversight state offices, the program ultimately helps to build buy-in to identify shared cost containment goals that can result in policy action.

### *Facilitating Cost Containment*

In developing a cost growth benchmark/target program, states are considering how its structure and engagement may be leveraged to support both the execution of the benchmark and also overall cost containment strategies. Can having health market participants examine the benchmark data help build support both to keep cost growth minimal and to develop collaborative cost containment policies?

- **Facilitating Cost Containment.** Specific data from participating parties are required to understand statewide health costs. Health plans, hospitals, providers, and others



need to submit detailed expense data to the state that they may not otherwise have reported. Data from APCDs and other hospital financials are helpful in adding context to this analysis but are not alone sufficient to understand total per capita expenditure. State offices with overarching cost authority review these data not only to assess the market's performance against the benchmark but also to inform other action, possibly including how best to set a global hospital budget.

## *Key Design Considerations*

- **Housing the Program.** States implementing a benchmark program will need to identify the responsible office, which may be easier if they have already established an office with health care cost oversight. States without such an office need to consider developing one with the authority to work with other state agencies—such as the Medicaid program, the employee health plan, corrections, and veterans' programs—that spend money on health care and also with insurers to collect data.
- **Authority to Establish a Program.** While authority may be given through an executive order, establishing such a resource-intensive program may have more sustainability if established under statute, given the political challenges of addressing health care costs.
- **Stakeholder Involvement.** Oversight or advisory bodies that include different perspectives with interest in health care spending—payer, provider, patient, state, employer, and others— help build needed support for establishing, assessing, and achieving the benchmark target (Angeles, 2023).
- **Data Collection.** States collect data directly from Medicare, Medicaid, other state agencies, and insurers to monitor total health care expenditures. All types of health care spending are collected for the cost growth benchmark programs (Angeles, 2023).
- **Benchmark Values.** To date, states have used data to set benchmarks related to predicted economic growth and/or median income growth. The benchmarks are set for several years to provide predictability and set expectations for all participating entities.
- **Enforcement.** States may consider whether and what enforcement mechanism will apply to entities that exceed the benchmark, such as performance improvement plans, penalties, or other measures. If using an enforcement mechanism, the state needs to decide when to use it and do so consistently.
- **Resources.** To fund benchmark programs, states can assess industry participants, insurance carriers, and hospital entities or other providers. These funds can support state costs to run the program, such as data collection, analysis, reporting, monitoring, and enforcement.

## *Challenges*

- **Leadership and Resource Intensive.** Establishing a benchmark program that includes substantial infrastructure needs is a big lift for states. Such a program also requires political will across executive and legislative leadership to overcome potential industry challenges to its establishment.
- **Maintaining the Program.** States may need continued buy-in with legislative and executive branch support to ensure that the program continues to be authorized and resourced.
- **Enforcement.** Lack of enforcement may limit a benchmark program over the long term if efforts to contain costs are not achieved through other policy efforts. Enforcement mechanisms may be challenging to obtain if there is industry opposition.
- **Expertise.** States need expertise to evaluate and analyze data and must build trust and credibility with stakeholders and the public for the program to be successful.

## *State Experiences*

Currently, six states (California, Connecticut, Delaware, Massachusetts, Oregon, and Washington) have codified cost growth benchmark programs, and two (New Jersey and Rhode Island) operate a benchmark program under executive order (Angeles, 2023). Vermont includes a cost growth benchmark as part of its all-payer model (Vermont Green Mountain Care Board, 2023). Maryland includes an all-payer hospital revenue growth target as part of its all-payer hospital global budget model (Maryland Health Services Cost Review Commission, n.d.).

As noted previously, Massachusetts created an office to implement and operate its cost growth benchmark program, while Rhode Island identified an established office with the needed capacity. Each state has a strong data infrastructure that supports the collection of expenditure reports to measure the market's performance against the benchmark and have APCDs to provide additional context for the benchmark assessment. The other important foundational component is that both states established and support advisory bodies to work with the state offices to buy in to and execute the benchmark. The support of the advisory members is particularly meaningful when the state is seeking regulatory and legislative policy change.

