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FOR PAYMENT REFORM

State of Healthcare:
Policy Considerations to Constrain Commercial Prices

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EXECUTIVE SUMMARY

Skyrocketing healthcare spending compels state policy leaders to consider price-restraining policies adapted to the specific economic, geographic, and sociopolitical needs of their residents. After publishing a policy research paper that profiled combinations of state-based policy interventions to rein in commercial health care prices and rebalance market power, Catalyst for Payment Reform (CPR) set out to test attitudes towards specific policy interventions in three states: Florida, Michigan and Nevada. These states were selected for their geographic, economic, and political diversity.

A total of 34 stakeholders described their perspective on challenges facing the healthcare system and a menu of potential policy interventions. These participants include representatives of self- and fully-insured healthcare purchasers, health plans, physicians, hospital systems, and other experts familiar with the industry. A thematic analysis of the interview transcripts identified several common themes:

- Participants are the most supportive of these policies:
    1. Prohibit facility fees for outpatient services,
    2. Prohibit anti-tiering and anti-steering clauses in network contracts,
    3. mandate that providers or health plans notify the state attorney general prior to any merger or acquisition.
- Purchasers support price-reducing health reforms which preserve their ability to choose among healthcare providers and plans.
- Purchasers often defer to health plans on health policy issues.
- Hospitals' significant influence among policymakers, businesses, and the general public is a significant barrier to policy proposals intended to limit health care prices.
- Effective strategies for policy outreach include coalitions assembled carefully to avoid conflicts of interest, education for both purchasers and policymakers on key health reforms, framing policies as pro-patient, and consideration for the current political landscape in each state.

Each state's policy ecosystem is complex, and residents face unique healthcare challenges which preclude one-size-fits-all policy solutions. While this report is based on research in Florida, Michigan, and Nevada, the findings regarding the attitudes and perceptions of stakeholders towards health policy options may provide insights which apply to many states.

INTRODUCTION

Healthcare costs have skyrocketed to encompass 17% of the United States economy in 2022 (Hartman et al., 2024). Personal healthcare costs amounted to $3.7 trillion in 2022, or $11,200 per capita. With administrative spending and insurance, this number increases to nearly $4.5 trillion, or $13,500 per capita. The average employer-sponsored health insurance premium for a family has risen from $8,500 in 2002 to $22,000 in 2022, rapidly outpacing wage increases (AHRQ, 2024). Increasing unit price of healthcare services (HCCI, 2023), rising patient cost sharing (KFF, 2023), and the consequences of deferring care during the COVID-19 pandemic (Gertz et al., 2022) together impose massive financial pressures on consumers. The general theme of rising health cost burdens applies in every state, even as each individual state contends with its own health cost challenges.

Florida

Florida is demographically diverse, economically strong, and leans conservative in its politics. The state has numerous urban areas, with most non-metropolitan counties adjacent to at least one major metropolitan center. (See Figure 1) Among states, Florida has the fourth-highest rate of uninsured non-elderly residents, at 14% (Census Bureau, 2024). Many Florida counties, particularly in Central Florida, are medically underserved (HRSA, 2024). Healthcare prices in the state are high and rising: Florida's employers pay the highest commercial hospital prices relative to Medicare in the nation (Whaley et al., 2024). Employer-sponsored insurance premiums have risen from less than $6,700 annually in 2018 to more than $7,500 in 2022, with employers insulating employees from the brunt of the increase (Kaiser Family Foundation (KFF), 2024). The private health insurance market is dominated by GuideWell, the operator of the regional Blue Cross Blue Shield plan (Florida Blue), which controls more than half of the market share for large- and small-group plans (KFF, 2024).

As of mid-2024, Republicans control both chambers of the state legislature and the Governor's office. In recent years, Governor Ron DeSantis and the Florida Legislature have passed some pro-patient healthcare reforms. In 2023, Florida adopted a Pharmacy Benefit Manager (PBM) reform package which promotes transparency and prohibits some PBM practices, including spread pricing (the practice of charging payers more than they compensate the pharmacy), clawbacks (retaining any copay in excess of the cost of a drug), and steerage. The law also requires PBMs to pass 100% of manufacturer rebates to payers (Office of the Governor of Florida, 2023). More recently, the state enacted the Live Healthy Package, a series of bills designed to bolster the healthcare workforce and incentivize healthcare innovation (Office of the Governor of Florida, 2024). In March 2024, Governor DeSantis approved legislation allowing Florida to participate in the Interstate Medical Licensure Compact, which allows qualified physicians to practice in multiple states. This step will improve access to healthcare, particularly for patients in underserved or rural parts of Florida

Of the 1,902 bills filed in the 2023-2024 Florida Legislative Session, only 13 (representing six distinct policies, when excluding companion bills) addressed private medical care prices directly. One bill passed: House Bill 7089 requires hospitals to post shoppable

healthcare service prices and outline patient rights when faced with medical debt collections, including a three-year statute of limitations on collection activities. Florida has previously implemented an All Payer Claims Database (APCD) administered by the Health Care Cost Institute (AHCA & HCCI, 2017).

Michigan

Michigan is a geographically and culturally diverse state, with two distinct land masses – the Lower Peninsula and Upper Peninsula – surrounded by the Great Lakes. Detroit and Grand Rapids are the two largest cities. Sixty-one of the 83 counties in Michigan are classified as rural. While manufacturing is the largest economic sector in the state, Michigan's economy includes a broad range of industries, including finance, real estate, higher education, construction, and agriculture.

Michigan has a robust health care sector. (See Figure 1) Commercial hospital prices in Michigan average approximately twice those of Medicare, making them the third lowest in the nation (Whaley et al., 2024). Only 6% of Michiganders are uninsured, far below the national rate of 10%. While this is attributable in part to Medicaid expansion, more Michiganders are enrolled in employer-sponsored insurance compared to the nation as a whole. Insurance premium prices for individuals have risen from $6,300 to $7,300 between 2018 and 2022. Employers have shouldered most of the increase and rates remain below the national average. Together, BCBS and Priority Health administer health benefits for more than 80% of Michiganders with private coverage (KFF, 2024).

Michigan is home to a progressive health policy landscape. In addition to expanding Medicaid following ratification of the Affordable Care Act (ACA), the Great Lakes State has also incorporated ACA provisions at the state level, ensuring that many of its most important pro-consumer reforms (*e.g.*, prohibitions on lifetime benefit caps, protections for persons with pre-existing conditions, identifying essential benefits covered by commercial health plans) will be preserved in the event of the ACA's repeal (Michigan House Democrats, 2023).

After two special elections in April 2024, Democrats regained control of the Michigan House of Representatives, giving them control of both legislative houses and the Governorship. Of the 2,562 bills introduced in the 2023-2024 Legislative Session, 13 bills (or seven policies, when excluding companion bills and substitutions) addressed private healthcare prices. These bills proposed a range of solutions, including establishing a state-specific healthcare exchange, private wholesale drug importation, and even a single-payer system. However, only one has left committee: Governor Gretchen Whitmer is spearheading a Prescription Drug Affordability Board (PDAB) package which would allow a state board of regulators to investigate drug prices and set cost ceilings (Camilleri, 2023). This bill passed the Michigan Senate and is expected to leave the House this session.

Nevada

Nevada is a frontier state. Much of Nevada is sparsely populated, with a few cities featuring a robust gaming industry (Haas, 2024). (See Figure 1) Healthcare in the Silver State faces unique challenges. (See Figure 2) A substantial number of counties are designated as Medically-underserved Areas (MUA) indicating an insufficient number of primary care providers (HRSA, 2024). The Commonwealth Fund ranks Nevada 45th in terms of healthcare access and affordability, and last for preventive services and treatment (Radley et al., 2024). Hospital prices average approximately 2.5 times the Medicare rate, ranking Nevada close to the middle among all states (Whaley et al., 2024). The uninsured rate of 13% exceeds the national rate of 10% (CB, 2024). An individual health plan in Nevada costs on average $6,850 annually, lower than many other states. Despite its rurality, the health insurance market is highly consolidated, with UnitedHealth providing coverage for almost two thirds of privately-insured persons in Nevada (KFF, 2024).

Nevada's policy response to its healthcare challenges has been robust. Anti-competitive practices such as anti-steering and anti-tiering clauses are prohibited in healthcare network contracts (Nev. Rev. Stat. § 598A.440). The state expanded Medicaid and operates its own health exchange, Nevada Health Link (2024). Additionally, healthcare entities are legally required to notify the attorney general 30 days prior to consummating any merger or acquisition which "would cause a group practice or health carrier to provide within a geographic market 50 percent or more of any health care service" (Nev. Rev. Stat. § 598A.370, 2024). However, it remains unclear to what extent such entities comply. An APCD is currently in development (Department of Health and Human Services, 2024).

