State Policies to Lower Commercial Health Care Prices

Problem: Patients and employers face significant challenges in affording their health care as high and rising health care prices increasingly put a strain on the budgets of American families, employers, and state governments.

Solution: States should implement policies to improve competition and rein in the high and rising prices charged by large, consolidated hospitals and other providers — the main driver of health care cost growth in commercial insurance, including for state employee health plans. Doing so would make health care more affordable and accessible for patients and their families, bolster wages and economic growth, and save states money.

Solutions should address 3 key issues:

1 Transparency and Accountability

State policymakers know health care costs are high, but lack visibility into the prices being charged for care, where care is being delivered, and the finances of hospital systems in their state, including their costs and revenues — and for nonprofit hospitals, their community benefit spending.

2 Market Consolidation and Distortions

Ongoing, unchecked consolidation has led most metro area health care markets to be dominated by 1 to 2 large hospital systems with substantial market power. Those systems use their leverage to demand higher prices, ultimately increasing costs for consumers, employers, and taxpayers without improving the quality of care. Consolidated hospital systems also shift patients from less expensive physician offices to higher-priced hospital outpatient departments, where they can add facility fees and charge higher prices for the same care.

3 Excessive Provider Prices

Hospital and physician prices in the commercial market are often irrational and excessive because they are determined through a system of imbalanced negotiations. When consolidated hospitals control the market, insurers may lack the power needed to demand lower prices. Patients experience wide variation in prices for the same service, both within and across markets. Data on hospital system finances has shown that for many hospital systems, the prices they charge significantly exceed the cost of care and average 2.5 times what Medicare pays for the same service.

1. Transparency and Accountability

- **Implement a state all-payer claims database** that provides data on the prices all payers in the state pay for specific services in each market, with the option for self-insured plans to opt in to share their data. All-payer claims databases enable state policymakers, employers, and researchers to better understand price variation and cost drivers in their markets and inform policies to address health care costs.
- **Require providers and facilities to report ownership data**, including type of owner, such as nonprofit or for-profit, plans, or private equity or other types of corporate ownership, and identification of any parent company when applicable. Ownership information is necessary to understand and regulate both horizontal consolidation between facilities and systems, as well as vertical integration between hospitals, providers, and other actors. Regulators can also use this data to determine if certain ownership structures are uniquely associated with predatory or anticompetitive practices.
- **Ensure financial transparency of hospital systems by requiring financial disclosures**, including hospital- and system-level reporting on revenues, costs, charges, and prices.
- **Require nonprofit hospitals to publish data on community benefit spending** to demonstrate whether they are providing enough community benefit to justify their tax breaks.
- **Implement a cost-growth benchmark to limit the growth of health care costs in the state.** Disaggregate the data to identify health care providers exceeding the benchmark and require those providers to pay back the amount by which they exceed the threshold.

2. Market Consolidation and Distortions

- **Expand state merger review authority** by broadening the scope of health care mergers and acquisitions subject to review, including those that currently fall below reporting thresholds but ultimately have anticompetitive effects. States should also consider enhancing state authority to approve, disapprove, or impose conditions on proposed transactions, such as limits on future price increases. These steps would give states the ability to prevent further consolidation that may otherwise go unchecked and exacerbate high prices, suppress wages, and further burden state budgets.
- **Prohibit anticompetitive contracting terms** between providers and insurers — including most-favored-nation, all-or-nothing, gag, and anti-tiering or anti-steering clauses — that consolidated hospital systems use to limit market competition and unfairly increase their prices.
- **Establish commercial site-neutral payment policies** to protect patients from paying hospitals more than they would pay an independent physician's office for the same routine medical services that can be safely provided in either setting. This reduces the incentive for health systems to purchase physician practices for financial reasons and shift services to higher-cost settings.
- **Eliminate facility fees** at off-campus hospital outpatient departments and for certain services that could safely be performed in a physician's office. This acts as a more incremental step toward site-neutral payment that prevents patients from bearing the cost of unnecessary facility fees and reduces the incentive for health system acquisitions.

3. Excessive Provider Prices

- **Use reference pricing** that limits the prices hospitals can charge to a percentage of Medicare rates in state employee health plans to lower health care costs for state employees and generate significant state budget savings.
- **Cap excessive provider prices** across the commercial insurance market. States can design this in different ways: by focusing solely on hospitals, expanding to other providers, or targeting the highest-priced hospitals or the most consolidated health care markets. States could also implement a more incremental cap on out-of-network prices to achieve fairer pricing by balancing negotiating dynamics between health systems and plans.
- **Enhance state insurance rate review processes** to ensure that savings from reference pricing or price caps are passed through to consumers and reduce their out-of-pocket costs. For example, an affordability standard could limit the growth in health care prices paid by insurers to hospitals — lowering the growth in insurance premiums over time.