In Massachusetts, the HPC is led by staff but overseen by the eleven-member Board of Commissioners that collaborates to monitor and improve the performance of the health system. The statute includes specific board member requirements, including mandates for representation by experts in health care delivery and management expertise, consumer advocacy, and the development and utilization of innovative medical technologies. Public Commission Board meetings are held regularly, both to discuss the annual benchmark performance and to assess overall health market dynamics and make policy recommendations for the state to pursue.

Rhode Island's OHIC supports the Health Care Cost Trends Steering Committee, which was developed in 2018 and executed the Compact to Reduce Growth in Health Care Costs and State Health Care Spending in Rhode Island that represents a voluntary commitment by health care stakeholders to take

reasonable and necessary steps to keep cost growth below the state's target. The steering committee includes representation from hospitals, academia, consumer groups, and employers. OHIC is leveraging the commitment and expertise of the steering committee to create specific workgroups that support the goals of reducing costs. Currently, that includes exploring what a hospital global budget may look like in Rhode Island.

Data collection and analysis is the first critical step in a benchmarking program. Next, the state shares the results and gains insights from the advisory body before making public the overall benchmark assessment and policy recommendations. In this way, the program creates infrastructure to help identify cost drivers, which can then inform targeted cost-containment policies.

Several states reported on spending from 2020 to 2021, the first year in which utilization rebounded after the sharp drop in 2020 that reflected COVID-19 social distancing protections. In all states, commercial spending growth far exceeded spending growth in Medicare and Medicaid. State experiences included the following:

- Overall spending in Connecticut grew 6 percent between 2020 and 2021, exceeding the 2021 benchmark of 3.4 percent in the first performance year. The governor used the deeper trend analysis in the report to bolster proposed legislation aimed at reducing hospital and health system costs and prescription drug costs (Office of Governor Ned Lamont, 2023). The state also identified the main driver of spending as the rebound in in-person health care utilization in hospital outpatient settings (Connecticut Office of Health Strategy, n.d.).
- Delaware's spending exceeded its benchmark in 2021, excluding COVID-19 relief payments (Delaware Department of Health and Social Services, 2023).
- Rhode Island's 2021 cost growth equaled its 2021 target of 3.2 percent, excluding COVID-19 relief payments (Rhode Island Office of the Health Insurance Commissioner, 2023).
- Oregon's spending grew 3.5 percent from 2020 to 2021, slightly exceeding its target of 3.4 percent (Oregon Health Authority, 2023).

## Conclusion

Each of the approaches described here requires significant state investment and the pairing of policy options with further action to promote competition and tackle the drivers of price and spending growth. State policymakers will balance their goals for addressing high and rising health costs with the state's existing and needed assets and capacity to determine how to design a supportive infrastructure.

As laboratories for policy, state policymakers design strategies for their unique circumstances that are influenced by political and other considerations. Some states may invest more heavily in infrastructure as presented here, while others may advance policy proposals to leverage existing supportive structures or to work across existing agencies. Regardless of the policy decisions they make, states are leading efforts across the country to tackle the challenge of increasing health care costs facing residents, businesses, and state budgets.



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## Appendices

- **Appendix 1: Working Group Participants**
- **Appendix 2: Special Guests**
- **Appendix 3: Program Staff and Acknowledgment**
- **Appendix 4: Program Conveners**



# Working Group Participants



COCHAIR

## **JIM DOUGLAS**

*80th Governor, State of Vermont (2003–2011)*

Jim Douglas was elected governor of the state of Vermont in 2002 and reelected three more times, capping a 35-year career of service to the state that began in the Vermont House of Representatives and included a term as House majority leader. He was elected secretary of state in 1980, a post he held for 12 years, and became state treasurer in 1994, where he served for eight years. During his tenure as governor, Douglas focused on strengthening the state's economy, reducing the cost of living, and protecting the state's natural environment. The groundbreaking health reforms he advanced have made Vermont a model among the states. Douglas served as chairman of the National Governors Association and was appointed cochair of the Council of Governors by President Barack Obama in 2010. He is now an executive in residence at Middlebury College, his alma mater, and serves on the boards of several companies and the Calvin Coolidge Presidential Foundation.