Perhaps most substantially, in 2021 the Nevada Legislature and Democratic Governor Steve Sisolak authorized a public option to begin offering health plans in January 2026 (Boger, 2023; Lombardo et al., 2023). This puts current Republican Governor Joe Lombardo in the position of implementing a policy which he campaigned against. The Governor's Office has since released a plan to rebrand the public option as a "market stabilization program," by including a federally-funded reinsurance program for participating plans, providing incentive payments for plans meeting quality benchmarks, and financial assistance for healthcare training (Lombardo et al., 2023). While some believe this constitutes the end of the public option, Governor Lombardo's Section 1332 Innovation Waiver Request filed with Centers for Medicare and Medicaid Services (CMS) still includes the creation of public option plans, called "Battle Born State Plans" (Whitley, 2024).

As of mid-2024, Nevada state government is under divided control. Democrats control both chambers of the state legislature. Of the 1,096 bills filed in Nevada during the 2023 Legislative Session,[1] six addressed private healthcare prices and of these three passed: S.B. 57 prohibits pharmacy benefit managers (PBMs) or insurers from removing a drug from a formulary tier only to add it back at a higher tier; S.B. 146 prohibits health plans from denying physicians the ability to join their network without cause; S.B. 348 applies

[1] Sessions of the Nevada Legislature are biennial, occurring in odd years. The 83rd Session of the Nevada Legislature will begin on February 3, 2025.

penalties for healthcare entities which fail to comply with existing merger notification laws. Additionally, S.B. 348 requires operators of hospitals to get approval from the Director of the Department of Health and Human Services in order to close the hospital or convert their facility type, allowing the agency director to consider potential anticompetitive harms of such a decision.

METHODS

The results of this report include a deductive evaluation of stakeholder perspectives on state health policy interventions identified by CPR and a thematic analysis which supports these perspectives. CPR conducted interviews with 34 stakeholders in Florida, Michigan, and Nevada. These stakeholders represent a broad sample of the healthcare continuum, including self-insured and fully-insured healthcare purchasers, hospitals and outpatient healthcare providers, health plans, and experts familiar with the industry. Each interview was recorded and transcribed autonomously via software to create the corpus analyzed here.

Aims

Policymakers and researchers have proposed a variety of potential statutory or administrative solutions to reduce the burden of healthcare prices, including regulatory reforms to constrain prices directly, pro-competitive policies to harness the market, and transparency requirements which would better inform patients making healthcare decisions. This report summarizes the findings of a series of thirty-four interviews conducted with healthcare stakeholders in three states: Florida, Michigan, and Nevada. The analysis features three aims:

- Describe attitudes and perceptions of stakeholders regarding leading healthcare challenges and potential policy reforms in the.
- Evaluate support for potential healthcare policy reforms and specific policy interventions.
- Synthesize themes into recommendations regarding state policy reforms and strategies to restrain healthcare prices.

Deductive Analysis

Each interview transcript was analyzed with Taguette (Rampin et al., 2021), an open-source qualitative analysis platform. Where the transcript proved insufficient, the recorded video interview provided additional context. First, each transcript was read for thematic analysis. Then, each transcript was re-read to identify attitudes toward designated policy proposals. These attitudes were categorized as *Supportive* if the participant expressed clear or qualified support for the proposed policy. Participants who opposed a policy or expressed substantial concern about its potential consequences were coded as *Opposed*. *Defer* described a participant who indicated they or their organization would have no interest in a policy, or at least would not organize to support or oppose a policy. Participants who were not asked about a specific policy are excluded from the denominator when calculating support or opposition.

Thematic Analysis

Figure 3 outlines the method of conducting a thematic analysis, adapted from Braun and Clark (2006). The process begins by carefully coding information in the text. A single code represents an indivisible attitude, behavior, or cognition expressed by the participant. A code may indicate, for example, attributions regarding why hospitals raise prices. Codes are grouped as expressions of broader themes such as *Attitudes toward hospitals*. Codes within a theme may differ between participants. While different participants may express

disagreeing codes within the same theme, in the present analysis themes indicate largely congruent attitudes. In addition to the content of responses, meaningful failures to respond or attitudes expressed implicitly may also be coded.

Limitations

Importantly, any qualitative analysis is subject to several constraints. First, the purpose is to describe attitudes expressed by stakeholders, not to estimate how common these attitudes are in the population. This report does not represent the proportion of support for these policies across Nevada. Perhaps most importantly, the coding of responses is subjective, frequently requiring interpretation and even interpolation. Different researchers may come to different understandings of the same text in the dataset. As such, the numeric results should be interpreted in conjunction with the thematic analysis for the most complete illustration of participant attitudes.

RESULTS AND INSIGHTS

The 34 interviews largely consist of healthcare purchasers (and their representatives), health plans, and providers such as physicians and hospitals. (See Figure 5.) Other participants include experts familiar with the industry. Every state has representation from each stakeholder perspective. Attitudes among stakeholders proved as diverse as their states. Participants almost unanimously recognized the burden that high prices place on healthcare purchasers and on patients but disagreed on the best methods to alleviate this pressure. However, some policy alternatives proved more popular than others. Tables 1 through 6, and Figure 6, summarize the support for each policy by stakeholder group and state. The themes below Figure 6 provide necessary context.

Figure 6. Support for selected policies across states and stakeholders[2]

Note. Green indicates generally supported policies while red reflects unpopular proposals. Larger and more opaque bubbles indicate a larger number of participants (as a percentage of all participants in that column) were asked about the policy. See the full screen graph image here.

Forces Promoting Intervention

Everyone feels the burden of healthcare costs

Almost unanimously, across all three states and stakeholders, participants indicated rising healthcare prices pose a burden to their organizations, their patients, or to the residents of their states. No participant felt unaffected or content with current cost of healthcare services. Purchasers in all three states shared examples of the price pressure on their organizations. One purchaser chose to be self-funded after facing a 75% premium rate

[2] The absence of a bubble indicates that the interviewer did not ask the participant about the specific policy because prior answers allowed the interviewer to determine that the interviewee would not be in favor of the policy (e.g., interviewee did not ask plans or providers about a cost-growth target policy because interviewees had expressed opposition to either a public option or an affordability standard).

increase, which equated to an additional $2 million in their premiums. Another purchaser said that $.20-$.22 of every dollar goes toward pharmacy spending.

Healthcare is the Second Largest Expense Line-Item

Purchasers used the most emotionally charged language when describing the current healthcare landscape, suggesting a particular urgency. They frequently used the word "burden" and other negative descriptors to describe prices. While some purchasers said they are not immediately panicking, they said the pressure of rising prices is building, and they worry about the sustainability of being able to offer coverage for their employees and dependents. Some purchaser participants said they have had to increase their employee premium contributions, increase deductibles, and reduce benefits to address their rising costs. Purchasers recognized in the interviews that when health care spending is the second largest expense for a company, they and their executives need to pay attention.

Most stakeholders have an appetite for policy changes

More than two thirds of participants expressed an interest in using state policy to lower healthcare prices. While health providers may benefit from high prices and health plans can distribute rising prices through premiums to their fully-insured book of business, self-funded purchasers are the most exposed to price increases. Appropriately, they expressed the greatest enthusiasm for policy interventions. Even purchasers who expressed concern about regulation decreasing competition, believe that government plays a role in providing relief to the high price of healthcare services.

Participants believe hospitals, drugs, public insurance, and rising wages are driving high prices

Rising healthcare prices are attributed to a combination of forces, including increasing consolidation and the influence of venture capital among both providers and plans, economic challenges following the COVID-19 pandemic (*e.g.*, nursing shortages and resulting wage increases, a rebound in care utilization, and a decrease in emergency spending), and a rise in high-cost medication. Participants implicated each of these factors and more, including a purchaser stating that the amount hospitals charge for services is "exorbitant" over the true cost of the service, and "we are all overpaying."

Most non-hospital participants blame hospitals for increasing unit prices simply because the market will endure such increases. Rather than attribute these increases to other forces in the market, non-hospital participants suspect hospitals are raising prices for their benefit in a way which hurts patients and is "morally impermissible." They believe this behavior is due to a lack of competition, knowledge or awareness by patients, or transparency.

