

Health Care Affordability

State Policy Options to Control Costs

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Testimony of Christopher M. Whaleyⁱ
The RAND Corporationⁱⁱ

Before the Select Committee on Health Care Reform
Texas House of Representatives

August 4, 2022

Chairman Harless, Vice-Chair Rose, and members of the Texas Select Committee on Health Care Reform: Thank you for the opportunity today to present on health care affordability. My name is Christopher Whaley. I am a health economist at the RAND Corporation, where I focus on health care price transparency and market structure. The information I share today draws upon a variety of peer-reviewed reports and journal articles that my RAND Corporation colleagues and I, as well as other researchers, have produced over the past several years.

In my remarks today, I will focus on individuals with employer-sponsored insurance, which is the most common source of insurance in the United States. In Texas, 13.5 million individuals (48 percent of Texans) receive health insurance benefits through an employer or union.¹ Employers provide health benefits to workers and their families as a form of compensation. While the employer-sponsored market is large and important, it also faces many affordability challenges.

Most notably, the costs to provide employer-sponsored health insurance have increased. It now costs over \$22,000 to provide health insurance coverage to a family, a \$7,000 increase from 2011.² These costs do not come out of nowhere. Instead, health insurance costs come directly out of worker wages and other benefits.³⁻⁶ In addition to downward pressure on wages, one prominent response to increasing health care costs has been the rise of high-deductible plans,

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which require families to cover most health care costs before insurance takes effect. Over the past decade, the average deductible for an individual employer-sponsored insurance plan increased by over \$700, to nearly \$1,700 (a 71 percent increase).² The share of workers with a deductible of at least \$1,000 has almost doubled, to 58 percent. In other words, over half of families with employer-sponsored insurance must pay \$1,000 out-of-pocket before their insurance coverage fully goes into effect.

These costs have a substantial impact on consumer finances. In addition to rising costs and higher out-of-pocket expenses, recent attention has focused on consumer debt owed to health care providers. As of February 2022, an estimated 19 percent of Texans have medical debt that is in collections, with an average debt amount of \$835.⁷ Both numbers are above the national averages of 13 percent and \$703, respectively. In fact, 34 of the top 100 counties with the largest share of adults who are unable to pay their medical bills are in Texas. Both in Texas and nationally, the share of adults with medical debt and the amount of medical debt are larger in communities of color than in white communities. Medical debt can have long-lasting impacts on well-being and household finances, including reduced medical care, worse mental health, and lower credit scores.^{8,9}

Rising health care costs burden employers but, more importantly, burden workers and their families. In this testimony, I hope to explain the underlying causes of rising health care costs and discuss potential policy options to address high costs. I will begin by discussing the role prices play in rising health care costs for the privately insured population. I will end by discussing three potential strategies that could be used to address prices for the commercially insured population.

Health Care Prices for the Privately Insured Population

A key driver of rising health care costs for the privately insured population is prices paid to providers. Medicare and many state Medicaid programs set prices administratively. While some variation exists across providers and markets, prices are relatively uniform. In contrast, prices for the privately insured population are negotiated between providers and insurers. This negotiation process has led to wide variation in prices, both across markets and among providers in the same market. It also incentivizes provider consolidation and market concentration as a tool to enhance negotiation leverage.

Starting around 2000, prices paid by private insurers relative to Medicare and Medicaid began to diverge, and the gap in payments has grown since.¹⁰ Our recent work has highlighted that employers and other private insurers pay prices that are above 200 percent of Medicare for hospital care.^{11,12} In Texas, private insurance prices are 252 percent of Medicare. Our work and other studies have found that prices also vary widely, with many markets experiencing an order of magnitude variation in prices for the same service.¹³ Among major Texas hospital systems, prices vary from below Medicare rates to over 300 percent of Medicare.¹⁴

These prices are not consistently driven by differences in clinical quality or patient outcomes.¹⁵⁻¹⁹ Prices are also not explained by underpayments from Medicare, Medicaid, or patients without insurance.²⁰ Instead, prices are driven by the market factors that enable providers to negotiate higher prices with insurers.²¹

An important contributor to negotiation leverage is provider market power.²² Using definitions of market concentration used by the Federal Trade Commission and the Department of Justice to monitor competitive market activity, 90 percent of U.S. hospital markets in 2016 were highly concentrated and were not considered competitive markets.²³ Applying the same

measures to Texas metro areas, only Dallas is a noncompetitive hospital market.²⁴ Over the 2016–2021 period, there were 490 total hospital transactions, with 44 in Texas.²⁵ A wide body of evidence has linked hospital mergers to increases in prices, with no accompanying change in quality.^{13,21,26,27} The competitive landscape for physicians is also rapidly changing. Over the past decade, the share of physicians employed by a hospital or health system has doubled and is now above 50 percent.^{28,29} Hospital employment of physicians leads to price increases through both increased negotiation power and increased referrals of “downstream” services to higher-priced hospital settings.^{30,31} A growing number of physicians work for a practice that is owned by a private equity company, raising concerns of price increases or changes to practice patterns.³²