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COCHAIR

## **KATHLEEN SEBELIUS**

*21st Secretary, US Department of Health and Human Services (2009–2014)*

*44th Governor, State of Kansas (2003–2009)*

Kathleen Sebelius, MPA, is an expert on health policy, healthcare reform, human service delivery, and executive leadership. She served as secretary of the US Department of Health and Human Services from 2009 to 2014, leading President Obama's charge to pass and implement the Affordable Care Act. From 2003 to 2009, Sebelius served as governor of Kansas. She chairs the board of Humacyte Inc. and serves on the boards of Devoted Health Inc., Exact Sciences Inc., Included Health Inc., and KFF, and she is a senior adviser to the Dole Institute of Politics, the National Cannabis Roundtable, Out Leadership, the Estée Lauder Foundation, and the University of Kansas College of Liberal Arts and Sciences. During her career, Sebelius has led numerous efforts on early childhood initiatives, women's health, tobacco control, mental health parity, HIV/AIDS, polio, prevention of chronic diseases, and global health security.

# Working Group Participants



## STUART ALTMAN

*Sol C. Chaikin Professor of National Health Policy  
Brandeis University*

Stuart Altman, PhD, Sol C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis University, is an economist with five decades of experience related to federal and state health policy within government, the private sector, and academia. Altman has advised five US presidential administrations, held leadership positions at both the federal and state level, and chaired influential task forces and commissions, including the Massachusetts Health Policy Commission, part of the state's attempt to moderate growth in healthcare spending. Recognized as a leader in the healthcare field by *Health Affairs* and *Modern Healthcare*, he has been designated one of the 30 most influential people in health policy and one of the top 100 most powerful people in healthcare. Altman has earned numerous prestigious national awards and is widely published; his books include *Beyond Antitrust: Health Care and Health Insurance Market Trends and the Future of Competition and Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle*. Altman is a member of the National Academy of Medicine and chair of the Health Industry Forum at Brandeis University.



## ELISABETH BENJAMIN

*Vice President of Health Initiatives  
Community Service Society*

Elisabeth Benjamin, MS, JD, is vice president of health initiatives at the Community Service Society, where she supervises health policy, health advocacy, and consumer health assistance programs. Collectively, these programs help more than 100,000 New Yorkers each year enroll in or use their health insurance or access low-cost healthcare. A leading patient advocate in New York State, she cofounded the Health Care for All New York campaign, a statewide coalition of more than 170 organizations devoted to securing affordable, quality healthcare for all state residents. She has published extensively and been a frequent media commentator on health equity, insurance coverage expansions, and medical debt. Previously, Benjamin worked as a health lawyer at the New York Civil Liberties Union, the Legal Aid Society, and Bronx Legal Services and on community health and humanitarian projects overseas. Her honors include the City and State Health Care Power 100, Crain's Notable Women in Healthcare, and the New York State Health Foundation Health Care Luminary Award.

# Working Group Participants



## **CLAIRE BROCKBANK**

*Director of Policy and Strategy  
32BJ Health Fund*

Claire Brockbank, MS, is the director of policy and strategy for the 32BJ Health Fund, a Taft-Hartley fund serving almost 200,000 covered lives. She is responsible for the fund's efforts to drive down hospital prices, including a multistakeholder campaign to draw attention to the central role that hospital prices play in healthcare costs and to drive action to lower those prices through public policy, operational innovation, and direct interaction with hospitals. Before joining 32BJ Health Fund, Brockbank served as CEO of Peak Health Alliance, a healthcare purchasing cooperative in Colorado. As the lead architect of the development and launch of Peak, Brockbank was responsible for leveraging data and community organizing to lower premiums by approximately 35 percent in its first two years of operation. Peak also pioneered innovative benefit designs to channel access to more value-driven services.