While not as common, a more diverse range of stakeholders (including providers) implicated drug costs as a major driver of overall price increases. One interviewee said that pharmacy is the "biggest black box when it comes to healthcare prices" and others expressed similar sentiments. This led some to believe that there is more of an appetite for government intervention in healthcare prices generally.

Many stakeholders, including purchasers, acknowledge that hospitals face systematic pressure from public programs (Medicaid and Medicare) which reimburse healthcare services at rates lower than the commercial market. These stakeholders assert that hospitals "have a lot of pressure [on their bottom line], and they transfer it to the commercial line of business." That is, hospitals increase unit prices for commercial payers in order to recoup revenue lost from public programs. Some hospital participants admitted this implicitly, acknowledging that they lobby state government to increase Medicaid reimbursement rates to avoid leveraging commercial payers, or lauding state government for taking "some major steps in the right direction on the Medicaid reimbursement front." Participants believe this cost-shifting also occurs among pharmaceutical manufacturers, who compensate for low Medicare reimbursement or rebates in 340B or other public programs by increasing drug prices for commercial payers.

Further, providers and other stakeholders identified rising salaries as cost drivers. Nursing compensation is implicated most strongly, particularly the rise in travel nursing associated with COVID-19 and the related healthcare workforce depletion. Labor costs cannot be factored into rates set by Medicaid or Medicare, instead being offset entirely through commercial healthcare prices. However, much of the burden of rising healthcare prices reported by stakeholders here predates the COVID-19 pandemic. One hospital participant said they experienced a "22% increase year of year from 2021 to 2022 in staffing costs." Another provider said that it wasn't just nursing costs that were driving overall costs. They said imaging, lab, and other highly specialized employees' rates are rising quickly, saying: "We've lost three employees this week to a competing hospital because they are offering a $30,000 'knowledge' bonus."

Barriers to Intervention

Hospitals are unpopular among stakeholders, but hold substantial political power

Purchasers and health plans made substantial negative comments regarding hospitals, their business practices, and their motivations. In short, these stakeholders believe hospitals leverage the complexity of the healthcare system to overcharge patients for services and fight cost-and price-reducing policies. They view hospitals, not politicians or insurers, as the primary opponents of common-sense policies to constrain healthcare prices. Hospitals benefit from the goodwill in their communities; however, among purchasers and stakeholders familiar with hospital business practices, deep frustration exists, saying that hospitals "are greedy," "they refuse to comply with transparency requirements," "they deny the conclusions of independent financial analyses," "they deceive or bully patients," "they encourage unnecessary utilization," and "they hide behind their non-profit status." Some interviewees said that hospitals "price gouge," with one interviewee giving an example of a relative being "charged $100 for Tylenol." Importantly, participants believe that hospitals are able to leverage public and political power to ward off policies which may cut into revenue or even to "punish opponents." No other stakeholder, even pharmaceutical manufacturers, received as many negative attributions.

Health plans hold notable political power, though less than hospitals

Participants also attributed insurers with noticeable power to influence policy. Whereas hospitals were frequently considered bad-faith actors, perspectives on health plans

proved more complicated. While health plans sometimes supported cost- and price-reducing policies such as surprise billing protections, they also effectively defend their bottom line. A few participants implicated health plans as the primary instigator of rising prices, but others recognized that the premiums insurers charge ultimately depend on underlying healthcare prices. One health plan admitted that both plans and provider have substantial power and "regulatory capture" and "we're all good at making sure we have 'our share' and are heard." On the other hand, purchaser participants expressed frustration that legislation "doesn't move" if it impacts health plans, saying, "their lobbying presence is so strong, we have had one or two hearings in four years." If bills are heard, participants described it as a "courtesy," and it is known by all parties that the "bill won't move" out of committee.

Stakeholders fear limiting their healthcare choices

Interestingly, when describing concerns about policy interventions, participants voiced fears that their choice of health plans or providers could be constrained more frequently than fears about increasing prices. Purchasers placed an emphasis on being able to offer benefits packages which meet their needs. They want the flexibility to choose between provider networks, differentiate amongst healthcare providers of varying quality, and design cost-sharing structures most appropriate for their employee base. Additionally, some stakeholders worry that supporting regulation of other industries has the potential to invite regulation of themselves. Participants in more highly-regulated industries expressed this fear more acutely, saying that such policies may "send the unintended message that it could be difficult to do business in the state."

While these proved to be the most common fears regarding policy interventions, other concerns percolated: new policies might simply be ineffective; any price reductions may be offset by increased prices elsewhere in the system; quality could be diminished or services cut; and, in the worst-case scenario, prices across the industry may rise faster than they would without intervention. However, purchasers' exhaustion from bearing the burden of high healthcare prices exceeded most fears.

Most stakeholders acknowledge having limited familiarity with specific healthcare policy proposals.

Health plans and providers demonstrated greater general knowledge of state policy interventions than employers, reflecting the extent to which these policies directly impact their business practices. To be successful, advocates for policy change must be fully educated and informed about proposed policies and why they will create benefits for healthcare purchasers and consumers. Based on our interviews, purchasers are still on the learning curve when it comes to various proposed policy solutions. Increased awareness and knowledge would help advance advocacy efforts.

Additionally, interviewees perceived that policymakers themselves often had little subject-matter expertise as they considered health reforms. Health plans and providers expressed greater fluency on specific health policies and regularly communicated their positions to policymakers. Purchasers have an opportunity to educate policymakers to balance the voices on new initiatives, explaining the nuances and intended benefits to those that buy health care for their employees and dependents.

Support for Policies in Florida
The Florida sample included several healthcare purchasers and only one health plan. This inflates the nominal support for policies which shift the burden of healthcare prices back to health plans and providers. With this in mind, Florida purchasers supported policies aimed to reduce hospital-associated healthcare prices and promote competition.

With 90% support, the most popular policy solution for rising prices proved to be a prohibition on anticompetitive contracting practices, such as anti-tiering and anti-steering contract clauses. Purchasers, in particular, rely on steering and tiering in the design of their benefits to promote the use of high-value care from the network of providers. However, Florida's deeply held free market ideals may make any policy reform related to contracting between private parties a battle in the State Legislature.

Of those asked, almost 89% supported mandatory merger notification. While this policy has traditionally targeted health system mergers, many participants also expressed an interest in merger notifications for health plans. Merger authorization was less favorable (75%), but still strongly supported among purchasers.

Interestingly, while a prohibition on facility fees is a popular policy nationally, only 57% of Florida participants supported such a law. However, self-funded purchasers, including public purchasers, often feel deceived when charged additional fees for outpatient services, and felt this issue could be framed as a pro-consumer reform. However, providers in the study opposed a prohibition on facility fees, equating it to site-neutral payment policies in Medicare, and many other stakeholders indicated no opinion.

Participants, particularly purchasers, showed appetite for even more progressive reforms. Almost 86% wanted to prohibit hospitals from collecting medical debt if they are out of compliance with federal transparency rules, and 75% supported a cost growth target for health insurance premiums. Only two thirds supported an APCD (Florida's APCD is active), and the same proportion supported taxing excessive hospital gains.

Support for Policies in Michigan
The Michigan policy ecosystem appears amenable to regulatory intervention. Legislation creating the pharmacy drug affordability board (PDAB) is currently working its way through the Michigan Legislature at the direction of the Governor. While not a likely vehicle for policies discussed in this report, passage of the PDAB bill may clear a path for further reform to address high prices and healthcare affordability.

Of the policy options presented to interviewees, the great majority (83%) of them endorsed a prohibition on anti-competitive contracting clauses between health plans and providers, and 83% of participants also support a prohibition of facility fees, including representatives from every stakeholder group. Additionally, participants expressed significant support for merger notification (100%). Purchasers fear their leverage in negotiations is diminishing as healthcare providers and plans consolidate. Despite expressing sentiments to keep government intervention low, one participant indicated a willingness to defer to the state legislature on merger notification or approval. However, non-purchaser stakeholders hold strong suspicions regarding merger notification or approval.

Some policies which attract interest in other states, such as a cap on OON healthcare prices or an affordability standard for insurance premiums, proved unpopular in Michigan. Opposition to these policies was 60% and 75%, respectively.

Michigan participants expressed substantial skepticism regarding APCDs and health plans and feel they already shoulder significant regulatory and transparency burdens.