Potential State Policy Solutions to Address Health Care Affordability

This market landscape contributes to high prices that stress employers that provide health insurance benefits and the workforce that is responsible for paying these prices. I will next outline three potential policy options that could be used to address prices for the commercially insured population. In previous studies, my RAND colleagues and I have evaluated the potential impacts of these types of policies and the estimated savings from implementation of these policy options.³³

Promoting Price Transparency

A first option is to promote price transparency. While research shows that consumers do not effectively use price transparency to shop for care,^{34–36} price transparency is critical to employer purchasing and state policy decisions. Employers have used price transparency to design benefit programs that incentivize the use of lower-priced and efficient providers.^{37,38} Employers have also used price transparency to monitor prices negotiated on their behalf and, in cases in which these prices do not align with value, have pushed for lower negotiated prices.³⁹ Price transparency information also enables innovators and entrepreneurs to develop programs that improve care efficiency.⁴⁰

Recent federal policies have expanded the scope of available price information, with requirements that hospitals post rates for common services and insurers post all negotiated rates. In part to improve compliance with these requirements, Colorado recently passed legislation that prohibits hospitals that do not post price transparency information from sending medical debt to collections.⁴¹

While these data are valuable, they do not contain information on the volume of care across facilities or differences in patient composition. These data can be supplemented with data from state-administered all-payer claims databases (APCDs). Currently, 25 states operate an APCD.⁴² These APCDs vary in scope and data breadth. Because of the *Gobeille v. Liberty Mutual Insurance Company* Supreme Court ruling, private sector self-funded plans submit to an APCD on a voluntary basis.⁴³

Innovative Insurance Benefit Designs That Align Prices with Value

A second area of policy innovation comes from the state’s role as a large purchaser of health insurance benefits. In many states, the state employee plan is either the largest or among the largest purchasers of health insurance. The size and importance of state employee health plans positions them as an innovator for how insurance benefits can improve the efficiency of care.

For example, following the Great Recession in 2009, the California Public Employees' Retirement System (CalPERS), which is the second largest public purchaser of private health insurance in the country, faced budgetary consequences caused by rising health care costs. In collaboration with its workforce, CalPERS designed and implemented a reference-based pricing model, in which patients are given financial incentives to receive care from lower-priced and high-quality providers. Across several procedures, this model has led to sizable financial savings.³⁷ In addition to CalPERS serving as a model for other employers, the size of the CalPERS population placed downward pressure on provider prices, which benefited non-CalPERS patients.⁴⁴ Similarly, the State of Montana employee plan implemented a program that caps hospital reimbursement at a fixed percentage of Medicare. This model led to large savings for the state employee health plan and enabled the plan to avoid rising premium and deductible costs that have dominated the rest of the employer-sponsored market.⁴⁵ Other notable examples include the tiered network plans implemented by the State of Massachusetts and State of Minnesota employee health plans.^{46,47}

These examples illustrate the power of state purchasers to drive health innovation for private insurance markets. In Texas, the Employee Retirement System and Teacher Retirement System could play a similar role in driving benefit design innovation. These innovations would both reduce spending and drive innovation for other employers in Texas.

Market Competition

A third potential policy option is to address the underlying market structure factors that contribute to high and variable pricing. Even perfect price transparency and high-powered benefit design programs are of limited efficacy in markets in which patients have few provider options. To promote market competition, some states have proposed additional approval and oversight of hospital mergers.⁴⁸ While well-intentioned, policies such as Certificate of Need and Certificate of Public Advantage laws can lead to anticompetitive behavior and discourage market entry.⁴⁹⁻⁵¹

While these policies can prevent further market concentration, they will have little impact on markets that are already concentrated. Reversing decades of market consolidation is likely not feasible. However, in markets that are likely to remain concentrated, policymakers have options to limit the price effects of market concentration. Some policies propose to limit patient exposure to high prices in noncompetitive markets.⁵² Federal and state legislation remove anti-steering and "all-or-nothing" restrictions. The State of California successfully challenged the prevalence of gag and all-or-nothing contracts used by a dominant health system. Existing evidence finds state restrictions on "most-favored-nation" clauses, in which health care providers and insurers agree to not lower prices, lead to meaningful reductions in prices in markets with concentrated hospital and insurer markets.⁵³

These policies use direct regulations to limit the price consequences of market power. Alternative approaches include policies that place indirect pressure on prices. One such example includes limiting out-of-network and surprise medical bills. In existing research, we have highlighted how limiting out-of-network bills can place downward pressure on in-network prices.⁵⁴ If designed appropriately, these restrictions can both protect patients from unexpected bills and limit the ability of market-dominant providers to negotiate high prices.

Conclusion

Health care markets in the United States face several challenges. While substantial state and federal policy efforts are focused on Medicare, Medicaid, and uninsured populations, there is relatively less attention given to individuals with employer-sponsored insurance. However, this population is large and faces unique challenges that threaten health care affordability. In particular, rising costs that are driven by price increases place downward pressure on worker wages and other forms of benefits and burden employers that provide health insurance benefits. Without market or policy intervention, it is unlikely that these trends will abate.

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