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## **ERIN C. FUSE BROWN**

*Professor of Law  
Georgia State University College of Law*

Erin C. Fuse Brown, JD, MPH, is the Catherine C. Henson Professor of Law and director of the Center for Law, Health & Society at Georgia State University College of Law. She specializes in health law and policy, and her research focuses on health reform, consumer protection in healthcare, and healthcare consolidation. Fuse Brown has published articles in leading legal, health policy, and medical journals about hospital prices, medical billing and collection, medical debt, healthcare competition and consolidation, and state health reforms. She has consulted with the National Academy for State Health Policy, Milbank Memorial Fund, Catalyst for Payment Reform, and others about legal and policy strategies to protect healthcare consumers, control healthcare costs, and address healthcare consolidation.

# Working Group Participants



## EILEEN CODY

*Former Member, House of Representatives  
State of Washington*

Eileen Cody served in the Washington State House of Representatives for almost 30 years. As chair of the House Health Care and Wellness Committee, she dedicated her legislative career to achieving affordable, quality healthcare for all state residents and led the effort to implement the Affordable Care Act at the state level. Among her other legislative priorities were patient safety, mental health parity, public health services, and the universal purchase of vaccines. A nurse certified in both rehabilitation nursing and multiple sclerosis care, Cody worked for four decades at Kaiser Permanente in Seattle. She is a founding member of District 1199 NW/SEIU Hospital and Health Care Employees Union.



## NANCY-ANN DEPARLE

*Managing Partner and Cofounder, Consonance Capital Partners  
Former Director, White House Office of Health Reform,  
Obama Administration*

Nancy-Ann DeParle, MA, JD, is a managing partner and cofounder of Consonance Capital Partners. She served as assistant to the president and deputy chief of staff for policy in the Obama White House from 2011 to 2013 and as counselor to the president and director of the White House Office of Health Reform from 2009 to 2011. Previously, she was associate director for health and personnel at the White House Office of Management and Budget and served as a commissioner of the Medicare Payment Advisory Commission, the advisory board to Congress on Medicare policy, and as an administrator of the Centers for Medicare & Medicaid Services. DeParle was also a senior fellow and adjunct professor of health systems management at The Wharton School of the University of Pennsylvania and a trustee of the Robert Wood Johnson Foundation and served on numerous corporate boards. She is a trustee at Duke University and serves as a director of Consonance Capital Partners portfolio companies Sellers Dorsey, Psychiatric Medical Care, Priority OnDemand, and Embark Behavioral Health as well as a director of HCA Healthcare and CVS Health. DeParle is an elected member of the National Academy of Medicine.

# Working Group Participants



## ANDREW DREYFUS

*Former President and CEO  
Blue Cross Blue Shield of Massachusetts*

Andrew Dreyfus, a healthcare executive and expert in healthcare system change, served for more than a decade as president and chief executive officer for Blue Cross Blue Shield of Massachusetts (BCBSMA), an innovator on payment models, quality improvement, mental health, and health equity. He is currently a Menschel Senior Leadership Fellow at the Harvard T. H. Chan School of Public Health. Previously, Dreyfus was founding president of the BCBSMA Foundation, where he oversaw the initiative leading to the 2006 passage of state health reform, which became the model for the Affordable Care Act. He has also served as executive vice president of the Massachusetts Hospital Association and held numerous senior health and regulatory positions in state government. Over the last two decades, Dreyfus has helped to create several collaborative health organizations in Massachusetts, including the Schwartz Center for Compassionate Care, RIZE Massachusetts, Massachusetts Health Quality Partners, and the Massachusetts Coalition for Serious Illness Care. He is a board member of Ironwood Pharmaceuticals and the Joint Commission, chairs the BCBSMA Foundation board, and serves on numerous advisory boards. His writing has appeared in the *Boston Globe*, the *Washington Post*, STAT, Politico, and The Hill.