Support for Policies in Nevada
Nevada has several laws on the books that are intended to put downward pressure on commercial prices, a public option, price transparency through an APCD, notification of intended mergers of healthcare entities, and a prohibition of anti-competitive clauses (anti-tiering and anti-steering) in provider-health plan contracts. Despite the existing statutory language, interviewees were still asked about these policies in the context of execution of implementation.

The most popular policy proved to be a prohibition on facility fees for outpatient services (78%). Purchasers endorsed the policy purely as a lever to reduce healthcare prices, while other stakeholders recognized that facility fees do not contribute to the value of care and constitute anticompetitive practices.

Nevada's APCD is currently under construction and some participants continue to believe it holds promise as a transparency tool to expose high prices and unnecessary price variability. This optimism was tempered as to whether the reporting system is easy to use.

Despite it being existing law, only 56% of participants expressed support for merger notifications. This relatively lower percentage could be attributed to participants' skepticism that current notification requirements are being followed or enforced. Prior authorization of mergers proved even less popular (38%).

While similar in percent support to the merger notification law, interviewees used positive, descriptive language that demonstrates continued support of existing Nevada law prohibiting anti-tiering and anti-steering clauses in network contracts (57%).

Policy Recommendations
CPR's policy menus consolidate many policy proposals into packages of functionally related solutions.

Florida
Of these menus, the policies endorsed by participants in Florida reflect two most closely: Shore Up Market Against Consolidation and Rising Prices, and Pick the Low Hanging Fruit. Based on the interviews, the three policies that are the most promising in Florida are:

1. Mandating merger notification
2. Prohibiting facility fees for outpatient services
3. Prohibiting anti-tiering and anti-steering clauses in network contracts

Merger notification would likely require implementation by state attorneys general, offices with existing antitrust infrastructure. A facility fee prohibition may require legal

enforcement, but patients and purchasers would be empowered push back on illegal fees. Other policies in both menus received support from purchasers and health plans, but these would likely prove controversial for hospitals and possibly policymakers. Potentially controversial but popular policies included: requiring hospitals to comply with federal transparency rules before collecting medical debt; building a database of audited hospital financial statements; and even capping commercial healthcare prices.

Michigan

The Michigan policy ecosystem is uniquely amenable to regulatory intervention, and, while hospitals are still powerful constituents, health plans also hold considerable political power. If PDAB becomes law, it may form the foundation for further reforms to address high prices and healthcare affordability.

The following policies received the most support among Michigan stakeholders. These policies most closely reflect *Shore Up Market Against Consolidation and Rising Prices*. While Michigan's policy landscape does not map perfectly to this menu, participants proved receptive to three core policies:

1. Prohibit anti-tiering and anti-steering clauses in network contracts
2. Prohibit facility fees for outpatient services
3. Require authorization for healthcare mergers

Nevada

Nevada's current healthcare policy landscape largely resembles several of CPR's menus: *Shore Up Market Against Consolidation and Rising Prices* (merger notification, banning anticompetitive contracting practices, public option). Nevada's APCD has the potential to support these policies, and the patient protection commission resembles a health policy commission.

Of the remaining policies on the *Shore Up Market Against Consolidation and Rising Prices* menu, and CPR's *Punish Bad Actors* policy menu, two policies rise to the top:

1. Prohibiting facility fees
2. Capping out of network (OON) prices[3]

Nevada has already prohibited anticompetitive contracting practices and can further prevent abuses of market power by banning unwarranted facility fees from health systems that have acquired physician practices. This policy will require robust transparency which can be provided by the state's APCD to analyze data and identify unwarranted fees.

Capping OON prices to a Medicare benchmark strengthens negotiating leverage for health plans and purchasers; however, it would likely require enforcement infrastructure via the state's APCD and patient protection commission to ensure that savings from lower prices are passed on to purchaser and consumers. Enforcement of an OON price cap might be further complicated by the fact that certain OON services are delivered out-of-state.

[3] This policy also falls under CPR's *Regulating Provider Prices* menu.

Finally, Nevada is currently implementing a public option health plan, which is part of CPR's *Shore Up Market Against Consolidation and Rising Prices* and *Empower Existing "Balancers" of Market Power (i.e., Employers and Carriers)* menus. While advocates may advance new policy solutions, CPR recommends stakeholders consider how best to inform the implementation of the public option and/or improve existing reforms. Additionally, policy solutions in Nevada must contend with its geography and access issues.

Insights

Assemble coalitions carefully to avoid conflicts

Business coalitions are important advocates for policy change and will undoubtedly contribute to any successful efforts to lower or limit the growth of commercial prices. Participants expressed enthusiasm for coalitions, recommended other businesses which would be powerful allies, and encouraged healthcare purchasers to participate. However, coalition leaders and participants with government affairs experience often painted a more nuanced view of how these coalitions may operate in practice.

The healthcare system, particularly within states, is tightly interwoven, contributing to complicated relationships that often have dual utility: a hospital is also a healthcare purchaser for its own employees; a health plan may be a political ally to a purchaser in a business coalition, even as they negotiate a contract renewal; a patient may struggle with medical debt, but still have good will toward their physician. As any healthcare policy is necessarily a reapportionment of financial risk among purchasers, providers, and plans, even when formal conflicts of interest are not present, advocates must consider how advancing a policy would impact a key relationship.

Advocacy organizations should be constructed carefully to avoid assembling a coalition that cannot be adequately leveraged, or may be constrained by, its member base.

Equip purchasers to use their market leverage against price-raising practices.

In order to maximize and apply their leverage, purchasers have several opportunities to use their buying power to their advantage. Purchasers can join coalitions to amplify their voices and possibly negotiate collectively where allowed. They can also be proactive with their health plans or third-party administrators to see if anti-competitive contract clauses exist and ask that they be removed, which can allow them to cut low-value care providers from their networks.

Coalitions with an emphasis on health policy play a substantial role in empowering purchasers and equipping them with the education and assistance necessary to more forcefully advocate for their covered populations. This may represent an avenue to advance a market-based solution to rising healthcare prices in states which are reluctant to use the levers of policy, while also serving as an opportunity to educate future political allies about policy solutions (*e.g.*, discussing a state prohibition on facility fees while also discussing methods to remove facility fees via contract).

Educate policymakers before others do

Participants described the strength of both the health system and health plan lobby in all states. Healthcare is a complicated industry; many policymakers must depend on the

counsel of subject matter experts to make informed decisions. This knowledge gap advantages hospital and health plan advocates seeking to maintain the status quo.

Purchaser advocates must lay a firm and accurate foundation of knowledge on which to build in subsequent legislative sessions. Importantly, policymakers need accessible, jargon-free information such as CPR's Policy Menus; listening sessions with constituents whose benefits have been impacted by harmful healthcare practices; and unbiased evidence comparing the efficacy of different policy solutions. The purpose of this education would not be solely to influence policy now, but to inform policymakers on key issues before they can become misinformed by entrenched interests. Purchasers, too, may benefit from a sustained education campaign.

Use pro-patient, pro-consumer language to frame health policy solutions
The negative language used by purchasers to describe healthcare providers, particularly hospitals, cannot be ignored: "greed," "bullying," "shocking to the conscience," "egregious," "smoke and mirrors," "price gouging," "lining their pockets." Even purchasers who expressed concerns about government intervention generally supported government involvement to address these practices. They suggest a functioning competitive market has failed due to an uneven playing field, and they are amenable to policies which may correct this.

Pro-patient reforms in recent sessions in Florida, for example, prohibit certain predatory practices. House Bill 7089 outlines a list of patient rights when faced with medical debt collection, including circumstances that must be satisfied before the debt may be pursued, what property is protected from seizure to settle the debt, and a three-year statute of limitations. These policies may be reasonably perceived as the government leveling the playing field, preventing powerful agents from using anti-consumer practices to prey on patients.

Similarly, bills prohibiting anti-tiering and anti-steering clauses in health plan and provider contracts are not simply policies affecting private party contracts. The provisions themselves are anti-consumer which can raise patient out of pocket costs and interfere in how businesses design and administer their own employee benefits. Similarly, facility fees are hidden fees which hospitals tack onto healthcare services just because they can and add no additional value to the patient. A cap on OON prices sends the signal that providers cannot take advantage of a sick person just because they want to choose their own doctor.

Adopt advocacy strategies sensitive to the political makeup of each state government
Naturally, the different political makeups of each state will inform the respective advocacy strategy. Currently, both houses of the Florida Legislature are under Republican control and the Governor exerts significant influence over the legislative process. An effective advocacy strategy likely includes working with the DeSantis administration, and the Legislature on parallel tracks.

In Michigan, advocates may feel able to pursue policies which may be considered non-starters in other states. The state of politics in Michigan may lend itself to forward-

thinking health reforms which specifically shift risk away from purchasers and plans toward health systems.

Nevada's divided government requires a more complex advocacy strategy. Governor Lombardo set the record for the most bills vetoed in a single legislative session.[4] To mitigate the veto risk, advocates should consider prioritizing relatively uncontroversial legislation, such as a prohibition on facility fees, which may be framed as a pro-consumer and pro-transparency reform. Additionally, advocates can offer guidance on the implementation of the public option, which may even be a vehicle for new health reforms.

[4] Nevada Independent. (2023). Lombardo Veto Tracker: Governor sets new record with 75 vetoes. https://thenevadaindependent.com/article/lombardo-veto-tracker-medical-debt-collection-mental-health-consortium-rejected

CONCLUSION

This study reveals attitudes and perceptions regarding the healthcare system and potential reforms among participants in Florida, Michigan, and Nevada. These perspectives may inform policy interventions tailored to each state, which can constrain health care cost growth in the state. Targeted policy interventions – especially prohibiting anti-competitive contracting practices, prohibiting facility fees, and strengthening anti-trust enforcement to include merger oversight, may have a viable path to enactment in the respective states.

More broadly, these interviews revealed findings relevant in other states:

- The following policies received the most support among interview participants:
    1. Prohibit facility fees for outpatient services,
    2. Prohibit anti-tiering and anti-steering clauses in network contracts,
    3. mandate that providers or health plans notify the state attorney general prior to any merger or acquisition.
- Purchasers support price-reducing health reforms which preserve their ability to choose among healthcare providers and plans.
- Purchasers often defer to health plans on health policy issues.
- Hospitals' significant influence among policymakers, businesses, and the public is a significant barrier to policy proposals intended to limit health care prices.
- Effective strategies for policy outreach include coalitions assembled carefully to avoid conflicts of interest, education for both purchasers and policymakers on key health reforms, and clearly demonstrating how proposed policies address patient needs.

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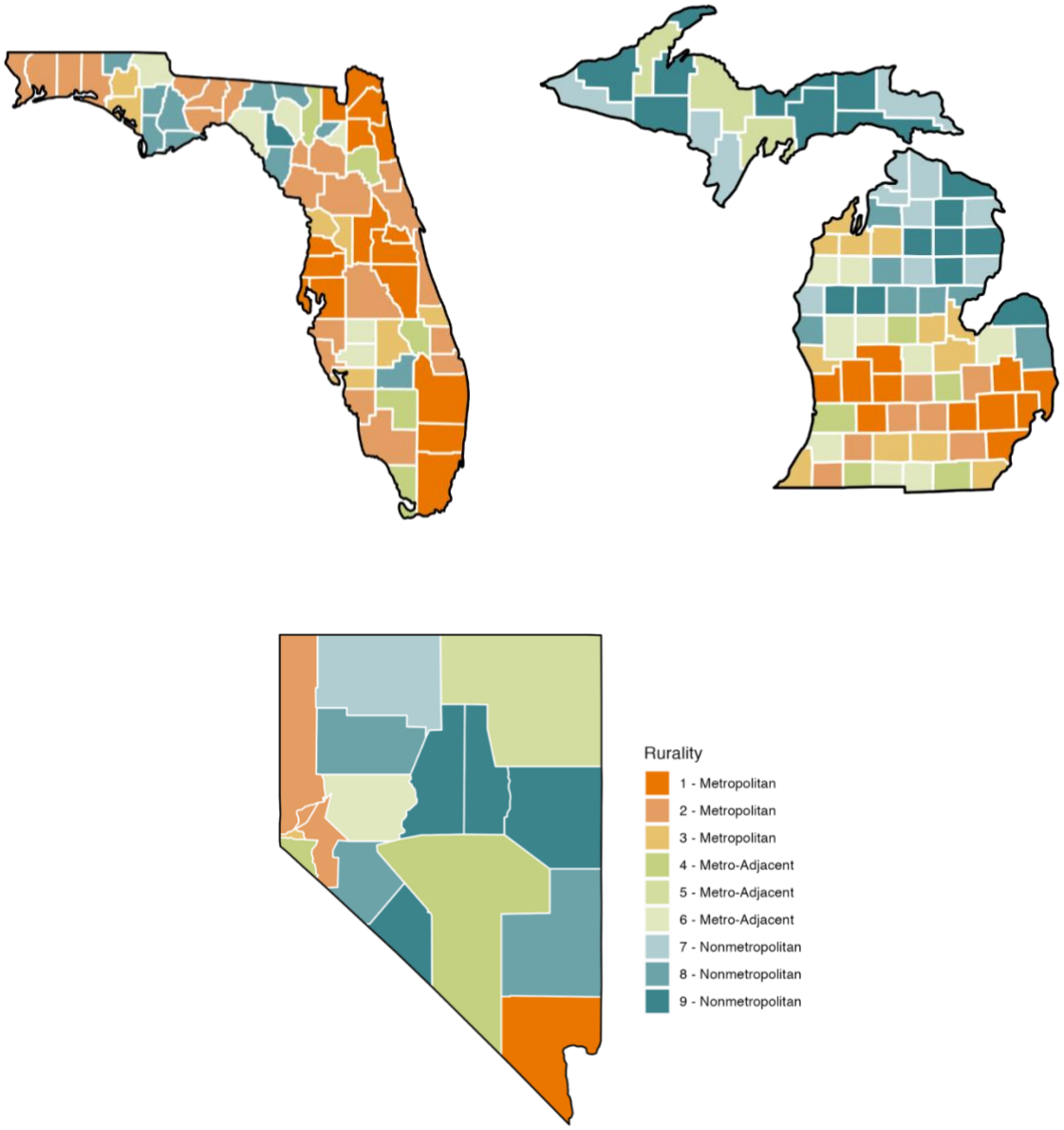
FIGURES

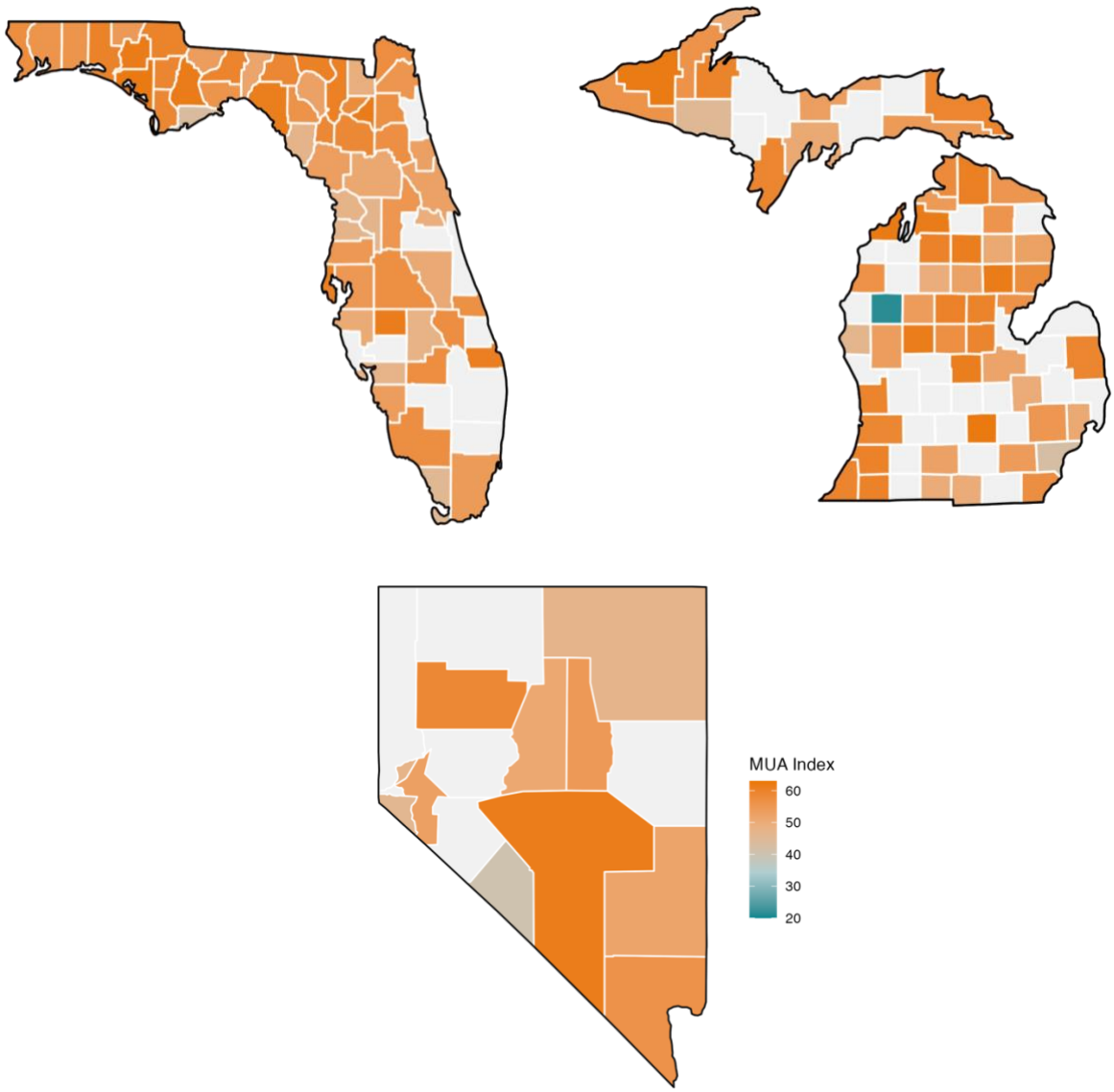
Figure 1. Rural designation of Florida, Michigan, and Nevada counties.