## DONNA KINZER

*Principal, DK Healthcare Consulting  
Former Executive Director, Maryland Health Services  
Cost Review Commission*

Donna Kinzer served as executive director of the Maryland Health Services Cost Review Commission from 2013 to 2018, leading the implementation of the all-payer hospital model. In 2018, she led negotiations with the Centers for Medicare & Medicaid Services for Maryland's 10-year total cost of care model, which extended Maryland's responsibility to encompass all healthcare services and improve population health. Her work has also included developing and implementing payment models for hospitals, physicians, and other providers as well as developing global total cost-of-care arrangements for various attributed populations. Previously, Kinzer served as a partner at Arthur Andersen and a managing director at Navigant Consulting and Berkeley Research Group. She returned to the private sector in 2020 and has since supported states and health systems with strategy and implementation of value-based payment arrangements. Her recent activities include serving on the board of the Pennsylvania Rural Health Redesign Center Authority, which administers Pennsylvania's global model for rural hospitals. She has also worked with the Vermont legislature to evaluate Vermont's regulatory strategy under its statewide all-payer accountable care organization model.

# Working Group Participants



## LARRY LEVITT

*Executive Vice President for Health Policy  
KFF*

Larry Levitt, MPP, is executive vice president for health policy, overseeing the KFF's policy work on Medicare, Medicaid, the healthcare marketplace, the Affordable Care Act, women's health, racial equity, and global health. He previously was editor in chief of kaisernetwork.org, KFF's online health policy news and information service, and directed its communications and online activities and its Changing Health Care Marketplace Project. Before joining KFF, Levitt served as a senior health policy adviser to the White House and the US Department of Health and Human Services, working on the development of President Clinton's Health Security Act and other health policy initiatives. He has also been the special assistant for health policy to California insurance commissioner John Garamendi and a medical economist with Kaiser Permanente and held a number of positions in Massachusetts state government.

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## ELIZABETH MITCHELL

*President and CEO  
Purchaser Business Group on Health*

Elizabeth Mitchell is president and CEO of the Purchaser Business Group on Health. This nonprofit coalition represents nearly 40 private employers and public entities across the United States that collectively spend \$350 billion annually purchasing healthcare services for more than 21 million Americans and their families. In her leadership capacity, Mitchell partners with large employers and other healthcare purchasers to advance the organization's strategic focus on advancing quality, driving affordability, and fostering health equity, leveraging her extensive experience working with healthcare purchasers, providers, policymakers, and payers to improve healthcare quality and cost.

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## KEVIN PATTERSON

*CEO  
Connect for Health Colorado*

Kevin Patterson, MPA, MURP, has served as chief executive officer of Connect for Health Colorado since April 2015. In that capacity, he has worked to improve the customer experience, focusing on health insurance with implications for tax credits. Known as a collaborative nonpartisan problem solver, Patterson brings a strong understanding of local, state, and federal government and stakeholder engagement to his role. Previously, he served as chief administrative officer and interim chief of staff to Colorado governor John Hickenlooper and has an extensive history of public service, holding many senior leadership roles in the city and county of Denver. Patterson was elected to the Denver Board of Education in 2001 and 2005.

# Working Group Participants



## CAROLINE PEARSON

*Executive Director  
Peterson Center on Healthcare*

Caroline Pearson is the executive director of the Peterson Center on Healthcare, where she tackles some of the most complex issues in healthcare and contributes to the Center's goal of creating a high performing health system that delivers better care at lower cost. Previously, Pearson was senior vice president for healthcare strategy for NORC at the University of Chicago, a nonpartisan research organization, where she built a new department of subject matter experts who deliver actionable research and analysis. She has also been senior vice president of policy and strategy at Avalere Health. A nationally recognized healthcare expert, Pearson focuses on state and federal health policy, public and private insurance, prescription drugs, and aging issues. Her 2019 article, "The Forgotten Middle," was the fifth most read *Health Affairs* article that year, highlighting the growing number of middle-income seniors with unmet health and housing needs. In 2009, Pearson drafted a Bipartisan Policy Center report, led by Tom Daschle and Bob Dole, which advanced a comprehensive health reform proposal in advance of the congressional debate over the Affordable Care Act.