Note. Rural designation indicated by RUCCs. Lower numbers and brighter colors indicate metropolitan or metropolitan-adjacent counties (USDA, 2024). Codes correspond to the following populations:

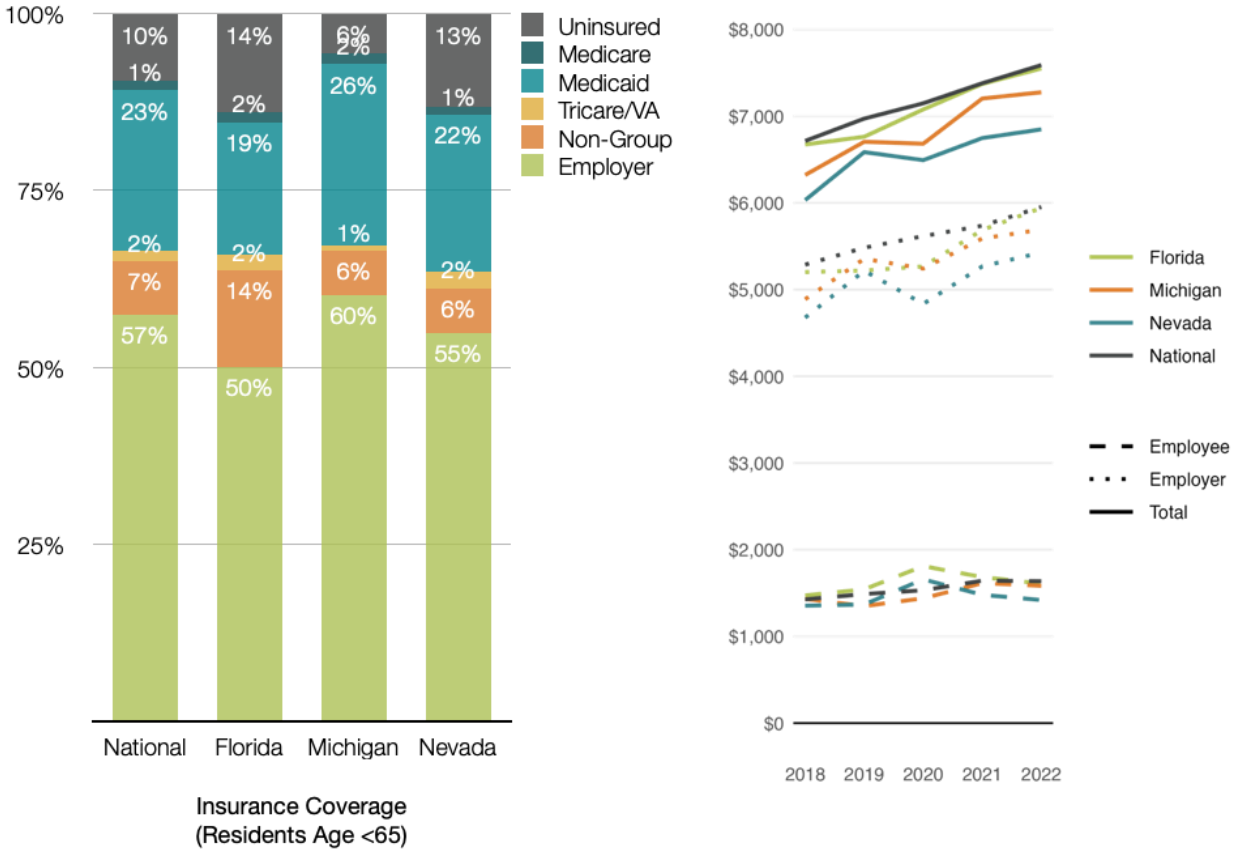
1 Metropolitan - Counties in metro areas of 1 million population or more
2 Metropolitan - Counties in metro areas of 250,000 to 1 million population
3 Metropolitan - Counties in metro areas of fewer than 250,000 population
4 Nonmetropolitan - Urban population of 20,000 or more, adjacent to a metro area
5 Nonmetropolitan - Urban population of 20,000 or more, not adjacent to a metro area
6 Nonmetropolitan - Urban population of 5,000 to 20,000, adjacent to a metro area
7 Nonmetropolitan - Urban population of 5,000 to 20,000, not adjacent to a metro area
8 Nonmetropolitan - Urban population of fewer than 5,000, adjacent to a metro area
9 Nonmetropolitan - Urban population of fewer than 5,000, not adjacent to a metro area

Figure 2. A snapshot of Florida, Michigan, and Nevada healthcare.
A) MUAs in Florida, Michigan, and Nevada (HRSA, 2024)

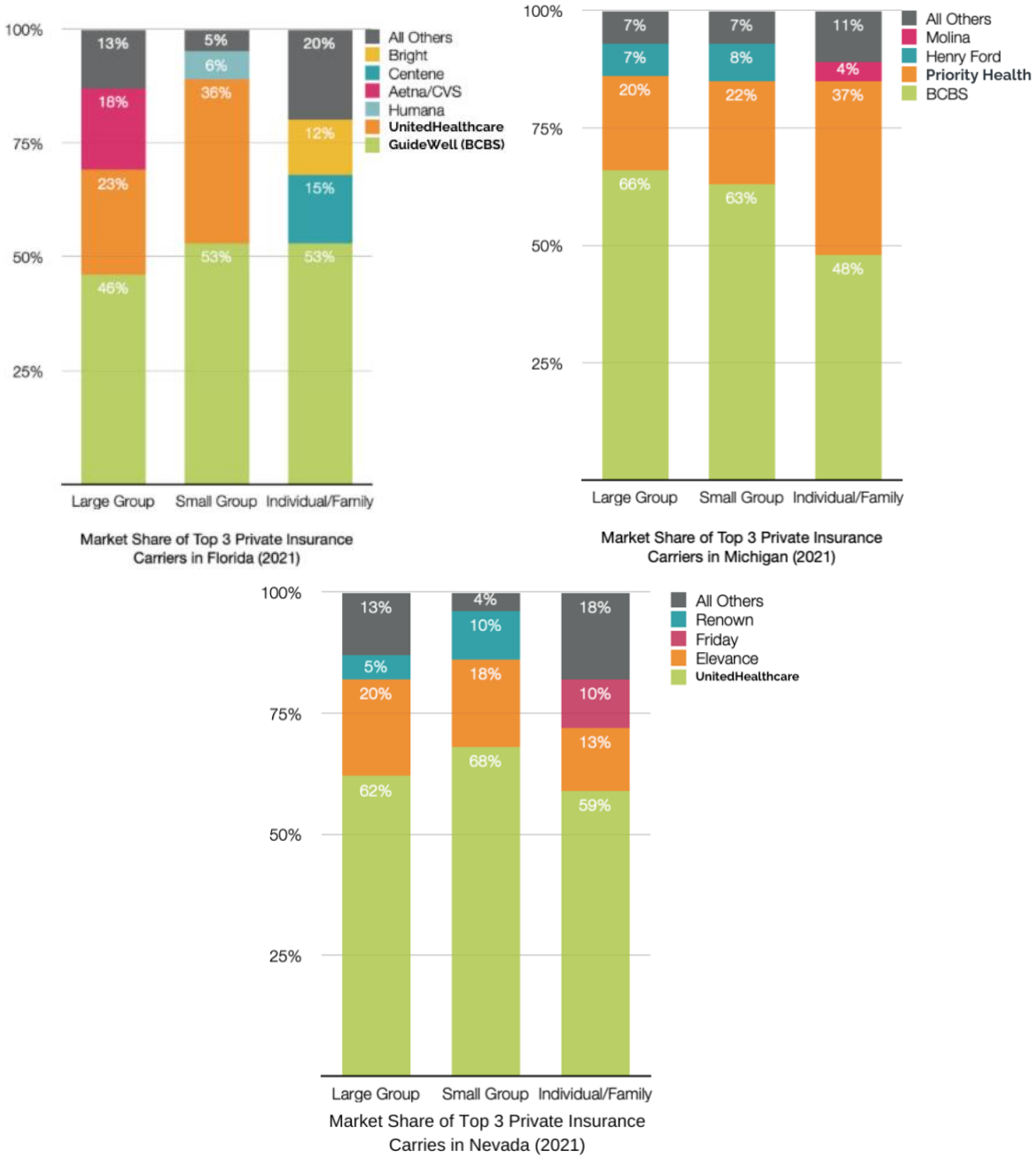


Note. A) Lower MUA Indices (lighter colors) indicate greater need for providers. Uncolored counties are not designated MUAs.

B) Sources of insurance and premium prices in Florida, Michigan, and Nevada (CB, 2024; KFF, 2024)



C) Top 3 private insurance carriers in large-group, small-group, and individual markets in Florida, Michigan, and Nevada (KFF, 2024)



Note. C) A noted carrier may have market share among *All Others* but be unreported as it falls below the market share of the top three carriers (*e.g.*, UnitedHealthcare may offer individual health plans in Florida, but because it is not one of the top three carriers in terms of market share, its enrollment is include among *All Others*).

Figure 3. Flowchart depicting the process of performing a thematic analysis
Note. Adapted from Braun and Clark (2006).

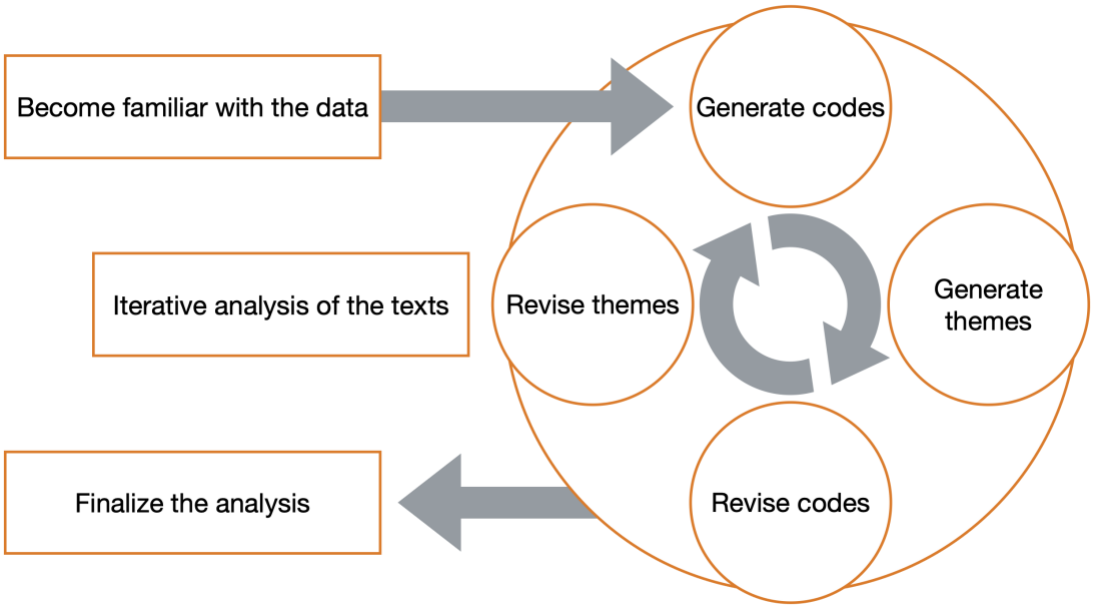
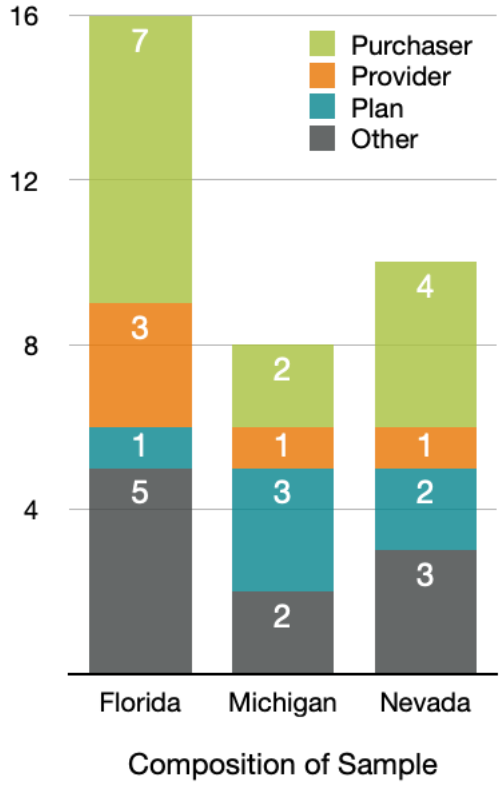
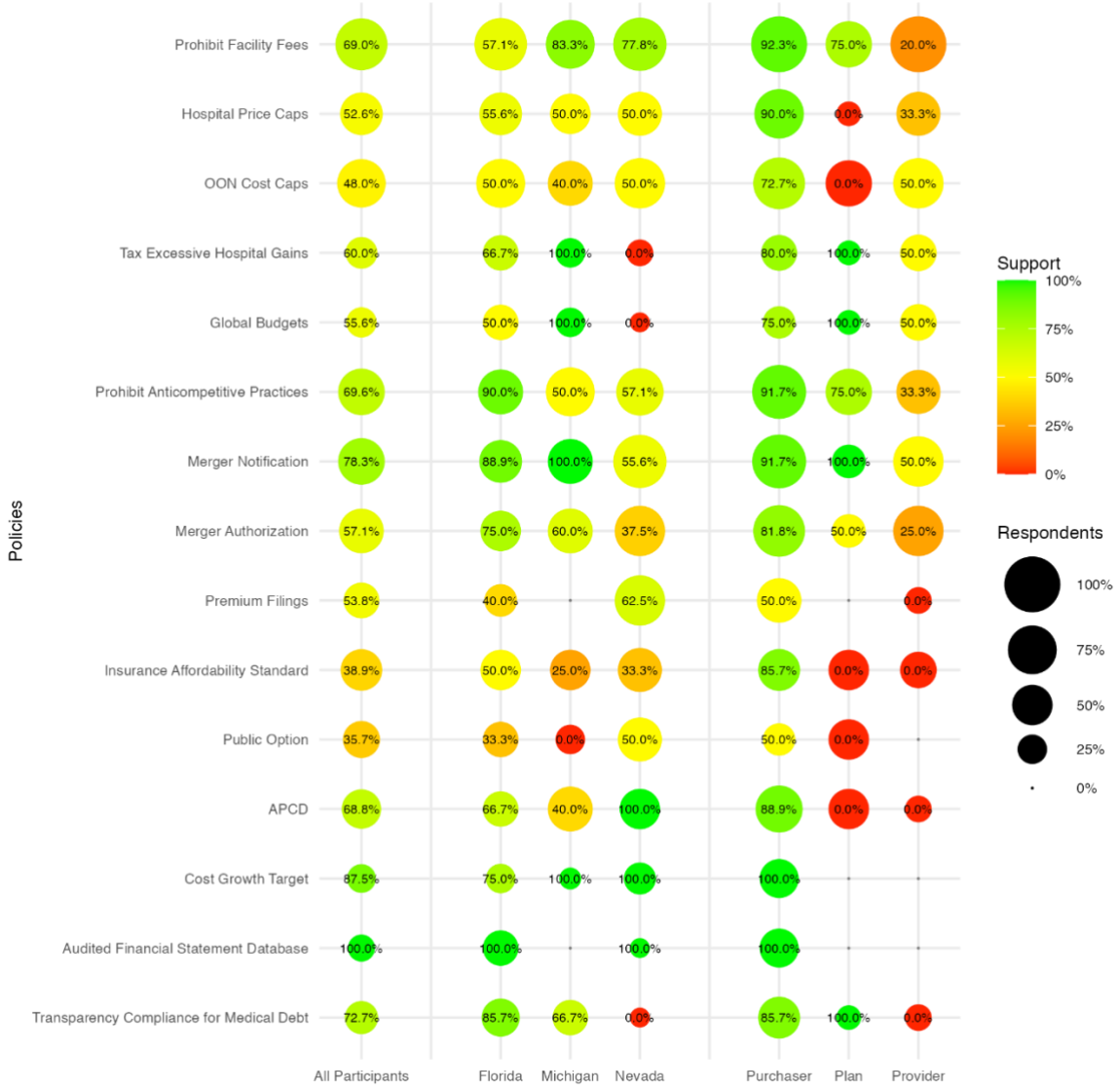


Figure 4. Participants interviewed



Note. Some organizations may blur the line among stakeholder perspectives. The categorization above indicates the principal business of each participant.