## ZIRUI SONG

*Associate Professor, Health Care Policy and Medicine  
Harvard Medical School*

Zirui Song, MD, PhD, is an associate professor of healthcare policy and medicine at Harvard Medical School and Massachusetts General Hospital (Mass General). His work focuses on healthcare spending and the effects of payment policy and social interventions on health and economic outcomes. Song also directs the health policy track in the internal medicine residency program at Mass General, where he is an attending on the inpatient medicine teaching service. He also serves as research director at the Harvard Medical School Center for Primary Care, codirects the health policy course for first-year Harvard dental and medical students, and advises students and fellows in their research. Song is an associate editor of *JAMA Health Forum* and a member of the editorial board of *Health Services Research*. He has worked on payment policy at the US Department of Health and Human Services and at the Massachusetts Health Policy Commission.

# Working Group Participants



## EMILY STEWART

*Executive Director  
Community Catalyst*

Emily Stewart is the executive director of Community Catalyst, where she oversees its work with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Stewart brings more than two decades of healthcare advocacy, campaign, and organizing experience to this role. Previously, she served as vice president of public policy for Planned Parenthood Federation of America and the Planned Parenthood Action Fund, where she led strategic initiatives and campaigns to protect and expand access to sexual and reproductive healthcare, including the I Stand with Planned Parenthood campaign to defeat efforts to repeal the Affordable Care Act and defund Planned Parenthood. Stewart also oversaw Planned Parenthood's Affordable Care Act implementation advocacy, including the successful effort to guarantee no-copay coverage for birth control. Recognized as a healthcare policy, finance, and delivery expert, Stewart led Planned Parenthood's work to ensure that the unique healthcare needs of people of reproductive age were being met, especially as the healthcare system undergoes sweeping change.

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## MIKE TRACHTA

*System Vice President, Rural Hospitals and Regional Operations  
MercyOne*

Mike Trachta, FACHE, MBA, MHA, currently holds leadership roles as the vice president of rural hospitals and the vice president for regional operations for MercyOne, a 43-hospital system based in West Des Moines, Iowa. In this role, he serves as the MercyOne executive leader for all 30 MercyOne-owned and -managed rural hospitals as well as having health system-wide oversight of several service lines and support functions. He previously served as chief executive officer for multiple community hospitals and in CEO and COO roles for large urban hospitals in Iowa. Trachta has also served as a network hospital chief executive officer with University of Iowa Health Care, where he founded its rural hospital network. Trachta is an active member of several Iowa hospital boards, councils, associations, and task forces as well as continuing to be actively involved with the University of Iowa College of Public Health.





## GAIL WILENSKY

*Senior Economist  
Project Hope*

Gail R. Wilensky, MA, PhD, is an economist and senior fellow at Project Hope, an international health foundation. She also cochairs the Bipartisan Policy Center's initiative on the future of healthcare. Previously, she directed the Medicare and Medicaid programs, served in the White House as a senior adviser on health and welfare to President George H. W. Bush, and was the first chair of the Medicare Payment Advisory Commission. Her expertise centers on Medicare, strategies to reform healthcare, comparative effectiveness research, and military healthcare. Wilensky currently serves as a trustee of the Combined Benefit Fund of the United Mine Workers of America and NORC at the University of Chicago and is on the boards of the Geisinger Health Foundation, the National Alliance for Hispanic Health, and Project Hope. She is also on the Council of Directors of the Henry M. Jackson Foundation for the Advancement of Military Medicine and previously chaired the board of AcademyHealth. She is a director of UnitedHealth Group, Quest Diagnostics, ViewRay, and numerous not-for-profit organizations and is an elected member of the National Academy of Medicine, where she served two terms on its governing council. Wilensky was awarded the 2019 Adam Yarmolinsky Medal by the National Academy of Medicine.



## **BENEDIC IPPOLITO**

*Senior Fellow  
American Enterprise Institute*

Benedic Ippolito, PhD, MS, is a senior fellow in economic policy studies at the American Enterprise Institute. His research focuses on a range of issues in health economics, including provider pricing, the pharmaceutical market and its regulations, and the effect of healthcare costs on the personal finances of Americans.

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## **JODI LIU**

*Policy Researcher  
RAND Corporation*

Jodi Liu, PhD, MSPH, MSE, is a policy researcher at the RAND Corporation. Much of her research focuses on healthcare financing and payment and dementia care. She has experience using simulation modeling to analyze the effects of healthcare policy changes on health insurance coverage, household and government spending, and provider revenues. Her work has also involved assessing alternative payment models, healthcare consolidation, policy options for single-payer healthcare, and care for people with Alzheimer disease and related dementias.

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## **HEMI TEWARSON**

*Executive Director  
National Academy for State Health Policy*

Hemi Tewarson, JD, MPH, is the executive director of the National Academy for State Health Policy, a nonprofit and nonpartisan organization committed to improving the health and wellbeing of all people across every state. The organization is at the forefront of engaging state leaders and bringing together partners to develop and advance state health policy innovations. Under her direction, the academy is leading efforts that include COVID-19 recovery, healthcare costs and value, coverage, child and family health, aging, family caregiving, healthcare workforce, behavioral health, social determinants of health, health equity, and public health modernization. Previously, Tewarson worked at the Duke-Margolis Center for Health Policy as a senior fellow and served as director of the health division at the National Governors Association Center for Best Practices. She has also been a senior attorney for the Office of the General Counsel at the US Government Accountability Office, addressing Medicaid and related healthcare topics for members of Congress.



## VICTORIA VELTRI

*Senior Policy Fellow*

*National Academy for State Health Policy*

Victoria Veltri, JD, LLM, is a senior policy fellow with the National Academy for State Health Policy, where she works with states on cost, coverage, and value policies, including hospital and health system costs. Previously, she was executive director of Connecticut's Office of Health Strategy, overseeing its mission to implement comprehensive, data-driven strategies that promote equal access to high-quality healthcare, control costs, and ensure better health for Connecticut residents. In that capacity, she led a bipartisan process leading to and implementing Connecticut's first healthcare cost growth benchmarks, primary care spending targets, and quality benchmarks. Veltri has also been chief health policy adviser to the lieutenant governor's office, coordinating the state's health reform initiatives, including the creation of the Office of Health Strategy and the Health Care Cabinet. In an earlier role as the state's healthcare advocate in the Office of the Healthcare Advocate, she oversaw the office's mission to assist consumers in selecting managed care plans and understanding their healthcare rights and to pursue systemic healthcare advocacy. Veltri has served on the boards of the Connecticut Health Insurance Exchange and Connecticut Partners for Health.



## RUTH KATZ

*Vice President; Executive Director, Health, Medicine & Society Program;  
Director, Aspen Ideas: Health  
The Aspen Institute*

Ruth Katz, JD, MPH, is executive director of the Aspen Institute's Health, Medicine & Society Program, which brings together groups of thought leaders, decision-makers, and the informed public to grapple with health challenges facing the US in the 21st century and to pursue practical solutions for addressing them. She also serves as vice president of the Aspen Institute and directs Aspen Ideas: Health, the opening three-day event of the renowned Aspen Ideas Festival. Before joining the Aspen Institute, Katz served on the professional staff of the Committee on Energy and Commerce in the US House of Representatives as chief public health counsel. She has also been Walter G. Ross Professor of Health Policy of the George Washington University Milken Institute School of Public Health, dean of that school, and associate dean for administration at the Yale School of Medicine.