Figure 5. Support for selected policies across states and stakeholders



Note. Green indicates generally supported policies while red reflects unpopular proposals. Larger and more opaque bubbles indicate a larger number of participants (as a percentage of all participants in that column) were asked about the policy.

TABLES

Table 1. Participant attitudes toward policies regulating hospital prices, by state.

State	Attitude	Prohibit Facility Fees	Cap OON Costs	Cap Hospital Prices or Increases	Tax Excessive Hospital Gains	Impose Global Budgets
Florida	Support	57.1%	50.0%	55.6%	66.7%	50.0%
	Oppose	7.1%	25.0%	22.2%	16.7%	33.3%
	Participants	14 of 16	12 of 16	9 of 16	6 of 16	6 of 16
Michigan	Support	83.3%	40.0%	50.0%	100.0%	100.0%
	Oppose	16.7%	60.0%	50.0%	0.0%	0.0%
	Participants	6 of 8	5 of 8	4 of 8	2 of 8	2 of 8
Nevada	Support	77.8%	50.0%	50.0%	0.0%	0.0%
	Oppose	22.2%	25.0%	33.3%	50.0%	0.0%
	Participants	9 of 10	8 of 10	6 of 10	2 of 10	1 of 10
Total	Support	69.0%	48.0%	52.6%	60.0%	55.6%
	Oppose	13.8%	32.0%	31.6%	20.0%	22.2%
	Participants	29 of 34	25 of 34	19 of 34	10 of 34	9 of 34

Table 2. Participant attitudes toward policies promoting competition, by state.

State	Attitude	Prohibit Anti-Tiering/Anti-Steering	Merger Notification	Merger Authorization	Premium Filings	Affordability Standard	Public Option
Florida	Support	90.0%	88.9%	75.0%	40.0%	50.0%	33.3%
	Oppose	10.0%	11.1%	25.0%	20.0%	37.5%	66.7%
	Participants	10 of 16	9 of 16	8 of 16	5 of 16	8 of 16	6 of 16
Michigan	Support	50.0%	100.0%	60.0%	0.0%	25.0%	0.0%
	Oppose	16.7%	0.0%	40.0%	0.0%	75.0%	50.0%
	Participants	6 of 8	5 of 8	5 of 8	0 of 8	4 of 8	2 of 8
Nevada	Support	57.1%	55.6%	37.5%	62.5%	33.3%	50.0%
	Oppose	14.3%	11.1%	25.0%	37.5%	66.7%	33.3%
	Participants	7 of 10	9 of 10	8 of 10	8 of 10	6 of 10	6 of 10
Total	Support	69.6%	78.3%	57.1%	53.8%	38.9%	35.7%
	Oppose	13.0%	8.7%	28.6%	30.8%	55.6%	50.0%
	Participants	23 of 34	23 of 34	21 of 34	13 of 34	18 of 34	14 of 34

Table 3. Participant attitudes toward policies promoting transparency, by state.

State	Attitude	APCD	Cost Growth Target	Audited Financial Statement Database	Forcing Transparency Compliance via Debt
Florida	Support	66.7%	75.0%	100.0%	85.7%
	Oppose	16.7%	0.0%	0.0%	14.3%
	Participants	6 of 16	4 of 16	6 of 16	7 of 16
Michigan	Support	40.0%	100.0%	0.0%	66.7%
	Oppose	60.0%	0.0%	0.0%	33.3%
	Participants	5 of 8	1 of 8	0 of 8	3 of 8
Nevada	Support	100.0%	100.0%	100.0%	0.0%
	Oppose	0.0%	0.0%	0.0%	0.0%
	Participants	5 of 10	3 of 10	1 of 10	1 of 10
Total	Support	68.8%	87.5%	100.0%	72.7%
	Oppose	25.0%	0.0%	0.0%	18.2%
	Participants	16 of 34	8 of 34	7 of 34	11 of 34

Table 4. Participant attitudes toward policies regulating hospital prices, by stakeholder.

Stakeholder	Attitude	Prohibit Facility Fees	Caps OON Costs	Caps on Hospital Prices or Increases	Tax Excessive Gains	Global Budgets
Purchaser	Support	92.3%	72.7%	90.0%	80.0%	75.0%
	Oppose	0.0%	0.0%	0.0%	0.0%	0.0%
	Participants	13 of 13	11 of 13	10 of 13	5 of 13	4 of 13
Provider	Support	20.0%	50.0%	33.3%	50.0%	50.0%
	Oppose	40.0%	25.0%	66.7%	0.0%	50.0%
	Participants	5 of 5	4 of 5	3 of 5	2 of 5	2 of 5
Plan	Support	75.0%	0.0%	0.0%	100.0%	100.0%
	Oppose	0.0%	100.0%	100.0%	0.0%	0.0%
	Participants	4 of 6	4 of 6	1 of 6	1 of 6	1 of 6

Table 5. Participant attitudes toward policies promoting competition, by stakeholder.

Stakeholder	Attitude	Prohibit Anti-Tiering/Anti-Steering	Merger Notification	Merger Authorization	Premium Filings	Affordability Standard	Public Option
Purchaser	Support	91.7%	91.7%	81.8%	50.0%	85.7%	50.0%
	Oppose	0.0%	0.0%	9.1%	25.0%	14.3%	50.0%
	Participants	12 of 13	12 of 13	11 of 13	8 of 13	7 of 13	4 of 13
Provider	Support	33.3%	50.0%	25.0%	0.0%	0.0%	0.0%
	Oppose	66.7%	50.0%	75.0%	100.0%	100.0%	0.0%
	Participants	3 of 5	4 of 5	4 of 5	1 of 5	2 of 5	0 of 5
Plan	Support	75.0%	100.0%	50.0%	0.0%	0.0%	0.0%
	Oppose	0.0%	0.0%	50.0%	0.0%	100.0%	100.0%
	Participants	4 of 6	2 of 6	2 of 6	0 of 6	3 of 6	3 of 6

Table 6. Participant attitudes toward policies promoting transparency, by stakeholder.

Stakeholder	Attitude	APCD	Cost Growth Target	Audited Financial Statement Database	Forcing Transparency Compliance via Debt
Purchaser	Support	88.9%	100.0%	100.0%	85.7%
	Oppose	11.1%	0.0%	0.0%	0.0%
	Participants	9 of 13	6 of 13	6 of 13	7 of 13
Provider	Support	0.0%	0.0%	0.0%	0.0%
	Oppose	100.0%	0.0%	0.0%	100.0%
	Participants	1 of 5	0 of 5	0 of 5	1 of 5
Plan	Support	0.0%	0.0%	0.0%	100.0%
	Oppose	66.7%	0.0%	0.0%	0.0%
	Participants	3 of 6	0 of 6	0 of 6	1 of 6

ABBREVIATIONS

Abbreviation	Term
ACA	Patient Protection and Affordable Care Act
AHRQ	Administration for Healthcare Research and Quality
APCD	All-Payer Claims Database
BCBS	BlueCross BlueShield
BLS	Bureau of Labor Statistics
CB	Census Bureau
COVID-19	Coronavirus Disease 2019
CPR	Catalyst for Payment Reform
DOI	Department of Insurance
HRSA	Health Resources and Services Administration
MLR	Medical Loss Ratio
MUA	Medically-Underserved Area
OON	Out of Network
PBM	Pharmacy Benefits Manager
PDAB	Prescription Drug Affordability Board
USDA	United States Department of Agriculture