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## ALAN WEIL

*Editor in Chief  
Health Affairs*

Alan Weil, JD, MPP, has been editor in chief of *Health Affairs*, the nation's leading health policy journal, since 2014. He was the executive director of the National Academy for State Health Policy and a center director at the Urban Institute and held a cabinet position as executive director of the Colorado Department of Health Care Policy and Financing, the state's Medicaid agency. An elected member of the National Academy of Medicine, Weil has been an appointed member of the Medicaid and CHIP Payment and Access Commission and a trustee of the Consumer Health Foundation in Washington, DC.

# Acknowledgement

We acknowledge Tricia Neuman and Zachary Levinson of KFF for their expertise and contributions to the convening and this report.



## ZACH LEVINSON

*Project Director*

*KFF*

Zachary Levinson, PhD, MPP, MA, is the project director of an initiative at KFF examining the business practices of hospitals and other providers and their impact on costs and affordability. Levinson has conducted research and analysis relating to the financial performance of hospitals and health systems, healthcare prices and reimbursement, hospital market consolidation, provider relief funding during the COVID-19 pandemic, and other topics related to affordable healthcare. His work has been published in *Health Affairs*, *Health Services Research*, *JAMA*, the *American Journal of Public Health*, and *Healthcare*. Before joining KFF, Levinson was an associate economist at the RAND Corporation. Earlier in his career, he worked as a policy analyst at KFF's Program on Medicare Policy.



## TRICIA NEUMAN

*Senior Vice President; Executive Director, Program on Medicare Policy;  
Senior Adviser to the President*

*KFF*

Tricia Neuman, DSc, MS, is senior vice president of KFF and executive director of its Program on Medicare Policy. She oversees policy analysis and research pertaining to Medicare and health coverage and care for aging Americans and people with disabilities. Her areas of interest include the health and economic security of older adults, the role of Medicare Advantage plans, Medicare and out-of-pocket spending trends, prescription drug costs, payment and delivery system reforms, and policy options to strengthen Medicare. Neuman was recently nominated by President Biden to serve as a public trustee for the Medicare, Social Security and Disability Insurance Trust Funds. The author of numerous papers related to Medicare, Neuman has presented expert testimony before congressional committees and independent commentary to national media outlets. Before joining KFF in 1995, Neuman served on the professional staff of the Ways and Means Subcommittee on Health in the US House of Representatives and on the staff of the US Senate Special Committee on Aging.



## Health, Medicine & Society Program

The Health, Medicine & Society Program of the Aspen Institute brings together influential groups of thought leaders, decisionmakers, and the informed public to consider health challenges facing the US in the 21st century and to identify practical solutions for addressing them. The rigorously nonpartisan work spans a range of timely topics—from the opioid epidemic, end-of-life care, and incarceration to health systems financing and innovation, public health communication, and much more. At the heart of most of its activities is a package of research, convenings, and publications that supports policymakers, scholars, advocates, and other stakeholders in their drive towards change.



## The Aspen Institute

The Aspen Institute is a global nonprofit organization committed to realizing a free, just, and equitable society. Founded in 1949, the Institute drives change through dialogue, leadership, and action to help solve the greatest challenges facing the United States and the world. Headquartered in Washington, DC, the Institute has a campus in Aspen, Colorado, and an international network of partners.



## KFF

KFF is the independent source for health policy research, polling, and journalism with a mission to serve as a nonpartisan source of information for policymakers, the media, the health policy community, and the public. KFF has four major program areas: KFF Policy; KFF Polling; KFF Health News (formerly known as Kaiser Health News, or KHN); and KFF Social Impact Media, which conducts specialized public health information campaigns. KFF does everything based on facts and data, and does so objectively without taking policy positions and without affiliation to any political party or external interest.